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Cognitive Behaviour Therapy: How is it Different with Older People?

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Abstract This paper discusses the treatment of depression in older adults (over age 65) using cognitive therapy techniques first developed by Beck and colleagues. The focus of this paper concerns whether modifications of CBT are required in order to ensure maximal efficacy and discusses what modifications may be suitable by advocating conceptual and theoretical reasons for their adoption. Some important contextual factors may need to be taken account of when working with older people such as dealing with expectancies about lifespan, the likelihood of chronic physical illness and longevity and chronicity of the personal history of problems. It is our contention that much more has been written about outcome in CBT with older people than has been written about psychotherapy process issues. This paper aims to address this perceived gap in the literature.

Keywords Cognitive behaviour therapy · Late life depression · Psychotherapy process issues · Successful ageing · Gerontology and geropsychology

Introduction

The world is experiencing a profound and irreversible demographic shift impacting upon the structure of societies (UN 2007) with psychotherapists much more likely to come into contact with older people (Laidlaw and Baikie 2007). Yet therapists may be ill-prepared to meet the needs of a ‘greying society’ as a recent survey of Clinical Psychologists in the US found. Qualls et al. (2002) asked practitioners about how much training they had in working with older people. Although a majority provided

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psychotherapy to older people only a minority had completed supervised practice in working with this population.

It may be that standard models of psychological treatment for depression and anxiety are adequate in terms of techniques and interventions for individuals of any age, especially as the empirical evidence base for a range of treatments for late life disorders is developing strongly (Gatz 2007). However as Knight (2004) notes, therapists unused to working with older people often believe they are unlikely to benefit from psychotherapy. Thus it may be that therapists faced with a growing client base of people in their eighth, ninth and tenth decades may experience uncertainty about the adequacy of standard models of care such as cognitive behavioural therapy (CBT). Understandably, therapists unused to working with older clients may be tempted to ask, how is psychotherapy generally, and CBT in particular, different when people have a much longer life experience?

CBT is a relevant form of psychotherapy for treatment of psychopathology in later life and is seen as an acceptable treatment for depression by older people (Landreville et al. 2001). While recent reviews and meta-analyses have concluded that CBT is an efficacious treatment for late life depression (Cuijpers et al. 2006; Frazer et al. 2005; Piquart and Sorensen 2001; Piquart et al. 2006; Scogin et al. 2005), there remains a persistent question regarding the issue of adaptation and modification for CBT with older people (Engels and Verney 1997; Koder et al. 1996; Laidlaw et al. 2004). Outcome studies by their nature are unlikely to answer questions about important process issues and it is this aspect of CBT for late life depression that may become the important future direction of research activity (Scogin et al. 2005).

Is CBT with Older People Sufficiently Different that Modifications are Necessary?

Psychotherapy outcome studies with older people have predominantly borrowed models of treatment from adult settings whilst largely ignoring gerontological theories of ageing that may be relevant in the application of practice with this population (Knight 2004; Satre et al. 2006). While the efficacy data suggests that older people benefit from psychotherapy it is interesting to speculate whether efficacy could be enhanced if modifications had been used in treatment protocols.

In many cases the complexity of problems that older people bring to therapy can be daunting and overwhelming to therapists unused to working with older clients. Paradoxically, as there is also great variability in the experience of ageing and much heterogeneity within this population (Zeiss and Steffen 1996), adaptations and modifications of therapeutic procedures may not always be necessary. While in many instances, CBT may be no different in terms of interventions and outcome when working with older versus younger clients (Laidlaw et al. 2003), the main difference for therapists is likely to resolve around the context of an individual's experience of the ageing process.

In many respects older people come into therapy for the same reasons that younger people do such as relationship problems and difficult life transitions

(Knight 2004). CBT with older people has as its primary aim symptom reduction (Laidlaw et al. 2003) therefore any incorporation of modifications to an already efficacious package of treatment ought to consider whether these are likely to *further* enhance outcome and should be made on the basis of need not age (Charlesworth and Greenfield 2004). Incorporating relevant information from the science of gerontology may enhance the development of a therapeutic alliance and promote a better level of empathy and understanding between younger therapist and older client which in itself may be associated with better treatment outcome (Martin et al. 2000). However, the case to either dispense with or modify effective and proven interventions is neither established nor recommended. CBT interventions can be very effective precisely because they emphasise a problem solving orientation towards skills acquisition that empower individuals to adaptively cope with challenges experienced as a result of ageing (Morris and Morris 1991). Caring for a relative with dementia exemplifies a situation where CBT emphasises this to good effect (Gallagher-Thompson and Steffen 1994; Gallagher-Thompson and Coon 2007).

Most suggestions about modifications or adaptations to CBT with older people have tended to endorse procedural modifications to take account of age-related changes. Usual recommendations suggest slowing sessions down, encouraging repetition of information, and ensuring that interviews take place in a quiet, well-ventilated, well-light room (Grant and Casey 1995; Zeiss and Steffen 1996). While it is not argued here that these modifications are wrong, or even unnecessary, nonetheless conceptual modifications have been neglected. Conceptual modifications provide a theoretical or psychological basis to consider possible modifications in order to enhance outcome for CBT with older people. Adopting this approach the basic interventions and procedures of CBT are retained whilst adopting a more sophisticated age-related contextual understanding.

How is CBT with Older People Different?

CBT is a time-limited therapy that is pragmatic and focussed on achieving a resolution of an individual's problems by emphasising goal-oriented activity. The issues raised here highlight a difference in emphasis when trying to reach an enhanced empathic position of understanding and may be especially relevant when there is a large age gap between the therapist and client, or where stereotypical beliefs may stand in the way of therapy taking place (see Charlesworth and Greenfield 2004). In total, six conceptual issues shape therapy with older people and illustrate the different and potentially challenging nature of working with this client group. The following are discussed: (i) incorporation of a comprehensive conceptualisation framework; (ii) understanding the different time-frame older people operate within; (iii) achieving goal focussed optimized coping with loss experiences; (iv) focussing on maintenance rather than cause in treatment; (v) understanding differences between generations (cohort); and (vi) the assessment of suitability. Each will be discussed in turn.

Developing a Comprehensive Conceptualisation Framework for Psychotherapy

The first major difference in therapy with older versus younger people is in developing a coherent conceptualization framework consistent with standard stress-diathesis models that take account of the individual's stage of the lifespan. Laidlaw et al. (2004) developed a comprehensive conceptualisation framework (CCF) for the application of CBT with older people that incorporates the standard CBT conceptualisation at its core but also takes account of other factors that may be relevant given the lifespan stage of the individual. As conceptualizations within CBT simultaneously affords the therapist with understandings about the idiosyncratic nature of a client's problems and predictions about the potential pitfalls that may lie ahead, for therapy with older people to be optimally effective, it is recommended that consideration is given to cohort beliefs, role transitions, intergenerational linkages, sociocultural context and health status. Each element of the CCF serves to enhance the understanding of the nature, intensity and complexity of the problems faced by the client.

The utility of the CCF is that it permits the therapist to incorporate aspects of the individual's life experience that would otherwise find no place within a standard CBT conceptualisation. Clearly when working with older people there may be important experiences such as dealing with losses that can be understood adequately within the cognitive model but enhanced by considering the role of cohort beliefs, the impact that losses may have on lifelong emotional investments and consequences for health status and (intergenerational) links within the family. The CCF guides the therapist to seek broader understandings in order to bridge the age gap between therapist and client and to lessen the importance of this.

Understanding the Different Time-Frame Older People Operate Within

Socioemotional selectivity theory (SST) suggests that the emotional life of older people can be better understood by considering the time-horizons shaping their experience (Carstensen et al. 1999; Carstensen and Mikels 2005). When time is considered to be open-ended, people develop more expansive motivations and goals and consequently they are more invested in acquiring knowledge and exploring novel social contacts (Carstensen and Lockenhoff 2003). As people age, however, they are motivated by the perceived finite boundary on their time to invest in more emotionally meaningful goals and as one ages values change towards emotional balance and the achievement of intimacy with a few valued others (Carstensen et al. 1999). In addition, older people are more likely to focus on positive emotions rather than negative emotions. Carstensen and Mikels (2005) note that "Older people appear to attend to, hold in mind, and remember emotionally positive information more than they do negative and neutral information" (p. 20). This is termed the positivity hypothesis and may have implications for therapists attempting to encourage older people to engage in cognitive restructuring where focus naturally emphasises discussion of negative emotions. As older people are much more focussed upon the 'here and now' (Carstensen et al. 1999, p. 168) and on emotion regulation, this would suggest that older people may arguably make the best candidates for CBT.

The experience of emotion in later life is therefore more complex than is often thought and SST has some interesting implications for therapists working with older people. A potentially positive implication is that as older people prioritize emotional regulation then they will be more likely to value the opportunities afforded by therapy and hence therapy will be more effective. Indeed, older people may especially value the strong affective and intimate bond that can develop in therapy. However, as older people value intimate emotionally balanced interactions with others this may suggest that termination from therapy may become problematic for older people. It may be that the older client is not simply 'dependent', but with a perception of a limited time frame they may feel more vulnerable and hence may not be motivated to work towards the termination of therapy. It is recommended that from the start of therapy onwards the therapist and client have an explicit understanding that therapy is likely to be short-term. Thus one should set clear, measurable and specific goals to be worked on in therapy. This may be particularly important when working with older people who have suffered the pain and loss of bereavement. Thus when considering issues of termination of therapy the therapist may wish to enquire whom the client feels able to maintain emotional investments with in their immediate social network. There may also be a rationale provided by the SST for increasing the social skills of older people in achieving and maintaining intimate nurturing relationships.

A further reason to take SST into account when using CBT with older people is that a perceived time limited horizon when one is depressed may focus people on their own mortality with the result that a heightened sense of hopelessness about the future may become manifest. Depressed older people may be more inclined to endorse a negative stereotype view of ageing. It may appear that change is less possible as there are too few 'good' years of life left. This could potentially have a negative impact on motivation for the client *and* the therapist if treated as a fact rather than as a negative automatic thought. Therefore it is recommended that therapists work with their clients to educate them about changes in life expectancy. Therapists knowledgeable about longevity statistics and demographic change will find it easier to differentiate symptoms of depression from apparently realistic (but erroneous) appraisals of lifespan. This can appear difficult to challenge from the naïve perspective of a younger therapist. However, as life expectancy data shows, older people have many years of life left as they reach their later stages of life. On average, older people in Europe will live 20 years more after reaching the age of 60 (Laidlaw and Baikie 2007). Thus one would wish to ask the client how they would like to spend the next 20 years or more. For older people who are not depressed the 'paradox of ageing' is often evident, that is high levels of life satisfaction at the stage of life associated with cognitive and physical decline (Carstensen and Lockenhoff 2003). Thus when an older client states "I'm depressed because I am old" or 'I'm too old to change my ways now' this is evidence of a cognitive processing error and is therefore a result of depression not age. Thus therapists may wish to embark upon an explorative dialogue about change and the possibility of gaining from it. This sort of dialogue works best when the therapist themselves endorse a lifespan developmental model that maintains the possibility for individuals to shape their development at any stage of life.

Goal Focussed Optimized Coping with Loss Experiences

Physical health comorbidity can be a very common complicating factor when working with older adults with depression (Krishnan et al. 2002). Indeed experiencing loss and change is a universal experience in the lifespan (Boerner and Jopp 2007) and health may be a common theme when working with older people (Zeiss and Steffen 1996). Many novice therapists less experienced in dealing with depression comorbid with chronic illness may find the application of cognitive elements of CBT particularly challenging when addressing hopelessness expressed by older people with physical illness (Laidlaw et al. 2003). At these times it may be more productive to arrange behavioural experiments to test out what older people can achieve.

In dealing with depression comorbid with a physical illness it is important that the therapist takes a careful history and seeks to understand the difference between the severity of a condition (impact) and, the patient's perception of its impact. The subjective appraisal of the impact of a disease condition may not match the severity level and excess disability may become evident. Excess disability is experienced when a person holds themselves back because of a disease and yet the disease is not primarily responsible for the person's inability to do something. Psychoeducation and behavioural experiments can be usefully employed to ascertain what an individual can achieve. It is also very useful when working with individuals with comorbid affective and physical illnesses, to remain in contact with members of multidisciplinary teams who may be attending to the care of the individual's physical health and who can provide useful backup and support when encouraging an individual to make changes to their lifestyle.

When older people are diagnosed with a chronic condition that can have a limiting effect on functioning this can often affect an individual's level of confidence and as a consequence they can become much more passive and isolated. For many older people, diagnosis with a chronic medical condition is equated with disability, even when this is not necessarily the case. It is important to remember that when older people 'experience' disability they do so within a historical context. In many instances older people will have memories of family members being disabled with conditions. This can result in the false expectation that their experience will be similar. Medical approaches to management and rehabilitation have changed over many years and it is often important for the therapist to gauge the meaning of diagnosis with an illness at the individual personal level. In addition, the opinions and stereotypical views of those around the older person may also need to be challenged. As a perception of increased frailty may result in others being reticent about allowing their relative opportunities to try things out, instead trying to protect them above all costs. This may lead to barriers and restrictions being put in place, which can serve to reduce an individual's confidence in their own personal agency and ability to continue to shape their development within limitations and constraints.

However, the use of a model of successful ageing developed by Baltes and colleagues (Baltes 1991; Baltes and Smith 2002; Freund and Baltes 1998; Freund 2006) provides therapists with a framework for helping patients maximise

functioning while at the same time minimising the impact of loss experiences (Boerner and Jopp 2007).

Conceived as a broader theory of lifespan development and as a meta-theory (Boerner and Jopp 2007) the model has three main components, *selection, optimization and compensation* (SOC). If a patient experiences a change in circumstance due to illness then using selection, goals can still be maintained but patients may need to select alternative means of achieving these goals (from a range of possible options) through optimization and compensation. SOC complements the problem-solving orientation of CBT as it is explicitly focused on helping a person actively manage to reduce potential limitations imposed by age-related changes in functioning. Selection often means a reduction in the behavioural repertoire of an individual in order to maximise functioning. In some instances selection can mean giving up on old goals and investments in light of developmental losses (Boerner and Jopp 2007). Optimization is where an individual strives for optimal levels of functioning by focussing resources to achieving this. In effect, it means the individual rehearsing or relearning a reduced repertoire of activities. Compensation is where an individual confronted with a loss, takes account of limitations and engages in a realistic alternative means of achieving the highest possible level of functioning in light of limitations (Freund and Baltes 1998). SOC appears to become used more by people as they age and even when resources are limited (Jopp and Smith 2006; Boerner and Jopp 2007); Laidlaw et al. (2003) provide examples of the use of SOC for helping people deal with chronic physical disability.

Addressing Maintenance Rather than Cause in Treatment

Longevity of problems can be a pitfall for many novice therapists working with older people. Often in an attempt to fully conceptualise a patient's problems, a lot of sessions may be devoted to the historical background to the patient's problems. It is not uncommon for older people to present with histories of depression and anxiety problems stretching back 60 years or more into early adulthood, or even in childhood in some cases. When therapists spend a lot of time on past issues, they may identify causal factors that appear to provide a background explanation to a lifetime of difficulties. While this may be satisfying it may be irrelevant to the current problems older people are experiencing. It is not uncommon for therapy at this point to lose focus and for the therapist and patient to lose confidence in achieving a resolution of current problems if they are not present-oriented and problem focussed. *It is much better when dealing with problems of longevity to focus instead on maintenance factors.* Laidlaw (2006) suggests that if a patient has a well-processed problem of long duration there is less therapeutic necessity and therapeutic gain to be made focussing large amounts of session time on historical issues. It will be more helpful to target factors that maintain an individual's low mood when they are depressed. For example, if a patient experiences a deterioration in their mood and wishes to ruminate about past losses and slights this is unlikely to be helpful, even if it is framed as a wish to resolve past issues. It may be more beneficial to focus on the consequences of depression such as increasing isolation, refusal to meet friends and staying in bed for much longer

periods of the day. In this instance it may be helpful for the therapist to work with the patient to look at instituting a behavioural programme of change when depression occurs. In this way the short-term symptom focussed nature of CBT interventions can be maintained.

Understanding Differences Between Generations (Cohort)

Older people may be accustomed to adopting a passive recipient role in any dealings with health professionals and this can be potentially challenging to the therapist who seeks to practice collaborative empiricism. It may mean that older people will need to be socialized into the ways of CBT (Zeiss and Steffen 1996).

Older people are part of a resilient generation and appear to be able to implement psychological adjustments that help them cope with the experience of ageing (Laidlaw et al. 2006). Having a framework of a historical context and remaining aware of the differences between cohorts is particularly useful when establishing a therapeutic relationship, particularly when the therapist and client may be two or three generations apart. Many societal changes have occurred over the last 100 years and it is helpful to consider the impact that this has had upon the beliefs and values of people living in such different times. For example, women's role in society has changed significantly throughout the 20th century. Many older female clients have been married for 50 or 60 years which, to a younger generation may seem almost incomprehensible, but for these women results in a particular role transition upon the death or ill health of one's partner. That is not to say that women of this era cannot learn to adjust to life without their husband but it is important to acknowledge the extent to which that partner has been an integral part of their existence.

On a very basic level, there is potentially the difficulty of having to rely on one's own judgement for all activities rather than being able to share the responsibility with an equal partner and a contributing problem may be dealing with the assumptions made by those around them. For example, family being reticent about these women being able to cope with activities on their own or husbands who, although due to ill health are unable to do activities themselves, continue to criticise the attempts of their wives. Understandably, these difficult interactions with those around them may leave women feeling confused and insecure. Therefore problem solving exercises can be an important part of intervention work, highlighting skills and building confidence.

This may be of particular relevance if individuals are dissatisfied with the care and support provided by family members. It is accepted that women tend to take on a carer role for elderly or infirm relatives (Pinquart and Sorensen 2006). Some elders (particularly women) who do not have daughters but instead have sons, comment on their dissatisfaction with the attention and understanding they receive. It may be that if they have cared for sick relatives in the past, they are judging others by their own standards, and it may be impossible for anyone to live up to those standards. However, it is important to consider whether as a society, compared with previous generations, we place much less emphasis on caring for our elders and more on the attainment of our own personal goals. Therefore, perhaps building

social networks is also important to prevent isolation and promote integration into society.

Similarly, work with men of the older born cohorts may require an understanding of the events that have influenced their lives and the ways in which society's perception of the role of men as fathers, husbands, providers and protectors has changed. It may be difficult for men of this generation to discuss innermost worries and fears with even their closest friends and relatives. Therefore, it may take a great deal of persistence and perseverance to encourage an individual to take seriously the potential benefit of discussing personal matters especially when there is the possibility that doing so may result in emotions such as crying. This may be especially difficult to do for some as they will be experiencing a vulnerable state when there may be long-standing unhelpful beliefs about appearing weak in front of others. Calmly and in a reassuring manner it can be helpful to engage the client in a discussion of the experience of displaying emotions and in the potential gains to be made when taking a courageous step of discussing and confronting often long held beliefs. It can also be helpful for the therapist and client to agree on some safety signals within sessions so that the client can be reassured that they retain some degree of autonomy and control. Overholser and Silverman (1998) states that it is important for therapists to have unspoken assumptions that convey the belief that no problem is insurmountable and unsolvable and while it is unrealistic that the therapist will have all the answers, collaborative work between client and therapist will at the very least leave the individual feeling understood and accepted.

Assessment of Suitability

The question of suitability of CBT for older people and vice versa is often asked, especially in light of the need to apply evidence-based treatments in clinical practice. This is a difficult and complex question to answer. The issue of suitability is an important one as Safran and Segal (1996) note there are always going to be some patients for whom a short-term intervention is unproductive but this may not become apparent until treatment has commenced and by then termination is not possible until therapy protocols have been completed. This can be especially relevant when working with older people. Unlike when questions are asked about suitability of adults for CBT where the question is about whether brief treatment may be possible, the question of suitability for CBT with older people is about whether to offer it at all.

Most studies that look at suitability criteria have tended to come from the psychoanalytic tradition, have achieved modest correlations with outcome and by and large have neglected to examine these factors in psychotherapy with older adults (for review see Valbak 2004). Therapists are encouraged to assess the individual and their circumstances rather than their age when considering CBT interventions with older people.

The development of suitability criteria has been the subject of much less consideration in the CBT literature. Safran and Segal (1996) have developed a set of guidelines that predict which patients will be suitable for CBT. The Suitability for Short-Term Cognitive Therapy Rating Scale (SSCTS: Safran and Segal 1996) is a

therapist-rated short questionnaire providing a measure of suitability for CBT. The scale measures patients' suitability in terms of their ability to access thoughts, awareness and differentiation of emotions, acceptance of personal responsibility for change, compatibility with cognitive rationale, alliance potential, chronicity of problems, use of security and safety-seeking operations, and the ability to maintain a problem focus in therapy.

Although the SSCTS is very interesting and has been thoughtfully developed, taking account of process factors that influence outcome, if applied with older people it may inadvertently present a barrier to CBT being offered for a number of reasons. For instance, when considering chronicity of problems, older people may have a life-long history of depression but no history of receiving psychotherapy, and on the face of it older people would be considered to be poor candidates for brief CBT, however differentiating between cause and maintenance factors as suggested above may allow short-term goals to be set that can be focused upon for treatment of the current acute episode. Another issue in terms of suitability of older people for CBT is awareness and differentiation of emotions as generally the level of psychological mindedness of older people can be quite low (Steuer and Hammen 1983). It would however be an appropriate aim of psychoeducation in the early stages of therapy to increase the psychological sophistication of the client. Similarly, older people often engage in story-telling and may be inclined to talk tangentially when discussing problems or issues in therapy, this could be confused with defensiveness if the therapist is not used to talking with older people. Security and safety seeking operations in therapy are "tangential or circumlocutory talking that makes it difficult to deal with any one subject in depth" (Safran and Segal (1996) p. 255). However, This should not be considered to be security operations because older people are used to talking to younger members of family and with fellow senior citizens but are not necessarily used to talking with such focus as is required in therapy and may need help keeping focused on discussions. When assisted, with empathy and warmth on the part of an active therapist, older people can reflect on problems with great focus and awareness (Zeiss and Steffen 1996). Used rigidly, all older people would be considered very poor candidates for CBT when applying the SSCTS, however it was not developed for use with older people therefore therapists are encouraged to resist interpretation and instead to focus on a phenomenological exploration of the patient's world (Safran and Segal 1996).

The question of suitability should be asked for positive rather than negative reasons, and rather than assessing whether older people are suitable for CBT, the question is how can CBT be made suitable for the particular needs of the patient. In other words how can older people *benefit* from therapy rather than will they fit the therapist's ideal criteria for therapy. Therapists may wish to adopt a collaboratively empirical stance with their client about treatment outcome at the start of therapy. To explicitly state that one does not know whether CBT will work or will be suitable for the client is to acknowledge that a journey of discovery has begun. CBT is at its best is when it is empirical and seeks to understand the meanings of an individual's problems. Suitability is thus an important question that ought to be in the mind of the therapist and examined again as therapy is being reviewed as treatment progresses. Only by testing it out can one truly answer this question, as there is no

clear or accurate clinical algorithm that can be applied. When in doubt it is probably better to offer older people therapy and assess the outcomes frequently rather than applying a negative filter at the pre-intervention stage.

Summary

Many therapists have asked whether CBT with older people requires conceptual, procedural or technological (in the form of interventions) adaptations in order to render it applicable for use with older people. This is understandable given that CBT as a model of treatment was not developed specifically for use with older people. Because of lifespan developmental experiences of loss and change, CBT may be challenging to apply with older people. This can result in a general sense that CBT may not achieve a good outcome with older people unless some steps are taken to adapt it. This is a misconception as shown by the fact that randomized controlled trials of standard CBT record good outcome for a range of problems experienced by older people (Gatz 2007). The collaborative stance of CBT is particularly helpful when working with older people as it encourages respect for the life-years experience of the individual (Zeiss and Steffen 1996). CBT is a form of therapy that is arguably the most applicable to meet the needs of older people particularly as it is problem-focussed, skills-enhancing and deals with the here-and-now of situations (Laidlaw et al. 2003).

As people are living longer, and living healthier, it is likely that therapists will increasingly need to take account of lifespan developmental issues when working with clients. The increased longevity to be enjoyed by many of us will also bring more people into therapy with a broader range of transitional problems as a result of ageing and longevity (Laidlaw and Baikie 2007). While it was once thought that older people would not wish therapy, this myth is being debunked by work by Landreville et al. (2001) that shows older people rate therapy as more relevant than antidepressants in the treatment of depression. Particularly useful for therapists working with older people will be the recognition that continued development and growth and change are normative across the entire lifespan (Boerner and Jopp 2007). Encouraging people to see that ageing is just another stage of life with associated stresses and transition points can be a profitable focus for psychotherapy. This is an exciting time to be engaging in therapy with older people.

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