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Age Augmented CBT to Enhance Outcome for Late Life Depression and Anxiety.

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Running Head: AGE-APPROPRIATE AUGMENTED CBT

Age Appropriate Augmented CBT to Enhance Treatment Outcome for Late Life Depression and Anxiety Disorders

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Abstract

We present an explanation of the benefits of using gerontological theory to augment treatment outcome in CBT. Traditional formulations/conceptualisations of CBT may not always be the most optimal fit when working with older people who may be experiencing different developmental life stages compared to adults of working age. In addressing the issue of how CBT may be different with older people, it is proposed that augmenting CBT outcome is made possible through the application of gerontological theory as 'vehicles for change'. This 'evidence-based' scientist approach is consistent with standard practice in CBT. This paper outlines some examples of how gerontological theory can be useful in bringing about an enhanced treatment outcome.

Keywords: CBT; older people; attitudes to ageing; selective optimization with compensation; wisdom enhancement

Cognitive behaviour therapy (CBT) has established itself as an efficacious and appropriate psychological treatment for use with older people with depression and anxiety disorders (Gould, Coulson, & Howard, 2012a, 2012b; Scogin & Shah, 2012) and is a mainstream treatment approach for the alleviation of psychological distress in later life. It is particularly appropriate as an intervention for older adults because it is skills enhancing, present-oriented, problem-focused, straightforward to use and effective. CBT with older people has two key foci: to help a client bring about symptom relief and to increase levels of positive affect (Laidlaw, 2015).

An important debate about CBT with older people is whether therapists need to modify or adapt techniques in order to use cognitive *and* behavioural techniques to bring about symptom relief. As recent reviews (Scogin & Shah, 2012) have demonstrated, standard non age-modified CBT protocols are efficacious. Furthermore, no major differences in psychological treatment outcome are evident when comparing evidence from research examining treatment outcome for psychological therapy and CBT between older people and adults of working age (Cuijpers, van Straten, Smit, & Andersson, 2009; Karlin et al. 2015).

However, it is important to note that efficacy of CBT for later life depression *and* anxiety disorders is currently predicated on data from young-older people and there remains little evidence on how this treatment approach works with much older generations. For example, two recent meta-analyses of CBT with older people reported a mean age of 68.4 years in depression trials, and 68.2 years in anxiety disorder trials (Gould et al. 2012a, 2012b). There remains to be a definitive trial of CBT conducted with the clients in their 8th and 9th decades.

With the increase in longevity evidenced across Europe, this has become an increasingly important point. The ‘new cohort’ of older people, the oldest-old, are likely to have more complex family and intergenerational structures, and may be more likely to have

multiple comorbidities due to increased longevity (Laidlaw, 2015). As clients age, the standard models of CBT may become less optimal with an age-appropriate CBT adopting a more relevant lifespan context increasingly necessary.

CBT works well with Older People

A fundamental and common misunderstanding of the applicability and efficacy of CBT with older people, however, is that it is less effective when people are facing 'realistic' or 'understandable' challenges. This is not the case, as it is somewhat naïve to assume that challenging circumstances are undifferentiated in their impact on individuals. In many cases, it is the personal meaning of events that determines its impact (Gotlib & Joorman, 2010). As Epictetus wrote, "Men are disturbed not by things, but by the views which they take of them". As ageing can be accompanied by specific challenges such as the loss of a spouse, reduced independence and even cognitive impairment. CBT is a pragmatic treatment approach when there is no readily apparent solution (e.g. socio-emotional, financial or physical problems).

For example, Mr Robert was exceptionally anxious about a 'substantial' bill he received out of the blue to pay for repairs to communal areas of his apartment building. For Mr Robert, his ability to manage this unexpected circumstance was magnified out of proportion by his appraisal of threat and appraisal of lack of resources (psychological as well as financial) to meet demands. CBT was helpful in encouraging Mr Robert to use cognitive restructuring to challenge his tendency to catastrophize about likely outcomes (destitution, leaving a legacy of debt for his children). Mr Robert was also encouraged to deal with concerns directly and to minimise avoidance in dealing with potentially stressful circumstances. While the nature (and size) of the financial demand was objectively stressful ('realistic') and did not diminish, CBT was effective in helping Mr Robert maintain a problem-solving orientation.

When dealing with ‘realistic challenges’, the sense of threat may be magnified by depression and anxiety disorder symptoms (Joorman, Teachman, & Gotlib, 2009). Individuals living with a longstanding and limiting physical condition may therefore experience excess disability as a consequence of failure to regulate emotional states (Gotlib & Joorman, 2010). Treating depression and anxiety is likely to help individuals manage to live with challenging situations more effectively. For example, CBT has been shown to be efficacious for depression in Parkinson’s disease (Dobkin et al. 2011), and for anxiety disorders in dementia (Spector et al. 2013).

In recognition that in some circumstances, CBT can be challenging to apply with older people (see Rybarczyk et al.1992) because of comorbidity and chronicity, some authors have started to address procedural adaptations to CBT. However, those procedural modifications to CBT by therapists often lack an explicit theoretical justification or apparent evidence for improved outcome (Karlin, 2011; Laidlaw & McAlpine, 2008). If therapists wish to meet the needs of their older clients, it is important that they educate themselves and invest in the development of their competencies in geropsychology practice (Karel, Gatz, & Smyer, 2012).

The case for an augmented age-appropriate approach to CBT with Older People

The aim of this review is to introduce a framework for an age appropriate evidence-based approach to CBT with older People. The approach advocated here is that gerontological theory be used to augment CBT with older people. The reason being that some theories from gerontology can ‘challenge’ therapists’ expectations about ageing and hence influence expectations for treatment outcomes (e.g., socio-emotional selectivity theory, stereotype embodiment theory), while others may be useful in developing new interventions within CBT (e.g. selective, optimisation with compensation, and wisdom theory).

As CBT is already an efficacious therapy, changes to evidence-based treatment protocols must bring about increased and sustainable gains over and above that which is currently achievable (Laidlaw, 2013). Augmentation, as opposed to adaptations or modifications as a term is chosen carefully in order to emphasise that a conceptually distinct and life-span developmentally appropriate format for CBT with older people must enhance treatment outcome (Laidlaw, 2015).

Sadavoy (2009) emphasised the need to consider how work with older people may require age-appropriate perspectives to be adopted. "While the models used for general adults are often useful for [use with] elders they are also incomplete in defining the complexities that are especially relevant to clinical interventions for the elderly" (Sadavoy, 2009, p8-10). This is an element that has been somewhat de-emphasised in CBT work with older people.

Age-appropriate CBT may be especially important with specific client populations where traditional non-modified CBT has not established efficacious outcomes, such as for some physical comorbidities or where problems are considered chronic or treatment resistant (Laidlaw, 2015). For example, CBT for post-stroke depression has reported very disappointing results (Lincoln & Flannaghan, 2003; Lincoln, Flannaghan, Sutcliffe, & Rother, 1997). The characteristics of CBT suggest it ought to be a good fit for the needs of people who develop depression post-stroke. CBT ought to be efficacious with this population given the focus on practical problem-solving techniques, emotion regulation strategies and activity scheduling in order to promote better self-efficacy and wellbeing. The best that can be said is that CBT should work rather than does work for post-stroke depression. Perhaps an answer to this conundrum can be found in the fact that non-modified CBT was applied. With stroke there are many nuances that therapists may need to take account of and as such an augmented approach to CBT (see Broomfield et al. 2011) may have a better chance of

success as it is more coherently linked to the nature of the challenges facing an individual with depression post-stroke. When Dobkin et al. (2011) demonstrated CBT to be efficacious for depression in Parkinson's disease they individually tailored treatment to meet the needs of this population.

An age-appropriate approach to CBT is also consistent with a recognition that a new cohort of older people are emerging that are unlike previous generations. These 'new' older people may challenge notions of what people expect in terms of psychological wellbeing and provision of care. "Baby boomers redefined each stage of life as they experienced it…They are about to change what we know about old age" (Pruchno, 2012, p149).

From this point onwards the paper will illustrate the usefulness of each theory when applied with clients using CBT as the primary mode of treatment. A modern approach to CBT will be based around case conceptualization and therefore a brief description of an age-appropriate and comprehensive conceptualisation framework (CCF: Laidlaw, Thompson, & Gallagher-Thompson, 2004) is described first. The CCF is itself influenced by gerontology and related concepts. In the following section, we will outline the 'candidate' theories from gerontological research considered to possess utility as vehicles for change in CBT. We will describe how each gerontological theory can be useful in bringing about an enhanced treatment outcome.

In brief an age-appropriate augmented approach to CBT with older people is characterised as follows:

1. An age appropriate contextual formulation is used to understand the client as they experience depression and anxiety within a developmentally appropriate lifespan context.

2. There is an appreciation that ageism may be a factor within the client and the therapist and these may be barriers to change.

3. Interventions within CBT are focused on helping clients to meet age-related challenges by adopting a more contemporary understanding of normal ageing.

4. A perspective is adopted that values life skills older people have gained across their lifetime in meeting challenges faced in maintaining emotional homeostasis.

5. An appreciation of these skills can be used to help clients manage current challenges by data-mining experiences from the past to promote enhanced compassionate self-acceptance and resilience in the 'here and now'.

Age-appropriate conceptualisations

Laidlaw et al. (2004) introduced a comprehensive contextualisation framework (CCF) for therapists applying CBT with older people. This framework was initially developed as a guide to alert therapists inexperienced in the use of CBT with older people to consider age-contextual factors when developing a conceptualisation. Figure 1 contains a schematic for the CCF.

Laidlaw et al. (2014) writes the following:

> The above conceptual model [CCF], although comprehensive, is clear and readily accounts for the complex nature of older people's experiences. This is thought to be an important feature as often CBT therapists unfamiliar to working with older people are vulnerable to feeling deskilled when working in the midst of such complexities (p9).

The CCF introduced the use of cohort factors in order to strengthen the therapeutic alliance when working with older people. Cohort is defined in the Oxford English Dictionary (extracted from the internet at http//:www.oxforddictionaries.com) as a group of people with a shared characteristic. Clearly when therapists work with older people, shared characteristics of older born cohorts can be generational beliefs that may not be endorsed or even understood by therapists born in a different time. For many younger therapists understanding cohort

beliefs when working with older clients is akin to gaining a cultural awareness when working with an ethnic group different to one's own. The past can feel a very different country to different generational cohorts.

Therapists may wish to consider whether differences in cohort beliefs can be also understood in terms of cohort beliefs within families. That is, it is proposed that familial shared characteristics and beliefs are as important as generational beliefs when seeking to understand a client's belief system. For example, there could be an important interaction between generational beliefs endorsed by a cohort born at similar times e.g. 'stand on your own two feet' (meaning it is wrong to ask for help), and cohort familial beliefs transmitted as family rules, e.g. 'One must never wash one's dirty linen in public' (meaning, one needs to be circumspect about discussing emotional difficulties).

Using Gerontology to augment CBT outcome with older people

In this paper three main 'candidate' theories from gerontology are reviewed for their utility in augmenting treatment outcome for CBT for late life depression and anxiety disorders. The theories are not simply 'bolted' on to CBT but are contextually embedded. Thus, Stereotype Embodiment Theory (Levy, 2009) is considered as a cognitive behavioural stress-diathesis akin to negative core beliefs; Selective, optimisation with compensation (Freund, 2008) is seen as being especially useful when working with depressed or anxious clients who are faced with challenges associated with age that may present functional limitations; and wisdom is viewed as a means of exploiting the life coping skills many people develop as they age but may lose temporarily when depressed or anxious. Wisdom (Baltes & Smith, 2008) promotes the use of life experience as a resource to draw on to manage current problems and promotes a respectful appreciation of the skills older people possess and that may not yet have been acquired by therapists.

More generally, however, gerontological theories may be useful to CBT therapists in a

number of respects. Knowledge of research on normal aspects of ageing can act as a counterbalance to working with older people who are not ageing normally. It could be the case that therapists who work with older people with emotional distress may become convinced that depression, anxiety and dementia are common consequences of ageing and this may have a consequence for the expectation of how much change is expected possible for older clients (Bryant & Koder, 2015). Evidence from gerontological research can act to debunk these myths and challenge previously held negative stereotypes of older people that may discourage therapists from wanting to work with older people (Koder & Helmes, 2008).

Therefore, gerontological research offers a very different and helpful perspective that may encourage therapists to be more likely to press for behavioural change in therapy. For example, Socio-emotional selectivity theory (Carstensen, Isaacowitz, & Charles, 1999) suggests useful lessons for therapists to reflect on as they apply CBT with older people. Socio-emotional selectivity theory (SST) suggests that as people age it occurs to them they have lived more years than are left remaining to them (apprehension of finite time-horizons) resulting in a change in values and goals. Consequently older people selectively focus on present goals and on maintaining emotional balance, or as Isaacowitz (2005) puts it, on 'feeling good' (p. 117). Thus as older people become more preferentially focused on achieving better emotion regulation, they value contact with a closer members of their social network. As such older people may make the *best* candidates for psychological therapy contrary to previous myths that older people are too rigid and set in their ways to benefit from psychotherapy. Therapists well –versed in contemporary gerontological theory are therefore better equipped to challenge their older clients to make the most of the opportunities afforded by the therapeutic relationship.

SST can be quite challenging for the stereotype expected for ageing and this makes it a useful theory to bring to the attention of neophyte older adult psychotherapists. Appraising

oneself of SST can be useful for therapists as some of the evidence for this theory may help therapist to adopt a more positive mindset when working with older clients. Thus for therapists used to working with depressed and anxious clients it can be challenging to understand that non-distressed older adults report better emotional stability as well as being more competent in emotional regulation compared to adults of working age (Carstensen et al. 2011) and that for non-depressed older people there is a positivity bias in recall of life memories. Older people appear to be skilled at anticipating and therefore avoiding emotionally negative situations (Scheibe & Carstensen, 2010). For younger therapists understanding that the normal experience of ageing promotes an upward emotional trajectory can be liberating and confirms a need to draw on the life experiences of their clients. "There is no doubt that experience plays a central role in improvements in emotion regulation across the life course, and every reason to think that experience is largely beneficial" (Carstensen et al. 2003, p. 108).

Understanding negative attitudes to ageing to augment outcome

There can be a very powerful dynamic at play with regard to stereotypical beliefs about ageing that may be endorsed unwittingly by therapist and client. Understanding negative age stereotypes and attitudes to ageing may be especially important in scenarios where clients primarily locate the origin of their problems as being to do with their age, or their experience of ageing.

Levy (2003, 2009) suggest prolonged exposure to ageist societal attitudes reinforced from childhood through to adulthood result in people developing negative ageing self-stereotypes reinforced by attentional biases towards negative information about ageing. This concept is analogous to the cognitive negativity bias underpinning CBT (Gotlib & Joorman, 2010), where individuals are hypothesised to overlook positive information by selectively and preferentially attending to negative stimuli. "In depression, we find a mood-congruent

bias for encoding negative material that is characterized by a heightened sensitivity for self-referent information involving themes of loss, failure, and deprivation." (Clark, Beck, & Alford, 1999, p. 177). In the case of CBT with older people, cognitive content is age-focussed with self-referent information concerned with losses, perceived as a consequence of ageing. This is rigid and self-reinforcing through the elicitation of data confirming one's fears. Consistent with this hypothesis, Meisner (2012) demonstrates that negative age-stereotypes have stronger effects on behaviour than positive stereotypes. A negative cycle develops as the individual becomes hyper-vigilant to other indicators of negative experiences of ageing, and these reinforce the individual's belief that old age is a depressing, fearful and unpleasant stage of life. Levy (2009) suggests negative self-stereotypes become more salient for the individual as they encounter multiple cues that endorse their view of themselves as 'old' so that an unhelpful self-fulfilling prophesy suggests unpleasant experiences of ageing are the norm. For the therapist inexperienced, or unconfident in working with older people, it can seem disrespectful and unempathic to dispute the perspective offered by their depressed clients with the result that both members of the dyad negatively reinforce expectations for change. This is especially painful for the individual client as they must endure symptoms that are amenable to treatment, but for therapists this experience can be particularly destructive as the next client they meet has to overcome the legacy of low expectations for change. The likelihood of positive outcomes may therefore diminish over time with an outcome that therapists avoid 'doing' CBT with older people.

In short, therapists who lack understanding that the majority of older people do not experience ageing as an especially distressing time of life, are unprepared for working with older people as they are not equipped to cognitively distance themselves from the strength of conviction with which the client attributes their cause of problems to ageing. Therapists unaware of age-stereotypes may erroneously assume that they cannot help their client as

problems are ‘realistic’, negative and unchangeable consequences of ageing (Laidlaw, 2015). In the worst case, therapists naïve in working with older people and uneducated in normal ageing, may inadvertently collude with depressed clients negative erroneous cognitions. Recognising that cognitive distortions can be age-focussed (and self-reinforcing) for clients, even if they are subject to a high degree of conviction on the part of the depressed or anxious client, affords therapists a means of treating these as thoughts rather than facts. At once these thoughts become testable and therefore amenable to challenge in same way that all negative cognitions are.

Therefore, ageing *self*-stereotypes ought to be integrated within CBT for older people. Incorporating negative attitudes to ageing and the internalised negative age stereotype within a CBT frame of reference is to simply acknowledge that a stress-diathesis exists focussed on ageing. This idea is illustrated in Figure 2.

When negative age stereotypes (diatheses) become activated by congruent negative experiences attributed to ageing (stressors), the outcome are negative cognitive-affective cycles leading people to fear ageing and expect ageing to be a depressing time of life focused on loss and decrepitude (Laidlaw, 2015). As is evident in Figure 2, an overt negative cognitive-affective-behavioural cycle develops as the individual becomes hyper-vigilant to other indicators of negative experiences of ageing reinforcing the belief that old age is a depressing, fearful and unpleasant stage of life. It is hypothesised this can prevent an individual seeking help for depression, or when being offered treatment may be declined.

Using selective optimization with compensation (SOC) within CBT

Selective optimization with compensation (SOC) is a meta-theory of optimal ageing comprising of three main components necessary for successful adaptation to challenges faced during aging (Freund, 2008). Selection is used to maintain valued roles and goals in the face

of resource changes, often requiring older people to select alternative strategies to maintain function (Jopp & Smith, 2006).

Optimization requires that an individual focuses resources on achieving goals through practising or relearning of activities. It must be done in an intentional manner. Compensation requires that an individual engage in alternative means of achieving the highest possible level of functioning, therefore taking account of the reality of a person's capacity and physical integrity. Baltes (1997) provides a cogent example of the use of SOC to promote optimal ageing by citing the example of the renowned concert pianist Arthur Rubinstein who continued performing well into his ninth decade. Rubinstein adopted a series of strategies to compensate for the challenges of performing without apparent loss of vitality and vigour. He reduced his repertoire (selection) and was thus able to practise this more frequently (optimization) and, "He suggested that to counteract his loss in mechanical speed, he now used a kind of impression management, such as introducing slower play before fast segments, so as to make the latter appear faster (compensation)." (Baltes, 1997, p. 371).

Most usually when using SOC in CBT helping an individual to dynamically adjust to age-related challenges, adopts 'loss-based selection' (Freund & Baltes, 1998) where the individual modifies goal attainment due to a reduction in resources (Jopp & Smith, 2006). Accepting the reality of a loss by using loss-based selection does not mean clients have to put up with losing something of value, instead it means in therapy they can use the principle of SOC to find a new way to maintain functioning. The real value of SOC is that it is most usefully applied when people are confronting a challenging set of circumstances in which there is not necessarily the option of aiming for cure.

SOC can be incorporated into CBT, as its problem-solving orientation is a good fit with an aim of symptom reduction and can be used within therapy as a set of homework tasks

to help clients maintain valued roles and goals in light of losses that may have developed recently (See Figure 3).

Wisdom Enhancement in CBT

Wisdom is a potentially rich concept for therapists to use when seeking to enhance positive affect in clients in CBT. It is one of the few positive attributes associated with ageing. In most 'folk theories' wisdom will be adjudged to have occurred after personal sacrifice and struggles to overcome adversity (Sternberg, 2012). Within gerontology there are a number of different theories of wisdom (see Staudinger & Gluck, 2011). Wisdom can be seen fundamental to living well and developing an appreciation of the lessons life can teach us. Baltes and Staudinger (2000) state that wisdom can be adjudged on how an individual deals with the recognition and management of uncertainty. Wisdom is useful as a vehicle for change in CBT as it may be used to suggest to clients that they can manage uncertainty and deal with ambiguity of decisions by focusing on past experience as a teacher. A strong premise of wisdom enhancement in CBT is that older people will have developed life coping skills by necessity through dealing with and overcoming adversity and challenge.

There are two ways in which older people can achieve enhanced wisdom in CBT, the first is by using their past experiences to help them cope with their current difficulties by recognising similarities to the process of managing uncertainty. The second is, by reflecting on their past life, they can recognise individual resilience and coping ability.

The ultimate aim of wisdom enhancement is to help clients start a process of compassionate self-acceptance (Laidlaw, 2013). When people are able to accept themselves unconditionally they may be more able to find a way of compassionately relating to oneself when dealing with difficult circumstances. When punitive self-talk in the presence of stressors are more helpfully managed with compassionate self-talk, increased recognition of personal resilience may be a potential outcome.

In using wisdom-enhancement in CBT, it is accepted that most people will have lived a life with 'peak' and 'nadir' experiences. Autobiographical reasoning is the process whereby an individual connects meaning of events and identity over a lifetime. It ensures that people retain a sense of identity shaped by experiences and with a sense of meaning (Pasupathi, in press). How a person has navigated their life experiences, and especially significant events in their lifespan, could be very useful data to draw upon in therapy with older people. Life experiences could be said to have redemptive elements to them that can promote psychological growth. McAdams (2006) states:

> Stripped to its psychological essence, redemption is the deliverance from suffering to an enhanced status, or state. In life stories, redemptive sequences begin with the protagonist's experience of a negative emotional state such as fear, guilt, shame or despair. The negative scene, however, gives way to the experience of happiness, joy, excitement, growth or some other positive emotional state (P88).

Wisdom can be enhanced in CBT by explicitly asking people to reflect on difficult life experiences in a structured way to see if they can identify anything good that may have come out of difficult experiences from the past and what they might use from this new learning to equip themselves better to deal with current difficulties. This may be a particularly useful technique to apply with older people as older people appear to report greater level of resilience in comparison to working age adults (Gooding, Hurst, Johnson, & Tarrier, 2012).

Using life experiences and life-skills in this way retains a 'here and now' orientation to sessions. Learning from past experience (a key component of wisdom), may not be an automatic outcome in the presence of mood disorders as depression impacts on a person's memory (Gotlib & Joorman, 2010). Autobiographical memory in depression is overgeneralised and non-specific. "Biases in memory may also affect emotion regulation in

important ways. For example, memory biases may influence people's perception of a specific situation, change their appraisals, and guide their attention toward specific aspects of that situation." (Gotlib & Joorman, 2010, p.302). Thus if a depressed person looks back over their life they may see each setback as evidence of failure, and this can become overgeneralised so that a person concludes they have failed in life. Taking a more specific and focused examination of past events may reveal a more nuanced reality of good and bad outcomes and a recognition of the ambiguity of possible outcomes as the time people were under stress. In some cases a different narrative, that of a resilient survivor, may emerge when understanding how individuals cope with each individual setback and survive nonetheless.

To help individuals' recognise that learning from past, means accepting the past and accepting themselves in order to enhance their ability to cope in the here and now. It also recognises that reflecting back when depressed can have negative consequences for individuals because of a bias towards overgeneralised recall. Moreover if an individual attempts to suppress or avoid unwanted negative thoughts or mood states, distress levels can become elevated and prolonged (Nolen-Hoeksema, 2012).

Consistent with work by Watkins, Baeyens, and Read (2009) work in treating depressive rumination, it is recommended that when reviewing negative events from the past, concrete and specific foci are adopted so as to avoid a biased and overgeneralized negative recall of past events. Thus individuals are encouraged to remain factual about events from the past and avoid falling into rumination, or emotional reasoning ("I feel guilty, therefore I must have done wrong") so as to ensure a more constructive concrete reappraisal is achieved. This reappraisal is usually compassionate, realistic and forgiving of human frailty. Wohl, DeShea & Wahkinney (2008) note that when people adopt a self-forgiving stance they think and act more constructively towards the self. Self-forgiveness entails accepting one's responsibility for one's actions and is associated with increased well-being and personal growth.

A life must be viewed with a more accepting frame of reference accepting that being human entails accepting mistakes while recognizing the need for (self)-forgiveness. In reviewing the past in CBT, a useful technique for the therapist to employ when understanding an individual's personal narrative is to ask them to construct a 'timeline' as a homework task.

The timeline can be located on a vertical line that connects the individual's birthdate at the start of the timeline with the current date at the end of the timeline. The therapist can ask the client to put all notable events from life on this timeline. By employing this simple technique the therapist gains an 'edited' summary of the high and low points of an individual's life. The figure below illustrates what a timeline looks like.

The important element of the use of timelines is to review the past and learn from it in a way that it is compatible with rumination focused CBT interventions. Clients are taught to be more specific, or 'concrete' in their appraisals and re-appraisals of past events (Watkins, 2009). Being more concrete in 'mining the past' means that therapists ask specific questions such as asking the client to keep as factual as possible in recalling events from the past. When reviewing a past event that evokes shame in the client the therapist sensitively and dispassionately asks; "In what way are you ashamed about what occurred, what did you do that was so bad?" It can also be helpful to ask the client to give a factual account of how things turned out from their initial memory and then to reflect on their actions by recalling specific details. In this way a reappraisal may surprise the client. It can be helpful to clients to discuss what a range of options might have been available at the time in advance of the decision they may have taken and to do this disconnected with how things turned out. Often people have difficult choices to make and are often left with a choice of the *least, worst* option rather than the best option. In doing so the therapist promotes a more 'psychologically healthy' reflective approach (MacFarland, Buehler, von Ruti, Nguyen, & Alvaro, 2007) to exploring what can be learned from the past in order to cope better in the present. Laidlaw

(2013) provides a more detailed account of how wisdom is used within a CBT perspective. Laidlaw (2015) has outlined a series of principles in the use of timelines in CBT that guide the therapist in helping the client to focus on what they can learn from the past.

Summary and conclusions

This paper advances a theoretical and practical approach to improving treatment outcome for therapists working with older people using CBT. In a real sense this is the first step towards finally elaborating upon an age appropriate form of CBT that is not merely a series of procedural recommendations. The use of theories from gerontology are used as convenient vehicles for change and can provide therapists working with older people additional interventions that are contextually and conceptually sympathetic to the stage of lifespan development clients are embedded in.

The paper here ambitiously sets out a roadmap towards developing a comprehensive and contemporary account of CBT to meet the new and emerging cohorts of older people. The ideas here suggest some age appropriate understandings but also suggest some new techniques that will be more appropriate to the lifespan context facing older people with anxiety and depressive disorders. This is by no means a finished project but we hope it is a strong step towards finally answering the question of how CBT is different with older people.

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Figure 1

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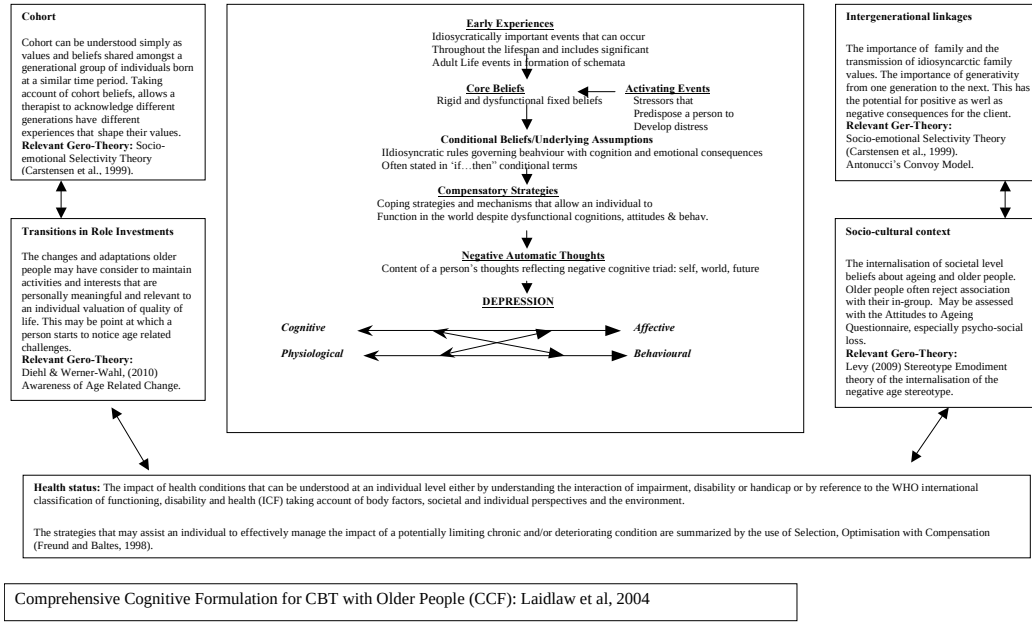

Figure 1. The key elements of the comprehensive conceptualization framework. Reprinted from CBT for Older People (p. 136), by K. Laidlaw, 2015, London: SAGE Publications. Copyright 2015 by Ken Laidlaw. Reprinted with permission.

Figure 2
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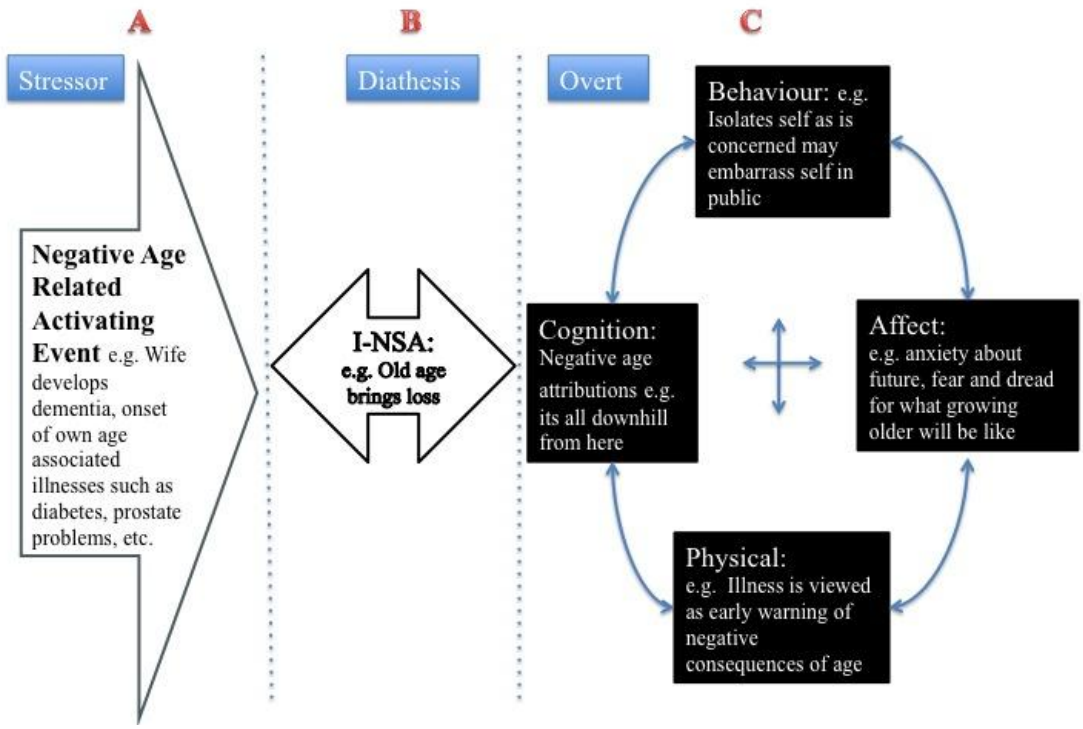

Figure 2. Negative attitudes to ageing can act like a stress-diathesis in CBT. Reprinted from CBT for Older People (p. 110), by K. Laidlaw, 2015, London: SAGE Publications. Copyright 2015 by Ken Laidlaw. Reprinted with permission.

Note. I-NSA = Internalised negative age stereotypes

Figure 3
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Using SOC in therapy can be seen as a 'problem-solving' procedure in order to hep a client manage a 'realistic' problem more optimally. An example of how SOC are applied with a client who has concerns with their memory is detailed in Figure1 below:

Problem: Mr Gray has noticed that he is developing memory problems

Selection: Mr Gray uses his resources as best he can by selecting to focus on a few key tasks every day. He is selecting (prioritising) what needs to be done in order to avoid overwhelming himself and to avoid stressing himself beyond his capacity.

Optimisation: Mr Gray needs to practice tasks to make sure he is comfortable with them. He rote learns important appointments and telephone numbers (memorizes by saying them over and over again, even turning it into a song!) He optimises his memory by use of diaries by frequently getting into the habit of writing things down.

Compensation: Mr Gray knows that his memory is worse when he gets tired. So he compensates for this by making sure he does his most important tasks in the morning. He also compensates for his poorer memory by using memory aids like setting an alarm on his phone that rings to remind him when he has an appointment. He also uses his paper diary.

Figure 3. Using selective optimization with compensation (SOC) in CBT

Figure 4
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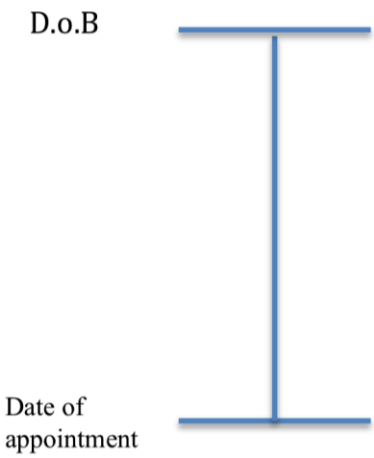

Figure 4. Using Timelines in CBT