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Cognitive Behavioral Psychotherapy
with Older Adults

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Abstract

Cognitive behavioral psychotherapy is readily adaptable to use with older adults. This review integrates discussion of cognitive and behavioral intervention techniques with recent research and clinical observations in the field of gerontology. Cognitive changes with aging, personality and emotional development, cohort effects and the social environment of older adults are discussed in relation to psychotherapy. Applications of cognitive behavior therapy to specific late life problems such as chronic illness and disability, depression, alcoholism, and insomnia are presented. The effectiveness of cognitive and behavioral techniques in treating these disorders in older adults is discussed.

Cognitive Behavioral Psychotherapy with Older Adults

In this review, we integrate discussion of cognitive behavioral therapy with current research and clinical observations in the field of gerontology. In the first section, we summarize current research on aging in several areas of practical interest to psychotherapists seeking to apply cognitive treatment techniques in their work with older clients: maturational changes in cognitive processes, intelligence, personality and emotional development, and the effects of cohort membership and social context on older people. The results of these studies frequently contradict generally held misconceptions regarding both the aging process and what older people are like, and have significant implications for the practice of therapy. The techniques based on cognitive behavioral theories are adaptable, with slight modification, to several of the specific challenges encountered in late life by older adults, which are frequent presenting problems in therapy with older clients. Deciding which modifications will be made, and how to do so, is predicated upon a thorough and accurate understanding of the various changes inherent in the aging process. These modifications to therapeutic technique are addressed at the end of each section discussing the potential sources of change: developmental, cohort-based, and the social environment of the older adult. In the last section, we review recent findings in outcome studies of cognitive behavioral therapy with older adults for several common problems.

Scientific Gerontology and Psychotherapy

Cognitive and behavioral approaches to psychotherapy, as with any approach, require an accurate understanding of the abilities, personality, and life circumstances of the client in order to

be successful. And just as cognitive therapy helps provide clients with a more rational and realistic understanding of the self and the world, the therapist needs current, unbiased information regarding the client. In the past, older clients have often been subject to negative stereotyping and inaccurate generalizations which have hindered their access to and success in psychotherapy. Perhaps the most infamous statement expressing this type of distortion came from Freud, when he stated that older people are not good candidates for psychotherapy because learning stops at age fifty (Freud 1905/1953, p. 264). In more recent years, writing about therapy with older adults has increasingly drawn upon scientific gerontology rather than stereotypes (Knight, Kelly, & Gatz, 1992). There are within the multi-disciplinary field of gerontology some general perspectives, trends in findings, and key sources of information that can offer the therapist more useful concepts of aging than the culture at large provides. The field itself, as we shall discuss, has evolved in its general view of late life as knowledge in the scientific study of aging has increased over the past few decades.

The early history of gerontology as a discipline was characterized by a split between researchers who were discovering that aging is a more positive experience than society presumably believed (e.g., Baltes & Schaie, 1976; Schaie, 1973) and practitioners who were struggling with the problems of selected elderly and who generalized the real problems of frail older adults to all aging persons. The result was a loss-deficit model of aging, which portrayed the normative course of later life as a series of losses and the typical response as depression (Berezin, 1963; Gitelson, 1948). This theoretical understanding of aging has been and remains an integral part of the practitioner heritage (e.g., Walsh, 1988).

As the field of gerontology developed, there remained a persistent discrepancy between the loss/deficit model followed by most practitioners prior to 1980 and the emerging view of life span developmental psychology of the 1970's, which focused on normal aging and was more positive (see Knight et al., 1992, for a review). In recent years this has led to the proposal of a contextual, cohort-based maturity/specific challenge model ("CCMSC," Knight, 1996). In this view, older adults are seen as more mature than younger ones in certain important ways, but also are recognized to be facing some of the hardest challenges that life presents to adults, including adjusting to chronic illness and disability as well as frequent grieving for others. The special social context of older adults and the fact that they are members of earlier-born cohorts raised in different socio-cultural circumstances may require adaptations to psychotherapy that are not dictated by the developmental processes of aging. In this discussion, maturation is considered first, followed by cohort differences and contextual factors as important potential sources of knowledge in working with older adults in therapy.

Maturity

Cognitive changes with aging

Slowing. The slowing that occurs in all cognitive tasks where speed of response is a factor is the most pervasive cognitive change with developmental aging. (Botwinick, 1984; Salthouse, 1985). Although reaction time can be speeded up in older adults by practice, exercise, and other interventions, the age difference is seldom completely eliminated. In a thorough review of this literature, Salthouse (1985) argued convincingly that the locus of slowing is probably the central nervous system. He speculated that slowing with age could be due to older adults having

developed a machine language (the internal control language of the "mind as computer") which handles abstract material better and faster but at the cost of slowing down in the lower level tasks typically measured in reaction time experiments (e.g., speed of hitting a lever after hearing a tone).

Intelligence. Intelligence can be divided up in a number of ways. A useful two factor model, which distinguishes fluid from crystallized intelligence, was proposed by Cattell and elaborated by Horn (see Labouvie-Vief, 1985, for a review). In the study of aging, fluid intelligence, which is usually measured by tasks that involve a speeded or timed component, shows clear evidence of change with developmental aging. Inferential reasoning (for example, as assessed by questions that ask what comes next in a series), is a part of fluid intelligence in this sense. Crystallized intelligence, which includes the types of tasks most often associated with intelligence in adults such as general fund of information and vocabulary, shows little change as a result of the aging process until age 70 or later (Schaie, 1996). Changes after 70 in average level of intellectual abilities are observed but are neither global nor universal, and may be due to early stages of dementing illness or to illness-related declines (Schaie, 1996).

Rybash, Hoyer and Roodin (1986) advanced some intriguing notions about the course of cognitive development across the adult life span. Drawing on the information processing "mind as computer" metaphor, they argued that increased experience can be seen as operating like an "expert system" program. With the accumulation of experience, older adults have a considerable store of knowledge about how things are and how things work, especially in their individual area of expertise, informed by work experience and family experiences. In these expert domains, the

more mature may tend to outperform the young. In contrast, the excess speed and energy of the young may be helpful in processing large amounts of new information without the aid of an expert system.

Learning and memory. Memory has probably been the most difficult topic to study in the area of cognitive changes in late life. In sharp contrast to the methodological sophistication of studies of other types of intellectual change in aging, most memory studies are cross sectional and so compare older adults with younger adults at one point in time, confounding aging effects and cohort differences. Longitudinal studies with the Wechsler Memory Scale show little developmental change in memory when health is statistically controlled (Siegler, 1983). In a more recent longitudinal study, Zelinski and Burnight (1997), show some effects of normal aging on recall, apparent only if measured at six-year intervals or greater.

Recent evidence has converged on a consensus that working memory typically declines with age (see Light, 1990, and Salthouse, 1991 for reviews). Working memory is the limited capacity resource through which information must be processed before being registered in long term memory. This limitation could influence the pace and effort of new learning and also affect language comprehension (Light, 1990). This finding would suggest yet more reason to slow down and use simpler phrasing when working with older clients.

One interesting problem in this area is that older adults do not spontaneously use mnemonic aids. They can be taught to do so in therapy, and this will improve their memory performance substantially. However, they have to be reminded to use the mnemonic aids at

subsequent sessions (cf. Botwinick, 1984). If older clients also need prompting to use newly learned strategies, it would be important even if specific to current cohorts of the elderly.

While there are clearly increasing numbers of dementing older adults with each decade of advanced age (Gatz, Kasl-Godley, & Karel, 1996), the functional significance of memory changes in normal aging are less clear. Age-associated memory impairment has been proposed as a diagnostic category (Crook, Bartus, Ferris, Whitehouse, Cohen, & Gershon, 1986) and is listed among “other conditions that may be a focus of clinical attention” in DSM-IV. Opponents of the move are concerned that such a category may be confused with normal aging, worry about memory changes, and nonprogressive or slowly progressive dementias (Smith, Ivnik, Petersen, & Malec, 1991). This problem is methodologically challenging and has important implications for our understanding of normal aging and our ability to estimate the prevalence of disorders like Alzheimer's disease in very late life. In general, what is known about memory now would suggest that differences between current younger and older adults in memory performance are not large when the material is meaningful and relevant to the older adult and the older adult is motivated to learn (Botwinick, 1984; Craik & Trehub, 1982; Poon, 1985; Hultsch & Dixon, 1990).

Personality and emotional development

The last fifteen years have seen a considerable increase in the amount of research available on personality development in adulthood and later life. The work of Costa, McCrae, and associates in the Baltimore Longitudinal Study on Aging (McCrae & Costa, 1984; Costa & McCrae, 1988) using self-report measures of personality and a nomothetic model of personality measurement has supported stability of personality across the adult life span. They find stability

on the Big Five personality factors: introversion/extroversion, neuroticism, openness to experience, dependability, and agreeableness (Costa & McCrae, 1988).

Using a very different methodology, Haan, Millsap, and Hartka (1987) found personality stability in cognitive commitment, dependability, and outgoingness, dimensions which are conceptually similar to the factors of openness to experience, dependability, and introversion-extroversion in the Costa et al. studies. This study included interviewer ratings rather than self-report and an ipsative model of personality that leads to description of the relative salience of dimensions within the individual, rather than the person's ranking in the group on predetermined scales. They found childhood to early adolescence to be the most stable period of life, followed by considerable flux and reorganization in adolescence and early adulthood, followed by moderate stability in adulthood (The period for which Costa and colleagues have data). Haan and her colleagues concluded that in spite of considerable stability across many transitions, the organization of personality in late life was very different than that of childhood. Of interest to therapists, we also know that in spite of objective stability in personality, people report believing that they have changed and grown (Bengtson, Reedy, & Gordon, 1985).

Emotional changes over the adult life span are a topic of considerable importance for psychotherapists working with older adults. Schulz (1982) argued that the accumulation of experience leads to more complex and less extreme emotional experiences in later life. New experiences may remind older adults of previous experiences which have a mix of negative and positive emotional connotations, whereas earlier in life it is possible to have simpler and more intense reactions with little or no prior experience to moderate reactions to new events (falling in

love) or losses (a friend moving away). Malatesta and Izard (1984) reporting on the study of facial expression of emotions, discuss evidence that older people's expressions convey elements of several feelings at once. Taken as a whole, this body of work argues that emotionality in older adults will be more complex and more subtle than that of younger adults.

Recent research has also led to new ways of thinking about the importance of emotional experience to older adults. Whereas previously older adults were thought to become emotionally disengaged, Carstensen (1992) has found that adults increasingly focus on emotionally close relationships as they get older, while casual relationships become less important. In a study of emotion and memory, Carstensen and Turk-Charles (1994) found that older adults recalled a greater proportion of emotional information than did younger adults. These findings suggest that emotion-related cognitions become increasingly important as adults age.

These findings from research on personality and emotion support continuity of personality and of emotion throughout adulthood and into later life. In fact, older adults would tend to have more years of stable personality characteristics (being several decades past the reorganization of the young adult years), would have more complex emotional reactions, and a greater focus on emotion and on emotionally intense relationships. Along with improvement in crystallized intelligence and the development of expertise in the cognitive domain, the research suggests a potential for continual growth toward maturity throughout the adult life span. In this sense, maturity means increasing cognitive complexity; development of expertise in areas of experiential competence including work, family, and relationships; and a greater emotional complexity with better comprehension and control of emotional reactions.

Maturity effects and cognitive behavioral therapy models. Slowing and memory changes have often been remarked upon as necessitating changes in cognitive behavioral therapy (see, e.g., Zeiss & Steffen, 1996; Gallagher-Thompson & Thompson, 1996). For example, the speed of therapeutic conversation may need to be slower with older clients. An important strength of this mode of therapy is the ability to adapt it to different cognitive levels of clients by adjusting the amount of cognitive work done by the therapist.

In the therapeutic setting, it is particularly important to be certain that the client is learning and remembering information and skills learned during the session. For an approach such as cognitive behavioral therapy, which uses assignments between sessions that the client must complete independently if real progress is to be made, this issue is especially important. In addition to using simpler phrasing, it is necessary for the therapist working with older adults to repeat new material and to ask the client to repeat it to be sure that he or she understands. Repetition and summary of new material should occur frequently during the session, rather than only at the end (Zeiss & Steffen, 1996; Gallagher-Thompson & Thompson, 1996). Asking the client to take notes on important points may also aid memory and increase the effectiveness of the therapeutic intervention. To the extent that emotion-related memories are more accessible and preserved with age, as suggested by Carstensen and Turk-Charles (1994), normal memory changes with aging may be less important in the psychotherapy context than in domains of life focused on information rather than emotion.

The more positive aspects of maturation may also result in changes in therapy. The stability of crystallized intelligence and the development of expertise in several life domains

implies that older adults have many useful strengths and existing skills. Therapy with older adults may frequently involve rediscovering these skills rather than teaching new ones (Zarit, 1980, also noted this as a change). When, as is typical, the client is older than the therapist, this process may well result in the client rediscovering skills which the therapist has not yet developed. Since cognitive behavioral therapy is about guiding processes rather than the therapist sharing life experience, this works; but it is likely to feel different for the therapist than does work with younger clients. Note, however, that the normal decline in fluid intelligence suggests that the therapist must rely less on the client's inferential reasoning and problem solving abilities. The therapist may need to lead the older client to conclusions rather than giving suggestions and expecting the client to infer the applications.

Personality stability across the adult life span suggests that older adults will not display any major shifts in neuroticism, extroversion, openness to experience, conscientiousness, or agreeableness. Instead, the full range of individual differences can be expected among older clients and continuity of individual patterns from earlier adulthood is the expectable norm.

Emotional changes with maturity may affect the presentation of problems and require more subtlety in the design of cognitive interventions. Cognitive behavioral interventions, like those of other therapy systems, are based on work with younger adult clients. Life span research on emotion would suggest that young adults have relatively pure and intense emotions, whereas an older client is likely to be experiencing sad and happy emotions in response to the same environmental or cognitive stimulus. Rather than substituting another cognition, it may be more strategic to have the client focus on the positive emotion along with the negative. For example,

an older adult needing assistance from her daughter may be both happy that the daughter is willing to assist and sad that she is a burden on the daughter who has multiple other responsibilities. Rather than considering the cognition about burden as irrational, it may be helpful to construe the daughter's willingness to care as a sign of her love and also to elaborate the observations that lead to concerns about being a burden and to encourage problem solving strategies to limit the burden as much as possible.

With longer life histories, cognitive work may be done at higher levels of abstraction as well. In addition to focusing on simple cognitions (the atoms of CBT), work with older adults may often involve schemas and relationship scripts. That is, in a manner that parallels the use of "expert systems" (Rybash et al., 1986), older adults can approach cognitive distortions that cut across multiple situations and multiple relationship interactions. This ability is based on having a larger experiential database and on decades long practice in analyzing problems and situations at this more abstract, "molecular" level. From a cognitive behavioral perspective, the post-retirement client's focus on reminiscence (Butler, 1963) may be taken as reworking of the life span construct (i.e., the schema that represents knowledge and beliefs about the self, including implicit theories of personal development past and future; Whitbourne, 1985) through life review and reinterpretation. That is, maturation and an accumulated experiential "database" of life experience makes "molecular" and "molar" level analysis more frequent. (For further discussion of the identification and modification of schemas in therapy, see Young, Beck and Weinberger, 1993).

Or, taken from the vantage point of working with older clients, younger adults simply do not have sufficient experience to have well-elaborated cognitive schema, life span constructs, or clear perceptions of themselves that cut across multiple relationships and multiple situational contexts. They have not had the time to accumulate sufficient data about themselves to work at this level. From the vantage point of working with older clients, current cognitive behavioral theories might be seen as specific to the developmental phase of early adulthood, characterized by limited self knowledge, limited experience, and a need to develop new skills rather than to apply old skills to new problems. An increased understanding of older adults within the cognitive behavioral framework may lead to new research questions about young adult clients that are rooted in a life span perspective.

The tendency toward reminiscence in later life (Butler, 1963) may make it difficult to maintain a focus on the present in cognitive behavior therapy. Older adults are likely to want and to need to talk about the past. It is likely to be counterproductive to attempt to keep an exclusively present-oriented focus when working with older adults. Allotting some time to reminiscence can be viewed as a reinforcement for other therapeutic work in session. One can also take the view that working with older adults, who have so much more life history, may take on a more abstract level of cognitive intervention. With the elderly client, the cognitive therapist may be working on scripts rather than automatic thoughts and in working on editing the life span construct itself, rather than editing schemata about specific social interactions.

While we take the research on outcomes of psychological interventions with older adults (see the section on intervention with specific disorders below) as indirect support for the global

assertion of this section that maturational changes with aging have no negative impact on the use of cognitive behavioral interventions with older clients, most of this section represents hypotheses about the processes of cognitive behavioral interventions with older adults. Since research on clinical interventions with older adults is in its infancy, process research is even more limited with this population than is outcome research.

Cohort differences

An important component of our understanding of older adults from life span developmental research is the ability to separate the effects of maturation from the effects of cohort membership. Much of social gerontology could be summarized as the discovery that many of the differences between the old and the young that society has attributed to the aging process are actually due to cohort effects. Cohort differences are explained by membership in a birth-year-defined group that is socialized into certain abilities, beliefs, attitudes, and personality dimensions that will stay stable as it ages and that distinguishes that cohort from those born earlier and later. For example, in the United States, later-born cohorts have more years of formal schooling than groups of individuals born earlier in the century.

Cohort differences in intellectual skills have also been identified. In general, Schaie's Seattle study shows that later-born cohorts tend to be superior in reasoning ability and spatial orientation. On the other hand, some earlier born cohorts (people who are now older) are superior in arithmetic ability and verbal fluency (Schaie, 1996). These examples illustrate the important point that the absence of developmental change does not necessarily mean that older people as

they exist today are not different from today's younger people. It also shows that some differences between cohorts favor the older group.

In studies of learning and memory, one aspect of the familiarity of materials to be learned is the discovery that older adults learn word lists better when the lists are made of "old words" (e.g., fedora) as opposed to "new words" (Barrett & Wright, 1981). This finding demonstrates that word usage changes over time.

Cohort effects may also appear in personality. For example, Schaie (1995) reported that from 1900 until World War II, successive cohorts declined in extroversion. But in the post-war and later cohorts, extroversion has been increasing. Threat reactivity has increased with each cohort since the beginning of the 20th Century (Schaie, 1995). In general, these results argue that observed personality differences between young people and older adults are more likely to be cohort differences than due to developmental effects of aging.

Cohort effects and cognitive behavioral assessment and interventions. Cohort differences, while not developmental, are real. Working with older adults involves learning something of the folkways of members of earlier born cohorts just as working with adolescents or young adults demands staying current in their folkways and world view. During times of rapid social and technological change (e.g., the Twentieth Century), cohort effects may overwhelm advantages of developmental maturation. Preparation to conduct therapy with older people has to include learning what it was like to grow up before we were born. Perhaps one of the most undeveloped aspects of understanding psychotherapy with older adults, comprehending

psychologically significant cohort effects is not essentially different in quality or difficulty from learning to work with clients from other cultures or from the other gender.

Even if older clients are not apprehensive about receiving psychotherapy, it is necessary to explain clearly the particular approach of cognitive behavioral therapy, that in many respects it is similar to receiving instruction in applying practical life skills. Many older adults are familiar only with popular stereotypes of psychoanalytic therapy, in which the therapist is nondirective and the client lies on a couch "free associating." From the first session, the therapist must explain the collaborative, structured nature of the therapy, and that the client is expected to take an active role in setting treatment goals and in actively changing his patterns of thinking (Thompson, Gantz, et al., 1991). The importance of between-session assignments must also be explained to the client as an integral component of successful therapy. The focus on simple jargon-free language and in keeping the response cost of assignments low are common elements of CBT that are useful in adapting approaches to individual earlier-born clients.

Earlier-born clients will show effects of being raised in a different cohort. Many of the differences will be in the establishment of rapport and in orienting the client to treatment. However, it may be necessary to change wording, scales, assignments, and so forth to adjust to different education levels of earlier cohorts, cohort-specific values or examples, and comfort with written assignments. For example, the cohort-related findings on word familiarity and memory suggest that therapists need to consider using appropriate word choices when communicating with older adults.

In the domain of assessment, it is clear that age norms for standardized tests are based on cross-sectional data which confound maturity effects with cohort effects. Given the existence of significant cross-cohort effects on intelligence, for example, one must take into account the cohorts on which the test is normed and on which standardized scores are based as well as the current age of clients. For example, change in intelligence with age should not be based on differing versions of the WAIS (Kaszniak, 1990). For similar reasons, we would hypothesize that when scales have been developed that are specific to older adults, the need for the specificity is more likely to be based on cohort differences than on maturational change. We would speculate that the need for an Older Person's Pleasant Events Schedule (Teri & Lewinsohn, 1986) is rooted in cohort differences rather than age changes. Similarly, changes in therapy technique and strategy are likely to be based on cohort differences (lower education, less exposure to psychological concepts during education) than on maturational change. The direct scientific test of this hypothesis would require longitudinal research using life span developmental psychology methodology which can untangle age and cohort effects (e.g., Schaie, 1995). When sufficient data exists that have been collected over long periods of time, it will be become possible to approximate the answer by reviewing the literature with an eye to cohort effects as well as age effects. That is, if the cohort hypothesis is correct, older adults of later born generations will show different and quite possibly smaller differences from the younger adults of later born generations (e.g., the need for older adult specific scales will vanish as later born elders become more educated). If the age hypothesis is correct, the differences should remain constant over generations. Since norms for older adults on psychological tests, age-specific scales, and

outcome studies of therapy with older adults have all been developed only in the last decade or two, that research is not yet possible.

The Social Context of Older Adults

Additional important knowledge for the therapist includes a general familiarity with the distinctive social milieu of older adults in the late 20th century. In the United States, this context includes specific environments (age-segregated housing, age-segregated social and recreational centers, the aging services network, age-segregated long term care and so on) as well as specific rules for older adults (Medicare regulations, Older Americans' Act regulations, conservatorship law and so forth). An understanding of social context that is based on both knowledge of what is supposed to be and experience of actual operations is important to the appreciation of what older people say about their experiences in these settings.

Therapists need not acquire extensive knowledge of these different systems, but they do need to go beyond the commonly believed but entirely false assumptions of many younger adults. For example, the assumption that living in an age-segregated environment will lead to increased friendships is something that only a naive outsider to that world would believe. In fact, many age-segregated environments are very intolerant of frailty and of social deviance of any sort (cf. Frankfather, 1977).

Although this information is not terribly difficult to acquire, the lack of it among psychotherapists working with a general population may be one reason why older adults can seem difficult to comprehend. The network of health and social services for older adults and the formal distinctions between different components of the system can be learned in a lecture or

two. Informal visiting at locations where the elderly receive services can do a great deal toward providing a more experiential framework for understanding the environments of the elderly.

These surroundings are unfamiliar territory for most younger and middle-aged adults.

Social context of elderly and cognitive behavioral models. This knowledge of the older adult's social context is essential for appropriate interventions within both classic behavioral and social learning models of therapy. The environmental context is often the source of reinforcement contingencies that create or maintain maladaptive behavior or negatively-valenced affect. In nursing homes, for example, older adults may be rewarded with staff approval for passive conformity to scheduled routines--passivity that may lead to reduced activity levels, decreased sense of control and worsened mood (Baltes, 1995). Improving the client's mood will often involve changing the environment or consulting with staff about environmental change (Smyer, Cohn, & Brannon, 1988; Lichtenberg, 1994). The therapist will need an accurate and older-client-centered view of the environment in order to make such changes. In nursing homes, this may include a realistic understanding of what can be changed and what cannot be changed in the client's highly structured residential setting.

The Use of Cognitive Interventions for the Specific Challenges of Late Life

Practitioners working with older adults may well be thinking at this juncture that the view of aging presented thus far is overly optimistic. However, the above outline of evidence for increasing maturation has intentionally focused on normal development through the life span. Many elderly clients seeking help in therapy are struggling with problems that threaten psychological homeostasis at any point in the life span: chronic illness, disability, and the loss of

loved ones to death. These problems are not unique to late life but are more likely in the latter third of life. In addition, late life is not immune to the usual vicissitudes of all of life: disappointment in love, arguments with family members, and failing at the tasks we set ourselves. Finally, many people who have struggled with depression, anxiety, substance abuse or psychosis all of their lives eventually become older adults who continue to struggle with these problems.

The focus on specific challenges in the CCMSC model (Knight, 1996) is a natural fit with cognitive behavioral theory and practice, which emphasizes specific problems and situational analysis. However, just as the deficit side of the loss-deficit model ignores evidence for maturation, the perception that generic losses are normative in late life fails to do justice to the specific nature of the losses incurred. Clinical experience suggests that it matters whether what is lost is one's spouse, one's vision, or the use of one's legs. Recognizing the specificity of loss and reconceptualizing losses as challenges implies that some losses can be overcome through rehabilitation counseling as well as adjusted to through grief counseling.

Empirical evidence for the effectiveness of psychological, mainly cognitive behavioral, interventions with older adults has been accumulated over the past twenty to thirty years. A meta-analysis of psychological interventions in the treatment of depression in later life shows an aggregate effect size ($d = .78$; Scogin & McElreath, 1994), roughly equal to that found in another meta-analysis for anti-depressant medications ($d = .57$; Schneider, 1994) and roughly equal to that found for younger adults in meta-analyses using cognitive behavioral approaches ($d = .73$;

Robinson, Berman, & Neimeyer, 1990; some studies overlap with those analyzed by Scogin & McElreath, 1994).

Another set of standards for evaluation of therapy effectiveness is found in the work of task forces on empirically supported psychological treatments within APA's Division 12. They have concentrated on specific treatments for specific psychological problems, mainly in adult populations, and have periodically updated these lists in The Clinical Psychologist (Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Chambless et al., 1996; Chambless et al., 1998). These guidelines for empirically supported psychotherapy have been applied to the literature on psychological interventions with older adults by Gatz and associates (1998). They report that behavioral and environmental interventions for older adults with dementia meet the standards for well-established empirically supported therapy. Probably efficacious therapies for the older adult include cognitive behavioral treatment of sleep disorders and psychodynamic, cognitive, and behavioral treatments for clinical depression. For nonsyndromal problems of aging, memory retraining and cognitive training are probably efficacious in slowing cognitive decline. Life review and reminiscence are probably efficacious in improvement of depressive symptoms or in producing higher life satisfaction. For anxiety disorders, the authors conclude that the few treatment studies of psychological interventions conducted to date (e. g., Stanley and Beck, 1995, King and Barrowclough, 1991) do not meet these standards, due to lack of a control group and concomitant treatment with anxiolytic drugs. In what follows, we examine the application of cognitive behavioral interventions to specific problems faced by older adults, with attention to available empirical literature.

Chronic illness and disability

Conducting psychotherapy with emotionally distressed older adults very often means working with older adults who are chronically ill and/or physically disabled and who are struggling to adjust to these problems. Estimates of the prevalence of adults over the age of 56 with at least one chronic illness range from 50% to 86% (Boczkowski & Zeichner, 1985; Ham, 1983; National Center for Health Statistics, 1987). Important components of working with this population include learning about chronic illnesses and their psychological impact, control of chronic pain, adherence to medical treatment, rehabilitation strategies, and assessment of behavioral signs of medication reactions. The increased proportion of chronic illness and disability with each decade of life and the increased correlation of the physical and the psychological in later life make therapy with older adults impossible without the ability to discuss physical problems and to understand when a problem may have physical causes.

A frequent component of treating chronically ill or disabled elders is addressing concurrent depression. Prevalence studies of depression in this population have found rates up to 59% (Finch, Ramsay, & Katona, 1992; Harper, Kotick-Harper, & Kirby, 1990). Further examination of the relationship of depression to physical illness has found that the disability that often accompanies physical illness, rather than illness per se, was a risk factor for depression in older adults. (Hays et al., 1998; Zeiss, Lewinsohn, Rohde, & Seeley, 1996). These studies indicated that, in the absence of disability or loss of functional capacity, illness alone appeared to be independent of depression. Conversely, depression is a serious problem in terms of physical as well as psychological health, and has been associated with increased disability, poorer

rehabilitation from health problems, and greater risk of mortality. Unfortunately, physicians frequently do not detect symptoms of depression in their older patients, so opportunities for treating the problem are often missed (Rapp, Parisi, Walsh, & Wallace, 1988). This is particularly unfortunate because older adults are likely to present symptoms of depression in the office of their physician rather than independently seeking out treatment from mental health professionals (George, Blazer, Winfield-Laird, Leaf, & Fischbach, 1988).

There has been little study of the effectiveness of cognitive behavioral therapy with medically ill older adults. However, the few studies completed to date have been encouraging. Arean and Miranda (1996) found this approach effective in relieving symptoms of depression in medically ill outpatients, although patients in the study were not randomly assigned. In another study, Lopez and Mermelstein (1995) found cognitive and behavioral interventions successful in treating depression with inpatients in a hospital geriatric unit. The authors of this study described a treatment program in which patients received 30 minute therapy sessions three to four times per week, with an emphasis on increasing pleasant events and cognitive restructuring. Psychological treatment was coordinated with physicians and nurses involved in patient care.

Rybarczyk and his colleagues (1992) have identified five important issues in implementing cognitive behavioral therapy with chronically ill older adults (1) resolving practical barriers to participation; (2) accepting depression as a separate and reversible problem; (3) limiting excess disability; (4) counteracting the loss of important social roles and autonomy; and (5) challenging the perception of being a "burden." For example, a cognitive component of challenging the perception of being a "burden" on a family caregiver may involve helping the

client to recall the things they have done for their caregiver in the past, thus giving the client a greater sense of balance in the relationship. This manner of breaking down the issues facing the chronically ill older adult is helpful to the therapist in formulating a strategy employing both cognitive behavioral techniques and practical considerations. This approach also has the advantage of viewing the potentially discouraging prospect of treating the chronically ill or disabled elder as an endeavor with discrete and manageable components.

Depression can also be a significant problem in elders suffering from Alzheimer's disease and other forms of dementia. Teri and Gallagher Thompson (1991) have described specific cognitive and behavioral approaches to addressing this problem, which include using a cognitive emphasis for elders with mild depression and behavioral techniques for moderate and severely demented elders. Specific issues that Teri and Gallagher Thompson addressed in outlining these treatment approaches include mood problems such as dysphoria, loss of pleasure and feelings of worthlessness, and behavior problems such as agitation, appetite and weight change, and sleep disturbances. For more severely demented clients, it is important to enlist the assistance of caregivers in implementing behavioral strategies to improve the mood of the client.

This raises the issue of screening for dementia, which is important in working with older people. Depression and dementia may present similar symptoms, such that an older client suspected of dementia should be screened for depression. Likewise, the clinician should be aware of possible cognitive impairment, and may want to use a brief screening instrument such as the Folstein Mini Mental State Exam (Folstein, 1975) as a matter of routine. Any indication by screening instruments of cognitive impairment suggests a need for additional assessment to

diagnose cause and extent of dementia, and may necessitate adjustment of treatment goals and style. If dementia is present, therapy should then incorporate regular checks on whether the cognitive impairment interferes with the interventions being used.

In addition to treating depression in medically ill or disabled elders, cognitive techniques can also be used to help manage pain. It has been estimated that 25% to 50% of community dwelling elderly suffer from chronic pain (Crook, Ridout, & Browne, 1984) with rates of 45% to 80% for elderly who live in nursing homes (Roy & Michael, 1986). Chronic pain is associated with rheumatoid arthritis and delayed healing from injuries. While medication is frequently indicated to help relieve pain in older adults, outcome studies have shown that cognitive and behavioral techniques are also effective in helping clients manage pain (Cook, 1998). In this study, which included a treatment group of 22 nursing home residents, participants who received cognitive behavioral pain management training reported less pain and less pain-related disability than those in an attention/supportive control group. Participants were randomized in this study, and were screened to eliminate subjects with serious cognitive impairment. Treatment gains in the cognitive behavioral group were maintained at a four-month follow-up.

Cognitive pain management methods include distracting oneself from the pain, reinterpreting pain sensations, using pleasant imagery, using calming self-statements, and increasing daily pleasurable activities (Widner & Zeichner, 1993). Employment of cognitive and behavioral techniques in therapy may help clients reduce dependence on medication to manage pain. Because chronic pain is associated with depression in older adults (Ferrell, Ferrell, &

Osterweil, 1990; Parmalee, Katz, & Lawton, 1991), effective pain management has the potential to reduce risk of depression.

Depression

Depression, as noted above, is prevalent in older adults who are chronically ill (if disability is present) or grieving. On the whole, however, research findings contradict the stereotype of the older person as frequently depressed, since this disorder is less prevalent in older adults than it is in younger ones: 1% of older adults have a lifetime prevalence of Major Depression, while 6% of younger adults have been diagnosed with a Major Depressive Episode (Robins, et al., 1984). Fortunately, depression in older people is highly treatable. Outcome studies have shown that cognitive and behavioral approaches to psychotherapy are effective in relieving depression in older adults. Gallagher and Thompson (1982) compared cognitive, behavioral, and brief insight-oriented therapy with a total of 38 adults over the age of 55. All three groups showed reduction in symptoms of depression, but the cognitive and behavioral groups maintained gains better at follow-up. A similar study with 115 subjects over the age of 60, with the same three treatment conditions and a wait-list control, found all three treatment approaches superior to the control group, with each mode of psychotherapy equally effective. At follow up, all three treatment groups maintained gains equally. (Thompson, Gallagher & Breckenridge, 1987; see also Teri, Curtis, Gallagher-Thompson, & Thompson, 1994). Their research group has also reported evidence that combining cognitive intervention with antidepressant medication was more effective than either treatment alone (Thompson, Gallagher, et al., 1991).

For the treatment of depression, the cognitive behavioral approach focuses on teaching new coping strategies to deal with problems and challenging cognition that interferes with effective coping. Therapy may also focus on the client's participation in daily events that affect mood. Using a chart for self-monitoring of the frequency of these events, the therapist helps the client to see the connection between pleasant events and moods, so that the frequency of the events can be altered. One such chart, designed specifically for older adults, is the Older Person's Pleasant Events Schedule (Teri & Lewinsohn, 1986). As therapy progresses, the therapist and the client work together to help the client increase the frequency of pleasant events and decrease the frequency of unpleasant ones (Zeiss & Steffen, 1996). The therapist may also address self-talk and negative interpretation of events through techniques such as the dysfunctional thought record, helping the client to recognize cognitive distortions and then to substitute negative and irrational thoughts with more adaptive ones (Thompson, Gantz, et al., 1991; Gallagher-Thompson & Thompson, 1996).

Alcoholism

Although alcoholism rates are lower for older adults than for younger ones, drinking remains a serious problem among the elderly. Aside from the psychological and social problems accompanying addiction, alcohol-related health risks to older adults include adverse interactions with medications, liver damage, increased risk of falling, and negative effects on cognitive functioning (see Bucholz, Sheline, and Helzer, 1995, for review). Bienenfeld (1987) found that elderly alcoholics were at five times greater risk for suicide than non-alcoholic elderly. While some elderly alcoholics have been addicted since their younger years, late-onset alcoholism also

occurs. Much more than younger drinkers, older problem drinkers often drink in response to loneliness, depression, and poor social support networks (Schonfeld & Dupree, 1989, 1995). As a result, cognitive behavioral approaches to treating alcoholism in older adults focus on improving the client's life in a variety of ways in addition to merely abstaining from drinking. In his intervention work with older drinkers, Glantz (1995) has concluded that it is important to establish a collaborative relationship with the client in which goals are set for each of the following areas (1) social life and friends; (2) family; (3) intimate or romantic relationships; (4) employment or practical achievement; (5) recreation or avocation; and (6) drinking. Clients may also identify additional goals. A mandatory goal in treatment is to stop drinking completely, or at least to achieve a period of abstinence followed by very limited and controlled drinking.

The drinking behavior itself is analyzed with the client to determine the maladaptive purpose underlying the drinking behavior. The client is also helped to study his or her pattern of drinking, and to identify the circumstances in which the urge to drink arises. Coping skills and behavior alternatives are then developed and rehearsed in therapy to address these difficult situations.

Irrational thinking in any of the six goal areas is likely to arise in the course of therapy. In general terms, older alcoholics frequently have maladaptive thoughts concerning their own guilt, thinking that they deserve to be punished, wanting not to live (though not necessarily wanting to die) and thinking that they deserve the bad things that have happened to them (Glantz, 1995). Addressing the irrationality of these thoughts in the course of treatment can have a beneficial effect on the mood and self-esteem of the client, which in turn helps to control drinking behavior.

Empirical studies suggest that cognitive behavioral treatment models are effective with older alcoholics, although further research is needed. In a review of published outcome studies of psychological interventions, Schonfeld and Dupree (1995) found the empirical evidence for the effectiveness of cognitive and behavioral interventions superior to that of twelve-step and social support treatment models. However, not all of the studies they review that support cognitive and behavioral treatment are controlled (e.g., Dupree, Broskowski, & Schonfeld, 1984). In one study that did include a control group, Kashner, Rodell, Ogden, Guggenheim and Karson (1992) compared subjects randomly assigned to a mixed-age confrontational treatment group to those in an age-specific group treatment for older adults called Older Adult Rehabilitation (OAR). Therapy for this group included a reminiscence component. Seventy-two male participants completed OAR treatment. OAR participants were more than twice as likely to maintain abstinence at a one-year follow-up. In another study that also addressed the long-term impact of intervention, Carstensen, Rychtarik and Prue (1985) found that a behavioral treatment program for older males was successful in maintaining treatment gains at a two year follow-up. Of the 16 older males included in the study, half had remained abstinent and two participants had significantly reduced their drinking. In conjunction with a cognitive behavioral treatment approach, these studies suggest that older adults benefit from being in a group setting with other older alcoholics as well as a less confrontational style on the part of group leaders.

Insomnia

Insomnia is a frequent problem for older adults, and may interfere significantly with day to day functioning. Between 12% and 25% of adults over the age of 65 complain of chronic sleep

difficulties (Ford & Kamerow, 1989). In sleep-maintenance insomnia, the individual may awaken in the middle of the night and be unable to get back to sleep. He or she may then take naps during the day in order to make up the sleep time lost, resulting in greater and greater time spent in bed in order to receive a normal amount of sleep.

Zeiss and Steffen (1996) have recommended a combination of education, sleep restrictions, and stimulus-control interventions in treating this type of insomnia in older adults. In sleep education, the client is taught about the effects of alcohol, caffeine, nicotine, exercise, sleeping aids, and nutrition on sleep, as well as about age-related changes in sleep. This latter information can help reduce unrealistic expectations regarding sleep time the client may be relieved to know that older people generally sleep less than younger ones. The therapist also teaches the client about the minimal harm done to most people by sleep deprivation, which helps the client to reduce anxiety and excessive concern regarding the insomnia.

The therapist combines this educational effort with instructions to eliminate naps during the day, and to not watch TV, read, or rest in bed. Sleep restriction limits the amount of time spent in bed to the amount of time sleeping, and a set schedule for going to bed and getting up is created, based upon diary entries the client makes during the preceding week. For example, if a client reports sleeping six hours per night out of nine hours spent in bed, then the initial prescribed sleeping schedule would be for six hours, perhaps from midnight to six a.m. The time spent in bed can be gradually increased as "sleep efficiency" (the amount of time spent sleeping as a percentage of time in bed) increases. This approach has been found effective in controlled outcome studies, with gains maintained up to one year following treatment (Morin, Kowatch,

Barry, & Walton, 1993; Gatz et al., 1998). The outcome study conducted by Morin and his colleagues found that treatment was effective in reducing sleep latency (difficulty falling asleep), wake after sleep onset, and early morning waking; sleep efficiency was increased.

The effectiveness of treating insomnia with cognitive and behavioral methods represents an important advance, given the high prevalence of insomnia and the negative side effects of sedative-hypnotic medications in older adults. These include cognitive impairment, increased risk of falls, and the fact that most medications lose their effectiveness over time (Morin & Kwentus, 1988).

Conclusions and Implications

Cognitive behavioral therapy, as we have argued, may be effectively adapted to use with older adults by applying relatively minor modifications to clinical technique. The core principles of cognitive and behavioral theory are assumed to be no different for older people than for younger ones.

Useful adaptations, as we have outlined in this chapter, are based upon the CCMSC model of aging (Knight, 1996). The CCMSC model is intended as a transtheoretical integrative model of psychotherapeutic interventions which can be applied to the question of whether various systems of psychotherapy need adaptation for work with older adults (see Norcross & Knight, in press, for more on CCMSC as a framework for integrative therapy with older adults). With regard to cognitive behavioral interventions, CCMSC is quite compatible with the problem-specific orientation and with the emphasis on environmental causation of psychological disorders. While the specific social context in which many older adults live may change both the

availability of pleasant events and the rationality of specific cognitions, the type of problem-focused and environment-focused analysis which the clinician uses adapts readily to understanding the environments of older adults.

CCMSC suggests the hypothesis that adaptations in cognitive behavioral assessment and interventions that have been attributed to age and thus implicitly to maturation are likely the consequence of cohort differences instead. For example, earlier-born adults have less education and may need materials that use simpler language. Cohort differences are likely to lead to different values, different goals, and possibly different reinforcers.

Some of the problems faced by older adults that we have discussed in this article are encountered more frequently in later life and have therefore come to be identified with old age. Coping with chronic illness and disability is a major challenge for virtually all adults and are the crux of what one might mean by “real problems.” To the extent that cognitive therapists such as Beck and Ellis are perceived as arguing that emotional distress is always unrealistic or irrational, these views are not likely to be acceptable to persons facing such obviously real problems (Beck, Shaw, Rush, & Emery, 1979; Ellis, 1958). On the other hand, the cognitive behavioral approach is relentlessly optimistic in arguing that some improvement in depressed mood is virtually always possible. The aim of the cognitive behavioral therapist is not to make the client happy, simply to reduce unrealistic sadness. Experience suggests both that older clients often have much to be unhappy about and that they are more unhappy than is necessary--due to excess depression brought on by (in Ellis' term) catastrophizing about bad events or by overgeneralizing concerning the causes or the effects of bad events. Sadness over lost eyesight is usual and a normal reaction;

clinical depression over lost eyesight is likely to be due to catastrophizing (“My entire life is over because I cannot see well.”) or due to attributing the loss to normal aging processes and so anticipating that hearing, thinking, and other functions will also be lost (the cognitive distortion of overgeneralization). This work is likely to be different for the therapist, especially if the therapist is used to working with younger, healthy clients, many of whose problems may be largely due to misperceptions and faulty thinking rather than to actual limitations.

Implications for research and theory development

We would argue that the primary limitation of current research on cognitive behavioral interventions with older adults is that there is simply not enough of it and that this is due to the newness of this field of study. The earliest empirical research on clinical interventions with older adults were of behavioral interventions with nursing home residents in the 1970s, with studies of depressed community resident elderly beginning about a decade later (Gatz et al., 1998). While much of what has been done has focused on depression, as noted here and by Gatz et al., there is empirical evidence for the efficacy of interventions with a fairly wide variety of problems that older adults encounter. The limited number of studies, the fact that many interventions have only been studied by one research group, and the reliance on no treatment or waiting list controls limit the number of studies that meet criteria for empirically supported interventions (see Gatz et al., 1998).

The CCMSC model also calls attention to the need for research into the processes that influence any adaptations needed in therapy with older adults. Existing studies document the effectiveness of therapy with older adults, but offer little information about the need for

adaptations. If adaptations are needed, then research can address whether the sources of such adaptation are developmental changes, cohort differences, or the environments in which the interventions occur (e.g., nursing homes).

From a life span developmental perspective rooted in later life, the CCMSC model also poses the question as to whether presumably general theories and interventions rely too much on young adult research participants and client groups. That is, concepts and techniques may be more specific to young adult cognitive and emotional development than has been recognized. Both of these conjectures require further conceptual analysis and empirical testing, but are offered here as scientific implications of the CCMSC model.

Theory and research on emotion in late life is just beginning a highly productive phase. The assumption that there is no difference in cognitive behavioral principles with the elderly may need to be revisited in ten years. Socioemotional selectivity theory posits a greater salience of emotion for the elderly and a tendency to foster social interactions that support positive emotion (See Carstensen, Gross, & Fung, 1997). Whether (and if so how) this affects depressogenic cognitions is a task for future research and theory in CBT with the elderly.

Conclusion

Cognitive behavior therapy has much to offer the older client, offering the possibility of change in emotional state within relatively brief periods of time. It is adaptable for use with a variety of issues, and includes focusing on daily problems and their common sense solutions. Clinical experience and outcome studies indicate that these treatments are effective in addressing many of the more common problems in late life, including but not limited to depression,

alcoholism, insomnia, and issues related to physical illness and disability. Working with older adults offers the cognitive behavioral therapist the opportunity of learning from clients whose cognitions were shaped in an earlier time, whose problems are among the most severe that adults face in life, and who have a lifetime of experience and problem solving skills to draw upon. The application of cognitive behavioral therapy to older clients involves a number of professional and intellectual challenges including learning about the social environment of older adults, working with clients whose learning history was different from and prior to our own, and confronting the interplay of physical and psychological problems on a regular basis. Those who accept the challenge are likely to find that their ideas about therapy and about aging will be changed by working with older clients.

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