

A Clinician's Guide to:

Low Intensity CBT with older people

Marie Chellingsworth, Naoko Kishita & Ken Laidlaw



Foreword from IAPT National Advisor for older people



The development of evidence-based psychological therapies for older people may have lagged behind those for younger cohorts due to overt ageism; but also because of a number of more subtle barriers. The aim of these clinical guides is to reduce these barriers.

The number of people over 65 now using Improving Access to Psychological Therapies (IAPT) services has risen from less than 2% of this population to more than 7%. The recovery rate in IAPT is around 47% in the general population, but among people over 65 that rate is now 57%. So when older people get access to IAPT they get better. Considering the multiple challenges of late life this represents a significant health and economic benefit to the nation.

What we have in these guides is a distillation of the up to date evidence for these interventions and advice on their implementation in an accessible but scientifically robust format, compiled by two leading experts in the field. Here you will find both a detailed “how to do it” manual and a clear explanation of why you are doing it. Your views of ageing will be challenged. You will be provided with comprehensive reviews of Cognitive Behaviour Therapy (CBT) and other evidence-based interventions with this group. You will also find the latest social gerontological thinking, along with practical exercises and case studies illustrating how to get this work done.

Psychological work with older people is the same and different, as any other such work. These guides will help you identify the things you already know about high quality treatment delivery, reduce your fears about working with older people and educate you in the essentials you need to know to work confidently with this group. I am proud to recommend these guides to you as a significant step forward in providing equity of service to older people.

Stephen Davies
National Clinical Advisor for Older People and Equalities
Increasing Access to Psychological Therapies Programme
NHS England

Foreword from Kevin Jarman



Fewer older people have accessed IAPT services than expected despite them having better outcomes than their younger counterparts. We have updated the IAPT older peoples curricula in 2016, which was first produced in 2013, to provide more detailed support to IAPT therapists and practitioners to help to improve the quality of their work and resources within in this area.

This is part of a portfolio of work to increase the numbers of older people gaining access to IAPT that includes working with Age UK to advertise the success of IAPT in supporting older people with depression and anxiety disorders to reach recovery. The purpose of the new curriculum and workbooks are to ensure that all IAPT therapists and practitioners are competent and confident in providing therapy to older people.

The guide calls for IAPT services to provide home visits to increase the availability of psychological therapies to older people, many of whom find it difficult to come to appointments in community settings. This must happen if we are going to be able to provide equity of access for these people. Can I congratulate Marie, Ken & Steve for producing these materials that provide excellent advice and techniques to improve both High Intensity Therapists and PWPs in their work with older people.

Kevin Jarman
Work and Health Joint Unit (DH/DWP)
Previously IAPT Manager



The authors have created a real world illustration of how to effectively support older people to use CBT interventions. Increasing access to CBT for the betterment of our aging population is clearly very important. I am especially delighted to read the in-depth clinical examples and worksheets you can use with your own patients.

Dr Aaron T Beck

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Providing the source is fully acknowledged, all materials in this work may be freely printed for teaching and clinical purposes.

This workbook is not a standalone training manual and is part of the psychological therapies CBT with older people curriculum training days. It does not alone confer eligibility to practice Low Intensity CBT with older people. At all times practice of these techniques should be done so in a stepped care service with relevant clinical and case management supervision. Before using ideas contained within this workbook you should seek the appropriate training during the low intensity training certificate course or as continuing professional development. Any training to use these techniques should be delivered by those with experience in working with older people.

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About the authors



Marie Chellingsworth

"I am Executive Director of CBT and Evidence Based Programmes in the Department of Clinical Psychology, Norwich Medical School at the University of East Anglia."

I have been involved in the delivery and dissemination of psychological therapies and CBT interventions for many years, previously working as IAPT Course Director at the University of Nottingham and then Director of the Postgraduate Certificate in Evidence Based Psychological Wellbeing (PWP) and BSc in Applied Clinical Psychology (PWP) programmes at the University of Exeter.

I have worked nationally in CBT within the Department of Health IAPT Workforce, Education and Training committee, BPS PWP Accreditation committee and as a Trustee of the BABCP board. I also Chair the PWP National Networking Forum and the annual North and South conferences and am a member of the IAPT Expert Reference Group for SBK Events. I am a Consultant to the Australian IAPT programme 'New Access' that is run by Flinders University with Beyond Blue and the Movember charities which has three pilot sites running and a special focus on increasing access to men. My own interest in mental health came back when I was at school after hearing a song called Howard Hughes (a B Side of a band I loved called Ride back in 1992!). Outside of work I love good music and spending time walking with my two Irish Setters Alfie and Monty in the Devon countryside.



Naoko Kishita

"I am Senior Post-Doctoral Research Associate in the Clinical Psychology Department in Norwich Medical School at the University of East Anglia. My current research projects focus on late-life mental health and dementia care."

I completed a Clinical Psychology training programme and qualified as a clinical psychotherapist in Tokyo, Japan. Throughout my training, I gained lots of knowledge and experiences in Acceptance and Commitment Therapy which has grown out of behaviour analysis and basic behavioural principles.

The experiences I gained during my clinical training increased my interest in the theoretical background of CBT interventions. I became enthusiastic about increasing theoretical understanding of how treatments have their effect and building stronger empirical evidence for the efficacy of interventions used in the mental health services. Thus, upon completion of my clinical training, I decided to continue studies as a Ph.D. student. I joined the Department of Clinical Psychology at the University of East Anglia in July 2014. Working with the team here has been fantastic and helped me broaden my expertise in clinical psychology, especially cutting edge expertise in CBT with older people. I am currently a Pedagogical Lead for a newly generated, interactive online CPD course on CBT with older people at the University of East Anglia. Outside of work I enjoy cooking, especially Japanese food such as sushi and tempura! I also enjoy baking, movies, and yoga.



Ken Laidlaw

"I am currently head of department of Clinical Psychology at the University of East Anglia. I have been here for two years and I am currently rebuilding a research department as well as leading a new direction for a successful Clinical Psychology Training Programme."

I trained in a post qualification programme of CBT when these developments were new. My first experience of training in CBT came when I was taught by Professor Ivy Blackburn at Edinburgh University as an undergraduate. I was just amazed by what CBT had to offer and then when later I was accepted onto the Edinburgh Clinical Psychology training Programme and had more experience of being taught by Ivy it just sealed my enthusiasm for CBT.

I've never lost that enthusiasm and I transferred it to work with older people. When I first started this work, it was thought CBT was too abstract for older people, or that older people wouldn't want therapy. Both ideas are now fully debunked. I also had the great good fortune to have mentorship in CBT from the real pioneers of CBT for older people; Professors Larry Thompson and Dolores Gallagher-Thompson. I also have trained in Philadelphia as a visiting scholar with Dr A. T. Beck. In all my travels and training I have learned that CBT is not easy, and the skills necessary to acquire competence in this powerful therapy should not be underestimated. I have been taught by the older people I have worked to understand that age is a number and not a barrier to change. Outside of work I mangle a guitar and learn time and again that my daughter can always outmanoeuvre me at chess. My wife outmanoeuvres me everywhere else!

Introduction

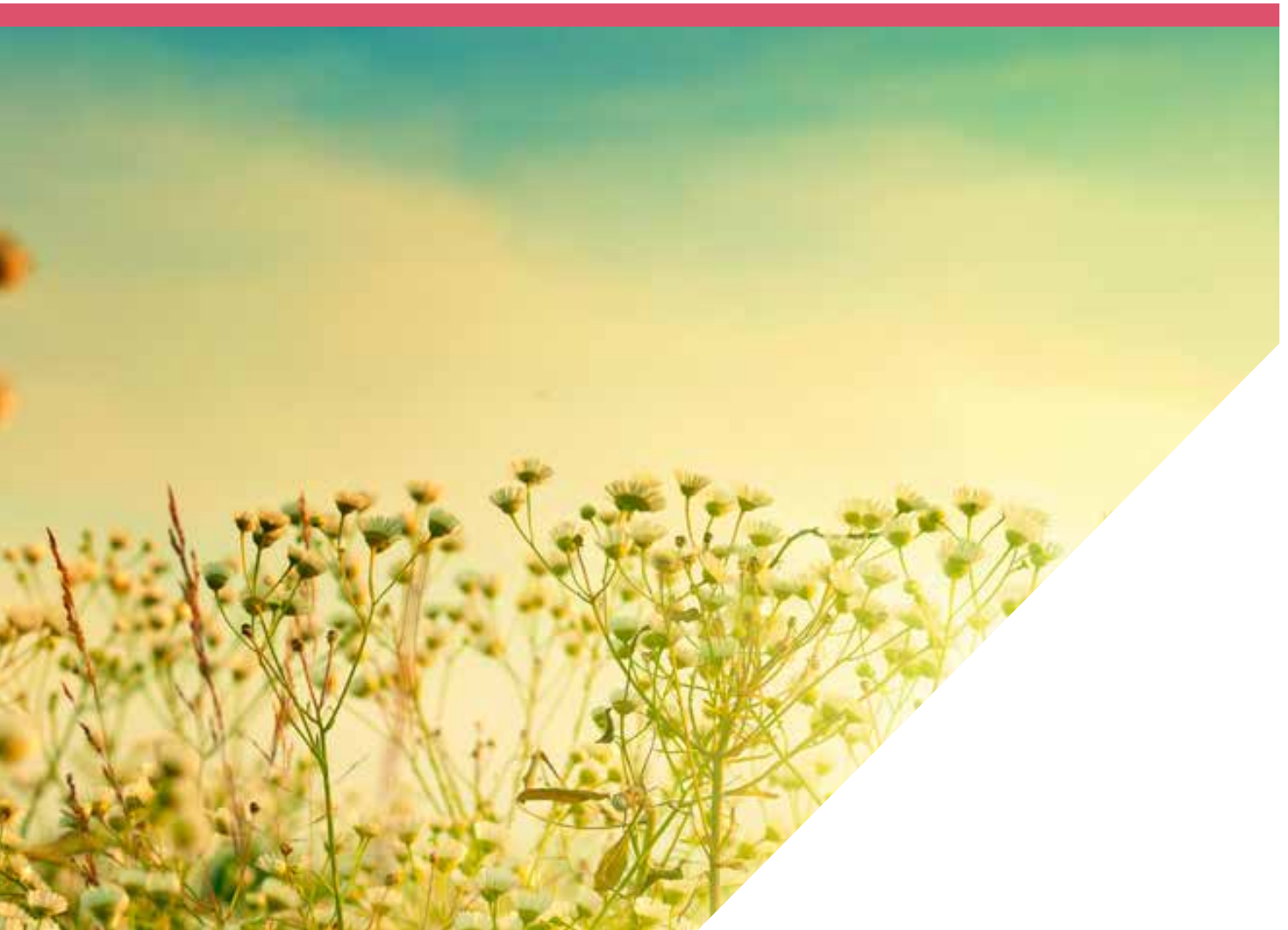
This workbook presents an opportunity for Low Intensity CBT practitioners to review the skills; competencies and knowledge needed to effectively and efficiently deliver Low Intensity CBT (LICBT) with older people.

While the workbook provides an account of how LICBT may be different with older people, at all times it is advocated that the structure and philosophy of the application of LICBT remains the same. A key issue covered is whether and in what way we may need to modify LICBT so it can be applied effectively with older people. To answer this question, we need practitioners to be able to understand and differentiate between successful, healthy ageing and less healthy ageing. We also need practitioners to understand something about the new cohorts of older people we will be treating as well as the demographic picture of ageing in the UK in the 21st Century.

The key to addressing this is to approach working with older people from a gerontological rather than a geriatric perspective. Gerontology is the science of ageing, whereas geriatrics is the science of illnesses of old age. As all CBT based approaches seek to empower the patient to become their own therapist, we can do this more effectively by appreciating that we must resist conflating ageing with loss and deficits. Ageing is not dying; it is the direct opposite, ageing successfully is living life to the fullest. Old age is not inevitably accompanied by depression, anxiety or dementia. These conditions are not the consequences or natural outcomes of old age and are not in fact experienced by the majority of older people. Where depression, anxiety or dementia is experienced, much can be done to help both the person themselves and their carers.



Using LICBT with older people may sometimes present some challenges for practitioners unused to working with this patient demographic. In some circumstances depressed or anxious patients may have multiple comorbid conditions or physical problems that practitioners may be concerned about working with, or may assume will impact negatively on any potential outcomes. In this respect practitioners may feel deskilled in using LICBT to treat depression or anxiety disorders in this context of complexity and feel that a more complex intervention is required or try to deliver multiple interventions at once with limited clinical time available to do justice to them. **We would argue that where there is complexity, the simplicity of the intervention provided is the most powerful option.**



On other occasions practitioners may be confronted by older patients who themselves present a convincing attribution of the nature of their problems being due to the ageing process 'It's understandable at my age.....'. Again this may seem to suggest that LICBT may not have much to offer these patients. It can be easy for the practitioner or referrer to fall foul of the understandability phenomena too. Hearing the situation and context in which the patient presents practitioners may think that it is understandable that they feel that way at their age in their particular situation. Depression and anxiety in later life are not an inevitable or understandable part of ageing and there is much that can and should be done to help. Practitioners need to maintain a stance of non-assumption about ageing and an appreciation of individual variation when working with older people.

As ever the essential collaborative nature of CBT approaches emphasise the message that we need to fit LICBT to the individual and not the other way round!

This workbook aims to help LICBT practitioners to gain confidence in working effectively with older people. The workbook is being developed as part of a suite of materials for the IAPT older people curriculum. It is consistent with the training slides and other practitioner tools. It is designed to equip you to become confident in applying your existing competences, skill and knowledge of LICBT with this patient group. We hope you find it useful for your clinical practice.

*Marie Chellingsworth, Naoko Kishita & Ken Laidlaw
September 2016*

The fundamentals of increasing access for older people

The Improving Access to Psychological Therapies (IAPT) programme in England has been working hard to successfully increase access to evidence based psychological interventions across the age spectrum. Yet we also know equal access to these interventions for people over 65 has not yet been fully achieved, although much progress has been made.

Analysis of data from the First Wave Improving Access to Psychological Therapy (IAPT) sites showed inconsistency in access at that time. Some services then saw no older people at all and on average only 4% of people seen were aged 65 or above. Luckily that situation has improved but there is still much to be done.

In 2014/15 7.09% of treatment completers were older adults. Very positively, the Improving Access to Psychological Therapies data, published by the Health and Social Care information Centre: <http://www.hscic.gov.uk/catalogue/PUB17880/IAPT-month-Apr-2015-exec-sum.pdf> shows that in Q4 2014/2015 that those over 65 achieved recovery rates of 58% and consistently across 2014/15 achieved higher recovery rates compared with working age adults. We already know from literature reviews and meta-analysis that CBT for older people has been shown to be effective in clinical trials. These results in routine clinical practice further demonstrate and cement that older people can make use of CBT and other evidence based interventions and need to be supported and encouraged to access them. The Department of Health has stated that particular attention must be paid to ensure appropriate access to psychological therapies for people over the age of 65 is available (Talking Therapies a 4 year plan of action, 2011).

Improving access for older people is important for a number of reasons, not least equity and the fact that we are a rapidly ageing population with greater life expectancy than ever before. The number of people aged 60 or over is expected to pass the 20 million mark by 2031 and the number of people over 75 is projected to double in the next 30 years. One in five of us alive today will live to see our 100th birthday. People are living longer than in any previous generation, with two-thirds of all the people who have ever reached the age of 65 years being alive today (HSBC ad) and two people celebrating their 60th birthday every second around the world (UNFPA, 2012). For practitioners it means the patient group we will see in our clinical careers is changing rapidly and we need to have an adaptable skill set to feel confident to work with people across the wide age spectrum to keep apace. The good news is that the majority of people generally remain in good health until the last few years of life, termed the constriction of disability.



It is amongst the oldest-old (i.e. people aged 80 years and above) that we find the most extraordinary relative increase in numbers. For instance, the number of centenarians shows rapid and exponential growth in numbers. According to the Office of National Statistics (ONS, 2011), there were 10,000 centenarians alive in the UK in 2009 and yet when these people were born there were only 100 centenarians living in the UK. By 2013, there were 13,780 and by 2051 there will be an estimated 280,000 people aged 100 years and above living in the UK (ONS, 2014). In relative terms, as the largest population increases are seen in the oldest-old group it will become increasingly common for mental health professionals to have nonagenarian (aged 90-99) and centenarians patients on their caseloads. There is a need for greater specialism in working effectively with older people as the baby-boomer cohort are turning 65 now and there will likely be increased demand for therapy services by this new cohort of older people. Our own views on ageing and working with older people may also need to move to reflect this change. We often think of older people as those who lived through the war; but this group is changing. Baby boomers are the new older people cohort.

The new generation of older people may in fact challenge our own assumptions of what ageing is like. Blondie, for example recently turned 70 and Mick Jagger is now 72; both are still touring worldwide to huge audiences and recording. We are also seeing more frequent examples of positive ageing in society. For example Hilda Bolger, the 102 year old psychotherapist in Los Angeles who is still working and pursuing her life goals (see www.beautyofageing.com for a documentary in which she is featured). Also, Fauja Singh who was born in India in 1911 and began running marathons aged 89 and continued to race until he was 102. Daphne Self is also an example of positive ageing, who is credited as being the world's oldest working super model who has been modelling since

1949 and recently turned 87 in July. In 2015 she published her book 'The Way We Wore: A Life in Fashion' and she frequently adorns advertising campaigns for designer brands seeking to market to a wider age group and has recently graced the front covers of Vogue, Harpers Bazaar and many other fashion and lifestyle magazines.

We need to understand more about how we can help to increase access to older people and what the barriers to access may be so that they can be overcome. We also need to ensure that the practitioners of the future that we may all supervise, train or work alongside also recognise the importance of this. With increasing longevity we may find that we need to consider how appropriate our developmental frame of reference for applying CBT interventions with older people is (Laidlaw & Kishita, 2015). With people living much longer lives it is possible that the patient will be much older than the practitioner and with the increase in the numbers of older people coming into psychological therapy services, it may be important to consider what issues practitioners may need to confront when working with patients who may be 4 or 5 decades older than they are. While this may present challenges for some, it also presents opportunities for practitioners alive to the possibility that older people are resilient survivors rich with life experience and possessive of life skills that practitioners may not have yet developed. In this frame of reference, enhanced collaborative working in CBT approaches respects, values and empowers older people to make significant progress in overcoming their problems. Healthy, successful ageing should be the norm. Depression and anxiety in late life are not the norm but are very treatable problems highly amenable to the interventions we can offer. To do this, we need a workforce of practitioners who feel confident and competent to work with this wide patient group, truly believe that change is possible at any age and that they effectively help the patient to help themselves.

Increasing older people's access to IAPT services

As you will see throughout this workbook, there is no doubt to the fact older people can benefit from CBT and when they are in treatment, achieve good recovery rates. As we have stated in the evidence section, consistently in 2014/15 the recovery rates achieved for those over 65 in IAPT services have been higher than those of working age adults. The challenge that exists however is in ensuring that older people do not face any obstacles to accessing the services and are seen in sufficient numbers. Services need to be increasingly responsive and flexible to increase access for this patient group. One way to do this is to take the service out into community settings such as residential, nursing homes or day centres. It provides an excellent opportunity to help older people themselves to see what services can offer them, how they can refer themselves and to build possibility and hope of change in those who may benefit.

The 'understandability phenomena'

Older people who are depressed or anxious can wrongly attribute their symptoms to be an understandable and unavoidable part of the ageing process. As a result, older people themselves may not ask for or actively seek treatment when they are depressed or anxious. This is known as the understandability phenomena. It is essential to help both older people themselves and potential referrers to recognise anxiety and depression and how this may present differently as we age so they know what to look out for and when treatment could benefit them. In the event that older people are referred to IAPT services, it is important to assess the individuals own idiosyncratic understanding of the reason for their referral and what they attribute their problems to.

Practitioners and healthcare staff can also sometimes wrongly attribute these symptoms as part of the ageing process and not accurately detect them. Healthcare staff inexperienced in working with older people psychologically may over-estimate the prevalence of distress as we age and also under-estimate the likelihood of good treatment outcomes. Depression or anxiety may be seen as 'understandable' in older people as it is wrongly assumed that ageing brings many losses leaving people more vulnerable to developing depression (Burroughs et al, 2006).



The Fallacy of good reasons (Unutzer et al. 1999)

People often attribute the onset and maintenance of problems to 'old age'. Take for example an 84 year old woman who is depressed. Her healthcare provider knows she is widowed and now lives on her own, she has a number of chronic physical health conditions, as well as being isolated due to family relocating and friends dying in recent years. Her healthcare provider, thinks, if this had happened to me, I'd be depressed too and unfortunately because of this, then erroneously believes there is no point in intervening as problems are seen as understandable to the context and unchangeable. Thus older people have an elevated risk of being denied access to psychological treatment despite the efficacy of these approaches.

This mistaken belief that depression in later life results from aging is known as the "fallacy of good reasons" (Unutzer et al., 1999). It is contradicted by evidence from long-term follow-ups of older people in community settings where levels of depression are actually lower in older people than in adults of working age (Blazer, 2010) and rather than ageing being a depressing time of life, there is in fact an increase in wellbeing and emotional stability as we age (Carstensen et al. 2011).

This has been found in a number of international studies on life satisfaction across the age spectrum. The Office for National Statistics have also recently published a document 'What age is Personal Well-being the highest' (ONS, 2016) (http://www.ons.gov.uk/ons/dcp171776_431796.pdf). It analysed personal well-being data for over 300,000 adults in the UK, collected over a 3 year period between 2012 and 2015 and the key findings were:

- Those aged 65 to 79 tended to report the highest average levels of personal well-being. Ratings of life satisfaction and happiness were at their lowest, on average, for those aged 45 to 59
- Those aged 90 and over reported higher life satisfaction and happiness compared with people in their middle years but were less likely to find their activities worthwhile compared to other age groups which has important implications for building in personally valued, meaningful and important activities when working with this age group
- Average anxiety ratings increased through early and middle years, peaking between 45 to 59 years, but then subsequently falling and remaining relatively unchanged for those aged 65 and over

IAPT services have a key role in educating those who work with older people in health or social care sectors about the evidence base and what can be offered, and achieved as well as debunking common myths of ageing and life satisfaction. It is vitally important to be able to promote what psychological therapies services can offer to older people and to clarify, where necessary, that older people can and do benefit from psychological therapies and that research has shown they value the opportunity to be referred to them.

Things you can do to counter the understandability phenomena, fallacy of good reason and to help to increase access for older people:

- Encourage referrals from older people themselves – set up a class in the local community about successful and positive ageing (and what are instead signs of depression and anxiety).
- Encourage referrals to IAPT from local primary care services – offer to talk to GPs, practice managers and community or residential services about how effective CBT is with older people and use this as an opportunity to debunk some common myths about ageing. The key facts on normal ageing can help to do this.

What is normal ageing

- Older people have lower rates of depression not higher than working age adults.
- Despite the challenges associated with ageing, older people report high levels of life satisfaction (the ageing paradox).
- When older people look back on their lives there is a positive bias for recall of past events. When depressed, recall is more likely to be influenced by the persons negative mood. Therefore people may characterise their lives as having been a catalogue of errors and failings. (overgeneralised autobiographical memory bias).
- Later life is a time of better emotional stability and a time of growth and personal acceptance.
- Contrary to popular belief, older people prefer 'talking treatments' and hold positive attitudes towards health seeking; viewing therapy as an option that is effective and as acceptable as a medication but with far fewer unwanted side-effects. If given a choice, older people prefer to receive psychotherapeutic treatments rather than psychotropic medication (Gum et al. 2006; MacKenzie et al. 2008).
- Older people do as well, if not better, when offered a course of CBT than working age adults with either no difference in treatment outcome (Cuijpers et al, 2009) or, as has been the case in IAPT, achieving better outcomes consistently in 2014/15 (HSCIC, 2015).
- Older people may even be better candidates for therapy as they are less likely to drop-out early compared to younger people as has been seen within the IAPT programme.

Detection challenges and barriers

Healthcare professionals in primary care will not necessarily have received training in care of older people (geriatrics), and there may be a reluctance to investigate mental health issues for fear of opening a 'Pandora's box' of complex and challenging scenarios professionals fear being ill equipped to manage (Unutzer et al. 1999). Detection of depression and anxiety may be particularly compromised because older people rarely use the terms depression or anxiety and often present in primary care settings with a number of physical comorbid conditions thus complicating detection and diagnosis.

We need to remember that detection, particularly of depression is a very specialised activity and if detection is missed this is not a systematic attempt to prevent access for older people.

Mitchell et al (2010) recommend GPs maintain a high index of suspicion of mood disorders and should ask about depression or low mood more often. Educating GPs and other health and social care staff about the service and giving out promotional materials or doing talks at protected lunchtime education slots or practice meetings, liaising with physical care and long term conditions (LTC) staff and working collaboratively to offer older people on LTC GP registers appointments are all ways in which services have identified are helping to meet local need (Department of Health, 2013).

GPs and other healthcare professionals may also ask you what are good questions to use when time is short to help to identify depression and anxiety in older people. The IAPT data set measures (PHQ9 and GAD7 and disorder specific) are all helpful and some may already be in use in the GP surgery or setting you are working with. What is also very helpful for identification of depression and is free to use (it also takes less than 5 minutes to administer, with a realistic range of 1-3 minutes to complete with older people) is the the 5 item Geriatric Depression Scale (Rinaldi et al., 2003). It has the same sensitivity (ability to detect depression) and specificity (ability to discriminate or not confuse non-depression symptoms) as the original 15 item version and works equally well with men and with women.

The GDS5

		Y	N
1.	Are you basically satisfied with your life?	0	1
2.	Do you often get bored?	1	0
3.	Do you often feel helpless?	1	0
4.	Do you prefer to stay at home rather than going out and doing new things?	1	0
5.	Do you feel pretty worthless the way you are now?	1	0

Total score:
(2 or more is likely to be depressed and warrants further investigation)

References: Hoyle, .T., Alessi, C.A., Harker, J.O., et al (1999) Development and testing of a five item version of the geriatric depression scale. J A Geriatric Soc. 1999, 47:873-878 and Rinaldi, P., Mecocci, P., Bendetti, C., Ercolani, S., Bregnocchi, M., Menculini, G., Catani, M., Senin, U. & Cherubini, A. (2003) Validation of the five-item Geriatric Depression Scale in elderly subjects in three different settings. J. American Geriatric Society, 51, 694-698

Seeing client's 'out of office' in their own home or residential care unit

IAPT has recommended routinely visiting people at home or the place they live and offering people older people a choice of being seen in the service or at home (Department of Health, 2013).

Seeing people at home rather than in a clinic or GP surgery can also offer numerous benefits to increase access when working with older people. Firstly, it offers the opportunity for the person to overcome any practical barriers to access that may exist, such as travel or caring responsibilities they may hold. Similarly, it can allow the patient to feel comfortable to share information and for the practitioner to see people who otherwise would not have an opportunity to be helped.

The options of older people being seen 'out of the office' is not really that different to IAPT services offering access 'out of hours' and telephone treatment to those who would not have been able access to IAPT without this adaptation. Although there are some realistic challenges to seeing people in their own homes, there are more advantages than disadvantages. There are many more advantages of seeing clients in their home than disadvantages. Of course, one challenge is time-constraints and staffing, but this may be offset by the enhanced data-collecting that occurs in seeing a patient in their own environment and increased access. The patient may be more relaxed being seen in their own home and may 'open up' about problems more readily. There may also be ethical issues around confidentiality if a patient is seen in an environment with others present but careful thought and sensitive preplanning can nullify these. For example, if you are seeing a patient in a ward or residential setting, it is good practice and professional etiquette to call up in advance of your visit to discuss this with the nurse in charge or manager and you can then request a private meeting space if available. If you see your client at their home, check that they are happy for family members to be present. If you do see patients out of the office, key policies and procedures for risk management and safeguards for lone working are essential. With a little forethought seeing patients in their own home environment can become a privileged insight into the reality of their lives. It can also enhance the therapeutic alliance as you demonstrate your commitment to their wellbeing. Many patients who may benefit from psychological therapies may live in residential or care homes and their low mood or anxiety go undetected. Working in partnership with local homes may offer much to the staff group and to the residents to change this situation for the better. To do this, being visible within these services is key to making a difference.

Challenging your own views on ageing

Exercise: Reflecting on working with older people

List some things that you would like to get from the training on Low Intensity CBT for older people:

Thinking about the older people you have worked with so far clinically (or imagine working with older people clinically if you haven't already done so) what do you feel are the challenges of working with this patient group?

What are the things you feel hopeful and positive about working with this patient group?

Worksheet: Your own views on ageing

We probably all have things we are looking forward to, or are not looking forward to about getting older. It is worth examining our own perceptions of ageing by reflecting for a moment on these. Take a few moments, either by yourself or with colleagues to consider those things and write them in the table below:

Things I am looking forward to when I get older	Things I am not looking forward to about getting older

Our own views on ageing



Now you have completed the views on ageing worksheet, what do you notice? Are there more things in one column than the other? Are the things in the positives column dependant upon the outcome of the things in the other? For example if you are looking forward to retiring, is this dependant upon your health status making it possible for you to enjoy that time?

Like other beliefs, our views on ageing are formed when we are in early childhood and will have been shaped the people around us who were older and their own views of ageing as well as environmental factors. With this in mind, it is conceivable that we may hold out-dated views on ageing that come from many generations behind us, for example our grandparents. In turn, our grand parents views on ageing will have been shaped by their own grandparents and so on. Therefore it is quite possible that the internalised views on ageing we hold, which may be triggered by an awareness of an age related change (finding a grey hair or wrinkle for example), are not in keeping with the context or generation in which we are living. An example of this is a person now in his 70's whose views on ageing will have been shaped by his own parents ageing and environmental factors growing up, as well as his own grandparent's views on ageing.

Life expectancy at that time was about 50 for a man. Therefore when the person now in his 70s turned 50 and noticed he had altered in some way due to his age such as wrinkles, losing his hair or a physical limitation, those beliefs about ageing may be activated leading to thoughts such as 'It is all downhill from here' and 'I am old now' when life expectancy for him would be much higher than that of his parents and grandparents.

Taking stock of the implications of this for your own ageing and for that of your children consider the year you were born in the table below and the age that you will reach 65 and may well reach 100. Then look at your parent's year of birth and when they would have/did turn 65 or 100 and then consider your grandparents. Reflect upon the different things you may have all lived through, different life experiences and ways of living. Now think about your own children, or those of your siblings or friends, when will they turn 65 and 100 and try to imagine what life may be like for them.

YEAR BORN	YEAR WILL BE 65	YEAR WILL BE 100
1920	1985	2020
1930	1995	2030
1940	2005	2040
1950	2015	2050
1960	2025	2060
1970	2035	2070
1980	2045	2080
1990	2055	2090
2000	2065	2100
2010	2075	2110
2020	2085	2120

Practitioners sometimes say it is difficult when working with an older patient to separate the situation and context from the problem that is amenable to treatment. It can be that some patients tell a convincing story of losses and deterioration that can seem understandable and that they themselves attribute their difficulties to their age. Read the two examples below and spend a few minutes reflecting on your thoughts as you do so. The first is Rose a 69 year old widow.

Clinical scenario: Rose 1



Rose is 69 years old and a widow. She has two grown up children Michael and Kate and lives in a small rural village in Norfolk. She lost her husband to cancer three years ago. Her GP practice has referred her to the local psychological therapy service as she was frequently seeing or phoning them due to aches and pains and they felt she might be experiencing some sort of depression or anxiety.

Michael and Kate her children both live in London for their work and Rose says they have 'busy lives' and that she 'doesn't want to be a burden to them' and that 'they don't have time to be bothered by her problems'. She has been finding it increasingly difficult to get about and no longer leaves the village. She will use the local shop for necessary things like milk or bread and either Kate or Michael will organise a supermarket to deliver groceries using online shopping each week. She has been diagnosed with mild arthritis in her hands and mild dry macular degeneration. Upon being diagnosed with her eyesight problems four months ago she gave her car away to her daughter Kate to use. There is a bus in her village but it only comes once a day in the mornings and Rose tells you she struggles to get going in the mornings then due to her age.

She previously used to enjoy walking with her husband at weekends, painting, reading and crafting but tells you that there is no point now due to her eyesight so she has stopped doing them. She says she is more tired than usual, has not been sleeping very well due to aches and pains that cause her to worry about her health and losing her eyesight completely. Her appetite has decreased but she says that it is to be expected at her age. She doesn't think the service could help and they would be better spending their time helping people more

deserving and younger than her. Rose used to work as an art teacher at the local comprehensive school and also ran a small art gallery with her husband until they retired at 60. Losing him was difficult for her. She struggled to complete the Minimum Data Set measures due to her eyesight and these had to be read to her one by one over the telephone in the assessment. They showed she has both a moderate level of depression and anxiety.

Reading through the Rose's scenario, what do you think the main difficulties are? What complexities or challenges would you predict may occur in working with her? Are any of her symptoms a consequence of age rather than mood? Do you feel she is suitable for treatment?

Clinical scenario: Rose 2



Rose is 43 years old. She lives in a small rural village in Norfolk. She lost her husband to cancer three years ago. Her local GP practice has referred her to the psychological therapy service as she was frequently seeing or phoning them due to increased aches and pains and they felt she might be experiencing some sort of depression or anxiety.

She is currently off on long term sick from her role as an art teacher at the local school. She has two adult children Michael and Kate who both live in London and Rose says they have 'busy lives' and that she 'doesn't want to be a burden to them' and that 'they don't have time to be bothered by her problems'.

She has been finding it increasingly difficult to leave the village as she worries she will not be safe and she will use the local shop for necessary things like milk or bread. She also asks her children to do her online shopping for her. She was diagnosed with mild arthritis in her hands aged 41. She was also recently diagnosed with mild dry macular degeneration that affects her eyesight. Upon being diagnosed with her eyesight problems two months ago she also stopped driving.

There is a bus in her village into the city but it only comes once a day in the mornings and Rose tells you she struggles to get going then. She previously used to enjoy her working with the children, walking with her husband at weekends, reading, painting and crafting but tells you that there is no point now, so she has stopped. She says she is more tired than usual, has not been sleeping very well, worries a lot

about her health and about losing her sight completely. Her appetite has decreased. She has been off sick for most of the past year. She struggled to complete the Minimum Data Set measures due to her eyesight and these had to be read to her one by one over the telephone. They showed a moderate level of both depression and anxiety.

Reading through the second scenario of Rose aged 43, are any of your views on her suitability for treatment different. Was it clear to you that the patient was the same person at different ages? Did you think any aspect of her presentation was understandable due to her age when you read the scenario this time? what challenges do you predict in working with the 43 year old Rose? Is she suitable for treatment? What has the exercise made you think or question about working with older people and the context or story we hear?

Ageing is a process rather than a static state entered at 65

It is often difficult for practitioners inexperienced in working with older people to separate the age and any physical health complexities from the symptoms of depression or anxiety, hearing instead the story and conceptualising them as understandable in the face of those challenges. Is it understandable for Rose to have stopped doing things due to her age, arthritis or eyesight problems? Or is it part of the avoidance pattern that maintains depression and low mood we see across the age spectrum? Are the thoughts she has given understandable in her situation, or the negative cognitions of someone with depression?

We need to recognise that older people are not a homogeneous group; they are individual people spanning many different generations. From ages 65-100+, the older life stage spans the largest period of our lives. There may be shared generational cohort beliefs or shared experiences such as key lifetime events, but ultimately, just like when working with any patient from any age group, the idiosyncratic experiences of that individual are key to understanding and helping them with their difficulties.

When we think about treating 'older people' we often have a single image of an age group in mind. Frequently problems can wrongly be attributed as an inevitable part of ageing or due to loneliness or grief rather than depression or anxiety. Practitioners often think older people may be best served in groups to combat loneliness and so they have a peer group of shared commonalities. With our ageing population and increasing life expectancy, that may mean people who are in their 60's being put alongside people in their 90's or centenarians. In no other life stage would we expect there to be commonalities shared across such a wide age span. It would be the same as working with a group of primary school aged children and those in their fifties in a room together and expecting them to have shared interests and things in common.

We must recognise the cohort the older person comes from and respectfully use their knowledge and wisdom gained during their lifetime to help them to help themselves. We must approach working with older people with genuine hope that change is possible at any life stage and that such change is possible for that individual.





It is increasingly important when working effectively with older people to recognise their own unique experience and story; but not get so overwhelmed in the story or context that we miss the key symptoms of depression or anxiety. Older people often do not recognise themselves as part of their own age group, feeling younger than their years. They may have their own negative stereotypes of ageing and not consider themselves yet part of their own peer group. Working respectfully with older people means seeing the person, not the problem or age. A good way of testing your own assumptions and beliefs is to reflect when working clinically with an older person, if this was someone of 25 or 35 would your views be the same?

As a practitioner, recognising successful ageing from unhealthy ageing is paramount. Understanding the prevalence of depression or anxiety in later life and being able to recognise how it may present is essential. Take a few moments to consider:

How common you think depression and also anxiety may be in those over 65?

Do you think it is higher or lower than in working age adults?

What makes you think that?

Are any symptoms of depression or anxiety different in older people presentations compared to other age groups?

Is it inevitable that life gets worse as people get older?

What are the implications of this for your own clinical practice?

Depression in later life



Depression is not nearly as common in later life as people mistakenly assume, and in fact, older people are less likely to be depressed than working age adults. Additionally, researchers have found that people's emotional wellbeing increases as they age and that those who experienced more positive emotions than negative emotions tended to live longer.

Researchers who study ageing report a common 'ageing paradox' that despite the challenges later life can bring for some, older people typically report higher levels of life satisfaction than any other age group.

People tend to accommodate to change and loss as they are seen as being 'on-time', meaning expected as a common event experienced as part of growing older. Certain medical conditions, such as dementia, become more common but are not inevitable and do not affect everyone.

While it is obviously good news that clinical depression affects only a minority of older people and is less prevalent than in working age adults, depression is still the most common mental health problem experienced in later life. Depressive symptoms, rather than clinical depression, may be more common for older people. People may experience a number of symptoms of depression, but would fall below caseness on clinical measures. Older people with clinical depression or depression symptoms may notice that they have less of an interest in hobbies or activities than before and they may find it hard to motivate themselves.

They might experience sleep or appetite changes. Often, the older person overlooks these symptoms and views them as an inevitable part of ageing. These are not symptoms of old age, but symptoms of depression. Depression in older people is treatable and Low Intensity CBT strategies can be used and augmented to treat them.

Key facts: Depression in later life



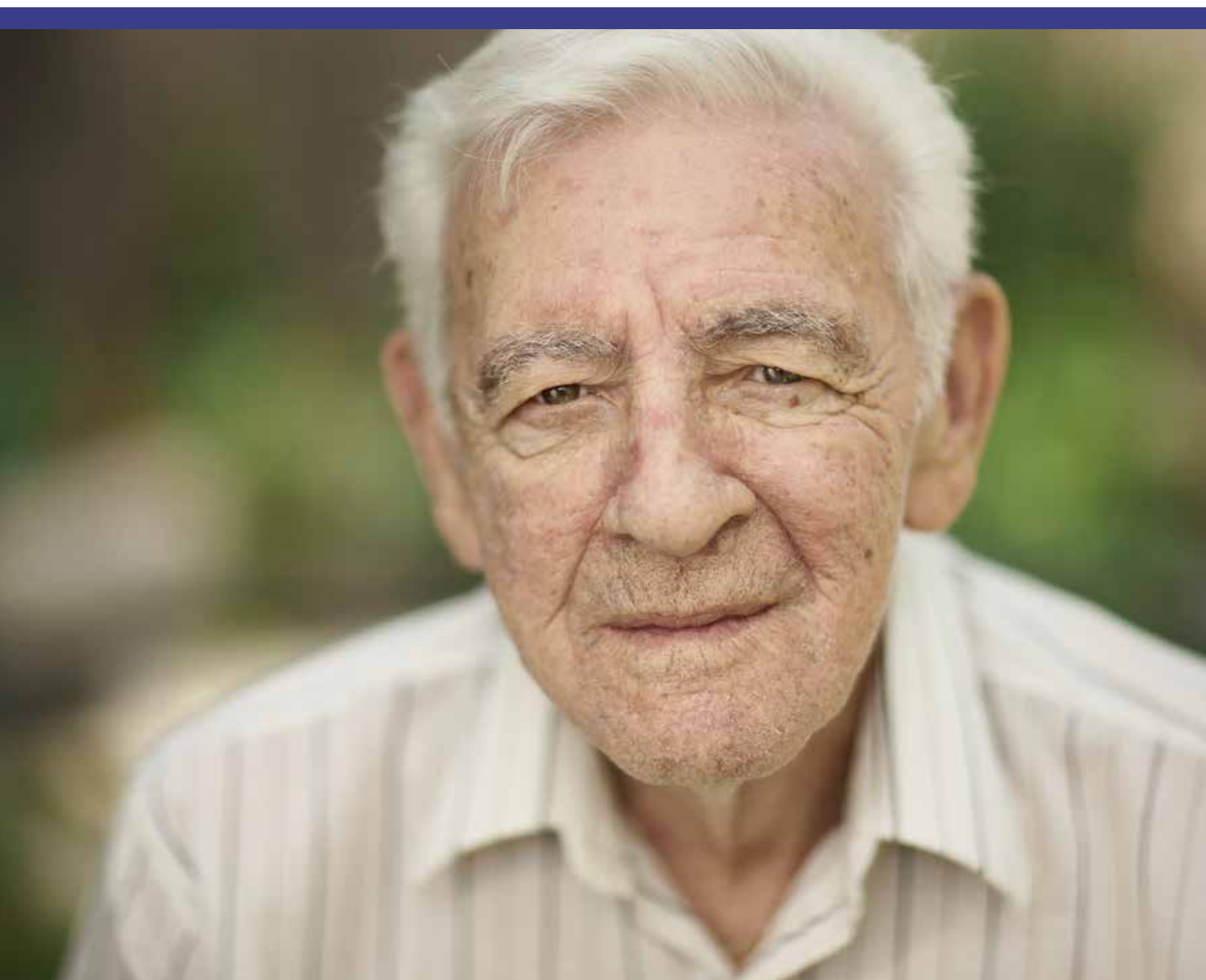
- Depression is not part of normal ageing.
- Depression in older people, irrespective of cause, is treatable and you can support someone to use evidence based Low Intensity CBT techniques.
- Treatment outcomes for depression in older people are no different from outcomes expected in other age groups (in fact they can be higher).
- Older people are not less likely to engage or more likely to drop out, in fact the reverse is true.
- Depression rates may increase, in certain circumstances, after a major physical illness at any age (e.g. after a stroke, or after onset of diabetes), BUT depression does not automatically result because of the presence of physical illness and it is not inevitable.

Anxiety in later life

Commonly, anxiety can occur alongside depression in older people (Vink et al., 2008) but an anxiety disorder may also be experienced by itself in later life. Often the older person may overlook the symptoms of anxiety or practitioners may not recognise them, and help seeking for anxiety by older people is less likely according to some sources (Scott et al., 2010). Scoring on measures may be lower or complicated by comorbid physical health conditions and so use of the Work and Social Adjustment Scale (WASAS) and relevant disorder specific measures is essential to ascertain symptoms and their impact.

An important consideration for the practitioner is to ascertain if the anxiety is part of a recurrent pattern that was present prior to entering later life, or if it is a new presentation. Similarly, a comorbid physical health condition or conditions may be impacting or may have played a contributory role in the onset.

When assessing in an LICBT framework, it can be challenging for practitioners to gather all the information they need to understand this picture in the time available. Similarly, patients may feel that their story has not been heard. The use of a brief time line of key life events and previous episodes of mood problems completed during the assessment or given as a homework task for the patient can help with this. A timeline can allow an older person's key life events and adversities to be recorded in brief visual form and save the practitioner time in collecting the rich data that may otherwise be overlooked. A time line is respectful of the patient and allows them to feel that they have been heard and understood as an individual. A worksheet for timeline collection is provided further into the workbook. If collected, the information it contains can be used clinically to help the patient to use their experiences to help with their current situation using wisdom enhancement (see the wisdom enhancement section).



EXAMPLE TIMELINE: MR. JONES, 72

First episode of depression after his father was killed in an accident. Aged 24

Mild depression when retired aged 65. Had medication

Had a stroke aged 71, left sided weakness and speech problems

Presented with an episode of depression and anxiety about having another stroke aged 72

CBT evidence-base for late life depression

CBT is the most extensively researched form of therapy for late life depression (Wilson et al., 2008). Below we have provided an up to date summary of the CBT evidence-base for late life depression.

Figure 1 provides a summary data for effect sizes derived from the major RCT studies of CBT for late life depression. Selected characteristics of the studies included in the figure are presented in Table 1. In Figure 1, the effect size of each study is presented as a square. A diamond at the bottom of the figure presents the overall summary effect size. Effect size is a simple way of quantifying the treatment effects. An effect size of zero indicates no difference in treatment effect between treatment condition and control condition. In this analysis, a positive effect size indicates a favourable outcome for CBT group. A negative score suggests that the control condition (can be active such as another psychotherapy or passive such as waiting list) is more effective than CBT.

Figure 1. Effect sizes (Hedge's *g*) derived from RCT studies of CBT for late life depression

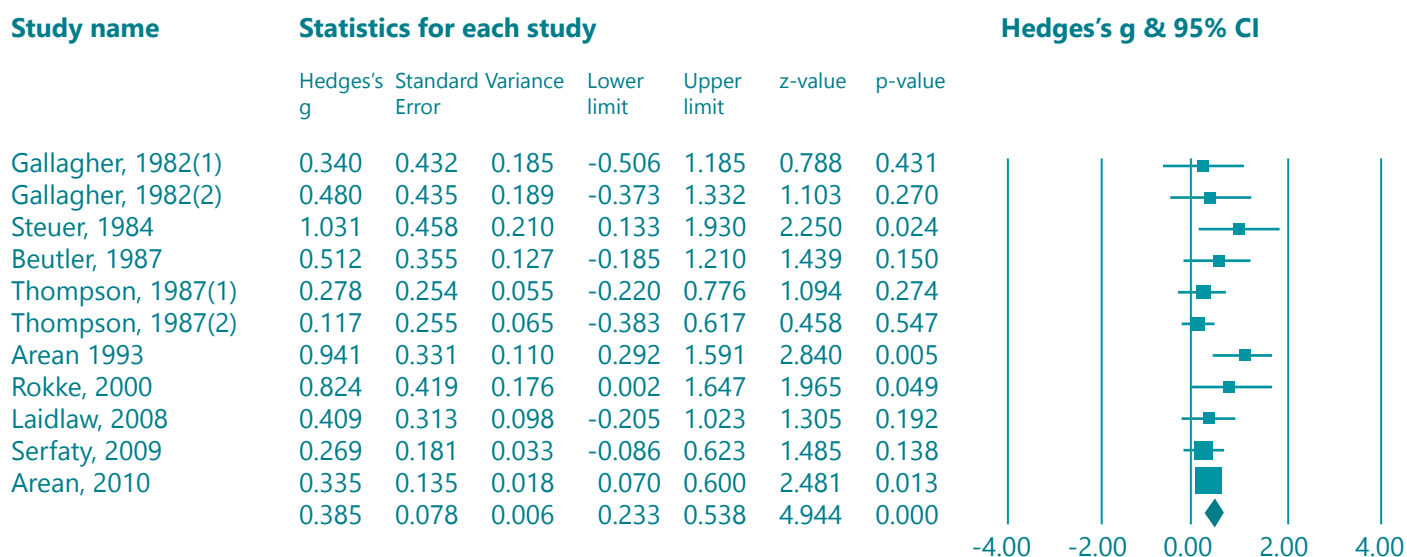


Table 1. Selected characteristics of RCT studies of CBT for late life depression

Study (First-named author)	CBT type	Type of control
Gallagher, 1982 (1) a)	CT	Brief insight-oriented psychotherapy
Gallagher, 1982 (2)	BT	Brief insight-oriented psychotherapy
Steuer, 1984	CBT	Psychodynamic psychotherapy
Beutler, 1987	CT + Placebo	Placebo only
Thompson, 1987 (1) a)	CT	Brief psychodynamic therapy
Thompson, 1987 (2)	BT	Brief psychodynamic therapy
Arean, 1993	PST b)	Waitlist
Rokke, 2000	Self-management therapy c)	Waitlist
Laidlaw, 2008	CBT	TAU
Serfaty, 2009	CBT + TAU d)	Talking control + TAU
Arean , 2010	PST	Supportive therapy

- a) The number in brackets represents different treatment conditions within the study (e.g., a study employing CT and BT treatment conditions)
- b) PST = Problem-solving therapy
- c) One form of cognitive-behavioural treatment based on the self-management theory of depression (Rehm, 1977)
- d) TAU = Treatment as usual

All 11 treatment conditions demonstrated positive effect sizes with four demonstrating medium to large effect sizes. The remaining seven studies evaluated the effects of CBT in comparison to an active control condition such as brief psychodynamic therapy (see Table 1). Figure 1 shows that effect sizes are smaller when CBT is compared to a treated control group than when compare to an untreated control group.

Overall effect size for the major RCT studies of CBT for late life depression was Hedge's $g = 0.39$ (95% confidence interval 0.23-0.54) considered to be a medium effect. According to the usual conventions, effect sizes of 0.2 are considered small, 0.5 are moderate and above 0.8 are considered large. Although the results in figure 1. demonstrate a moderate effect for treatment, overall CBT compares very favourably in terms of benefits for patients.

Cuijpers et al., (2009) examined the differential effectiveness of psychological therapies with older people and for adults of working age. Cuijpers et al., (2009) examined 112 studies comparing therapy outcome between older people and adults of working age, of these studies, 20 involved participants characterized as older people. When examining the effect sizes between younger and older people there is no difference in treatment outcome; older people effect size = 0.74; adults of working age (i.e. aged between 18-65 years) effect size = 0.67.

Two recent studies, conducted in UK primary care settings incorporated into a recent systematic review by Gould et al. (2012) address many of the methodological flaws evident in the earlier (US) outcome studies. Laidlaw et al. (2008) evaluated individual CBT for late-life depression in primary care by randomly allocating people to one of two treatment conditions; CBT alone or treatment as usual (TAU). In the TAU condition, older participants received the range of treatments they would ordinarily receive in primary care, without external influence. The CBT treatment consisted of cognitive and behavioural elements of treatment.

While participants in both treatment groups improved in depression outcome at the end of treatment and at six months follow-up, after taking account of baseline scores between the

groups, a significant difference in outcome emerged, favouring the CBT treatment as people receiving this option recorded significantly lower scores on the Beck Hopelessness Scale at six months after the end of treatment, compared with participants in the TAU group. Moreover, significant differences favouring CBT also emerged on evaluation of the number of participants who remained depressed according to Research Diagnostic Categorisation (RDC) status (a way of systematically agreeing symptom level measures of depression) at the end of treatment and at three months follow-up. This study remains one of the very few to compare the efficacy of psychological treatment with treatment usually offered in primary care (provided in the main by GPs) at follow-up beyond a few weeks after the end of treatment, and one of the very few that has systematically measured the effectiveness of CBT as a treatment in a non-medicated treatment group.

Marc Serfaty and colleagues (Serfaty et al. 2009; 2011) provide compelling evidence that CBT is an efficacious treatment for late-life depression in participants recruited from primary care. This study recruited people into three treatment groups: CBT plus TAU, TCC (a talking control condition) plus TAU, and TAU alone. CBT participants on average achieved better treatment outcomes compared to the talking control condition and TAU, with 33 per cent of those receiving CBT recording a 50 per cent or greater reduction in Beck Depression Inventory (BDI) scores, compared to 23 per cent and 21 per cent, respectively, for those receiving TAU and The talking control treatment. Importantly results of the RCT by Serfaty et al. (2009) discredit the idea that 'talking therapies' simply provide sad and lonely depressed people with a listening ear and empathic attention is the active ingredient, as those in the talking control group did less well than those in the CBT treatment group.

CBT evidence-base for late life anxiety

Figure 1 provides an up to date summary of data for effect sizes derived from the major RCT studies of CBT for late life anxiety. Selected characteristics of the studies included in the figure are presented in Table 1.

Figure 1. Effect sizes (Hedge's g) derived from RCT studies of CBT for late life anxiety

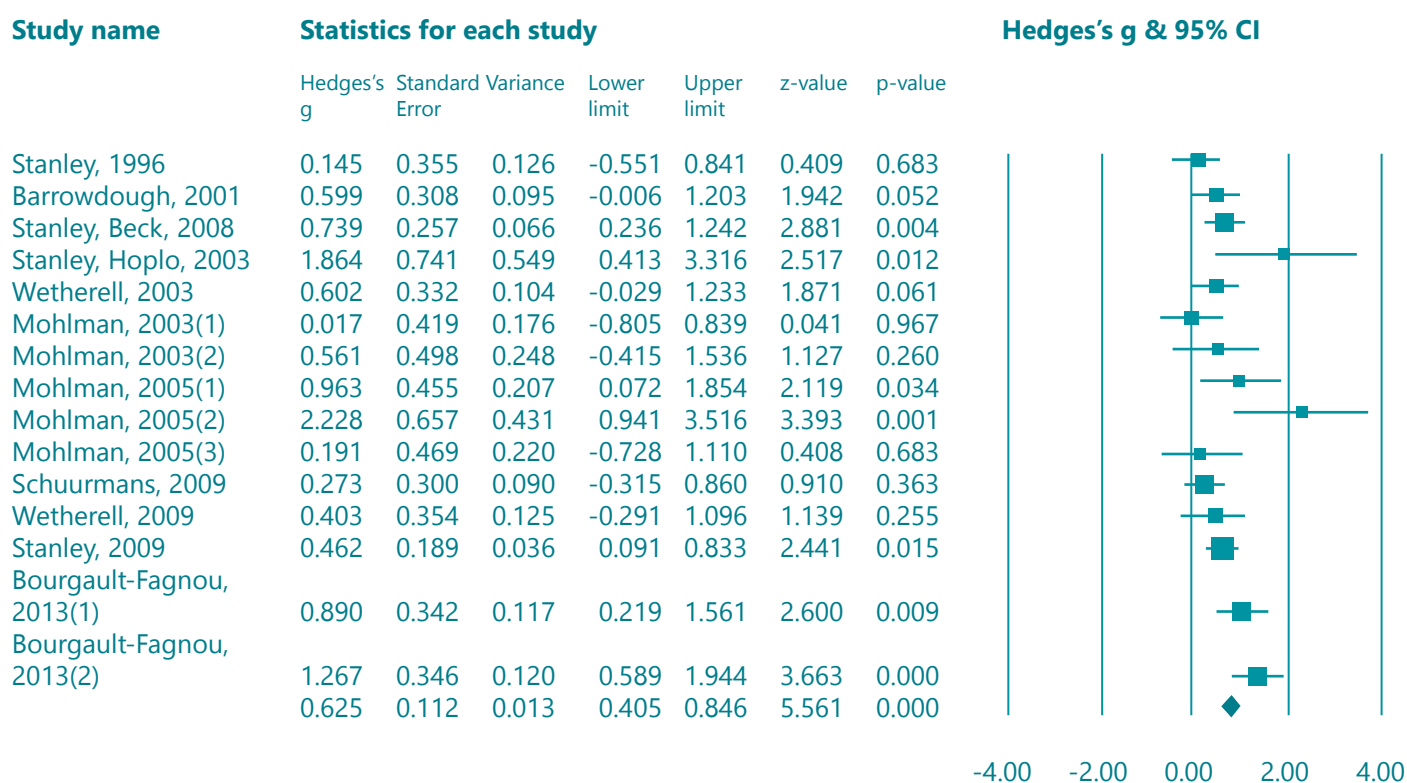


Table 1. Selected characteristics of RCT studies of CBT for late life anxiety

Study (First-named author)	Target disorder	CBT type	Type of control
Stanley, 1996	GAD	CBT	Supportive psychotherapy
Barrowclough, 2001	Anxiety Disorders b)	CBT	Supportive counselling
Stanley, Beck, 2003	GAD	CBT	Minimal contact control
Stanley, Hopko, 2003	GAD	CBT	Usual care
Wetherell, 2003	GAD	CBT	Waitlist
Mohlman, 2003 (1) a)	GAD	CBT	Waitlist
Mohlman, 2003 (2)	GAD	Enhanced CBT	Waitlist
Mohlman, 2005 (1) a)	GAD	CBT - Intact EF d)	Waitlist
Mohlman, 2005 (2)	GAD	CBT - Improved EF e)	Waitlist
Mohlman, 2005 (3)	GAD	CBT - Exec Dys f)	Waitlist
Schuurmans, 2009	Anxiety Disorders b)	CBT	Sertraline
Wetherell, 2009	GAD or ADNOS c)	Modular psychotherapy g)	Enhanced community treatment
Stanley, 2009	GAD	CBT	Enhanced usual care
Bourgault-Fagnou, 2013 (1) a)	Health anxiety	Enhanced CBT	Waitlist
Bourgault-Fagnou, 2013 (2)	Health anxiety	CBT	Waitlist

- a) The number in brackets represents different treatment conditions within the study (e.g., a study employing CBT and Enhanced CBT treatment conditions).
- b) Participants with multiple anxiety disorders were recruited.
- c) ADNOS = Anxiety disorder not otherwise specified.
- d) Intact EF = This CBT condition included individuals with intact executive functioning at both pre- and post-treatment.
- e) Improved EF = This CBT condition included individuals with low executive scores at pre-test but intact at post-treatment.
- f) ExecDys = This CBT condition included individuals with low executive scores at pre- and post-treatment.
- g) Modular form of psychotherapy using cognitive and behavioural components.

All 15 treatment conditions demonstrated positive effect sizes. Nine studies demonstrated medium to large effect sizes with the overall effect size for RCT studies of CBT for late life anxiety disorders, Hedge's $g = 0.63$ (95% confidence interval 0.41-0.85). This is considered to be a medium effect size for treatment. The results show a moderate effect size for CBT for late life anxiety.

Although empirical evidence supports the efficacy of CBT for late life depression and anxiety, there remains room for improvement. A recent review suggests CBT for older people may be augmented by applying gerontological theory in practice as "vehicles for change" (Laidlaw & Kishita, 2015). For example, evidence suggests that attitudes to ageing, which is a well-established concept in the area of gerontology, can be a useful predictor for earlier detection of risks associated with ageing and may therefore provide further insights into interventions to support active and healthy ageing among older adults (Kishita et al. 2015).

CBT evidence-base for people with dementia and their carers



The literature in this area can be divided into the efficacy of CBT in anxiety and depression in dementia and the evidence-base for caregiver interventions. Although the development of the evidence base for CBT with people with dementia is still a work in progress, the emerging findings have been reported. In total nine studies with a mix of methodologies have provided the evidence supporting the positive outcome of CBT treatments in people with dementia (e.g., Spector et al., 2013). An up-to-date evidence-base for caregiver interventions can be found in recently published two comprehensive reports. A systematic review by Goy et al. (2010) provides a very up-to-date evidence base of interventions aimed at informal caregivers (<http://www.hsr.d.research.va.gov/publications/esp/DementiaCaregivers.pdf>). A report by Elvish et al. (2012) provides a series of recommendations for professionals working with caregivers based on the evidence for psychosocial interventions with caregivers (http://www.bacp.co.uk/admin/structure/files/pdf/9346_dementia.pdf).

Low intensity CBT interventions

Although there is a large amount of evidence for the efficacy of CBT for late life depression and anxiety, the evidence for low intensity intervention formats is in its infancy and there is more research still to be done.

Scogin and colleagues (2009) in their published review of effective treatments for late life depression found 6 treatments to be effective, three of which: behavioural therapy (BA), bibliotherapy (CBT Self-Help), and problem-solving are classed as low-intensity interventions in the UK. Similarly, Cuijpers 2009 review of psychotherapy in younger and older adults found outcomes to be equivalent in the two groups younger ($d=0.67$) and older (0.74) also looked at delivery format and examined individual, group and guided self-help formats in their results.

Two important low intensity CBT research trials underway are CASPER (Collaborative Care in Screen Positive Elders) and CASPER PLUS. They are the largest trials of collaborative care for older people to date, undertaken by Simon Gilbody and colleagues at the University of York. The trials bring together screening of depression, collaborative care and Low Intensity BA delivered over the telephone. The aim is to find out if this is effective in reducing the severity of symptoms in older people in a cost effective manner in people with sub clinical or low threshold symptoms of depression and those with clinical presentations. The results of CASPER are due out in Spring 2016. Early results reported by the team show that telephone delivery was acceptable and older adults readily engaged with this form of delivery. This has important implications for the way that treatment is delivered. The longer term impact will be examined across a range of domains including symptoms of depression, quality of life and survival. Further information about the trials can be found here: <http://www.york.ac.uk/healthsciences/research/mental-health/projects/casper/details/>. A recent study using telephone delivered CBT for GAD versus non-directive telephone support by Brenes et al. (2015) also found that telephone delivered CBT was more effective than a non directive approach and was acceptable to patients.

The three authors of this workbook are also currently undertaking a comprehensive meta-analysis on low intensity CBT with older people which is being presented at the World Congress of CBT in 2016 and will be published shortly after.



CBT efficacy: How much change can you expect in CBT with older people?



Many times, we find ourselves surprised when one of our older patients adapts to a stressor more effectively than we could ever imagine.” (Blazer, 2010)

While the summary of evidence presented here suggests therapists can be confident of a good outcome with older people using CBT, this data has been generated by and large within clinical research trials. The outcome may be different in community and primary care settings, however there are a number of ways of examining this. One such approach is to examine datasets generated from within IAPT services. Using data from IAPT services nationally suggests an interesting finding that older people make good use of CBT. Very positively, the latest IAPT data published by the Health and Social Care Information Centre (HSCIC) at the time of report shows that in Q4 2014/15 those over 65 achieved recovery rates of 58% and consistently across the year achieved higher recovery rates than their working age counterparts. The report is available here: <http://www.hscic.gov.uk/catalogue/PUB17880/IAPT-month-Apr-2015-exec-sum.pdf>

Using the 2013/14 data with kind permission from DoH it can be seen that older people who are referred for treatment tend to stay in therapy. As the table below shows for 2013/14, 2 in every 5 older people complete a course of treatment. The comparable data for adults of working age is 34% or close to 1 in 3 adults of working age completing treatment.

CBT efficacy: How much change can you expect in CBT with older people?

The figures for 2014-15 show 43% of older completed treatment, this is getting close to a figure of 1 in 2 older people completing treatment. This type of data is similar to the clinical experience of one of us. As a clinician having worked for many years in older people services, the stereotype of an older therapy client is that they stay in treatment and usually attrition rates are low. Indeed, in the RCT by Laidlaw et al. (2008) attrition rate was just 10% for the CBT group.

Data on treatment completion rate compared to referral by age group 2013-14

	65 - 74	75 - 89	90 +	ALL
NUMBERS COMPLETING	17,605	6,267	163	24,035
NUMBERS REFERRED	41,496	17,920	820	60,236
COMPLETED / REFERRED	42.43%	34.98%	19.88%	39.90%

Data on treatment completion rate compared to referral by age group 2014-15

	65 - 74	75 - 89	90 +	ALL
NUMBERS COMPLETING	24,180	8,869	242	33,291
NUMBERS REFERRED	51,857	23,702	1,240	76,799
COMPLETED / REFERRED	46.65%	37.42%	19.52%	43.35%

From the tables above, it seems evident that older people aged 90 years and above are not doing as well as other age groups and this is a cause for concern as these clients may be facing more challenges associated with ageing and arguably could be seen as a group especially in need of evidence-based treatment. There may be less guidance on CBT with this age group. Readers are encouraged to review the section on age-appropriate CBT when working with oldest-old people (e.g aged 75+). One other piece of relevant evidence for treatment outcome for CBT with older people is to look for evidence of naturalistic outcome evidence (see Laidlaw 2013).

The foundations of Low Intensity CBT with older people

How is CBT for older people different?

In many respects older people come into psychological therapy services for the same reasons that younger people do such as relationship problems and difficult life transitions (Knight, 2004).

A CBT based approach with older people has as its primary aim symptom reduction (Laidlaw et al., 2003). Therefore any modifications to an already efficacious package of treatment ought to consider whether these are likely to further enhance outcome and symptom reduction. They should be undertaken on the basis of individual need not age only (Charlesworth & Greenfield, 2004).

Outcome studies with older people have predominantly borrowed models of treatment from adult treatment (Laidlaw & McAlpine, 2008), nonetheless studies of non-modified CBT for older people report good outcome (Gatz, 2007).

It is accepted that psychological therapies with older people can differ from working with younger people in a number of important respects because of the higher likelihood of physical conditions, changes in cognitive capacity, potential loss experiences and different cohort belief systems. Whilst some actual procedural adaptations for sensory limitations or losses may be required for some patients, such as those with sight or hearing difficulties requiring changes to hand-outs or the way in which a session is delivered (as would be done for a patient of any age) not all patients have such difficulties as a result of ageing as a matter of routine and these should not be unnecessarily applied, to do so may actually be disengaging and stigmatising for the patient. Often less experienced practitioners assume that sessions with older people require more time for example. In fact, for patients with physical health problems that affect sitting or concentrating for long periods, or those who struggle to take information in at the same rate, shorter rather than longer sessions may actually be more beneficial.

Depression and anxiety symptoms are the same across the age spectrum and do not change in later life, although the context in which the patient is in may be different.

A thorough assessment of symptoms leading to a disorder specific problem statement and provisional diagnosis in a Low Intensity CBT framework provides a frame of reference for the practitioner. Then, the same evidence based interventions for reducing those symptoms should be provided, with augmentation to the intervention to meet the needs of the contextual factors the patient presents with, where necessary.

As practitioners are often much less comfortable dealing with physical problems they may become negatively biased in terms of what outcomes are possible when patients present with co-morbid health problems.

Less experienced practitioners can also overstate the importance of losses experienced by older people, which can also lead to lowered expectations of the possibility of change and outcome. It should be remembered that the efficacy of CBT for older people has been demonstrated successfully both within systematic reviews and analysis but also within the Improving Access to Psychological Therapies (IAPT) data where older people in 2014/15 have consistently achieved higher outcomes than working age adults.

Consequently, there was a need to develop a model that addresses age related issues within a coherent framework suitable for older people. The contextual framework is augmented with additional account taken of cohort beliefs, intergenerational linkages, sociocultural context, health status/beliefs and role investments/ transitions (Laidlaw et al., 2003; Laidlaw et al., 2004). This may be completed after the assessment or notes made during it, to get an overall picture for case management supervision and assessment of suitability for the approach. It can also help the practitioner to separate out the context of the older persons situation from the clinical symptoms of depression and anxiety that can be treated whilst being mindful to augment treatment to the context in which the patient is experiencing them.

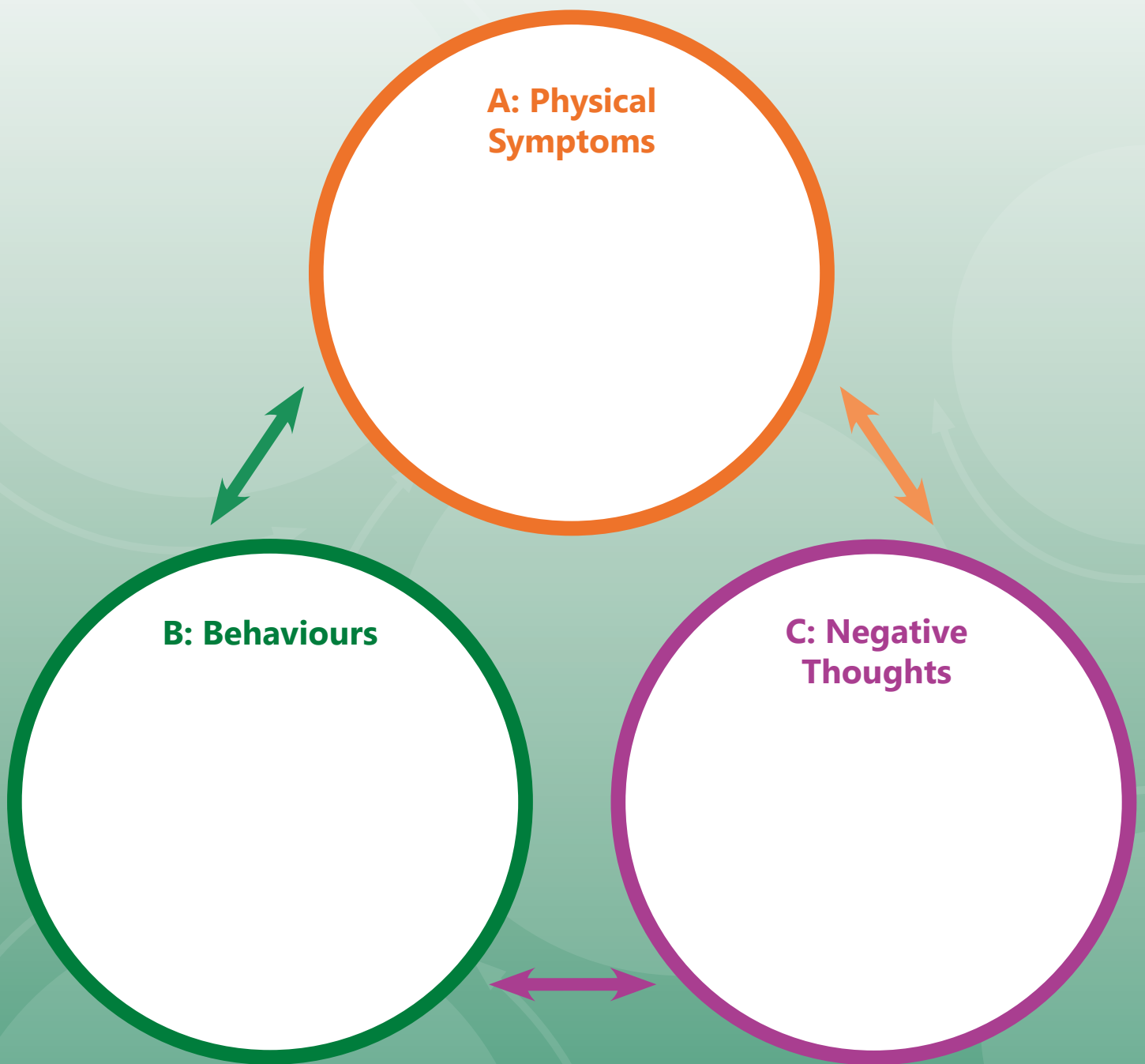
The elements of the framework are outlined in the table on the following page.

Element	Description	Clinical relevance
Cohort Beliefs	Beliefs held by groups of people born in similar years or similar time periods (Neugarten & Datan, 1973) and held across age specific generations (Smyer & Qualls, 1999).	Cohort experiences produce the potential for misunderstandings and miscommunication between generations, because generations may not always understand the context in which beliefs have formed. Cohort beliefs of older generations can also sometimes clash with the practitioner's beliefs. For example, beliefs about lifestyle choices, and gender roles may differ markedly, making practitioners feel uncomfortable.
Intergenerational Linkages	Older generations tend to value continuity and transmission of values, whereas younger generations tend to value autonomy and independence (Bengtson et al, 2000). The change in family and society demographics, such as increased longevity, reduction in family sizes, and the increased rate of divorce with subsequent re-constitutions of families has meant that grandparents and great-grandparents often perform an important role in our societies, sometimes providing strong intergenerational linkages across families (Bengtson & Boss, 2000; Bengtson 2001) and often taking on caregiving roles for younger generations.	Intergenerational relationships can result in tensions, especially when older generations do not always approve of, or understand, changes in family structures or marital relationships (Bengtson et al, 2000). Likewise when elders provide important supports such as caring for grandchildren so as to permit adult children to work this too can be a potential source of intergenerational tension. From adults caring for their parents there can be intergenerational linkages that can cause distress such as when caring for a parent who is unable to live independently. The elder may in turn experience distress as they feel they are a 'burden' on their family.
Socio-Cultural Context	Older people may state that 'growing old is a terrible thing'. Unfortunately professionals may be swayed into believing such statements are factual and realistic appraisals of a difficult time of life (Unutzer, Katon, Sullivan & Miranda, 1999), but in fact these reveal the internalisation of socio-cultural negative stereotypes about growing old. As Levy (2003) states "when individuals reach old age, the ageing stereotypes internalized in childhood, and then reinforced for decades, become self-stereotypes."	Many older people have an implicit assumption that old age inevitably means loss and decrepitude. As one gets older, the growing sense of dread about what ageing will bring can often be accompanied by an increased vigilance for the first signs of 'the slippery slope'. In CBT terms the negative age stereotype can be considered to be a latent and maladaptive vulnerability about ageing that has been reinforced and often endorsed by themselves and society for decades. Hence, older people may assume that if they are unhappy or depressed that this is a normal part of ageing and is not therefore amenable to treatment. Especially in depression, beliefs such as these often prevent individuals from seeking treatment.

Element	Description	Clinical relevance
Transitions in Role Investments	<p>Remaining invested and involved in activities and interests that are personally meaningful, purposeful and relevant is likely to improve quality of life and maintain psychological health (Vaillant, 2002; Rowe & Kahn, 1998). The transitions in role investment experienced by people are therefore likely to be important variables to consider when working with older people. In later life there may be transitions that an individual needs to navigate in order to adapt successfully to age related changes.</p>	<p>Transitions in role investments commonly seen in later life are when people cope with a change in circumstances by rigidly and inflexibly adhering to outmoded coping strategies that may in the past have served them well. Examples of transitions in role investments with the potential for distress are when an individual loses independence because of a change in physical health status or, when taking on a new role, such as caregiving. The amount of investment one has in the roles that give life personal meaning may be an important determinant in how successfully one adapts to a changed circumstance.</p>
Health Status	<p>Increasing age brings with it an increased likelihood of developing chronic medical conditions. Ill-health can be understood in terms of three components: impairment, disability and handicap (WHO, 1980). Impairment refers to the loss or abnormality of body structure, appearance, organ or system (e.g. Infarct in a stroke). Disability is the impact of the impairment (i.e. infarct in a certain part of a person's brain) on the individual's ability to carry out 'normal' activities. Handicap can be thought of as the social impact that the impairment or disease has on the individual. Consequences of handicap are visible when a person interacts with his or her environment. Thus a person who has experienced a stroke may find that other people now treat him differently, by excluding him or her from normal communications.</p>	<p>CBT practitioners can usefully employ behavioural strategies and develop problem-solving skills to help the person minimise levels of disability so as to minimise handicap to the lowest level possible.</p> <p>Sometimes the biggest challenge when working with older people with physical health problems is remembering that although the problems may be real (as in stroke for example), the attributions people make about the problems may nonetheless exaggerated and erroneous.</p>

Source: Laidlaw & Thompson, 2008

The contextual framework



Contextual Area	Relevant Factors
Cohort	
Intergenerational Linkages	
Role Transitions	
Socio-Cultural Context	
Health Status	

Example: Mrs. Kelly, an 81 year old woman with depression

A: Physical Symptoms

Tiredness
Concentration problems
Decreased appetite

B: Behaviours

'I am useless'
'What is the point'
'I cannot be
bothered these days'

C: Negative Thoughts

Avoiding seeing people,
answering the door or
phone, stopped going
to play cards or
reading

Contextual Area	Relevant Factors
Cohort	Needing help is a sign of weakness, make do and mend
Intergenerational Linkages	Two adult daughters, Mrs. Kelly disagreed with how they raised their own children and felt they had 'no rules or boundaries'. Her views causes some friction in the family. Oldest granddaughter not married but lives with her partner and child. Mrs. Kelly disapproves of this.
Role Transitions	Moving from being in her 70s into being in her 80s was hard for Mrs. Kelly. She thinks life is over now. Husband died a year ago and suffered from dementia and she was his carer, so has lost the role of wife and care giver. Transition from being needed when daughters had their own children to having grandchildren who don't need her to care for their children in the same way.
Socio-Cultural Context	Feels it is 'all downhill from here' and that there 'isn't much life left to live'. Thinks she has 'had her life and is now in the way'
Health Status	Having memory problems herself. Does not want to give up her independence and move into sheltered accommodation but 'knows what lies ahead' due to her husband having dementia. Struggles with hip pain and arthritis. Walks with a stick but fairly mobile. Some hearing loss and wears a hearing aid.

Reflection

How might using the LICBT assessment contextual framework worksheet on pages 25-26 be helpful for you to separate the older persons story and context from their symptoms? Is there a way you might find it helpful to use in clinical practice for treatment planning or to summarise the context?

Managing time effectively



Low Intensity CBT practitioners often have valid concerns about managing time effectively when working with some older people. Practitioners want to ensure that their patients get the most from clinical sessions with the limited nature of PWP sessions and contact time. This is often compounded with practitioner anxieties about using the telephone with older people and accommodating any physical or sensory difficulties that may be present. Practitioners frequently report difficulties in managing the session with some older patients who find it difficult to work with a structured approach and often 'story-tell' rather than answering the direct question asked.

Agenda's help us structure our sessions and manage the time. As older people may be less used to structured psychological therapies they may need additional help in ensuring that they make the best use of the time available and understand what is required of them. Agenda setting will help with this.

Agenda setting

The use of an agenda can help ensure that a focus is maintained on important clinical topics. If the focus drifts away from reviewing homework and planning the next inter-session task, then the intervention being used is no longer the active form of evidence based CBT it should be and this should not happen as it is not in the patients best interests, is unlikely to bring about sustainable change and is not in keeping with evidence based practice. Working to an agenda can be challenging with some patients, however often practitioners are their own worst enemy with timekeeping and agenda setting by not sticking with them in the face of complexity or challenges. Often, practitioner expectations are not made clear enough at the outset of treatment. In the face of complexity or 'storytelling' from an older person, often practitioners become less confident and do not want to interrupt or set boundaries for fear of being disrespectful or dismissive of the person. Beck (1995) suggests this discomfort is due to negative predictions by the practitioner such as; 'my patient won't like it'; 'this is too rigid' or 'I could miss important topics'; 'my patient will feel controlled', etc. When a patient is 4 or 5 decades older than the practitioner these thoughts can get in the way of applying LICBT effectively with older people.

Making clear the boundaries of the approach and its structure from the outset is paramount and is a respectful way of working with any patient; not least with the short term and brief session contact time of Low Intensity CBT. Practitioners often say a patient cannot work with the structure, but the structure has never been outlined to them, meaning the patient has not been given an informed opportunity to do so. Patient expectations of psychological therapies usually come from what they have seen on TV or in the media, heard from friends or been part of in previous healthcare appointments.



Many patients mistakenly believe they are coming for a counselling approach (not always helped by the referrer terminology who often use this as a catch all phrase) and the very dialogue and discussion that takes the practitioner away from their aims for the session, is exactly what the patient expects they should be doing. If expectations are not made clear from the outset, how can we then expect them to make the best use of the time and session? If we do not manage patient expectations, how can we then respectfully and politely get sessions back on track? Managing expectations and making use of an agenda is vital in this approach. This should start at the very first meeting in the introduction:



"The approach that I use is called Low Intensity CBT. It is an evidence-based form of treatment that is recommended in clinical guidelines. Have you heard of a CBT approach before?....."

(check their understanding and fill any gaps)

....."It is an active, time-limited, self-help approach. My role is to provide you with tools and the techniques that you can then put into action between our sessions and then we review your progress each time and make a new plan for you to carry out. It is the work that you will do outside of our sessions that brings about the changes you would like to see and I will support you to use the techniques in your daily life, monitor your progress and help to problem solve any difficulties that may arise. We will have a weekly phone or face-to-face meeting that will focus on reviewing your progress and making a new plan for the next week. The sessions we have will take approximately 35 minutes. We usually have four sessions together and then have a review of how things are going"

"The purpose of today's session is for you to have the opportunity to tell me about the main difficulties you are experiencing, for me to then tell you about what options may be available to help with these difficulties and then hopefully for us to collaboratively come to a decision together about next steps. We have up to 30 minutes for today's session"

When explaining the Low Intensity CBT approach it should be made clear that it is an active and time limited form of treatment in which sessions are focused around the tasks that they will do between the sessions you provide. This enables you as practitioner to reflect back upon this should it be necessary to do so should the session drift in the future:

This should continue into subsequent sessions, where from the outset of the session the phases of the treatment session are outlined to the patient using a clear agenda:

"The purpose of today's session is that we will first collect the routine information that we gather each session, then for you to have the opportunity to tell me about how your between session tasks we decided upon have gone, then we can decide upon next steps based on that. There is some time at the end if you would like to add anything to the agenda"

Problem statements and goals

Homework should always be focused upon improving the symptoms the patient presented with at the start of treatment and moving towards the goals that they set. The use of a problem statement enables the most effective use of time and a clear way of intervention planning to provide appropriate symptom relief. Remember that CBT interventions should always aim to reduce symptoms. Asking yourself how your planned interventions are likely to bring about relief from the symptoms identified in the patient's problem statement is essential when planning what intervention you are going to use. However, similarly to the lack of adherence with clear agenda setting, practitioners often move away from using problem statements post training or do not realise their significance to managing time effectively and maximising patient outcomes. When working with older people, a clear problem statement and setting goals is a fundamental foundation of effective treatment.

The problem statement is the baseline of the symptoms that the patient presents with at the start of treatment and written in the negative. These are the targets for the intervention chosen and goals are then set from the problem statement and written in positive terms of where the patient wants to be if these symptoms improve.

A clear link in the mind of the practitioner to these symptoms and how the planned intervention will target them is essential. The goals the patient is guided to set should be stated in the positive and be things that are realistic and attainable should the symptoms improve.

Unclear or absent problem statements and misaligned or poorly constructed goals can also contribute to problems managing time or the structure of sessions effectively. When working with older people, the problem statement and clear aligned goals can help older people to recognise the session structure and focus and work within it. It can also enable the practitioner to gently remind the patient of the importance of the agenda and maximise the use of the session to work on the problems. This can be done in each session by reminding the patient of the problem statement at the start of each session, checking if there has been any change for the baseline and as well as asking them if it is still the problem they want to be the focus of the work that you do together.

Example problem statement and goals: Ben



Ben is a 71-year-old man with panic disorder with agoraphobia. He lives alone and has a grown up son called James who lives nearby. Ben and his wife divorced in their fifties and he has never remarried, but has a partner called Emily he met shortly after his divorce. Emily does not live with Ben but does visit him often. Due to his difficulties, their relationship is difficult as Ben struggles to leave his flat.

Ben's problem statement:
My main problem is feeling very panicky when I go out to busy or crowded places. My heart races and I get sweaty. I think I am having a heart attack and avoid going out of my flat as much as possible. I no longer go to the supermarket, the pub or to see football matches. As a consequence I don't spend enough time with my partner Emily, our relationship is strained and I am isolated.

Ray set the following goals:

1. To be able to shop for myself in the supermarket
2. To go out with Emily to restaurants and the cinema
3. To watch home game football matches
4. To go to the pub once a week with my friends

The importance of homework



It should be remembered that homework is an essential component of all CBT based interventions. Research tells us that patients who are compliant with homework get the best outcomes (Coon & Gallagher-Thompson, 2002; Kazantzis et al., 2005) and that reviewing homework on the part of the practitioner increases patient compliance (Tompkins, 2002). As Laidlaw (2015) states, homework is not an optional extra to be used as and when it suits, but must form the start and end of every session.

Unlike high intensity CBT approaches, where the session time is longer and somewhat more flexible, due to the time and evidence of Low Intensity CBT and the way in which it brings about change, the focus should always be on the tasks that the patient does between sessions.

Effective Low Intensity CBT treatment sessions, whether delivered on the telephone or face to face should always use a Plan It, Do It and Review it cycle structure.

This means the focus of the first treatment session should be on making an effective plan for the inter-session task that the patient is to carry out between your sessions. Whether you use the term homework or inter-session task is entirely down to you and what your patient would prefer. Some patients with negative experiences of school may prefer the latter. Any potential internal things that may get in the way of their plan (things within them like confidence or understanding for example) or external things (like neighbours popping round or a friend calling on the telephone) that are outside of their control should be considered and problem solved when homework setting.



The patient should then go off and carry out their plan. The focus of subsequent sessions should be to review the tasks completed, problem solve any difficulties that have arisen and then make a new plan for the patient to go off and do (and so on....).

This structure does not and should not change in the context of working with an older person. At times, the person we work with may not be used to a structured approach or may find it difficult to work within it and present challenges. When this occurs sessions can easily drift away from homework planning and reviewing into eclectic and non-evidence based support. If drifting from the agenda becomes problematic in a session, having already outlined the structure and way of working in the approach from the outset allows a gentle but clinically important reminder to be made such as:

"As I mentioned when we first met, this is a time limited and active approach and to get the most from the sessions it is important we keep to the structure of reviewing how your tasks went this week and making a new plan for next week. With that in mind, can I bring us back to....."

OR

"It is important to me that you get the most from the limited number of sessions and time that we have together, to do that we need to keep focused upon the tasks you did between session and make a new plan. I want us to look at your homework next. It sounds important what you have told me so far. But to make sure that we keep to the session can we move back to your worksheets and then if there is some time left at the end we can pick up this discussion if you would like to"

Managing endings

When working with older people, practitioners can find it challenging to raise the issue of discharge, particularly if the patient is socially isolated or lonely. Patients may wrongly assume that treatment will go on for longer than the short-term nature of Low Intensity CBT. A clear discussion at the start of treatment about the structure of the approach can stop this from feeling abrupt when it arises. Practitioners may also find it helpful to remind patients at each subsequent contact about the number of sessions before a review will take place (usually at session 4 of treatment).

Remembering the focus of LICBT should be on the symptoms identified and improving these through the use of the intervention is key. Practitioners cannot alone solve every aspect of the patient's situation through treatment and indeed may not be the most skilled person to do so. The use of signposting for practical difficulties such as debt or housing issues and referral to local community groups and befriending for patients', whose social situations have not improved through the intervention for example, should be used to manage this.



Clinical scenario: Ray



Ray was a 72 year old retired factory worker who lived by himself in a warden aided complex. He had never married but had an active social group of friends and had remained living in the same area most of his adult life. Ray was diagnosed with depression and was using Behavioural Activation with the support of his PWP. At the start of treatment he set the following problem statement:

"My main problem is feeling down, particularly in the mornings. I feel tired, have problems sleeping and my appetite is not what it used to be. I am avoiding seeing my friends or going to the social club and I am not keeping up with the housework. I have thoughts that I am a failure and that there is no point in doing things and as a consequence I am feeling isolated and that I am letting myself down"

Ray set the following goals:

1. To be doing the housework each week on a Saturday morning
2. To go to see the football with my friend Jim
3. To go the social club each day to see my friends

Reflection exercises

During treatment you find it difficult to keep Ray to structure as each week he talks in detail about how things have been and how he is feeling. How could you gently but effectively move Ray back onto discussing the homework tasks and what he has learned from them by using his problem statement, goals or the structure you set at the beginning of treatment?

Is it easy to manage time effectively, does it feel comfortable to interrupt an older patient or to bring them back to the agenda topic? Can you currently do this?, if not, why not, what things stop you from doing so? How might you be able to make a plan to practice this to feel more able to do so in the future?

Do you currently use problem statements with the older people you work with and ensure that you help your patient to set goals with your patient that they can achieve if their symptoms improve? If not, how can you ensure you build back in these techniques to enable you to manage time and maximise outcomes and intervention planning?

When you plan an intervention with an older patient are you aware of how the intervention you have chosen will target those symptoms and work towards those goals each time you set homework? Do you remind the patient of the focus upon these symptoms and goals at each session? If not, how can you build this into your practice and is there any support that you need from clinical skills supervision to help you to do this?

Practitioner factors working with older people

When working with older patients using psychological therapies or indeed patients of any age, as practitioners we can develop certain thoughts and beliefs, which can influence our own behaviour. Examples of such thoughts are practitioners holding back on asking patients to complete homework tasks, out of concern that they may be overburdening the patient or through thinking that their patients will not complete the homework task anyway. Similarly, some practitioners may think that you cannot work with an older person unless you have shared life experiences or are similar in age or think that interrupting an older person is disrespectful.

It is important to examine our own thoughts and our beliefs as these may have the effect of limiting what can be achieved both within sessions and over the course of treatment. Padesky (1998) suggests that the ultimate efficacy of CBT approaches are enhanced or limited by the beliefs of the practitioner practising them. It is arguable that skilled practitioners who hold beliefs that interventions are potentially beneficial to the patients they come in contact with will be more inclined to adopt a 'try it and see' approach. This approach arguably enhances rather than limits treatment options that potentially has an effect on outcome.



Reflection exercises on practitioner factors

Exercise 1

Ask yourself, is there anything that you feel inhibited to express during your clinical work? (Padesky (1998) suggests some examples such as; allowing silences, self-disclosure etc.). Make a list and reflect upon this. If you feel able please share this within clinical supervision as a topic with other colleagues who have done the same exercise.

Exercise 2

Ask yourself, what behaviours might you express too much during your clinical work? (Padesky (1998) suggests some examples such as; giving lengthy explanations, giving your patient the answers to questions too quickly without checking their understanding, being too didactic etc.). Make a list and reflect upon this. If you feel able to, please share this within clinical skills supervision with other colleagues who have completed the same exercise.

Exercise 3

Are there any expressions of emotion that make you uncomfortable during your clinical work? (Padesky (1998) suggests some examples such as; a patient's expression of anger, a patient being visibly upset and crying, or your own personal feelings such as feeling irritated with your patient, etc.). Make a list and reflect upon this. If you feel able to, please share this within clinical skills supervision with others who have completed the same exercise.

Exercise 4

There may be other factors that we need to take into account when exploring these issues. Would your responses change depending upon the characteristics of your patient? For example, does your patient's age, how frail they look, physical appearance, comorbid physical illnesses influence your expectations for outcome?

Socialising people to the Low Intensity CBT model

The main aim of LICBT is that skills are being passed on to patients to enable them to help themselves deal with their own difficulties both now and in the future.

To do this they need to understand the intervention and rationale well enough that they could use it again in by themselves if they ever needed to. An important early practitioner goal is to educate the patient about LICBT. This can be quite a daunting task. All too often this can become a 'lecture' within the session and the patient can often end up feeling 'none the wiser' about what LICBT is. It is important that the patient is asked to repeat back information to check their understanding regularly. The practitioner should aim that the patient is asked to be actively involved every few minutes, at least.

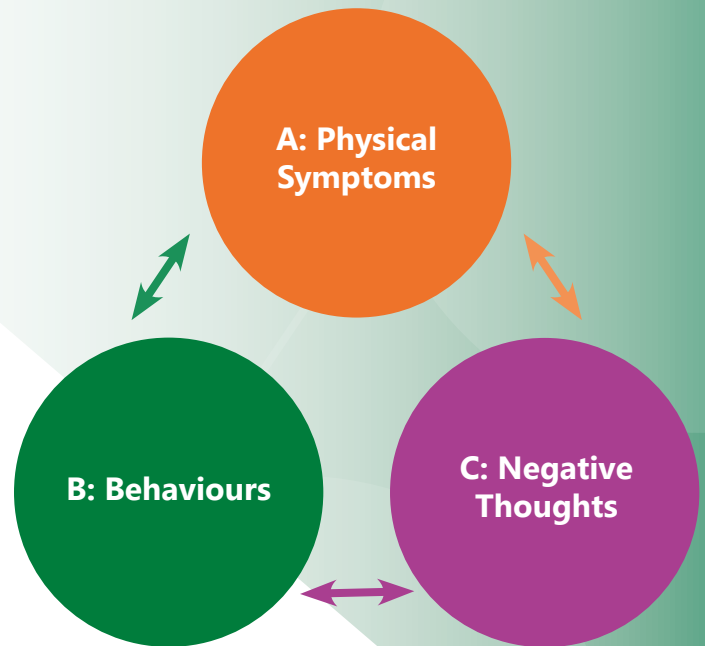
The problem is that patients can detach from the session and introducing the model and in order for socialisation to really take place, real active examples from the patient need to be used in explaining the LICBT model and how changing thoughts, feelings and behaviour can be used to beat depression. Given that we work with depressed and anxious patients who, when not engaged in a task may be prone to ruminate or worry, there is a high possibility that they may be lost in their heads ruminating or worrying during the session and not in the moment taking in the information that we hope they may be. As a practitioner we cannot always see this may be happening and may mistakenly think that they are listening to us intently. Keeping the patient an active participant aims to check understanding but also helps to keep their attention focused in the moment and the task at hand – understanding and socialising to the model to set up the relevant treatment option.

This can be achieved by asking the patient to feedback and give their own example of their difficulties in the model, rather than the practitioner presenting back previously gathered information didactically. All too often patients are presented with an already completed diagram the practitioner has already filled in, or fills in in front of them which takes away the learning opportunity for socialising and checking the patients true understanding. On the next page is an example of how this can be done in a more interactive way by firstly presenting a generic example of the presenting problem and how thoughts, feelings and behaviours are linked on the diagram, then, asking the patient to explain back an example of the symptoms they have discussed already and how they are linked. Reassessment should be avoided, and this should not feel repetitive for the patient, so it is important to reflect back to the patient that you have discussed the symptoms.

Presentation of Low Intensity CBT model

Practitioner:

"You may have noticed that I asked you about three main areas today, how your low mood has affected how you are feeling physically, how it has affected what you are doing or not doing and how it has affected your thinking, as on the diagram here. In the CBT model, these three areas are interlinked and can have a knock on effect on each other. For example, when people are feeling low, they may notice symptoms of low mood physically like tiredness and that their thoughts are more negative. In turn they may avoid doing activities they would otherwise have done, which initially gives some relief from how they are feeling and thinking in the short term. In the longer term however, it takes them away from things that give them a sense of routine or pleasure and necessary tasks can build up and mood can spiral down and down. Is that something that you feel applies to you?"



Patient:

"Yes, exactly I suppose it is yes"

Practitioner:


"Just to check your understanding and that I have explained it well enough, could you perhaps explain back an example of how your symptoms we discussed are affecting you in the cycle?"

Patient:

"So I have not been sleeping well, feel tired all the time and I don't have any energy, I haven't been going to the social club or residents lounge as a result and am not cleaning the flat or seeing my friends I have negative thoughts like I am a failure which then makes me feel more tired and down"

Practitioner:

"Yes absolutely, it seems you have a really good understanding of how mood can spiral and the things that initially give some relief from the symptoms may not be so helpful in the longer term. The good news is that just like it took a while to take hold and spiral down, we can do things that will break into the circle to help to reverse it the other way and bring about a more positive change....."



Introducing the depression maintenance spiral (or similarly the anxiety maintenance spiral) is essential and is useful in a number of ways; first it highlights the importance that behaviour may play in the development of the difficulties, and sets up a rationale for introducing the relevant treatment intervention to brake into the vicious circle and hope to reverse it. Secondly, it is non-judgemental and blaming, thirdly, the patient can see that depression or anxiety may have developed gradually and recovery means reversing the spiral and this may also occur gradually therefore realistic aims are introduced and finally, the importance of understanding (psycho-education) is brought to the table as a way of defeating and managing depression or anxiety. Once a problem is understood then a more coherent approach can be adopted. This may also help to overcome any concerns on the part of the older person that depression is somehow their fault, is an understandable or inevitable part of the ageing process or that there is nothing that can be done about it.

Sometimes when working with older patients they may have associated physical health difficulties that are impacting on their mood or some may view depression or anxiety as a sign of personal weakness and blame themselves. This can challenge some practitioners at first and they may assume they have nothing to offer the patient that could help or that they require a more complex or intensive intervention, as their difficulties are more complex. This is usually not the case and practitioners have much to offer these patients. Using the case examples below you may wish to practice engaging and socialising them into the LICBT model and checking their understanding in clinical skills supervision. When faced with comorbid physical health problems or difficulties, LICBT has much it can offer. When there is complexity often the simplest interventions and explanations are required, not complex difficult ones. Later in this workbook you will learn techniques to augment your interventions that can help you work with patients with associated physical limitations or losses.

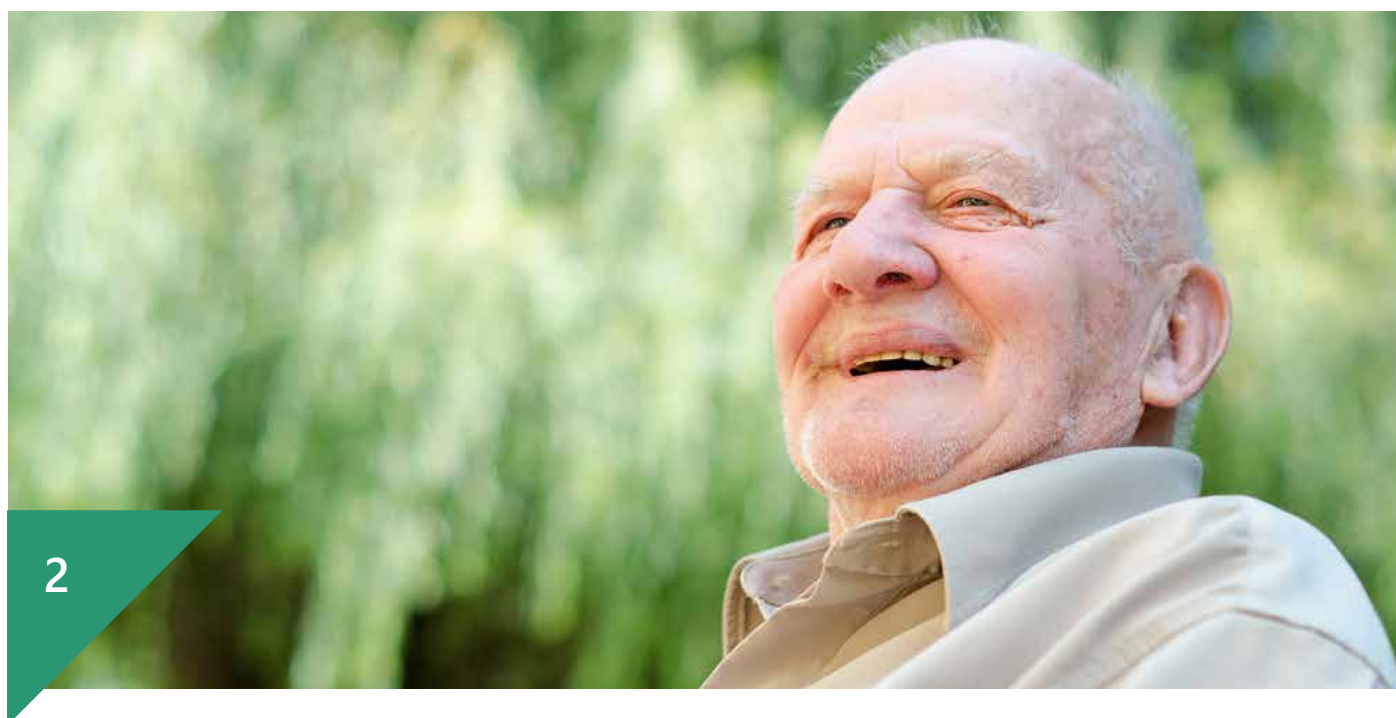
Clinical skills supervision exercises:



David is a 78-year-old retired army drill sergeant. About 9 months ago he had a stroke that left him paralysed down his right side.

He has been referred to you because he has been depressed since, but refuses to take antidepressants. He thinks depression is a sign of weakness and was previously depressed after he retired at 60. He did not have tablets then and instead he used a self-help material and 'got himself through it through exercise and things'. He feels that just is not possible now as he is wheelchair bound. He is married and has always been very 'traditional' in his values and believes he ought to be 'master of his domain' and be able to 'pull himself together'. He will remain wheelchair bound and needs help dressing in the morning. He is used to being in control and finds having to wait for carers who come in to help him very difficult and irritating. He has thoughts such as 'I am a failure'; 'I'm a

useless pathetic creature now.' 'I'm no longer a real man'. He pushes himself to try and 'beat this stroke' and tries to get dressed by himself. He has also pushed himself to try and walk. (Often though he can't do the things he sets himself and this has led to falls and further decreases in his mood). He has stopped spending time with his wife and he does not join his wife for dinner in the dining room anymore he eats alone in his room. His appetite has decreased and he has some slight difficulty with his speech and swallowing that he finds difficult and embarrassing. He has stopped seeing his golf friends or socialising as he 'can't be bothered' and feels like there is no point, as 'we have nothing in common anymore'. He is not currently suicidal and has no plans to harm himself in anyway and has no previous history of risk. He will spend time in the house with his dog Lucy a retriever who he says is loyal and makes him feel a little better but he no longer goes on walks with Lucy, his wife takes her out alone.



2

Mr Smith, a retired postman, has a mild form of Parkinson's disease (PD). His own problems developed soon after his close friend James died from end stage PD. When he was diagnosed with this condition he automatically assumed that he too would develop the same symptoms and experience the same end as James.

He became depressed, feeling lethargic, not sleeping well with a decreased appetite and concentration. He had fleeting thoughts that he would be better off dead, but was not actively suicidal and had no plans and had not taken any action towards suicide or self-harm either currently or in the past. He had stopped his hobbies such as photography and his hill walking immediately and he stopped seeing his friends as he felt embarrassed about his tremor and couldn't be bothered to make the effort to go anywhere saying 'what is the point now'.

He tended to monitor his symptoms and was always on the look out in case his tremor got bad. He was also convinced people stared at him because of his tremor and would be hyper vigilant when in company to see if people were looking which in turn made him feel anxious and made his tremor worse.

Playing the role of Patient and Practitioner explain the vicious circle to Mr Smith who has mixed depression and anxiety and then to David who has depression and ensure that they are actively involved in the explanation and understand the links between the two difficulties and areas.

Augmenting Low Intensity CBT interventions with older people

Sometimes when patients have physical limitations or losses as a result of injury or illness it can be hard for them to contemplate becoming behaviourally active again, as the things they used to previously enjoy or that gave them a sense of routine feel impossible to do in the same way, or may be out of their grasp. Practitioners need to be consciously aware that they need to build optimism and hope that change is still possible and that there are ways that treatment can be augmented to help overcome these challenges.

Selection, optimisation and compensation

A way of helping people deal with the challenges associated with ageing and still optimise their level of functioning is to augment behavioural activation with Selection, Optimisation and Compensation (SOC) strategies in LICBT as a specific treatment component to assist an individual to successfully adjust to their changed circumstances.

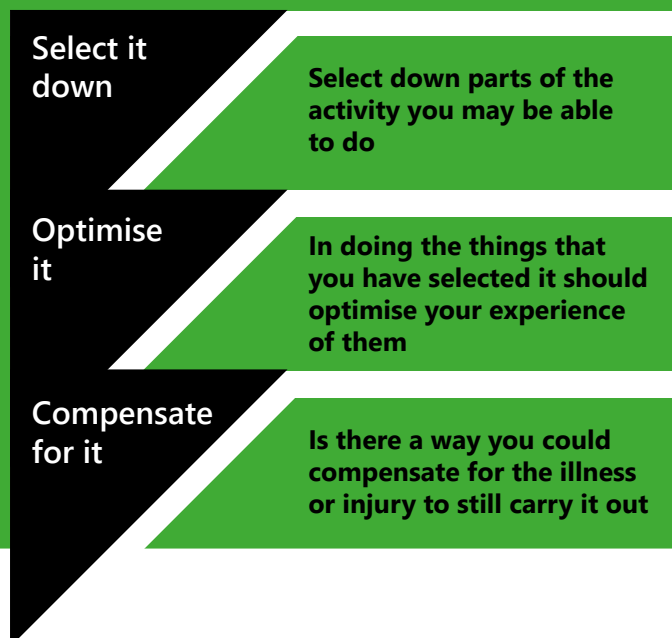
The theory of selective optimisation with compensation (Baltes & Smith, 2002; Baltes, 1990; Baltes, 1987) focuses on maintaining functioning in later life in the faces of challenges experienced when aging.

People cope with restrictions in capacity by compensating for these losses using the strategy of optimization and selection (Baltes, 1990; Baltes & Smith, 2002). This approach has been successfully used within high intensity CBT approaches for some time (Laidlaw et al, 2003; Laidlaw, 2105) and has been augmented within recent Low Intensity CBT training for older people (Chellingsworth & Laidlaw, 2013; 2015) and within Behavioural Activation self help materials for patients (Chellingsworth & Farrand, 2015).

The pianist, Arthur Rubinstein, who continued to perform at a high level late into life, illustrates how each element of the SOC model has to be orchestrated to compensate for age-associated restrictions. When asked for the secrets of his success, Rubinstein mentioned three strategies; First he reduced the scope of his repertoire (an example of selection), and secondly, Rubinstein, practised this restricted-repertoire more intensely than would have been the case when he was younger (an example of optimisation), and finally Rubinstein, created the illusion of speed of playing by purposefully slowing down just immediately prior to playing the faster segments of his repertoire thereby giving his audience the impression of greater dexterity than was actually the case (an example of compensation).

SOC can help a patient to keep doing an activity or return to an activity that they have been avoiding or stopped as a result of their health status or physical decline. SOC can be used where the patient could get back to the activity but may need to adapt or augment how they do it. A good example of how SOC could be used is if someone who was a regular gym user injured their left forearm.

The SOC technique has three parts:



They would not be able to do the same weights exercises in the same way they did before they had the injury. Through using SOC, they could consider ways to keep doing exercising other parts of the body for example, such as the legs. Repetition of those particular exercises more often may mean the person becomes stronger in their leg muscles and they can maintain exercise despite their physical limitation, optimising their experience. They may be able to compensate for the injury to their arm by wearing a splint, support bandage or perhaps by having physiotherapy for example.

The key part of using SOC successfully is that the practitioner does not problem solve or generate the ideas for the patient, but guides them to generate their own ideas in each of the three areas, seeing the patient as the expert in the activity. Trying to avoid jumping in with solutions for the patient is important (the 'have you tried x' conversation). The practitioner's role is to help the patient to try and think through ways to use the technique to get back to doing an activity they enjoyed or used to do they want to maintain or keep doing.

If a patient used to enjoy gardening but no longer can bend and kneel as easily, it is easy for the practitioner to jump to attempting to solve this situation for the patient with statements such as 'have you considered raised beds, or perhaps a kneeling pad. You can also get weeding tools you use standing up'. This can be met with resistance and 'yes... but...' responses on the part of the patient. It is well intentioned but not respectful of their own skills and abilities to generate ideas, or listen to what they may already have tried and it also does little to help the patient develop better problem solving skills. The key part of SOC is the patient, being the one who is most expert in their own limitations and particular activity gets the framework of SOC and is guided to use it in their own context and situation.

Of course if the patient has a physical injury or illness that the activity may impact upon, it should always be checked out first with their GP, physiotherapist or anyone else involved in their collaborative care as necessary.

A second, equally important component of SOC, is that the patient selects down the activity in a way that increases their experience of it (optimises it) not decreases it. For example, if the patient has difficulty with pinch and grip but used to play golf, selecting down how often they play may decrease their handicap or enjoyment and do little to optimise it for them. Similarly, not playing at all and coaching others may be an option, but does it optimise their own experience of golf? Ensuring the way in which they select down actually helps them to optimise their experience is important. This will be individual and personal to them and what may be acceptable and optimising for one patient, may not be the same for another.

Clinical example: Mike

Mike was a 69-year-old retired teacher who had been experiencing depression for the past year. He used to love to play golf, but on being diagnosed with mild basal joint arthritis a year and a half ago (which affects pinch and grip), he found it increasingly hard to play and also noticed he wasn't keeping up with the others he used to play golf with because of he said, 'my age'. He had given his golf clubs to his son a few months ago saying he no longer needed them, but he says he misses playing and his golf chums.

Mike was using behavioural activation to generate routine; necessary and pleasurable activities he was avoiding or had stopped doing with the support of his PWP Gemma but struggled to think of previously enjoyed activities for his list. He spoke of how he used to enjoy golf, but could not imagine being able to play any more because of his arthritis. Gemma augmented BA with SOC to help him to consider if it could offer him a way that he may still be able to play golf. After explaining the technique and giving Mike the worksheet to think about and some examples Mike and Gemma agreed to speak on the phone a few days later.





Mike had thought about things that he could do to select and optimise and said he could perhaps select down the number of holes he played with his golfing friends and practice those more holes more frequently than he used to which should help him to get better at those shots. He also suggested it may be possible to practice with a smaller number of clubs which may help to optimise his playing. Gemma and Mike discussed how he might be able to compensate for his pinch and grip difficulty. Mike said he knew a golfer who used to play with foam rings on his clubs and wondered if that may be something that could help him and he had agreed to check this out with the club golf shop and see. He had also thought about contacting his physiotherapist to see if there was anything else that could help him. He had been referred to the physiotherapist by his GP but had only been once. She had given him some exercises to do, but he had not done them regularly and then with his mood had not kept up his appointments. Mike made a plan with Gemma to contact his Physiotherapist and to make a trip to the golf club shop as tasks on his BA planning sheet.

Clinical example: George



George was a 67-year-old artist who had developed early stages of osteoarthritis in his hand and used SOC to continue to paint with the support of his PWP.

Firstly he selected down the amount of time he would paint for and what time of the day he would paint. His pain and stiffness was worse in the mornings, so he decided that he would start his day slightly later when this had eased off. Instead of then painting for long periods of time without a break, he built in short breaks every hour. He also selected down the work he would take on, instead of taking on lots of just large oil commissions, he took on smaller oil ones and increased the number of watercolours that he took on as he found these easier to paint and less stressful on his hand. That meant his income wasn't affected, they took less time each to complete and because he was painting more watercolours he found his work got better in that medium and got great feedback. To compensate for the arthritis, he wore a wrist and hand splint when he needed it and he also found special rings he could put around his brushes at the local art shop that allowed him to get a better grip but without pain from the hard wood of the brush.

Source: Chellingsworth & Farrand, 2015

Exercise



Mr Shaw 78 had a stroke and has a slight weakness on his left hand side but made a good recovery. Since the stroke, he has been experiencing depression and is keen and motivated to use BA to get back to activities he has been avoiding as a result. He lights up when he talks about ballroom dancing, but is unsure he could get back to it due to the effects of the stroke which make him embarrassed.

Working alone or with colleagues in skills supervision, can you think of ways in which Mr Shaw may use SOC in practice?

He used to love to ballroom dance and being a man of a certain age, he had the pleasure of many different women to dance with at the club he went to as there were more women who went than men. He would like to get back to dancing, but is embarrassed about his left sided weakness and he finds he tires more easily so struggles with the faster paced parts of the dance these days. Mr Shaw is the expert at ballroom dancing, so it is important he generates the ideas using SOC and that the ways he selects down the activity optimises his experience rather than decreases it.

Selective optimisation and compensation (SOC) worksheet

Doing the best you can with what you have at your disposal

Selective optimisation with compensation (SOC) is a way of problem solving to help you to still achieve your goals in light of any losses that may have developed. Accepting the reality of a loss does not mean you have to just put up with losing an activity, role or hobby of value to you, instead it can mean you work to find a new way to keep it in your life. In the face of a changed circumstance, continuing to do the same thing in the same way you did before may not be possible or may result in frustration or other problems. It can be easy to give up on the activity.

SOC aims to help you to consider if there are ways in which you may be able to select the way in which you do the activity to optimise your experience of it, whilst compensating for the loss or injury.

In research people who use SOC have reported better life satisfaction. The pianist, Arthur Rubinstein, who continued to perform professionally late into his life despite having been physically affected by the ageing process, illustrates how each element of SOC can be used. When asked for the secrets of his success, Rubinstein mentioned three strategies; First he reduced down the scope of his repertoire he played (an example of selection), secondly, he practised this restricted-repertoire more intensely than would have been the case if he still played a larger repertoire of pieces (an example of optimisation) meaning he got better at them through more practice, and finally he created the illusion of speed he had lost due to his physical limitations by purposefully slowing down just immediately prior to playing the faster segments of his repertoire thereby giving his audience the impression of greater dexterity than was actually the case (an example of compensation).

Use the worksheet to consider some possibilities of using SOC to keep doing the activity of value to you, with the help of your practitioner.

Selective optimisation and compensation (SOC) worksheet

Select it down

Sometimes, we are faced with losses that challenge our quality of life. Consider what activity/role/hobby you have given up or reduced as a result of a loss of physical ability and is there a way to select part of the activity to ensure you optimise your experience of it. Consider ideas here:

Optimise it

Thinking of the activity and options you considered above. Is the way in which you selected to do it going to increase your use of the activity and hopefully provide opportunity for you to optimise it as a result. Write down how it may help you to optimise it here:

Compensate for it

Can you compensate for the loss in some way by adding in something to help that will enable you to do more of the activity? Is there a way of making use of certain support tools, aids or strategies that can help you to still do the activity. Write down ideas that can help you to compensate here:

Clinical example: Jack

Jack was a 71 year old man who had been experiencing depression since having a stroke 12 months ago.

As a result of his stroke he had a mild weakness on his left side and had previously had physiotherapy to help him to regain as much function as possible. Prior to the stroke and becoming depressed, Jack used to play golf and was a keen member of his local club, both for the social aspect as well as it helping to keep him fit. Since the stroke Jack had not played and had given his clubs away to his son. Using behavioural activation with his PWP to help him with his mood, Jack had discussed how he used to like golf but as he grew tired quickly and struggled to walk as far since the stroke, as a result he did not think he would be able to get back to his much loved hobby. An excerpt from his completed SOC worksheet is on the next page.



Select it down

Sometimes, we are faced with losses that challenge our quality of life. Consider what activity/role/hobby you have given up or reduced as a result of a loss of physical ability and is there a way to select part of the activity to ensure you optimise your experience of it. Consider ideas here:

I could select down the holes I play so I am not walking as far
I would feel more comfortable playing with Mike and Steve as they know about my stroke and are supportive, so I could just play with them. Mike had a heart attack so he takes things a bit easier on the course these days.
I could try and practice a few shots more often and focus on them
I could not play and just have drinks in the club house!

Optimise it

Thinking of the activity and options you considered above. Is the way in which you selected to do it going to increase your use of the activity and hopefully provide opportunity for you to optimise it as a result. Write down how it may help you to optimise it here:

I think playing with Mike and Steve more often would mean that I get more practice in with them and hopefully improve again. Perhaps playing less holes more often would help too and certainly more practice of the shots is always a good thing so I could go to the driving range and practice. Just joining the social aspect of golf wouldn't be the same and I would miss out on the exercise and the fresh air even though it would be fun, it wouldn't help me to optimise my golf!

Compensate for it

Can you compensate for the loss in some way by adding in something to help that will enable you to do more of the activity? Is there a way of making use of certain support tools, aids or strategies that can help you to still do the activity. Write down ideas that can help you to compensate here:

I could speak to my physio and see if there is anyway of using an aid to help me to grip with my left hand better or any types of clubs I need to buy a new set anyway. She may also get me doing some exercises again which could help. I could also book in to see one of the coaches and see if they recommend anything. Mike and Steve sometimes get a golf buggy or caddy to help with the clubs and that would help me with the walking aspect if I got tired, helping me to carry on playing longer and more often.

Reflection

Thinking about your own clinical practice how applicable do you feel that SOC would be within your work, does it offer a way of augmenting your intervention to help the patient to overcome the challenges they may face in activating?



Some practitioners find it challenging to not generate the solutions and make suggestions for the patient to problem solve for them, limiting their learning and overlooking their knowledge and experience gained in the activity. The 'why don't you..' or 'have you tried' conversation. Consistent with a CBT approach, when using SOC, the patient is seen as the expert in the activity and should be guided to generate his or her own ideas. Reflect on your own ability to be Socratic rather than leading. How can you be more Socratic to ensure this takes place? What may be good questions to ask or a good way in which to approach the patient being the expert?

Values



Sometimes due to physical health problems or bereavement, a patient may not be able to carry out an activity they previously enjoyed at all anymore. For example, a patient who used to love to walk with their partner may find that walking offers no enjoyment since they were widowed; or a patient who previously loved to play guitar, may no longer be able to do it at all, due to the effects of a stroke.

These losses can be devastating for the patient and be a challenge to both them and the practitioner when trying to generate activities in behavioural activation.

If the patient is no longer able to complete an activity, finding out what they valued from it when they did do it can provide a way of generating alternatives. Whilst these alternatives may not be the same, and this requires recognition and validation with the patient, they are activities in line with their previous values and will help to regulate routine and get a balance of activities whilst recognising the context of their losses.

A Values worksheet to work collaboratively with the patient to consider their values is provided below:

Clinical example: Rod



Rod was a 70 year old man who loved to cycle, but after having a stroke he could no longer use his left arm or leg as easily due a left sided weakness and it was impossible for him to keep cycling.

He found it devastating as cycling was a big part of his social life as well as being something he was passionate about as a hobby and had done all his life. Rod used the values sheet with the help of his PWP to consider what he valued about cycling. Although not easy as he found it difficult to adjust to the fact that that cycling was something he could no longer do, thinking about what he valued about it helped him to generate ideas for other activities for his BA list which were still in keeping with his values and would help him to build back balance and routine. What Rod identified he valued from cycling was the social aspect and spending time with his friend Graham. He also valued being outdoors in the countryside and the feeling he got when he had been out cycling that he had done a good exercise session and felt exhilarated from it. Graham worked with his PWP to identify activities that may be possible that he could still do, which brought him into contact with his values. He added to his list spending time with Graham, walking in the countryside and exercising.

Some of these felt more difficult than others with his current mood and the fact he had not done anything physical since his stroke and needed breaking down into easier tasks. For example, Rod planned to make contact with a physiotherapist through his GP and ask about exercises he may be able to do first. After this he then went to the local hospital gym to meet her for a look around as his physio had suggested he attend and he had not been before. Together they devised an exercise programme that he could do around his weakness on his left side and to help to build strength as well as more cardiovascular exercises that would help him to feel exhilarated afterwards. Rod built up to doing this in stages that felt manageable and fitted in with his BA planning. Rod also built back in social contact, meeting Graham for short walks in the countryside. With his wife, they also got an older small dog from the local rescue. This meant Rod had a good reason to get out and walk in the countryside.

Values worksheet

Sometimes, physical health problems, illness, or a loss in our life means that we cannot do the activity we would like to do anymore and are prevented from doing it at all. This can be frustrating and even devastating, and can lead to giving up on a range of other things too. The important balance of activities we need in our life can start to slip and affect our mood. If you think this applies to you, the values exercise aims to help you to generate activities that whilst not the same, may be activities that you can do that are still in keeping with what you valued about the activity that can no longer be done.

What was the activity I can no longer do?

Thinking back to when I did that activity, what about it did I value about doing it, list the things you valued here:

Thinking about the values listed above, are there any alternative activities that you could do which would still bring you into contact with that value. For example, if you valued being outside in the activity you used to do, is there a way you can build this back in, in a different way? Consider some activities that would bring you into contact with your values below:

Clinical example: Emma

Emma was a 72-year-old patient with depression who also had a diagnosis of cancer and was having chemotherapy as a palliative care treatment, which meant being in hospital each week and unpleasant side effects like tiredness and sickness.

Prior to being depressed and having treatment for her cancer, Emma and her husband were very active and would always take their grand children out each weekend to a different place for a family day out and to give their daughter some time alone with their son in law. They would always surprise the grand children with a new place each week and give them clues on the way so they could try and guess where they were headed. Since becoming ill, they had not been able to do the trip each week both because of Emma's hospital appointments and tiredness but also because of her mood Emma had not wanted to go out or see people. The trips were not going to be possible anymore due to her deteriorating health, the impact of her treatment and the fact Emma could not manage long trips in the car or lots of time away from home because of her side effects. Emma completed the Values activity worksheet and identified that the things she valued most about the trips wasn't the places they went to particularly, it was the sense of fun and spending time the four of them doing something together. She valued this a great deal, along with surprising them as she valued seeing how happy it made them. She discussed this with her PWP and by doing the values exercise Emma decided that instead of day trips out which were no longer possible for her, another activity that they could still do which brought her into contact with those same values was to watch a film together as a family.



This was shorter and felt manageable in the home even if Emma wasn't feeling very well as she could still join them. Her mood was also better as the day went on so Emma thought about doing this together in the afternoon.

Talking through the values worksheet with her husband, he also came up with the idea of surprising them with the film each time and giving them clues and asking them questions for them to guess. Her husband built a den on the sofa with duvets for the children, and made popcorn and large drinks with straws. Emma was able to lie down and watch the film with everyone snuggled up together. They would all take it in turns to choose the film and then the others had to guess what they were going to watch. After the film Emma's husband would do a quiz for everyone with questions like 'What colour was the waiters shirt?' or 'how many people were in the lift scene'. They really enjoyed it and it brought them together in a different way. The grand children loved being able to spend quality time with their Grandmother again.

Reflection

Thinking about your own clinical practice how applicable do you feel that the values technique would be within your work, does it offer a way of augmenting your intervention to help the patient to overcome the challenges they may face in activating?

Wisdom enhancement

Another augmentation that can be made to LICBT is the use of wisdom enhancement strategies. Wisdom enhancement is a logical approach that utilises the learning and experience that a person has accumulated through their life.

Older people bring a rich factual knowledge with them to treatment. Wisdom comes through challenging or difficult life situations that change us (Laidlaw, 2015).

Depression causes autobiographical memory to become overgeneralised and vague (the memory the person has of their own past events). The person may recall negative information and evidence rather than positives when considering the past due to the negative affect. As a result of these changes, it is difficult for them to access and use the previous learning and wisdom that they have accumulated and apply it to their current situation. Depression may block wisdom attainment because of the selective and overgeneralised nature of recall in depression and the excessively negative attributions an individual makes about themselves (Laidlaw, 2015; Joorman et al., 2009). This negative recall can be seen when older people fail to use their lifetime experience to help them to deal with their fears or mood (Laidlaw, 2010).

Wisdom can be enhanced by helping the patient to reflect upon any adversities or challenges they may have previously faced, to see if there is any learning (wisdom) that they took from that experience, that may help them with their current difficulties.

It allows the patient to see that challenges are a normal part of life at any age and whilst challenging to experience, they provide an opportunity for growth and also help them to recognise their own resilience in the face of current or future adversities and challenges (Laidlaw, 2015). If a patient has experienced depression before previously and come through that episode, what did they do then that may help in this situation? If they have a current loss, have they previously experienced losses that may help them to manage the current situation?

The context in which the practitioner discusses these adversities or challenges and what they have learned from them that may be helpful for their current difficulty is one which recognises the patients strengths and abilities. It is respectful of their life experiences and is consistent with helping them to recognise their own ability to help themselves in the future. The discussion should be a Socratic one; guiding the patient to their own discovery (Padesky, 1993).

The solutions should be generated from the patient's own reflection rather than being chosen or pointed out by the practitioner.

The use of a timeline, either previously gathered during the assessment or as a homework task can be beneficial as it allows the practitioner to see the patients life events and mood history in a brief visual form. This technique can save clinical time and provide an 'edited' version of the highs and lows of an individual life (Laidlaw, 2015) whilst still enabling the patient to feel their story has been heard.

My timeline worksheet

Complete the following worksheet by putting your key significant life events that you have experienced from birth to today on the worksheet below. Also make a note of any previous episodes of depression or anxiety.

Birth



Today

Wisdom enhancement



Using wisdom enhancement in sessions can enable patients to consider and access their own learning and reflect upon how this can be applied to their current problem area. By looking at the timeline together, the practitioner can look at past examples and ask the patient if they learned anything from having lived through the experience. Could they apply that learning to their current situation in a way that would be helpful, or is there an example of a time when they would consider that they did something wise. Asking the patient what they learned from these times and what stops them from using that learning in their current situation can enable an open dialogue to take place and help the patient to think more concretely about their own experience, wisdom and resilience in the face of life's challenges. This can open new opportunities for them to apply that learning in action to their current problem and consider their own skills for managing this. Used well, wisdom enhancement can increase hopefulness and decrease feelings of helplessness.

Clinical example: Gordon

Gordon was an 84-year-old retired plumber. He lived alone in residential accommodation as he had struggled to look after the home after his wife died. He was experiencing depression and generalised anxiety disorder.

Gordon had been a worrier most of his life and his family used to make jokes about his fretting. At times during his life this had built to a peak, such as when he got engaged to his wife Moira, when they were expecting their first child and when their Son Matthew moved to Scotland for University. Gordon had periods of time when his worrying was manageable, but others when this was very problematic. He had also experienced two episodes of depression previously, having had medication at the time and being referred to a psychologist.



At the same time he moved into the residential home, Gordon's good friend Jo had been diagnosed with dementia and had been taken into hospital. This caused a great deal of worry for Gordon about his own memory and health. He would check for signs his memory was failing, which only served to make him more anxious. He had a number of tests and they had shown that his memory was fine. He still felt anxious however and would worry most of the day about what the future held and about how much he was worrying, concerned it would never go away and ruin 'what time was left'. As he had completed a timeline with his PWP Sarah, she asked him questions about his previous episodes of anxiety and what he did then that helped. He had also experienced some very challenging situations, such as his wife being diagnosed with cancer and her subsequent ill health and death as well as his son being in a large car accident whilst on holiday. Sarah helped Gordon to see what resources he had gathered from these experiences and to think about how he could use what he had learned to apply to his current episode of anxiety and low mood.

Gordon's timeline worksheet

Complete the following worksheet by putting your key significant life events that you have experienced from birth to today on the worksheet below. Also make a note of any previous episodes of depression or anxiety.

Birth

1943

Aged 12 had a big period of worrying about my Dad dying after he had a heart attack. I would get up at night and check he was still breathing

1952

Aged 21 Really anxious when I got engaged to Moira

1954

Period of anxiety and depression when Moira was expecting Matthew. Had antidepressants prescribed but side effects were not great

1991

Anxiety bad when Matthew left home for university and then became depressed again. Had to see my GP and a psychologist again. Went back on antidepressants, a different one this time and they helped

2010

Matthew is involved in a big car crash and ends up in intensive care. He pulled through

2013

Moira died from cancer aged 79

2014

Had to move into care after Moira died

2015

Worried that I am getting dementia, check for signs I am forgetting things and have lots of tests. Feeling fed up and down

Today

Summary



This new booklet contains a lot of information necessary when working with older people. Practitioners should bear in mind that older people belong to a very heterogeneous population grouping containing people aged from 60 up to and above 100 years of age. As such some clients may benefit from practitioner adopting an age-appropriate approach to CBT, whereas other clients will benefit from a traditional non-adopted approach.



Chronological age is going to be the least useful indicator of this decision and choice for practitioners. The answer is to be found in understanding your client in their context. For many this means an age context but the main way to enable your client to benefit fully from your CBT sessions is simply to remain open to the possibilities of change.

What things are you taking away into your practice from using this workbook and the training you have attended on working with older people? Use the traffic light below to record:

**Something that I have
learned that has made
me stop and think**

**Something I want
to take away and
learn more about or
practice**

**Something I can
take forward and try
straight away in my
practice**

Reflection

CBT with older people

What have I learned
from using this
workbook?

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