

A Clinician's Guide to:
CBT with older people

Ken Laidlaw, Naoko Kishita & Marie Chellingsworth



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

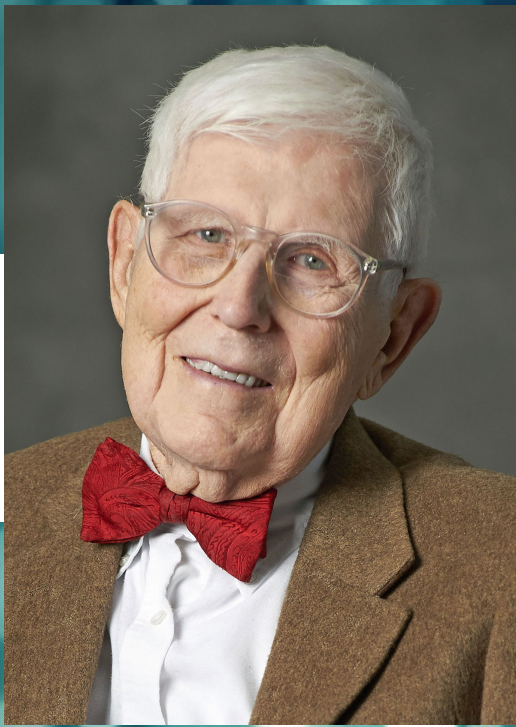


Fewer older people have accessed IAPT services than expected despite them having better outcomes than their younger counterparts. We have updated the IAPT older peoples curricula in 2016, which was first produced in 2013, to provide more detailed support to IAPT therapists and practitioners to help to 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 CBT. At all times practice of these techniques should be done by appropriately trained and supervised CBT therapists. Before using the ideas contained within this workbook you should seek the appropriate training in CBT with older people during high intensity training or as CPD. Any training to use these techniques should be delivered by those with appropriate clinical experience and training in CBT for older people.

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Contents

1-2

About the authors

3-4

Introduction to the workbook

5-12

The fundamentals of increasing
access for older people

13-20

Challenging your own views of
ageing

21-49

Depression and anxiety in later life

50-62

Formulation

63-66

Age appropriate augmentations

67-68

Working with emerging issues -
complexity and comorbidity

69-94

Age appropriate CBT

95-102

Summary & useful references

About the authors



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!



Marie Chellingsworth

"I am Executive Director of CBT and Evidence Based Programmes in the Clinical Psychology Department in 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 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.

Introduction

This workbook presents an opportunity for CBT therapists to review the skills, competences and knowledge needed to effectively and efficiently practice CBT with older people. While the workbook provides an account of how CBT may be different with older people, at all times it is advocated that the structure and philosophy of the application of CBT remains the same. As with all age groups CBT with older people is an action-oriented therapy whose primary aim is symptom reduction (Laidlaw, 2015).

Using CBT with older people may sometimes present some challenges to therapists unused to working with this demographic/client group. In some circumstances therapists may be confronted by depressed or anxious clients who have multiple comorbid conditions that appear to have psychological consequences and may appear to impact on potential outcomes. In this respect therapists may be feel deskilled in using CBT to treat depression or anxiety disorders in this context. On other occasions therapists may be confronted by older clients who present a convincing attribution of the nature of their problems being due to the ageing process. Again this may seem to suggest that CBT may not have much to offer these clients. On the contrary, CBT teaches us that it is not the circumstances or even the difficulties that determine affect, but it is the idiosyncratic appraisal that is most problematic for clients hoping to maintain well-being in later life. As in standard CBT approaches we need to remind ourselves that 'A situation is neither good nor bad, but thinking makes it so' (Epictetus).



From the foregoing a key issue is going to be whether and in what way one needs to modify one's approach to ensure CBT can be applied with older people. The answer is more nuanced in that one cannot answer this question by recourse to chronological age as that is the least good indicator of any factor of significance. Instead to understand and answer this question, one needs to understand and to be able to differentiate health ageing from unhealthy ageing and to understand something about the new cohorts of older people as well as the demographic picture of ageing in the UK in the 21st Century. Once the therapist has understood and appreciated these factors, one needs to return to the individual and to appreciate the appraisals and attributes they make about the nature of their problems.



The key to addressing the above issues 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 CBT seeks to empower our clients we can do this more effectively by appreciating that one must resist conflating ageing with loss and deficits. Ageing is not death, it is the opposite of that and ageing is not inevitably accompanied by depression, or dementia. These conditions are not the consequences or natural outcomes of old age and are in fact not experienced by the majority of older people.

Therapists 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 emphasises the message that we need to fit CBT to the individual and not the other way round! This workbook is part of a suite of materials for the IAPT older people curriculum and aims to help CBT practitioners and trainees to gain confidence in applying the efficacious, tried and tested interventions of CBT, with older people. The workbook is consistent with training slides and other therapist tools.

*Ken Laidlaw, Nao Kishita & Marie Chellingsworth
January 2016*

The fundamentals of increasing access for older people

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.

Ageing in the UK

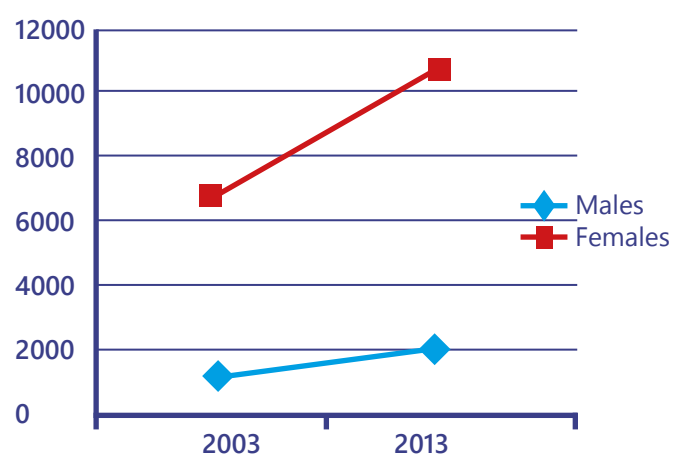
Older people alive today are already exceeding the lifespan of their parents and are going to live beyond their own expectations for lifespan. This means they have no real role-models to follow in how to age successfully. The patterns for ageing successfully are changing and may be reinvented by the baby boomer generation (those born 1945-1962).

People are living longer than any previous generations, 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). People are living longer than at any other time in the history of humanity, and 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.

In the UK, life expectancy at birth has reached its highest ever level in the UK with life expectancy of 83 years for a female born today and 79 years for a male born today (ONS, 2014). Yet in 1910 in the UK, life expectancy at birth was 51 for men and 55 for women (ONS, 2015). This has fundamentally changed in the UK now with people expecting a period of retirement and living life free from disability well into the 8th decade. Life expectancy at age 65 years in the UK is also increasing with men now expected to live 19 years and women expected to live 21 more years (ONS, 2014). The gender gap in life expectancy is narrowing with women now expecting to outlive men by 4 years, decreasing to less than 3 years at age 65 (ONS, 2015). There remains a life expectancy age divide between the Regions of England with higher life expectancy at birth in people born in in the South.

It is amongst the oldest-old (i.e people aged 80 years and above) however, that we find the most extraordinary relative increase in numbers. For instance, the number of centenarians (people aged at least 100 years old) show 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 centenarians (710 of these were aged at least 105 years of age) and by 2051 there will be an estimated 280,000 people aged 100 years and above living in the UK (ONS, 2014). For those of you wanting to settle an argument as to which sex is the weakest, you may wish to reflect on this: Of the centenarians alive in 2013 there were 6 women for every one man. Of those people aged 105 (and above) in 2013, there were 10 women (600) to every one man (60).



This figure shows the total number of male and female centenarians alive in the UK between 2003 and 2013 and shows that age is a gender issue. More women live longer than men and this is magnified as people age. (Source: ONS, 2014).

Do the math: ageing and demographics

Let's figure this out! If there were 13,780 people aged 100 alive in 2013, and by 2051 there will be 280,000, what is the relative increase over that time period? How have the numbers increased? Simply divide $280,000/13,780$ to find out. Write your answer here:

Now, take a moment. What does this tell you? How do you feel when you realize, you or a loved one, are living at a time in human history when it is becoming more commonplace to reach 100 years?

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 octagenarian (aged 80+) and nonagenarian clients (1 in 5 men and 1 in 3 women aged 70 are expected to celebrate their 90th birthday in the UK; ONS, 2015). What we need to consider is how well our CBT models fit with this demographic change and with the older people we seek to help overcome depression and anxiety, especially if some of these challenges faced by older clients appear to be age-related. As such, as CBT therapists we may need to develop additional knowledge and competences to ensure that our assessments, formulations and treatments will be fit for purpose. As the baby-boomer generation turns 65 now, there will likely be increased demand for therapy services by this new cohort of old people. With increasing longevity we may find that we need to consider how appropriate is our developmental frame of reference for applying CBT with older people (Laidlaw & Kishita, 2015).

The current model of CBT that we apply with older people is based on an acute adult presentation of acute psychological distress (Laidlaw, 2015). It does not consider that the client will be much older than the therapist and with the increase in the numbers of older people coming into therapy, it may be important to consider what issues therapists may need to confront when working with clients who may be 4 or 5 decades older. While this may present challenges for some, it also presents opportunities for therapists alive to the possibility that older people are resilient survivors rich with life experience and possessive of lifeskills that therapists may not have yet developed. In this frame of reference, enhanced collaborative working in CBT means respecting, valuing and empowering older people to make significant progress in therapy in overcoming problems. This workbook contains information and tools to help you become a more effective CBT therapist with older people.

Challenging your own views on ageing



The negative stereotypical image of older people as 'warm but incompetent' (Cuddy et al. 2005) can inform our view of ageing as being about loss and decrepitude. It can hold enormous power for older people and for ourselves as therapists. Take a moment, think of what image comes to mind when you think about an older person. Use the text box here to record some thoughts, or images.



What do you think of when you imagine an 'older person'?

What thoughts, images and ideas come to mind when you project into the future and see yourself as an older person? What age are you when you are old? How does this image of yourself fit the image for a 'stereotypical older person'?

Challenging your own views on ageing

In an exercise within CBT workshops delivered by us we often provide exemplars of older people. You may want to consider how they fit with your own ideas of older people. Bob Dylan is 75 years and well past picking up his bus pass! Helen Mirren picks up Tony Awards for acting rather than picking up her pension. Mick Jagger, Keef, Charlie and Ronnie Wood are all past pension age but still rocking out on the world's stage. Did you know that the AARP magazine (American Association for Retired Persons) is the largest print magazine by circulation in the US with close to 24 million readers...And it is edited by ex-editor of Rolling Stone Magazine. If you look at this cover of a recent issue of the AARP magazine, you may be surprised that older people are interested in the same things the rest of society is; lifestyles, health and finance.

In case you think it is only celebs who age well, think of members of your own family? Do you know of someone who ages well? It's the norm rather than the exception.

People cope better than we expect when faced with the challenges of ageing. For instance reflect on this quote from Professor Dan Blazer (one of the world experts on depression in later life). This suggests that those of us who work with older people there is a recognition that this population is more resilient than we give them credit. Think about what this means for CBT with its emphasis on being active and directive.

"Given the plethora of risk for late life depression, we find it easy to focus upon these risks. Yet a balanced perspective will augment our ability to treat our patients effectively... 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)



Source: (c) American Association for Retired Persons. Permission sought.

Think of ordinary men and women who cope with the loss of spouses they may have known for most of their adult lives. Mr. Ellis was widowed at the age of 80 and for the first time in his adult life found himself living on his own. He had to adapt and to learn to do things like using washing machines and cooking for himself.

While these may seem rather mundane and trivial challenges, imagine being in your 9th decade and being faced with having to do all this on your own for the first time ever. Take Faujua Singh as another example, at the age of 100 he was running the London and New York Marathons. He started running in his 80s after relocating to London following the death of his wife and then one of his sons who he was in business with. He relocated to live with another of his sons and unable to read or write English, he took up running as something to fill his time. He ended up replacing David Beckham in a sports goods ad campaign. Faujah is not alone in achieving extraordinary things at an age we'd not expect. Mieko Nagaoka is 100 years old, and in 2015, she set a 1500m swimming record. Yet she only took up swimming at the age of 82 years as a therapy for her knees!

Worksheet: Your own views on ageing

Before moving on, think about ageing in terms of negatives and positives. In a workshop exercise, we regularly ask participants to make a positive and negative list of ageing. You could try making your own list of negative and positive thoughts about ageing. Don't filter or censor the list, let the ideas flow out and list everything you can think of. As this is a private exercise you do not need to avoid any thoughts. Use the form here.

Negative aspects of ageing	Positive aspects of ageing

In a recent workshop, one of us recorded this list from a group of CBT trainees and experienced CBT therapists. Compare your list with the one listed here. Are there similarities and differences? Is there anything that is a surprise to you?

Negative aspects of ageing	Positive aspects of ageing
<p>Decline Psychological, Physical, Social existential losses, energy.</p> <p>Cognitive impairment/memory failings</p> <p>Loneliness</p> <p>Physical Change</p> <p>Loss- health, partners, sexual identity, autonomy.</p> <p>Bereavement</p> <p>Death</p> <p>Loss of independence having to be cared for</p> <p>Social invisibility especially gender</p> <p>Increased vulnerability</p>	<p>Retirement/Freedom (from work)</p> <p>Wisdom</p> <p>Lifeskills/experience/longevity</p> <p>Looking after younger generations</p> <p>Emotional stability 'more relaxed within one's own skin'</p>

What is interesting from the above is that the list of negatives is much longer than the positives, and in the generation of it, it was much easier and quicker to derive the negative list, rather like the way that depressed people are able to quickly and easily list negative attributes about themselves, and positives, are much harder to generate. Thus one might suppose that negative thoughts about ageing can operate like negative thoughts in depression. Thus as in affective disorders where thoughts are NOT facts, the same may be said in ageing, ageing thoughts expressed by people are not facts.

If you look at the (long) list of negatives and you don't question this as a stereotype for ageing, when a client arrives in your clinic and presents their depression or anxiety symptoms as 'understandable' reasons for their emotional problems you may be unwittingly reinforcing their view that things are unchangeable and without even being consciously aware of it, you may also lower your expectations for change in therapy. Use the table above to help challenge the stereotype. Ageing is not dying, and ageing is not loss. Ageing is life.

A final thing about the list before moving on is to note that wisdom is noted as a positive aspect of ageing. This is an issue to come back to when we discuss wisdom enhancement in CBT.

When does one become old?

Chronological age is the least good indicator of anything when we work clinically with older people. Ageing is a process rather than a state. We don't suddenly experience ageing as a step-change in our lives and there is a great deal of heterogeneity in how people experience ageing. As a result of demographic change affecting the developed and developing world nations there is a need for therapists to become knowledgeable about working with older people. In the near future, CBT therapists are increasingly likely to work with older people seeking to enhance their psychological wellbeing. The issues older people bring into therapy may change as longevity of life increases and therefore the presentation of problems may appear to be age-related (Karel et al., 2012; Laidlaw & Pachana, 2011).

What do you think older people see when they look in the mirror?

It is interesting to speculate when we become aware of ageing; the first grey hair, the laugh-lines on our faces that are becoming deeper? When you look in the mirror who do you see?



A few years ago, one of us was involved in a study developing a new cross-cultural attitude to ageing questionnaire (Laidlaw et al. 2007) with a large number of partners across Europe, Asia and N. America. As part of this study there was the opportunity to ask normally ageing older people the question, "At what age, does one become old?" The answers were usually the same in that older people often do not consider themselves to be old (see table below), and ageing is apparently viewed in relative terms. It depends upon one's frame of reference as George (2010) notes older people are more inclined to make 'downward social comparisons' when comparing themselves and their ageing.

Making personal comparisons with others one perceives to be less fortunate than ourselves enhances individual well-being so even in times of loss and change, older people may report good levels of life satisfaction. Consistent with this is the phenomenon of the ageing paradox. The ageing paradox is older people report better emotional experience and are more skilled at living in the moment, so at a time of age-related challenges involving potential losses, health, partners so on, older people report more not less life satisfaction. See Laura Carstensen Ted Talk: https://www.ted.com/talks/laura_carstensen_older_people_are_happier?language=en

"At what age does one become old?"

"I don't feel old inside" - 84 yr old woman

"Its such a gradual process..." - 82 year old woman

"It depends upon the psychology of the person"
84 yr old woman

"I know we are getting old, but I don't feel old"
84 year old woman

"I'll tell you when I get there" - 92 year old man

Typical answers about the start of ageing suggests that if a client you are working with says they feel old, this is NOT necessarily a normative experience and may be a symptom of depression. In other words your client may be erroneously attributing the nature of their difficulties to age when it can be more usefully related to depression. Using CBT, one can reverse depression but as yet no one can reverse ageing! In CBT we focus on changeable aspects in order to bring about symptom alleviation so the focus needs to be on facts rather than thoughts or feelings about events. Thus therapists need to draw on existing skill and competence in the use of socratic questioning when exploring an individual's appraisal of ageing experience.

Older people selectively prefer psychotherapy

Contrary to popular belief, older people hold positive attitudes towards health seeking for mental health problems (MacKenzie et al. 2008) and hold positive views about therapy; as acceptable as medication but with far fewer unwanted side-effects. If given a choice, older people prefer to receive psychotherapeutic treatments rather than psychotropic medication but may be less likely to receive this option (Gum et al. 2006). Older people who ask for a referral for psychological help are likely to have to discuss this with healthcare professionals with a lack of training in aging and geriatrics (Burroughs et al. 2006; Karel et al. 2012) which may prove to be a substantial barrier in a number of ways. There may be a lack of awareness amongst primary care providers about late life depression and anxiety or a reticence to investigate this further for fear of opening a 'pandora's box' of complex and challenging scenarios they fear being ill equipped to manage (Burroughs et al. 2006; Kishita et al. 2015). All IAPT services must become more 'age-friendly' and ought to adopt specific outreach strategies to increase the numbers of older people treated (Boddington, 2011).

Make some notes here as to what you think might improve access of older people into your service. Can you look at the types of referrals your service receives and see if you identify how many older people are referred and how many are actually seen.

You may want to look at this guide produced by the DoH:
<http://www.iapt.nhs.uk/silo/files/op-compendium.pdf>

Depression and anxiety in later life



Health professionals inexperienced in working with older people may also endorse more negative beliefs about ageing where depression is seen as a 'justifiable' and 'understandable' (Burroughs et al. 2006).

Described as the "fallacy of good reasons" (Unutzer et al. 1999; p235), poor treatment outcomes are expected as healthcare providers misattribute depression symptoms as a consequence of ageing, so that distress is normalized and diminished and it is possible that such a viewpoint will discount psychological therapies as a viable treatment option. This negative stance about aging can also be found in healthcare professionals' estimation of life expectancy, with medical doctors untrained in geriatrics consistently underestimating life expectancy (Wirth & Sieber, 2012) perhaps suggesting inappropriate treatment decisions as a consequence. Therapeutic nihilism endorsed by professionals may also find a resonance in the beliefs of depressed older people themselves as depressed older people attributing their depression to ageing, were less likely to seek treatment for it (Sarkisian et al. 2003).

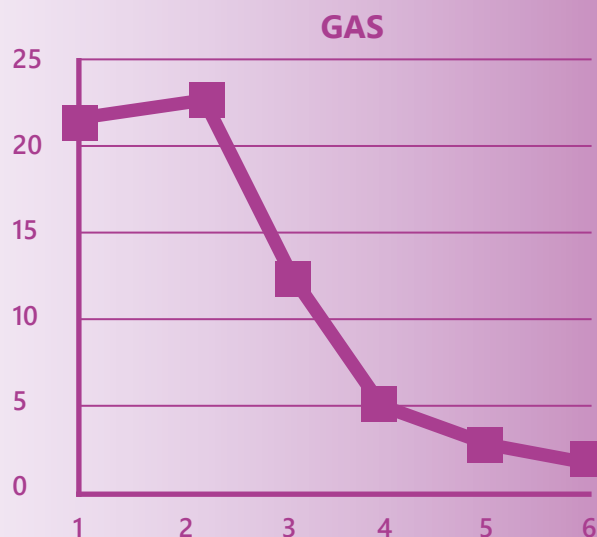
Depression and anxiety in later life

Real people experiencing real distress and likely to benefit from working with a skilled CBT Practitioner are being denied access to evidence-based psychological therapies.



Take for example, Margaret Curran. She is 83 years old with a long history of contact with psychiatric services. Currently she experiences a mix of anxiety and depression symptoms. She lives with her husband who is in poor health. She is not able to tolerate medication and has not yet found a treatment that will help her. She experiences a lot of upsetting thoughts and often thinks about ending her life. She is distressed by these thoughts and does not want to act on them, and in fact they frighten her. She has a loving family and frequent contact with her daughters. She has stopped going out of the home by herself in case she self-harms. She doesn't think there is much that can be done for her at her age and has resigned herself to a much reduced quality of life. Margaret was referred to an IAPT service but was not considered suitable for CBT.

Using a standard course of less than 10 sessions, with CBT treatment structured with agenda and always applying homework to test out ideas discussed in session incorporating the use of timelines to foster a sense of resilience and empower Margaret the graph opposite shows how treatment turned out.



The graph shows scores on the Geriatric anxiety scale where a score of 22-27 indicates moderate anxiety. Below 12 is non-clinical. At the start of treatment Margaret's scores were in the moderate range and at the end of treatment had diminished and she no longer scored in the symptomatic range. Her frequency and intensity of distressing thoughts were no longer problematic and she was able to go out on her own again. She had also taken up meeting with her friends, and her daughters commented that they had their mum back.

Perhaps you might reflect on the case above. What are your criteria for helping older people increase access to psychological therapy?

Older people are better fits for CBT on the following:

They are more psychologically minded	Y / N
They can differentiate thoughts from feelings	Y / N
They are free from disabling conditions	Y / N
They do not experience chronic symptoms	Y / N

Take a moment to answer the above. Margaret would be rejected if older people are required to be able to answer Yes to all of the above. She was not psychologically minded as this was her first experience of therapy.

The job of the CBT therapist is to help communicate ideas through psychoeducation and we would reject many more candidates than we'd accept if we expected everyone to see their problems in psychological terms.

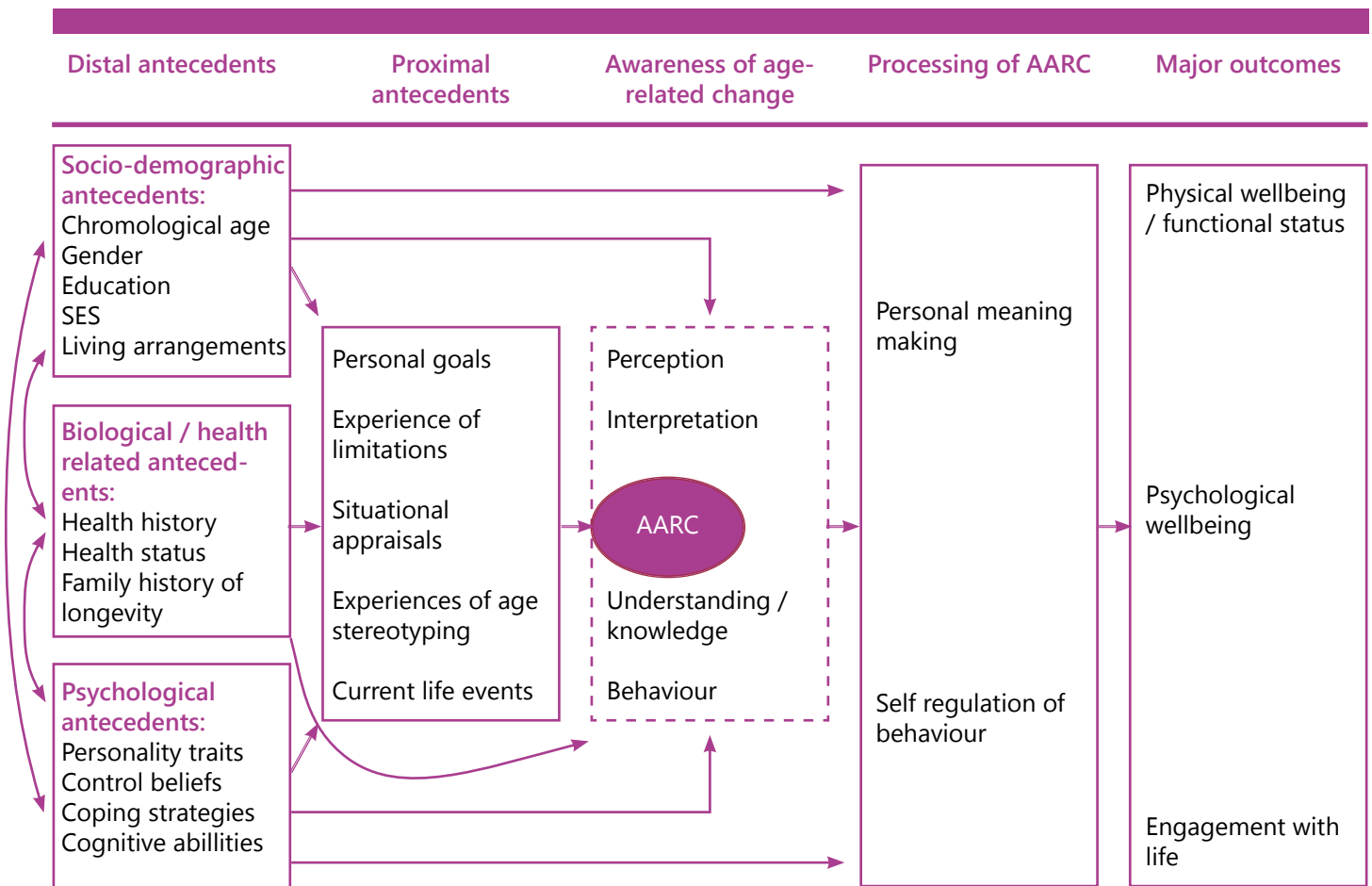
Margaret, like most clients' uses the term feelings when she means thoughts all the time. Rather than being semantic the key message is to use Margaret's language to educate her that 'feelings are not facts'. Margaret has a number of physical problems and this is likely the case with most older people. It may be that she may explain some of her psychological problems with reference to her physical state but again a skilled CBT therapist will set up behaviour experiments to test out what the client can achieve. Finally, her anxiety symptoms have been present for at least one year and she also experiences a low level of depression and has done for more than one year. The anxiety symptoms are unlikely to spontaneously remit and the depression symptoms are non-responsive to medication. Nonetheless the graph here representing actual scores from a routine primary care case shows that CBT techniques are powerful and how much change is possible in CBT with older people.

Understanding Mood biases in CBT with older people: impact on perception of ageing experience. Idiosyncratic awareness of ageing can exacerbate depression and anxiety

Diehl and Werner-Wahl (2010) have developed an interesting psychological model that suggests ageing is subjectively (idiosyncratically in CBT terms) understood incrementally and across a number of domains.

The awareness of age related change (AARC; Diehl & Werner-Wahl, 2010) suggests a person becomes aware of ageing once they apprehend that life has changed due to some consequence of aging, and in a domain of life that is important and meaningful. These changes attributed to age are perceived as either positive or negative (expressly not as neutral, or else they would be noticeable).

The subjective awareness of age-related changes does not necessarily align with chronological age. In depression mood congruent biases may affect a person's perspective and thus the subjective awareness of age may be affected by a depressogenic, or anxiogenic point of view. Thus therapists may need to consider whether the 'age-related' changes reported by clients may not be caused by age but by their thoughts about ageing. As is classic in CBT thoughts, no matter how convincing, are not facts. Thus CBT therapists may wish to examine a client's thoughts about ageing especially if problems are attributed to ageing.



Applying the AARC in CBT: Case example

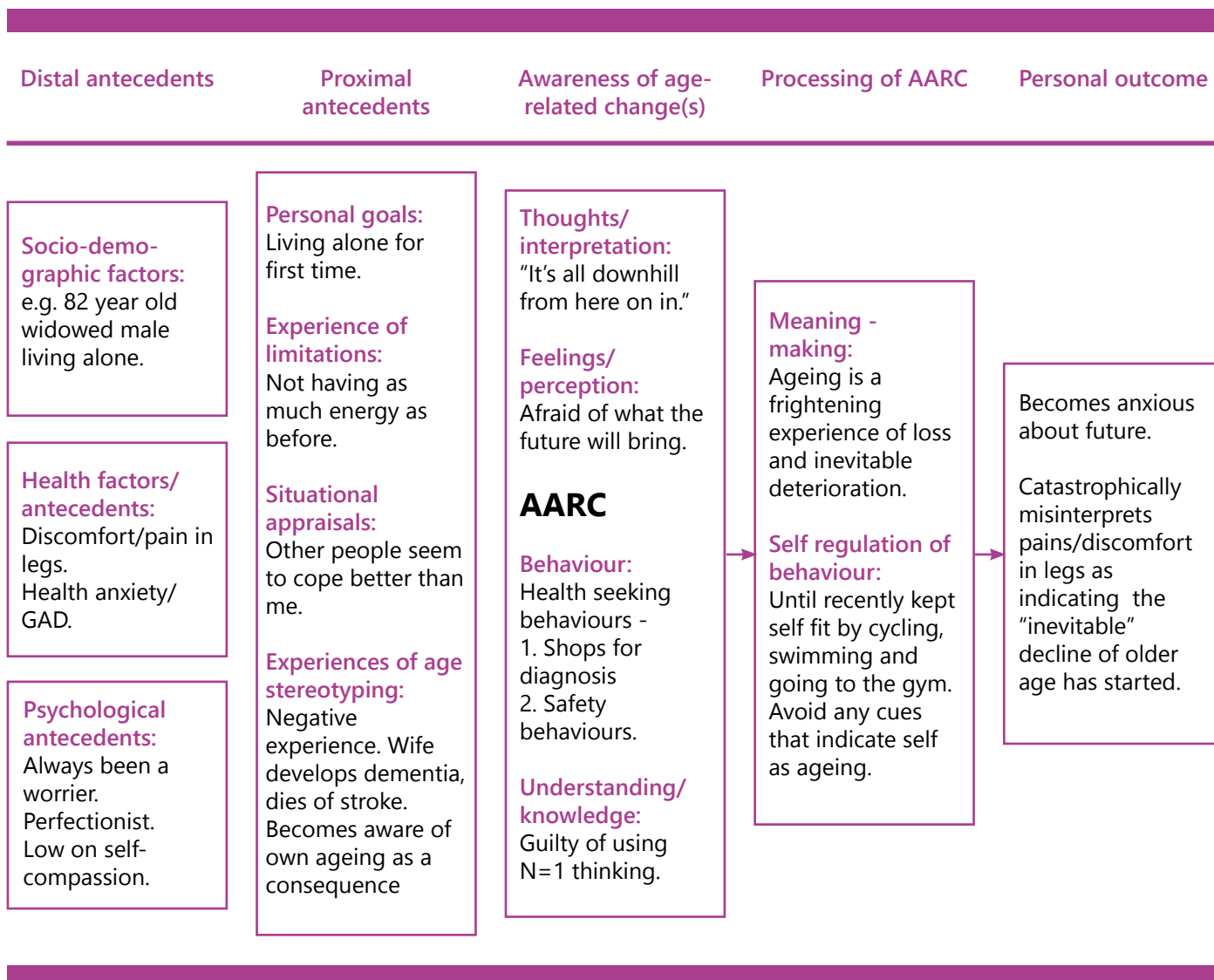
As Diehl and Werner-Wahl (2010) comment, older people who become aware of ageing may perceive a vulnerability and this may 'trigger' self-regulation strategies and responses to maintain a self-identity under threat. In depression, this akin to a vicious cycle and may result in maladaptive coping strategies that may undermine, rather than preserve a sense of identity. The figure below, explores how the AARC model developed by Diehl and Werner-Wahl (2010) may be influenced by mood congruent biases in depression.



Mr Ellis experiences pain and discomfort in his legs. Initially he consulted his GP for diagnosis and treatment and was told this was 'wear and tear' and likely a consequence of his cycling and exercising; he is a keen fit cyclist aged 82 years who also goes to the gym and swims regularly.

Mr Ellis was referred to a neurologist for consultation and he interpreted from what was said to him, that he may be at risk of cervical myelopathy (CM). After he got home he looked up this condition on the internet and read a number of different webpages.

He catastrophised about his situation to the point where he believed (with 100% conviction and certainty) that he would end up in a wheelchair. It would appear that CM is more common in older men than older women and when he returned for his follow-up appointment with his neurologist he was told that nothing had been found. While initially relieved by this news, as his discomfort did not resolve he became concerned about the meaning of his symptoms. Perhaps unsurprisingly Mr Ellis sought a second and third opinion and eventually, as his symptoms persisted he became convinced that his doctors had missed some important clinical and diagnostic feature. He believed these symptoms were the first indication of ageing and became his first awareness of age related changes. As a way of understanding the meaning of these symptoms the conceptual model of AARC may help us understand how Mr Ellis reached his catastrophic conclusion.



Because people like Mr. Ellis fear ageing and worry it is universally about loss and deterioration (which is contrary to normal ageing evidence, and the normal experience of most older people), they expect old age to be a depressing time of life and when depressed they 'normalise' this state with very negative consequences. For example, depressed older people often attribute the cause of their depression to ageing and as a consequence are less likely to seek treatment (Sarkisian et al., 2003). Negative events, such as changes to one's physical status are seen as harbingers of more serious and irreversible negative aspects of growing older and a sense of hopelessness develops. This describes Mr Ellis' experience and an age-sensitive CBT therapist may find it useful to explore the data on ageing that Mr. Ellis draws upon. We will return to this when we examine the use of timelines in CBT.

A fear of ageing?



Problems such as those experienced by Mr Ellis attributed to as a consequence of ageing are thought of as the 'tipping point' in that things are as good as they are likely to get, with the result that a person expects a future filled with loss and deterioration.

Thus therapists working with Mr Ellis need to contend with marked levels of hopelessness about the future. For Mr Ellis, his current physical function is seen as poor in comparison to previous levels and is also seen as likely to deteriorate further. This means that Mr Ellis is likely to experience free-floating anxiety about his future but without a specific and actual sense of what action he can take to manage his fears. This fear for ageing can be understood in terms of a stress-diathesis.

Attitudes to ageing and CBT with older people: An age stress-diathesis

When working with older clients the negative age stereotype may act much like a diathesis in depression. In ageing we see a similar dysfunctional schemata about ageing that when 'primed' by a stimulus, or experience that is associated or perceived (erroneously) as a consequence of ageing.

A diathesis is a pre-existing (and latent) predisposing vulnerability that individuals possess that may become activated by congruent matching life events and stressors. In CBT, the Beck model is based upon a stress-diathesis as follows, "Cognitive vulnerability in the form of dysfunctional schemas and maladaptive personality are diatheses that remain latent in the nondepressed state until primed or activated by an eliciting event or stimulus" (Clark, Beck & Alford, 1999, p177).

Levy (2003) suggests prolonged exposure to ageist societal attitudes reinforced from childhood through to adulthood result in people developing negative ageing self-stereotypes reinforced by attentional biases towards negative information about ageing. This is very similar to the negativity bias evident in the cognitive theory underpinning CBT (Gotlib & Joorman, 2010). Therefore, ageing self-stereotypes can be integrated within a CBT frame of reference with a stress-diathesis focussed on ageing, i.e. negative self-stereotypes of ageing, provide an explanatory construct for understanding individual causal explanations of depression as being a consequence of ageing.

Negative age stereotypes are activated by congruent negative experiences attributed to ageing. In other words as older people fear ageing and expect it to be a depressing time of life focused on loss and decrepitude, negative events can quickly (and erroneously) be attributed to the ageing process (Laidlaw, 2015).

Thus when a person says "all my problems are to do with being old", or "old age is a depressing time of life", this may be stated with 100% conviction (as with negative cognitions in depression), this may indicate the activation of dysfunctional schemata about ageing.

By selectively attending to negative indicators of ageing, such as unwanted changes in physical appearance and losses of vitality, depressed or anxious older people may attribute problems to age rather than depression.

This serves to activate the internalised negative age stereotype (the stress–diathesis is complete). Older people selectively attending to negative indicators of aging such as loss due to bereavement, or physical health changes such as longstanding limiting non-life-threatening condition may be more prone to activations of the internalised negative age stereotype (the Diathesis). Consistent with the selective processing hypothesis (Clark et al., 1999) in the cognitive behavioural model depression, there is a negativity bias where individuals overlook positive information by selectively and preferentially attending to negative stimuli. A negative cycle develops as the individual becomes hyper-vigilant to other indicators of negative experiences of ageing, and these reinforce the individual's belief that old age is a depressing, fearful and unpleasant stage of life.

Levy (2009, p334) suggests negative self-stereotypes become more salient for the individual as they encounter multiple cues that endorse their view of themselves as 'old' so that an unhelpful self-fulfilling prophecy suggests unpleasant experiences of ageing are the norm.

Levy and Leifheit-Limson (2009) found a stereotype matching effect with the impact being greater when the content of stereotypes matched outcomes. Participants exposed to positive rather than negative age-stereotypes performed better on cognitive and physical stimuli. Meisner (2012) demonstrates that negative age-stereotypes have stronger effects on behaviour than positive stereotypes. A negative cycle develops as the individual becomes hyper-vigilant to other indicators of negative experiences of ageing, and these reinforce the individual's belief that old age is a depressing, fearful and unpleasant stage of life (Laidlaw & Kishita, 2015).

Depressed older people endorse negative attitudes to ageing that are plausible, distorted and unhelpful. In this mode, therapists unaware of age-stereotypes and less experienced in working with older people may erroneously assume that they cannot help their client as their problems are 'realistic', negative and unchallengeable consequences of ageing (Laidlaw, 2015).

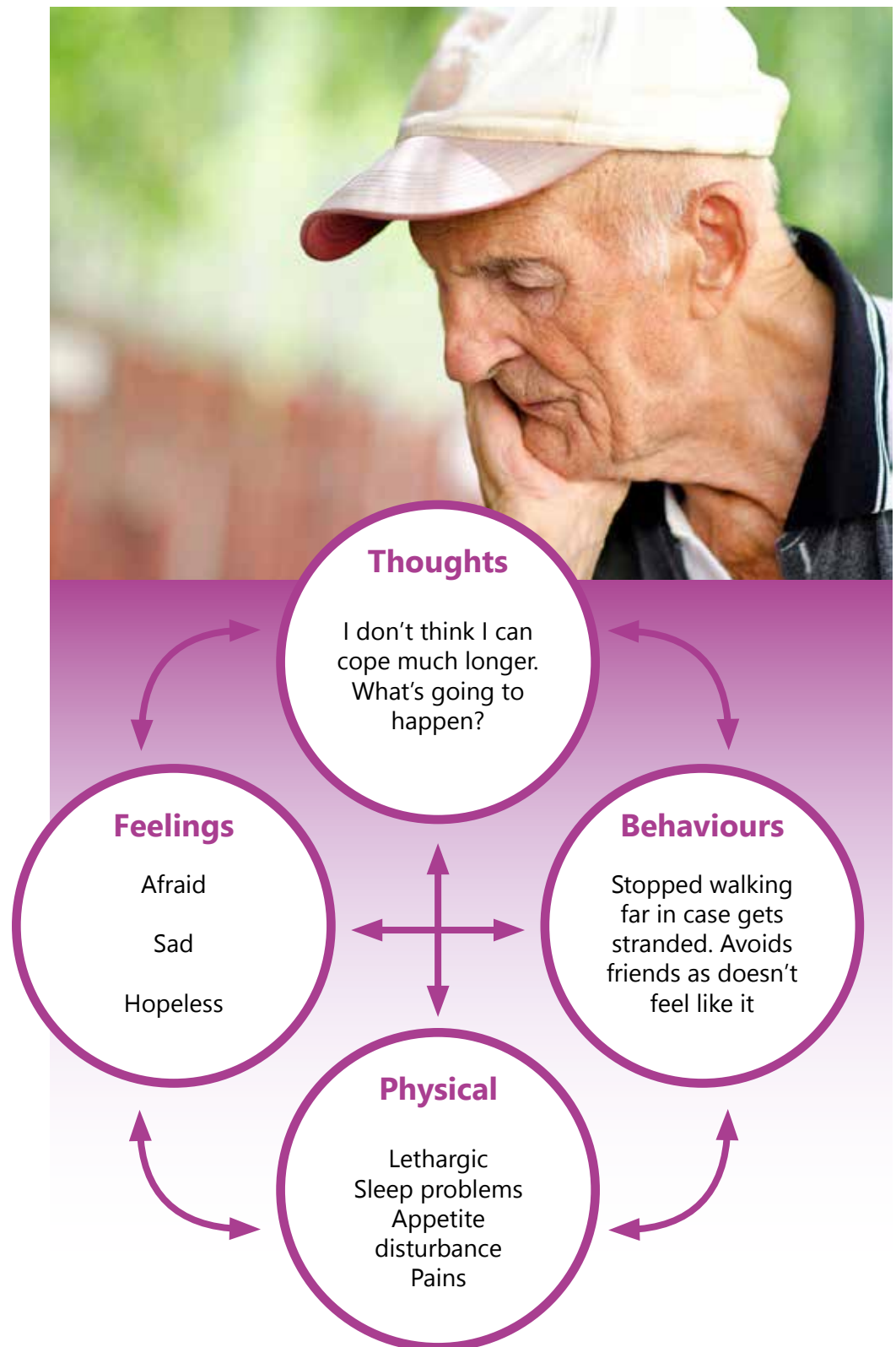
When older people in therapy espouse negative attitudes to ageing, therapists may be less willing, or confident, in challenging the veracity of these age-related beliefs or consider they be symptom-contaminated. The consequence is very often that the therapist and client are reinforced in their erroneous beliefs that there is simply ageing is a terrible stage of life and expectations for change are low in both parties. Thus the next older client that is seen is also subject to this erroneous belief and so on.

Case example: Internalised age stereotypes and CBT

Mr Ellis believes that his pain and discomfort in his legs mean that he will end up in a wheelchair. We can examine his thoughts, feelings and behaviours at an overt level by drawing out a simple 4-components (hot cross bun) model.

Mr. Ellis says:

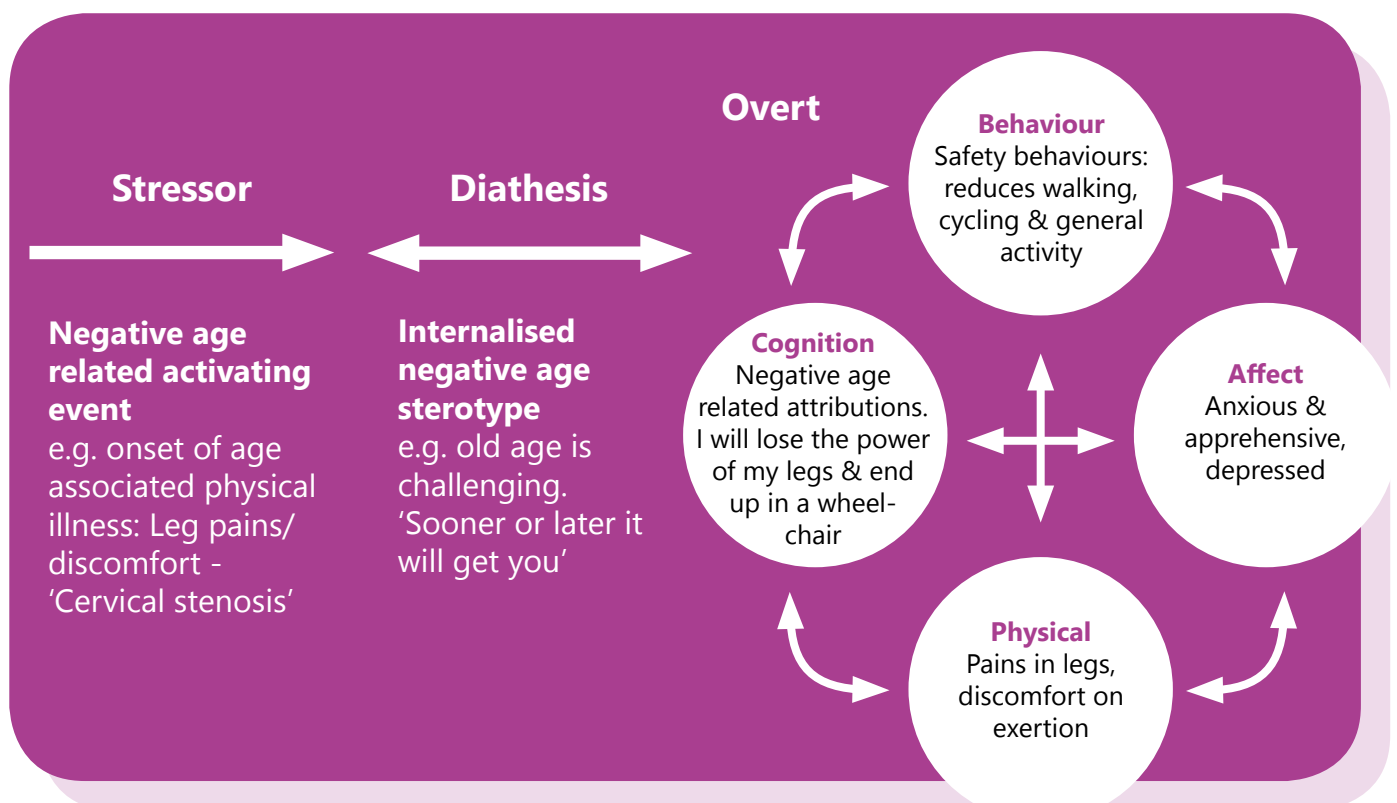
"My doctor says he doesn't know what is causing tiredness in my legs? This makes me feel worse, I start to visualise other things...will I end up in a wheelchair, will I still be walking in a few months time?"



Mr. Ellis beliefs, as indicated in the above HCM is missing an important explanatory construct. The CBT model hypothesises a stress-diathesis and suggests that underlying our thoughts and feelings are latent maladaptive schemata that can act as pre-existing psychological vulnerabilities. They are only latent, until activated by a congruent, or matching stressor, in which event they become dysfunctional and active.

If we consider that Mr Ellis' experience of ageing has not been kind in the witnessing of his wife's ageing. She developed cardiac problems in her 60s, and became less mobile, having a mastectomy in her 70s, she then developed dementia and just prior to her 75th birthday she died of a stroke. One might suppose that Mr Ellis' experience of witnessing his wife's ageing process began to activate his internal negative age stereotype (his diathesis) and the stressor of witnessing his wife's death from stroke and caring for her with dementia activated his fears. Thus the HCM model is better understood as being part of a two-dimensional conceptualisation. The overt presentation of the HCM is underpinned by the more covert internalised negative stereotype of ageing which explains his fear of ageing and the future. Thus therapists are recommended to use typical methods of challenging core beliefs when dealing with the internalised age stereotype.

The figure here puts an age-appropriate covert level of understanding to the overt level of understanding that we achieve with the 'hot-cross bun' model.



Depression in later life



Depression is NOT an outcome of old age; neither is it an understandable response to challenges of ageing. Older people become depressed for a whole host of reasons and mainly for the same reasons as those experienced by adults of working age.

Depression in later life is a major public health issue as it is linked with increased morbidity, mortality and reduced quality of life (Fiske et al. 2009). Rates of depression and anxiety in later life may actually be lower than rates reported for younger or middle aged adults (Blazer, 2010). When working with depressed or anxious older people, or when working with people with dementia it may be useful for clinicians to remember that the majority of older people age successfully.

Furthermore Cartensen et al, (2011) in their longitudinal follow-up of a cohort of adults, ranging in age from 18 to 94, over ten years demonstrate that emotional stability and wellbeing improves with age.

Blazer (2010) suggests three protective factors associated with ageing to explain the lower rate of depression in later life. These are, better emotional regulation competence through selectively optimising positives; increased wisdom (Baltes & Smith, 2008) through learning to deal with adversity and uncertainty, and, resilience as older people cope better with stressful events as these are experienced as being 'on time' (Blazer 2010, p.172). Thus depression rates being lower at later stages of life because of positive lifespan development factors such as older people being more skillful in emotional regulation is an intriguing explanation for anyone wishing to work therapeutically with this client group. This proffers the possibility that older people may make better candidates for psychological therapy. "The more traditional, largely pessimistic, view has been that adult development and increased experience make people rigid and set in their ways. Yet some clinicians working with the elderly have felt that the effect is quite the reverse: that growth and experience teaches adults to be more flexible, less dogmatic, and more aware that there are different ways of looking at life." (Knight, 2006, p24).

In a systematic review of community-based studies assessing prevalence of late life depression, Beekman et al., (1999) calculated an average prevalence rate of 13.5 per cent for clinically relevant depression symptoms. More recently, McDougall et al., (2007) reported findings from a large epidemiological study looking at the prevalence of depression in people aged 65 years and older from across England and Wales and estimated depression prevalence among older people to be 8.7 per cent, with a prevalence rate for severe depression of 2.7 per cent.

Recent evidence suggests that while anxiety disorders in later life may be very common (Bryant et al., 2008) and disabling, nevertheless anxiety symptoms remain neglected and under-treated in primary care (Vink et al., 2008).

While medical illness may increase rates of depression in later life, with a greater burden of illness resulting in an increased risk of depression (Alexopoulos, 2005), the majority of older people who develop physical problems do not develop depression (Blazer 2010; Blazer & Hybels, 2005). Nevertheless medical illnesses complicate the recognition and treatment of depression and anxiety (Krishnan et al., 2002).

Depression is also increased in the presence of cognitive impairment and dementia with a consequent impact on treatment responsiveness (Wilkins et al., 2010). While rates of major depression in later life may be relatively low, subsyndromal or 'subclinical' depression (subclinical depression is the presence of significant symptoms of depression that don't fully meet DSM criteria for major depression) prevalence is much higher in older people (Alexopoulos, 2005). As subsyndromal or subclinical depression can become chronic, it is likely to have an adverse impact on the quality of life and relationships in the older person's life. Lyness (2008) notes a strong association of increased mortality in older people with subclinical depression and the naturalistic outcome is poor for subclinical/subsyndromal depression on its own (Lyness, 2008).

Anxiety in later life



Anxiety disorders in later life appears to present very often (Bryant et al., 2008) and may be more common in older people than depression.

More likely, depression and anxiety overlap so therapists ought to assess for anxiety when they suspect the presence of depression symptoms and vice versa (Laidlaw, 2013). Older people often experience poorer health than adults of working age and this may complicate treatment outcome for anxiety as it can be difficult to separate physical symptoms of illnesses from anxiety symptoms (Bryant et al., 2008; Worlitzky-Taylor et al, 2010). There are many different anxiety conditions but perhaps with older people the comorbidity of physical conditions can make these cases more complex (Laidlaw, 2015).

Anxiety remains neglected and under-treated in primary care (Vink et al., 2008). This is especially problematic as evidence suggests anxiety does not spontaneously remit and can become a very chronic disorder measured not in years but in decades (Lenze et al, 2005). Anxiety persists because of avoidance and to the untrained eye, avoidance can go unnoticed ensuring anxiety symptoms persist.



For example, Elizabeth is 68 years old and has lived with emetophobia (a fear of vomiting and of being in the presence of someone vomiting) since she was 8 years old. Like many anxiety disorders she can give a very precise description of the onset of the problem and while the causal factors are interesting, it is the maintenance factors (covert and overt avoidance) that has kept this condition live. As a married mother of three boys she was able to dictate cleanliness routines, plan family holidays that reduced risk of vomiting (staying in caravans, not eating in restaurants on holiday etc). As a result 6 decades after she first developed her fears they still have a hold on her. The good news is that a standard graded exposure programme took her symptoms away and enabled Elizabeth to live free from her fears. Thus symptoms may be of long duration but they are still treatable.

When anxiety (either experienced as symptoms or disorder) is comorbid with a mood disorder, older people are more likely to come in contact with mental health services and more likely to be seen by mental health specialists indicating greater severity and complexity of presentation.

Lenze et al., (2005) examined the naturalistic course of Generalized Anxiety Disorder (GAD) in older people. In their sample, the mean age of onset was 49 years and in this sample 46 per cent had recorded a late onset of GAD (i.e occurring >60 years of age). The chronic nature of anxiety was evident in the mean duration of GAD of 17 years. With 82 per cent having a continuous episode of GAD, Lenze et al., (2005) concluded "This finding enhances the rationale for long term treatment of GAD." Avoidance means symptoms could remain unrecognised and unaddressed, even to close family members and as result the person either does not seek help, or is not encouraged to address anxious symptoms. Given Elizabeth's example of successful treatment after many years of living (covertly; her sons did not know about her fear, they thought she was squeamish), and given that information suggests older people are not accessing CBT in sufficient numbers, Do not allow more barriers to treatment to occur for older people with anxiety disorders. Be open to change, and rather than adopting an expectation for poorer change, act as if older people are better candidates for treatment, and then observe your results.

Case example: Anxiety and intergenerational stressors



Mrs Alloway is a 76 year old widow. She has 2 adult sons who live far way from her. She has had an estranged relationship with her eldest son.

He tends to come in out of his mother's life in an erratic manner. They have had numerous rows and 'fallouts'. There are unrealistic expectations about their relationship on both sides. Mrs Alloway tends to worry and catastrophise about a whole range of topics. A recent example is when she was having a telephone conversation with her eldest son. He was talking on his mobile phone while driving. The phone call was cut off abruptly and without warning. Her immediate thought was "John is dead!" She explained, "he could have had a heart attack during the phone message (because he hasn't phoned back)"

She believed this thought 100% and called his mobile phone 10 times in very quick succession leaving more and more anxious and angry messages. Her son did not call back.

What do you do?

Here's what the CBT therapist did...

The therapist established whether the son had indeed called back at some point. He had although this was after a few days. The therapist was empathic in sharing with Mrs Alloway that this was an uncomfortable and upsetting experience. The therapist also established that she wanted to avoid such fear and anxiety again. She did. So the therapist asked, about a day or so after the broken phone call, and prior to her son calling her back, "How much did she believe her son was dead?" She replied about 85%. She knew that it was unlikely that he was dead but she couldn't shake off the fear that this might be so. The therapist took some moments to establish the impact of this thought on her emotions, behaviour and ultimately quality of life.

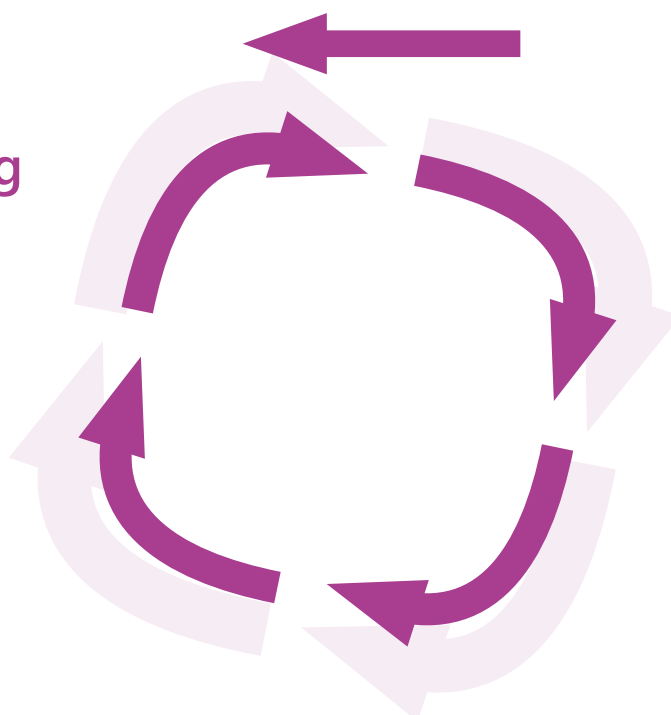
The therapist then asked Mrs Alloway to look at the evidence for and against her '**thought**' that her son is dead (some people may feel a little uneasy asking such questions, but in this

instance with someone who catastrophizes then it is important to be explicit, or the specific nature of the fear will not be targeted).

In response to the question, about evidence that her son is dead, Mrs Alloway responded, "I thought I heard a slight crunch as the phone went dead." She added that she **thought** that might be he had died while driving his car along a country lane. She immediately **felt** a rush of anxiety. As he hadn't returned her calls, or hadn't called back immediately following the call being cut off, this was 'evidence' of him having a heart attack and dying. She then **behaved** in a fear escalating way by repeatedly calling his phone number.

At this point you may wish to see if you can formulate an anxiety-worry cycle that explains the situation to Mrs Alloway. Consider the sequence of "activating event – thought – feeling- behaviour."

**Anxiety
Generating
Event**



Alternative explanations for her son not calling back...

At first when Mrs Alloway was asked about alternative thoughts to "My son is dead", she said, 'I knew he wasn't dead' but she couldn't think of any evidence that this wasn't so. The therapist patiently asked if she could think of any reason that her son hadn't phoned back immediately. She said, "Maybe there had been a technical fault [with the phone or the line] and that it was persisting."

She then thought again and said, "Perhaps, more realistically, he couldn't be bothered to call back when the phone went dead as he had said everything he wanted to." (An useful thing to do at this point is to break-off from asking about alternatives for a moment and ask whether this has ever happened before, as it had, this was useful data for her to access when dealing with future anxiety attacks).

Returning to the conversation about alternative evidence, Mrs Alloways said that it was also possible that the line went dead because his mobile phone had run out of call credits.

Once the alternatives had been discussed, Mrs Alloway was asked to compare the reality of alternatives with her original thought. She stated she could see that the alternatives were all more likely than her original thought.

Mrs Alloway said that "Afterwards when Robert [her son] called me, I was so relieved and a little upset at myself for thinking such 'ridiculous' thoughts."

Note here that this sense of 'ridiculous' can result in people dismissing the problem of anxiety. It acts as a disincentive to deal with anxiety as the thoughts seem 'silly'. Having discussed with Mrs Alloway the impact on her of having an anxiety thought hang around unchallenged, it is apparent that the emotional impact is quite great.

Sufficient enough, in fact to develop an alternative set of coping strategies for the future occurrence of anxiety thoughts.

The therapist asked Mrs Alloway to reflect on how it was that she hadn't been able to generate these rational alternatives herself and 'short-circuit' the development of anxiety.

Mrs Alloway reflected for a moment and said, "I feel they (anxieties/worries) are really realistic, but results show otherwise" As her anxiety levels rise, she becomes focussed on 'action' in a flight or fight response and acts on her feelings of extreme danger by overreacting to what is a non-threatening or non-serious event. Recalling past events, Mrs Alloway was able to see that at times she had alienated people by acting on her fears. As she was able to note, "If you act when you are anxious you will regret it."

Behaviour fuelled by anxiety often has a paradoxical nature to it. In effect making the feared consequence more rather than less likely.

The therapist discussed with Mrs Alloway that one of the 'dangers' of anxiety is of acting on one's fears. Her repeated calls were her attempt to get her son to call her back, but paradoxically, the number and frequency of call probably annoyed her son to the extent that he was less likely to call back. Mrs Alloway was able to see that the main thing to do was not to act at the moment of panic but to wait until one feels calmer and then to consider a list of possible explanations and to choose an action.

Later, Mrs Alloway decided to have a calm talk with her son about her fears and rehearsed this conversation with her therapist before calling her son and carrying out her plan. The talk went well, as she felt her son dealt with what she said with humour, warmth and compassion.

Mrs Alloway has a long history of living with anxiety and knows that her fears are often just that, fears with no basis in any reality. The therapist needs to help Mrs Alloway become more adept at using experience from past history to emphasize the unhelpful nature of her anxious thoughts in terms of emotional impacts and negative behavioural consequences. In this scenario she was able to see that a negative pattern had developed that resulted in her acting on fears she knew were most likely unfounded and that her behaviour often resulted in having the opposite result to that which she desired. Mrs Alloway, set up a new 'rule' for herself. Prior to acting on her fears, she would take a moment to ask herself, "By acting now and in this way, will I be closer or further away from my desired consequences?" This example also shows that wisdom can develop if one reflects on the consequences of past experiences. The rule that Mrs Alloway has developed for herself has compassion for herself, and for others.

Empirical evidence for CBT with older people

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

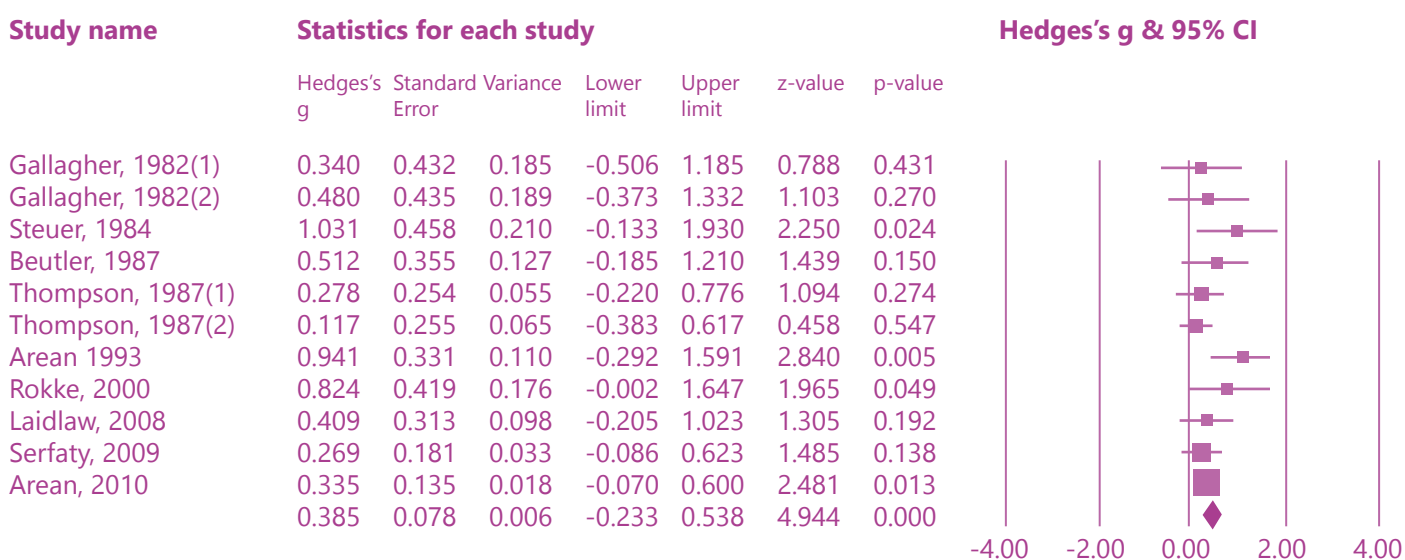


Table 1. Selected characteristics of RCT studies of CBT for late life depression

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 compared 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
Schuermans, 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.hsrd.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).

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).

One other piece of relevant evidence for treatment outcome for CBT with older people is to look for evidence of naturalistic outcome. Interested readers may wish to consult a book chapter by Laidlaw (2013) providing a description of treatment outcome for CBT.

When working with older people you may be surprised about how much improvement your patient can achieve. Mrs Anderson was originally referred because of panic disorder with agoraphobia. She was very anxious when leaving her home on her own. She found it difficult to be in constrained situations she would easily be able to escape from such as traveling in elevators, traveling on public transport (trains and buses). Indeed Mrs Anderson found it difficult to tolerate being on a bus for more than two stops. After two stops her anxiety overwhelmed her and she would get off her bus and wait for the next bus or walk the remainder of her journey. When we started working together and discussed her management of her anxiety symptoms, Mrs Anderson exclaimed *"I am concerned that I cannot see how I will ever be able to face these situations"*

Yet by the end of treatment, Mrs Anderson had overcome her anxiety and was able to face a number of situations on her own, taking elevators, traveling city to city on buses and trains. Thus a good outcome was achieved and she recorded subclinical scores on the Beck Anxiety Inventory at the end of treatment. Mrs Anderson's quote above is quite significant if you match it up with the picture of the postcard here.

Mrs Anderson's course of treatment for anxiety symptoms was interrupted twice because of hip operations and therefore she was seen for an extended period of time as some sessions were required to explore her treatment choices in terms of her surgery and there were interludes of contact during periods of rehabilitation.

As a result, the therapist in this case agreed to offer Mrs Anderson a follow-up appointment before final discharge. Just prior to coming back for her final appointment, Mrs Anderson sent her therapist a postcard from South Africa (see below). It appears that she had a final personal step in her own graded hierarchy and she had flown to visit her friend whom she had not seen for many years. It would appear that outcome for older people after CBT is open to the same parameters of all our clients regardless of their age; Be open to the possibilities of change and your client's possibilities will not be constrained by you. In short expect the same change of your older clients as you do of your younger clients.



Postcard from a client with panic disorder and agoraphobia.

Formulation in CBT with older people

Formulation is a key skill for High Intensity CBT therapists. Formulations afford therapists with a highly personal and intimate window of how the person experiences the world and how they perceive and respond to stimuli in their environment via pre-existing and (mal)adaptive belief structures (schemata).

Formulation with older people may present a challenge as the client has such an extensive life-history. It clearly makes no real sense if we continue to focus questions around early development.

When formulating with older people it is important to gain a sense from the client about formative adult experiences. By doing so, one recognises that while important developmental experiences occurring in childhood can have an important impact on our adult lives, they are by no means the end of development.

Formulation in CBT affords us the opportunity to develop an individualised clinical theory of our clients, linking overt symptoms of depression or anxiety with underlying, or covert beliefs that are important in helping us to gain an idiosyncratic understanding of the nature of a client's difficulties.

People born in the 1920s will be in their 90s now but will have been young adults during the second world war. They are part of the 'make do and mend' generation.

People born in the 1930s will be in their 80s now and became part of the first 'teenager' generation in the 1950s. They will have experienced a lot of rationing and also will be very much ingrained in beliefs about 'making do, and carrying on.'

People born in the 1940s are now in their 70s and at the start of the 1960s they would be young adults and will have witnessed, and been part of a social change.

People born in the 1950s are now in their 60s and are likely to be different in attitude to other older generations. They will have been teenagers during the mid 60s and their generation is known as the baby boomers. They may have different expectations for access to psychological therapies such as CBT.

All of the above generations will fit within our category of older people but each cohort (generation) is different from the other. Don't see all older people as the same. Not only is age the least good indicator of anything therapeutically meaningful it can be disrespectful to ignore the differences each generation has encountered and that will influence their attitudes and values

The importance of (familial) cohort in CBT



Understanding the importance of cohort factors in CBT when working with older people is likely to enhance the therapeutic alliance as it promotes a more general acceptance and appreciation of the differences that may exist in value structures of generations born in different time frames. For many therapists there may be an incomplete understanding of just how different Britain was in the 1930s and 1940s in terms of attitudes and what was considered acceptable and appropriate.

Women born in the 1930s had very different expectations from women born in the 1980s. Therapists may wish to reflect on what it would have been like to be born at a time when women had only recently won the right to vote and when expectations and freedoms were very different from what may be expected today. For many younger therapists understanding cohort beliefs when working with older clients is akin to gaining a cultural awareness when working with an ethnic group different to one's own. The past can feel a very different country to different generational cohorts.

Familial cohort and CBT

Therapists may wish to consider whether differences in cohort beliefs can be also understood in terms of cohort beliefs within families. For CBT therapists, Familial shared characteristics and beliefs are as important as generational beliefs when apprehending a client's beliefs and values. For example, there could be an important interaction between generational beliefs endorsed by a cohort born at similar times e.g. 'stand on your own two feet' (meaning it is wrong to ask for help), and cohort familial beliefs transmitted as family rules, e.g. 'One must never wash one's dirty linen in public' (meaning, one needs to be circumspect about discussing emotional difficulties). These two factors come together and often prevent older people from asking for help even at times of great distress.

Mary and familial cohort: An example

Mary's grandmother always said that it was a woman's role to put everyone else's needs first and put oneself last.

To understand familial cohort better, let's take the example of Mary an 83 year old woman who now lives on her own, as her husband died suddenly a few years ago.

Born in Glasgow in 1932 as the youngest of five children and the only girl, Mary's mother and father were born in 1900 and 1901 (when life expectancy at birth in the UK was 45 for men). Mary recalls her grandparents were born between 1875 and 1880.

Growing up as a young girl, it was the norm that she spent a lot of time with her grandparents. They were a strong influence on her and her attitudes. Her grandmother moved into the family home when Mary's grandfather died. Mary's mother (born when Queen Victoria was still on the throne) was always keen to stress to her what was right and proper for 'good' girls. Mary's mother's attitudes and lessons for what was 'proper' came from her own mother and father (Mary's grandparents).

Thus when you talk with Mary in therapy you are also communicating with someone born roughly 140 years ago; Her grandparents still influence Mary now.

This belief has stopped Mary from asking for help, and when she has been depressed in the past it has undermined her sense of self. She says she is weak and selfish and wonders if she is stopping other people who need (and deserve) help from getting it by taking up your (therapist) time. Left unaddressed this could result in Mary prematurely discontinuing treatment that is proving beneficial.



These beliefs may be quite ingrained in your older clients and while they may take on some similarities with core beliefs they are quite different. Where they share similarities with core beliefs is that they can be maladaptive for the person who endorses them. In CBT the more we learn about the client's view of the world, the more we are able to help them, and the more we appreciate that generational and familial cohort factors may influence how the client interacts with others, the more we are able to gain a respectful appreciation for their values and beliefs positively influencing the development of a strong therapeutic relationship.

A final thing to consider is that Mary has a model for ageing from her grandparents that is completely different from her own experience, (she is alive and relatively healthy). She is independent and she lives on her own. This is very different from the ageing she witnessed for her mother and grandmother.

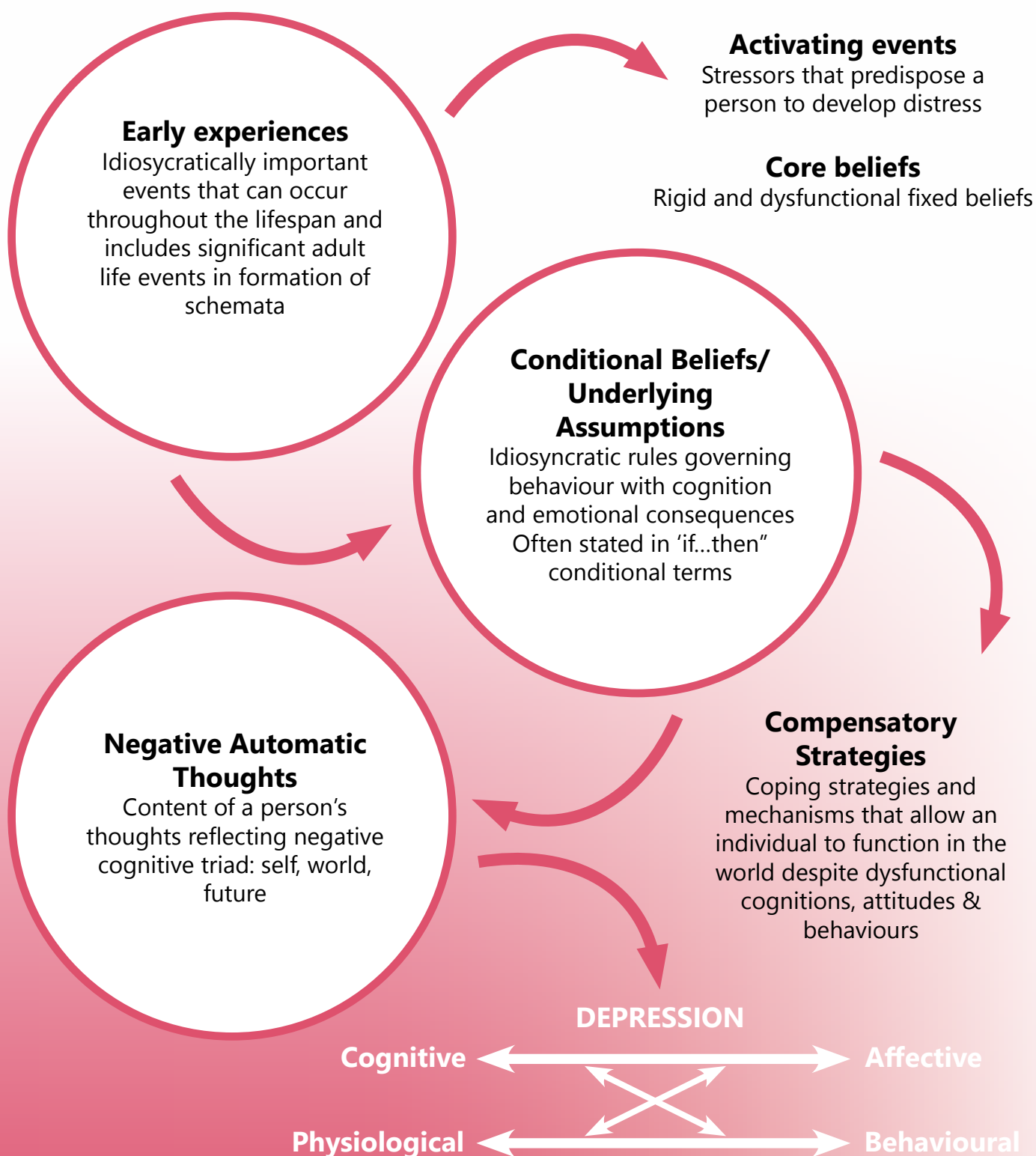
Age appropriate formulation in CBT

Laidlaw et al. (2004) developed the comprehensive conceptualisation framework (CCF) for CBT with older people to help therapists, particularly those unused to working with older people, to contextualise older adults problems within a CBT model. "The conceptual model [CCF] overleaf, although comprehensive, is clear and readily accounts for the complex nature of older people's experiences. This is thought to be an important feature as often CBT therapists unfamiliar to working with older people are vulnerable to feeling deskilled when working in the midst of such complexities (Laidlaw et al. 2004; p9)

Age-appropriate formulation/case conceptualisation in CBT will require the use of many of therapist existing skills in understanding the meaning of events for clients. Formulations therefore perform an important function in describing the nature and source of the client's difficulties. Additionally, as with adults of working age, formulation must be useful in focusing the therapist and client on planning and implementing interventions whose primary aim is symptom reduction. Finally formulations can be useful in anticipating potential obstacles to achieving a good outcome in CBT; either because of potential relationship/relating factors, or because of internal factors that are idiosyncratic to the client but that must be understood by the therapist in order that maximal gains can be achieved. When working with older people, understanding that clients are at a different development stage of life, or on a qualitatively different lifespan trajectory from that of the therapist may help contextualise the difficulties experienced by the client and of the presentation of symptoms. Older people often present for therapy because of transitions in circumstance that are proving hard to navigate alone by recourse to habitual strategies.

The main elements of the CCF are cohort beliefs, transition in role-investments, intergenerational linkages, the sociocultural context and health status (Laidlaw & Thompson, 2014). Each element serves to broaden the understanding that a therapist will draw on when working with elders. The main elements are presented in table 1. (on the next page).

Comprehensive Cognitive Formulation for CBT (CCF)



Element of CCF	Description of CCF element	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 therapist's beliefs. For example, beliefs about lifestyle choices, and gender roles may differ markedly, making therapists 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 terrible', or 'All my problems are to do with my age'. Unfortunately professionals may be swayed into believing such statements are factual and realistic appraisals of a difficult time of life. For all of us, prolonged exposure to ageist societal attitudes reinforced from childhood through to adulthood result in people developing negative age-stereotypes that can become important schemata that attentionally bias an individual towards processing negative information about ageing. Much like the stress-diathesis that occurs in depression where a depressed person selectively	Many older people have an implicit assumption (that can be challenged with cognitive restructuring techniques) 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 '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. In CBT, therapists are advised to explore the age-attitudes of their clients at the start of therapy.

Element of CCF	Description of CCF element	Clinical relevance
Socio-Cultural Context cont.	processes negative stimuli and other cues that maintain a sense of hopelessness and prolonged low mood.	Formulations of beliefs The socio-cultural context also takes into account the values of the therapist.
Transitions in Role Investments	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.	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.
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).</p> <ul style="list-style-type: none"> • 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. • You can also apply the more complex, but very useful WHO International Classification of Functioning (ICF). 	<p>CBT therapists can usefully employ behavioural strategies and develop problem-solving skills minimise impact of illness on individuals</p> <p>The WHO (1980) classification to therapists is that it allows one to consider an individual's impairment separate from the consequences of the impairment for the individual. CBT works at the level of disability and handicap, but does not seek to necessarily impact upon levels of (physical) impairment.</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), attributions people make about the problems may exacerbate their attempts at managing life with impairments. This is also important when excess disability may be suspected.</p> <p>Source: Laidlaw & Thompson, 2014</p>

An important clarification on using the CCF

An important point about the CCF is that one should **not** expect that therapists will necessarily need to populate every element of the CCF with every client. As the CCF is pan-theoretical, this also means that the CCF can be used to provide an age-contextualised understanding to many different formulation models and diagrams. Thus the CCF may equally add important contextualising information to a formulation of a older person presenting with Panic Disorder, conceptualised using the Clark CBT model, and an older person presenting with a major depressive disorder using the 'standard' Beck model.

The CCF provides a means of contextualising an individual's current set of difficulties within a lifespan developmental perspective. For example, taking account of cohort beliefs, allows a therapist to acknowledge that value systems may have changed over the years and in order to be truly collaborative it may be necessary for the therapist to accept that values may differ across cohorts.



Likewise there may be transitions in role-investment such as becoming a carer for one's spouse who has developed dementia. Cohort beliefs about the marriage may be important in determining whether caregiving is perceived as burdensome. Moreover, there may be scope for overlap between intergenerational linkages and cohort beliefs about the notions of family. Neugarten and Datan (1973) introduced the concept of the social clock in which people have certain socially influenced (and hence cohort) notions about the timetable for accomplishing life's tasks.

For example, older generations may express disappointment or disapproval at their adult children if they have not settled down and started a family by their thirties. The increase in longevity may result in certain life stages being reached at different ages for different generation cohorts, resulting in misunderstandings and tensions across generations.



An important clarification on using the CCF

The CCF is most appropriate to use when older people may be experiencing depression or anxiety symptoms linked with an age-related challenging situation.

Take this example; Mrs MacIntosh has been married to her husband for 46 years. She is aged 67 years old and her husband is 76 years old. He has recently been diagnosed with Alzheimer's dementia. Mr MacIntosh did not believe that there was anything wrong with his memory and accused his wife of plotting to get him 'put away'. Mrs MacIntosh found the prospect of her husband developing dementia highly distressing. Premorbidly, the relationship between Mr and Mrs MacIntosh has always been marked with tension and arguments. There was a marked lack of intimacy and support in the relationship, to the extent that when either Mr or Mrs MacIntosh had problems they rarely shared them with one another. Arguments were usually resolved after an exhaustive and abusive battle of wills. They have never developed a shared way of resolving problems or of working together. They have one son who lives in the house with them and he often takes the side of his mother.

Although they have never got on and have limited shared interests there has never been a question of the marriage breaking down. Mrs MacIntosh says at first her parents would have been shamed if she had left such a good provider as her husband has been. There was some hint of a scandal involving her father when she was younger and she felt a responsibility to keep up the good name of the family and to have her parent's approval. She also believes that divorce is too easy these days and "once you have made your bed you must lie in it."



She has always sought to hide the 'state of our marriage' from her friends and admits to being envious when she is out and sees her friends' husbands always being so loving towards their wives. When pushed she admits she is loving in public 'for appearances sake' Mrs MacIntosh has a lot of friends but would never dream of confiding anything about herself to her friends as she is convinced they would disapprove of her. Mrs MacIntosh is very kind but somewhat cold in her manner and presentation. Mrs MacIntosh also has a fierce façade that is softened when she relaxes.



Mrs MacIntosh thinks her husband's dementia is embarrassing and has tried to hide this from her friends.

A delicate issue in therapy is exploring the longer-term nature of the relationship. During discussion's in therapy it was discovered that Mrs MacIntosh often ascribes meaning to behaviour that may not warrant it and that alternative explanations may be equally or even more plausible. For example, when Mrs MacIntosh repeats the same question over and over again, she thinks, 'He is only asking me this question again to wind me up'. Mrs MacIntosh also wishes to be a good wife, but says 'where there is no love this is impossible. I am letting everyone down. I should care for him more, I should want to care for him and I don't'

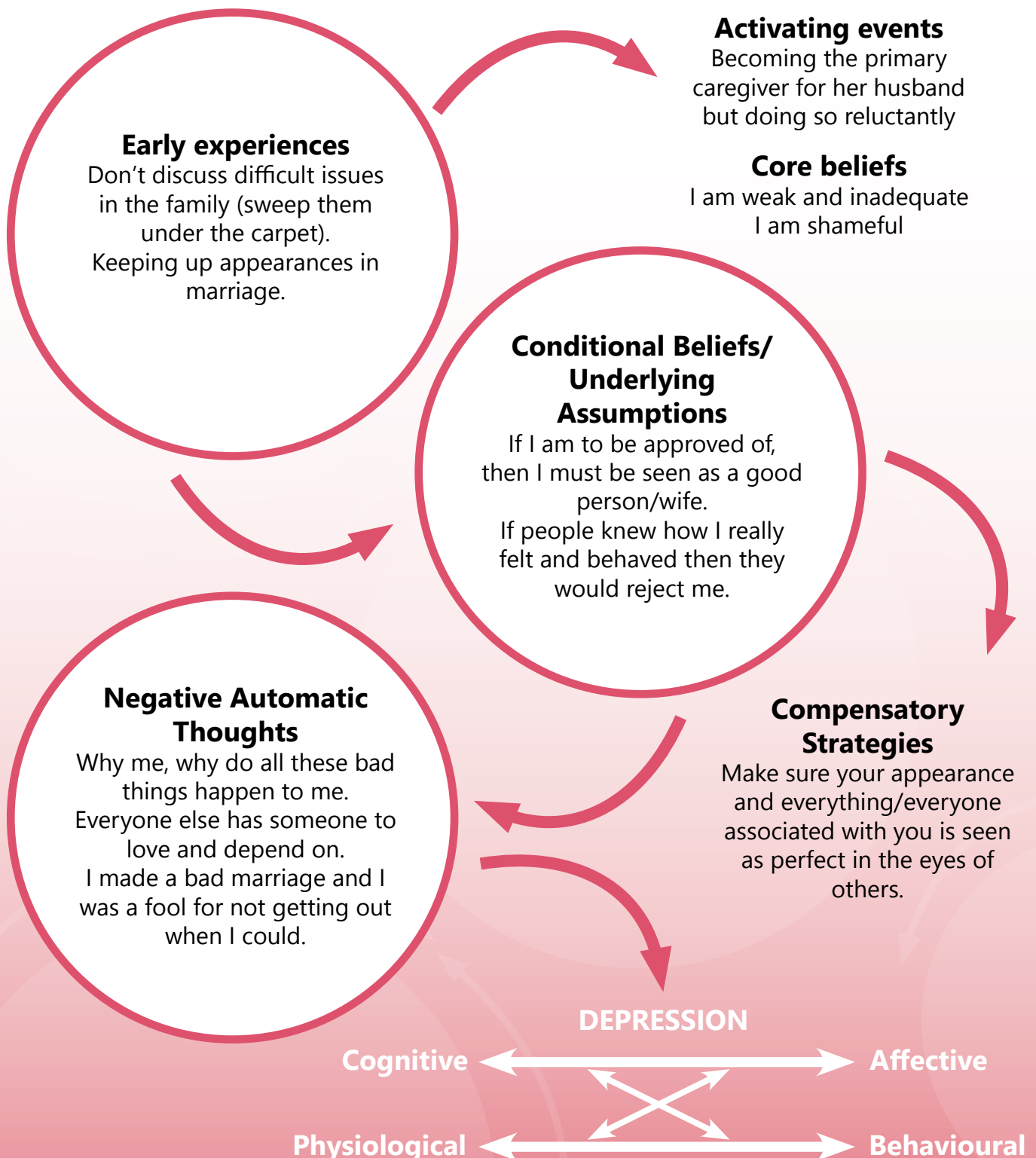
Use all this information to formulate Mrs MacIntosh's presentation taking account of Cohort, Intergenerational Linkages, Sociocultural Context, Physical Health Status, Role Investments/ Transitions.

Her great fear is of being 'found out' as being not as perfect as all her friends seem to think she is, or as Mrs MacIntosh perceives her friend's beliefs.

Mrs MacIntosh finds 'caring for someone I don't care for' (her husband) to be extremely stressful and she has been diagnosed as depressed by her doctor but she refuses to take medication as she sees this as an admission of weakness. She reluctantly accepted an appointment with a psychologist in order to find out more about dementia.

You can find a completed formulation for Mrs MacIntosh. The interaction of core and conditional beliefs about shame and wishing to appear perfect in the eyes of everyone else is made more acute by her reluctant role transitions and cohort beliefs about the role of a 'good wife'. Without understanding Mrs MacIntosh within an age appropriate context we may not be able to establish as good a therapeutic relationship and our understandings of the idiosyncratic appraisals made by Mrs MacIntosh will be substantially impoverished.

Mrs. MacIntosh: CCF worked example



Contextual Area	Relevant Factors
Cohort	A marriage is for life, for good or ill. A good wife cares at all times and is never cross. You've made your bed now you must lie in it.
Intergenerational Linkages	Enmeshed negatively reinforcing relationship with son.
Role Transitions	Developing a role as a primary caregiver Position amongst friends and in community is very important.
Socio-Cultural Context	People get old and sick. Induces sense of hopelessness as she fears her 'remaining good years' are being wasted caring for someone she does not care for.
Health Status	Nothing currently but is attending family GP for a series of blood tests as may be developing diabetes.

Age appropriate CBT with older people

Growing older is not about inevitable decline or loss of function. Most older people do not develop depression or anxiety in later life (Blazer, 2010) and the unprecedented increases in life expectancy witnessed in the developed and developing world are not matched with increases in disability (UNFPA, 2011). Simply put, people are living longer and healthier. The WHO in their global strategy and action plan on ageing and health (WHO, 2015: [hyperlink](#)) explicitly state that ageing is a socially valuable and good process with communities better off for having older people as active members. An important determinant in achieving a healthy old age is mental health. Thus when working with older people with depression and anxiety, our goal is to achieve symptom reduction in order to enable an individual to achieve a good age.

There may be age-appropriate experiences and situations that can make it more challenging at the individual level for someone to age well. Therefore in these circumstances we are likely to need to develop an age-appropriate CBT that is developmentally consistent with the life circumstances of the individual.

This final section of the workbook focuses on an age-appropriate approach to CBT with older people. This approach has been informed and developed using conceptual augmentations drawn from the evidence-based science of ageing (Gerontology). Suggestions and approaches to CBT with older people here are derived by evidence-base theoretical approaches that understanding cognitive and emotional development in later life. As CBT is the application of theory to practice, this approach is consistent with standard evidence-based approaches to CBT.

Some of the theories you will be introduced to focus on emotional development, (SST), some focus on optimal ageing and others are consistent with the problem-focused orientation of CBT (SOC). All interventions focus on how we can empower our clients to bring about behavioural and cognitive change at any age. Wisdom enhancement (promoted using timelines) are consistent with learning theories underlying behaviour change in CBT.



Emotional development in later life

Socio-emotional selectivity theory (SST) suggests that the emotional life of older people can be better understood by considering the time-horizons shaping their experience (Carstensen, Isaacowitz & Charles, 1999; Carstensen & Mikels, 2005). When time is considered to be open-ended, people develop more expansive motivations and goals and consequently they are more invested in acquiring knowledge and exploring novel social contacts (Carstensen & Lockenhoff, 2003).

As people age however, they may become motivated by the perceived finite boundary on their time to invest in more emotionally meaningful goals and therefore values change towards emotional balance and the achievement of intimacy with a smaller group of significant others.

Carstensen & Mikels (2005) note that “Older people appear to attend to, hold in mind, and remember emotionally positive information more than they do negative and neutral information.” This is termed the positivity hypothesis and may have implications for therapists attempting to encourage older people to engage in cognitive restructuring where focus naturally emphasises discussion of negative emotions.

This can be important to take account in CBT. If older people selectively attend to strong affectionate bonds that promote balance then they may find it difficult to disengage from therapy. Thus it is not simply that an older person is lonely.

Remembering that there is a positivity bias for recall in older people (Mather & Carstensen, 2005) suggests that negative bias for recall of past events is evidence of abnormal aging, and likely symptom (depression or anxiety) contamination. Negative recall may be seen as negative cognitions rather than realistic appraisals of the challenges of aging.

It's in the eye of the beholder?

If you think back to some recent older adult clients who may have been unwilling to be discharged, if you conceptualise this as dependency or as being driven by a sense of a perceived finite boundary upon their time, how would this change your approach? Perhaps 'map' your answer in the table below:

Think about a client who was older and who seemed to be reluctant to be discharged. It could be that they are lonely, or are starved of companionship, or it could be something else?

Your client is reluctant to be discharged and you see this as loneliness, or worse, neediness in your client. Write down evidence supportive of this hypothesis.

Your client is reluctant to be discharged and you see this as loneliness, or worse, neediness in your client. Write down evidence contrary to this hypothesis.

Use this space to outline what your approach would be:

Now consider this. Is it possible a reluctance to be discharged is consistent with a change in values/priorities as outlined by Carstensen's model of Socio-emotional Selectivity Theory. Write how your approach would be in line with this hypothesis.

Managing physical comorbidity, emerging issues and age specific challenges in CBT

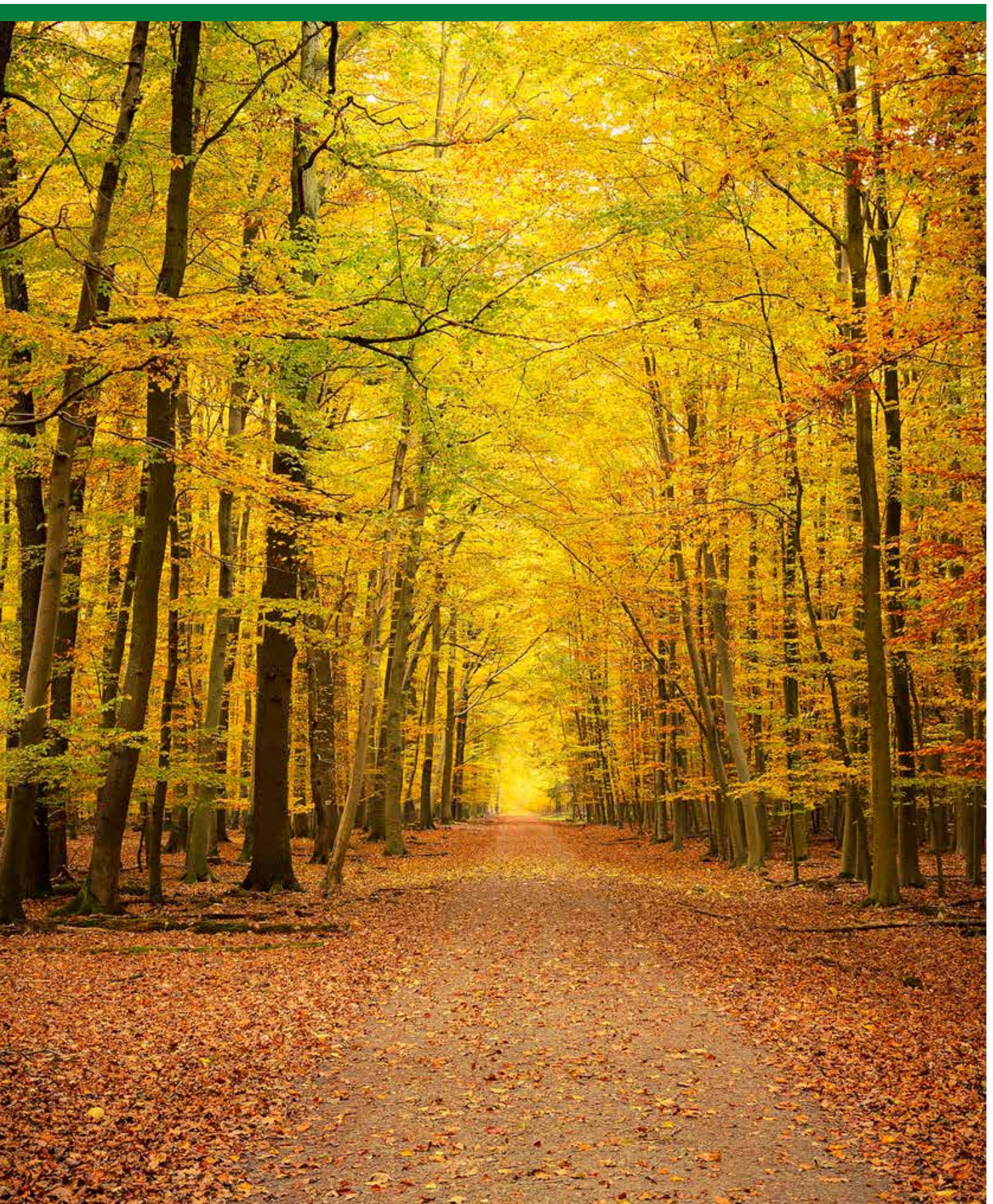
Physical health comorbidity issues are common when working with older adults. Many novice therapists may be less experienced in dealing with depression comorbid with chronic illness and therefore may find the application of cognitive elements of CBT particularly challenging when addressing hopelessness expressed by older people with physical illness (Laidlaw et al. 2003).

In dealing with depression comorbid with a physical illness it is important that the therapist takes a careful history and seeks to understand the difference between the severity of a condition (impact) and, the patient's perception of its impact. The subjective appraisal of the impact of a disease condition may not match the severity level and excess disability may become evident. When older people are diagnosed with a chronic condition that can have a limiting effect on functioning this can often affect an individual's level of confidence and as a consequence they can become much more passive and isolated.

Behaviour following a diagnosis is important to understand as much as the meaning people make in response to a diagnosis. For many older people, diagnosis with a chronic medical condition is equated with disability, even when this is not necessarily the case.

Medical approaches to management and rehabilitation have changed the experience of living with a number of chronic conditions, but older people may have memories of family members being disabled with conditions resulting in the (false) expectation that the same thing will happen to them.

The use of a meta-theory of successful, or more accurately optimal ageing developed by Baltes and colleagues (Baltes, 1991; Baltes & Smith, 2002; Freund & Baltes, 1998; Freund, 2006) provides therapists with a framework for helping patients maximise functioning while at the same time minimising the impact of loss experiences (Laidlaw & Kishita, 2015).

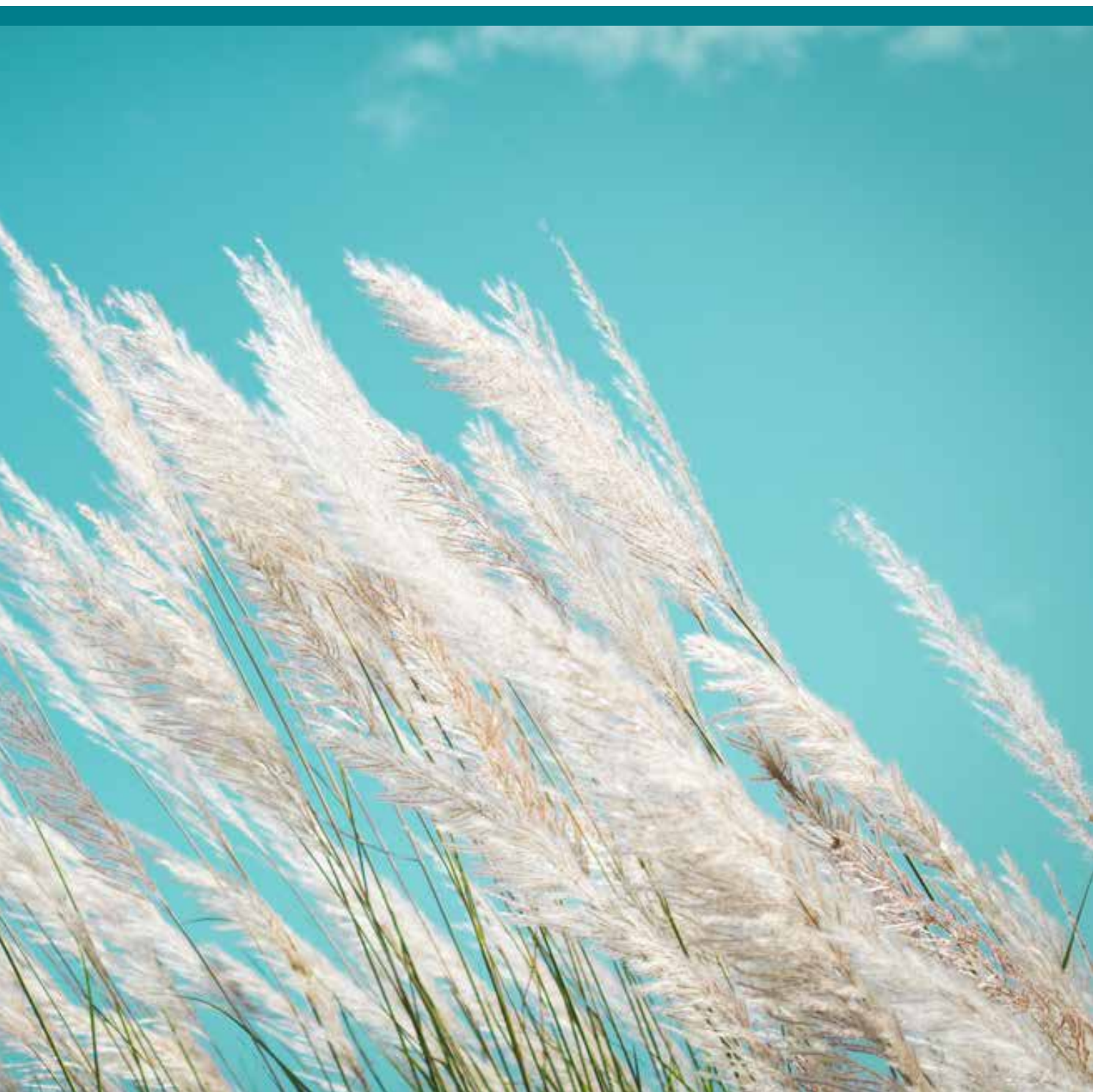


Age appropriate CBT and SOC

Selection, Optimisation with Compensation (SOC) within CBT is a specific treatment augmentation to assist an individual to successfully adjust to (age)-challenging circumstances by maintaining functioning in later life focusing on important roles and goals. SOC requires the conscious adaptation of a change of the means to maintain what are considered to be the most important roles and goals in later life.

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 his playing just immediately prior to the part of the musical score when the tempo changed, (i.e playing faster), thereby giving his audience the impression of greater speed and dexterity than was actually the case (an example of compensation). Thus he was able to optimise his functioning at the highest possible level allowing him to maintain valued roles and goals, despite the challenges and realities of playing concert halls around the world in his 80s. Thus SOC possesses a lot of potential when we are helping clients optimise their functioning to its highest level despite challenges.





A good example of the use of SOC can be found in managing post-stroke depression. In the SOC worksheet (Laidlaw & Kishita, 2015) the example in the explanatory notes for the worksheet comes from a real case of a person with memory problems.

Exercise: Applying SOC in CBT

Steven is a 78 year old widower and although previously in good physical condition, and despite being a keen attendee at his local gym, he experienced a stroke in his recent past. His geriatrician referred him for CBT because although he has made a good recovery he remains very fearful about having another stroke and has reduced his activity levels so that he never gets close to exerting himself (unhelpful safety behaviours). When you meet Steven, he says he misses his hobby but he doesn't see the point of going back to it until he has made a full recovery from his stroke. Steven is a keen ballroom dancer. After his stroke he stopped going to dancing leaving him cut adrift from his friends and his wider social network. He now has much less to occupy his time so he tends to ruminate about his situation and he 'overmonitors' his stroke recovery. He is quite depressed and becoming more isolated?

How is SOC helpful and consistent with the model of CBT? Think about how you might apply the example of Arthur Rubinstein here?



Selection?

Optimisation?

Compensation?



SOC is a very good fit with the problem-solving orientation of CBT as it is explicitly focused on helping a person actively manage to reduce potential limitations imposed by age-related changes in functioning. Selection often means a reduction in the behavioural repertoire of an individual in order to maximise functioning. Optimization is where an individual strives for optimal levels of functioning by focussing resources to achieving this. In effect, it means the individual rehearsing or relearning a reduced repertoire of activities. Compensation is where an individual confronted with a loss, takes account of limitations and engages in alternative means of achieving the highest possible level of functioning (Freund & Baltes, 1998). The use of SOC requires creativity and collaboration on the part of the therapist and patient.

For Steven, selection meant that, like Rubinstein he reduced his dance-partners, to those he felt most comfortable with, and this afforded him the opportunity to optimise his dance practice.

With a very few of the ladies in his social set (his 'repertoire') he dance more often and practiced specific steps more frequently (hence optimising his performance). Finally, as a stroke had impacted upon Steven's stamina level he needed to compensate for this when dances became too complicated or too energetic. So he would elect to start a dance mid-way through or would elect to end his dance before a part was too complicated. SOC allowed Steven to dance again and to improve his level of functioning to its highest level in the face of real-life challenges of ageing.

To help you with the application of SOC, you may wish to use a new worksheet for SOC in CBT (Source: Laidlaw & Kishita, 2015).

SOC worksheet

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

Name of therapist:

Name of Client:

Problem list:

1.

2.

3.

Main issue or problem requiring the use of SOC:

What is SOC?

Selective optimisation with compensation (SOC) is a simple problem-solving procedure that we can use to help ourselves achieve our goals in light of losses that may have developed recently. In research people who use SOC reported better life satisfaction.

When to use SOC?

The steps to using SOC can be outlined in the following simple example.

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

Selection: Mr Gray uses his resources as best he can by *selecting* (prioritising) what needs to be done in order to avoid overwhelming himself and to avoid stressing himself beyond his capacity.

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

Compensation: Mr Gray knows that his memory is worse when he gets tired. So he *compensates* for this by making sure he does his most important tasks in the morning.

He also compensates for his poorer memory by using memory aids like setting an alarm on his phone that rings to remind him when he has an appointment. He also uses his paper diary.

The key principles to using SOC: From the example above, to use SOC, ask your therapist to work with you to identify a loss or a deterioration in your ability to complete activities that you are concerned about. *Accepting the reality of a loss does not mean you have to just put up with losing something of value to you, instead it can mean you work to find a new way to keep important roles/goals in your life.* In the face of a changed circumstance continuing to do the same thing often just results in frustration. Use the worksheet (over page) to consider some possibilities and bring it with you to your next appointment.

Selection

Find a new way to do things.

Sometimes as we age, we are faced with losses that challenge our quality of life. Consider what activity/role/hobby you have given up and not replaced with other activities (it may have negative consequences for how you feel). Can you focus on what activities of goals make life more pleasant for you? Make a note of what are the most important things you want to continue to do or to start doing again. Make a list here (and that will make a positive difference to you):

Optimisation

Practice makes perfect!

Think of what you focused on (your goal) and find ways to increase your use of the chosen activity/task or goal. Outline here what you are going to practice and why:

Compensation

Make the best of a bad lot!

Can you do more by changing the way you do things? Think of how you can do the things that are important to you but with support, different approaches or use of tools/technologies. Make a plan here:

Selection

Find a new way to do things.

Sometimes as we age, we are faced with losses that challenge our quality of life. Consider what activity/role/hobby you have given up and not replaced with other activities (it may have negative consequences for how you feel). Can you focus on what activities or goals make life more pleasant for you? Make a note of what are the most important things you want to continue to do or to start doing again. Make a list here (and that will make a positive difference to you):

I have pains/discomfort in my legs and am afraid to cycle in case I can't manage (lose my balance or get stuck away from home). I will use my turbo trainer to cycle indoors (in my garage) using my own bicycle set up with a wheel trainer.

Optimisation

Practice makes perfect!

Think of what you focused on (your goal) and find ways to increase your use of the chosen activity/task or goal. Outline here what you are going to practice and why:

As I don't fear losing my balance or getting stuck, I can cycle my own bike 3-4 times a week and keep up my fitness levels.

Compensation

Make the best of a bad lot!

Can you do more by changing the way you do things? Think of how you can do the things that are important to you but with support, different approaches or use of tools/technologies. Make a plan here:

If my pains are bad I can stop at any time and probably that means I'll be able to do more, or push myself a bit more.

Selective optimisation and compensation (SOC) additional readings



Baltes, P. B. (1997) On the Incomplete Architecture of Human Ontogeny: Selection, Optimization, and Compensation as a Foundation of Developmental Theory. *American Psychologist*, 52, 366–380.

Baltes, M. M., & Carstensen, L. L. (1996). The process of successful ageing. *Ageing and Society*, 16(4), 397–422.

Freund, A. & Baltes, P. (1998). Selection, optimization, and compensation as strategies of life-management: Correlations with subjective indicators of successful aging. *Psychology & Aging*, 13, 531–543.

Freund, A. M (2008). Successful aging as management of resources: The role of selection, optimization, and compensation. *Research in Human Development*, 5, 94–106.

Age appropriate CBT: Wisdom enhancement

As people age they also may have developed a more compassionate and accepting understanding of mental health issues in later life if they have experienced previous episodes (Quinn et al. 2009) and therefore may be more open to the process of psychotherapy.

One of the simplest and most apparent ways that older people are different from their therapist is that they lived longer and sometimes this age difference can extend to three or more decades. This means that as our clients have lived longer than we have and are at a different developmental stage in the adult lifespan they may have faced, and overcome, a number of challenging life-events (such as spousal bereavement, onset of degenerative conditions, etc) that we as therapists have not yet faced, nor have a clear sense of how we would cope with these challenges.

An appreciation of the difference in age ought to develop a healthy respect within the therapist for the resilient survivor their clients undoubtedly are.

In CBT we are often encouraged to be ahistorical in our approach and we most certainly ought to be focused on the 'here and now' when trying to appreciate the impact of the client's problems. This may mistakenly leave us less educated about how we can use life history and the 'lifeskills' accumulated by our older clients. Working with clients with a life history stretching back 8 or 9 decades can be overwhelming for therapists used to working with age-peers.

If a client has overcome adversity at different time points in their life, they may have developed a set of 'lifeskills' that can be used within CBT. We can ask clients about key points in their life when they may have overcome a difficulty and which they think they may be 'wiser' for having experienced. If so the lessons they learnt at the time may usefully be employed when the client is dealing with their current problems. This is the essence of the concept of wisdom-enhancement in CBT with Older People. To summarise, therapists can tap into how clients have overcome difficulties in the past and by gaining a specific and factual representation of past events, they can use socratic questioning that may help their clients make use of these past lessons in the 'here and now'.

An age-appropriate format of CBT is useful in two ways:

1. Challenge therapist beliefs about capacity for change
2. Focuses attention on development of 'new' intervention strategies

Elements of an age appropriate CBT:

1. Applies appropriate theory to practice (i.e. gerontology)
2. Recognises age-specific challenges (chronicity, complexity) require age specific formulation models
3. Positively affirms life-skills to (Learning from the past helps people cope better in the here and now) enhance positive affect and emotion regulation
4. Resilience and compassionate self-acceptance may be enhanced by adopting a concrete/specific orientation to past events/challenges. Such an orientation challenges clients erroneous over generalized autobiographical memory that may encourage passivity and hopelessness in the face of current difficulties.

There are a number of assumptions to address when working with older people using their life-history, but the first and most important one is that the past should only be 'data-mined' in order that we can learn how clients have coped with adversity and setbacks in the past so as to use that data in helping our clients overcome their current adversity.

The perspective to adopt when data-mining (i.e reviewing a life-history for what can be used in therapy to help the client in the here and now) is to recognize the different developmental context separating the client and therapist. The difference is celebrated as we have two experts in the room;

- The older client has overcome adversity not yet experienced by the therapist and therefore possesses lifskills the therapist does not necessarily possess. These can be identified and employed in therapy.
- The therapist possesses skills and competences in CBT and in understanding depression and anxiety.

This collaborative set between therapist and client is respectful and empowering; everything good CBT should be.

Wisdom enhancement in CBT

Wisdom is a theoretically rich area in gerontology and provides a positive frame of reference when attempting to develop appropriate targets for work with depressed older people in psychotherapy (Knight & Laidlaw, 2009). When asking people to name positive aspects of ageing wisdom is usually first or second on the list. Wisdom is likely a valued concept for people as it emphasises growth through adversity across the lifespan with many people assuming that wisdom is positively correlated with advancing age (Bluck & Glück, 2006).

Wisdom is not an outcome of age, but a product of coping with adversity and dealing with ambiguity. In this sense wisdom constitutes the product of difficult circumstances with people gaining lifeskills in the process. The theoretical perspective adopted here is that "Wisdom is expert knowledge about the fundamental pragmatics of human life" (Baltes & Staudinger, 2000). Five criteria are defined as the means of assessing wisdom behaviours (Baltes & Staudinger, 2000). These are, rich factual & procedural knowledge, which is about 'knowing what' as well as 'knowing know' in the execution of decisions and activities. Lifespan contextualism emphasising accretment of experiences informing an individual's development of self-identity, and relativism of values and priorities considered important for the individual. Finally, wisdom can be adjudged on how an individual deals with the recognition and management of uncertainty.

The wisdom model described by Baltes and Staudinger (2000) corresponds very well with the experience of older people participating in psychotherapy. When someone comes into treatment in CBT their idiosyncratic way of seeing the world and understanding their problems is analogous to lifespan contextualism. In order for therapy to proceed

the therapist and client must agree on a shared sense of priorities and goals, and this is similar to the concept of relativism of values and priorities. Using wisdom of one's years is integrating all that one has learned about the world and about oneself and using that to its best advantage.

As CBT is skills enhancing this requires the therapist to recognize and respect that clients bring a rich factual and procedural knowledge with them into therapy and these lifeskills can be utilized in subtly different ways so that a different outcome may be achieved.

An essential step in helping older people with depression become 'wise' about how to help themselves when they are depressed is to help clients understand the toxic and maintaining effects of overgeneralised autobiographical memory, as this will likely result in rumination and self-blame (see Sumner, 2012 for review).

Some studies have shown that CBT approaches that encourage clients address OGM by developing 'concrete' thinking styles have produced promising results (see Watkins et al. 2009; Watkins et al. 2012) that not only reduce depressive symptoms but also levels of self-criticism. Concrete thinking focuses clients on distressing events but does so from a more active and directive perspective, the client is in effect 'walked through' the distressing event and a factual account of events is encouraged through the use of questions that maintains clients in a narrative that recognises chronology of events, context and actual actions rather than affect-laden recall of events (Watkins et al. 2012). This approach could be very useful with depressed or anxious older people who may state that they have wasted their life, or have made a number of wrong choices. There may also be a sense of the client expressing a narrative of personal failure and poor fortune

that would be important to address if progress in therapy is to be maximised.

Often when working with older people they may express a personal narrative that is mood congruent and biased towards recall for negative events from the past or are characterised by an overgeneralised autobiographical recall of past events. A CBT therapist can work collaboratively and effectively with clients by helping them to become more focussed, concrete and specific when thinking about the past so as to enhance their present coping. This more realistic, compassionate reflection on past mistakes, past hurts, is used to help people deal with their current problems by avoiding the past mistakes that they may habitually fall into. Uniquely among the psychotherapies, CBT lends itself to this wisdom enhancement process because of its psychoeducational, non-pathologising stance and emphasis on data collection and problem-solving.

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In this way, CBT provides the means by which people can put their past history under the lens in order to learn more about themselves but also crucially more about how they can utilise their pre-existing resources to learn from past mistakes. The positive message underlying this is that learning never stops and that people we see in our clinics are survivors. They have survived past setbacks and may have survived past episodes of depression. They have had to overcome adversity and many will have coped with events and experiences that a younger therapist has not faced. In this way older people are tried and tested and as we help people to recognize and acknowledge internal resources the empowering message of CBT rings out loud and true.

Promoting wisdom enhancement in CBT: Case example

Tapping into past experiences to help a client develop a sense of themselves as resilient and able to overcome current difficulties can be achieved using standard CBT approaches such as guided discovery and socratic questions.

Lizzie is a 72 year old woman with a history of recurrent depression stretching back most of her adult life. She has experienced at least six separate episodes of major depressive disorder since she was a young adult. In this current episode of depression, Lizzie is utterly convinced that she will not be able to make recovery. She says, "I can't see me ever getting back to how I used to be", "I think I'll be in hospital for the rest of my life now." She has been admitted to hospital for treatment of her depression. It is evident that Lizzie is hopeless about her future prospects for recovery and has a negative expectation that is to an extent age-influenced. It is very easy for therapists to inadvertently collude with this belief as it is said with such conviction. This can be very challenging to deal with in therapy.

It is clear that no one knows what the future is and while it can be a useful intervention in its own right to point out to Lizzie that she is 'fortune-telling' and it is not helpful, this may be perceived as non-empathic.

Lizzie tells you that other professionals have sought to reassure her that she would make a full recovery and will be home again. While this sort of reassurance is given in the kindest possible sense, it is nonetheless a mistake as it is uncertain whether she will make a full recovery and over what sort of timescale.



To retain credibility as an open and honest therapist with your client, it is crucial to avoid making promises that can't necessarily be delivered upon. Instead of providing reassurance the therapist sought to elicit hope for the potential of change by asking Lizzie to make use of the 'wisdom of your years'.

The therapist introduced the idea that by having previous episodes of depression she might be able to use those experiences to help her manage her current episode and recovery from it.



head. I can see myself sitting in the ward in 1973, here in this hospital, and I'm staring out the window."

Lizzie was able to use the vivid sense of having previously been convinced that recovery was not possible for her to challenge her belief about the lack of recovery for her current episode. Thus Lizzie used information from a negative experience in the past that demonstrated that she had overcome adversity before and her experience suggested she was likely to do so again. By using guided imagery to have the client remember previous events in terms of specific details rather than in terms of negative affect, Lizzie was able to use the past to help her cope better in the here and now. Guided imagery requires the client prepare to put herself back into a previous situation and to describe the situation in as much detail as is possible. In this example, the therapist asked Lizzie to think back to a previous time when she had been admitted to hospital.

When she affirmed her recall, the therapist was able to ask specific details such as where was she, who else was there, etc. In this scenario, Lizzie was able to call to mind a powerful memory and strong image.

What made this image all the more powerful is that at that time of her depression in the 1970s she did make a full recovery and she went on to marry and have a child. None of these experiences seemed at all possible to her at the time and this was powerful data for her to reflect upon in managing her current sense of hopelessness and despair. It is very empowering for clients to realise that they often have answers for current problems from using their own experiences.

The therapist asked Lizzie, "When you were depressed before, did you ever think that you would not recover?" Lizzie was able to recall that in every previous episode of depression she doubted whether the bad feelings would end, and she recognized the negative expectations were a symptom of her illness.

The therapist asked, "So, what does that tell you? Lizzie said, "Well maybe I was wrong then and I'll be wrong this time." The therapist asked Lizzie if she thought this might be possible whereupon she said, "I have this image in my

Age appropriate CBT: Using timelines in CBT

Timelines allow a therapist to review a person's life without having to get stuck in the past. It overcomes overgeneralized recall without becoming focused on unchangeable aspects in therapy.

Specific (factual) questions are asked about how a person has coped with adversity in the past. Connections with coping in the present are made in order that a new narrative of resilience can be substituted for ones of failure and ineptitude.

Timelines are therefore used to encourage self-compassion, recognize resilience and promote coping in the here & now.

Wisdom enhancement is the process of using lifeskills to enhance psychological wellbeing.

Timelines are the means by which wisdom enhancement is enacted in CBT.

Use of timelines in CBT with older people

In order to tap into this potential resource a technique will be needed and it is advocated that 'timelines' are used as the primary means of 'data mining' the internal resources that our older clients possess. The timeline fits into CBT quite easily and it is recommended that timelines are introduced near to the start of therapy. Ideally timelines can be introduced by session 3 as a homework task. It is introduced to the client as part of the therapists attempt to understand them better and to appreciate a context of how they have coped with problems or difficulties as they have occurred.

The timeline itself is a simple technique and has two horizontal lines connected by a vertical line (the lifespan line). The two horizontal lines are the start of life (DoB line) and the current point in life (the current dateline).



Timeline worksheet

Life is full of ups and downs, and experiences may sometimes challenge our beliefs about ourselves or may 'teach' us something. This worksheet may help you review your own ups and downs in your own lifetime. When completing this sheet try not to evaluate whether the experience is good or bad or even whether you are good or bad. It may be that as you look back on your life (your timeline) you can identify a few key moments in life. These may be events you are proud, but equally they be events that evoke feelings of shame or embarrassment. Alternatively there may be some bittersweet moments. When you complete this task, think of your whole lifetime and add all that you think is important. If you need to, please use the back of the sheet to add additional events. Please complete the 'timeline' by first put your date of birth at the top of the timeline, i.e. on the topmost horizontal line. Under the bottom horizontal line write todays date. On the vertical line (i.e. the line connecting the top and bottom line) use this space to mark in chronological (i.e. date order) the occurrence of events. Use both sides of the line to make the most of the space. Your therapist will want to review your timeline with you at your next appointment.



Timeline worksheet

Name:

Date of next appointment:

DOB



Today's date

Jennifer's timeline



Timelines are the means by which the rich experience of overcoming adversity can be examined within therapy. To recap, the use of timelines is to promote the sense of resilience of clients and to see how it is that people have overcome adversity in the past. This will provide therapists with essential information about the skills and competences the client possess in terms of problem-solving abilities.

In line with work by Watkins et al., (2008) it is recommended that when reviewing negative events from the past on the timeline a concrete and specific focus is adopted so as to avoid a biased and overgeneralized negative bias in recall of past events. The therapist needs to remain focussed on how difficult experiences from the past can be reviewed for their utility in helping people.

Timelines can be used to empathically review the challenges overcome by your client. They are an explicitly positive technique in CBT whose aim is to enhance positive affect as well as reducing negative affect. Look at the example of the timeline for Jennifer here.

Born

1940

1948 Mother married in pink gown because of me. Deeply ashamed**1949** Moved to St. Andrews from Edinburgh
Dad joined RAF

1950

1952 School in St. Andrews**1953** Back in Edinburgh**1954** Private school**1956** Tonsils out**1957** Mum and dad in and out of hospital (mum with hypertension and dad with ulcers)
Steve died from polio**1959** First prize in singing competition

1960

1963 Left school and trained as a hairdresser**1964** Met Sam**1969** Got engaged

1970

1971 Got married**1972** Eve born**1973** Moved to Ipswich**1974** Got Glen (dog) (Died 1979)**1975** Sarah born**1976** Moved to Edinburgh. Did hairdressing at home. Was Snowy Owl in Brownies.
Sang in church choir**1977** Counselling**1978** Coil fitted**1979** Miscarriage

1980

1980 Sterilised**1985** Hysterectomy

1990

1990 Mastectomy. New job at library. Sam and I visited family in Canada**1993** Sarah's 18th party**1994** Eve and James married. Holiday in New Zealand
Sam died and mum died**1996** Sarah's 21st party

2000

2000 William committed suicide**2001** Got M.E?**2002** Frank born. Uncle died**2004** Robert born. Rogie (dog) died**2005** Sarah and John married**2008** Eve and Boys posted abroad**2010** Aunt died

Today

Jennifer's timeline

Consider what thoughts you may have when reviewing this timeline. You may also wish to consider using some of the socratic questions suggested in the figure below.

Jennifer considers herself to be a selfish individual and she also describes herself as unable to cope with life. She believes that when she looks back over her life she sees failure and weaknesses. She believes that being depressed is evidence of selfishness on her part as it means she only ever thinks about herself.

Take a moment to review the timeline here (see above). What do you observe? Is Jennifer a weak person (are our patients ever as they see themselves?). Jennifer has overcome quite a number of challenges over her life and survived them all. Her husband died suddenly when she was still relatively young and with two daughters to look after she returned to the world of work for the first time in many years. Never having experienced positive praise or explicitly stated love in her own upbringing she has stopped this negative cycle with her own daughters and made sure they felt loved and supported. Look at the timeline above to see where else you would focus to gain a realistic appraisal of her character strengths and coping style.

Timelines can encourage individuals to reappraise themselves in compassion and more self-forgiving ways. When individuals are able to become self-forgiving, their attributions and emotions about themselves become less negative and more positive. "Simply, self-forgiveness disinclines people to attribute negative qualities to the self." (Wohl et al., 2008, p8). Intriguingly, Wohl et al., (2008) note that when people become more self-forgiving they think and act more constructively towards the self and the positive attributes are associated with less depression. Self-forgiveness entails accepting one's responsibility for one's actions and is associated with well-being.

After she had completed therapy, Jennifer commented on what she had gained in therapy and she noted that

"I could use the problems which I have experienced through my life to help me deal with stressful periods which may occur in the present or future."

This is a good commendation for the use of timelines as it has helped Jennifer to see herself in a new light: as a resourceful and strong person who can overcome difficulties when she needs to.

Timelines and socratic questioning

Timelines are used in CBT with a series of socratic questioning in order for a collaborative exploration is engaged in by the therapist and client (see figure below). The therapist is open to gaining a newer understanding of the client based on the life history presented in the timeline. The timeline is suggested as a homework task at the end of the third session in CBT and the subsequent data is used to reframe the 'narrative' a client may possess of being a failure, or having failed in, and often, at life.

By a specific factual examination of key events in the timeline, the therapist and client arrive at a different narrative and perspective: that of a resourceful and resilient survivor. This new perspective suggests that clients possess the skills necessary to overcome their current difficulties and emphasises a symptom reduction agenda for CBT treatment, regardless of the circumstances of age of the client. Laidlaw has produced a series of suggested socratic questions for use with timelines in CBT with older people. See figure here.

- When examining a life event on a T/L: looking back on that now, what does that tell you about yourself?
- Events from the T/L can be used to help people with difficult decisions: Have you been in a similar position in the past? If so how did that turn out? How does this help you?
- Enhancing sense of resilience: If you could somehow go back in time, as you are now and talk to your younger self, what would you say to yourself about how you coped?
- Encouraging Self-acceptance/compassion: In the past, in times of crisis how, and in what way, has being self-critical been helpful to you.
- Realist appraisal of coping: Looking back at this timeline, what do you learn from dealing with crises? What does that tell you?

Use of timelines to understand the client better

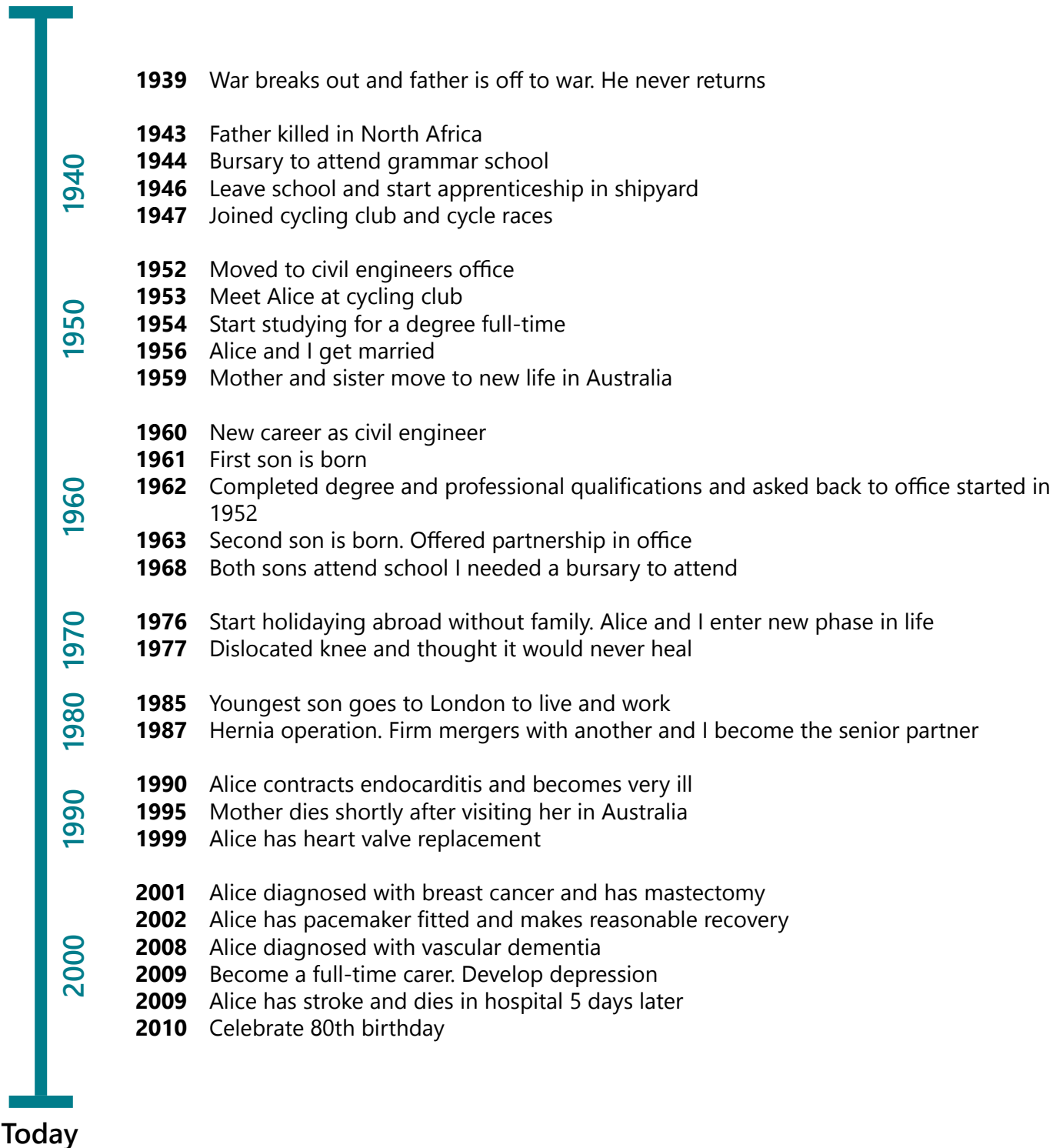
Timelines can also be used in other ways in therapy. For instance when we are formulating it may be useful to make sure the timeline has been completed as there may be certain themes that emerge that will predict the development of the therapeutic relationship in therapy and predict factors influencing outcome. Lets return to Mr Ellis.

You may recall that Mr Ellis held a negative attitude to ageing and equated ageing with decline and death. This was seen as a latent maladaptive schemata (or diathesis) that was going to be activated by congruent events. How do we make sense of the activation when the activation seems to have been his aches and pains in his legs.

When we look at his timeline we see that since 1990 onwards his wife had faced a number of health challenges and a number of these could be seen to be age-related, e.g. heart disease, dementia and stroke. From the timeline you can see that his fear of ageing was being triggered by what he was witnessing happening to his wife. It should be clear that pains and aches would be interpreted as the onset of own ageing and death. Thus the timeline here can be used to make sense of his symptom response and to predict what interventions may be necessary from a CBT point of view to enhance functioning and reduce distress. For completeness we have added in the formulation here.

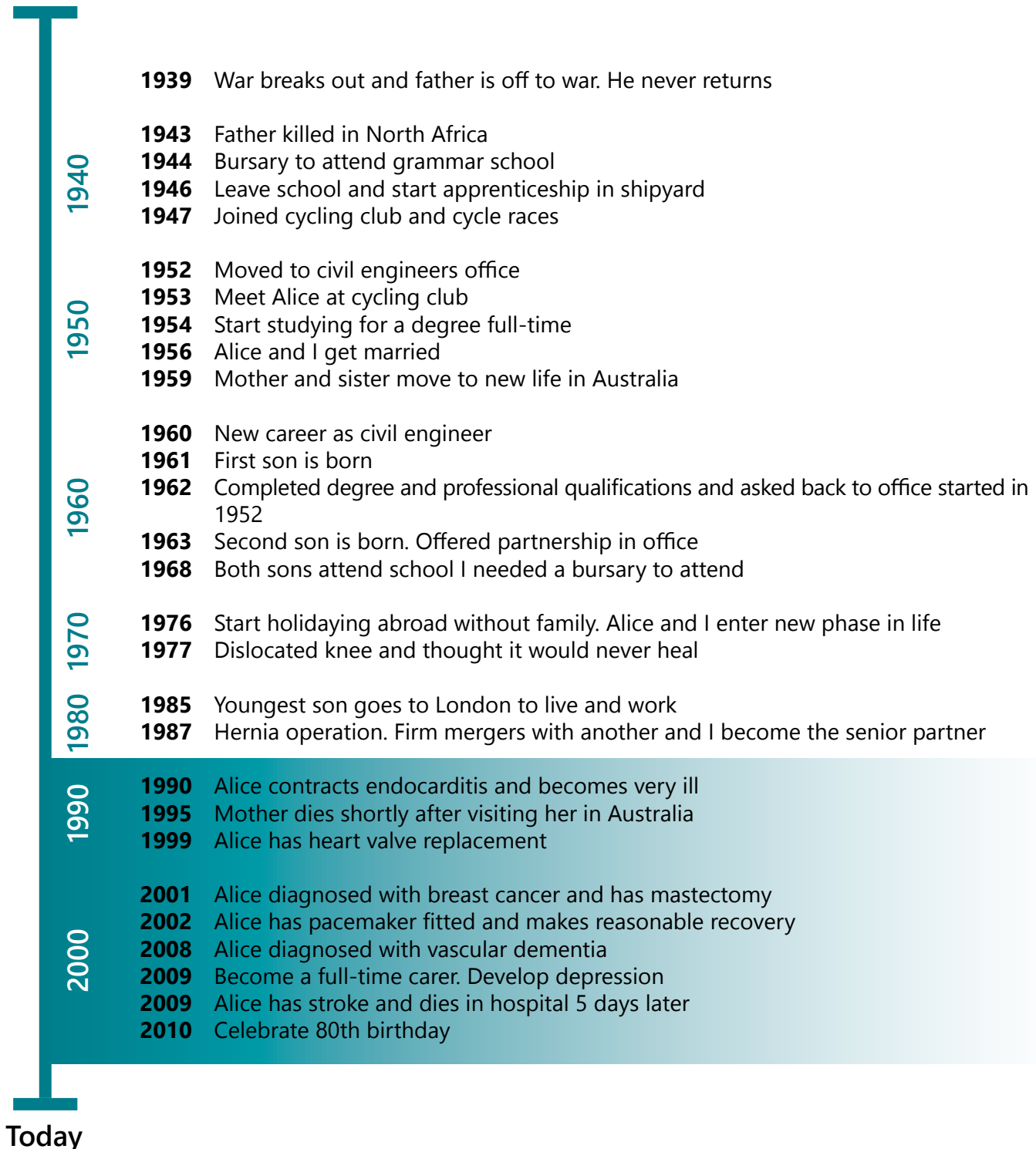
Mr. Ellis timeline

Born 1930



Mr. Ellis timeline - highlighted

Born 1930





Contextual Area	Relevant Factors
Cohort	Solve your own problems. Find your own solutions. There is an answer to every problem. If you haven't found it yet you haven't looked hard enough
Intergenerational Linkages	Brought up son's to be self-sufficient and competent. Looking for more contact with sons but is fearful of becoming a burden
Role Transitions	Transitioning from being a caregiver to living on one's own. Transitioning from seeing self as fit and independent to seeing oneself as becoming 'old'. Self-sufficient and confident, Arthur has started to doubt himself.
Socio-Cultural Context	Attributes a number of his problems to ageing and has an expectation current health problems will only get worse. Negative age-stereotype is becoming a self-stereotype and is becoming hypervigilant to signs of further 'slippery slopes'
Health Status	Sensations in legs being investigated but despite a number of investigations nothing has been found. Consider using S.O.C to maintain optimal functioning.

Summary



This new booklet contains a lot of information necessary when working with older people. Therapists 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 therapist 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 therapists. 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.

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