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COMPREHENSIVE CONCEPTUALIZATION OF COGNITIVE BEHAVIOUR THERAPY FOR LATE LIFE DEPRESSION

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Abstract. Cognitive behaviour therapy (CBT) has proven efficacy as a treatment for depression in older people. An important debate amongst therapists working with older people is whether CBT needs to be adapted to ensure optimal treatment outcome and, if so, what adaptations are necessary. It is accepted that psychotherapy with older people can differ from psychotherapy with younger people in a number of important respects because of the higher likelihood of chronic conditions, changes in cognitive capacity, potential loss experiences and different cohort belief systems. As psychotherapists are often much less comfortable dealing with physical problems, they may become negatively biased in terms of outcome when patients present with co-morbid health issues. The impact of loss experiences in older people can also be overemphasized in their importance by inexperienced therapists and can result in lowered expectations for therapy outcome. Consequently, there is a need to develop a model that addresses age related issues within a coherent cognitive therapy framework suitable for older people. This paper describes a CBT model that is augmented with applied gerontological knowledge, taking account of cohort beliefs, intergenerational linkages, sociocultural context, health status/beliefs and role investments/transitions. Clinical examples are used throughout to illustrate clinical implications of the model.

Keywords: Cognitive behavioural therapy, gerontology, generativity, cohort, late life depression, longevity, successful ageing.

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Depression in later life

Treatment for depression in older people is commonly managed by GPs in Primary Care settings (Rothera, Jones, & Gordon, 2002) with infrequent referrals to secondary specialist services (Laidlaw, Davidson, & Arbuthnot, 1998; Collins, Katona, & Orrell, 1997; Orrell, Collins, Shergill, & Katona, 1995). Although GPs primarily use antidepressants to treat depression in older people, many prescribe sub-therapeutic dosages of antidepressants because of fears about side effects (Katona & Livingston, 2002; Isometsa, Seppala, Henriksson, Kekki, & Lonnqvist, 1998; Heeren, Derksen, Heycop, & Van Gent, 1997; Orrell et al., 1995). Additionally, amongst older people there is a low rate of compliance with antidepressant prescriptions because they may already be using a large number of medications for a range of conditions (Katona & Livingston, 2002; Unutzer, Katon, Sullivan, & Miranda, 1999). With many older people now expressing a preference for psychotherapy as a treatment for depression (Landreville, Landry, Baillargeon, Guerett, & Matteau, 2001), it is clear that psychotherapeutic alternatives constitute a welcome addition to the treatment of late life depression (Gerson, Belin, Kaufman, Mintz, & Jarvik, 1999).

Cognitive Behaviour Therapy (CBT) is a very relevant form of psychotherapy with older people (Morris & Morris, 1991) as it is an active, directive time-limited, structured problem-solving treatment approach whose primary aim is symptom reduction. The application of CBT with older people is comprehensively described in Laidlaw, Thompson, Dick-Siskin and Gallagher-Thompson (2003). Primarily, research into CBT for late life depression has largely focused on outcome, while generally ignoring the importance of process issues.

Why do we need a conceptualization of CBT specific to older adults?

Since CBT outcome research demonstrates that unmodified and non-adapted CBT is efficacious for older people (Laidlaw, 2003a, 2001; Gatz et al., 1998; Koder, Brodaty, & Anstey, 1996; Scogin & McElreath, 1994), one might enquire as to why a specific CBT conceptualization, that modifies and extends the bounds of therapeutic investigation, is really needed with older adults. There are, however, a number of reasons why a specific conceptualization framework is needed. For example, at the end of an empirical review of CBT efficacy with older people, Koder et al. (1996) conclude, "The debate is not whether CT is applicable to elderly depressed patients, but rather how to modify existing CT programmes so that they incorporate differences in thinking styles in elderly people and age-related psychological adjustment". Koder et al. (1996) also argue that Life Review and Reminiscence can be usefully incorporated into CBT treatment programmes. Likewise, earlier cognitive therapy researchers have also stated that cognitive therapy needed to be adapted for use with older people, suggesting that "abstract" elements of therapy such as cognitive restructuring may not be beneficial, or perhaps even possible with many older people (Church, 1983, 1986; Steuer & Hammen, 1983). This is potentially confusing for some therapists as it suggests that unless one substantially alters one's practice, standard CBT approaches are not applicable with older people.

Further, because of an overemphasis on negative changes in later life, such as loss, bereavement and physical illnesses, some therapists may be sceptical about applying "standard" CBT (Laidlaw, 2003a). Padesky (1998) suggests the ultimate effectiveness of CBT may be enhanced or undermined by a therapist's own set of beliefs. Certainly, changes

in cognitive capacity, potential loss experiences and different cohort belief systems can leave some therapists feeling out of their depths, and at a loss as to how to apply psychological interventions in the face of "external" rather than internal difficulties.

Many experienced therapists working in the field consider standard CBT conceptualizations are inadequate as a description of the complexity of the age-specific issues facing their clients. The comprehensive conceptualization framework applied here with older people provides an answer to such criticisms and applies gerontological knowledge that is consistent with clinical emphasis important to any therapist working with their patient. Simply put, the more authentic and collaborative the understanding that develops between the patient and the therapist, the better the outcome is likely to be (Persons, 1989). Hence, the current paper seeks to find a way to incorporate age-related differences within standard CBT frameworks using a comprehensive conceptualization framework for older people. For CBT with older people, modifications rather than adaptations may be all that is required (Laidlaw et al., 2003). Modifications suggest that treatment outcome can be enhanced by consideration of certain client specific variables, whereas adaptations require that substantive changes are necessary to a treatment model in order for it to be effective with any specific client group (Laidlaw, 2001). In summary, there is a need to develop a conceptualization model for older people that addresses age related issues within a coherent cognitive therapy framework suitable for older people (Grant & Casey, 1995).

A comprehensive conceptualization of CBT for older people

A brief description of each element of the conceptualization framework of CBT for late life depression is illustrated in Figure 1. At the centre of this conceptualization framework is the standard CBT model for depression (Beck, Rush, Shaw, & Emery, 1979), reflecting the focus that is placed upon standard CBT techniques for treatment interventions. Each element of the conceptualization framework is discussed in greater detail below and clinical examples are used to illustrate key issues.

Cohort

Cohort beliefs are those beliefs held by groups of people born in similar years or similar time periods (Neugarten & Datan, 1973). Cohort beliefs are the shared beliefs and experiences (cultural and developmental) of age specific generations (Smyer & Qualls, 1999). It follows that certain cohort beliefs may impact on the process and outcome of psychotherapy. Knight (1996) emphasizes this when he states that working with older adults entails learning something of the folkways of people born many years before. People born at the beginning of the 20th century will have different cultural and socio-historical experiences to those born at the end of the 20th century and hence may develop different cohort beliefs. It is, however, more than just a "generation gap". Historical events can have had tremendous impact on developmental experiences, leading people to develop different expectancies and beliefs about life. Laidlaw et al. (2003) state "Understanding cohort experiences, and taking these into account when working psychotherapeutically with older people, is no more difficult and no less important than when working with cohorts such as ethnic minority groups." Cohort differences become apparent if one reflects on the experiences of someone growing up in the 1930s, where

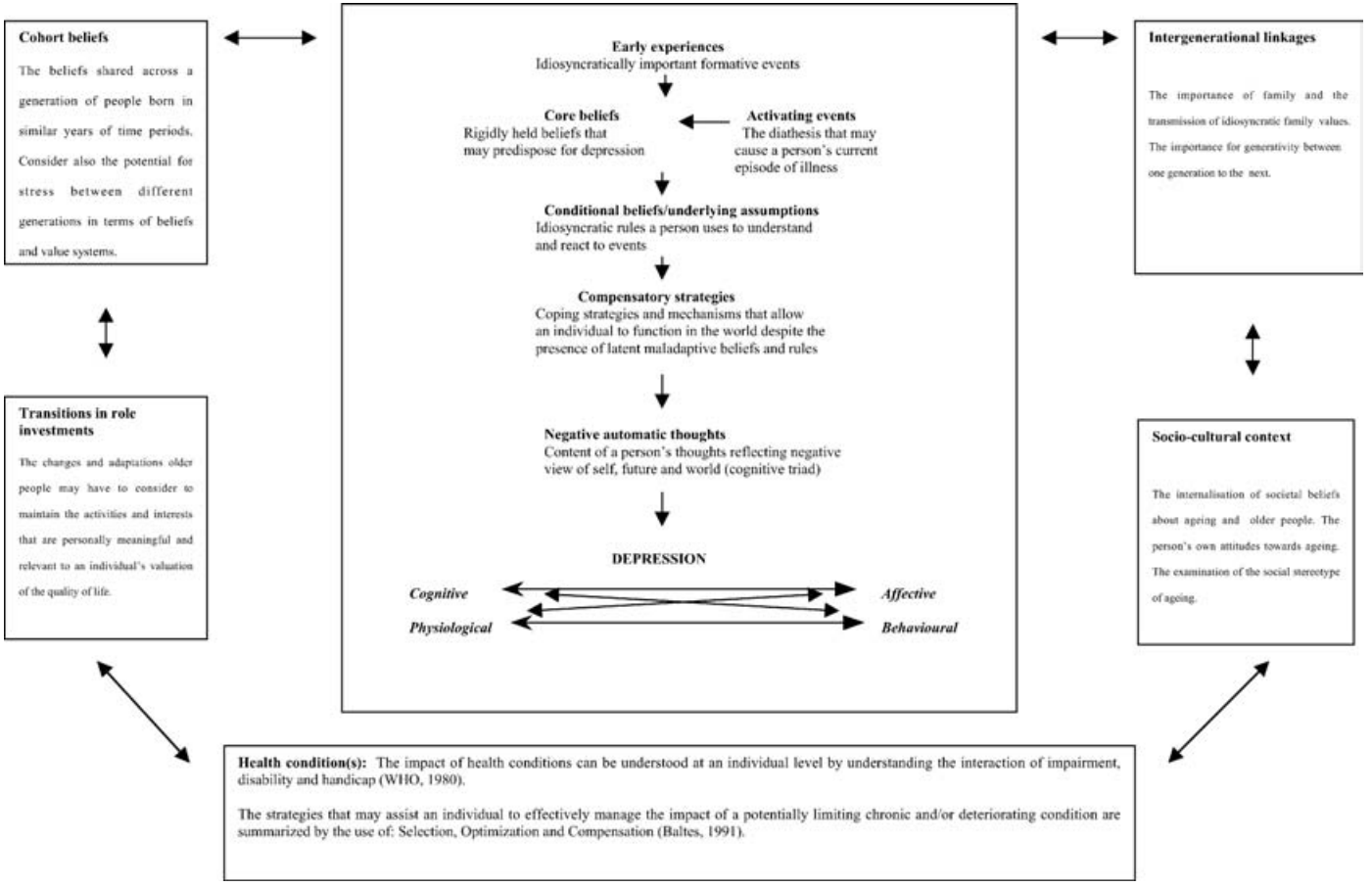

Figure 1. CBT conceptual framework for older people

great historical events like the Great Depression or World War II occurred and became shared socio-historical experiences. Cohort experiences produce potential for misunderstandings and miscommunication between generations. 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.

Combining cohort beliefs with idiosyncratic core beliefs provides an age and generational context to therapy work. For instance, discussing how depression was understood within a specific age cohort and how this relates to personal beliefs about failure can provide a therapist with an opportunity to provide psychoeducation about depression. It may also help one to discover more about the individual's belief system and coping strategies. Lebowitz and Neiderehe (1992) state, "The stigma of mental illness is especially strong in the current cohort of elderly people, who tend to associate mental disorder with personal failure, spiritual deficiency, or some other stereotypic view." For instance, Mr Robson had been experiencing depression since he retired from a lifetime working with a local firm of builders. Mr Robson also experienced significant problems with agoraphobia and rarely left his house. Although Mr Robson was a keen gardener, he found it extremely difficult to be seen outside by people walking past his front garden. It appeared that Mr Robson had always strongly ascribed to the cohort belief that depression was a shameful mental illness. Thus he avoided people seeing him for fear that others were judging him as deficient and mentally abnormal. This cohort belief was extremely painful and he could not avoid experiencing deep feelings of shame and guilt. The impact of these emotions prevented him from managing his depressive symptoms, further confirming his belief that he was weak and a failure as a man. The therapist sought to normalize Mr Robson's fears by explaining that his generational cohort may have shared similar beliefs, but such perspectives would no longer be shared generally by society; especially, given changes in knowledge about mental illnesses. This intervention also introduced some flexibility into a belief system that was rigid and maladaptive. It is noteworthy that treating his avoidance as simple agoraphobia would have probably resulted in a misdirected effort on the part of the therapist.

Transitions in role investments

Active engagement in life is considered an important determinant of successful ageing (Rowe & Kahn, 1998) and often for an older adult this means maintaining close relationships with family and loved ones. For an older adult, remaining invested and involved in activities and interests that are personally meaningful, purposeful and relevant (Rowe & Kahn, 1998) is likely to improve quality of life and especially mental and emotional functioning (Laidlaw, 2003b; Vaillant, 2002). Role investment is therefore an important variable to evaluate in any conceptualization with older adults. Also, at this stage in one's life there may be transitions that an individual needs to navigate in order to successfully adapt to age related changes. Champion and Power (1995) state that vulnerability to depression is related to the extent to which an individual invests in certain highly valued roles and goals. Over investment, that is investment in certain roles and goals to the exclusion of all others, may constitute vulnerability for the development of depression. Champion and Power (1995) recognize a gender bias in the sorts of roles and goals that are invested in. Women are more likely to invest in interpersonal relationships and men are more likely to invest in areas of achievement-orientation, such as work. An important role transition for some, though not all older people, is signalled by

occupational retirement. Generativity, the concern for and commitment to the wellbeing of one generation for another (Erikson, 1997), is considered an important element in the successful ageing of an individual (Vaillant, 2002). Mr Kirk was a successful expatriate engineer who prior to retirement was strongly invested in his work, like many men of his generation. His work provided an important method of self-definition, validation and indication of self-worth. An key role for Mr Kirk was a generative one; he liked to pass on knowledge and experience to his fellow workers (his company employed him to consult and teach younger engineers prior to his retirement) and to his adult children. On retiring from engineering, Mr Kirk returned "home" to Scotland. On his return, Mr Kirk quickly became depressed as a number of important roles had become lost to him. His adult children had remained abroad and he no longer felt needed. He applied to provide voluntary advice to a local engineering college but he was rejected because of his age. For Mr Kirk, CBT interventions focused upon reconstructing a new way of maintaining a sense of investment in activities of personal meaning. Hence, transitioning from one way of achieving meaning to an alternative way that was adaptive to the change in circumstances. Thus, an important element of therapy was finding ways in which he could continue to feel important and valuable to society. Mr Kirk invested his time in voluntary activities by joining the board of a local charity and importantly investing his time in education, enrolling in an Open University course. By investing in these activities, Mr Kirk gained a new sense of value that linked meaningful values from the past. He was able to maintain a sense of continued growth and potential, an aspect of life that is so important for successful ageing and longevity (Vaillant, 2002).

Intergenerational linkages

With the change in family and society demographics (increased longevity, smaller family sizes, increased rates of divorce and subsequent re-marriage) grand parents and great-grandparents perform an important role in our societies, providing strong intergenerational linkages across families (Bengtson & Boss, 2000; Bengtson 2001). Older generations tend to value continuity and transmission of values, whereas younger generations tend to value autonomy and independence (Bengtson et al., 2000). Intergenerational relationships can often create tensions, especially when older generations do not always either approve of, or understand, changes in family structures or marital relationships (Bengston et al., 2000).

For many older people, intergenerational linkages may be confusing and distressing as they clash with cherished cohort beliefs about the notions of family. Neugarten, Moore, & Lowe (1965) 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. Levine (1996) notes that older women may have different expectations about marital fulfilment and roles in society compared to younger women. Levine (1996) also notes that differences in expectations may become an important relationship issue to address in therapy.

Thompson (1996) notes that it is common for relationship strains between older adults and their adult-children to precipitate a depressive episode. Parents, regardless of the age of their children, often still retain a sense of responsibility for things that affect their children.

In depression, this sense of responsibility can become magnified. For example, Mr Ross felt a sense of having let his youngest son down when he learnt that his son had separated from his wife. He stated, "I've obviously not done the right things by him" and "If we had stayed, we might have been able to help . . . we might have prevented the divorce." Cognitive methods of thought challenging were the principal, and successful, method of dealing with this presentation. Eventually, Mr Ross was able to state, "I lived in the same district as my oldest son and that did not prevent him from divorcing." Mr. Ross was also able to see why his youngest son had originally hid his marital difficulties from him. He was able to accept eventually that this was not because his son didn't respect or need his father's advice, but probably because the son felt he had failed at his marriage. Mr Ross was also able to state that he understood that this was a common and understandable reaction on the part of anyone experiencing marital difficulties.

Socio-cultural context

The variable of interest here is primarily people's attitudes towards their own ageing. Often patients will explicitly state that "growing old is a terrible thing". Statements such as this may appear to be realistic appraisals of a difficult time of life, but in fact reveal the internalization of socio-cultural negative stereotypes about growing old. As Levy (2003) states "when individuals reach old age, the ageing stereotypes internalized in childhood, and then reinforced for decades, become self-stereotypes." Many older people have an implicit assumption (that can be challenged in therapy) 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". Thus many older people have a latent and potentially 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. Unfortunately, beliefs such as these often prevent individuals from seeking treatment or at the very least making the most of treatment when it is offered (Unutzer et al., 1999). Therapists ought to explore the socio-cultural context of the patient when they are socializing the patient into therapy. Formulations of beliefs about ageing are very important if therapy is to proceed in a timely and efficacious fashion. The socio-cultural context also takes into account the values of the therapist. One must work to develop a realistic understanding of ways of working with older people. There are many erroneous "age related" negative cognitions that may sound "understandable" to younger therapists: such as, "Old age is a terrible time", "All my problems are to do with my age", "I'm too old to change my ways now". To avoid endorsing such concepts, it is important that therapists ask themselves a few key questions: "Would I accept this cognition as fact in a younger patient?" and "Would I accept the limitations this person places on his expected outcome in therapy in someone younger?"

Physical health

Increasing age brings with it an increased likelihood of developing chronic medical conditions. However, it does not follow that all older people have a chronic medical condition that has a limiting functional effect. In any formulation it is important to enquire about the presence and impact of medical conditions (Zeiss, Lewinsohn, Rohde, & Seeley, 1996). Equally, it

is important to enquire about patients' understanding about diseases and to examine what they think will be the outcome of any chronic condition. In the cognitive model for late life depression, health status is formulated using the WHO (1980) classification of disease where physical ill-health is understood in terms of three components: impairment, disability and handicap. This is an extremely useful way for therapists to conceptualize illness. In this system, impairment refers to any loss/abnormality of body structure, appearance, organ or system. For example, in the case of someone having a stroke, the impairment would refer to the damage caused to neural tissue caused by the vascular event. Disability is the impact of the impairment on the individual's ability to carry out "normal" activities. So, following a stroke, the person may now find it difficult to dress himself without assistance. Handicap can be thought of as the social impact that the impairment or disease has on the individual. Consequences of handicap are reflected in the disadvantages an individual experiences in his interaction with, and adaptation to, the environment. Thus the person who experienced the stroke may find that other people now treat him differently, and he increasingly feels excluded from normal communications. The notion of handicap is useful for looking at the consequences of disease for an individual. Indeed, it highlights the loss of opportunity to participate in society that many older people will experience should they develop certain disease conditions. In this tripartite framework, it is apparent that the way a person copes with the disability and handicap components is under much more conscious control by the individual as compared to impairment component. The usefulness of this system to psychotherapists is that it allows one to consider the consequences of impairment or disease for an individual. While this system of classification has recently been superseded by a framework that more explicitly focuses on a more complex way of formulating health status (WHO, 2001), the simplicity of this model makes it useful.

A further helpful way of conceptualizing ill health is via Baltes' (1991) components of successful ageing. In this latter framework, individuals select a limited set of behaviours that they optimize to allow them to compensate for any limitations due to illness (SOC: selection, optimization and compensation). Use of these strategies can enable an older adult to accommodate to the changes associated with ageing and promote maximal independent functioning even in the presence of a chronic disabling condition. The model is exemplified by Baltes (1991), with reference to the concert pianist Arthur Rubinstein who continued to perform at an exceptional level late into life. 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 repertoire more intensely than would have been the case when he was younger (an example of optimization). Finally, Rubinstein used "tricks" such as slowing down his speed of playing just immediately prior to playing the fast segments of his repertoire, thereby giving his audience the impression of faster play than was actually the case; an example of compensation for the effects of ageing on speed. Thus the psychological consequences of physical illnesses can be dealt with by first understanding the disability and handicap experience by the individual and then managing this by developing creative solutions using the SOC model (Baltes, 1991).

Concluding thoughts

Within this comprehensive conceptualization framework, a developmental approach is adopted across the entire lifespan of the individual. Later life is seen as another stage of life that shares

similarities with all other stages of life. Transitions and challenges will have to be faced by the individual in order to maximize his emotional and physical independence. Adopting this perspective gives CBT therapists a rationale for treatment. The authors have found that mapping out the various domains has helped many therapists specializing in the field to conduct assessments, and consequently interventions, in a more focused manner. For example, the explication of the physical domain has provided therapists with a treatment rationale even where depression is considered to be a "biological" effect of illness, such as in stroke or heart disease. An important attribute of this conceptualization framework is that elements overlap and interact. Indeed, as outlined earlier, cohort beliefs may influence how an individual reacts to a change in health status ("I must not be a burden to my family"), and may determine some aspects of an individual's sociocultural beliefs ("Growing older is growing weaker").

The above conceptual model, 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. Such as, when working with a depressed older client, presenting with a range of physical illnesses, multiple loss experiences, and age related negative thoughts (such as "It is depressing to be old"). It is in the light of these challenges that cognitive therapists who work with older people need a specific age related conceptualization that integrates CBT interventions within a gerontological cognitive framework. The age stereotype of ageing equates this phase of life with decrepitude, and this needs to be addressed in order for a patient to challenge erroneous thinking that may prevent him from fully making changes in his life. Thus in applying CBT using this conceptualization, one challenges the age stereotype in a problem focused, specific and pragmatically oriented way, allowing older adults to get the maximal quality of life possible in their circumstances.

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