

Preface

There was a time in the last century when professionals from any discipline involving mental health (e.g., nursing, psychiatry, psychology, social work) held the belief that the elderly would gain little from psychiatric treatment of any kind. Indeed, very little time and effort was invested in attempting to help older adults with mental health problems. As late as the mid 1960s, one could still occasionally hear arguments emphasizing that older persons simply could not benefit from “true” psychotherapy. The treatment of choice would thus have to be a trial with one of the latest “breakthrough” psychoactive medications, or ECT if they weren’t too frail; otherwise, they would just have to settle for some type of supportive counseling. Even as these arguments were challenged with countering evidence, few clinicians moved beyond the languorous posture of “why bother.”

Without making this a history lesson, a number of significant individuals and policies came to light during the 1960s that began to change this scene. Politicians began to feel pressure from their constituents that the elderly population was increasing, and something needed to be done to assure that older adults had adequate health care. Congress saw to it that federal funds were allocated for aging research; by the late 1960s, burgeoning gerontological and geriatric research activities stimulated numerous discussions at many different levels, leading to the creation of an independent Institute of Aging within the National Institutes of Health. As more funds were committed to research, so too, was the interest of the scientific and academic communities.

More importantly, theories focusing on the elements of change in psychiatric patients began to incorporate data and models from the psychological literature. Interesting comparisons between learning theories and psychoanalytic/psychodynamic models began to occur. The growing number of clinical psychologists, which started in earnest during World War II, quickly saw the value of applying these change models when working with mentally disturbed patients. Within short order, behavioral and cognitive intervention models were developed, refined, and empirically tested, leading to compelling arguments that there were more efficient ways of treating mental patients than psychoanalysis or vintage psychodynamic psychotherapy.

And so, we have had a wealth of prominent theorists to lead us, some of whom have become household names rivaling the reputation of Sigmund Freud. This

list begins, perhaps, with Watson (a little before our time), but then moves on to Guthrie, Meehl, Dollard, Miller, Jacobs, Wolpe, Kelly, Lewinsohn, Beck, Jacobson, and many more, all of whom laid the groundwork with conceptual models and intervention strategies more favorably disposed to the treatment of the elderly.

Despite these developments, there were few nurses, psychiatrists, psychologists, and social workers in those early days who were interested in working with elderly psychiatric patients, let alone attempting to apply therapy techniques that were notably different than the traditional analytic/dynamic therapies. One such clinician in the trenches, who comes to mind, is Bob Kahn. When few were thinking of a clinical geropsychology profession, he was forging ahead in Chicago and training some of our leading geropsychologists; these individuals are active today in shaping the pathways that behavioral and cognitive interventionists, of whatever discipline, must traverse.

We provide the above narration to illustrate how much this group of papers symbolizes the rapidity with which the times have changed. Conceptualization, assessment, and interventions that rely heavily on behavioral and cognitive approaches (CBTs) have advanced significantly in the past four decades. The recent name change of the premier interdisciplinary international professional association devoted to the development, evaluation, and dissemination of these approaches, from *Association for the Advancement of Behavior Therapy (AABT)*, to the *Association for Behavioral and Cognitive Therapies (ABCT)*, signifies a number of interrelated changes in the field. Included is the transition of CBTs to mainstream professional practice, increased attention to the role of cognitive processes in behavior change, and acknowledgement of the wide range of theories and clinical practices that are covered by the terms “behavioral,” “cognitive,” and “cognitive-behavioral.” For example, from earlier work on behavioral (Goldfried & Davidson, 1976) and cognitive (Beck, Rush, Shaw, & Emery, 1979) therapies, the range of populations and problems addressed by CBTs has expanded dramatically (Craighead, Craighead, Kazdin & Mahoney, 1994) and continues to grow. We are very pleased to be able to offer this handbook as an indicator of the ongoing progress being made in the application of CBTs and newer integrative approaches to understanding and ameliorating mental health problems in older adults.

We attempted to sample a broad range of CBT interventions that would reflect their use with a wide variety of patient populations. Authors were asked to include a discussion of the empirical support for their approach, a brief description of the intervention, followed by a case illustration. In each chapter that describes a specific intervention approach, we have also asked authors to address issues of cultural diversity (Hays & Iwamasa, 2006) when applying the conceptualizations and interventions with ethnically diverse older adults.

The chapters included can be viewed as falling within four general categories. The first section reviews a number of common mental health problems and the evidence base documenting the efficacy of each treatment. The topics covered in this section include depression, anxiety, insomnia, alcohol abuse, pain management, and chronic stress of caregiving. The second section focuses on treatment of patients with more severe mental illness, such as schizophrenia and other

psychoses, suicidal behavior, personality disorders, and dementia. The third section includes patient groups where the evidence base is not yet strong, but the interest on the part of many clinicians in using CBTs is. These chapters describe issues in treating patients with severe bipolar disorder, stroke victims, patients suffering with complicated bereavement, the indigent, and patients with PTSD. The final section includes three chapters discussing several issues that have relevance for the development of future directions. While not exhaustive, issues in training and compensation warrant consideration. Finally, we have included a chapter that turns our attention to more positive features in aging that are deserving of attention as we consider the mental health needs of the elderly. It is noteworthy that in our short history of treating older patients, we have yet to build a treatment model that is uniquely relevant for the elderly. What we have done thus far is adapt models developed for use with other younger groups, and then tweak them in ways to make them applicable for work with the elderly. This makes *abundant good sense*, but many characteristics of importance may often get left by the wayside. The chapter on positive aging reminds us of important constructs we need to consider as we begin to develop intervention models specifically for use with this segment of our population.

Although varied in focus, behavioral and cognitive theories and interventions are generally characterized as utilizing basic research in learning, cognitive processes, and emotional regulation, as well as fostering the accompanying principle that learning is a life-long process. Thus, the CBTs are well suited to helping the field address the diagnostic (Jeste, Blazer & First, 2005) and treatment challenges of working with older adults (Gallagher-Thompson & Thompson, 1996). These interventions are grounded in coherent theories of psychopathology and change, and involve structured, often time-limited or time-efficient approaches that use guided mastery of behavioral, cognitive, and emotional self-regulation skills through instruction, in-session practice, and between-session assignments. Also, specific efforts are made so that the skills developed during treatment can generalize to future problems and challenges. Depending upon the severity of the condition, goals range from better symptom self-management and psychosocial functioning to the client being able to initiate and pursue self-interventions after treatment is over; essentially, individuals become their own “therapist” or interventionist.

Although chapters in this handbook describe a wide range of intervention approaches that are considered behavioral and/or cognitive in nature and designed for use with other specific groups, we recommend that professionals working with older adults also become familiar with recommendations for adapting interventions for work with older adults (Zeiss & Steffen, 1996). With significant interindividual differences in physical and cognitive functioning in late life, such recommendations should be viewed as general guidelines as opposed to rules. These suggestions reflect adaptations to better fit the learning style of older adults, including a slower pacing of material presented, multimodal training (i.e. “say it, show it, do it”), using memory aides (e.g., written homework reminders, providing tapes of sessions to listen to in between sessions, etc.), making use of strategies to stay on track during sessions (e.g., refocusing, keeping agenda

visible, etc.), and planning for generalization of training. It is also important for clinicians to identify strengths of the older client that can be used to advance therapy, and consider the role of wisdom in responding to life's challenges. Scogin (2000) expands on these issues in a very nice discussion of skills needed for beginning clinical work with older adults. We also would like to emphasize the strongly multidisciplinary nature of work with older adults, and suggest that professionals become familiar with concepts and practices in interdisciplinary team functioning (Zeiss & Steffen, 1998).

Behavioral and cognitive approaches to conceptualization, assessment, and intervention are also characterized by a strong emphasis on empiricism; this is true for each clinician who uses an individual case formulation approach, and also for the field in demonstrating treatment efficacy and effectiveness. That is, a great deal of attention is paid by clinicians to ongoing assessment of targeted problems, identifying mechanisms of change for a specific client, and isolating the strategies leading to a successful treatment response. Because of the emphasis on documenting both intervention mechanisms and outcomes, behavioral and cognitive approaches have strong empirical support in the treatment literatures for many mental health issues, and are ideally suited to many mental health problems in later life. In this handbook, we have attempted to balance our coverage of topics that have led to the development of empirically supported therapies (Chambless & Hollon, 1998) with attention to newer areas of inquiry that are perhaps better viewed from an evidence-based approach that acknowledges the role of clinician judgment in the absence of strong empirical support for a specific therapy (APA, 2006; Goodheart, Kazdin, & Sternberg, 2006; Norcross, Beutler, & Levant, 2006).

We would also like to remind prospective investigators that, although considered the "gold standard" for demonstrating treatment efficacy, large and correspondingly expensive randomized clinical trials are not the only means of advancing the science of mental health interventions for older adults (Stiles et al., 2006). In their description of the criteria used to define "empirically supported treatments," Chambless and Hollon (1998) discuss the role of carefully controlled single case experiments and their group analogues. An intervention would be labeled "possibly efficacious" if shown to be beneficial to three or more participants in research conducted by a single group. Multiple replications of controlled single case experiments (with three or more participants) by two or more independent research groups are needed to demonstrate treatment efficacy. Thus, professionals unable or uninterested in doing large scale intervention trials still have much to contribute. In addition, whether an intervention is being tested in an RCT design or in a controlled single case experiment, Chambless and Hollon (1998) emphasize the essential need for independent replication in at least two studies (i.e., by investigators unaffiliated with the group where the intervention originated). Therefore, in addition to developing new interventions, we would all be well served by taking the time to replicate those interventions originally developed and tested by others.

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