

REVIEW

Cognitive therapy with elderly people

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Introduction

Following an expansion in the range of psychological treatments used to treat psychiatric disorders in younger adults there is now increasing interest in the use of these techniques with older patients. This is accompanied by an awareness of the often poor prognosis of emotional disorders in older people, particularly depressive illness, and a need to develop effective interventions. Up to two-thirds of depressed elderly patients may fail to achieve a good outcome despite the use of conventional physical treatments and these treatments may themselves present problems because of concurrent medical problems. There is, therefore, a need to expand the range of suitable interventions. The recent US National Institute of Health consensus development conference [1] highlighted the need for the continued development and evaluation of psychosocial interventions, with particular reference to the way in which such treatments may complement or provide alternatives to physical treatments. Treatments for older patients should also address physical symptoms, whether these are the result of physical or psychological disorder.

Psychological treatment methods used with older adults include those designed specifically for this population, such as validation therapy and reminiscence therapy, as well as adaptations of techniques used with younger patients, such as behaviour therapy, psychodynamic therapy and family therapy. This paper outlines the use of another such treatment, cognitive therapy, examining evidence for its effectiveness with elderly people and describing the adaptations required when working with the older age group.

Cognitive therapy

Rationale

According to Beck's cognitive model of emotional disorders [2] problems such as depression or anxiety arise from an individual's specific and exaggerated beliefs about him or herself and the world around.

Once activated, such beliefs give rise to unpleasant emotions mediated by negative thoughts or *cognitions*. Cognitive therapy aims to equip a patient with skills to modify distorted underlying beliefs principally through techniques of identifying and testing the validity of such biased thoughts. Therapy is problem-focused and relies on an active collaboration between patient and therapist. A jointly derived conceptualization of problems is drawn up which links historical information about the patient with current problems and in turn informs the choice of suitable interventions. These range from behavioural experiments which challenge beliefs to direct methods of modifying biased thinking during agreed inter-session 'homework' tasks.

The cognitive distortions typical of depression in later life reflect the difficulty often experienced in adapting to a range of losses such as retirement and physical disability, as well as the process of reviewing life and anticipating death. There may be a tendency to attach exaggerated importance to unpleasant events, to hold unrealistically bleak expectations of ageing, or to blame oneself for uncontrollable events. Such cognitive distortions often reflect the attitudes to ageing held in society in general. In anxiety disorders, typical cognitions are those predicting an exaggerated likelihood of threatening events with a reduced capacity to withstand them. Thoughts may concern external threats, such as harm to family members, or internal threats, such as the possibility of illness or death.

Applications

Cognitive therapy is now widely applied in the treatment of a range of problems amongst younger adults, including depression, anxiety disorders and eating disorders. In practice, cognitive therapy is often combined with drug treatment—especially where drug treatment alone has failed to produce significant benefit—although it is not clear if there are benefits in combining treatments. Although less widely used amongst older adults, cognitive therapy has been applied mostly in the treatment of depressive illness, for which the validity of the cognitive model has been demonstrated.

Outcome research in younger adults

Cognitive therapy has undergone extensive evaluation in adults younger than 65 years: it is as effective as antidepressant medication in treating mild to moderate depressive illness and may have a more beneficial long-term effect in preventing relapse [3]. It is also of proven efficacy in the treatment of anxiety disorders [4, 5] and in physical presentations of psychological disorders [6].

Evaluation of cognitive therapy with older patients

Depressive disorders

There has been a small number of outcome trials evaluating cognitive therapy in elderly subjects. These trials are mainly restricted to the treatment of depression. Steuer *et al.* [7] compared group cognitive with group psychodynamic therapy in patients with a mean age of 66 years. There was no control group and treatment lasted on average 37 weeks. The patients under investigation were atypical as they were media-recruited patients with a high level of educational achievement. However, there was improvement with both treatments with evidence of superiority of cognitive therapy. Other studies have included control groups. Beutler *et al.* [8] compared group cognitive therapy with placebo and alprazolam over a period of 20 weeks and showed superiority of cognitive therapy over no active treatment. Thompson, Gallagher and Breckenridge [9] compared group cognitive, behavioural and psychodynamic therapies over 20 weeks with a 6-week delayed treatment group and demonstrated effectiveness of all treatments. Finally, Scogin *et al.* [10] compared the use of written cognitive therapy material with written behavioural therapy material with a delayed treatment group and found equal improvement in both treatment groups when compared with control.

Two studies address the longer term effects of cognitive therapy with older patients. A trial comparing group cognitive therapy of depression with behavioural therapy and insight-oriented therapy [11] showed early improvement in all groups. Improvement was sustained only in the cognitive and behavioural groups, with evidence that patients were continuing to use skills they had acquired. In a study conducted in the UK [12], patients received their usual treatment for depression and in some cases also received adjunctive cognitive therapy over a mean number of 14 individual sessions. After recovery, patients were maintained on either placebo or lithium carbonate. Those who had received cognitive therapy had significantly reduced depression scores at 1 year follow-up. The study, however, was of limited size and had a 50% drop-out rate.

There has also been some interest in treating the depressed carers of dependent elderly people. Gallagher-Thompson and Steffen [13] treated depressed caregivers (mean age 62 years) of elderly relatives with cognitive-behavioural and psychodynamic therapies: 71% were no longer depressed after treatment, with generally equal benefit from both therapies.

Although encouraging, these studies have methodological limitations such as small sample sizes, relatively young subjects, absence of more suitable control groups and unspecified treatment techniques.

Anxiety disorders

The treatment of anxiety disorders in old age is relatively neglected in the research literature. A pilot case series, however, demonstrates the successful application of conventional individual cognitive therapy for a series of National Health Service outpatients with panic disorder, generalized anxiety disorder or agoraphobia, with reductions in most self-report measures of anxiety which were maintained over the 6 months studied [14].

Adapting cognitive therapy to the treatment of elderly patients

In general, the same treatment strategies apply to the treatment of older patients as apply to younger patients, although certain adaptations may be required to accommodate specific problems and circumstances.

Cognitive changes

To accommodate minor cognitive changes such as reduced capacity for abstraction and greater distractibility [15], therapy may need to progress at a slower pace with more frequent pauses and summaries in order to prompt memory. The use of increased structure in sessions and of simple devices such as notebooks and tape-recorded sessions is also suggested. Reduced abstract thinking potential presents some patients with difficulties using and generalizing from dysfunctional thought records. Regular discussion with the patient of concrete examples to repeatedly identify cognitive distortions may be necessary.

Carers

Older patients are more likely than younger patients to depend upon others for their care. Carers (with patients' consent) may be usefully recruited into treatment to aid in assessment and challenging of cognitive distortions. If, however, the carer is subject to similar problems such collaboration may not be beneficial. At present, specific guidelines to effective working with carers and families are lacking.

Dependency

To isolated elderly people, contact with a therapist may constitute a significant relationship with the potential for dependence. This risks inhibiting therapy if the patient seeks to attribute benefits directly to the therapist and could make the end of therapy difficult to negotiate. In this situation, reference to the case conceptualization and strategies encouraging the patient to attribute improvement to his or her own efforts are advised, followed by a gradual tailing-off of sessions and access to appropriate social supports [16].

Physical disability

Older patients are particularly likely to suffer with co-existing physical illness and disability which may indeed have been the trigger to the development of problems. For this reason, the therapist must remain attentive to the limitations that illness may incur and on occasions arrange therapy in the patient's home. Disability will also need to be taken into account in the planning of homework tasks, requiring careful and realistic goal-setting in the design of behavioural experiments.

Attitudes to therapy

Therapy may be influenced by the attitudes that older people hold towards their problems. Patients may attach shame to emotional problems or may consider themselves incapable of new learning. These may themselves be significant attitudes contributing to the patient's problems; if therapy is to get underway they will need to be challenged early on, possibly with the provision of information from the therapist regarding age-related changes in learning capacity.

Group therapy

Problems such as aversion to psychological approaches and minor cognitive limitations may be reduced by providing therapy in a group setting. Yost *et al.* [17] describe a 20-session package combining education in the nature of depression with strategies for the monitoring of cognitions. Acknowledging that older patients take longer to learn new information, it is suggested that exchange of information be kept to short segments with frequent cueing and advance notification of tasks. As therapy progresses towards termination, the therapist or therapists take a more passive role as patients challenge thoughts and devise behavioural experiments together. Certain patient skills are bolstered to help prepare for future setbacks; these include use of the therapy notebook and a technique called 'stimulus control' to help patients watch out for and control the negative cognitions occurring in response to the inevitable daily reminders of the problems.

Use of educational material

Education of patients about aspects of depression, such as the manifestation of physical symptoms plays a key role in the treatment of older patients. Emery [18] highlights the need for information as an introduction to therapy, and advocates the provision of a handbook explaining the treatment rationale and stressing the influence of negative attitude on mood. Use of reading material may be more acceptable to older patients. A recently published clients' manual [19] includes a case example of a patient using cognitive therapy to overcome a typical late-onset depressive illness.

Physical symptoms

In work with older patients, skills for assessing and managing physical symptoms are essential; a medically qualified therapist may be at an advantage. Physical symptoms may arise from physical or psychological disorder, or may be of uncertain aetiology. Engaging a patient with prominent physical symptoms in a psychological treatment may prove difficult unless sufficient time is given to acknowledging their complaints and health anxieties. This is facilitated through the drawing up of a comprehensive conceptualization. Close collaboration with physician colleagues should ensure that patients with physical symptoms and psychological disorders receive appropriate treatment and that unhelpful physical investigations are avoided.

Additional adaptations

Cognitive therapy has been adapted to other age-related problems. Work with stroke victims who have a degree of cognitive impairment is feasible but requires some treatment modifications [20]. Again, a package incorporating education followed by cognitive restructuring is recommended, centering on acceptance of the consequences of stroke, modulation of emotional states and development of skills to adapt to the new lifestyle. In the treatment of late-life insomnia, cognitive treatments aim to change maladaptive sleep patterns and correct dysfunctional beliefs about sleep and sleeplessness [21]. Finally, cognitive interventions addressing the phobic and depressive elements of grief reactions are also described [22].

Case examples

Two case examples illustrate the use of cognitive therapy in treating older patients

Case 1: patient with a depressive disorder

Mr P is a 70-year-old professional who was referred for help with poor concentration, lack of energy, loss of motivation and episodes of poor memory. As a

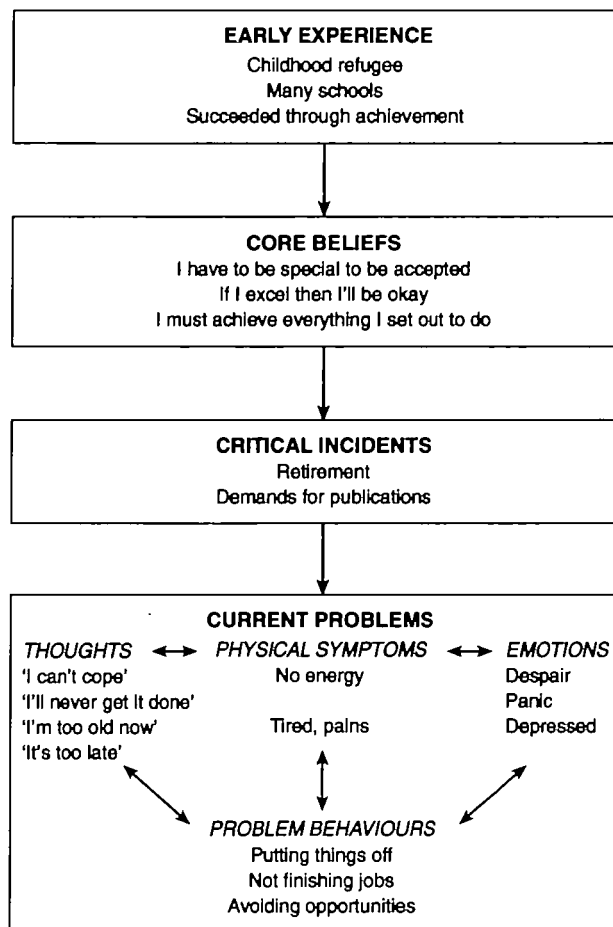


Figure 1. Conceptualization of case of Mr P.

consequence, he was experiencing difficulty preparing the publications he had hoped to complete following his retirement. He was already receiving antidepressant treatment (moclobemide 450 mg) with limited effect. Mr P had arrived in England in his childhood as a refugee from war-torn Europe; he had achieved scholarships to good schools and grew to believe that in order to be acceptable to others he should always be the best. A conceptualization was drawn up with him in therapy (Figure 1).

Initial interventions were aimed at increasing Mr P's activities and energy through monitoring and re-scheduling of his activities. Use of a written activity record demonstrated that he had been expecting himself to reach unreasonable targets whilst avoiding starting tasks. With these interventions he began to schedule and approach activities more effectively.

Treatment then moved on to directly tackle troublesome thoughts regarding himself, his past life and his future such as 'I'm not as good as I was'; 'my children don't contact me because I've been a bad parent'; 'I won't be able to enjoy anything again' and, after an episode of joint pain 'I'll be like this for ever'.

Initially he was instructed in simple distraction techniques to cope with these thoughts and then later began to challenge them directly. For example, in response to the thought 'I'll be like this for ever', he generated alternatives such as 'today and other days I've been mainly okay, so how can I expect that I'll be like this for ever?'

Later in therapy Mr P's complaints of minor memory impairment were tackled. Lapses in his memory or concentration caused him great anxiety with thoughts that he would not achieve his highest standard of work and fears of a dementing illness. To deal with this he learned to challenge his perfectionist thoughts so that he could set realistic and achievable work goals. He also acquired further information to help him accept the normal cognitive changes of ageing and learned to use simple practical techniques to aid his memory where necessary.

In all, Mr P received 12 sessions of cognitive therapy during which he reported good progress in coping with his problems using the techniques learned. His improvement was reflected in decreasing scores on the Beck Depression Inventory.

Case 2: patient with physical symptoms, health fears and anxiety

Mrs K is a 76-year-old former business owner who was referred for cognitive therapy with a range of physical symptoms, including sweateness, headaches, shortness of breath, abdominal discomfort, blurred vision and dizziness. Although examination and a range of laboratory investigations failed to demonstrate any physical pathology, she continued to worry about having a heart attack and requested investigations to rule out cancer. Previous antidepressant treatment with amitriptyline and later venlafaxine had not been tolerated because of side-effects; treatment with paroxetine was tolerated but had produced only transient benefit. Her regular medication was cimetidine 400 mg bd, aluminium hydroxide suspension and co-dydramol as required.

Mrs K had retired in her mid-sixties after suffering two myocardial infarctions and developing osteoarthritis of the hips. At the age of 70 she underwent a total hip replacement. Earlier in her life she had had surgery for a duodenal ulcer. She had been fit and active until her retirement, for instance coping with the premature death of her first husband and continuing to run her business and raise a family. She acknowledged that she was bored and lonely in retirement but because of her symptoms found it very difficult to develop outside interests and spent a lot of time inactive at home. On assessment, Mrs K rated highly on measures of anxiety and moderately on depression measures.

In treatment, early sessions were spent carefully recording and rating Mrs K's symptoms and identifying links between her physical complaints and anxious mood, aided by the use of a patient treatment manual

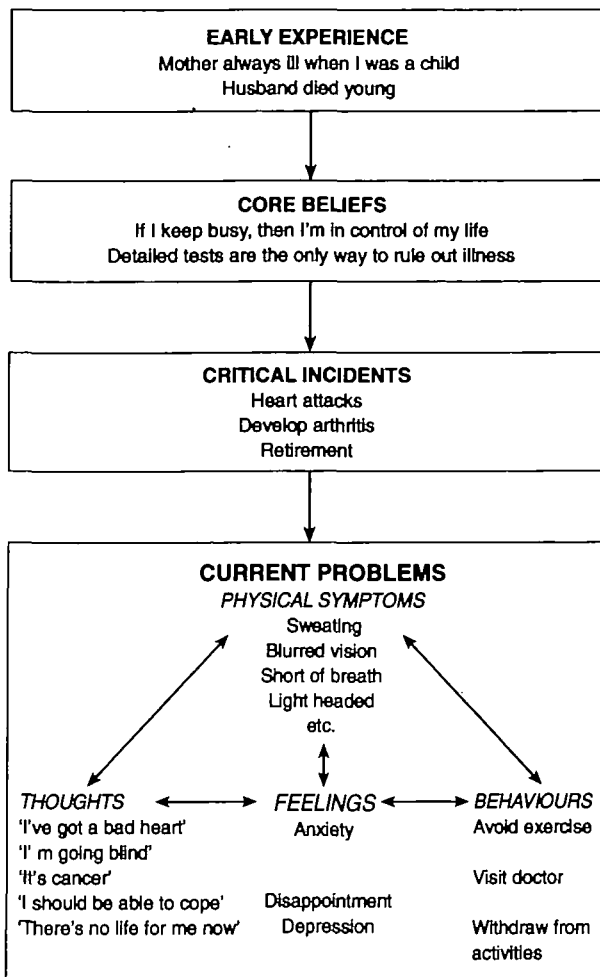


Figure 2. Conceptualization of case of Mrs K.

[19]. Next, the background to her problems was elucidated in the drawing up of a conceptualization (Figure 2). Treatment interventions included thought challenging to help her manage anxiety-provoking cognitions and time spent in helping her to modify her beliefs regarding her health and her unrealistic expectations of medical care. With the help of her husband, she was also helped to overcome her avoidance of social and public situations and to increase her range of pleasurable activities. She reported clear improvement in 15 sessions of treatment, mirrored by improvements in her ratings of anxiety, depression and social functioning and a reduction in medical help seeking.

Conclusion

The development of psychological approaches to treatment of older people has been relatively neglected. There is, however, a need to develop treatments that are feasible and effective with elderly patients and which improve longer term outcome of depressive disorders.

Cognitive therapy is an active, collaborative psychological treatment that is effective in a range of psychiatric disorders in younger adults. Cognitive therapy can also be applied in the treatment of older adults but may require certain adaptations to accommodate problems such as minor cognitive changes, disability, or social isolation.

The limited outcome research carried out to date indicates that it is effective in the treatment of depressive disorders but further, more rigorous research is required. This would include treatment of patients typically encountered in routine practice, such as those with concurrent physical illness and disability. Larger randomized controlled trials are required comparing cognitive therapy with current drug regimes and other established psychological interventions; these should include demonstration of adherence to up-to-date treatment programmes by competent therapists, with follow-up periods of up to 2 years.

Cognitive therapy is particularly suited to the treatment of patients with physical symptoms, whether of physical, psychological or combined origin. Geriatricians are in a position to refer patients to psychiatric services where cognitive therapy is available and in some circumstances joint management is indicated. Further guidance is still required on specific adaptations to using cognitive therapy with older patients; in particular, means of effectively working with family members.

Key points

- Cognitive therapy is a structured psychological treatment suitable for the treatment of depressive and anxiety disorders in elderly patients.
- Specific adaptations may be required when cognitive therapy is used to treat elderly patients.
- A small amount of outcome research indicates that cognitive therapy is an effective treatment for depressive disorders and that it may improve long-term outcome.
- Further more rigorous evaluation is needed.
- Cognitive therapy is suited to the treatment of patients with combined physical and psychological symptoms.

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References

1. NIH Consensus Development Conference. In: Schneider L, Reynolds C, Lebowitz B, *et al.* (eds) *Diagnoses and Treatment of Depression in Late Life*. Washington, DC: American Psychiatric Press, 1994.

2. Beck AT. Cognitive Therapy and the Emotional Disorders. New York: International Universities Press, 1976.
3. Scott J. Psychological treatments for depression. An update. *Br J Psychiatry* 1995; 167: 289-92.
4. Butler G, Fennell M, Robson P, Gelder M. Comparison of behavior therapy and cognitive behavior therapy in the treatment of generalized anxiety disorder. *J Cons Clin Psychol* 1991; 59: 167-75.
5. Gelder MG. New ways of treating panic disorder. *Ann Med* 1991; 23: 97-9.
6. Sharpe M. Cognitive behaviour therapies in the treatment of functional somatic symptoms. In Mayou R, Bass C, Sharpe (eds.) *Treatment of Functional Somatic Symptoms*. Oxford: Oxford University Press, 1995.
7. Steuer JL, Mintz J, Hammen CL, Hill MA, Jarvik LE, McCarley T, *et al*. Cognitive-behavioral and psychodynamic group psychotherapy in treatment of geriatric depression. *J Consult Clin Psychol* 1984; 52: 180-9.
8. Beutler LE, Scogin F, Kirkish P, Schretlen D, Corbishley A, Hamblin D, *et al*. Group cognitive therapy and alprazolam in the treatment of depression in older adults. *J Consult Clin Psychol* 1987; 55: 550-6.
9. Thompson LW, Gallagher D, Breckenridge JS. Comparative effectiveness of psychotherapies for depressed elders. *J Consult Clin Psychol* 1987; 55: 385-90.
10. Scogin F, Jamison C, Gochneaur K. Comparative efficacy of cognitive and behavioural bibliotherapy for mildly and moderately depressed older adults. *J Consult Clin Psychol* 1989; 57: 403-7.
11. Gallagher DE, Thompson LW. Treatment of major depressive disorder in older adult outpatients with brief psychotherapies. *Psychotherapy Theory Res Practice* 1982; 19: 482-90.
12. Wilson KCM, Scott M, Abou-Saleh M, Burns R, Copeland. Long-term effects of cognitive-behavioural therapy and lithium therapy on depression in the elderly. *Br J Psychiatry* 1995; 167: 653-8.
13. Gallagher-Thompson D, Steffen AM. Comparative effects of cognitive-behavioural and brief psychodynamic psychotherapies for depressed family caregivers. *J Consult Clin Psychol* 1994; 62: 543-9.
14. King P, Barrowclough C. A clinical pilot study of cognitive-behavioral therapy for anxiety disorders in the elderly. *Behav Psychotherapy* 1991; 19: 337-45.
15. Bradbury N. Problems of elderly people. In: Dryden W, Rentoul, R (eds). *Adult Clinical Problems: A Cognitive-Behavioral Approach*. London: Routledge, 1991.
16. Gallagher-Thompson D, Thompson LW. The older adult. In: Freeman A, Dattilio FM (eds.). *Comprehensive Casebook of Cognitive Therapy*. New York: Plenum Press, 1992.
17. Yost EB, Beutler LE, Corbishley MA, Allender JR. *Group Cognitive Therapy: a Treatment Approach for Depressed Older Adults*. New York: Pergamon, 1986.
18. Emery G. Cognitive therapy with the elderly. In: Hollon SD, Bedrosian R. (eds). *New Directions in Cognitive Therapy*. New York: Guilford, 1981.
19. Greenberger D, Padesky CA. *Mind Over Mood: A Cognitive Therapy Treatment Manual for Clients*. New York: Guilford, 1995.
20. Hibbard MR, Grober SE, Stein PN, Gordon WA. Post-stroke depression. In: Freeman A, Dattilio FM (eds). *Comprehensive Casebook of Cognitive Therapy*. New York: Plenum Press, 1992.
21. Morin CM, Kowatch RA, Barry T, Walton E. Cognitive-behavior therapy for late-life insomnia. *J Consult Clin Psychol* 1993; 61: 137-46.
22. Kavanagh DJ. Towards a cognitive-behavioural intervention for adult grief reactions. *Br J Psychiatry* 1990; 157: 373-83.

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