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Cognitive-behavioral therapy with older adults

Geriatric patients can benefit from cognitive-behavioral therapy alone or in combination with medication.

ABSTRACT: Cognitive-behavioral therapy (CBT) is a popular and empirically supported treatment for a number of common mental health problems, including mild to moderate major depressive disorder, generalized anxiety disorder, panic disorder, social phobia, and bulimia nervosa. CBT helps patients reduce or eliminate thinking styles and behavior patterns that contribute to suffering. Typically a therapist and patient work together to replace dysfunctional patterns with those that promote health and well-being. A manual is often used to help set goals and identify strategies for change. Older adults can benefit from CBT, especially when modifications recommended for this population are used. One modification for older adults involves addressing physical health as well as spiritual/religious beliefs in the treatment. Resources for health care practitioners pursuing training in CBT techniques and for patients seeking therapy are both readily available in British Columbia.

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Cognitive-behavioral therapy (CBT) was developed in the 1960s. Over the last 50 years it has become one of the most widely used forms of psychotherapy. The rapid and extensive adoption of CBT is largely the result of strong empirical support for its effectiveness when treating patients suffering from a wide range of mental disorders. In addition, CBT is a relatively short-term treatment that can be administered effectively to individuals, couples, families, or groups. CBT is used in a variety of settings and by a number of different professions. A strength of CBT when compared with other similar forms of psychotherapy is its use of manuals that facilitate the effective provision of therapy by professionals whose primary training may not be in psychiatry, psychology, or counseling. These manuals come in individual, group, and self-help formats.

Principles of CBT

CBT is a highly structured and interactive form of psychotherapy. The patient and therapist work together to identify and achieve concrete goals for the therapy. These goals are established collaboratively and are designed to reduce the patient's symptoms and associated suffering. The specific goals that arise in any particular course of therapy are highly individual and are determined by both patient and illness-specific characteristics. For example, the goals for a depressed patient might be to increase exercise, increase social activities, and reduce negative rumination about past life events. The goals for a patient with panic disorder with agoraphobia might be to take a walk around the block alone, increase awareness of hyperventilation as a trigger for panic attacks, and identify and modify automatic thoughts that trigger panic attacks. A combat veteran with posttraumatic stress disorder might decide to practise exposing himself to common situations that have triggered panic and unwanted intrusive memories in the past.

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CBT is characterized by a number of principles. The primary principle involves recognizing that there are multiple and reciprocal relationships between thoughts, behaviors, and emotions, and that making a positive change in any one of these will have a positive impact on the other two. For example, a depressed older adult who starts an exercise class (changes behavior) will find it hard to ruminate during the class about "being useless since I retired" (reducing unhelpful thoughts), and will experience a lift in mood during the class as a result of the physical activity, social connection, and sense of accomplishment (increased positive emotions). Identifying and acknowledging the patient's experience of these benefits (changes in thoughts and emotions) can then be used as evidence against the common depressogenic automatic thought "Nothing I do helps my depression."

Extensive research shows that specific habitual patterns of behavior and thinking are associated with a number of mental disorders.[1-3] The purpose of CBT is to help the patient reduce or eliminate the behavior and thinking patterns that are contributing to his or her suffering and to replace dysfunctional patterns of behavior and thought with patterns that promote health and well-being.

In order to effectively change these habitual patterns, CBT stresses the need for frequent practice and application of adaptive behaviors and thinking patterns in a number of settings to ensure that these skills truly generalize and become habitual. Patients undergoing treatment with CBT must practise the skills they learn in sessions outside of therapy. "Homework assignments" directly related to the specific goals of therapy are generated by the patient and therapist together.

A number of key behavioral skills are taught during CBT. While the amount of time spent using each of these skills varies somewhat depending on patient characteristics and diagnosis, most patients are taught basic relaxation skills and encouraged to increase their physical exercise and social activities, and to participate in events and activities that they find enjoyable. Patients are encouraged to approach making behavioral changes by viewing them as experiments. They are encouraged to write about these experiments in diaries and logs, in order to see what kinds of behavioral changes are most effective for them and to help track the progress they are making over the course of therapy. The use of diaries and logs is also helpful for increasing patient awareness of dysfunctional thinking patterns.

Cognitive change strategies

Making behavioral changes alone is not usually enough to lead to complete remission of symptoms. Patients are also taught to increase their awareness of and ability to identify their automatic thought patterns, particularly dysfunctional automatic thoughts.

Humans are thinking beings and we constantly experience a stream of thoughts, unusually semiconscious ones, as we go about our business during the day. Thoughts constantly arise in response to internal and external stimuli and constantly shift in response to changes in our environment, our emotional state, and our behavior. Although we are not usually paying attention to our moment-by-moment thoughts, it is relatively easy to identify them once we shift our attention to them. In many cases, increasing the awareness of these thoughts alone can produce some improvement in mood and symptoms because patients no longer feel as powerless in the face of their emotional reactions, which previously seemed surprising and inexplicable.

Once automatic thoughts are identified, patients are then encouraged to examine the accuracy and usefulness of their thoughts. There are a number of specific techniques used to examine automatic thoughts, but the most commonly used is the thought record. When completing a thought record, the patient notes the details of the situation that led to an unpleasant or unwanted emotional reaction and the emotional reaction itself. The patient then identifies the thinking that might have led to that emotional reaction, and examines whether the thought is accurate, appropriate for the context, or useful.

In order to challenge automatic thoughts, patients may be asked to list the evidence that either supports or does not support the thought. They may be asked to deconstruct the thought and to identify aspects of the thought that may be accurate, as well as other aspects that may be overgeneralized or inaccurate. Patients are encouraged to examine the consequences of believing any particular thought, and to reflect on where their automatic thoughts may have been learned in the past. When patients are able to identify automatic thoughts that may have been adaptive in the past, they are encouraged to examine whether these automatic thoughts are still accurate and helpful in their current situation. For example, the widowed patient of an abusive husband may often have the automatic thought "It is not safe to speak my mind." This automatic thought may lead to feelings of powerlessness and a withdrawn, overly compliant, or passive-aggressive behavioral style. The patient can learn to examine whether the thought "It is not safe to speak my mind," which was accurate and adaptive while her abusive partner was alive, is still appropriate. She would then be able to conduct behavioral

experiments to test a new adaptive automatic thought such as "When I directly ask most people for what I need, I am more likely to get what I need."

As therapy progresses, many patients are able to identify broad and repetitive patterns of dysfunctional automatic thoughts that have contributed to their experience of anxiety and depression.[1-3] In addition, patients may identify dysfunctional core beliefs about themselves. Dysfunctional core beliefs are global, absolute, negative views of the self and the world. Core beliefs often fall into two general categories: a belief that one is helpless, incompetent, or a failure; and a belief that one is unlovable or unworthy.[4] These beliefs contribute to a number of Axis I and Axis II disorders.[1-3] Core beliefs are challenged in the same ways that dysfunctional automatic thoughts are, although making changes in dysfunctional core beliefs may require a longer course of CBT.

Empirical support for CBT

The research supporting the use of CBT in younger adults is compelling. For a number of psychiatric conditions, including mild to moderate major depressive disorder, generalized anxiety disorder (GAD), panic disorder with or without agoraphobia, social phobia, and bulimia nervosa, CBT alone is a recommended first-line treatment, with level I evidence for efficacy.[5-8]

CBT in combination with appropriate medication is also a recommended first-line treatment for all forms of major depressive disorder, for relapse prevention in major depression, for patients with at least partial response to antidepressant medication, for chronic pain, and for panic disorder with or without agoraphobia.[5,6]

In addition, level II evidence suggests probable efficacy for CBT in obsessive-compulsive disorder, relapse prevention in substance abuse, marital discord, sexual dysfunction, and body dysmorphic disorder.[8]

Empirical support for CBT in older adults

Literature on the effectiveness of psychotherapy specifically in older adults is more limited because less research has been conducted with this population generally. However, a Cochrane review of psychotherapeutic treatments for older depressed adults shows that both cognitive therapy and behavior therapy, the two components of CBT, have a significantly better effect than placebo on clinical outcome measures of depression. Moreover, there is a significant difference in favor of CBT when comparing drop-out rates for CBT and wait-list control groups.[9] CBT is effective for relapse prevention of mood disorders and may also play a preventive role in the development of major mood disorders in older adults who initially present with subthreshold symptoms.[10]

CBT and behavior therapy are recommended interventions for the treatment of unipolar major depressive disorder, with clear data on efficacy as per guidelines developed by the Canadian Coalition for Seniors' Mental Health. The evidence, although limited, suggests that in older adults, the combination of CBT with antidepressants (desipramine) results in a greater response rate than treatment with medication alone.[11]

CBT has also demonstrated efficacy in the treatment of GAD in older adults,[12,13] and may have a role to play in the prevention of other clinically significant anxiety disorders in older adults followed in primary care for 1 year.[10] However, response rates in older adults treated with CBT may not be as robust as those seen in younger adults treated with CBT, or in older adults treated with medication. One study looking at CBT for older adults in the primary care setting demonstrated that when compared with enhanced usual care, CBT resulted in greater reduction in worry severity and depressive symptoms, and improvements in general mental health, although a global measure of GAD severity did not show significant improvement.[14]

Modifications benefiting older adults

The core principles of CBT remain unchanged treating older adults. However, many CBT programs for older adults do explicitly address physical health as well as spiritual and religious beliefs and behavior in the treatment.[15] Although one meta-analysis of psychotherapeutic and psychosocial interventions in older adults suggests that individual interventions may be more beneficial than group interventions, the national guidelines prepared by the Canadian Coalition for Seniors' Mental Health (CCSMH) indicate that there are benefits to group treatments, including social interaction and a lower financial cost. Despite this, the CCSMH makes no specific recommendation regarding the effectiveness of individual versus group therapy.[11]

A number of practical issues may limit the effectiveness of CBT for a specific patient, including patient beliefs about the usefulness of therapy compared with medication, financial considerations, active health issues, sensory impairment, mobility, transportation issues, and cognitive changes. Consideration should be given to these factors when recommending or delivering CBT to older adults.

The majority of CBT programs developed specifically for older adults make adjustments to the standard CBT manuals. For example, type size may be increased to account for visu-

al impairment, the number of sessions may be increased to provide for added summary and review, or explicit learning and memory aides may be incorporated. One pilot study examined an enhanced version of CBT for late-life generalized anxiety disorder and found that patients completing enhanced CBT showed improvement on more measures than did patients in the standard CBT and wait-list control groups.[16]

There are a number of circumstances in which the effectiveness of CBT may be limited. Elderly depressed patients with comorbid personality disorders are generally less responsive to both pharmacological and psychotherapeutic treatment. The presence of a personality disorder is not a contraindication for CBT for the treatment of depression or anxiety, but it may affect the setting in which CBT is delivered (e.g., individual versus group therapy). Similarly, the presence of active substance abuse or dependence may limit the effectiveness of CBT, but literature exploring these comorbidities in an older population is lacking.

Mild cognitive impairment is not a barrier to benefiting from CBT. One study looking at CBT for generalized anxiety disorder in those without dementia showed that there was no relationship between treatment response rates and overall Folstein Mini-Mental State Exam (MMSE) scores. The predictors of response to treatment were the severity of the baseline GAD, psychiatric comorbidity, and compliance regarding homework assignments. Also, difficulties in orientation on the Folstein MMSE were a significant predictor of worse outcome after 6 months of follow-up.[17]

Limited literature exists on the effectiveness of CBT for treatment of depression or anxiety in older adults with comorbid dementias. In practice, however, experienced therapists at some clinics are delivering CBT to patients with mild dementia, using a format focusing more heavily on behavioral interventions. Care should be taken in a group setting to ensure that group members have similar cognitive abilities, otherwise progress of the group may be compromised.

Training opportunities for BC health care professionals

There are a number of training opportunities for BC health care professionals with an interest in learning how to provide CBT or increasing their skills when providing this treatment. The most readily available are the Changeways Clinic (www.changeways.com) and the Vancouver CBT Centre (www.vancouvercbt.ca). Both provide regular therapist training opportunities. Additionally, there are various well-publicized training sessions from visiting CBT experts offered regularly throughout the province. Further structured training opportunities may be available through individual health authorities and at national and international mental health conferences.

Health care professionals from many disciplines may provide CBT. Psychiatrists, psychologists, social workers, licensed professional counselors, marriage and family counselors, family physicians, and nurses may all provide CBT. Very few studies have been done directly comparing patient outcomes obtained by different mental health professions. A large study sponsored by Consumer Reports found that a broad spectrum of patients generally felt that psychotherapy had benefited them and that they were equally satisfied with psychologists, psychiatrists, and social workers.[18]

Other studies also show no major differences between patient-perceived outcome based on the therapist's professional training, although more experienced therapists and those who have undergone more extensive training may be somewhat more effective when assessed using objective measures of improvement.[19] A recent Cochrane review also finds benefit for the use of paraprofessionals, such as trained peer counselors, when compared with no treatment.[20]

Resources for BC patients

Cognitive-behavioral therapy is available within the provincial health care system throughout BC, with free self-help programs being most easily accessed. The British Columbia Ministry of Health provides a useful website that summarizes current resources for the treatment of mental health conditions in British Columbia (www.bcguidelines.ca). In addition, the Canadian Mental Health Association offers a free DVD, patient workbook, and brief telephone-administered paraprofessional coaching to patients referred by their family doctors (www.cmha.bc.ca/services/bounceback). Patients do not need to meet formal criteria for a mood or anxiety diagnosis to participate in this province-wide Bounce Back: Reclaim Your Health program.

Other resources are available through the psychiatry departments of individual hospitals and community mental health teams. The programs offered vary significantly by locale and are frequently limited to patients who meet the care mandates of the team providing the service. For example, in Vancouver, there are CBT groups for older adults offered through the Geriatric Psychiatry Outreach Team at Vancouver General Hospital (http://psychiatry.vch.ca/gpot.htm) as well as through Vancouver Community Mental Health Services (via the Older Adult Community Mental Health Referral Line, 604 709-6785).

If financial considerations are not an issue, referral to a private provider for individual or group CBT is also an option. Here to Help, a project of the BC Partners for Mental Health and Addictions Information provides a referral list and patient education materials (www.heretohelp.bc.ca/publications/cbt/prog/1). Private psychiatrists and psychologists may also offer individual or group CBT. Patients should be encouraged to specify that they are seeking cognitive-behavioral therapy when calling private therapy providers.

Summary

Older adults with a range of mental health problems can benefit from cognitive-behavioral therapy. Empirical support exists for using CBT alone or in combination with appropriate medications for the treatment of depression and generalized anxiety disorder. The majority of CBT programs developed for older adults make adjustments to the standard manuals and recognize that the effectiveness of therapy may be limited in cases of comorbid personality disorder and active substance abuse. Health professionals in BC wishing to pursue training in cognitive-behavioral therapy can do so through the Changeways Clinic, the Vancouver CBT Centre, and individual health authorities. Patients seeking therapy can do so through various provincial health service programs and private providers.

Competing interests

None declared.

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