This book serves as an in-depth resource for health care practitioners and graduate-level students who provide mental health services to the geriatric population. Evidence-based and provider-friendly, it emphasizes adapting CBT specifically for older adults suffering from anxiety, depression, mood disorders, sexual dysfunction, and dementia.

This essential text discusses the epidemiology, diagnosis, assessment, and treatment of prevalent mental health issues among older adults. Chapter authors, who are leading experts in the field, identify useful assessment tools and proven strategies emphasizing the use of CBT. The book features discussions on current innovations in the use of CBT across various settings, including primary care, VA Health Care System, cognitive rehabilitation, palliative care, home-based interventions, and with varied clients, including the family caregiver.

Key Features:
- Enriched with case studies providing detailed strategies for implementing CBT into various care settings
- Incorporates practical tools such as the 5-Column Thought Record, a Pocket Card on Suicide Risk Assessment, and other clinical and educational tools
- Discusses new innovations in the use and integration of CBT, with neuropsychological functioning, prolonged exposure therapy with veterans, and depression care
- Provides cutting-edge discussions on the VA Health Care System as a major provider of mental health care to older veterans

It also includes a digital ancillary comprised of clinical and educational tools available online.
COGNITIVE BEHAVIOR THERAPY WITH OLDER ADULTS
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COGNITIVE BEHAVIOR THERAPY WITH OLDER ADULTS

Innovations Across Care Settings

Kristen Hilliard Sorocco, PhD
Sean Lauderdale, PhD
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This book contains an excellent selection of chapters designed to introduce the reader to the field of clinical gerontology: the application of psychological and developmental theories and practices to diagnosis and treatment of mental health problems of later life. This field is attracting more attention on the national level now that Medicare has recognized that mental health services can be given by various providers—such as licensed clinical social workers, licensed psychologists, clinical nurse practitioners, and board-certified psychiatrists—can be reimbursed. Until relatively recently, the lack of government-sponsored reimbursement was a significant barrier to older adults seeking care for their problems. Recent legislation has emphasized parity among providers of both standard health care and mental health care, so in the future, it is anticipated that more individual providers will become Medicare-eligible, and more older adults will take advantage of their mental health benefits under the law. Given this context, there is a substantial need for information about just what the common mental health problems of later life are, and what effective ways to treat them have been developed. In this book the editors have brought together, in one volume, chapters that address many of these needs.

Part I discusses the use of various forms of psychosocial interventions (emphasizing cognitive behavioral therapy, CBT) for treating common problems such as depression (both unipolar and bipolar), generalized anxiety disorder, and PTSD. The book is enriched by the inclusion of several other chapters that are not commonly found including a detailed discussion of how to assess suicidal risk in older adults, and how to use CBT to help the person become less suicidal. This is an innovative feature of this volume and one that has great relevance to clinical practice. The chapters in Part II discuss innovations in treating late-life mental health problems in a variety of settings, including primary care, hospice, and the patient’s home. An informative chapter on the VA Health Care System as a major provider of mental health care to older veterans is also included. As in the first section, the flexibility and breadth of application of CBT are emphasized, and the reader is
strongly encouraged to incorporate this approach into his/her every-
day practice—regardless of where it takes place.

Several other features of this book are worth noting: first, it is
clearly written and easy to follow; second, the chapters are written
by practitioners and clinical researchers from a variety of disciplines,
including nursing, social work, cognitive rehabilitation, and psychol-
ogy (which adds to the breadth and depth of topics being discussed);
third, each chapter includes clinical case examples that bring the infor-
mation “to life” and finally, various forms and other self-help tools are
included, making it easier for busy practitioners to incorporate these
methods into their practice.

In short, this book is strongly recommended as a textbook on the
graduate level in courses containing content on mental health and
aging. It provides a fine introduction to the field and gives a strong
overview of what is currently known—and not known—regarding
the disorders the editors chose to focus on. It definitely fills a gap in
the field at the present time. The writing is clear, and the information
is tremendously valuable for students from a wide variety of disci-
plines who are planning to develop a career in the mental health care
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Preface

This book was designed to be a one-stop shop for all practitioners of mental health disciplines, including nursing, medicine, psychology, and social work, who provide care to older adults. The contributing authors of this book represent various disciplines, including nursing, social work, and psychology, and bring expertise from various health care settings. The primary goal of the book is to provide an overview of cognitive behavioral therapy (CBT) and evidence-based practices specifically designed for older adults. The book begins with an introduction that provides an overview on CBT and adaptations that need to be made when working with older adults.

Following the Introduction, the book is divided into two parts. Part I focuses on the most prevalent mental health issues among older adults, including mood and anxiety disorders, dementia, and sexual dysfunction. Each of these chapters provides an overview on the epidemiology, diagnosis, and assessment procedures specific to the common mental health disorders among older adults. Useful assessment tools are identified, described, and guidelines for administration are highlighted. Evidence-based practices concerning the treatment of common mental health issues among older adults are reviewed, with a heavy emphasis on CBT.

Part II of this book highlights innovations in the use of CBT across health care settings such as primary care, cognitive rehabilitation, hospice and palliative care, home-based interventions, and the VA Health Care System. Implementation issues and necessary adaptations to CBT are discussed by the contributing authors. For example, the flexibility of CBT allows for briefer sessions in fast-paced clinics such as primary care, and tips for talking with medical providers are highlighted. Furthermore, the cognitive rehabilitation section discusses adaptations to CBT that need to be made based on the region of the brain impacted by a cognitive impairment. Insights provided are critical to the dissemination of evidence-based practices among the diverse settings that serve older adults.
Incorporated into each chapter are the following:

1. Case examples to illustrate how to implement cognitive–behavioral skills and therapies to treat common disorders; and
2. Tools to assist mental health providers to integrate cognitive–behavioral skills and therapies within various health care settings designed to address the needs of older adults.

Contributing authors have included practice friendly tools, such as a five-column thought record, a pocket card on suicide risk assessment with older adults, and an assessment note template for working with older adults in primary care. A complete toolkit, comprised of clinician and educational tools, can be copied from the Appendix sections of the book or can be downloaded with the code provided by the publisher to the buyer at the time of purchase.

The partnership for this book began when the editors were geropsychology interns at the Palo Alto Veterans Administration Health Care System. Drs. Lauderdale and Sorocco continued their collaboration following internship and co-lead the Aging Behavioral and Cognitive Therapy Special Interest Group within the Association for Behavioral and Cognitive Therapies. Being the editors, it is their hope that readers find this book a useful tool for both everyday practice as well as for training of future mental health care providers.
As the next generation of cognitive behavioral therapists working with older adults, there are many individuals who are responsible for getting us to this point in our careers. We would like to acknowledge our mentors, including Dolores Gallagher-Thompson, PhD; Gayle Iwamasa, PhD; David Freed, PhD; and Antonette Zeiss, PhD. The Association for Behavioral and Cognitive Therapies (ABCT) has provided us with a professional home throughout our career development, for which we are truly grateful. The guidance from our mentors and involvement in ABCT has led to our collaboration with the contributing authors. A special gratitude goes to our contributing authors for their time, dedication, and expertise, without whom this book would not be possible. We are truly honored to work with such a dedicated and inspiring group of clinicians, researchers, and educators.

We would like to express our sincere appreciation to Springer Publishing Company for the opportunity to provide the field with this innovative book. Without the perseverance and support of Sheri W. Sussman, Senior Vice President, Editorial, this book would not have been born. We’d like to recognize and thank Kristi Bratkovich, PhD, for assisting with the final submission of the book. The production editor and staff took our words and turned it into an amazing final product.

Major endeavors, such as this book, are only feasible with the support of institutions, colleagues, and families. We would like to thank our affiliated institutions and colleagues for the opportunity to engage in a work for which we truly have a passion. Our settings provide us with the opportunity to collaborate with and learn from older adults and their families, which in turn allows the field to grow. Finally, we’d like to express our appreciation to our families who have sacrificed their time with us, to enable us to dedicate the time necessary to complete this book. We also are grateful to our families for reminding us of the importance of finding balance between our personal and professional lives.
COGNITIVE BEHAVIOR THERAPY WITH OLDER ADULTS
Cognitive behavioral therapy (CBT) is a brief, structured psychotherapy that focuses on the key roles that cognitions and behaviors have in the onset and maintenance of mental illness. CBT has been shown to be effective in treating a wide range of mental disorders, including depression, anxiety, bipolar disorder, substance use disorders, eating disorders, insomnia, and personality disorders (e.g., Butler, Chapman, Forman, & Beck, 2006). In addition, recent research has also shown CBT to be efficacious in treating symptoms of schizophrenia (Beck & Rector, 2005), with additional research currently underway. CBT has also been shown to be at least as efficacious as medication for moderate-to-severe major depression (e.g., DeRubeis et al., 2005). For many patients, a combination of CBT and medication has shown to be more effective than either treatment alone (e.g., DeRubeis et al.). CBT has also been shown to have enduring effects that often far outlast the completion of treatment (e.g., Hollon, Stewart, & Strunk, 2006).

Over the last several decades, there has been significant research examining the efficacy of CBT with older adults, specifically. This research has consistently shown that CBT is efficacious with older individuals. Much of this research has focused on the use of CBT for treating depression in older adults (e.g., Pinquart & Sörensen, 2001; Scogin, Welsh, Hanson, Stump, & Coates, 2005), although there has been increasing research in recent years documenting the efficacy of CBT for the treatment of late-life anxiety (Barrowclough et al., 2001; Stanley et al., 2003), insomnia, and pain (Morin, Colecchi, Stone, Sood, & Brink, 1999; Vitiello, Rybarczyk, Von Korff, & Stepanski, 2009). In general, older adults can benefit from CBT to approximately the same degree as younger adults. Specific adaptations to the therapy strategies and process can maximize treatment gains with older clients, although the core ingredients of CBT remain the same when working with older adults. This chapter provides an overview of CBT, identifying the theoretical
foundations and core therapy processes and strategies, along with important considerations and modifications for adapting CBT to, and maximizing outcomes with, older clients. Particular emphasis is placed on the application of CBT for depression with older adults. Readers interested in a more detailed discussion of CBT for depression are referred to a therapist manual and specific protocol we have developed for veterans and military Servicemembers (Wenzel, Brown, & Karlin, 2011).

THEORETICAL FOUNDATIONS OF COGNITIVE BEHAVIORAL THERAPY

The backbone of CBT is the integration of cognitive theory and behavioral theory. According to cognitive theory, how we think about or interpret situations affect our mood and behaviors. It is our beliefs and perceptions of events—not the events themselves—that lead us to feel the way we do in a given situation (Beck, 1967). The notion that our thoughts or beliefs mediate the relationship between a situation (or “activating event”) and our emotional or behavioral response is often referred to as the “ABC” model, where “A” refers to activating event, “B” refers to the belief or interpretation of the activating event, and “C” refers to the consequent emotional, physiological, and/or behavioral response. This is presented diagrammatically in Figure 1.1.

Because it is the meaning that we ascribe to situations or encounters that contribute to how we feel about a situation, two people in the same situation may have different emotional reactions. For example, consider Elena and Fred who work on a team together in an advertising firm. Elena and Fred, 67 and 69 years of age, respectively, are employed as marketing consultants and recently completed a proposal for a new advertising campaign, which they submitted to their supervisor for review. After reviewing the proposal, their boss sent Elena and Fred an e-mail message stating, “This looks okay; let’s meet tomorrow to discuss some ideas further” (Activating event). In response to this message, Elena immediately had the thought, “She hates it; I can’t do this job, and others are starting to figure this out” (Belief). Consequently,

<table>
<thead>
<tr>
<th>Activating Event (Situation)</th>
<th>Belief (Thought/Interpretation)</th>
<th>Consequence (Emotional, Physiological, and/or Behavioral Response)</th>
</tr>
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</table>

**FIGURE 1.1** ABC Model
she feels great disappointment and dreads the meeting tomorrow, and the next day she calls in sick (Consequent emotion and behavior). The type of sudden, negative thought that Elena had in this example is called an “automatic thought” in CBT. An “automatic thought” is a sudden thought, often unrecognized by an individual, that leads to a negative emotional or behavioral response. Unlike Elena, however, Fred reacts to his boss’s e-mail message with the thought, “I’m glad she thinks this is a reasonable first draft; it would be good to discuss this further tomorrow” (Belief). This leaves him with feelings of contentment and curiosity (Consequent emotion).

What accounts for the different interpretations individuals may have to a common event, and why some individuals may have one or more automatic thoughts in response to a situation whereas another individual in the same situation will not? In the previous example, why is it that Elena had the interpretation that she did, whereas Fred had a much more neutral interpretation of the same e-mail message from their boss? According to cognitive theory, individuals develop cognitive schemas that affect how they evaluate and make meaning of internal and external stimuli. Schemas are influenced by experiences and help to organize the massive amount of incoming information with which individuals are presented and need to process. Schemas can be thought of as filters or lenses through which we perceive situations. Schemas serve a necessary organizing function for dealing with abundant amounts of information. However, some individuals may develop depressive or anxious schemas that lead to overly negative, pessimistic, or fearful views about oneself, the world, or the future. In essence, these individuals perceive incoming information through “colored” or distorted lenses. This distorted information processing may lead to overly extreme interpretations, as well as a tendency to focus on negative pieces of information and to minimize or ignore positive information.

Furthermore, schemas bring about core beliefs individuals have about themselves, the world, and the future. These core beliefs make up a central belief system of an individual. Core beliefs typically lay dormant in the background until activated by stressful and context-relevant events. When activated, the core belief(s) affect how events are interpreted and give rise to automatic thoughts that are consistent with them. Examples of negative core beliefs are “I am unlovable” and “I am unworthy.” These specific core beliefs and their associated schema are usually the result of early childhood experiences of abandonment, neglect, or severe criticism. Elena had the core belief, “I am incompetent”, related to years of being told and learning that she would and
could not accomplish tasks on her own and that she needed to be reliant on others for help. Earlier in her life, Elena was infrequently given the opportunity to engage in independent tasks, much like how her mother was treated by her father. Following from her core beliefs of incompetency, she interpreted her boss’s e-mail message to mean that she failed at her assignment.

Significantly, individuals often engage in specific compensatory strategies in an effort to help cope with the difficult core belief, although these attempts at coping ultimately serve to maintain and strengthen the core belief. Such compensatory strategies include behaviors that support the belief (maintaining behaviors), behaviors that try to invalidate the core belief (opposing behaviors), and behaviors that are designed to avoid activation of the core belief (avoidance behaviors). Elena displayed avoidance behavior by calling in sick the following day to avoid further activation of her core belief of incompetency. She also frequently avoided volunteering for assignments and preferred group tasks where she felt she could rely on the superior skills of others. Elena also has the core belief “People don’t like me.” To compensate, she often tries hard to please others, including not standing up for herself so that others will not dislike her.

Individuals who harbor maladaptive core beliefs and automatic thoughts are highly vulnerable to developing depressive and anxiety disorders. Conversely, depressed and anxious patients commonly harbor negative core beliefs and rigid and extreme automatic thoughts. Furthermore, individuals with depression tend to have an internal attributional style in which they excessively attribute blame to internal (versus external) factors. Cognitive behavioral therapists work closely with patients to develop more realistic and flexible thinking styles and information processing, including learning how to identify, challenge, and modify maladaptive automatic thoughts and core beliefs. This process is discussed in further detail later in this chapter in the section “Cognitive Strategies.”

The process of identifying and changing maladaptive cognitions and thinking patterns is only one core component of CBT. The other key focus in CBT is on changing maladaptive behaviors. According to Lewinsohn’s behavioral model of depression, depression is the result of limited meaningful engagement with, and response-contingent positive reinforcement from, the environment (Lewinsohn, Sullivan, & Grosscup, 1980). Individuals who are depressed often engage in few activities that provide a sense of pleasure and/or mastery. This leads to a vicious cycle, as the more depressed they become, the less they pursue enjoyable or rewarding activities and interactions, which further maintains and exacerbates depression and related symptoms.
Low rates of response-contingent positive reinforcement may be caused by few available positive reinforcers in an individual's environment, lack of skills to take advantage of positive reinforcers, or reduced strength of the positive reinforcers (Lewinsohn et al., 1980). Moreover, for some older individuals, late life can present particular challenges at one or more of these levels. As individuals age and their environments change, previously available reinforcers may no longer be available. For example, friends or relatives may relocate or pass away, physical surroundings may change, or health or physical status may mean that older adults can no longer engage in certain previously enjoyable activities, or at least not in the same way. For example, cognitive impairment caused by stroke or dementia may render previous hobbies like crossword puzzles or reading more difficult; they may also expose or inflame vulnerabilities the individuals were previously able to compensate for. These aging-related changes notwithstanding, older adults can derive significant meaning from their environment, and it is not normative for older individuals to lack any positive reinforcers. Rather, the key is adapting to changes one might experience in late life and incorporate what is meaningful into one's life to match the individual's present lifestyle.

Although the main focus of Lewinsohn's behavioral model of depression is on the lack of response-contingent positive reinforcement, it also provides that depression can result from a high rate of aversive experiences, such as when (a) there are many punishers in patients' lives, (b) patients lack coping skills for dealing with adversity, or (c) the impact of aversive events is heightened. Accordingly, another behavioral strategy in CBT is to help patients to develop effective problem-solving strategies and social skills to minimize the negative impact of and overcome adverse events. Loss and other changes relatively common in late life fit well with this component of Lewinsohn's model. That said, it is worth noting that many older adults develop significant coping abilities from their years of experience and wisdom that can be harnessed in CBT.

Behavioral theory also has an important role in accounting for and treating anxiety in CBT. Anxiety may result from experiencing an uncontrollable or unpredictable traumatic event, watching others having a traumatic experience or reacting with fear, or by learning from others that certain things are dangerous or should be avoided (Mineka & Zinbarg, 2006). Anxiety is maintained or exacerbated when individuals avoid thoughts or contact with stimuli associated with the anxiety. Not all individuals, however, develop an anxiety disorder after experiencing a traumatic life event. Genetic vulnerability, personality factors (e.g., neuroticism, inability to tolerate uncertainty), and environmental factors (e.g., early childhood environments with limited, previous
experiences with the feared stimulus) increase the risk of developing significant anxiety responses. Moreover, what follows a stressful or traumatic life event can influence the likelihood of subsequent onset of anxiety. Later experience of anxiety is more likely to occur when the individual is unable to escape the event, when the traumatic event is followed by another highly stressful or traumatic event shortly thereafter, when an individual learns after a highly stressful event that the event was more dangerous than he or she originally perceived it to be, and when an individual mentally rehearses the stressful or traumatic event (Mineka & Zinbarg).

In CBT, cognitive theory and behavioral theory are blended to provide a more sophisticated understanding of clients’ problems and to develop a comprehensive treatment approach than would be provided by singly focusing on each component separately. This integration of cognitive theory and behavioral theory forms the cognitive behavioral model. Beyond their individual effects, the interaction of cognitions and behaviors contributes significantly to the onset and maintenance of mental disorders. Thoughts affect behaviors and behaviors affect thoughts in a highly interactive and cyclical fashion. In this way, the integrated cognitive behavioral model is greater than the sum of its individual parts. For example, patients who are depressed often have cognitions, such as thoughts of self-doubt or pessimism, that contribute to behaviors (e.g., inactivity) that maintain and often exacerbate the depression by strengthening or confirming the very cognitions that led to the maladaptive behavior. In the case of Elena, who has long been battling depression, she has limited her involvement in activities that may activate, or be inconsistent with, her core belief of incompetence. This avoidance has also prevented her from disproving this belief and receiving satisfaction from engaging in activities of pleasure and mastery. Thus, it is essential to break the vicious thought–belief cycle. When individuals learn how to change extreme cognitions, they come to do things differently; and, when individuals do things differently (e.g., engage in rewarding activities), the self-defeating thoughts are weakened and new self-affirming thoughts and beliefs are strengthened. With depressed patients, particularly severely depressed patients, it is typically best to initially focus on instilling some behavior change, which may quickly provide some relief, increase energy, and instill confidence in the therapeutic process, before extensively working on changing entrenched thoughts with a particular client.

Before implementing CBT, it is essential for the therapist to recognize the constellation of (interacting) components that contribute to the individual’s current problems. This is done through the case
conceptualization process (Persons, 2006). Case conceptualization is an essential component of CBT, which is often not incorporated in purely psychoeducational and skills-based cognitive-behavioral approaches. Case conceptualization is often an especially important component of CBT when working with older clients because this can allow for aging-related factors (e.g., loss, physical decline, changes in appearance) that may play a contributing role in the onset or maintenance of psychological symptoms to be identified and addressed in therapy. For example, Elena’s thoughts of incompetence have been strengthened by recent health problems and occasional forgetfulness she experiences. These experiences, and her interpretations of these experiences, may be a focus of therapy.

In the case conceptualization process, therapists generate hypotheses about cognitive, emotional, behavioral, and situational factors, including early childhood experiences, as well as later-life experiences, that contribute to, maintain, and exacerbate a client’s problems. For example, early childhood experiences (e.g., parental divorce, abuse, neglect) may lead to the formation of particular core beliefs, as well as intermediate beliefs and compensatory strategies, that affect cognitive, emotional, and/or behavioral reactions to situations or circumstances in the patient’s present life. These hypotheses are generated by applying cognitive behavioral theory to an understanding of the patient obtained by the therapist through information gathered during an initial interview with the client and from other available sources. As new information is gathered over the course of treatment and specific hypotheses are validated or disconfirmed, the case conceptualization is modified accordingly. A diagram, such as the one presented in Figure 1.2, can be helpful for piecing together the components of the case conceptualization and for illustrating the relationships between key past events, core beliefs, intermediate beliefs (i.e., conditional rules and assumptions), and compensatory strategies as they relate to a specific client (Beck, 1995). The form also allows for identifying key situations, automatic thoughts and their associated meanings, emotions, and behaviors in a client’s current life that fit within the overarching conceptual framework.

MOTIVATIONAL ENHANCEMENT AND TREATMENT SOCIALIZATION

After the initial case conceptualization is developed, the therapist identifies specific cognitive and behavioral strategies to incorporate
Relevant Childhood Data

Core Belief(s)

Conditional Assumptions / Beliefs / Rules
Positive Assumption(s):
Negative Assumption(s):

Compensatory Strategies

Situation #1
Automatic Thought
Meaning of AT
Emotion
Behavior

Situation #2
Automatic Thought
Meaning of AT
Emotion
Behavior

Situation #3
Automatic Thought
Meaning of AT
Emotion
Behavior

FIGURE 1.2 Case Conceptualization Diagram
into treatment. However, before implementing these strategies, it is important to assess for and, if necessary, enhance motivation for treatment. This is especially important with older adults who infrequently use mental health services and are often especially unaccustomed to psychotherapy (Karlin & Duffy, 2004; Karlin, Duffy, & Gleaves, 2008). Further, some older clients may attend therapy for external reasons, such as persuasion by a child, spouse, or primary care physician. Accordingly, assessing older clients’ readiness to change is highly recommended at the outset of treatment.

To assess an older client’s motivation for therapy and readiness to change, it is important to inquire about the client’s reasons for seeking treatment, attitudes and expectations for therapy, past experiences in psychotherapy, and potential obstacles to attending and participating in treatment. Potential obstacles may include, but are not limited to, transportation factors, financial issues, lifestyle factors (e.g., disorganization, crises), and/or physical issues (e.g., decreased energy, sensory impairment, pain). The therapist should brainstorm with the client ways to overcome identified obstacles.

If an older client expresses limited motivation for therapy, nondirective motivational enhancement approaches, akin to motivational interviewing, are recommended. The goal of motivational enhancement is to help the client recognize through his or her own eyes how therapy may be relevant and useful to him or her. As part of the process, the therapist may ask the client to identify areas of his or her life that he or she would like to change and the benefits of participating in therapy to achieve those changes. The therapist then works with the client to develop specific measurable short-term goals. If a client remains ambivalent to participate in therapy, the therapist may consider suggesting a “trial,” whereby the client agrees to commit to a limited number of sessions, after which time the therapist and client agree to assess how treatment is going and whether therapy should continue. It is recommended that this be a minimum of four sessions to allow for sufficient exposure to the treatment.

Following the motivational enhancement process, the therapist should educate the client about the structure and process of CBT to ensure that the client has accurate expectations of his or her role and responsibilities in treatment, the therapist’s role and responsibilities in treatment, and of how treatment will proceed. Socializing clients to CBT is especially important with older individuals, given that older clients are often unfamiliar with the treatment. Moreover, the active, change-oriented focus of CBT may be different from more medically oriented interventions that older individuals are often more accustomed to, which typically assign a
more passive (sick) role to the patient. Older adults may also be unfamiliar with homework, which is a core component to CBT. Some older clients may also not identify with the concept of homework. With some older clients, it may be preferable to use the term “practice.”

Topics to cover in socializing the client to treatment include (a) structure, length, and frequency of sessions; (b) rationale for regular attendance, homework, and full participation; (c) goals of CBT and how they relate to the client’s goals and problems; (d) roles and responsibilities of the client and therapist; (e) research on the effectiveness of CBT; (f) personal experiences of the effectiveness of CBT with past (older) clients; and (g) the relationship between thoughts and emotions.

In the next section, specific cognitive and behavioral strategies in CBT are reviewed. However, before implementing cognitive or behavioral strategies, it is strongly recommended that therapists conduct a suicide risk assessment when working with older clients. This typically occurs as part of or immediately following the initial clinical interview. Suicide risk assessments should also be conducted, as needed, throughout therapy. Although a full discussion of the suicide risk assessment is beyond the scope of this chapter, clinicians should consider conducting a suicide risk assessment following a recent suicide attempt; report of new or increased severity or frequency of suicide ideation, intent, or plan; threat or other behavior indicating imminent risk; questionable impulse control; sudden positive or negative change in clinical presentation; no positive clinical change or worsening of symptoms during treatment; or a significant loss or other significant life stressor. Furthermore, a suicide risk assessment should be conducted when a client endorses a 1 or higher on the suicide item of the Beck Depression Inventory, or on a similar item of another clinical measure a client may routinely complete as part of treatment. Clinicians should also take into account risk and protective factors for suicide when conducting a suicide risk assessment. For clients for whom there is concern about imminent danger to them or others, appropriate actions and steps should be taken. These may include hospitalization, other treatment (possibly in addition to ongoing CBT), and/or the development of a safety plan (Stanley, Brown, Karlin, Kemp, & VonBergen, 2008).

Behavioral Strategies

Behavioral strategies in CBT for depression are designed to promote engagement in activities that provide pleasure and a sense of mastery. As mentioned earlier, a secondary benefit of such behavioral change is the impact that self-promoting behaviors have on cognitions, including
thoughts about oneself, the world, and the future. Given that depressed clients often have limited energy and become caught in the depressive thought–behavior cycle described earlier, behavioral strategies are often implemented before cognitive strategies to activate patients and engage them in treatment.

**Activity Monitoring**

Activity monitoring is a process by which the client monitors how he or she is making use of his or her time. Patients with depression often have a low baseline level of engagement in activities that provide them with sense of pleasure, meaning, or accomplishment. As part of activity monitoring, clients record the activities they engage in as they occur throughout the day. In addition to recording the activity, patients are also asked to rate the degree of pleasure (P) and mastery (M), each on a scale of 0 to 10, with 10 indicating maximal pleasure and mastery, as well as their overall mood for the day on a scale of 10 to 0 with 10 being the most depressed the client could imagine being, and 0 being not depressed at all. A form, such as the one included in Figure 1.3, is typically used for making these recordings throughout the week. (Note: An enlarged version of this form is recommended for use with older adults.)

Clients are asked to bring the completed activity monitoring form to the next session for review together with the therapist. It can be most effective to review the form sitting alongside the client. The therapist should use questions to guide discussion and enhance clients’ understanding of the types and frequency of activities they engage in and the association between their mood and their behaviors. This exercise can also help clients identify activities they enjoy, if they have engaged in enjoyable activities. It can be useful to ask clients “Were there times when you experienced pleasure?” or “What kinds of activities gave you pleasure?” Higher ratings of pleasure, mastery, and mood should be given greatest attention.

After reviewing her activity monitoring form, Elena made two key discoveries: (a) she spends a great deal of time sitting on the couch watching television (which she rated as providing very low levels of pleasure and mastery), and (b) when she goes out of the house, even just to sit on her front porch, she feels better.

**Activity Scheduling**

Baseline activity data gathered through the activity monitoring process can help to inform the next behavioral exercise—activity scheduling. Activity scheduling is a process by which the client and therapist work together in a structured manner to identify and schedule throughout the week specific activities that provide the client with a sense of pleasure.
### Activity Monitoring Form

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>7–8 am</td>
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### Overall mood

(0–10)

10 = Most depressed

**FIGURE 1.3** Activity Monitoring Form

*Note: For each time frame, use $P$ to indicate degree of pleasure and $M$ to indicate degree of mastery or accomplishment.*

$0 =$ No pleasure/No accomplishment; $10 =$ Greatest pleasure/Accomplishment
and/or accomplishment. Some such activities may have become apparent during the activity monitoring process. However, many depressed clients may have difficulty identifying pleasant or rewarding activities. This is sometimes even more common with older clients because it may have been some time since they have engaged in certain activities, and they may have few pleasant activities in their behavioral repertoire. If this is the case, the therapist can ask the client what he or she previously enjoyed when he or she was happier. In addition, activity checklists that list a wide range of activities that individuals may find enjoyable can be provided to clients. These checklists are often very useful and they do not rely on memory, which can be quite fallible and can often neglect very small behaviors (e.g., taking a bath, eating an ice cream cone) that can make a difference on one’s mood, especially highly depressed individuals who have not engaged in such activities for some time. One commonly used checklist of pleasant activities in CBT is the Pleasant Events Schedule (PES; MacPhillamy & Lewinsohn, 1982). An adapted version of the PES, known as the California Older Person's Pleasant Events Schedule (COPPES; Rider, Gallagher-Thompson, & Thompson, 2004), that includes more age-relevant activities for older individuals and takes less time to complete has been developed. The COPPES includes 66 age-appropriate and mood-related items, with activities organized into the following five domains: socializing, relaxing, contemplating, being effective, and doing. Examples of items on the COPPES are listening to the birds sing, helping someone, meditating, and working on a community project. The COPPES and accompanying manual can be downloaded free of charge at http://oafc.stanford.edu/coppes.html. In addition, a version of the PES for individuals with Alzheimer’s disease (Pleasant Events Schedule-AD) has also been developed (Teri & Logsdon, 1991). A version of the PE is also available for use with nursing home residents (Pleasant Events Schedule-NH; Meeks, Shah, & Ramsey, 2009).

When introducing activity checklists with older clients, it is recommended to complete a few items in session to begin the process stimulate interest on the part of the client. It can also provide an opportunity for the client to ask questions about the task or the rationale behind it.

Some older clients may not engage in previously enjoyable activities because of age-related changes (e.g., physical decline, sensory impairment) and, more specifically, what clients believe these changes mean. This author has experienced this relatively frequently in depressed older clients; in many cases, the no longer engaged-in activity involves an activity that was once quite meaningful to the client and may have been a significant part of their self-identity.
This author has developed the following 4-A approach (see Figure 1.4) for such situations (Karlin, 2008):

1. **Assess** types of activities in which the patient used to engage. Have the patient describe the experience in detail, and listen carefully to the patient’s description of the activity. Also watch for important nonverbal cues (e.g., tone, pace, and volume of speech; facial expressions; posture) that may indicate interest or pleasure.

2. **Acquire** information and knowledge about the patient’s physical functioning and medical condition.

3. **Assess** actual versus perceived level of physical ability relative to areas of interest. Some patients may have extreme or overly pessimistic beliefs about their abilities that are incongruent with their actual abilities, either because of lack of information or understanding or because of the negative cognitive bias of depression. For example, some patients may hold beliefs such as, “I don’t feel well enough to do anything,” “I’m too tired,” or “There’s no one left of my old friends to play cards or go out with” and subsequently fully abandon activities that they once enjoyed.

4. **Adapt** previously engaged-in pleasant activity to patient’s current level of functioning. After identifying one or more activities that previously provided significant meaning to the patient, the therapist, with creativity, can adapt the activity to fit the patient’s current life. In so doing, the therapist can enable the patient to reconnect with the meaning of the activity, even though the specific relationship with the activity may now be different. The overall goal is to identify the significant thematic area(s) for the client (e.g., baseball, gardening, teaching) and adapt the activity to fit the client’s current abilities, while staying within the same thematic area.

The 4-A approach was used very effectively with Robert, a 76-year-old homebound client who was in the moderate stage of Alzheimer’s disease and several other medical and physical conditions. Robert had significant difficulty in identifying activities that he found enjoyable.
He spent most of his hours and days sitting in his rocking chair in front of the television. On multiple occasions during previous sessions, Robert had made mention of his experiences growing up in New York (where this author/therapist author also grew up), and how he frequently went to the horse track and bet a few dollars on the thoroughbreds. His affect brightened and his voice became more robust as he would talk about the days visiting “the track.” Robert now lived in a highly suburban city in Utah where he had great difficulty getting around and had no access to a horse track. However, this therapist learned that his local newspaper published the list of horses to race that day at the major horse tracks, along with the results of the previous day’s races. After discovering this, Robert and I worked to develop an approximation of his previously enjoyable activity of going to the horse track in which Robert would select the horses he thought would win, which he would match up against the results in the next day’s newspaper. Robert found great pleasure (and often mastery) in this exercise. This also brought him positive anticipation as he looked forward to the race results in the newspaper the next day. Beyond the activity itself, it became apparent that this exercise harnessed meaning from his earlier life with which he was now more deeply connected.

Once the therapist and client have identified pleasant or meaningful activities, they begin the process of planning activities that the client commits to engage in during the week at specific times. An activity scheduling form is used to schedule specific activities on specific days and times. The activity scheduling form looks very similar to the activity monitoring form, although the activity scheduling form lists specific activities that the client commits to engage in during the coming week. Like the activity monitoring form, the activity scheduling form includes a place for the client to record his or her overall mood for the day on a scale of 10 to 0, with 10 being the most depressed the client could imagine being, and 0 being not depressed at all. For some older clients, it may be difficult to schedule every hour of their day. In these instances, a simplified version of the activity scheduling form may also be used. This may also be useful early on when beginning activity scheduling. An excerpt from a simplified activity scheduling form used with Elena is presented in Figure 1.5.

As clients implement the activity schedule, they continue to monitor their activities and mood. With their own behavioral data, they can usually come to quickly recognize a close relationship between the nature and frequency of activities they engage in and their mood. Therapists can use Socratic questioning to help clients see this relationship.
When beginning this process of activity scheduling with older clients, it is important to be specific and to start with activities that can be easily achieved. This can help to activate clients and build behavioral momentum and confidence. Furthermore, small activities (e.g., shaving, eating a good meal) can have a significant impact on depressed clients who may engage in few, if any, self-promoting or rewarding behaviors.

Behavioral activation is a simplified approach to activity scheduling that can be particularly useful with older clients, particularly older clients who are more significantly depressed or who are experiencing executive functioning difficulties. In behavioral activation, the client identifies one or two activities he or she believes may improve his or her mood within a short period. The therapist encourages the client’s participation in just the one or two activities, without adding additional activities or expectations. The goal is to get the client activated and break the chain of inactivity. Once initially activated in this manner, the client is usually more likely to carry out a more sophisticated behavioral plan.

Another specific behavioral technique that is often very useful with older clients with more significant levels of depression or with...
executive functioning or organizational difficulties is graded task assignment. Graded task assignment involves simplifying behavioral tasks into smaller component parts. Graded task assignment was used with Ruth, an 81-year-old widow who had suffered a stroke and was receiving CBT for major depression. Ruth felt overwhelmed by her depression and diminished cognitive ability resulting from the stroke. After talking with her therapist and completing the COPPES, she identified volunteering as something she wanted to engage in. Because Ruth was previously a nurse and teacher, this seemed like a good fit for her, but this seemed too overwhelming to make happen. Therefore, she and her therapist broke this down into more easily smaller tasks throughout the week: On Monday, Ruth would call the Jewish Community Center Volunteer Line to request a list of volunteer positions and the volunteer application; on Wednesday and Thursday, Ruth would review the list of volunteer activities and identify one or more activities of interest to her; on Friday, Ruth would complete the top portion (identifying information section) only of the application; on Saturday, she would complete the rest of the application.

Finally, behavioral anxiety management techniques can be very useful for promoting psychological and physical relaxation with older clients. Breathing exercises, including breathing retraining (use of diaphragmatic breathing) and meditative breathing, require little modification for use with older individuals. It is important, however, to assess for any breathing difficulty or related medical condition (e.g., severe asthma, chronic obstructive pulmonary disease) before beginning breathing exercises. Furthermore, clients should be instructed not to breathe too rapidly because this can lead to lightheadedness.

Progressive muscle relaxation (PMR), which involves the systematic tensing and relaxing of muscles throughout the body, is another effective anxiety management technique commonly used in CBT. However, PMR is not recommended for clients who have arthritis or physical pain (e.g., joint or knee pain). An alternative to traditional PMR for use with older clients is imaginal PMR, whereby the client imagines the tensing and relaxing of specific muscles, rather than physically engaging in the exercises. In fact, imaginal PMR has been shown to be as effective as traditional physical PMR (Crist & Rickard, 1993; Scogin, Rickard, Keith, Wilson, & McElreath, 1992).

Cognitive Strategies

Cognitive strategies in CBT focus directly on the “C” in CBT, although given the reciprocal relationship between cognitions and behaviors,
cognitive strategies can also help promote behavioral change, especially when cognitions impede self-promoting behaviors. Cognitive interventions are designed to promote more accurate and flexible information processing through a process of “cognitive restructuring,” or the restructuring or changing of rigid and extreme thoughts and beliefs.

**Recognizing Automatic Thoughts**

Cognitive work in CBT typically begins with helping the patient to recognize the link between his or her thoughts and emotions, behaviors, and physiological responses (the “A–B–C” relationship discussed in the section “Theoretical Foundations of CBT” earlier in this chapter). This key principle is often very new to older clients. Imagery exercises can be used to help demonstrate this relationship. This author will often ask clients to first think of an unpleasant event in their life and then to report their emotion(s) and the intensity thereof. Next, clients are asked to replace the thoughts of the unpleasant event by thinking about a very happy or pleasant time in their life and to report the emotions that they feel at that moment. This exercise is often a powerful demonstration of the impact of thoughts. After introducing the relationship between thoughts and emotions, the therapist typically educates the client about automatic thoughts. The therapist typically asks clients to describe situations where there was an identifiable shift in mood. As clients provide this description, the therapist uses questioning to identify the cognitions at work. This process of using questioning to promote understanding is known as “guided discovery.” A question the therapist might ask the client to help identify the automatic thought(s) is, “What was running through your mind just then?” If the patient has difficulty identifying the thought, the therapist may help to guide the client by asking, “Might you have been thinking _______ or _______?”

After learning about automatic thoughts and their role in producing emotions, clients are then introduced to the three-column thought record for recording the emotion (and intensity on a 0 to 100 scale), the related thought, and the specific situation or event that immediately precipitated the shift in emotion. The three-column thought record is displayed in Figure 1.6.

It is recommended that the therapist begin completing the three-column thought record in session with older clients to ensure understanding and get the process started. Events from that day or earlier in the week can be used for the initial entries. With some older clients, it can be helpful for the therapist to record the first couple of entries, sitting alongside the client with the thought record in hand. If the client comprehends the exercise and is agreeable, the client can be asked to
monitor his or her thoughts and complete the three-column thought record as practice between sessions.

_Evaluating and Changing Automatic Thoughts_

Socratic questioning is the core skill employed by the therapist in helping clients to evaluate their automatic thoughts. Specifically, the therapist asks questions that enable accurate and more complete examination of the thought and the situation. However, with older clients in particular, it is important not to directly challenge the validity of the thought or to take a highly directive stance in the evaluation process because this may feel insulting, disrespectful, or dismissing. Further, the more the client draws the conclusion, the more likely it is that he or she is going to believe in it. Thus, rather than serve as a teacher, the therapist’s role here is to serve as a _guide_, helping the client to engage in the necessary process to perform his or her own examination. Specific questions the therapist can ask to help the client examine his or her automatic thoughts are the following:

- What evidence supports that thought? What evidence does not support that thought?
- Could there be any other explanations of the situation?
- If the worst thing were to happen, how bad would that be?
- What would you tell a friend if he or she were in the same situation?

Additional questions can be found in Beck (1995).
An extension of the three-column thought record is used to help clients evaluate their thoughts. This is known as the five-column thought record. The five-column thought record adds two additional columns to its more basic three-column counterpart. In addition to situation, emotion, and thought, the five-column thought record has a column for clients to record an alternative response to the situation after evaluating the automatic thought. In the fifth column, clients record the outcome resulting from the alternative response (e.g., reduction in intensity of initial emotion, new emotion, new behavioral response). The outcome could also be an adaptive behavioral response that the patient initiates because of the more balanced alternative response. An example of the five-column thought record is presented in Figure 1.7.

With repeated practice, clients become increasingly more adept at identifying, challenging, and changing their automatic thoughts. As they see the rigidity or bias in their automatic thoughts and develop more balanced responses, they come to experience important emotional changes. In some instances, clients may develop reasonable alternative responses that do not lead to a reduction or change in the emotional

<table>
<thead>
<tr>
<th>Date</th>
<th>Situation</th>
<th>Emotion</th>
<th>Thought</th>
<th>Alternative Response</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What event led to a shift in emotion?</td>
<td>What emotion(s) did you experience? (Rate intensity on a 0–100 scale)</td>
<td>What thoughts or images ran through your mind? What did the situation mean to you?</td>
<td>Use the questions to evaluate the automatic thought and construct a more balanced thought.</td>
<td>Re-rate the intensity of the emotion you listed in column 2 or list a new emotion you are experiencing. Describe what you will do differently as a result of the alternative response.</td>
</tr>
</tbody>
</table>

**FIGURE 1.7 Five-Column Thought Record**
response. This may be because the client does not truly believe the alternative response or because there are other more significant automatic thoughts that are not identified and evaluated.

**Coping Cards**

Use of coping cards is another technique for challenging and changing automatic thoughts. The coping card can be a very useful supplement to the five-column thought record or as an alternative tool for older clients who may have difficulty learning or regularly using the five-column thought record. Coping cards are often better suited and are recommended for older clients with some degree of cognitive impairment or who prefer more simplified approaches. Coping cards capitalize on recognition memory, which is typically more enduring than recall memory. A coping card consists of an index card or similar card in which a common automatic thought (or core belief, which can also be used for challenging) for a particular client is written on one side and an alternative response is placed on the opposite side of the card. Coping cards are simple and concrete, and they have the advantage of being easy to carry around and can be accessed in any situation. Moreover, in addition to their use for facilitating cognitive restructuring, coping cards can also be used for listing or providing reminders of behavioral coping strategies that older clients can engage in for managing specific situations or experiences.

**Core Belief Identification and Modification**

In addition to identifying and changing automatic thoughts, cognitive behavioral therapists can also work with older clients to identify and change core beliefs. This typically occurs later in therapy, after the therapist has developed a case conceptualization and cognitive restructuring at the level of automatic thoughts has progressed. Although a detailed examination of core belief modification is beyond the scope of this chapter, a brief review of how therapists can identify and change core beliefs is provided here.

Core beliefs are often identified during Socratic questioning during discussion of situations of acute stress when core beliefs are typically activated from their dormant state. Therapists may begin to make hypotheses about possible types of core beliefs as clients describe critical negative events in their lives and their reactions to these experiences. Therapists may solicit feedback on these hypotheses at appropriate opportunities. It is often best to do this when the core belief is most accessible—that is, when the emotional experience is being discussed or occurs in session. In such situations, core beliefs may also be articulated as automatic thoughts. Other means of identifying
core beliefs include, but are not limited to, identifying themes across automatic thoughts or core beliefs, completing a core belief questionnaire, and employing the downward arrow technique (Burns, 1999), whereby therapist repeatedly asks the client, “What does this mean to you?” (or similar question). This occurs following identification of a key automatic thought. A key time to use this technique is when the severity of the emotional reaction on the part of the client does not fit with the content of the automatic thought. This typically suggests that there may be more than the automatic thought itself that is contributing to the client’s reaction.

Once identified, a core belief may be selected for focusing on during therapy. Often, the therapist and client begin working on the client’s most strongly held or central core belief. A core beliefs worksheet or thought record may be used to evaluate the thought similar to how automatic thoughts are evaluated (Beck, 1995). Therapists may also put the core belief down on paper and use Socratic questioning to evaluate the validity of the belief. This may also include continuous shaping of the core belief until it changes its meaning. This chipping away at core beliefs is often more likely than is clients fully letting go of them, given their enduring and formative nature. However, sometimes, just the act of separating the core belief from the client, with whom it has long been fused, so that the client can more objectively visualize and consider it can yield progress.

Adjustments to the Therapy Process With Older Clients

In addition to important considerations in and adaptations to the implementation of cognitive and behavioral strategies already identified, there are several adjustments to the therapy process that can maximize engagement and CBT outcomes when working with older clients. These adjustments are summarized as follows:

1. **Slow general pace.** Because of the reduction in the speed of information processing and increased reaction time with aging, it is often useful to slow the general pace of therapy with older clients.

2. **Speak slower and clearly.** Because of the changes in auditory perception with aging, it is important that the therapist speak slowly (though naturally) and that the pronunciation be clear, so that older clients do not miss or misinterpret information conveyed by the therapist. Moreover, many older adults may consider it to be impolite or may be embarrassed to ask the therapist to speak louder or more clearly.
3. **Use multiple modalities (“say it, write it, show it”).** It is often very useful to present material in multiple modalities to older clients to facilitate and reinforce learning. Using a white board or flip chart and printed materials with large print can be helpful.

4. **Incorporate greater structure, as appropriate.** Incorporating greater structure can be very useful with some older clients. This includes writing down the session agenda on a white board or flip chart and notating as the session progresses where on the agenda the therapist and client are. This can be helpful in keeping the client in parallel with the therapist.

5. **Minimize “storytelling” and redirect.** Some older clients may think of therapy as being their time to discuss whatever is on their mind. Providing visual and verbal cues and redirecting clients, as necessary, can help keep the client focused on the session content and goals.

6. **Encourage note taking by the client, if desired.** Note taking may help the client to remember key information from session, although excessive note taking can be counterproductive.

7. **Provide examples and role-play demonstrations when appropriate.** Examples and role-play demonstrations can help make concrete and more easily understandable new or more complex topics and principles. Examples and role-play demonstrations can also be valuable prior to homework or practice exercises outside of session that the client will be engaging in for the first time.

8. **Begin homework or practice in session.** Beginning practice or homework in session allows the client the opportunity to ask additional questions and enables the therapist to see if the client understands the task or exercise.

9. **Provide and elicit more summaries.** Therapist summary statements can help older clients make important connections in session and can reinforce or promote deeper learning. Periodically requesting summaries from older clients can also be valuable for seeing what clients have understood or interpreted from the discussion. This can provide valuable feedback to the therapist to slow down or present information in a different way.

10. **Provide a folder or binder for organizing notes and materials.** If the client does not have access to one, it is recommended to provide a folder or binder to promote organization.

11. **Regularly incorporate bridge from previous session and assist client with this, if necessary.** The bridge from the previous session is a standard part of the CBT session structure, in which the therapist asks the client what he or she learned from or found especially helpful about the previous session. The goal is to link sessions to ensure...
seamless flow and continuity. This is an especially useful exercise with older clients. Questions that the therapist may ask include, “What did we cover in the previous session that you found helpful?” or “What stood out for you about our last session?” If the client has difficulty recalling content or discoveries from the previous session, the therapist may help the client by mentioning two key pieces of information from the previous session and asking the client which, if any, he or she found helpful.

12. **Lengthen course of therapy.** Slowing the pace of therapy, increasing the use of multiple modalities, and incorporating more summaries often necessitate that therapy be extended by a few extra sessions for the full therapy protocol to be implemented. This also allows for some time for review of gains and information covered at the end of therapy. Furthermore, as noted earlier, it may sometimes be beneficial to shorten the length of therapy sessions. When this occurs, there may not be sufficient time to cover all material in each individual session.

### Therapeutic Relationship

The therapeutic relationship is a critical, and sometimes underrecognized, component of CBT. The strength of the therapeutic relationship moderates the success of cognitive and behavioral strategies used with clients. In this author’s experience, without a truly collaborative therapeutic relationship, cognitive and behavioral strategies will virtually always fall flat. This is especially true with older clients for whom CBT is often very new and unfamiliar and who often value respect. Therefore, CBT therapists should devote important attention to developing (and maintaining) a strong therapeutic relationship with older clients. At the outset of therapy with older clients, it is important to show respect and empathy and to listen carefully and actively. It can also be beneficial early on to demonstrate competence and expertise on aging issues, which can often increase older clients’ confidence in and identification with the therapist.

Furthermore, attention to “transference” and “countertransference” issues is important in establishing and maintaining a collaborative and productive relationship with older clients. Older clients may knowingly or unknowingly associate a younger therapist with a child or grandchild, which could undermine the authority of the therapist and inhibit progress of the client inside or outside of session. Converely, younger therapists may implicitly or explicitly behave toward older clients as they would toward a grandparent or older relative.
This may include being overly passive or providing too little structure or direction to the therapy process. Therefore, it is important for therapists to be attuned to how they and their clients perceive and behave toward each other during the course of therapy. Scogin (2000) provides additional suggestions and information on developing the therapeutic alliance with older adults.

To assess the strength of the therapeutic relationship, the therapist may take note of relevant, nonverbal cues (e.g., posture, speech, level of attention), although we find that often the most useful way to assess the strength or degree of collaboration of the therapeutic alliance is to inquire about it. One way to do this is by administering a measure of the therapeutic relationship. This is often especially useful with older clients who initially may feel more comfortable reporting on the therapeutic relationship by completing a questionnaire. A brief measure that we recommend incorporating as part of CBT for depression and have included in our CBT for depression protocol (Wenzel et al., 2010) for administration at the end of sessions 1, 4, 7, and 11 is the Working Alliance Inventory–Short Revised (WAI-SR; Hatcher & Gillaspy, 2006), an abbreviated version of the Working Alliance Inventory (Horvath & Greenberg, 1989). The WAI-SR contains 12 items that measures (a) agreement on the treatment goals, (b) agreement on how to achieve the goals, and (c) development of a personal bond between patient and the therapist. After the client completes the WAI-SR (or similar measure), the therapist can review and briefly discuss the client’s responses, if the client agrees. Clients usually find the structure of a brief therapeutic alliance measure helpful for organizing discussion on the therapeutic relationship and, more generally, on how therapy is going. In our experience, this feedback provides very useful information on how the client is perceiving therapy and on whether any midcourse adjustments may need to be made. Moreover, the solicitation of feedback sends the message to clients that the therapist cares about and values their feedback.

Special Issues With Termination

Finally, there are important issues and considerations that CBT therapists should be aware of with respect to terminating therapy with older clients. In light of the role that loss often plays in late life, it is important for therapists to attend to the meaning that loss of the therapist may have to the client. Asking clients whether they have thought about what it will be like (or, directly, what it means) for
therapy and regular meetings to end can help provide the therapist with insight along these lines. Furthermore, some older adults give themselves less credit for changes in therapy than they deserve. Therefore, reinforcing attributions that the client is the agent of change and that self-change can and will continue after termination of the therapy can help to promote confidence and internal locus of control.

Lastly, tapering of therapy sessions so that sessions occur less frequently toward the end of therapy may help clients adjust to termination. “Booster” sessions (i.e., one or few sessions scheduled some time, often 3 to 6 months, following the termination of therapy) are also often valuable with older clients because they provide an opportunity for the therapist and client to discuss how the client is doing at a later time and to review how therapy skills that the client used may be used to address or to head off to new or reemerging issues. Booster sessions can also provide the older client with something to look forward to at the time of termination of therapy. Of course, clients should be encouraged to call the therapist (or take other appropriate action) if the client’s condition should worsen and additional treatment is needed.

CONCLUSION

CBT is an effective psychotherapy for late-life depression. The theoretical and applied components of CBT are often very well suited to depressed older individuals. In light of mounting evidence demonstrating CBT to be effective for late-life mental health and behavioral health conditions beyond depression, and increases in the accessibility of psychotherapy in the years ahead because of forthcoming changes in Medicare and private insurance (Karlin & Humphreys, 2007), CBT very well may soon be an increasingly prominent psychological treatment for older adults. Although CBT with older adults works in much the same way as it does with younger individuals, specific considerations and adaptations to CBT strategies and the therapy process with older clients can significantly enhance engagement, adherence, and outcomes.

Finally, for CBT clinicians who practice with older adults, the experience is often extremely rewarding. Older adults have extensive experience, personal resources, and wisdom to draw on that can make CBT a very dynamic, creative, and meaningful experience for therapist and client alike.
REFERENCES


