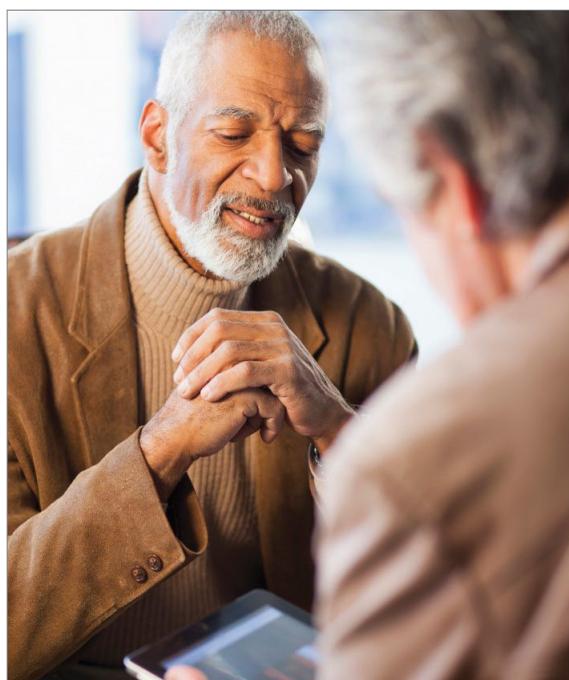


## How to adapt cognitive-behavioral therapy for older adults



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### To improve efficacy, focus on losses, transitions, and changes in cognition

Some older patients with depression, anxiety, or insomnia may be reluctant to turn to pharmacotherapy and may prefer psychotherapeutic treatments.<sup>1</sup> Evidence has established cognitive-behavioral therapy (CBT) as an effective intervention for several psychiatric disorders and CBT should be considered when treating geriatric patients (*Table 1*).<sup>2</sup>

Research evaluating the efficacy of CBT for depression in older adults was first published in the early 1980s. Since then, research and application of CBT with older adults has expanded to include other psychiatric disorders and researchers have suggested changes to increase the efficacy of CBT for these patients. This article provides:

- an overview of CBT's efficacy for older adults with depression, anxiety, and insomnia
- modifications to employ when providing CBT to older patients.

### The cognitive model of CBT

In the 1970s, Aaron T. Beck, MD, developed CBT while working with depressed patients. Beck's patients reported thoughts characterized by inaccuracies and distortions in association with their depressed mood. He found these thoughts could be brought to the patient's conscious attention and modified to improve the patient's depression. This finding led to the development of CBT.

CBT is based on a cognitive model of the relationship among cognition, emotion, and behavior. Mood and behavior are viewed as determined by a person's perception and interpretation of events, which manifest as a stream of

automatically generated thoughts (Figure, page 12).<sup>3</sup> These automatic thoughts have their origins in an underlying network of beliefs or schema. Patients with psychiatric disorders such as anxiety and depression typically have frequent automatic thoughts that characteristically lack validity because they arise from dysfunctional beliefs. The therapeutic process consists of helping the patient become aware of his or her internal stream of thoughts when distressed, and to identify and modify the dysfunctional thoughts. Behavioral techniques are used to bring about functional changes in behavior, regulate emotion, and help the cognitive restructuring process. Modifying the patient's underlying dysfunctional beliefs leads to lasting improvements. In this structured therapy, the therapist and patient work collaboratively to use an approach that features reality testing and experimentation.<sup>4</sup>

### Indications for CBT in older adults

**Depression.** Among psychotherapies used in older adults, CBT has received the most research for late-life depression.<sup>5</sup> Randomized controlled trials (RCTs) have found CBT is superior to treatment as usual in depressed adults age ≥60.<sup>6</sup> It also has been found to be superior to wait-list control<sup>7</sup> and talking as control.<sup>6,8</sup> Meta-analyses have shown above-average effect sizes for CBT in treating late-life depression.<sup>9,10</sup> A follow-up study found improvement was maintained up to 2 years after CBT, which suggests CBT's impact is likely to be long lasting.<sup>11</sup>

Thompson et al<sup>12</sup> compared 102 depressed patients age >60 who were treated with CBT alone, desipramine alone, or a combination of the 2. A combination of medication and CBT worked best for severely depressed patients; CBT alone or a combination of CBT and medication worked best for moderately depressed patients.

CBT is an option when treating depressed medically ill older adults. Research indicates that CBT could reduce depression in older patients with Parkinson's disease<sup>13</sup> and chronic obstructive pulmonary disease.<sup>14</sup>

Table 1

### Indications for CBT

Mild to moderate depression. In the case of severe depression, CBT can be combined with pharmacotherapy

Anxiety disorders, mixed anxiety states

Insomnia—both primary and comorbid with other medical and/or psychiatric conditions

CBT: cognitive-behavioral therapy

As patients get older, cognitive impairment with comorbid depression can make treatment challenging. Limited research suggests CBT applied in a modified format that involves caregivers and uses problem solving and behavioral strategies can significantly reduce depression in patients with dementia.<sup>15</sup>

**Anxiety.** Researchers have examined the efficacy of variants of CBT in treating older adults with anxiety disorders—commonly, generalized anxiety disorder (GAD), panic disorder, agoraphobia, subjective anxiety, or a combination of these illnesses.<sup>16,17</sup> Randomized trials have supported CBT's efficacy for older patients with GAD and mixed anxiety states; gains made in CBT were maintained over a 1-year follow-up.<sup>18,19</sup> In a meta-analysis of 15 studies using cognitive and behavioral methods of treating anxiety in older patients, Nordhus and Pallesen<sup>16</sup> reported a significant effect size of 0.55. In a 2008 meta-analysis that included only RCTs, CBT was superior to wait-list conditions as well as active control conditions in treating anxious older patients.<sup>20</sup>

However, some research suggests that CBT for GAD may not be as effective for older adults as it is for younger adults. In a study of CBT for GAD in older adults, Stanley et al<sup>19</sup> reported smaller effect sizes compared with CBT for younger adults. Researchers have found relatively few differences between CBT and comparison conditions—supportive psychotherapy or active control conditions—in treating GAD in older adults.<sup>21</sup> Modified, more effective formats of CBT for GAD in older adults need to be established.<sup>22</sup> Mohlman

### Clinical Point

For depressed older adults, RCTs have found CBT is superior to treatment as usual, wait-list control, and talking as control



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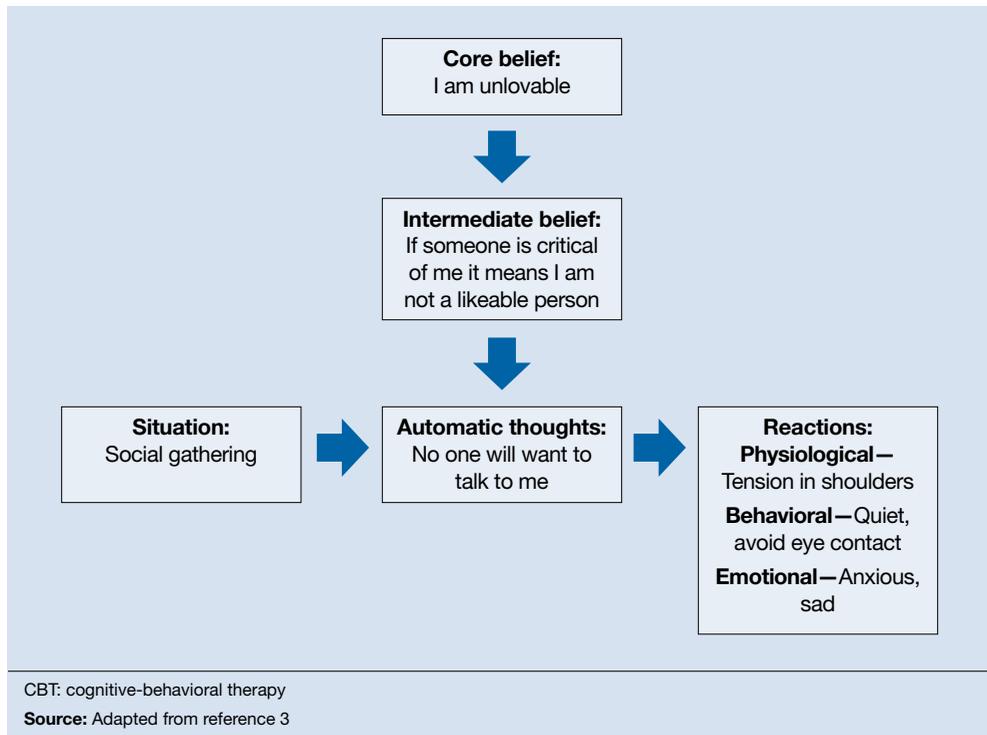


## CBT for older adults

### Clinical Point

Adding memory and learning aids to CBT for anxious older patients may improve the response rate

**Figure**  
**The cognitive model of CBT**



et al<sup>23</sup> supplemented standard CBT for late-life GAD with memory and learning aids—weekly reading assignments, graphing exercises to chart mood ratings, reminder phone calls from therapists, and homework compliance requirement. This approach improved the response rate from 40% to 75%.<sup>23</sup>

**Insomnia.** Studies have found CBT to be an effective means of treating insomnia in geriatric patients. Although sleep problems occur more frequently among older patients, only 15% of chronic insomnia patients receive treatment; psychotherapy rarely is used.<sup>24</sup> CBT for insomnia (CBT-I) should be considered for older adults because managing insomnia with medications may be problematic and these patients may prefer nonpharmacologic treatment.<sup>2</sup> CBT-I typically incorporates cognitive strategies with established behavioral techniques, including sleep hygiene education, cognitive restructuring, relaxation training, stimulus control, and/or sleep restriction. The CBT-I multicomponent treatment package meets all criteria to be considered an evidence-based

treatment for late-life insomnia.<sup>25</sup>

RCTs have reported significant improvements in late-life insomnia with CBT-I.<sup>26,27</sup> Reviews and meta-analyses have also concluded that cognitive-behavioral treatments are effective for treating insomnia in older adults.<sup>25,28</sup> Most insomnia cases in geriatric patients are reported to occur secondary to other medical or psychiatric conditions that are judged as causing the insomnia.<sup>25</sup> In these cases, direct treatment of the insomnia usually is delayed or omitted.<sup>28</sup> Studies evaluating the efficacy of CBT packages for treating insomnia occurring in conjunction with other medical or psychiatric illnesses have reported significant improvement of insomnia.<sup>28,29</sup> Because insomnia frequently occurs in older patients with medical illnesses and psychiatric disorders, CBT-I could be beneficial for such patients.

### Good candidates for CBT

Clinical experience indicates that older adults in relatively good health with no significant cognitive decline are good can-

didates for CBT. These patients tend to comply with their assignments, are interested in applying the learned strategies, and are motivated to read self-help books. CBT's structured, goal-oriented approach makes it a short-term treatment, which makes it cost effective. Insomnia patients may improve after 6 to 8 CBT-I sessions and patients with anxiety or depression may need to undergo 15 to 20 CBT sessions. Patients age  $\geq 65$  have basic Medicare coverage that includes mental health care and psychotherapy.

There are no absolute contraindications for CBT, but the greater the cognitive impairment, the less the patient will benefit from CBT (Table 2). Similarly, severe depression and anxiety might make it difficult for patients to participate meaningfully, although CBT may be incorporated gradually as patients improve with medication. Severe medical illnesses and sensory losses such as visual and hearing loss would make it difficult to carry out CBT effectively.

### Adapting CBT for older patients

When using CBT with older patients, it is important to keep in mind characteristics that define the geriatric population. Laidlaw et al<sup>30</sup> developed a model to help clinicians develop a more appropriate conceptualization of older patients that focuses on significant events and related cognitions associated with physical health, changes in role investments, and interactions with younger generations. It emphasizes the need to explore beliefs about aging viewed through each patient's socio-cultural lens and examine cognitions in the context of the time period in which the individual has lived.

**Losses and transitions.** For many older patients, the latter years of life are characterized by losses and transitions.<sup>31</sup> According to Thompson,<sup>31</sup> these losses and transitions can trigger thoughts of missed opportunities or unresolved relationships and reflection on unachieved goals.<sup>31</sup> CBT for older adults should focus on the meaning the patient gives to these losses and

Table 2

### Contraindications for CBT

High levels of cognitive impairment
Severe depression with psychotic features
Severe anxiety with high levels of agitation
Severe medical illness
Sensory losses
CBT: cognitive-behavioral therapy

transitions. For example, depressed patients could view their retirement as a loss of self worth as they become less productive. CBT can help patients identify ways of thinking about the situation that will enable them to adapt to these losses and transitions.

**Changes in cognition.** Changes in cognitive functioning with aging are not universal and there's considerable variability, but it's important to make appropriate adaptations when needed. Patients may experience a decline in cognitive speed, working memory, selective attention, and fluid intelligence. This would require that information be presented slowly, with frequent repetitions and summaries. Also, it might be helpful to present information in alternate ways and to encourage patients to take notes during sessions. To accommodate for a decline in fluid intelligence, presenting new information in the context of previous experiences will help promote learning. Recordings of important information and conclusions from cognitive restructuring that patients can listen to between sessions could serve as helpful reminders that will help patients progress. Phone prompts or alarms can remind patients to carry out certain therapeutic measures, such as breathing exercises. Caretakers can attend sessions to become familiar with strategies performed during CBT and act as a co-therapist at home; however, their inclusion must be done with the consent of both parties and only if it's viewed as necessary for the patient's progress.

**Additional strategies.** For patients with substantial cognitive decline, cognitive

### Clinical Point

Older patients tend to complete CBT assignments, and are interested in applying the learned strategies



## CBT for older adults

### Clinical Point

CBT for older adults should focus on the meaning of losses and transitions in the patient's life

### Related Resources

- Academy of Cognitive Therapy. [www.academyofct.org](http://www.academyofct.org).
- American Psychological Association. [www.apa.org](http://www.apa.org).
- Association for Behavioral and Cognitive Therapies. [www.abct.org](http://www.abct.org).
- Laidlaw K, Thompson LW, Dick-Siskin L, et al. Cognitive behaviour therapy with older people. West Sussex, England: John Wiley & Sons, Ltd; 2003.

### Drug Brand Name

Desipramine • Norpramin

### Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

restructuring might not be as effective as behavioral strategies—activity scheduling, graded task assignment, graded exposure, and rehearsals. Because older adults often have strengthened dysfunctional beliefs over a long time, modifying them takes longer, which is why the tapering process usually takes longer for older patients than for younger patients. The lengthier tapering ensures learning is well established and the process of modifying dysfunctional beliefs to functional beliefs continues. Collaborating with other professionals—physicians, social workers, and case managers—will help ensure a shared care process in which common goals are met.

The websites of the Academy of Cognitive Therapy, American Psychological Association, and Association for Behavioral and Cognitive Therapies can help clinicians who do not offer CBT to locate a qualified therapist for their patients (*Related Resources*).

## Bottom Line

Cognitive-behavioral therapy (CBT) is an efficacious, enduring treatment for late-life depression. CBT also is considered effective for older patients with anxiety disorders, although research is limited. CBT is a beneficial and effective treatment for insomnia. Modifying CBT to focus on the meaning of losses and transition and accommodating cognitive decline is likely to improve efficacy.

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# This month's instantpoll

Mr. W, age 78, describes low mood, insomnia, and lack of energy. He is no longer interested in his woodworking hobby. His depressive symptoms began after his wife died a year ago. Mr. W denies suicidal ideations, but reports memory impairment. **How would you treat him?**

- Prescribe a selective serotonin reuptake inhibitor (SSRI) and a hypnotic
- Prescribe an SSRI and begin cognitive-behavioral therapy (CBT) focusing on the loss of his wife
- Begin CBT for insomnia
- Refer Mr. W for a comprehensive neurologic examination to rule out dementia

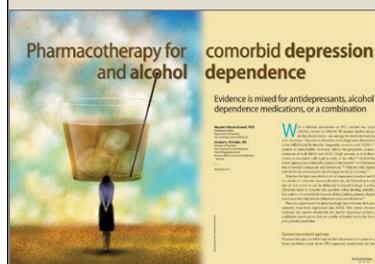
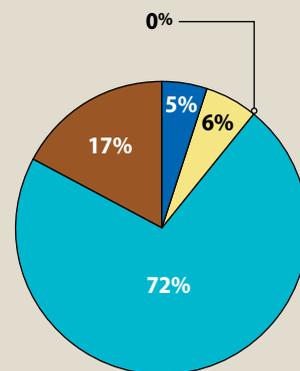
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Visit **CurrentPsychiatry.com** to answer the **Instant Poll** and see how your colleagues responded. Click on **"Have more to say?"** to comment.

## JANUARY POLL RESULTS

Ms. G, age 42, presents with feelings of worthlessness, difficulty concentrating, and fatigue; she's had these symptoms for the last 6 months. She also meets DSM-IV-TR criteria for alcohol dependence, stopped drinking 10 days ago, and craves alcohol. **How would you treat her?**

- 5%** Prescribe fluoxetine, 20 mg/d
- 6%** Start disulfiram, 250 mg/d
- 0%** Prescribe amitriptyline, 75 mg/d
- 72%** Start sertraline, 50 mg/d, and naltrexone, 50 mg/d
- 17%** Refer Ms. G for inpatient alcohol detoxification



**SUGGESTED READING:**  
Gianoli MO, Petrakis IL.  
*Current Psychiatry.*  
2013;12(1):24-32.