COGNITIVE-BEHAVIORAL THERAPY

FOR LATE-LIFE DEPRESSION:

A THERAPIST MANUAL

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We have borrowed concepts and techniques liberally from our teachers, Aaron T. Beck, MD and Peter Lewinsohn, Ph.D. and many other cognitive/behavioral therapists too numerous to mention in the development of this manual. We encourage others who might find these materials useful to feel free to duplicate or modify them as they see fit. We ask that if the use of these materials contributes in some manner to subsequent publications, acknowledgment should be made by including the following citations:


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We wish to thank all of the clients and patients of the Older Adult Center in particular (and the VA, more generally) for their patience and persistence while we developed and refined our therapeutic treatment interventions. We appreciate all the feedback you have given about our approach; it has helped considerably to improve our work.

We also wish to thank Aaron T. Beck, M.D., Peter Lewinsohn, Ph.D., and their associates for their initial belief in our efforts and continued support and encouragement over the years. Through our contact with this group of professionals over the past decade, many new insights were gained that have been modified and integrated within our general framework, in order to improve our effectiveness in treating depression and related affective disorders in older adults.

Finally, we wish to extend our appreciation to the VA Palo Alto Health Care System (in particular, the Psychology service) for supporting our work and enabling our team of clinicians and researchers to find a professional “home” in which we could cultivate our ideas, and thrive in their application.
HOW THIS MANUAL IS TO BE USED

This manual was developed to provide therapists from varying backgrounds (such as psychiatrists, psychologists, social workers, psychiatrically trained nurses, and licensed marriage and family counselors) with a guide for conducting cognitive-behavioral therapy with older adults. There is a companion manual which our group also developed that is intended to be used by the client as part of treatment and we strongly recommend that they both be used together to supplement one another.

This work is a product of over a decade of experience treating older adults on an outpatient basis—with primary diagnoses of affective disorders, particularly episodic or chronic depression and/or a variety of anxiety disorders such as simple phobias or agoraphobia. We have found such explicit and detailed manuals to be effective in helping both the therapist and the client stay on track and more readily accomplish their goals.

Although the manual is set up as if it is to be used sequentially, we encourage therapists to be flexible in their use of this material. After patients have become oriented to the general procedures of how therapy will progress, and therapy goals have been established, therapists may want to focus on specific sections that seem most appropriate for addressing the therapy goals of that particular client. For example, if the person has a plethora of potentially pleasurable activities occurring regularly in their life, but tends to discount these, while remaining preoccupied with some seemingly trivial event, then the focus of therapy should be on their unhelpful thoughts and general belief systems. On the other hand, if the client is undergoing many hardships with few positive events occurring in their life, then the therapist may want to emphasize the importance of increasing pleasurable activities first, before dealing with other topics covered in this manual. Of course, since the client version of the manual parallels this one, the client will need to be directed to the appropriate chapters, so that he or she can follow along and attend to the relevant material and homework assignments. Many who have used this manual have found it advantageous to give clients only those sections of the manual on which they are actually focusing at any one point in time.

Feedback from a number of therapists and clients over the years has been incorporated into these manuals. Hopefully we have achieved both clarity and thoroughness in our presentation of the concepts and techniques that are critical to success in time limited cognitive
behavioral therapy. Some clinicians have found the reading level too difficult for their clients, in which case it is reasonable to simplify the language. We would appreciate learning of any efforts along this line. We would welcome your comments and those of your clients in how to improve upon these manuals so that we can revise them at least every two years, thereby making them as relevant as possible to the rapidly changing face of mental health care in this country.

**BACKGROUND INFORMATION**

**WHO IS THE OLDER ADULT?**

Our society defines “aging” as referring to persons who are 65 years and above. In 1989, 31.0 million people in the United States were over 65, which was approximately 13 percent of the total U.S. population. About one in every 8 of the baby boom generation will reach “old age” (AARP, 1990), which means that the proportion of this group will continue to increase over the years.

*Older American Demographic Fact Sheet* (Information obtained from AARP, (1990) and U.S. Bureau of Census, 1988).

- Older men are twice as likely to be married than older women
- Half of all older women are widows
- Two thirds of older adults live with their families, which may be a spouse, child, or sibling
- Only 5 percent of all older people live in nursing homes
- 90% of U.S. elderly are Caucasian
- 8% of U.S. elderly are African-American
- 2% of U.S. elderly are Native American, Asian, or Pacific Islander
- 3% of the older population is Hispanic
- In 1989, the median income for households headed by older adults was $23,179
  12% of households reported incomes below $10,000
  36% of households reported income over $30,000
- Income for older adults comes from the following sources:
  - Social Security earnings
  - personal savings pension plans
- 12% of older Americans are employed with 50% of persons employed part time
- Older adults report a median education level of 12.1 years with 54% reporting a high school diploma, and 11% have graduated from college
Older adults report greater health concerns than younger adults
33% of all hospital stays are older adults

**Chronological vs. Functional Age**

In working with older adults it is important to appreciate that individual differences increase substantially in this age range. Thus, some individuals in their 80’s and 90’s (e.g., Pablo Casals and Albert Ellis) remain active and productive, while others in their 50’s and 60’s are no longer able to function without assistance. Reasons for this are varied and beyond the scope of this manual. Never-the-less therapists must be alert to the distinction between chronological age and functional age, so that they can minimize the tendency to stereotype individuals.

**Chronological age:** This is the number of years since birth. It does not provide accurate information regarding an older adult’s individual capabilities.

**Functional age:** Functional age represents the integration of biological, social, and psychological functional capabilities. **Biological age** represents where the individual is in relation to his/her potential life span. **Social age** refers to the person’s roles and behavior relative to his/her peer group. **Psychological age** refers to how individuals cope with the changing environment. Examples of abilities that comprise one’s psychological age are cognitive functioning, ability to cope with stress, and one’s sense of self-esteem.

**The Importance of Cohort**

Cohort refers to the population of individuals who were born in the same time period, thus sharing the same set of cultural norms and historical events, that occurred during a specific generation. Each generation can identify specific sociocultural factors that influence their style of coping with problems, family relationships, as well as a general outlook on life. For example, today’s older adult would be affected by the Great Depression, WWII etc.

- Understanding older adults in terms of their cohort becomes an essential part of developing the therapeutic relationship, especially if you yourself are considerably younger. Showing an interest in how the older individual views the nature of the problems at hand, as well as the coping style they are familiar with, can only enhance the older adult’s perception that he/she is being respected.
• ASSESSMENT ISSUES

Besides developing sensitivity to the above-mentioned concerns, it is critically important to conduct an adequate assessment of the psychological status of the older adult before initiating any type of psychotherapy. This is particularly true when considering whether or not to utilize a cognitive-behavioral approach, which requires certain abilities on the part of the client. These include the ability to read, write, and comprehend somewhat complex concepts; initiate new activities; report accurately on events that occurred; and plan how to use cognitive and behavioral skills to handle future, potentially depresssogenic and/or anxiety-provoking situations.

A great deal has been written on this topic; we will refer the reader to what we consider to be key references for further study and for much more detail about these matters. Here we will simply give a brief overview of this very complicated subject, in the hope that this will whet the reader’s appetite for more substance. We need to remind the reader that the diagnosis of most psychiatric disorders in older adults is often a very difficult task, for several reasons. First, the existing diagnostic standards, as articulated in DSM-IV, do not generally address age-related issues or concerns in any depth. For example, research has documented the fact that sub-syndromal depression is much more common in older adults than is either dysthymic disorder or an episode of major depression but categories that capture these types of disorders are not available at present in the current DSM-IV (Blazer et al., 1991).

A second issue concerns the interaction of medical factors (such as the number of chronic illnesses present, and the kinds and frequencies of medications taken on a regular basis) with psychosocial factors in the development and maintenance of affective disorders in older adults. Most psychologists (and other non-medically trained mental health workers) are not comfortable factoring in the client’s medical situation along with psychosocial factors to determine an accurate diagnosis. Therefore, it is very important for mental health professionals to learn the skills necessary to establish collaborative and communicative relationships with the elder’s primary care physician, so that the most accurate decisions possible can be made about the nature of the presenting problem.
A third issue revolves around the fact that most older adults suffering from depression and/or anxiety disorders do not first seek out a mental health professional for diagnosis and treatment; rather, they solicit help from their primary care physician, who often does not have specialized training in geriatrics, thus making it potentially more difficult for the client to be referred appropriately. This is an additional reason why it is so important for psychologists and other non-medical mental health professionals to establish solid working relationships with those primary care physicians who tend to have large numbers of older adults on their panels. Finally, it is important to assess not only the emotional and medical status of the older adult, but also his/her cognitive status: how well certain key cognitive processes are performed such as memory, problem-solving, and learning new material. While it is simply incorrect to assume that “all older people are senile” as was once thought, it is important to be sensitive to mild or minor changes in cognitive status (as well as the more dramatic indices of dementia) in order to be maximally effective with given clients. For instance, memory aids may be very important to the success of therapy for one client, but unnecessary for another, for whom using their hearing aid as directed would enable greater ease of communication, not only in therapy, but outside as well.

**SUGGESTED READINGS ON DETAILS OF CONDUCTING AN ADEQUATE PSYCHOLOGICAL ASSESSMENT WITH OLDER ADULTS**

The following six sources contain very specific information about the measures and methods that could be used to evaluate the mental health of an older client. While this list is by no means exhaustive, it will provide useful suggestions for the newcomer in this field to follow.


It is strongly recommended that the reader familiarize himself or herself with the information in at least one of these sources in detail, so that the assessment process is as carefully done as the psychotherapy! If one reference is all your time will permit, we recommend the chapter by Kazniak (1990). However, in order to provide some basic assistance to the newcomer in this field, we will here make several specific recommendations for measures that should be included in every initial assessment of an older client being considered for psychotherapy.

First, the Mini-Mental Status Examination (Folstein, Folstein & McHugh, 1975) would be used to screen (on a gross level) for cognitive impairment. A score suggesting impairment should be followed up with a more detailed neuropsychologically oriented test battery, to provide a more accurate description of the strengths and weaknesses in the individual’s cognitive function.

Second, either the Beck Depression Inventory or the Geriatric Depression Scale (Yesavage and colleagues, 1983), would be used to assess level of depression, and the State-Trait Anxiety Inventory of Spielberger would be used to assess self-reported anxiety symptoms.

Third, a screening measure for alcohol abuse, such as the CAGE or the Michigan Alcohol Screening Test (MAST-geriatric version) would be included to assess this dimension.

Fourth, a variety of other self-report measures could be used to assess specific symptoms, such as: intensity of grief following bereavement; hopelessness and suicide ideation; caregiver
‘burden’ or distress; degree of anger, frustration, and guilt the client is experiencing; and scales to measure coping, personality, and social support (to round out the picture and help the clinician to get a sense of the client’s strengths as well as weaknesses).

The information from these various sources would then be reviewed and inquired about further in a face-to-face interview, since responses on self-reports can be deceptive. The interview also gives the clinician the opportunity to obtain valuable history (about the person as well as his/her symptoms) and to observe the older adult interacting with someone usually one or perhaps two generations their junior. All of this adds valuable information to the diagnostic formulation. As well, family members may be consulted if available, to verify information and to provide a different perspective on the problems the older person is experiencing. Finally, permission both to obtain relevant medical records, and to communicate directly with the primary care physician, should be obtained from the client at the outset so that these additional sources of data can be tapped in order to develop the diagnostic profile.

In our practice, we routinely conduct this type of “intake interview” before deciding whether or not the client is likely to be appropriate for cognitive-behavioral therapy. We then share the results of the assessment process with the client, and actively use the information to help in goal-setting and in socializing the client into therapy (see below).

In closing this section let us reinforce the importance of being aware of the changes that occur with normal aging, the impact of cohort differences on attitudes and belief, and the importance of a careful assessment before accepting the client into therapy. We also advocate continued communication with the primary care physician (and family members, when indicated) throughout treatment. We have found that establishing a solid foundation of communication and collaboration among all interested persons can make a key difference between success and failure in the psychotherapy that follows.
- The session by session manual follows.
- It is organized on a 20 session model, but it can (and should) be used flexibly. Sessions 1 to 3 are used for getting started (chapters 1 & 2); sessions 4 to 16 cover the skill training phase (chapters 3 thru 9); and sessions 17 to 20 reflect the termination process (chapter 11). Chapter 10 stands alone & describes how to do a mid-therapy evaluation (chap 10: optional)
- Note that for each chapter, the page #'s are given for both Therapist & Client manuals, for easy cross-reference.
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