CBT FOR OLDER PEOPLE

AN INTRODUCTION

KEN LAIDLAW

CBT FOR OLDER PEOPLE

AN INTRODUCTION

KEN LAIDLAW

SAGE

Los Angeles | London | New Delhi
Singapore | Washington DC

Los Angeles | London | New Delhi
Singapore | Washington DC

SAGE Publications Ltd
1 Oliver's Yard
55 City Road
London EC1Y 1SP

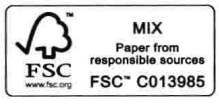
SAGE Publications Inc.
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road
New Delhi 110 044

SAGE Publications Asia-Pacific Pte Ltd
3 Church Street
#10-04 Samsung Hub
Singapore 049483

First published 2015

Editor: Kate Wharton
Assistant editor: Laura Walmsley
Production editor: Rachel Burrows
Copyeditor: Dan Harding
Proofreader: Bryan Campbell
Indexer: Bill Farrington
Marketing manager: Camille Richmond
Cover design: Wendy Scott
Typeset by: C&M Digitals (P) Ltd, Chennai, India
Printed in Great Britain by Henry Ling Limited at
The Dorset Press, Dorchester, DT1 1HD



Library of Congress Control Number: 2014941226

British Library Cataloguing in Publication data

A catalogue record for this book is available from
the British Library

ISBN 978-1-84920-459-0
ISBN 978-1-84920-460-6 (pbk)

CBT FOR OLDER PEOPLE

SAGE was founded in 1965 by Sara Miller McCune to support the dissemination of usable knowledge by publishing innovative and high-quality research and teaching content. Today, we publish more than 750 journals, including those of more than 300 learned societies, more than 800 new books per year, and a growing range of library products including archives, data, case studies, reports, conference highlights, and video. SAGE remains majority-owned by our founder, and after Sara's lifetime will become owned by a charitable trust that secures our continued independence.

Los Angeles | London | Washington DC | New Delhi | Singapore

About the Author

Professor Ken Laidlaw is Head of the Department of Clinical Psychology and Programme Director of the ClinPsyD Clinical Psychology Training Programme within the Norwich Medical School, at the University of East Anglia. Professor Laidlaw is also currently honorary consultant clinical psychologist with Norfolk and Suffolk NHS Trust, having for many years served as Professional Lead of an Older Adult Clinical Psychology Service in Scotland. He maintains active and ongoing research activity in cognitive behaviour therapy (CBT) for late life depression and anxiety, especially with complex, chronic and comorbid conditions. From 2000 to 2001 he was invited to spend a year at the University of Pennsylvania (PENN) in Philadelphia with Aaron T. Beck, the father of CBT, as visiting scholar. He has a long and productive association with Professors Larry W. Thompson and Dolores Gallagher-Thompson at Stanford University, California, USA. He was the Principal Investigator on the first UK RCT of CBT for late life depression. His manual for this trial has subsequently been used in other clinical trials. He also led the development of a cross-cultural Attitudes to Ageing Questionnaire (AAQ), that was piloted and field trialled in 20 countries worldwide. This is now used widely in international trials. His conceptualisation framework for CBT with older people is part of the UK's Increasing Access to Psychological Therapies (IAPT) initiative, and informs the IAPT curriculum materials for HI IAPT workers. He authored the older adults section of the evidence-based guide to the commissioning of psychological therapies for the NHS in Scotland (*The Psychology Matrix*, NES, 2011).

Acknowledgements

I want to acknowledge the great generosity of all my clients in allowing me to learn with them when facing their current life challenges and I am very grateful to those who agreed to have some of their stories shared for training purposes. The clients I worked with always showed great resilience and tenacity in facing problems with a strength of character forged from adversity that always impresses and inspires me, even if they sometimes found it very hard to give themselves much credit for what they did. I hope to have gained some important insights as a result that I can pass on in this text.

I am also indebted to the editorial team at Sage, Kate and Laura in particular showed me the greatest patience in waiting for this book to be finished. They never seemed to give up on this book, and were always positive and supportive. I am so very grateful they kept their faith in me. I could not have hoped for a better team to work with.

Finally, I am fortunate to have an amazing support system at home. My wife Mary and our daughter Katherine were very forgiving of the time I took away from family tasks in order to write. I dedicate this book to them in love and gratitude.

Contents

PART 1

Preparing to Use CBT with Older People

One
Introduction to CBT

Learning Objectives
By the end of this chapter you will:

- Have increased your understanding of the Beck model of psychopathology
- Understand why therapists need to use CBT theory in order to be more skilled and flexible in applying CBT
- Be introduced to the idea that while CBT has an elegantly simple model, the application of CBT requires discipline and practice
- Understand the basic structure of a course of CBT-based treatment for depression or anxiety

What is CBT?

Cognitive behaviour therapy (CBT) with older people is a mainstream treatment approach for the alleviation of depression and anxiety in later life. It is particularly appropriate as an intervention for older adults because it is skills enhancing, present-oriented, problem focused, straightforward to use and effective (Laidlaw et al., 2003).

Central to CBT for people with depression or anxiety is the concept that an individual's appraisal of their experience, rather than the experience itself, is what determines its impact. A useful way of helping your client to understand that there are different ways to think about any situation is to introduce your client to optical illusions. Optical illusions illustrate the idea that every experience is perceived uniquely and idiosyncratically. Thus, when we have a thought about an event or an experience our thoughts are just one of many different interpretations from an abundance of possibilities, and what gives an experience its impact on us individually is not the character of that event, but the meanings and significance ascribed to it. This idea is quite subtle, as many people assume that our thoughts can be the only way to look at something. Visual illusions show us this is not the case.

Figure 1.1 is a classic visual illusion drawn by the cartoonist W.E. Hill based on postcards dating from the nineteenth century. Published in 1915 in the magazine *Puck*, it is known as 'My wife and mother-in-law'. It is an ambiguous illusion, and as

FIGURE 1.1 *Visualising CBT*

such the 'data' may be resolved in different, but equally valid, ways. Thus, when you ask your client to look at this figure and ask what they see, you can discuss not only whether they see an old woman or a young woman, but you can discuss the way our minds make sense of ambiguous data. In the cognitive behavioural approach to understanding the impact of thoughts on feelings and behaviour this is an important explanatory concept. It is the way we see things that is important, and just because we see things in a certain way this does not mean it is the only way to view things. If we think something that does not make it a fact or any more correct than the way someone else will see a situation. It really is *in the eye of the beholder.* Figure 1.1 provides us with an example of how we might make sense of things in one way, but there are often many more ways to view a situation – hence the reason we consider our thoughts in CBT.

The Beck CBT model as it applies to depression is beguilingly simple, but one of the first challenges to becoming a skilled cognitive therapist is to understand that simple ideas require discipline and practice. The connection between thought, mood and behaviour seems so simple and self-evident that it can come as quite an unpleasant surprise when your clients do not instantly get better or their cognitions become difficult to challenge and modify. This book aims to equip you with a realistic appraisal of CBT.

The techniques and ideas contained in this book are the product of the author's many years' experience studying and practicing. If you as the therapist approach CBT as a simple concept this will wrong-foot you from the start, as CBT requires discipline, skill, perseverance and great patience.

While there are many 'cookbook' guides to applying CBT, these can sometimes be unhelpful as they suggest a simplicity of approach incompatible with an idiosyncratically delivered treatment programme that is much more than a collection of techniques and tools. CBT explicitly sets out to understand the person's world, and a full understanding can only be achieved through careful and deliberate exploration augmented with a methodology that emphasises a 'test it out' approach. CBT educates, motivates and challenges the person to bring about symptom change.

Techniques do not make a therapy work however, *people do*, and it is in the sympathetic and skilled application of techniques allied to a good therapeutic treatment alliance that CBT becomes an effective and powerful treatment intervention for late life depression and anxiety. CBT aims to be empowering of individuals and seeks to promote self-agency, as it adopts a non-pathologising stance to understanding how a client's problems may have developed (Zeiss & Steffen, 1996). As such, it can be a very attractive form of therapy for older people who often endorse strong cohort beliefs about personal independence and problem solving. To do CBT well requires great skill and ingenuity – one must be scientific, approachable and accessible. The goal is for clients to become their own therapists.

CBT can be differentiated from other forms of psychotherapy as:

- Sessions are structured according to an explicit agenda
- Collaborative empiricism is emphasised throughout treatment
- Negative interpretations are hypotheses requiring empirical testing (thoughts aren't facts and are open to disputation)
- Homework tasks are essential to generalise learning outside of the session and to promote an enhanced sense of agency
- The primary means of exploration is Socratic questioning, although ...
- CBT is a 'doing cure' as much as, if not more than, a 'talking cure' (enduring change comes from the client doing things differently). Nevertheless ...
- CBT assumes that behaviour change will also bring about cognitive change
- Interventions are linked to individualised case-conceptualisations

It is of course recommended that you seek out supervision from an experienced cognitive behaviour therapist when applying CBT as your main treatment approach in your workplace. You may wish to look at the website of the British Association of Behavioural and Cognitive Psychotherapists (BABCP: www.babcp.com) to learn more about the requirements for competence in the practice of CBT.

Starting now, think about what you know about CBT and what you want to know. This is a useful technique to figure out the gaps in your knowledge. It can also be useful to write down your beliefs and then test them out later by trying to find evidence for and against them. Doing this exercise gives you a small insight into the types of tasks we ask our clients to do. Use the worksheet here.

What do I know about CBT?	
Things I like and understand	Things I don't like or don't understand
Gaps in my knowledge	Ways to address these (✓) ☐ Further study/CPD ☐ Specific reading ☐ Supervision ☐ Complete CTRS ☐ Share CTRS with someone ☐ Go to workshops ☐ Find a mentor
Gaps in my competence	Ways to address these (✓) ☐ Further study/CPD ☐ Specific reading ☐ Supervision ☐ Complete CTRS ☐ Share CTRS with someone ☐ Go to workshops ☐ Find a mentor

Once you complete the worksheet, set yourself a homework task to achieve over the next week based on how you have completed the form. It should be linked to the task in hand, so perhaps you might like to read a specific article about the theory of CBT, or alternatively you might like to read a paper on a specific technique or aspect of therapy. Once you have completed your homework task, write a few notes about what you have learned.

Note: if you engage in this task, not only will you learn a bit more about CBT, you will be learning something about the process behind it. You will learn what it feels like to embark on a homework assignment and hopefully how good it feels when you learn something new or unexpected.

The Aaron T. Beck Model of CBT

In this book the form of CBT utilised draws mainly upon that developed by Aaron T. Beck (see Beck et al., 1979; Beck, 1983; Beck 2008). In this book, the philosophical orientation of the author is to appreciate that talking can be helpful and important in helping clients understand and address problems, but in order to bring about enduring change, therapy needs to be more than a 'talking cure' – it needs to be a 'doing cure'.

Thus, behaviour experiments are vital if you want your clients to bring about real and lasting change in their lives and, as Garratt et al. (2007) note, the cognitive model assumes that behaviour change facilitates changes in cognitive structures (schemata). In this way behavioural and cognitive interventions are likely to be necessary to bring about improvement in dysphoria.

The mechanism of change in Beck's model remains somewhat elusive. While Beck (1976) originally proposed that CBT brought about a fundamental change in dysfunctional schemata following treatment, this has been under scrutiny and alternative suggestions are that dysfunctional schemata become deactivated following successful treatment, or that compensatory schemata are developed that reduce the impact of existing schemata and mental models (Garratt et al., 2007). Whatever theory you prefer, it is clear that successful treatment in CBT can be a profound experience for your client as they develop new ways of interacting with, and understanding, the world.

The schematic in Figure 1.2 provides a representation of Beck's cognitive model of psychopathology. The model provides therapists with a way of describing the nature of the presentation of their client but also a way to predict future challenges in the therapeutic process.

Notice that it actually operates on two levels: the overt level (which is often the symptom level and the more overt thoughts, feelings and behaviour associated with distress) and the covert level (schemata etc.). The covert level is the underlying belief structure or core values of an individual. Note that an individual may be unaware that their beliefs are maladaptive and ultimately self-defeating.

The Beck model is a stress–diathesis model (Garratt et al., 2007; Liu & Alloy, 2010) that operates on two different levels. The first level is overt and it takes very little 'digging' on the part of the therapist to uncover the client's overt distress.

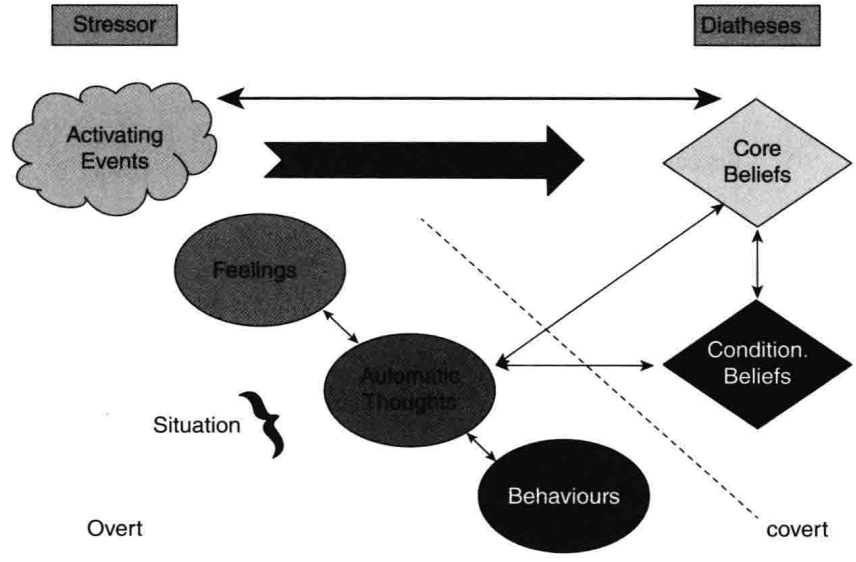


FIGURE 1.2 *Beck's model of psychopathology*

This is most commonly seen in the client's thoughts and is illustrated in Figure 1.2. Underlying the negative thoughts, at a covert level, are core beliefs, which may contribute to the themes evident in negative cognitions. This concept is illustrated in Figure 1.3.

The underlying covert level acts as the diathesis, usually activated by a linked stressor. This model may assume that the person is relatively passive and at the mercy of external events. This can be an oversimplification, as research suggests there may be a stress-generation process, as people with depression are likely to interact with stressors in a bidirectional manner (Liu & Alloy, 2010), in that people with depression may interact with stressors in a way that make it more likely that aversive experiences occur more frequently. This is a particularly troubling aspect of depression and anxiety symptoms – problems are magnified and multiplied by maladaptive responses.

Thus, it is usually important for therapists to ask themselves why the client is experiencing difficulties, what are the meanings they are ascribing to events and how may this be understood by considering the underlying maladaptive structure of *core beliefs*, *conditional beliefs* and *compensatory strategies*. Is there a reciprocal interaction between the individual, the stressors and their (over)reactions and (over)compensatory strategies? The structure of the Beck model is illustrated in Figure 1.4.

In the Beck model, thoughts are crucial for understanding the emotional reactions and behavioural responses in someone experiencing a depression. The schematic in Figure 1.4 can function as a useful conceptualisation diagram and is a useful format to use when sharing your thoughts with your client, especially if there is a theme or

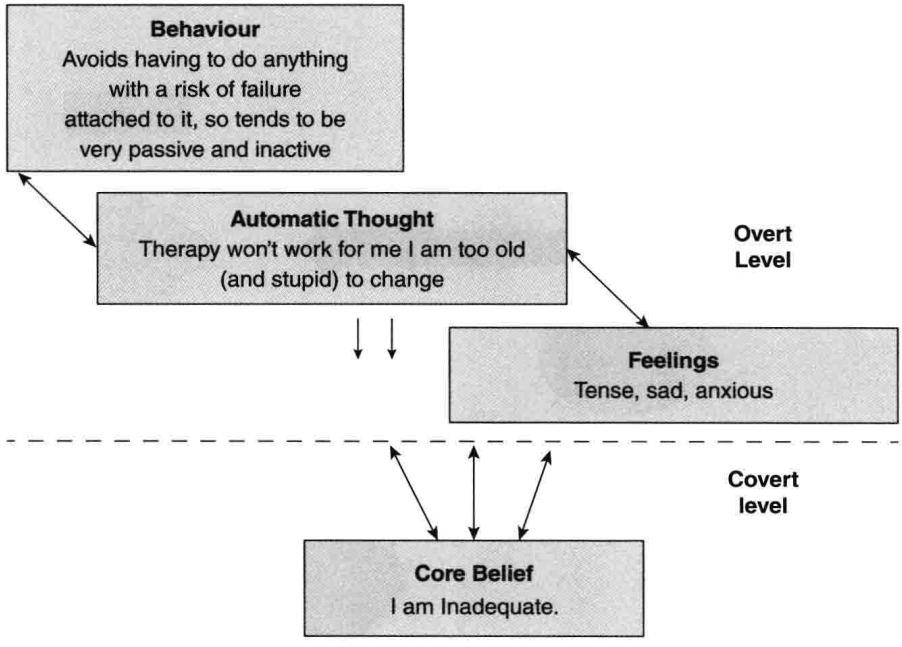


FIGURE 1.3 *Negative thoughts and their underlying covert structure*