Behavioural and Cognitive Psychotherapy, 2004, 32, 385–388
Printed in the United Kingdom DOI: 10.1017/S1352465804001572

Special Issue: Editorial

This edition has a special focus on cognitive and behavioural work with older people. Many of the papers have been written by national and international experts in their respective fields and demonstrate the variety and breadth of work undertaken within the specialty. Older people bring heterogeneity to the therapeutic context, with unrivalled opportunity for challenge, versatility and creativity. For example, during a single working day one could find oneself treating a centenarian with depression, a 60-year-old patient with early onset dementia, a person with pseudo-dementia whose anxiety mimics a Parkinson's presentation, a depressed person with chronic heart failure, and a depressed family carer. Alternatively, one could find oneself working with nursing home staff who are struggling to deal with a resident with challenging behaviour. Practitioners require knowledge and skills in neuropsychology, chronic disease management, standard 1:1 therapy, family and systems work. They must also be able to apply a wide ranging set of conceptual frameworks and associated interventions to people with varying degrees of cognitive impairment as well as undertake activities such as supervision, consultation and training of carers, staff and colleagues. Thus therapists working with older people are often acutely aware of the importance of extending treatment to the individual's supporting social context and the system within which treatment is offered.

Between 1900 and 1990 the average gain in life expectancy at birth in developed countries was 66% for men and 71% for women. The world's older adult population is therefore set to grow three-fold over the next 50 years with a near five times increase in the over 80 age group (see UN, 2001). Since older people will therefore gain greater sociopolitical power (the so-called "grey vote"), this is likely to have a bearing on the way in which health services (especially mental health services) are structured and delivered. Therefore as the population ages, the demand for health care for older people will increase and many therapists will need to broaden their skills and practice beyond the clinic to include a wider variety of ways of working.

A special issue on work with older people seems timely. However, there are inherent dangers to producing such an issue, such as the risks of perpetuating unhelpful and inaccurate stereotypes of old age and of implying that therapy adaptation is essential for this group. In this editorial the issues of stereotyping and adaptation are considered, followed by an overview of the papers.

Risks of stereotyping

Therapists, in common with other people, organize their experiences by categorizing people and events, drawing upon stereotypes and overgeneralizing the similarity of those in unfamiliar groups (Yarhouse, 2000). Given that depression, physical illness, cognitive impairments and lack of psychological mindedness are not uncommon in current cohorts of older people, such characteristics may inappropriately be assumed to be inevitable characteristics of the population. Stereotypes can cause problems if they are applied to a person without gathering

more information about that individual (Stangor & Lange, 1994). Therapists have been characterized as holding pessimistic views about the value and utility of psychotherapy with older people (Butler, Lewis, & Sunderland, 1998) and the stereotype of the older adult as mentally inflexible has been used as a rationale for excluding older people from therapy. However, older adults are the least homogeneous of all age groups and, as Zeiss and Steffen (1996) indicate, at least two generations comprise this age grouping. Therapists should bear in mind that chronological age will not tell them everything about an individual, and that presence of a disability does not necessarily make therapy less effective (Kemp, Corgiat, & Gill, 1991). Indeed published literature demonstrates that not only can older adults benefit from cognitive therapy (see Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003 for a review), but that they may show better outcomes than their younger counterparts (Walker & Clarke, 2001).

Padesky, at the World Congress on Cognitive Therapy in 1998, suggested that the ultimate efficacy of cognitive therapy was enhanced or limited by the beliefs of the therapist practising cognitive therapy. Where therapists hold stereotypical views of old age, they may need to utilize a cognitive approach to address their own unhelpful beliefs, in order to reduce barriers to successful therapy.

Are adaptations necessary?

Adaptations to therapies are often suggested for use with older adults, and Laidlaw et al. (2003) stress the importance of both socializing the patient into therapy and an initially educative approach. Woods and Charlesworth (2002) suggest that therapy adaptations should be used irrespective of age and should be considered for individuals with one or more of the following: adverse life circumstances; cognitive impairment; sensory impairments; chronic illness or physical disabilities; dependency upon others or poor social networks; "anti-therapy" beliefs; and/or chronic psychological difficulties or poor coping history. Cognitive therapists who aim to match the therapy to the client, rather than select the client for the therapy, must therefore practise a therapy that: is adaptable for differing cognitive abilities; is able to handle multiple problems (including physical disabilities and adverse life circumstances); encompasses "here and now" concerns for future and life review (including chronic problems and intervention history); allows for inter- and intra-personal issues; addresses beliefs incompatible with current circumstances and self-limiting beliefs, including internalized ageism and "cohort-characteristic" beliefs; and, is holistic rather than mind-body dualistic.

The articles in this edition reflect the diversity of work with older people. The first group of papers focuses on conceptual models. Laidlaw, Thompson and Gallagher-Thompson present a comprehensive overview of a conceptualization of depression. Catering for the heterogeneity previously mentioned, Laidlaw's model provides a flexible framework that, in addition to including CBT features, coherently integrates key interpersonal aspects. Charlesworth and Reichelt then approach the same area from the other extreme, highlighting the role and function of mini-formulations. These seem to be particularly helpful frameworks in acquiring shared conceptual perspectives. In the third paper Charlesworth and Greenfield go on to discuss the issue of collaborative conceptualizations.

The fourth and fifth articles pay more attention to change process issues. Smith discusses the use of mindfulness training with older people, while James and Barton provide guidelines on

how to use the continuum technique. The former paper provides first hand experience of how to conduct this promising form of therapy. The latter article provides a bridge with the previous papers on conceptualization, as it also examines the reasons for patient engagement or non-engagement in core belief and/or complex conceptual work. In the next paper, Collerton and Dudley provide an integrative theoretical model for the experience of visual hallucinations, drawing from the literature on dementia and psychosis. They also provide detail on assessment and treatment. Hilton and Moniz-Cooks' empirical paper examines the utility of Beck's concepts of sociotropy and autonomy in people with dementia. Their findings suggest that these styles are maintained despite the onset of cognitive decline, and may be useful in improving targeting for therapists' interventions. In the eighth paper, Taylor, DuQueno and Novaco, also researching in the area of dementia, introduce us to a new scale, the WARS. The Ward Anger Rating Scale, initially developed for use with mentally disordered offenders, rather uniquely focuses on the issue of anger, distinguishing it from aggression and also examining its potential role as a predictor of aggression. Completing this section, Coon, DeVries and Gallagher-Thompson review suicidality in older people. The paper reintroduces Laidlaw et al.'s earlier model (this edition), and provides a CBT framework for developing psychotherapeutic interventions with suicidal older people, using case example illustration. In the Brief Reports section, Walker presents a short case study on the use of CBT for depression in a person with dementia. Then Dagnan, Grant and McDonnell report on the development of a new scale, initially developed in the field of learning disability, which has relevance for examining the attitudes of staff caring for people with dementia. The final paper, by James, Allen and Collerton, reports on the emotional content of supervision conducted in a neurorehabilitation setting. It demonstrates that a wide range of emotions are experienced during a series of supervision sessions, with the most common being anxiety.

This special issue will, I hope, inspire therapists to embrace the needs of the changing health care population with optimism, and to enjoy the variety and opportunity that I have personally found since my own move some years ago from the field of working-age adults to older adults.

Ian James

Guest Editor, in collaboration with a number of his fellow contributors

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