

Commentary on Deconstructing Demons: The Case of Geoffrey

**Adapting Older Adults to Cognitive Behavior Therapy
and Vice Versa: The Case of Geoffrey**

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ABSTRACT

Mohlman et al.'s (2008) case history of Geoffrey makes a compelling case for adding training to improve cognitive functioning in older adults to enhance responsiveness to CBT. They also provide by example a demonstration of therapist flexibility in working with older adults. Along with attention to the influence of cohort differences and ethnic differences, the case provides a good model for what changes in working with older clients.

Key words: older adult, aging, cohort effects, cognitive changes, cultural differences

Mohlman et al.'s paper (2008) has much to recommend it as an exemplar of psychological intervention with older adults. The detail of the description of intervention and the reporting of quantitative data in an N = 1 style of case report is unusual in the clinical geropsychology literature, and practices that one hopes will become more common in the future. The selection of a client with multiple diagnoses is a welcome addition to the literature, which has all too often seemed to assume that older adults present with either depression or dementia. Geoffrey's combination of clinical depression with co-morbid clinical diagnoses of claustrophobia and social anxiety disorder as well as subsyndromal PTSD and a history of substance abuse are important reminders of the potential diagnostic complexity of older adults in need of psychological intervention. Anxiety disorders and substance abuse are diagnoses that have only recently begun to be addressed by clinical geropsychology in a systematic manner (e.g., see review by Knight, Kaskie, Shurgot, & Dave, 2006).

Health Problems. There is a mention of Geoffrey having diabetes and high blood pressure. These health problems do not appear to have affected the therapy to any important degree, although it is noted that the deficits in executive functioning could be partly influenced by poor health. Given his history of drug abuse, it is interesting that his health is this good. Of course, given his lower income status, he may not be getting great medical care and aggressive diagnosis and treatment. In the current example, there is no reason to suspect psychologically relevant health problems, but it is always wise with older adults to be alert for such issues.

Individual Differences Between Client and Therapist. The fact that Geoffrey is an older African American man and the therapist is a young, White woman adds another layer of contextual complexity to the case history. Most discussions of ethnic issues in clinical geropsychology stay at a fairly abstract level. This case history places age as one individual differences variable among several and describes ways in which therapist and client get past the cultural background differences as well as the adaptations for age and cohort differences. The use of the “What would Richard Pryor do?” question is a gem, and an intriguing, paradoxical way to help a client critique potential life choices and exercise greater wisdom in making those choices. The example of a young, White woman in a university setting who can display “...a working knowledge of African American culture...” and to use this knowledge in adapting therapy provides both concrete example and encouragement to others reaching across such potential social divides (see Crowther, Shurgot, Perkins, & Rodriguez, 2006, for a recent review of literature on this topic).

Session Flexibility. The flexibility of the sessions’ location is another general common adaptation of working with older adults. Going to the senior center because he could not easily get to her on-campus office is an exemplar of the kind of flexibility that is often needed with older adults, as is the use of follow-up telephone interviews when the therapist moved. The description of *in vivo* exposure therapy is more common in behavior therapy with younger adults than in descriptions of therapy with older adults, and is a great model for therapists working with the elderly.

It is also noteworthy that the exposure therapy follows a general increase in attention to the anxiety components of his symptoms, which were triggered by getting a job interview and then a new job. This part of the case history is an important counter-stereotypical event in therapy with an older adult: a 66 year old client, eligible for age-based Social Security and unemployed for several years, gets a job. One source of growth experiences and enjoyment for the therapist in working with older clients is events like this that shake us free of stereotypes that we may not have been aware we had.

Being willing to cope with the limitations of working in a semi-private space is also important in therapists working with large numbers of older adults. In tandem with that flexibility is Mohlman et al.’s thinking to be sure that the client is accepting of the potential limits on his confidentiality. In my own work with older clients, I have found the clients usually less concerned with confidentiality issues than therapists, who all too often use such concerns to rationalize staying in their own office or not contacting family members or health care providers when good patient care would point to those contacts being useful (and the client gives consent).

Another aspect of flexibility is the therapist’s varying of the timing of sessions, with two in the first week, and four during the final week. The number of sessions changed from the eleven originally planned to fourteen in person, and then some telephone sessions after the therapist moved away. The shaping of the therapy to the client’s needs (increased anxiety due to new job at end of planned therapy) and the therapist’s scheduled move are laudable.

Cognitive Training. A specific aspect of Mohlman et al.’s approach which is novel in clinical geropsychology is the use of the cognitive training in executive functioning sequence in

conjunction with CBT to facilitate the use of CBT with an older adult client. To my knowledge, Mohlman is unique in taking the approach of modifying cognitive deficits related to normal aging as an adaptational approach (Mohlman & Gorman, 2005; Mohlman et al., 2003). By far the more common strategy has been to use unmodified CBT or to make adjustments in the CBT materials or presentation to meet the older adults at their level of cognitive functioning (e.g., Satre, Knight & David, 2006; Laidlaw, 2006).

One could certainly initiate a debate as to whether it is a better approach to change the therapy or to change the client. To me, the compelling aspects of Mohlman's use of cognitive training is that it works and the client appears to enjoy it. Given the salience of cognitive changes to older adults, including normative changes that are independent of dementias, a therapeutic intervention that demonstrates improvement in cognition is an important contribution, whether or not it directly enhances the impact of the CBT. The cognitive intervention and the CBT both appear to have worked. Figure 1 seems to suggest that the two often changed together, rather than either leading the other in any clear cut manner.

Cohort Effects. While I appreciate Mohlman et al.'s focus on cohort effects, an influence on therapy with older adults that I have been writing about since I was a young therapist (see Knight, 2004, for a recent description), I will sound off for a bit about using Geoffrey as an example of the Boomer cohort. He is described as having been born in the mid-1930s, which places him about 15 years ahead of the earliest born Boomers. He would have been a child during World War II and come of age in the mid-1950s, a time of national yearning for "normality," with a return to gender-specific roles and some attempt to get African Americans back to pre-war social roles as well. He would have been a late adolescent to young adult at the time of the Supreme Court ruling outlawing desegregation, and well into adulthood during the civil rights gains of the 1960s. Against this background, it would be very interesting to know what his early experience of racism was. Was his education segregated or not? Was part of his reason for leaving college after two years due to racist attitudes of fellow students?

Since he would have been in his late 30s in the 1970s, what prompted volunteering to go to Vietnam at that point in his life? This timeline also means that he was about 50 when he got introduced to crack cocaine, a somewhat atypical point in life to turn to recreational drug use. He was nearing 60 when his girl friend died.

As is often true with placing earlier-born clients in their sociohistorical context, the timeline does not necessarily offer definitive information or new insights in itself, but does suggest a different framework for thinking about how his experience of growing up African American may have been even more difficult than for a later-born cohort. It also raises questions about what was going on in his life that may have influenced changes like volunteering to go to Vietnam or becoming addicted to drugs in middle age.

In summary, this is a refreshingly detailed case history that provides a good sense of the challenges and rewards of working with older clients. The degree of quantitative tracking of progress in the case report, the presentation of a multi-problem older adult, and the cross-cultural aspects are each contributions to the clinical geropsychology literature. The description of the multi-component treatment and of Mohlman et al.'s approach of treating the older client's

normal cognitive deficit as part of the therapy are novel contributions to the literature on work with older clients that could stimulate creative solutions in both the research and clinical practice arenas. This case history is the type of description of work with older clients that could easily engage the imagination of therapists and researchers not yet focused on therapy in later life and encourage them to take a closer look at this professionally engaging and personally rewarding line of work.

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