

Commentary on Deconstructing Demons: The Case of Geoffrey

**New Wine in Old Bottles:
The Transdiagnostic Model in the Case of Geoffrey**

LEE HYER^{a,b}

^a Georgia Neurosurgical Institute, Mercer School of Medicine, Macon, GA, USA

^b Correspondence concerning this article should be addressed to Lee Hyer, Georgia Neurosurgical Institute, Mercer School of Medicine, 840 Pine St, Suite 880, Macon, GA, 31201, USA.
Email: leehyer@ganeurosurg.org

ABSTRACT

This reaction to the “Case of Geoffrey” by Dr. Jan Mohlman et al. (2008) highlights its use of a state-of-the-art, clinical combination of the transdiagnostic model and empirically supported, cognitive-behavioral therapies in the treatment of an older adult with multiple problems. I comment on Dr. Mohlman et al.’s creative use of cognitive rehabilitation, as a necessary adjunct to both anxiety and depression in the elderly, and, more generally, on Dr. Mohlman’s et al.’s unerring use of tactics, strategies, and interventions with Geoffrey. More specifically, I comment on: (1) the context of aging, both as it applies and serves as background to treatment in later life; (2) evidence-based practice of psychological and psychiatric treatments, as necessary for psychotherapy for older adults; (3) common factors of treatment in Dr. Mohlman et al.’s case that address aging-related issues in therapy which require case-specific alterations that they creatively considered, applied and monitored; and (4) a discussion of what was missing or lacking in Dr. Mohlman et al.’s approach. Their case of Geoffrey should serve as a model for graduate teaching in psychotherapy for older adults.

Key Words: aging, psychotherapy, transdiagnostic model, cognitive-behavior therapy

The case of Geoffrey represents a state-of-the-art presentation that encompasses the best admixture of the latest information regarding the current cohort of older adults; psychological/psychiatric issues at late life; relevant and empirically supported interventions using the transdiagnostic model; specific and non-specific factors of therapy with this population; assessment; and, most especially, the use of cognitive rehabilitation (CR). Dr. Mohlman et al. are quite precise in their use of an armamentarium of tactics, strategies, and interventions. This case is a pleasure to respond to because of the use of this model, and the fact that Geoffrey is a prototype for the “young old” – that is, not quite young and not quite old.

I divide this paper into four sections. First, I discuss aging itself, both as it applies and serves as background to treatment at later life. Next, I consider the *evidence-based practice* model (EBP; APA Presidential Task Force, 2006) of psychological and psychiatric treatments.

Knowledge of the data in this area is a necessary but far from sufficient condition for proper care. Third, I discuss the common components of treatment, considering aging-related issues in therapy in the context of the case. I discuss here alterations in this case that were creatively considered, applied and monitored. Last is a brief discussion of what was missing or lacking.

AGING

Dr. Mohlman et al. wisely apply context to the case. We are an aging society and are not well prepared for the challenge of care at late life. This applies to mental and physical health, which are more highly comorbid at late life and often confusing to parse apart. While there is a disconnect between syndrome and symptom, symptom levels among the elderly are robust, as they apply to depression, with rates upwards of 18-20% (Blazer, 2003; Gallo & Lebowtiz, 1999); anxiety, with rates of 20% (see Hyer & Intrieri, 2006); and cognitive impairment, with rates of mild cognitive impairment at 30% over age 70 and rates of dementia approaching 50% over age 85 (see Hyer & Intrieri, 2006). Many older adults go to primary care clinics (PCCs) for emotional problems with prevalence rates high (e.g., depression 17-34%) (Hyer & Ragan, 2003). In long term care rates soar (e.g., depression 30-50% in most studies [Katz & Parmelee, 1994; Parmelee, Katz, & Lawton, 1989]). Sub-syndromal symptoms too are prevalent and cause problems at levels close to those of the full disorder (Parmelee, et al., 1989; Teresi et al., 2001).

As if this were not sufficient for a clinical hell, symptoms of depression, anxiety, and cognitive decline co-occur in all forms of ugly permutations (Burns, Jacoby, & Levy, 1990; Devanand, Sano, & Tang, 1996; Lyketsos et al., 2000). Disability results, with severity of depression, medical burden, and cognitive impairment accounting for 36% of the variance of disability (Alexopoulos, et al., 1995). Interestingly too, depression at late life is different than at other ages –more medical burden, less hypersomnia, longer duration, less negative thinking, and less reported suicidal attempts (Husain, et al., 2005). Finally, a significant number of older adults receive little or no treatment for any of these problems, for reasons related to cohort biases, insurance, and nosological inapplicability (Hyer & Intrieri, 2006).

For context, the arena of aging problems is awash with theories. What started as theories that view aging problems as a response to loss and deficit with disengagement and inactivity quickly segued to issues of competence based on the ecology (Lawton & Nahemow, 1973), a person-environment fit (related to social exchange and age stratification; Kahana, 1982), or life-span ideas based on differentiating components of maturity as a result of aging (see Hyer & Intrieri, 2006). Older people utilize emotions (Carstensen & Turk-Charles, 1994) and intelligence (Thornstam, 2000) in more economical or different ways, for example. In general, as Baltes and Carstensen (1996) argued, older people have problems but accommodate well in most circumstances. Aging too is a highly variable process: individual differences generally outweigh chronological differences. At late late-life, disease and frailty are the rule and these factors trump the potential positive influence of psychological and self-protective processes. While this last feature did not apply to Geoffrey, Dr. Mohlman et al.'s work implies that the careful care of older adults requires the knowledge of aging in the context of therapy.

Dr. Mohlman et al. note too that aging comes fully equipped with other- and self-imposed biases. Here we see that Geoffrey is anything but “old,” as he demonstrates

compliance, interest, and even creativity, requiring only minor changes in therapy tactics. Perhaps more than any aspect of aging in this case, we see that this patient has primary care needs in his mental health treatment. Dr. Mohlman et al. integrate this. The recent plethora of studies represented in the alphabet soup of mental health interventions in primary care settings -- e.g., PRISM-E, IMPACT, STAR-D, PROSPECT, RESPECT, and UPBEAT -- all point to the value and efficacy of integrated care, as well as the value of planned, cognitive-behavioral or problem solving interventions (see Gatz, 2007; Oxman, Dietrich, & Schulberg, 2005). In passing, I note too that mental treatment is more frequent in primary care clinics, but the empirical evidence for efficacy is far from conclusive.

EVIDENCE-BASED PRACTICE

Overview

Recently there have been at least five different, discrete research-based and evidence-oriented initiatives in the practice of psychotherapy, creating a virtual tsunami of change and specialized phrases. These include *empirically supported treatments* (ESTs; Chambless & Ollendick, 2001), or what are sometimes called *evidence-based psychological treatments* (EBTs; Powers, 2008b); *empirically supported relationships* (Norcross, 2002; Norcross, Beutler, & Levant, 2005); *empirically supported principles* (Castonguay & Beutler, 2006); the *transdiagnostic approach* (Brown & Barlow, 2002) based on the tripartite model of depression and anxiety (Clark & Watson, 1991); and an integrative model, *evidence-based practice* (EBP), based on the work of a Presidential Task Force of the American Psychological Association (APA, 2006) and officially endorsed by that Association.

APA's (2006) EBP model integrates elements from each of the other models mentioned above. Barlow (2007) points out that the EBP model includes three perspectives: empirically supported treatments (ESTs), with a nomothetic focus on treatment procedures; clinical practice guidelines, with a nomothetic focus on disorder or problem; and an idiographic focus on patients. EBP is based on three factors: use of the best available scientific data, clinician expertise, and client values and preferences. Barlow (2007) argues that the best approach to EBP involves: (1) assessment of pathology (targets of change); (2) diagnosis and case formulation; (3) matching the patient's problems to nomothetic, empirically supported treatments (ESTs); (4) decisions on an intervention based on psychopathology and patient factors; and (5) flexibility in altering treatment, if the patient is non-responsive with the application of a functional analysis.

With Geoffrey, Dr. Mohlman et al. used the best of EBP -- use of clinical expertise in the application of the match between the best available evidence (ESTs) and the idiosyncratic features of the patient. The transdiagnostic model enters at the beginning of this process as a paradigm for case conceptualization, with a reasoned and ordered array of interventions and problem-specific measures monitored over time. In fact, as part of Geoffrey's case (and in line with the transdiagnostic, EBP process), Dr. Mohlman et al. applied ESTs that were relevant and feasible. They initiated treatment with psychoeducation on the cognitive-behavioral therapy (CBT) model, following quickly by mood ratings and behavioral activation. They were liberal and apt in their application also of *evidence-based incorporative treatments* (EBITs; Powers, 2008b), which extend ESTs and include treatments that meet the criteria for ESTs but also

include non-psychological, practical life components such as work, medical, and housing issues (Powers, 2008a).

From another conceptual perspective, Dr. Mohlman et al. conducted psychotherapy with Geoffrey as one would with older adults in need of some support and some direction, consistent with the “REM” model of *restore*, *empower*, and *mobilize* (Carpenter, Ruckdeschel, & Van Haitsma, 2002). In effect, in the short number of sessions they addressed practical issues, as well as psychological ones, always in the service of the transdiagnostic model, applying core EST strategies (e.g., behavior activation, cognitive alterations, assertion) in the context of aging.

As if designed for older adults, the transdiagnostic model supplements or replaces with a dimensional approach the discrete diagnostic categories of the American Psychiatric Association’s (2000) diagnostic statistical manual (DSM). Core factors are rated along a continuum of severity. Individual patients can then be treated based on their presentation along these core dimensions, rather than on the basis of their membership in discrete psychopathological categories. The transdiagnostic process is concerned, then, with the psychopathological processes that account for the persistence of the disorder. Based on evidence-based theory of the maintenance of the disorder, ESTs are extended in focus to embrace core maintaining mechanisms: clinical features are viewed as being maintained by similar psychopathological processes.

A basic premise behind transdiagnostic treatments for anxiety stems from models of affective disorders that highlight a common element influencing both anxiety and depression. Negative affectivity (NA), negative affect, or neuroticism (Norton & Philipp, 2008) are the markers. The most promulgated model is that of Clark and Watson (1991), where anxiety and depression share common elements in NA, and anxiety specifically is characterized by physiological hyperarousal and depression, characteristically noted by low positive affect. Recently Barlow and colleagues (Barlow, Allen, & Chaote, 2003) developed protocols appropriate for Negative Affect Syndrome (anxiety and depression plus other problems). The specific components of this general problem state share many common features, leading to the application of common therapeutic components, like psycho-education, self-monitoring, cognitive restructuring, and exposure. There are now several transdiagnostic models to treating patients with anxiety and depression disorders, and these hold considerable utility for clinical practice (see Norton & Philipp, 2008).

The application of case formulation and the transdiagnostic dimensional modules are deliberative and interacting models for identifying the etiological, precipitant, and maintaining problems of the person and deciding where to treat. They represent the formulation of theory into practice. They are integrative and dynamic, and look for the whole picture. Symptoms are placed in the context of cyclical patterns, both internally and externally driven. The patient becomes a participant observer, is informed about the therapy, and generally assists in the care process. It is in this process that the whole of treatment is informed and decided. It is here that we can tell if “treatment receipt” and “treatment enactment” are in place.

The Institute of Medicine’s (2001) landmark report, *Crossing the Quality Chasm: A New Health Care System for the 21st Century*, cited person-centeredness and control of health as

primary aims of a transformed quality health care system. Under this idea the therapist fosters integrated care with both disease management and health promotion. With older adults, a shift is in play from a provider-driven focus on specific interventions for specific symptoms to a person-centered focus on response/remission, recovery, wellness, resilience, and community integration. Implied is the interplay between data and the person. This is done too in the form of a road map, not necessarily sequentially but logically and strategically.

At late life, the melding of a commitment to person-centered care and the use of evidence-based practice is what is at issue. The ultimate demonstration of evidence is the fit between the individual at a particular point in time as judged by the participation and response of that person. To date, there is really little data articulating the exact sequential road map of using EBP, despite its appeal. But, the core components of pathology at late life continue to be depression and anxiety. In effect, this model broadens the full range of depression and anxiety problems, and it embraces a greater range of maintaining mechanisms that extend most current theories concerning depression and anxiety. Dr. Mohlman et al. chose to highlight three overlapping mechanisms (social withdrawal and avoidance, negative views of self, and cognitive distortions) that expanded the current DSM symptom cluster.

Efficacy Studies

For Geoffrey an amalgam of problems revolving around depression and anxiety are addressed. Let's discuss this. For starters, the field of psychotherapy as it applies to late life is, from all indications, as efficacious as its use with younger groups. There are some exceptions. Lebowitz et al. (1997), reacting to American Psychiatric Association recommendation, noted that cognitive-behavioral therapy (CBT) for later life problems is not less efficacious but understudied. One review using American Psychological Association criteria for empirically supported treatments concluded that CBT was a well-established treatment for depression in young and older adults; another review concluded it was probably efficacious for depression in older adults; and a third asserted that it was efficacious for depressive disorders in a wide variety of older adult patients (Chambless & Ollendick, 2001; Gatz et al., 1998; Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003; Thompson, Davies, Gallagher, & Krantz, 1986). Scogin and McElreath (1994) and Engels and Vermey (1997), among several others (see Hyer & Intrieri, 2006), viewed the literature on the use of CBT with older adults and concluded that CBT is an effective treatment for depression and other affective disorders of the frail elderly. Other papers have also supported these conclusions for depression (Brodaty, Green, & Koschea, 2003; Gatz, 2007; Pinquart, Duberstein, & Lyness, 2006), as well as for psychosocial interventions for caregivers of dementia patients (Gallagher-Thompson & Coon, 2007).

There are also randomized controlled trials in older adults showing positive effects of CBT for treating sleep disorders (Rybarczyk, Lopez, Benson, Alsten, & Stepanski, 2002), and promoting behavior change (Schneider, Mercer, Herning, Smith, & Prysak, 2004).. This applies to persons with dementia (Gatz et al., 1998; Teri et al., 2000). In addition, primary care clinics have been receptive to such effective treatments for both depression and anxiety (see Gatz, 2007). Other treatment methods, like problem solving therapy (PST), interpersonal therapy (IPT), life review, and acceptance-and-commitment (ACT) therapies have been successfully applied to depression for older clients (see Hyer & Intrieri, 2006).

Regarding anxiety, Ayers, Sorrell, Thorp, and Wetherall (2007) reviewed geriatric outcomes, identifying 17 studies that met criteria for evidence based therapies. In another review of older adults, 27 randomized trials of psychotherapy were evaluated. Results show that this problem can be treated by CBT or PST (Arean & Hegel, 2007), even in the home (PST: Gellis, McGinty, Horowitz, Bruce, & Misener, 2007; CBT: Scogin et al., 2007). Effect sizes range from .35-.75 (Cuijpers et al., in press). This conclusion is supported by other reviews (Mohlman, 2004; Norhus & Pallesen, 2003; Stanley et al., 2003; Wetherell, Gatz, & Craske, 2003; Wetherell, Lenz, & Stanley, 2005; Wetherell, Sorrell, Thorp, & Patteson, 2005). Evidence is largely provided for four types of interventions; relaxation training, CBT, supportive therapy, and cognitive therapy. CBT was the most robust of the grouping.

Most studies show that the combined use of CBT, IPT, and problem solving therapy along with the judicious application of medication provide the best chance of change. Recently Wetherell, Lenz, & Stanley (2005) found sufficient evidence for the combined use of medication and psychotherapy. Mackin & Arean (2005) did the same thing for depression at late life and Gatz (2008) for psychological problems with severe medical problems. Several studies compared psychotropic medication with IPT, finding both efficacious in treating depression in elderly individuals (Frank et al., 2006; Reynolds et al., 1999). (For an updated review, see Hinrichsen, 2008.) Other studies have demonstrated that, in both younger and older adults, psychotherapy in conjunction with pharmacotherapy is significantly more efficacious in treating depression and other mental health problems than is pharmacotherapy alone (Areán & Cook, 2002; Scazufca & Matsuda, 2002).

Unfortunately, the default standard of care for older adults in the 21st Century is pharmacology, a truly blunt instrument with both helpful and harmful effects. Reynolds (2007) notes several problems with medications: the optimal duration of acute psychopharmacology at late life is unknown; type and timing of switches of therapies is unclear; the best augmentation strategies of any treatment remains a mystery; predictors of treatment response are not settled; indications for and duration of maintenance therapies is also in doubt; and what constitutes the best mediators and moderators of therapy is cloudy.

Geoffrey is a complex man; Afro-American, “young old,” nosologically intricate, lower SES, and, above all, in pain and searching. He has more than one chronic medical problem and little means, but is educated and motivated. In such cases at late life in the real world of care, medication rules! Unfortunately, there exist are no solid main effects for empirically supported treatments that address relapse, continuation or maintenance phases of care regarding older adults. In fact, most of the risk factors for poor prognosis for depression and/or anxiety (Hyer & Intrieri, 2006) are present for Geoffrey. These include: older age, being female, functional impairment, negative life events, impaired social support, cognitive impairment, lower SES, widowed or divorced, cognitive impairment, personality problems, severity of symptoms, and medical comorbidity. On the positive side, Geoffrey has insight and psychological mindedness (Kennedy, 2000), is motivated for and committed to treatment (Snow et al., 2006), and is being seen by a highly qualified therapist (Pinquart & Sörensen, 2001) who, in the context of cognitive-behavioral principles, is empathic (Goldfried & Davila, 2005).

If there were a reason for the use of guided care that emphasizes an individualized case formulation and treatment plan, in the context of complexity, Geoffrey would qualify as a candidate. Models such as Peterson's (2001) "Disciplined Inquiry," APA's (APA Presidential Task Force, 2006) "Evidence-Based Treatment," Fishman's (2005) "Pragmatic Case Study Method," Elliott's (2002) "hermeneutic single-case efficacy design," and Persons' (2007) "cognitive-behavioral case formulation" as well as the transdiagnostic model all can apply here. For Dr. Mohlman et al., the serial treatment approach to each individual diagnosis gave way to a model that frontally attacks cross-diagnostic, negative affective states. Geoffrey did meet *Diagnostic and Statistical Manual for DSM-IV* (APA, 2000) criteria for Major Depressive Disorder (Recurrent), Social Anxiety Disorder (Generalized, Moderate), and Claustrophobia (Severe), and was sub-syndromal for PTSD. With the exception of depression, ESTs for the other diagnoses in later life are virtually non-existent. The comorbidities of depression and anxiety in a bed of low SES factors especially lend themselves to the transdiagnostic approach where techniques are selected to alter multiple symptoms.

Dr. Mohlman et al. nicely discuss the value of the tripartite model (Brown & Barlow, 2005), including negative affectivity, positive affectivity, and fear/arousal symptoms. These markers are precise and measurable. This was actually the intent of the Axis II as a dimensional approach setting the scaffold for the Axis I problems (see Millon, 1997). The construct of personality disorders, however, will likely not be helpful, as this construct is often a waste-land of empirically elusive factors that are salient at late life but not amenable to empirical change. Heterotypic continuity is especially a problem where the construct of personality is concerned (Hyer, Molinari, Mills, & Yeager, 2008).

In the treatment of Geoffrey one can "feel" the unfolding of various therapeutically mediated components, like self-understanding, compensatory skills, and self esteem (Gibbons, 2006), as well as the power behind the more-than-good-enough therapist who doles out solutions to complexity according to a plan. This is no formulaic adherence to curative manuals; rather there is the clinical process of dismantling and matching needed nomothetic-idiographic principles to this man. The noise at late life is compelling. One could not imagine Dr. Mohlman being effective had she as the therapist not mixed and matched core ESTs of schema identification and alteration, behavioral activation, walking-the-walk exposure at the drug clinic, use of homework throughout, psychoeducation, and use of a (even if flawed) coach; as well as use of off-script interventions, including a diabetes manager, therapy in a store front, phone calls, and the like. Recall that explicit attention to individualized case formulation in therapy generally, even if not specifically empirically tested for older clients, improves treatment outcome (Silberschatz, Fetter & Curtis, 1986), correlates with better accuracy of interpretations (Crits-Christoph, Cooper, & Luborsky, 1988), enhances treatment in difficult and complex cases (Persons, Bostrom, & Bertagnoli, 1995), and aids in the identification of when to deviate from standard treatment protocol (Malatesta, 1995). A transdiagnostic approach, along with an understanding of late life issues, directed and allowed for this type of individualized case formulation.

COMPONENTS OF THERAPY

Common and Core Factors

I now highlight several features of the Geoffrey's treatment as it relates to older adults in the context of psychotherapy. The central elements of change in therapy, I believe, for younger and older adults alike are to experience the emotion and to change cognitions and behaviors. With older adults, there are additional issues: the processing of emotions is more problematic (Goodwyn & Intrieri, 2006); cognition is often a problem (60% of older adults presenting at mental health clinics have cognitive problems; Butters, et al., 2004); and there are distal and proximal extenuating circumstances related to outcomes in therapy itself, both mediators and moderators. These factors alone make the transdiagnostic scaffold, supported by the case formulation and spoon-fed by extant data and the idiosyncratic features of the client, viable, if not necessary.

As background, aspects other than technology are very important at later life. Several authors (e.g., Hyer, Kramer, & Sohnle, 2004) have shown that the path from cognition to outcome in older adults in therapy is independently mediated by the alliance and by homework. No surprise here: Get the older adult to like you and to work outside therapy, and change is likely. As always, common factors in therapy, as well as the technology of therapy, then, are both critical for positive outcomes (e.g., Hill, 2005). Rapport building and guided intervention strategies were interwoven throughout the course of Geoffrey's treatment. At a practical level a key in most of the therapies at late life is to assure the connection between current symptoms and the problems in living. CBT and problem solving therapy do this well; in fact, it is a signature feature of both. If this is done within an empathic frame, the possibility of change increases. As therapists who work with older adults know, therapy ruptures are subtle but influential.

There are several other key features of therapy at late life relevant here. CBT traditionally underplays current interpersonal relationship patterns, de-emphasizes the origins of relationship problems, and avoids emotion. Contrariwise, the gero-therapist often uses these, as each has been shown to make a difference for older adults (Hyer, Molinari, Yeager, & Mills, 2008). With the exception of origins, Dr. Mohlman et al. used these in various ways for the better. In passing, I note that the apt structural model accounting for outcome has not yet been developed for older adults, but the best current bet about the "correct mix" of specific and non-specific factors in late life is telling: 50/50.

There were many alterations in the treatment of Geoffrey. In this case Dr. Mohlman et al. borrowed cognitive help from Feeling Good and Mind Over Mood, behavioral activation from Depression in Context, exposure exercises from Cognitive Behavioral Group Treatment for Social Phobia and Mastery of Your Specific Phobia, and exposure tasks for PTSD symptoms from the work of Foa. As there are few manuals specific to older adults (e.g., Dick et al., 1999), these do just fine, certainly for someone like Geoffrey: "young old," not frail, perturbed (a high score on the Beck Depression Inventory and on anxiety scales), and reasonably cognitively intact.

The effective application of CBT modules with Geoffrey involved the creative use of the standard tasks, involving psychoeducation, cognitive restructuring, pleasant events (behavioral activation), use of a confederate, and monitoring. Geoffrey was asked to engage in cognitive restructuring by pretending he was an admired character; he was asked to study and provide a list of cognitive distortions from two of the most friendly and popular self help books; he was requested to log thoughts over the week for homework; he was given chapters to read; he was asked to agree to exposure tasks to practice; and he was behaviorally activated with desired and necessary tasks (including volunteering). In unpacking these tasks, the correct “zone of proximal development” in an older person is often fickle and sometimes hard to read, requiring therapists to push and cajole clients. Feedback in the context of the transdiagnostic model is optimal for this understanding. Dr. Mohlman et al. did this masterfully.

Medical and Cognitive Factors

Treatment of mental health problems at late life is most often performed in Primary Care Clinics. It goes without saying that medical comorbidity and cognitive decline are pervasive in these patients. Unfortunately, efficacy rates in such settings are less robust than in mental health clinics (Blazer, 2003). Often disability that accompanies physical illness is a greater contributor for depression than the actual illness (Blazer, 2003). If this is not the culprit, cognitive decline related to either depression or physical debility is (Wurm, Tesch-Romer, & Tomasik, 2007). In a persuasive way, medical care and predictive risk/etiologic factors impact mental health care (and vice versa), as well as quality of life in late life.

Dr. Mohlman et al. nicely discuss the interaction among depression, high blood pressure, diabetes, cognitive problems, and aging. Geoffrey was in reasonably good physical health with modal problems for an older Black male his age: high blood pressure, Type II diabetes, and often a lack of compliance with a self-care regimen recommended by his doctor. He was a smoker and had the history of alcohol and polysubstance dependence. Geoffrey did receive good care as Dr. Mohlman saw to his integrative needs. This is not usually done in therapy with younger groups. Two of the more active interventions included Geoffrey seeing a behavioral health case worker (obtained through participating in a research study at a local hospital), who assisted Geoffrey with his self-care regimen; and Geoffrey visiting a diabetes clinic weekly. In this process Dr. Mohlman fostered important, often critical elements for compliance and resultant positive outcomes – that is, participatory decision-making based on clear goals and targets (Heisler, Cole, Weir, Kerr, & Haywood, 2007).

One important factor here involves the possible (indeed probable) physical substrates of depression and cognitive impairment at late life, vascular problems. The vascular depression hypotheses have been in existence now for over 15 years (Blazer, 2003). Depression at later life is thought to be striatofrontal impairment. Cerebral vascular risk factors (CVRF)-- involving high blood pressure, diabetes, atherosclerotic heart disease, as well as small vessel disease -- usher in depression. In a sense depression can be construed as a vascular disease at late life. MRI changes of late life depression or with CVRF are pervasive and consistent; enlarged ventricles, cortical atrophy, increased incidence of periventricular hyperintensity, increased incidence of basal ganglia lesions, small caudate nucleus, and small putamen nucleus (see Alexopoulos, 2005). The Duke concept of “Subcortical Ischemic Depression” (Krisnan, 2007)

and the Cornell concept of “Depression Executive Dysfunction” (Alexopoulos, 2005; Alexopoulos et al. 2000) have led the charge, positing that the frontal ganglia-thalamocortical networks are impacted because of vascular problems (white matter hyperintensities, small vessel disease, occlusions) and predispose one to depression and later dementia. Depression may even be a marker of cognitive impairment. This applies to normal aging as well as mild cognitive impairment (Royall, Chiodo, & Polk, 2000). Empirically, subclinical structural brain disease has been noted in 30%-100% of community-based older adults (Cook et al., 2004). Older people with any of these physical problems then are depressed for many reasons, but one of them is almost certainly organic. Older adults with these problems also score lower on tests that measure executive functioning and show worse responses to antidepressants (Alexopoulos, et al., 2000; Dunkin et al., 2000).

Dr. Mohlman et al. convincingly make the case that CBT hinges upon the client’s ability to engage in focusing, dividing, and shifting attention, self monitoring, metacognition, and perspective taking, all of which involve executive abilities. Using the APT-II, a series of modules that address executive function and attention, she did something novel in therapy, even for older adults: the application of cognitive rehabilitation (CR) conjointly with CBT modules. In one of the few studies on this area, Mohlman (2004) had experimental participants practice executive function tasks, APT-II, in sessions for 45 minutes (sessions 1-4), and as homework (sessions 1-8), with the remainder of each session devoted to CBT, while control subjects received CBT only. The CBT/APT-II group showed a significant improvement in executive skills following the intervention, relative to the control group. Other studies have fallen short of showing an improvement between a form of CR and problem-solving cognitive therapy with older depressed adults. Alexopoulos et al. (2000), for example, showed that older adults who are depressed and have executive functioning problems do remit regarding depression, but show no changes in executive functioning as a result of this therapeutic change.

For Geoffrey each therapy session lasted 90 minutes: 35 minutes of executive skills training, 35 minutes of CBT exercises, and homework review. While there is now a revolution in cognitive aging with several models vying for attention and validation as therapy (e.g. “POSIT” and “Cogmed”), the APT II was selected because it targets attention, it follows the client’s pace and increases tasks, and it has some validation. In a very creative way, Dr. Mohlman as the therapist provided a skills generalization process, as she used CBT techniques under naturalistic conditions in the later sessions.

Two issues warrant discussion. First, whether this process becomes an EST with older adults (or just for those compromised in executive functioning) has yet to be shown, but its use with this man is both logical and seductive. Many studies have suggested that cognitively stimulating activity preserves mental performance and prevents cognitive decline in later life (Ball et al., 2002; Ercoli et al., 2005; Scarmeas, Stern, Tang, Mayeux, & Luchsinger, 2006; Studenski et al., 2006; Wilson et al., 1999, 2002, 2003, 2005). Rebok et al. (2007) examined the empirical basis for classifying memory training methods as evidence-based. This review examined evidence for both normal and cognitively impaired elders. Using criteria similar to that of the American Psychological Association’s Division 12 task force for empirically supported treatments (ESTs) in psychotherapy (number of studies, number of subjects, use of measures, use of manuals, etc.—see Chambless & Ollendick, 2001), Rebok and colleagues reviewed almost

300 studies. Of these, 39 gave preliminary support for 16 treatments to qualify as evidenced-based. These included studies involving instruction in multiple mnemonic techniques and in specific techniques, such as visual memory support, story mnemonic, method of loci, and cognitive restructuring. The authors concluded that, while there are several promising methods that improve memory in normal older adults, the question of its use for impaired elders or in real world situations has yet to be answered.

Second, it is likely further that positive changes in cognitive functioning are critical to having a beneficial impact on neuropsychiatric symptoms, especially mood and anxiety symptoms. In effect, successfully managing the psychiatric aspects of the disease depends on optimizing the patient's cognitive and functional capacities. Neuropsychiatric problems and adjustment are, then, necessarily cognitively-mediated and reflect the outcomes of cognitive training in patients. Sitzler, Twamley and Jeste (2006) suggested as much in their review of dementia; that is, cognitive rehabilitation (CR) assists, with medium effect sizes, in multiple functional domains, such as learning, memory, executive functioning, activities of daily living (ADLs), general cognitive problems, depression, and self-rated general functioning.

This combination of treatments is far from proven. Based on many studies and meta-analyses, the differential effects of psychotherapies are generally small. Some of the many factors responsible for this small effect include researcher allegiance, therapist factors, client characteristics, study method factors, and organizational factors. None of these have been carefully assessed at late life. Fortunately, most psychotherapies developed for younger adults appear useful for older adults when applied in an age-informed, age-sensitive manner (Hinrichsen, 2008).

Necessary Therapy Alterations

There has been relatively little research regarding the processes that influence adaptations to therapy with older adults. This includes data on how information is gathered in clinical assessment, as well as the curative processes in treatment. Standard changes in therapy itself involve alterations in the treatment length, less use of assimilative methods, an emphasis on relaxation, and a management focus. In fact, there is little data on the exact methods or alterations that influence change in therapy. Additionally, these may change as cohorts do. If adaptations are required, then we need to know if this is due to developmental changes, cohort differences, or the environment in which the intervention has occurred.

Powers (2008b) underscores the suggestions of others regarding the needed knowledge base for the practice of empirically supported therapies in a hard-to-study setting such as an inner city outpatient center or a nursing home. This knowledge base should involve descriptive research on the incidence, prevalence, and expression of psychological difficulties in the particular settings; research on the benefits of interventions that could be applied in such settings yet are not presently empirically based; research conducted in other settings that is relevant to the type of patient or problem in that setting; and research or scholarly writings that enumerate suggestions from clinical experience as well as empirical research on the benefits of psychotherapy that qualifies as EBT. Much of the practice of psychotherapy for Geoffrey involved the application of methods that are empirically supported from other populations or

contexts.

In her therapy with Geoffrey, Dr. Mohlman applied established treatment modules in both a standard way and in an altered manner. There was considerable patient education and socialization. They were also wise to check expectations frequently and to query about Geoffrey's level of knowledge. Alvidrez, Arian, & Stewart (2005) examined the impact of a brief psychoeducational intervention on treatment entry and attendance for clients referred for psychotherapy. This included a 15 minute individual psychoeducational session of what therapy is about tailored for African Americans. This brief intervention proved helpful in the numbers who entered therapy and those that dropped out.

The importance of cognitive distortions with older adults is at present unknown. While there are data to the contrary (see Blazer, 2003), the level and types of distortions can be a problem with this group as with younger ones. The problem occurs in the challenge stages of the dysfunctional thought records, often necessitating more psychoeducational effort (Thompson, 2007). For Geoffrey this is not a problem, perhaps because of his cognitive training. He was also given homework in the form of bibliotherapy (even in the form of structured exercises). This has promise for older adults (Scogin, Jamison, & Gochneaur, 1989). The use of pleasant events too is pervasive in aging literature and used well here (Teri & McCurry, 2000).

Dr. Mohlman also targeted Geoffrey's physical health. Skillfully she was able to do many things at once. Using a diabetes coach the therapist was able to target a critical element of the therapy and empower Geoffrey. One of the primary goals in CBT is to teach the client to "function as their own therapist." Geoffrey was taught and empowered to perform several tasks, including general assertive interventions, health homework, assorted behavioral requests, and relational tasks with a friend. His ability to use his newly developed skills to help a friend contributed to his perception of a positive outcome and increased his overall self-efficacy. There is a strong evidence base supporting the effectiveness of CBT in treating depression and increasing coping skills in caregivers (Akkerman & Ostwald, 2004; Gallagher-Thompson et al., 2003; Teri, Logsdon, Uomoto, & McCurry, 1997). He was even asked to listen to session tapes and kept a tally of the number of times he uttered a phrase. In an effort to increase transferability, CBT exercises were substituted for APT-II content. Such exercises are performed in cognitive rehabilitation (CR) or with defined learning tasks, not usually with CBT. Tasks again were directed by the case formulation and monitored and re-worked if necessary based on feedback from self-report forms to judge depression, anxiety, and pleasant emotions.

Other classic CBT modules were applied. While no interoceptive tasks were performed, a hierarchy was established for panic reactions in closed settings. Imaginal exposure was also applied along with writing on a traumatic event. Extinction measures for problem drug habits were used effectively to extinguish cue reactivity by systematic, repeated, unreinforced exposure to cues. All these procedures were carefully considered, checked with the patient, and were successful.

Assessment and Homework

Assessment is part and parcel of CBT. It is necessary with older people in general as mental and physical health changes often and quickly (Heath, Gartenberg, & Beagin, 2006). Assessment also dictates which modules to use for the transdiagnostic interventions. In sum, assessment provides the data for on-going tasks, as well as pre/post outcome. It legitimates the care. In time, a “pay-for-performance” (“P-4-P”) reimbursement system may mandate such procedures.

To assess Geoffrey’s cognitive functioning, he was given a battery of psychotherapeutic and neuropsychological tests. The application of five self-report measures (BDI, GSIS, BAI, STAI, and SAIS) at the beginning and end of therapy and the monitoring of pleasant events with mood ratings over the course of treatment allowed for immediate and accurate feedback. Dr. Mohlman et al. even applied norms from an older group (except for the SAIS), an increasingly important consideration (Busch, Chelune, & Suchy, 2006) in clinical work with older clients, including in the use empirically supported assessment strategies (Dozois, Covin, & Brinker, 2003). Geoffrey remitted at post-treatment according to the SCID and at six months he was sub-syndromal for PTSD. The application of the Himadi and Borkovec criteria allows for completeness in an understanding the results of the case.

Targeted homework was applied. If there is one component of CBT that is critical for older adults, it is homework. As part of a larger study, Coon & Thompson (2003) assessed the added value of homework on 63 older clients given CBT or combined treatment. Results of the hierarchical regression revealed that homework compliance contributed significantly to post treatment outcome as measured by both therapist and patient. For Geoffrey, it was clear that he was compliant and active in the use of homework. His effort here was as much a sign of his therapy success as anything. As a relevant aside, disease management is moving in the direction of active participation in primary care settings. Heisler, et al.(2007) found that effective disease management among older adults is critical for improved clinical outcomes. Involving patients in the participant decision-making process in an active manner was associated with better self management and outcomes. This involved patients in assessing values, goals, and capabilities and arriving at mutually agreed upon treatment plans. Patients who do best are those who are actively involved in decision-making in key areas -- such as diet, exercise, and blood glucose monitoring -- that need to be tailored to fit the patient’s lifestyle.

Booster Sessions and Extra-therapy Tasks

There is the longstanding recognition that late life mental disorders have a heterogeneous and tenacious quality. One might even argue that the chronic disease model fits best for this population -- a model in which symptom amelioration or suppression but not complete resolution applies. Concomitantly, it follows that a partial response is a frustrating but frequent outcome leading to a recommendation of multimodal interventions and treatment over time.

Monthly booster sessions were applied in the case of Geoffrey. This has been found to add to the efficacy of CBT with younger groups (Hollon, 2006). It makes sense here: More is better than less. As many as 38% of elderly patients who experience a first depression episode

will relapse within six years, and many more with two or more episodes (Hyer & Intrieri, 2006). Additionally, many will subclinically wax and wane with depressive symptoms, depending on initial response/remission status, current circumstances, health status, and comorbidities, especially anxiety. In effect, this form of relapse therapy is not only logical, but critical.

Extra-therapy interventions are equally important. They are routine in many primary care studies with older adults (e.g., Unitzer, 2006; Unitzer et al., 2002). In structured studies with older adults who have anxiety, extra-therapy elements (i.e., phone calls, home visits, and longer meetings) can be used to good effect (e.g., Stanley, et al., 2003; Mohlman et al., 2003). It is not entirely clear why symptoms of anxiety/depression in the elderly differ from those of younger groups, but this aspect of reassurance and commitment appears helpful, even necessary, for change in older groups.

WHAT WAS MISSING

Very little! This is a case that appeals to the scientist-practitioner in all of us. Problems were readily and aggressively addressed. Targets were prioritized as a function of extant ESTs, the reality of the case, and likely responses. We know that treatment that involves comorbid problems, especially when anxiety is involved, have positive outcomes, but treatment takes longer (Borkovec, Newman, & Castonguay, 2003). We know also that African American males have special difficulties with mental health care, especially when older. Throw in significant medical comorbidities, a suspect social support system, possible mild cognitive decline, a substance abuse history, as well as other psychiatric problems andwell, you know. The winning factors were a patient with high motivation and compliance, and a therapist who masterfully applied the transdiagnostic model.

Alliance

No alliance measures were administered. Despite efficacy, emotional deepening and making use of the relationship may have added to the therapy, as Borkovec and Sibrava (2005) asserted. That said, this therapist was empathic and down-to-earth with Geoffrey; on the one (hand making a special effort not to treat him with “kid gloves,” on the other respecting his situation, needs and state-dependent conditions. I believe too that this is one of the better representations of motivational attunement as recommended by Castonguay (Hortforth & Castonguay, 2005). The fostering of the bond, goals and task agreement with a careful watch on therapy ruptures was well done. Whenever possible, examples from his culture were used to illustrate positive themes. Booster sessions were applied; alterations in the treatment venue were made to accommodate the client; and exposure tasks were changed to accommodate problems. It is important to say also that the case of Geoffrey is unique because this is not treatment that he would have received in other places. He had limited means.

Relaxation

It was a surprise that no formal relaxation method was applied. The method works with older adults (DeBerry . Davis, & Reinhard, 1989; Scogin et al., 1992; Welden & Yesavage, 1982). In fact, relaxation has even been found to be superior to cognitive restructuring and

assertiveness training (Deberry et al., 1989). Geoffrey also appeared to be a good subject for this technique. He was anxious, responded well to coping methods, and was an ideal client for reporting problems.

Contamination of Results

As is the case with any evaluation, repeated measures are susceptible to practice effects. This may especially apply to cognitive measures like the Stroop. It is hard to imagine that the Stroop Color Word module would not be subject to practice effects or that it could easily be administered in each session without disrupting the therapy. In this regard too, Dr. Mohlman acted as both the assessor and therapist, with the possibility of a contamination between the two roles.

Wellbeing

At the risk of a translation problem, I wish to highlight success from another perspective, wellbeing. With age, Geoffrey struggles with who he is and what he can do. The concept of wellbeing is much discussed at late life and is perhaps the best marker of quality of life. Wellbeing is a broad ranging concept incorporating in a complex way the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationships to salient features of the environment. Other concepts often used to describe wellbeing include subjective wellbeing, contentedness, peace, joy, a sense of security, morale, adjustment, happiness, comfort, healthy relationships, resilience, and optimism (Allen, Carlson, & Ham, 2007). From one important perspective, Cohen-Mansfield (2008) posited a shifting baseline theory that makes some core assumptions of wellbeing: (1) multiple levels of wellbeing exist at any given time; (2) wellbeing is affected by both a trait and a state component; (3) people tend to return to their baseline level of wellbeing after changes in their baseline level of function; and (4) there are specific exceptions to returning to baseline, such as cases in which a new baseline emerges that involves physical pain.

Although not articulated, Geoffrey struggles with his life. Significant longitudinal changes in determinants of wellbeing, such as loneliness and health, occur with aging and with Geoffrey. In his case something important is occurring: He adapts to his situation and does so in the present and using CBT principles. Wellbeing is often independent of level of functioning, and one's quality of life can change changes throughout the progression of depression/anxiety. This involves shifting baselines of quality, similar to the concept of the treadmill effect (Kahneman, 2000), which postulates that external circumstances make only small contributions to the variance in happiness. More specifically, the most important aspects of care here are to minimize depression/intrusions and to maximize contentment or pleasure. Treatments are most effective that emphasize both the psychological wellbeing of older persons (activity, socialization, freedom from pain, perspective) and also focus on overcoming barriers that can prevent the return to a baseline level of wellbeing, such as physical discomfort or social isolation. A very recent study by Segal, Levenson, and Coolidge (2008) confirmed this, showing the physical health made the most important contribution (over age and stress, optimism, and depression) to quality of life (reasons for living). Geoffrey's case reflects the presence of both of these components. As a result, the reader can sense the phenomenology of Geoffrey's selfhood

being tested and expanded as he explores his increased consciousness, self-concept, and self-experience.

Critical Issues At Late Life

There are many issues that are not well understood. How does substance abuse in later life relate to depression and anxiety? Are these constructs different at late life? Is there a core fear or existential depression? Does old age decrease/increase the person's vulnerability to develop distinct forms of anxiety and depression? What is the effect of cohort? How does cognitive impairment interact with depression/anxiety? What are Geoffrey's values and could these have been used? What is quality of life at late life? These are important questions, although beyond the scope of this commentary.

One reason that psychotherapy works for older adults involves the details of the process. Psychotherapy with older adults is much like that at younger ages with an increasing emphasis on creating in the client the right state-dependent moments for the therapy to take hold, maintaining an alert status for tasks, being aware of the environment, remaining calm under stress, optimizing reflection and the ability to keep a narrow problem-solving focus, and assuring that the client can achieve a relaxed mental and physical state. Additionally, research on depression and anxiety, as well as outcome studies in PCCs, suggest that alteration of therapy models is in order. Table 1 outlines many features in therapy with older adults either not discussed or marginally considered here (Satre, Knight, & David, 2006).

Finally, it may be that the acronym order is incorrect for case formulation and treatment at late life: "EBP" (evidenced-based practice) should be "PBE" (practice-based evidence) (Hellerstein, 2008). PBE This involves is the application of high quality scientific evidence that is developed, refined and implemented in real word settings with real patients. Operative features are that the practice setting becomes the laboratory; that quality improvement is optimized (that is, change in focused areas is monitored in goal attainment ways); that medical and social markers are required before and during treatment; and that clearly defined, modular treatments are employed (Hellerstein, 2008). Clearly Geoffrey benefited from these PBE elements in his therapy.

Conclusion

In the last decade we have seen three psychotherapies to be most successful with older adults: cognitive-behavior therapy (CBT), problem-solving therapy (PST), and interpersonal therapy (IPT). These therapies have also experienced success (with modification) in primary care. This is no surprise. They have in common an extended dose of socialization, much psychoeducation, common-sense practicality, meaningful technologies based on validated theory, and reasonable empirical support in randomized clinical trials.

With Geoffrey, Dr. Mohlman et al. applied CBT and assorted EST modules according to a transdiagnostic case formulation and related treatment plan in a nosologically complex patient. They brought sense and order to a complicated and "messy" case with a theoretical model, a therapy structure, the effective use of time, and assessments that reflected the process of the

therapy. This recipe, applied by a skilled therapist, is going to work with older adults as well as younger ones. At the end, Geoffrey's psychopathological markers were normal and there was reported improvement in his mood and the quality of his life, including his ability to think, show confidence, use social attachments and interpersonal skills, and find a new job. Qualitatively, he was pointed in the right direction – commitment to his new learned skills in his new job, as well as aspirations to attend courses at an educational facility for older adults. Perhaps too the single most remarkable fact about human existence is how hard it is for humans to be happy (Wilson, 2008). For psychotherapy this has rarely been a goal. That said, Geoffrey was happy.

In 2008, we have reached the moment in the treatment of older adults when evidence-based practice can be translated into the clinical world. I now believe that better psychological treatments are so because they not only reduce avoidance, eliminate symptoms, and correct thinking, but they also increase flexibility. In cognitive behavioral treatment with older clients, the case of Geoffrey illustrates the value of using the transdiagnostic model and of mixing effective therapies with the assimilation of constructs and methods from other orientations. It is no surprise to this reviewer that this case was a success.

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Table 1: Important Additional Features in Therapy with Older Adults Either Not Discussed or Marginally Considered in this Comment (from Satre, Knight, & David, 2006)

Older adults progress at their own pace, often slower than other ages. Generally a longer length of therapy is more efficacious.

Older adults show more individual variability than between-age differences.

The context of care is critical: Older adults initially seek primary care clinics (PCCs), rarely mental health clinics.

Empirically supported treatments (ESTs) should have “the right of first refusal,” but often are not practical.

Therapist effects and the working alliance are important.

The realities of managed care create limitations.

On-going assessment makes for relevant care in mental health.

Thinking broadly (e.g., in terms of social support, primary care, and cognitive status) is as necessary in planning for change as the categories of the American Psychiatric Association’s (2000) Diagnostic Statistical Manual (DSM).

The role of late life moderators is equal to that of the DSM in determining outcomes.

Cohort has an influence, evidenced by the increased interest in mental health and improved cognition among today’s “young old.”

Older adults perform better with structured material, with more time on task, with greater environmental support, and with less time pressure.

The taxonomy of depression at late life is more advanced than anxiety, and newer constructs of both have been discussed over the years – depression without sadness, depletion anxiety, depression executive dysfunction, and subcortical vascular ischemic disease, among others.

The teaching of coping skills may have a greater positive therapeutic impact than does a focus on dysfunctional thinking.

Emotions are different at late life. Older adults have a lower physiological response to emotionally evocative cues and are biased toward more positive events, even in cases where psychopathology exists (Tasi, Levenson, & Carstensen, 2000).