CHAPTER

1

Unique Aspects of Psychotherapy with Older Adults

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In the past, older clients were often subjected to negative stereotyping and inaccurate generalizations that hindered their access to and success in psychotherapy. A loss-deficit model of aging took a negative approach to life span development and portrayed the normative course of later life as a series of losses and the typical response as depression (Berezin, 1963; Gitelson, 1948). More recently, writing about therapy with older adults has drawn on scientific gerontology rather than stereotypes and has portrayed the process of aging in a more positive light (Knight, Nordhus, & Satre, 2003; Knight & Satre, 1999). This has led to the proposal of a contextual, cohort-based maturity/specific challenge model (CCMSC; Knight, 2004).

BACKGROUND: THE CONTEXTUAL, COHORT-BASED MATURITY/SPECIFIC CHALLENGE MODEL

The CCMSC model is informed by research on aging in such diverse fields as developmental and cognitive psychology, medicine, and sociology. According to this model, the special social context of older adults

and the fact that they are members of earlier-born cohorts raised in different sociocultural circumstances may require adaptations to psychotherapy that are not dictated by the developmental processes of aging. Older adults are more mature than younger ones in certain respects but also are facing some of the hardest challenges that life presents, such as chronic illness, disability, and grieving for others. Each of these areas—contextual factors, cohort differences, and maturation—has significant relevance to working with older adults in therapy.

Social Context Factors

Therapists working with older adults should have general familiarity with their distinctive social contexts. These include specific environments (e.g., age-segregated housing, social and recreational centers, the aging services network) and laws affecting older adults (e.g., Medicare regulations, Older Americans' Act regulations, and conservatorship law). This information is not difficult to acquire, and the lack of it among psychotherapists at large may contribute to misunderstanding the world in which older adults live. Informal visiting at locations where the elderly receive services can help create an experiential framework for understanding the environments of the elderly.

Cohort Differences

Cohort differences are explained by membership in a group defined by birth year. Each generation is socialized into beliefs, attitudes, personality dimensions, and even academic abilities that remain relatively stable and that distinguish a cohort from generations born earlier and later. In understanding the effects of aging, therefore, it is important to separate the effects of maturation from the effects of cohort membership. This separation is accomplished in studies using sequential designs that can compare individuals of the same age from different cohorts. In some areas of social gerontology, it has been discovered that many of the differences between the old and the young previously attributed to the aging process are actually due to cohort effects. For example, in the United States, later-born cohorts have more years of formal schooling than cohorts born earlier in the twentieth century, up to the 1970s.

Cohort differences in intellectual skills have also been identified. Later-born cohorts tend to be superior in reasoning ability and spatial orientation (Schaie, 1996). However, some earlier-born cohorts (people who are now older) are superior in arithmetic ability and verbal fluency (Schaie, 1996), showing that some differences between cohorts favor the older group. The absence of developmental change does not imply that older people today are not different from today's younger people because differences can be explained by cohort effects rather than aging. Personality is also affected by birth cohort. For example, Schaie (1995) found that from 1900 until World War II, successive cohorts declined in extroversion, but in the cohorts that followed, extroversion increased. Likewise, threat reactivity has increased with each cohort since the beginning of the twentieth century (Schaie, 1995). These findings suggest that the personality differences observed between younger and older adults are often cohort differences rather than developmental aspects of aging.

Even though cohort differences are not developmental, they are nevertheless real effects that distinguish older adults from younger ones. To conduct psychotherapy effectively with older adults, it is useful to learn about historical forces and social norms that shaped earlier-born cohorts. Developing a working knowledge of psychologically significant cohort effects is just as essential as learning about cultural differences before working with clients from another country.

Maturity-Related Differences

The most pervasive cognitive change with developmental aging is the slowing that occurs in all cognitive tasks where speed of response is a factor (Salthouse, 1996). Although slowing reaction time can be partially reversed in older adults through practice, exercise, and other interventions, age differences are seldom completely eliminated.

Memory is a complex topic in the study of cognitive changes in late life. Recent longitudinal investigations of memory change in older adults over time have generally confirmed decline with age on some memory functions, such as word recall (e.g., Small, Dixon, & Hultsch, 1999; Zelinski & Burnight, 1997). In the same studies, other functions seem

to be relatively preserved, such as recognition memory. Older adults do better with structured material, more time to study the material, and greater environmental support (e.g., when able to use notes; recognition and cued recall are better than free recall; see Smith, 1996, for a review).

In general, what is known about memory now suggests that even differences between current younger and older adults in memory performance are not large when the material is meaningful and relevant to the older adult and the older adult is motivated to learn (Hultsch & Dixon, 1990; Smith, 1996). Of special interest for psychotherapy, there is evidence that older adults retain emotional material better than neutral material (Carstensen & Turk-Charles, 1994). Older adults benefit from memory training (Verhagen, Marcoen, & Goossens, 1992), and so the lower memory functioning compared to younger adults is at least partially reversible.

A two-factor model distinguishing fluid from crystallized intelligence was proposed by Cattell and expanded by Horn (see Dixon, 2003, for a review). Fluid intelligence, and its components of speed of processing, encoding newly learned material, and inferential reasoning, show clear evidence of aging-related change. Crystallized intelligence, and its general fund of information and vocabulary, show little age-related change until age 70 or later (Schaie, 1996). These changes in average level of intellectual abilities are observed but are not universal and may be caused by early dementia or illness-related deficits (Schaie, 1996). Baltes and Staudinger (2000) made a similar distinction between the mechanics of intelligence (how we acquire knowledge) and the pragmatics of intelligence (the content of what we know) with parallel age trajectories.

Drawing on the information-processing "mind as computer" metaphor, Rybash, Hoyer, and Roodin (1986) argued that increased experience can be seen as operating like an "expert system" program. Accumulation of experience provides older adults with a considerable store of knowledge that is informed by their work and family experiences. Older adults may outperform younger adults in these expert domains. Conversely, greater processing speed may help younger adults successfully process new information without the advantage of an expert system.

Similarly, Paul Baltes and colleagues with the Berlin Aging Study have proposed a model of the development of wisdom in later life. Wisdom is

composed of rich factual and procedural knowledge, life span contextualism, relativism of values and priorities, and recognition and management of uncertainty (e.g., Baltes & Staudinger, 2000). In general, wisdom in this sense should be an asset for the work of therapy and make older clients easier to work with. Working with clients who have more wisdom than you do can be inspiring or somewhat daunting and anxiety arousing, depending on the therapist.

Emotional changes over the adult life span are a topic of considerable importance for psychotherapists working with older adults. Carstensen (1992) proposed a theory of emotion across the life span called socioemotional selectivity theory. This theory began with the observations that our social support network gets smaller as we age (much of the change occurs in the 30s), but life satisfaction stays stable. Carstensen suggested that younger adults have a motivational focus on information seeking and finding a mate and so need a large network of contacts. Later in adulthood, the motivational focus shifts to maintaining emotional balance. This motivational focus underlies a shift toward positive affect as adults age (e.g., Carstensen, Fung, & Charles, 2003).

The Specificity of Challenges in Late Life

Practitioners working with older adults may well be thinking that this view of aging is overly optimistic. The outline of evidence for increasing maturation has intentionally focused on normal development through the life span. Yet many elderly clients seeking help in therapy are struggling with problems that threaten psychological homeostasis at any point in the life span: chronic illness, disability, the loss of loved ones to death, and prolonged caregiving for family members with severe cognitive or physical frailty. These problems are not unique to late life but are more likely in the last third of life. In addition, late life is not immune to vicissitudes common throughout the life span: disappointment in love, arguments with family members, and failing at the tasks we set ourselves. Finally, many people who have struggled with depression, anxiety, substance abuse, or psychosis all of their lives eventually become older adults who continue to struggle with these problems.

In brief, clients come into psychotherapy because they have problems that produce emotional distress. Older people in hospitals or nursing

homes are there because they are physically ill, and often chronically ill. Stated clearly, these facts are entirely obvious; however, it is not uncommon to implicitly assume that these problems are due to advanced age rather than to the underlying illness, psychological disorder, or severe life stress. The tendency to identify young-old and old-old periods within the older years and to equate young-old with a healthy, leisure-oriented postretirement lifestyle and the old-old years with illness, frailty, and disability is common. Such problems are stochastically more common in the old-old years, and this fact is likely due to underlying biological changes in the "wear and repair" systems of the body. However, the actual shift from the healthy, active years of aging to physical or mental frailty is due to specific disease processes that differ across individuals and that differ in age of onset. These individual variations, which are common, lead to our observations that an 80-year-old does not seem old (i.e., she is still healthy and mentally alert), whereas a 60-year-old seems very old (she has severe arthritis and moderately severe dementia). In some instances, these individual variations can result in an old-old parent caring for a disabled young-old child. Common everyday notions of what old age is like are wound up in notions about illness and disability. The reality involves some association between aging and frailty, but the association is far from a one-to-one correspondence, and the belief that they are identical causes many problems for older adults.

The *specific* nature of these problems is important to the practice of psychotherapy with individual older persons. Just as the deficit side of the loss-deficit model ignored evidence for maturation, the perception that *generic* losses are normative in late life fails to do justice to the *specific* nature of the losses incurred. Clinical experience suggests that it matters whether what is lost is one's spouse, one's vision, or the use of one's legs. Recognizing the specificity of loss and reconceptualizing losses as challenges implies that some losses can be overcome through rehabilitation counseling as well as adjusted to through grief counseling. Turning from a loss-deficit model to a maturity/specific challenge model also helps us to recognize when depression is not normative for a given life experience. For example, depression following retirement may be seen in this model as atypical (because most older adults enjoy free-

dom from the demands of work) and therefore in need of careful therapeutic assessment.

Chronic Illness and Disability

Clinical experience with older adults has made it clear to me that working with emotionally distressed older adults very often means working with older adults who are chronically ill and/or physically disabled and who are struggling to adjust to these problems. In setting out to do psychological work with older adults, I have had to learn about chronic illnesses and their psychological impact, pain control, adherence to medical treatment, rehabilitation strategies, and how to assess behavioral signs of medication reactions. This work has taken me into hospitals, nursing homes, cardiac rehabilitation programs, emergency rooms, and to the bedside of many severely disabled older adults.

In doing this work, I have become acquainted with physicians and nurses and have learned how to talk to and with them. I have learned much about the limitations of medicine and about the demands that patients place on doctors. I have learned to think about hospitals and other medical settings as organizational systems inhabited by human beings but operating according to distinctive social rules. I have come to better appreciate my own expertise by observing that many people with medical training are as uncomfortable with emotionality, psychosis, and suicidal threats as I am with blood, physical symptoms, and medical emergencies. Learning to work with other disciplines in this way is an essential aspect of doing psychotherapy with older adults (cf. Zeiss & Steffen, 1996).

This aspect of working with older adults involves specialized knowledge and specialized skills, as compared to other areas of psychotherapeutic practice where physical problems and the physical dimension of the person can be more safely ignored. The increased proportion of chronic illness and disability with each decade of life and the increased correlation of the physical and the psychological in later life require therapists to discuss physical problems and to understand when a problem may have physical causes. This principle does not mean that every psychotherapist working with the elderly must be a physician. It does mean that we must be able to talk intelligently and cooperatively with

physicians and with older clients who need to discuss the very real physical problems they face.

The specific-challenges part of the CCMSC model differs from the loss-deficit model in that the loss-deficit model argues that the work of therapy with the elderly is adjustment to the natural losses of late life and grieving for them. This model is wrong on two counts. First, there is nothing especially *natural* about blindness or heart disease or cancer. The fact that they happen more frequently to older adults does not make these diseases and disabilities part of normal development. It certainly does not make the individual older person experience these problems as normal or as less of a crisis than they would be for a younger adult.

Second, the loss-deficit model fails to suggest the next step of optimizing functioning. Rehabilitation may start by accepting the deficit in functioning, but it does not end there. The next step is to consider how life may be improved. The goal is often not the return to premorbid levels of functioning and mood, but there is always room for improvement over the level of mood and functioning present when the client enters therapy. It should be noted that the presence of these issues in work with older clients makes assessment more complex and challenging, that many psychotherapists are uncomfortable discussing physical problems or even being with clients who are ill and disabled, and that seeking improvement (but not total return to pre-illness mood levels) in the lives of clients with serious and chronic health problems is different from seeking the complete remission of acute depression.

These issues may be even more troubling when the illness is a dementia that produces cognitive impairment. The progressive nature of most of the dementias makes the long-term outlook negative, and the diminishing cognitive ability will eventually directly interfere with verbally oriented therapy. Nonetheless, there can be considerable value in working with older adults in the early to middle phases of a progressive dementia, in a way that parallels the value of work with persons with a terminal illness. The therapist must continually monitor the level of cognitive impairment and the client's ability to benefit from the therapy. (See Knight, 2004, for a more extended discussion of this complex topic.)

Grief

In a similar manner, working with older adults in outpatient therapy often involves grief work. Although loved ones die throughout our lives, the experience is more common in later life. Older adults seeking help for depression frequently have experienced the deaths of several loved ones in the preceding months or years. Much of psychotherapy with older adults will involve some grief work.

As was true for chronic illness and disability, older adults do not seem to experience grief as a normal and expectable part of later life. Losing a loved one, even a loved one who has been ill for some time, is often experienced as surprising and tragic. The loss may be experienced more deeply because of the length of the relationship.

Unlike the loss-deficit model, the maturity/specific challenges model goes beyond emotional grief work and the acceptance of loss to explore the question of what the remainder of the grieving client's life will be like. Grief work is not only about accepting loss, but about finding a new way of living without the deceased in one's life.

Caregiving

Given the relatively high levels of illness and disability in later life, many older adults who are not themselves ill or disabled will be caring for a family member who is. The nature of the caregiving will depend in part on the nature of the underlying illness of the care receiver, in the sense that this will determine the nature of the tasks of caregiving, the length of the caregiving period, and the degree of strain likely to be experienced. In broad terms, it is known that caring for a person with dementia is more stressful than caring for a physically frail family member (Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999), although individual reactions will vary.

Compared to noncaregivers, caregivers experience higher levels of symptoms of emotional distress (Schulz, O'Brien, Bookwala, & Fleissner, 1995) and have been found to have higher levels of clinical depression and clinical anxiety disorders (Dura, Stukenberg, & Kiecolt Glaser, 1991). There is some evidence for effects of caregiving on physical health as well,

although this evidence is less consistent across studies (Schulz et al., 1995). My own involvement with services for caregivers initially grew out of noticing that a substantial proportion of therapy clients in the caseload of the senior services program that I managed in a community mental health center were caregivers. The emotional distress of caregivers is typically considered within a stress and coping framework (Aranda & Knight, 1997; Knight, Silverstein, McCallum, & Fox, 2000; Lazarus & Folkman, 1984) in which the perception of caregiving as burdensome, the caregiver's coping style, and the available social support are key influences on mental health outcomes.

Caregiving always occurs in the context of a family relationship and is typically a relationship with a long history. At least implicitly, and often explicitly, working with a caregiver will require some conceptualization of the family system in which the caregiving takes place and may well require family sessions or ongoing family therapy (see Knight & McCallum, 1998; Qualls, 1996).

In brief, the specific-challenges part of the CCMSC model recognizes the gravity of the problems faced by older adults. It emphasizes the specificity of the problems and assumes that problems in later life can be overcome. In fact, one implication of the model is that work with older adults facing a specific problem should draw on the available knowledge about helping all adults with similar problems. Therapy with older adults should not become so specialized that techniques and concepts developed for other clients are not readily generalized to older adults and that techniques and concepts developed in gerontological counseling are not tried with younger adults as appropriate.

Summary

The CCMSC model portrays older adults in a complex light that draws on scientific gerontology. The normal developmental process of maturation is seen as making older adults more mature in some ways and as producing mild deficits in other cognitive processes. In general, the normal developmental processes of adulthood and later life are characterized by small, slow changes and an overall picture of continuity rather than marked change. However, cohort differences shape many distinctions be-

tween young and old adults, and these differences affect psychotherapy with older adults, both in terms of building rapport and often in communication and understanding between client and therapist when they come from different cohorts. The social contexts in which many older adults live invite us to understand older adults in a specific context and to consider the context as a source of their problems and as a target of change to benefit them. Finally, some of the problems faced by older adults are encountered more frequently in later life and have come to be identified with old age. Although these problems require specific expertise, they should not be overidentified with the age of the client: Younger adults have chronic illness, disabilities, grief, and caregiving responsibilities as well, if less frequently than older persons.

ADAPTING PSYCHOTHERAPY FOR WORK WITH OLDER CLIENTS

Drawing on the previous discussion of general findings in gerontology, the following discussion explores the possible changes to be made in therapy to maximize success with older clients. Adaptation might be required by the social circumstances of older adults, cohort effects, or developmental changes that take place during adulthood. Each of these three sources of change has different implications for the nature and scope of adaptation in therapy with older adults. The specific challenges of later life form a fourth basis for adaptation of therapy, one that is problem specific rather than client specific.

Therapy with older adults may need to adapt to specific social circumstances: retirement, widowhood, segregated housing, nursing homes, and so on. As noted before, working in nursing homes requires expertise in the social setting of the nursing home as much as it requires knowledge of the process of aging. These adaptations need to respond to change in the social definition and context of the elderly. For example, the past decade or so has seen the rise and proliferation of assisted-care homes as a new level of long-term care for older adults.

Changes due to cohort effects will differ with each cohort and will require that adaptations in therapy be constantly revised as each cohort

becomes old. Adaptations based on cohort differences imply that knowledge and skills specific to a given cohort will remain useful with that cohort as it ages. For example, if we have norms for a psychological test for people in their 60s and those norms are now 20 years old, we would use those norms with today's 60-year-olds if developmental influences are primary and with today's 80-year-olds if cohort differences are the operative influence. Developmental changes affect all older adults and are relatively consistent over time. If most adaptations were due to development, then therapy with older adults might be different from therapy with younger adults, as is therapy with children.

Adaptations Based on the Social Context of Older Adults

To the extent that older clients inhabit the specific social world of older adults in American society (and not all older people do), the older client must be understood in relation to his or her external social environment. This concept, and especially interventions derived from it, has its roots in social learning theory, which emphasizes the interrelatedness of person and environment and the need to understand both to plan appropriate interventions (Bandura, 1977; Rotter, 1954). In this sense, the "older American" is created by social policy and by stereotypical thinking of others in our society.

Older people are usually retired and therefore living on a fixed income. Their health care decisions are influenced by Medicare regulations. They often (although not as often as is thought) live in age-segregated areas. The men are usually married, and the women are usually alone; the discrepancy creates pressures on both men and women in later life. Stereotypical thinking about aging means that many older people find their relationships with others, including other older people, conditioned by certain misconceptions, such as "All older people get Alzheimer's disease," "All elderly people are isolated and lonely," "Older people are (or ought to be) asexual," or "Older people are greedy geezers."

Therapists have three interests in the subculture of the elderly. One is to understand the various ways our society makes life difficult for the elderly and so creates some of the emotional problems that the therapist is trying to ameliorate. With regard to this interest, without some explo-

ration of the subculture and our formal and informal social policies, the therapist will often be perplexed as to when the client is being realistic about being insulted or discriminated against as opposed to when there is some psychologically important level of suspiciousness indicating anxiety or paranoia.

The second interest is that the therapist needs to understand the social context in which the client lives to be able to understand the client and work effectively with him or her. The social ecology of the organizations in which older adults live, seek health care, spend leisure time, and so on affect the individual's self-concept and shape options for behavior. The way that this plays out in residential settings is described by Frazer in Chapter 9.

Residential settings are only one of many special characteristics of the older adult lifestyle. Programs funded by the Older Americans Act and other social programs for senior citizens have created a variety of social settings with special characteristics, including congregate meal sites, senior recreation centers, senior volunteer programs, and various advisory and advocacy councils. For many seniors, doctors' waiting rooms, hospital emergency rooms, and other health care settings also function as major social outlets. Those readers who have tried to make social chitchat with a busy physician can understand the likelihood of frustration for both doctor and patient. For the therapist to function effectively and to understand what clients are talking about, some exposure to each of these settings is very useful. Preferably, visits should take place when the therapist (or therapist in training) can be somewhat removed from the professional role and more of a participant observer in the anthropological sense.

The third interest of the therapist in the social context of older clients relates to the need to understand the social context well enough to be of active assistance to the older client when this is needed. Most discussions of psychotherapy with the elderly emphasize—and correctly so—the complex nature of the problems faced by elderly persons and the need for intervention in nonpsychological areas of their lives (e.g., Smyer & Qualls, 1999; Zarit & Zarit, 1998). Various authors have suggested the need to do casework for older clients, the need to work within a biopsychosocial model, and the need to take a more interdisciplinary focus. Casework services, which can include a wide variety of activities, are used here to refer

to two types of activities on the part of the therapist working with older clients. One is providing accurate information on available services for problems the client has that do not fall within the scope of the problems that therapy is likely to resolve; the other is actually providing or setting up services for the client.

Each community will have a somewhat different network of services. Important services to look for in any local context are the following:

- Physicians who are knowledgeable about and comfortable with the elderly
- Various types of residences available to older adults, including independent living, assisted living, residential care, and skilled nursing facilities
- Geriatric case management services
- Specialized services for older persons with dementia
- Services for caregivers of frail older adults
- Congregate meal sites and home-delivered meal programs
- Senior recreation centers
- Day care centers for the elderly
- Income assistance programs
- Transportation services
- Hospital-based programs
- Legal services, including regulations and agencies that cover guardianship of dependent adults or elderly
- Home health services
- Emergency services that provide monetary loans or food or pay utility bills in bad weather
- Elder abuse laws and hotlines

To locate supportive services, good initial sources are the local Area Agency on Aging, Alzheimer's Association chapters, geriatric case managers, the aging service section of public social services, ombudsman programs, adult protective services, self-help groups, and hospital discharge planners. Remember that both public and private resources must be considered.

At times, the decision to refer is quite clear-cut. The client needs a given service that is available, and providing the information is the easiest way to resolve the issue. In other cases, there is a judgment to be made about whether clients would do better to resolve the problem on their own. In one instance, a client who was quite delusional and disorganized in her thinking was facing eviction from an apartment where the rent had been raised beyond her fixed retirement income. While proceeding with therapy, the therapist actively attempted to secure a placement in public housing. This was not an easy task as the supply was far smaller than the demand. While the housing bureaucracy was being dealt with, the client recovered sufficiently to implement her own plan: the recruitment of three roommates to share expenses. The arrangement lasted for 2 years.

The outcome of the preceding example points to a potential conflict between the values of psychotherapy and those of case management. Therapy is generally oriented toward increasing client independence and working to have clients do things for themselves and solve problems for themselves. Casework is often about solving problems for people by providing concrete service solutions. As the preceding example indicated, it is not always easy to know when an impaired client can still solve a problem independently. The other end of this conflict is illustrated by considering whether it makes more sense to pursue therapy with clients who are so depressed that they have not eaten well in weeks or to immediately refer them to home-delivered meals services and start therapy after a few days of good meals.

Cohort-Based Adaptations

As noted, there are many sources of differences between younger and older adults that are due to cohort dissimilarities rather than to developmental changes. These differences include variations across cohorts in cognitive abilities, educational levels, word usage preferences, normative life trajectories, and the sociohistorical context within which the individual's life story unfolds. These differences hold implications for the adaptation of therapy with older clients who, in this context, are better described as earlier-born clients. This phrasing emphasizes that it is the era into

which one is born, rather than the current position in the life cycle, that is the basis of the adaptation.

The lower levels of education in earlier cohorts suggest that therapists should rely less on abstraction and complex terminology and not assume that the client will share the therapist's psychological worldview. Older adults may require simpler language to describe therapeutic processes and a lengthier explanation of the nature of therapy. These changes are similar to those used when doing therapy with clients of lower socioeconomic status (Goldstein, 1973; Lorion, 1978). The focus on cohort differences and education as the causes of these changes reminds us that more highly educated cohorts will be getting older in the near future and that not all older clients require this adaptation, but only the ones who do have less education.

Life patterns change across cohorts, and then (sometimes) change back. Knowing what is normative for a client depends a great deal on understanding these cohort differences. The psychological significance of a woman not marrying but pursuing a career may be very different for a woman who came of age in the 1940s or 1950s as compared to one who came of age in the 1970s or later. The social stigma and psychological distress of growing up as the child of divorced parents was different for children in the 1930s and 1940s than for children of the late-twentieth century. The later-born therapist can miss such cues by interpreting a 1940s (or 1950s) young adult life by early twenty-first-century standards.

To understand the client's life history, it is helpful to be able to place him or her in the flow of historical time. That is, to some extent, working with earlier-born clients implies a need to understand in outline the history of the twentieth century and especially the events that often have great personal or familial significance: World War I, World War II, the Great Depression, the waves of immigration from Europe in the 1920s, the Jazz Age, the ebb and flow of progressive and conservative politics and moral thinking, and so on. In trying to understand clients, I find myself constantly doing mental arithmetic to construct a sense of the client's life cycle and how it fits into historical time. It is generally helpful to keep in mind when a client reached adulthood and to think about the history and values of that period. To keep the math simple, I add 20 years to the birth year to get an

approximate sense of the cohort that the client reached young adulthood with. Then I transform statements about "I changed jobs 12 years after I married" into "That means he was 34 then, and so it was 1944. Why wasn't he in military service during WWII?" The life course paradigm in sociological conceptions of aging describes this process as using "multiple time clocks" to track where the individual is in the life cycle and to place him or her in the flow of historical time (as well as in the changing roles of the family context over time; see Bengtson & Allen, 1993).

Cohort-based changes may be some of the more significant changes confronting therapists working with clients who are earlier born and whose lives are shaped by events that the therapist does not recall from personal experience. It implies some need to have an understanding of history, not always common among psychotherapists. Much of what one needs to know can be learned from the client, especially as the real issue in all cases is what the client understood the impact of these historical events to be. The questions must be asked, however, and I often find that younger therapists do not want to ask such questions for fear of displaying ignorance or of calling attention to the age difference between them and the older client. On the whole, I find that clients appreciate being asked such questions and feel more clearly understood when they explain events of which the therapist is ignorant.

Cohort differences provide one basis for thinking of older adults as a special population. In a sense, older adults present problems similar to those of clients who are fluent in English but raised in a different culture: Words are the same but may be used in different ways, and the client's experiences are rooted in a social context with which we are not familiar and may be influenced by values different from our own. Earlier-born cohorts are from a different time rather than a different place, but the same responses apply: sensitivity to cues that words are used in different ways, awareness of not sharing a similar background, and being willing to use one's ignorance constructively to learn from the client about the client's experience.

Adaptations Due to Development and Maturation

The earlier overview of gerontology suggested that consistent developmental changes occurring with aging are seen in the slowing of cognitive

processing, changes in cognitive abilities and in memory performance, changes in emotional complexity, and the opportunity to have developed expertise in relationships. Much of maturation in adulthood is characterized by stability or by positive change, with negative changes often being small, not important for socially significant functioning, and compensated for by use of other intact abilities. In addition, it was emphasized that adult developmental change is far from consistent either across individuals or among any one individual's various characteristics. The potential impact of each of the consistently observed factors on the practice of psychotherapy is considered in this section.

Slowing

The slowing of cognitive processes that occurs with normal aging, which is increased with many chronic diseases, can become a noticeable influence on communication between older and younger adults. The smaller capacity of working memory in later life is likely to have a similar impact on processing conversation and written materials. It is especially noticeable if the younger professional is feeling rushed or talks quickly as a matter of habit, or when the older person has the additional slowing that comes with depression, hypertension, dementia, or other disorders with psychomotor slowing as a symptom. In any case, the recommendation is clear: If there appears to be some uncertainty in communication, the younger therapist should relax and slow down the pace of the conversation.

The impact of slowing in therapy is that the conversational flow of each session is usually slower than with younger adults in both the pacing of sentences and the latency between client speech and therapist speech. Speaking quickly often leads to communication inaccuracy and the need to repeat. The therapist working with older clients will need to be more aware of pacing in sessions and may need to resist actively any personal tendency to speak quickly in response to time pressure, anxiety, or excitement.

If these changes were not compensated in other ways, one would expect that therapeutic progress as a whole would be slower with older adults in terms of number of sessions required to reach therapeutic goals. In a meta-

analysis of therapy outcome studies with older adults, Pinquart and Sörensen (2001) reported that studies using more than nine sessions achieved better outcomes than shorter interventions. One study of therapist-rated change suggested that the old-old need more sessions to achieve gains comparable to the young-old (Knight, 1988).

Memory

Changes in the capacity of working memory in later life (Light, 1990; Salthouse, 1991) may also require some modification of communication style in the therapy setting. Working memory is the active processing capacity of memory—the number of things that can be actively held in memory and worked on at one time. This limited capacity store may be slightly smaller in later life. If so, it may account for changes in comprehension of speech and in problem-solving abilities. Both of these changes can be compensated for by slowing the pace of speech, simplifying sentence structure, and presenting problems in smaller pieces.

Fluid versus Crystallized Intelligence

To the extent that therapy mostly draws on well-learned information about oneself and the world, there is not likely to be any major effect of developmental aging on the therapeutic process. The tasks associated with fluid intelligence often have a timed component or involve visually mediated processing. Reasoning is usually associated with fluid intelligence. If reasoning declines with aging, it may have some impact on therapy. The required changes are likely to be similar to those that one might make working with less educated adults; that is, one may have to use more concrete examples and do more of the inferential work oneself rather than relying on the client to think through the implications of abstract interpretations.

Expertise and Greater Cognitive Complexity

The development of expertise through life experience will, in general, be an asset when working with older adults. Older clients often have expertise that is relevant to the problem they brought to therapy. Their accumulated knowledge of people and relationships can be brought to

bear on current relationship problems. Tapping into this expertise can be an adaptation for the therapist in a couple of ways. First, therapists working with younger adults may be more used to encouraging people to explore themselves to discover untapped strengths. Switching to helping people recall and use already existing strengths is not more difficult, but it is different. Second, working with clients who have more experience and expertise than you do is a change of perspective for the therapist. It can be quite exciting for therapists who are open to learning from clients; it may be anxiety arousing for therapists who are uncertain of their own abilities.

When older adults do exhibit greater cognitive complexity, these attributes are likely to be helpful in therapy. An ability to appreciate the ebb and flow of change in life, to take the other person's viewpoint, to appreciate differences in perspective based on cultural, religious, or family differences are all beneficial to the work of therapy. As with expertise, it can be unsettling to work with clients who may have more of these abilities than you do. Older adults may explain to you how they resolved a problem or may explain their understanding of an interpersonal event because it is outside of your comprehension. For example, my own understanding of how parents negotiate adult-to-adult relationships with grown children while still retaining vivid memories of this individual as a child and a deeply felt sense of needing to protect him or her comes from clients who explained it to me.

Emotional Changes in Later Life

Emotionality is thought to be more complex and probably less intense in later life. In general, my experience has been that sessions with older clients involve less expression of emotion than sessions with younger adults. Older people are less inclined to cry (especially to sob), less inclined to shout in anger, and less inclined to bounce up and down for joy. They often describe complex mixes of emotional reactions to the events of their lives. An argument between an older client and her middle-aged daughter may arouse a mixture of anger, sadness, guilt, and pride; the same incident in a younger client may well be associated with only one of these emotions.

CONCLUSION

We have considered and rejected the presumed pessimism about therapeutic work with older adults. The discussion of possible adaptations of therapy with the elderly has considered the following three perspectives on why modification might be needed:

1. The contextual view points to differences due to socially created and modifiable differences in lifestyle between the young and the old. These differences are specific to those elderly who are in that social contexts: retired, live in segregated environments, become senior advocates, and so forth.
2. Cohort differences are differences between groups born at different times. There is a need to comprehend the historical background and the values of the generational groups that are now older and to be aware that these differences are specific to persons of a given era. Future generations of elders will, of course, be different from the current ones. There is some evidence (e.g., Schaie, 1996) that differences between cohorts born in the early to mid-twentieth century are larger than cohort differences between those born in midcentury and later, at least with regard to differences in intellectual functioning. Whether this will be true for values, life experiences, and so forth remains to be seen.
3. The developmental perspective suggests that modification may be needed because of developmental changes in the adult as he or she ages. The conclusion so far is that such changes primarily mean a possible need to slow down the therapeutic conversation and rely less on the client's inferential reasoning abilities and also to recognize the client's greater maturity, expertise based on adult life experiences, greater cognitive and emotional complexity, and more mature coping strategies.

The discussion of these sources of change has laid a groundwork for arguing that the major adaptations to therapy with the elderly will arise from cohort effects and social context effects rather than from

developmental changes. This perspective makes the therapist's task in approaching work with the older client easier in that comprehending persons of different backgrounds is easier than comprehending stages of life that one has not yet experienced. It also brings the work of understanding the elderly within the range of familiar skills: Most therapists have had exposure to different cohorts and to persons of different social backgrounds. In addition, reflection on therapeutic experience suggests positive characteristics of older clients that may make them very well suited to the work of therapy.

Before leaving the topic of adaptations to therapy, there are other observations based on clinical experience that lead to an optimistic attitude toward therapy with older people. Older people bring to therapy a broad range of experience, richer psychological histories, and opportunities to experiment that are characteristic of the postretirement lifestyle.

Perhaps the most obvious thing that can be said about the potential for change in older adults is that they have lived longer than younger adults. This implies a broader range of experience and more time to have learned about themselves and others. The more traditional, largely pessimistic, view has been that adult development and increased experience make people rigid and set in their ways. Yet some clinicians working with the elderly have felt that the effect is quite the reverse: that growth and experience teach adults to be more flexible, less dogmatic, and more aware that there are different ways of looking at life.

A closely related reason for optimism about therapeutic change with the elderly is that older adults have a much richer psychological history with which to work. Although there is seldom time to work through all of it, exploration of any given theme in life can produce multiple examples that provide the therapist with much richer data to build a conceptualization of the person's approach to that special aspect of his or her life. If, for example, the client is concerned about some quality of the relationships in his or her life, the older client can relate the rich experience of a lifetime of diverse relationships with friends, lovers, spouse(s), children, coworkers in various job settings, grandchildren, and others. If the issue has been of concern for some time, there likely are examples of many different ways that the client has approached the problem in the past with various patterns of success and failure. The therapeutic challenge is to be able to absorb as much information

as possible and to interpret and reinterpret the data of the client's life in new and helpful ways that are relevant to current issues.

Therapy involves more than simply understanding oneself and learning new ways of looking at things. Once the understanding is reached there is usually a need to do some things differently. For making these changes, some of the very factors that are traditionally considered losses in old age remove significant barriers to change. When a younger adult reaches a new understanding in therapy and wants to follow up with changes in life outside the therapy room, there is often considerable pressure to remain the same from coworkers, spouse, and family. In addition to actual pressure from others, the energy drain of working and raising a family may seriously reduce the ability to devote time and energy to making the change. The postretirement older adult with more leisure time and relatively little involvement in stable and stabilizing social environments such as work and family is in an excellent position to explore various alternative ways of acting and being. Virtually any change that clients desire to make can be experimented with in the context of the options provided by enhanced leisure time and decreased social pressure.

This spirit of optimism about the possibility for change in late life runs counter to common folk wisdom about aging and clinical lore about older adults. It is, however, based on an understanding of aging gathered from gerontological knowledge and clinical experience with a large number of older adults in various community settings. In the absence of ill health, not only is there no block to normal therapeutic work with the elderly, but these positive factors can make working with the elderly a very rewarding experience for the therapist.

REFERENCES

Aranda, M. P., & Knight, B. G. (1997). The influence of ethnicity and culture on the caregiver stress and coping process: A sociocultural review and analysis. *Gerontologist, 37,* 342–354.

Baltes, P. B., & Staudinger, U. M. (2000). A metaheuristic (pragmatic) to orchestrate mind and virtue toward excellence. *American Psychologist, 55,* 122–136.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Bengtson, V. L., & Allen, K. R. (1993). The life course perspective applied to families over time. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 469–498). New York: Plenum Press.

Berezin, M. (1963). Some intrapsychic aspects of aging. In N. E. Zinberg & I. Kaufman (Eds.), *Normal psychology of the aging process*. New York: International Universities Press.

Carstensen, L. L. (1992). Social and emotional patterns in adulthood: Support for socioemotional selectivity theory. *Psychology and Aging, 7,* 331–338.

Carstensen, L. L., Fung, H. H., & Charles, S. T. (2003). Socioemotional selectivity theory and the regulation of emotion in the second half of life. *Motivation and Emotion, 27,* 103–123.

Carstensen, L. L., & Turk-Charles, S. (1994). The salience of emotion across the adult life span. *Psychology and Aging, 9,* 259–264.

Dixon, R. A. (2003). Themes in the aging of intelligence: Robust decline with intriguing possibilities. In R. J. Sternberg & J. Lautrey (Eds.), *Models of intelligence: International perspectives* (pp. 151–167). Washington, DC: American Psychological Association.

Dura, J. R., Stukenberg, K. W., & Kiecolt-Glaser, J. (1991). Anxiety and depressive disorders in adult children caring for demented parents. *Psychology and Aging, 6,* 467–473.

Gitelson, M. (1948). The emotional problems of elderly people. *Geriatrics, 3,* 135–150.

Goldstein, A. P. (1973). *Structural learning therapy: Toward a therapy for the poor.* New York: Academic Press.

Hultsch, D. F., & Dixon, R. A. (1990). Learning and memory in aging. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (3rd ed., pp. 259–274). New York: Academic Press.

Knight, B. G. (1988). Factors influencing therapist-rated change in older adults. *Journal of Gerontology, 43,* 111–112.

Knight, B. G. (2004). *Psychotherapy with older adults* (3rd ed.). Thousand Oaks, CA: Sage.

Knight, B. G., & McCallum, T. J. (1998). Family therapy with older clients: The contextual, cohort-based, maturity/specific challenge model. In I. H. Nordhus, G. VandenBos, S. Berg, & P. Fromholt (Eds.), *Clinical geropsychology* (pp. 313–328). Washington, DC: American Psychological Association.

Knight, B. G., Nordhus, I. H., & Satre, D. D. (2003). Psychotherapy with the older client: An integrative approach. In I. B. Weiner (Series Ed.) & G.

Stricker & T. A. Widiger (Vol. Eds.), *Comprehensive handbook of psychology: Vol. 8. Clinical psychology* (pp. 453–468). New York: Wiley.

Knight, B. G., & Satre, D. D. (1999). Cognitive behavioral psychotherapy with older adults. *Clinical Psychology: Science and Practice, 6,* 188–203.

Knight, B. G., Silverstein, M., McCallum, T. J., & Fox, L. S. (2000). A sociocultural stress and coping model for mental health outcomes among African-American caregivers in southern California. *Journal of Gerontology: Psychological Sciences, 55B,* P142–P150.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Light, L. L. (2000). Memory changes in adulthood. In S. H. Qualls & N. Abeles (Eds.), *Psychology and the aging revolution: How we adapt to longer life* (pp. 73–97). Washington, DC: American Psychological Association.

Lorion, R. P. (1978). Research on psychotherapy and behavior change with the disadvantaged. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 903–938). New York: Wiley.

Ory, M., Hoffman, R. R., Yee, J. L., Tennstedt, S., & Schulz, R. (1999). Prevalence and impact of caregiving: A detailed comparison between dementia and nondementia caregivers. *Gerontologist, 39,* 177–185.

Pinquart, M., & Sörensen, S. (2001). How effective are psychotherapeutic and other psychosocial interventions with older adults? A meta-analysis. *Journal of Mental Health and Aging, 7,* 207–243.

Qualls, S. (1996). Family therapy with aging families. In S. H. Zarit & B. G. Knight (Eds.), *A guide to psychotherapy and aging: Effective interventions in a life-stage context* (pp. 121–138). Washington, DC: American Psychological Association.

Rotter, J. B. (1954). *Social learning and clinical psychology.* Englewood Cliffs, NJ: Prentice-Hall.

Rybash, J. M., Hoyer, W. J., & Roodin, P. A. (1986). *Adult cognition and aging.* New York: Pergamon Press.

Salthouse, T. A. (1991). *Theoretical perspectives on cognitive aging.* Hillsdale, NJ: Erlbaum.

Salthouse, T. A. (1996). The processing-speed theory of adult age differences in cognition. *Psychological Review, 103,* 403–428.

Schaie, K. W. (1995). *Intellectual development in adulthood: The Seattle Longitudinal Study.* New York: Cambridge University Press.

Schaie, K. W. (1996). Intellectual development in adulthood. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (4th ed., pp. 266–286). San Diego, CA: Academic Press.

Schulz, R., O'Brien, A. T., Bookwala, J., & Fleissner, K. (1995). Psychiatric and physical morbidity effects of dementia caregiving: Prevalence, correlates, and causes. *Gerontologist, 35,* 771–791.

Small, B. J., Dixon, R. A., & Hultsch, D. F. (1999). Longitudinal changes in quantitative and qualitative indicators of word and story recall in young-old and old-old adults. *Journal of Gerontology: Psychological Sciences, 54B,* P107–P115.

Smith, A. D. (1996). Memory. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (4th ed., pp. 236–250). San Diego, CA: Academic Press.

Smyer, M. A., & Qualls, S. H. (1999). *Aging and mental health.* Malden, MA: Blackwell.

Verhagen, P., Marcoen, A., & Goossens, L. (1992). Improving memory performance in the aged through mnemonic training: A meta-analytic study. *Psychology and Aging, 7,* 242–251.

Zarit, S. H., & Zarit, J. M. (1998). *Mental disorders in older adults: Fundamentals of assessment and treatment.* New York: Guilford Press.

Zeiss, A. M., & Steffen, A. M. (1996). Interdisciplinary health care teams: The basic unit of geriatric care. In L. L. Carstensen, B. A. Edelstein, & L. Dornbrand (Eds.), *The practical handbook of clinical gerontology* (pp. 423–450). Thousand Oaks, CA: Sage.

Zelinski, E. M., & Burnight, K. P. (1997). Sixteen year longitudinal changes in memory and cognition in older adults. *Psychology and Aging, 12,* 503–513.