Professional Psychology: Research and Practice
2009, Vol. 40, No. 6, 601–608

0735-7028/09/$12.00 DOI: 10.1037/a0017215

Aging, Mental Health, and Demographic Change: Challenges for Psychotherapists

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People are living longer, and in better health, than in any prior point in history, with far-reaching but as yet underrecognized implications for mental health professionals. This phenomenon affects both the developed and the developing world. With greater numbers of older people, mental health professionals will need to develop greater awareness, understanding, and appreciation of gerontology to deliver optimally effective psychotherapy with this population. The nature of psychological issues encountered in clinical practice will also change—for example, intergenerational issues among blended families, increased retirement and leisure time, and expectations of greater health and productivity in later life from baby boomer cohorts. These issues are important for mental health professionals to recognize, as the increased sophistication of the baby boomer generation in terms of health care will lead to higher expectations of mental health care. The authors have chosen to discuss the implications of an ageing population with reference to a cognitive–behavioral perspective, but the issues raised here and practical suggestions contained within this article are not restricted to practitioners of Cognitive–Behavior Therapy.

Keywords: geropsychology, demographic-change, psychotherapy, cognitive-behavior therapy, lifespan-development.

The world is experiencing a profound and irreversible demographic shift that will impact on the structure of societies (United Nations Department of Economic and Social Affairs, Population Division, 2007b). A change to life expectancy is affecting the developed and the developing world alike, and the good news is that people are living longer and healthier. Over the next 50 years, the population of older people across the world (aged 60 years and over) is expected to triple from 673 million people in 2005 to 2 billion by 2050 (U.N. Department of Economic and Social Affairs, Population Division, 2007b). Although increasing longevity is a global phenomenon, Europe is aging particularly rapidly so that, when considering the percentage of population aged 60 years and above, with the exception of Japan (first oldest with 27.9% of its population aged 60 and over), all of the world's 30 oldest countries are European (U.N. Department of Economic and Social Affairs, Population Division, 2007a). Meanwhile, the United States is on the threshold of a boom in the older population as the first of the baby boomers turn 65 in 2011 (Wan, Segupta, Velkoff, & DeBarros, 2005).

The U.S. Census Bureau (2008) projected that the number of Americans aged 65 and over will more than double from 38.7 million in 2008 to 88.5 million by 2050; by 2030, when all baby boomers will be 65 and over, 20% of all Americans will be aged 65 and over. The diversity of the population in the United States will be increased by relatively large levels of immigration resulting in a much more ethnically diverse population, with minorities expected to become the majority by 2042 (U.S. Census Bureau, 2008). However although new immigrants tend to be young, the net effect of immigration is small for the aging of society, raising the percentage of the working age population by about one percentage point (Camarota, 2007). Thus, psychologists are increasingly likely to come into contact with older people, and geropsychology is likely to be a growth area for psychologists (Koder & Helmes, 2008).

Population aging for nations is not solely determined by increasing numbers of older people; it is also important to consider fertility rates (Kinsella & Velkoff, 2001; U.N. Department of Economic and Social Affairs, Population Division, 2007b: World Health Organization [WHO], 2002). As fertility rates for the developed world are below replacement level (i.e., the proportion of births needed to keep populations from declining), this can lead to rapid population aging (U.N. Department of Economic and Social Affairs, Population Division, 2007b), where the proportion of older people increases, mirrored by a decline in the numbers of

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the population aged 18 and under. This information is summarized in Table 1.

Health policies may need to better promote choice, independence, and control, with a move away from institutional care and an orientation toward assisting people to reside in the community, providing supports for caregivers and encouraging people to take proactive steps to maintaining their health (Administration on Aging, 2007). As the psychological and physical health needs of a 65-year-old will be markedly different to a 95-year-old (Wan et al., 2005), societies in the developed world are going to have to consider the potentially powerful implications of failing to train sufficient numbers of health care professionals to work with older people (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Laidlaw & Baikie, 2007).

One consequence of a demographic transition at a societal level is that women are marrying later, impacting on the age at which they complete education, enter the workforce, and start a family (Matheson & Babb, 2002). In the United States currently, women are now more likely to have fewer children, with only 10% of women having four or more children in 1998 compared to 36% of women in 1976 (U.S. Census Bureau, 1999). This is an important change for psychotherapists working with older people to take note of because women have predominantly been the main source of informal caregivers for older people in need of care (Pinquart & Sorensen, 2006). Thus, the demographic shift resulting in smaller family sizes has potentially important financial and policy implications for the long-term care of older people. However, although an increasing proportion of older people in society may present some challenges, one must not lose sight of the fact that older people as a whole often make many contributions to society such as voluntary work with charities, and unpaid family work involving grandchildren, or long-term informal caregiving (WHO, 2002).

Increases in Longevity Most Evident With "Oldest Old"

Globally, the fastest growth in population is seen in the oldest old (people aged 85 years plus), with projections for a nearly fivefold increase from 88 million in 2005 to 402 million in 2050 (U.N. Department of Economic and Social Affairs, Population Division, 2007b). In the United States, this group is projected to double in number from 4.7 million in 2003, to 9.6 million in 2030, and to double again to 20.9 million by 2050 (Wan et al., 2005). The number of centenarians is expected to increase globally by a factor of 20 (U.N. Department of Economic and Social Affairs, Population Division, 2007b). In the United States, the numbers of centenarians is projected to rise by a factor of close to eight, from 79,000 centenarians in 2010 to 601,000 by 2050 (U.S. Census Bureau, 2008).

Table 1
Population of the World 2005 and 2050 by Age Groups, (Medium Variant)

	Population in millions			
	2005		2050	
Variable	0 to 14 years	60+ years	0 to 14 years	60+ years
World total	1,845	673	1,824	2,006
More developed regions	207	245	190	406
Less developed regions	1,638	428	1,635	1,600
Least developed regions	318	39	491	179
Africa	382	48	59	207
Asia	1,104	363	946	1,249
Latin America/Caribbean	166	50	138	187
Europe	116	151	97	229
North America	68	56	76	121
Oceania	8	5	9	12

Note. Source: United Nations (2007) Population Division of the Department of Economic and Social Affairs of the U.N. Secretariat. Reprinted with permission.

Although there may be many unexpected challenges associated with great age, there may also be unexpected positives. Therapists will likely need to maintain a stance of nonassumption about aging and an appreciation of individual variation when working with older people in the future. Being sensitive to the evolving perspectives of those entering advanced age will be required, particularly as the age divide between therapist and patient widens. Although there could be a difference of seven generations between therapist and client, age by itself is less informative than an understanding of differing social, cultural, and technological experiences across generations. For example, women's expectations and the options available to them have changed markedly, particularly in the last 50 years. This may create barriers to understanding between cohorts within the therapeutic relationship and may result in poorer treatment outcomes. Therefore, knowledge and understanding of gerontological theories of aging, rather than age per se, is likely to become more important for psychotherapists (Knight et al., 2009).

We are inflexibly tied to chronological age when working with older adults because so much of our language is tied up with age. Although we may make distinctions and therefore assumptions about adults who fall into young–old and old–old categories, older adults are a heterogenous group and likely to become even more so as longevity increases. Although longevity may be determined by genetics and heritability, we ignore at our peril the social effects of lifestyle choices, chronic illness, and experience of life events on people's physical and mental health and ultimate longevity (Kirkwood, 2002). Chronological age may provide some limited orienting information about general expectations, but at an individual level, the therapist needs to retain a data gathering perspective to understand what are the true variables. Perhaps, age here may be the least important variable for the therapist to take account of.

Aging Is a Gender Issue

Aging is a gender issue (U.S. Census Bureau, 1999; WHO, 2002). Women outnumber men at every age band, with the gap widening as people age and men on average dying 7 to 8 years before women (Kinsella & Velkoff, 2001). In the United States, 14.4% of the over-65 female population live to age 85 compared to just 8.4% of men, representing a gender ratio of more than two women for every man (Gist & Hetzel, 2004). At age 55 and above, there are 81 men for every 100 women, but at age 85 and above there are only 49 men for every 100 women (U.S. Census Bureau, 1999). Psychotherapists working with older people will need to take account of the fact that aging affects the sexes differently and aging therefore may be perceived differently. The longer lifespan of women means they will face more challenges of aging such as dealing with chronic illnesses, and as they are more likely to be

widowed than older men, they are more likely to be living alone (U.S. Census Bureau, 1999; WHO, 2002).

It is estimated that in the United States, 7.5 million older women live alone compared to just 2.5 million men (Gist & Hetzel, 2004). This is likely to impact on the sorts of mutually supportive networks that the genders develop (Ajrouch, Blandon, & Antonucci, 2005; Gray, 2009). In midlife, women are much more likely to be integral members of extended-family generations, and with demographic change many more women in their 60s and 70s will be part of three- and sometimes four-generation families. This will mean that as well as meeting the responsibilities of caring for adult children, women are also more likely to have care responsibilities for frail mothers (Grundy & Henretta, 2006). Thus, psychotherapists may have to conceptualize new ways of working with these pivot or sandwich generations, in which demands are simultaneous across three generations. With life expectancy increasing the complexity of dealing with four-generation families, a stronger role for family systems work to be developed for use with older adults is needed (Qualls, 1999).

Therapists may also have to confront increasingly complex cultural issues in their practice (Knight & Lee, 2008). Although it may only affect a minority of mental health professionals working with older adults, a dearth of research on aging in cultural groups, most particularly aboriginal persons, will disproportionately affect the ability of such therapists to have an evidence base for their interventions. For example, in Australia it has been accepted for many years that mental health professionals working with aboriginal groups did not need to pay attention to aging concerns because in this population the likelihood of an individual reaching age 65 and beyond was relatively remote. However, new data on patterns of improved morbidity and mortality in these populations (Manly & Espino, 2004) signal that a renewed emphasis on strategies for assessment and intervention with these groups should begin in earnest. This is beginning to happen in Australia with the recent development of the Kimberley Indigenous Cognitive Assessment (KICA) by LoGiudice et al. (2006). The KICA is at present the only empirically validated dementia assessment tool for use with older Indigenous Australians.

Psychotherapy Practice Implications of Demographic Change

Psychotherapists Will Need To Understand Normal Aging

Therapists will need to become knowledgeable about longevity statistics and demographic change (Knight et al., 2009). Equipped with information contained in practice guidelines (see APA Working Group on the Older Adult, 1998), therapists will be better equipped to identify and challenge erroneous age related negative cognitions (e.g., growing older is depressing) that could sound understandable and realistic to therapists inexperienced in working with older people (Laidlaw, Thompson, & Gallagher-Thompson, 2004).

Depressed older people may erroneously appraise their remaining years as bound up with negativity, loss, and decrepitude. Thus, depressed older people often view their age as being against them when it comes to managing depressive symptoms. When one speaks with a depressed older adult about increased lifespan, their view about aging may be mood congruent, and therefore negative. For instance, when an older person says "Old age is a terrible time," or "All my problems are to do with my age," or "I'm too old to change my ways now," this can appear difficult to challenge from the naïve perspective of a younger therapist. Therapists need to bear in mind that these appraisals are examples of age-related negative cognitions that can be challenged by standard Cognitive–Behavior Therapy (CBT) techniques such as cognitive restructuring. This technique works by identifying rigid, unhelpful, and unrealistic appraisals and substituting these with more helpful and realistic evaluations (Beck, Rush, Shaw, & Emery, 1979). Thus, CBT can be used to challenge the evidence that people have to support their fears, not so much that they have a limited and restricted timeframe, but that their remaining years will be filled with unhappiness and despair.

Some individuals find transitions associated with aging, such as retirement, unwelcome and difficult because they do not recognize themselves as members of the older population and may reject this definition or engage in denial (Levy, 2003). Aging stereotypes operate outside of many people's awareness and influence health status and the will to live. Levy (2003) stated that "When individuals reach old age, the aging stereotypes internalized in childhood, and then reinforced for decades, become self-stereotypes" (p. P204). For someone with an internalized negative age stereotype, there may be a growing sense of dread about what aging will bring accompanied by an increased vigilance for the first signs of "the slippery slope." This may be triggered by bereavement, accident, or physical illness. In these situations, the older person may not have reflected on their aging until the occurrence of such an event, and losses associated with aging such as the development of a chronic illness may activate negative aging stereotypes (Levy, 2003) and become the first "unwelcome" intimation of aging for an individual. Psychotherapists can deal with this by using standard techniques in CBT by helping their client to examine the evidence for and against their beliefs and by coming up with alternative explanations for their thoughts. The behavioral responses used to deal with changes to circumstances can also be evaluated for their utility, and by these means positive adjustment can be accelerated and successful aging recommenced. Challenges associated with aging could be conceptualized as a diathesis consistent with the Beck model of cognitive therapy (Beck et al., 1979), especially in those individuals with a latent maladaptive internalized negative schema associated with aging.

Many of the current cohort of older people will have experienced the early deaths of their own parents. In 1900 in the United States, average life expectancy at birth was 47 years, whereas by 2000 average life expectancy at birth was 77 years (Wan et al., 2005). Thus, many of the current cohort will assume that they will likewise die at young age. As people approach the age at which their parents died or developed serious illnesses such as dementia, they may become anxious that they cannot escape their presumed "biological inheritance." In fact, people will have many more years of life than previous generations, and familial disability and longevity are not necessarily predictive of one's own morbidity and mortality (cf. Fries, 1983). Social and lifestyle factors are important as well as biology and genetics in determining how an individual ages. The transmission of such information by the therapist can free an individual to view their own aging as independent of factors that they had previously thought were immutable.

Psychotherapists Will Need To Be Able To Deal With Physical Comorbidities When Dealing With Depression and Anxiety

Depression and anxiety are major causes of mental health problems in later life, and although depression rates may increase with age, rates of depression and anxiety in later life are lower than rates reported for adults of working age (Blazer & Hybels, 2005). The Centers for Disease Control and Prevention and National Association of Chronic Disease Directors (CDC) recently produced a health brief based on findings from a behavioral risk factor surveillance system. The CDC (2008) noted that contrary to popular belief older people do not report experiencing frequent mental distress and lifetime histories of depression and anxiety are low (10.5%, 7.6% respectively) and lower than those reported for adults aged 50 to 64 years (19.3%, 12.7% respectively). Medical conditions increase rates of depression in later life, with a greater burden of illness resulting in an increased risk of depression (Alexopoulos, 2005), but most older adults who develop physical problems do not develop depression (Blazer & Hybels, 2005). Nevertheless, medical illnesses complicate the recognition and treatment of depression and anxiety (Krishnan et al., 2002). As it is estimated that 80% of older Americans have at least one chronic health problem and up to 50% will have two (Wan et al., 2005), therapists may be confronted with an increase in medical issues with a complexity and chronicity attached to them that is rarely seen currently. Death is also more likely to arise because of noncommunicable diseases such as cancer, heart disease, and stroke rather than due to injury or infections. Thus, older people may be more likely to have lived with a number of chronic diseases for many more years before their eventual demise. This again provides a complicating factor that psychotherapists may need to reconcile with new or existing models of psychotherapy.

A useful model (or metatheory) that promotes optimal aging in the face of realistic challenges has been developed by Baltes and colleagues (Baltes, 1991; Freund & Baltes, 1998). The selective optimization with compensation (SOC) model has three main components that are necessary for the successful adaptation to challenges faced during aging (Baltes, 1997). There are indications that using SOC as a life-management strategy may have protective buffering effects for well-being in later life (Jopp & Smith, 2006). Selection is a process in which highly valued roles and goals can be maintained in the face of loss, but older people may need to select alternative strategies to achieve these. In most circumstances when helping an individual to dynamically adjust to age-related challenges, the individual will be adopting "loss-based selection" (Freund & Baltes, 1998), in which the individual modifies goal attainment due to a reduction in resources (Jopp & Smith, 2006). Optimization requires that an individual focuses resources on achieving goals through practicing or relearning of activities. It must be done in an intentional manner. Compensation requires that an individual engage in alternative means of achieving the highest possible level of functioning, therefore taking account of the reality of a person's capacity and physical integrity. Baltes (1997) illustrated SOC in action when he cited the example of the acclaimed pianist Arthur Rubinstein who at the age of 80 was interviewed about his skill. (Rubinstein retired from performing at the age of 89 due to deteriorating eyesight.) He explained his enduring level of prowess by stating that as he reduced his repertoire (selection), he was thus able to practice this more frequently (optimization) and, "He suggested that to counteract his loss in mechanical speed, he now used a kind of impression management, such as introducing slower play before fast segments, so as to make the latter appear faster (compensation)" (Baltes, 1997, p. 371).

SOC can be incorporated into psychotherapy, especially CBT, as its problem-solving orientation is a good fit with an aim of symptom reduction and achievement of an improvement in functioning. Laidlaw et al. (2003) gave the example of a man who, having made a good recovery from stroke, declined to re-engage with hobbies such as ballroom dancing because of embarrassment at enduring consequences of his stroke. As a result, he became isolated and cut off from his social network. The therapist used SOC to help initiate a program of graded task assignment and activity. Selection reduced the range of possible dance partners to those that the client felt most comfortable with in terms of his "disability." In addition selection was also employed to reduce the repertoire of dances that the client might attempt after his stroke. Optimization was employed so as to increase his comfort with his chosen dance moves and partners. Finally, compensation was employed in the dancehall because it was likely fatigue levels would present a potential obstacle. Thus, the client chose to sit out parts of dances, and to either join dances later or finish dance sequences midway through. The act of compensation was normalized as the client noted that many other men in the dancehall did not dance all the steps in every dance and often joined and left dances when they wished. By using SOC, the therapist used a problem-focused, goal-oriented means of helping a client increase his activity while simultaneously accepting and working within realistic physical obstacles to the completion of previously highly valued roles and goals. As Laidlaw and colleagues noted, "Although there were restrictions that were not evident before the stroke he was nonetheless able to participate where before he had not" (p. 138).

Demographic Change May Reduce Social Capital Available to Older People

Social capital is the amount of emotional and practical supports that one can draw on from families and friends, and viewed in this way social support is an outcome of social capital (Gray, 2009). When working with depressed or anxious people, it may be important to assess social capital because social networks may become modified as one ages. In addition, as a result of increased longevity, relationships may also come under strain as people now face an increased number of years together, after retirement. For many couples, retirement may require a period of adjustment, and it is more helpful to view this as a process rather than a state (Kim & Moen, 2002). Women appear to find this a more difficult adjustment as retirees and as partners (van Solinge & Henkens, 2005). Families are becoming smaller, and the increases in the rates of divorce, family break-ups, and reconstitutions are having an impact on the potential pool of informal caregivers. Older people are also participating in more complex family structures (Ajrouch et al., 2005). As a result of increased longevity and changes to fertility rates, adults could have more parents than children (Lowenstein, 2005). In addition, in working with couples the therapist is wise to remember that quantity is not equivalent to

quality when it comes to relationships, and the longevity of a relationship does not mean that the partnership is supportive and nurturing. Older adult psychotherapists will therefore need to carefully assess the familial and intergenerational context when working with older people who may be members of families of four generations with different roles and demands.

Future cohorts of older people (the baby boomers) are likely to endorse radically different attitudes to previous older cohorts (Gilleard & Higgs, 2007; Hillman, 2008). Although longevity may bring an increasing experience of loss (Boerner & Jopp, 2007), for many aging overall will be a positive and happy time (Laidlaw, Power, Schmidt, & the WHOQOL Group, 2007). Living longer may mean experiencing comparatively larger amounts of leisure time after retirement from work with unanticipated interpersonal and sociocultural consequences. Research has shown that older people with unresolved regrets experience reduced levels of emotional well-being (Torges, Stewart, & Nolen-Hoeksema, 2008). Socio-emotional selectivity suggests that emotional regulation and emotional investments in close relationships become more important as people age (Carstensen, Isaacowitz, & Charles, 1999; Carstensen & Mikels, 2005). There may be a loosening of constraints that had been in place because of fears about career prospects, or social consequences. If one is retired and in reasonable good health, without work or other commitments, then all aspects of life may be open to reappraisal in terms of the personal fit (Gilleard & Higgs, 2007). Thus, psychotherapy for this phase of life may afford a transitional period of reflection resulting in an individual introspectively (re-) appraising lifestyle choices.

Psychotherapists Will Need To Become More Sophisticated in Understanding Whether Conceptual or Structural Changes to Psychotherapy Are Required

Empirical evidence suggests that psychotherapy with older people, particularly CBT, is efficacious (Gatz, 2007; Pinquart, Duberstein, & Lyness, 2006; Scogin, Welsh, Hanson, Stump, & Coates, 2005; Wilson, Mottram, & Vassilas, 2008). Research has tended to evaluate outcome of manualized nonmodified therapies using treatment models largely without consideration of lifespan developmental theories of aging (Laidlaw et al., 2004). Nonetheless, there remains a persistent question regarding the issue of adaptation and modification of CBT with older people (Laidlaw & McAlpine, 2008; Secker, Kazantzis, & Pachana, 2004). Outcome studies by their nature are unlikely to answer questions about process issues, and it is this aspect of CBT for late-life depression that may become the important future direction of research activity (Scogin et al., 2005).

The need to consider whether modifications are necessary to enhance outcome may arise because, understandably, therapists unused to working with oldest-old clients might become confused as to what adaptations or modification may be necessary and under what circumstances. When working with older people, it is not uncommon to work with people whose history of depression and anxiety may stretch back 60 years or more into early adulthood or even in childhood in some cases. This may provide more of an acute challenge for therapists adhering to a CBT approach as this model emphasizes a "here and now" problem-focused symptom-reducing orientation; thus, the therapist can become confused as to how far back in a client's history one must delve (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003). The answer may lie in part in examining major stressors and life events in their historical context and locating these on a personal timeline. This can be very helpful in understanding the developmental history of a client, as well as gaining an understanding of how the client generally reacts to difficulties and challenges. Spending too much time on historical factors often provides information about mainly nonmodifiable experiences. A more efficacious approach is to focus on changeable aspects of a current problem such as behaviors that prolong low mood resulting in isolation (Laidlaw & McAlpine, 2008). Thus, addressing maintaining factors rather than causal factors is likely to be more productive in psychotherapy with older adults.

It will become increasingly common for mental health professionals to have nonagenarian (aged 90 to 99 years) and centenarian clients. This is largely uncharted territory with respect to both biological and nonbiological approaches to psychological distress in later life and certainly to the application of existing psychotherapy treatment models. Ultimately, current models of psychotherapy will need to take heed of demographic changes so as to maximize therapeutic outcomes. Mohlman and Gorman (2005) hypothesized that successful treatment outcome in CBT with older adults is partly determined by intact executive functioning abilities and skills enhancement. In a different approach, Knight and Laidlaw (2009) conceptualized wisdom enhancement as a legitimate target of CBT outcome when dealing with depression. In this new approach, wisdom is considered a way of capitalizing on the many years of experience older people possess in taking a problem-solving orientation to symptom reduction. As depression often results in cognitive biases, this can block access to wisdom utilization among older people such that people ruminate about the past and only see a catalogue of failures. When examining a history of dealing with difficult circumstances, a different narrative may emerge, that of a resilient, resourceful survivor that provides the rationale for the individual to utilize the wisdom of their years to deal with current challenges.

Psychotherapists Need To Develop Interventions for Dementia Care

Dementia is not an inevitable outcome of old age. As a result of demographic change, the relative numbers of people diagnosed with dementia will increase although the relative proportion of the population of older people developing dementia will not. The prevalence of dementia increases with age, occurring in about 1.3% of people 65 to 69 years and approximately doubling with every 5-year increase across the age span, rising to 32.5% in people aged 95 years and older (Alzheimer's Society, 2007). As the number of centenarians is likely to increase within the next 50 years, the likelihood is that dementia will be high in this group, although this research is at an early stage (Silver, Jilinskaia, & Perls, 2001). Increased demand for psychological support for people with dementia and for caregivers is likely. In particular, psychosocial interventions may need to be developed specifically for depression in dementia because the presence of depression increases the burden of disease for the individual. Although work has progressed on developing psychosocial interventions with older people with depression in dementia, this work is still at an early stage and outcome evaluation is at best mixed (Burns et al.,

2005; Logsdon, McCurry, & Teri, 2008). For psychologists working with patients in long-term care, the impact of anxiety is obvious and yet research in this area is largely absent (Powers, 2008). Anxiety is important because it is more prevalent in older populations and also accounts for a greater proportion of burden of disease later in life than does depression (Pachana et al., 2007).

Although an apparently vast literature has developed with respect to interventions for persons with dementia, the amount of empirically validated and theoretically supported evidence is smaller than one might expect (Alzheimer's Australia, 2003, NICE, 2007). Indeed, Gallagher-Thompson and Coon (2007), when reviewing evidence for caregiver interventions, found only three categories of evidence-based treatments for caregiver distress to be efficacious: multicomponent programs, psychotherapy, and symptom-focused skills enhancing psychoeducation interventions. Individualized CBT caregiver interventions are most efficacious for caregivers with significant levels of depression, and group-based CBT interventions are most efficacious for caregivers exhibiting high levels of stress but without overt symptoms of depression.

Summary and Implications

The consequences of increased numbers of older people signal for psychotherapists increasing levels of complexity when working with older people. If people can expect to live 20 or 30 years after retirement, then it is entirely possible that many older people will seek out psychotherapy as a means of maintaining personal growth or for grappling with the challenges of aging.

A recent U.S. survey of clinical psychologists found a majority of respondents worked with older people despite the fact that only a minority had received supervised practice in working with this population (Qualls, Segal, Norman, Neiderhe, & Gallagher-Thompson, 2002). Thus, training and education are fundamentally important to prepare practitioners to meet the needs of older people (Knight et al., 2009). Yet, to date few psychologists actually choose to specialize in work with older adults. Perhaps this may be due to a fear of aging among psychologists themselves. Paradoxically, when Koder and Helmes (2008) investigated this, it appeared that specialist psychologists working with older people rather than generalist psychologists may be more at risk of developing negative attributions about aging. If this intriguing result could be replicated in other countries, then it suggests a need for increased exposure to gerontological theories challenging biased views of aging. For the majority of older people, aging is a surprisingly positive experience and a surprising satisfactory stage of life (Laidlaw et al., 2007). It would seem there is apparently a mismatch between the actual experiences of older people and the attitudes of specialists working with older people as they focus on the minority whose experience of ageing is bound up with distress and loss associated and become biased by it. As Knight (2004) commented, depression, anxiety, and suicide are more common in the professional experience of the clinician than in the population at large. Thus, there is a need for more research into attitudes, motivations, and experiences of practitioners, so that we can improve their desire and ability to work with an aging client population.

Changing demographics have rarely been featured in most writings about psychotherapy with older people. This is surprising because it heralds an important and profound change in the structure of society. With the advent of larger numbers of older people in society, there will be a greater need for more psychotherapists to be trained to work with older people, and the types of issues dealt with in psychotherapy may change (Knight et al, 2009). It is abundantly clear that there is an urgent need to prepare to meet the challenges and opportunities that demographic change will bring. In addition, as the baby boomer generation reach 65 plus, the psychotherapist's own understandings of the attitudes, values, and mores of older people may need to become more contemporary (Hillman, 2008). Many psychotherapists working with older people are confronted with their own unacknowledged fears about aging and mortality. What has been an abstract concept of morbidity and frailty may now assume an uncomfortable saliency (Koder & Helmes, 2008). The demographic changes already in motion have profound implications for clinical training, education, and practice.

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Received November 27, 2008
Revision received June 15, 2009
Accepted June 16, 2009 ■