

***Response to Commentaries on Deconstructing Demons: The Case of Geoffrey***

**Balancing Between Empirically-Supported Methods  
and Individualized Treatment Design in the Case of Geoffrey**

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**ABSTRACT**

This is a response to the commentaries by Dr. Knight (2008) and Dr. Hyer (2008) on “The Case of Geoffrey” (Mohlman et al., 2008). The response focuses on three major themes: the notion of cultural competence in the psychotherapeutic setting; possible risks inherent in and alternatives to the medicalization of mental health treatment for older adults; and the growing use of cognitive remediation in the treatment of psychiatric disorders. We also address some of the other excellent issues raised by Drs. Knight and Hyer regarding cohort effects in the study of older therapy clients and missing elements in the case of Geoffrey.

*Keywords:* African American; aging; comorbidity; transdiagnostic approach; augmenting cognitive behavior therapy (CBT); baby boomers

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**RESPONSE TO KNIGHT AND HYER COMMENTARIES**

The commentaries on *Deconstructing Demons: The Case of Geoffrey* (Mohlman et al., 2008) by Dr. Knight (2008) and Dr. Hyer (2008) were thoughtful and comprehensive. We appreciate Dr. Knight’s observation that there are few didactic resources for psychologists whose clients have multiple diagnoses (e.g. psychiatric, cognitive, medical), which is the rule rather than the exception with aging adults. Dr. Hyer points out the usefulness and appropriateness of the transdiagnostic approach, especially with clients who have a range of symptoms and poor prognostic indicators. The empirical case study is one way to begin to amass the necessary documentation for mental health practitioners to make informed choices about treatment planning when working with older adults with multiple problems. This response will address three major themes raised in the commentaries: the notion of cultural competence in the psychotherapeutic setting, possible risks inherent in and alternatives to the medicalization of mental health treatment for older adults, and the growing use of cognitive remediation in the treatment of psychiatric disorders.

## **CHANGING THE THERAPY TO FIT THE CLIENT: CULTURAL ASPECTS OF THE CASE**

We wish to respond to Dr. Knight's astute comments on changing the therapy to fit the client, and the cultural aspects of the case of Geoffrey. Dr. Knight rightly points out that the discussion of ethnic issues is too often left at an abstract level in the literature of geropsychology. This may stem from a more pervasive problem – the serious lack of data on modifying existing therapy protocols for use with diverse clients of all ages (e.g., on the issues of ethnic matching in the clinic setting and on the benefits of ethnic-specific services). Moreover, practice guidelines in this area are relatively vague (e.g., APA, 1990) and do not specify any particular changes that should be made to evidence-based therapy when working with minority clients (e.g., Hall, 2001; Lam & Sue, 2001).

As mental health care practitioners, we know that it is important to be culturally competent but we don't always know exactly *how* to achieve this goal. Indeed, in a recent review of the literature on tailoring therapy to special populations (e.g., minority, feminist, lesbian, gay), Lam and Sue (2001) found no published studies testing the benefits of ethnic-specific therapies, despite the fact that modifications to established protocols are often recommended. We also found surprisingly few culturally sensitive cognitive behavior therapy (CBT) protocols (e.g., Munoz & Mendelson's 2005 version of "Control Your Depression" for use with Latino populations). Informal resources such as the Multicultural Skills Training website, <http://www2.hawaii.edu/~jharris/mc-mks.html>, are difficult to locate and are also likely to be underutilized.

We hope that the few suggestions found in the case of Geoffrey will be useful to therapists who are working with clients from different racial and ethnic groups and are puzzled about how to modify the therapeutic dialogue. Also, at the individual case level, we recommend the recent case study by Liu (2007a, 2007b). This case study presents methods by which cognitive-behavioral approaches were concretely and successfully modified to accommodate the ethnic and cultural specificities and complexities of the successful case of "TC," a mid-20s Chinese American male with Major Depressive Disorder and Generalized Anxiety Disorder. The broader implications of these specificities and complexities for general practice with such clients is well-discussed in two commentaries on the TC case by Chu (2007) and Hwang and Wood (2007). For example, Chu uses the case to illustrate the nature of cultural competence by placing it within "a general approach that clinicians can use to become oriented to a culture [with which they are not necessarily familiar], make use of evidence-based frameworks, and treat the therapy as an ongoing cultural exchange" (p. 34). We believe Chu's idea of an "ongoing cultural exchange" nicely captures the relationship between the therapist and Geoffrey.

In the relative absence of any clearly indicated modifications to standard CBT protocols, we argue that practitioners can proceed under the general guidelines of cultural competence. However, this strategy is also problematic in that cultural competence has yet to be unequivocally defined. Sue (1998) recommends that therapists working with clients who are members of minority groups should strive for scientific mindedness (e.g., active hypothesis testing versus falling prey to assumptions), dynamic sizing (e.g., knowing when to individualize

versus generalize cultural aspects), and culture-specific expertise (e.g., the ability to translate interventions into culturally consistent strategies). Similarly, cultural competence or sensitivity has been defined as the effective balance of taking universal, culture-specific, and individual norms into account in assessment and treatment practices (Lopez et al., 1989). Also, Hwang and Wood (2007) stress “the importance of an interactional perspective between the client and the provider, noting that cultural competence requires the therapist to understand his/her cultural self in relation to others, as well as a substantive understanding of the client” (p. 45).

Taken together, it is necessary, then, for therapists to have enough knowledge of a particular culture to deliver effective interventions to members of that culture. Therapists might need to conduct research into the culture of different ethnic and racial groups while balancing such knowledge with universal and individual norms to achieve competence. Hall (2001) also recommends that the concepts of interdependence, spirituality, and discrimination be integrated into culturally sensitive therapies. Others suggest, however, that the very assumptions of conventional science upon which evidence based therapies are founded (e.g., “universal determinism,” or the belief that invariant natural laws that govern human behavior can be discovered and articulated) are fundamentally inconsistent with some cultural values and will have to be made more flexible to accommodate the different worldviews of some ethnic and racial groups (Bernal & Scharron-Del-Rio, 2001). Much more research is needed to resolve these issues.

## **HOW IMPORTANT IS THE CLIENT-THERAPIST MATCH?**

In a review of cultural competence in psychotherapy, Sue (1998) has identified several important elements of counseling with members of minority groups. First, although findings are mixed and some studies suggest a clear benefit of ethnic matching with certain minority clients (e.g., Query’s 1985 study of Native Americans), in one of the largest studies to date of ethnic issues, Sue and colleagues (1991) found that African American clients were no more likely to terminate treatment prematurely, and showed equivalent increases on posttreatment Global Assessment of Functioning (GAF) ratings when the therapist was White as compared to when the therapist was African American. Similar findings were reported by Jones (1978; 1982) and Lerner (1972), although Jones notes that his 1982 study did not include those who dropped out before their eighth session, precluding the analysis of very early dropout. Ethnic matching has, on the other hand, shown a positive association with the number of sessions attended, as reported by Sue et al. (1991) and Rosenheck, Fontana, and Cottrol (1995). Sue (1998) notes that this particular finding has been held up as evidence *against* matching, given the lack of differences in overall outcome in these studies, and the limitations on the number of sessions covered by most insurance providers. A recent meta-analysis (Maramba & Hall, 2002) of seven studies testing the effects of ethnic matching on service utilization (number of sessions attended), premature termination, and GAF scores yielded small effect sizes of  $d = .10$  (utilization),  $d = .05$  (dropout), and  $d = .00$  (GAF) for African American clients. The authors concluded that ethnic match is a poor predictor of clinical outcome. One divergent set of results reported by Gamst et al. (2000) indicated that African American clients who were paired with African American therapists attended fewer sessions and had lower posttreatment GAF ratings than those who saw a therapist from a different ethnic group. Based on this small group of existing investigations, there is no

compelling evidence that African Americans derive enhanced treatment benefits when matched with African American therapists. However, there may be areas of improvement associated with matching that have not yet been identified, such as cultural orientation, ethnic identity (e.g., Bennett & BigFoot-Sipes, 1991), or related constructs (e.g., Sue et al., 1994).

Interestingly, a determinant of positive outcomes in Sue et al. (1991) and Maramba and Hall (2002) was the extent to which the client and therapist were *cognitively* matched; in other words, when worldviews, treatment goals, and therapeutic conceptualizations were similar regardless of ethnicity or race. Although both sets of authors ultimately concluded that ethnic matching is neither necessary nor sufficient for positive treatment outcomes, there may be additive or interactive effects of ethnicity with cognitive matching that are currently unrecognized, which is a potentially important avenue for future studies.

Finally, in light of the above, we suggest that the issue of client-therapist match is a complex one that should be examined in detail within individual cases. For example, in the case of Geoffrey, the therapist and client differed in gender, age, ethnicity, and socioeconomic status, but found a variety of bases for “joining,” as described below. This situation can be contrasted with the case of TC (Liu, 2007a) mentioned above, in which the therapist and client were matched on age, ethnicity, and socioeconomic status, although not gender. We suggest that comparing and contrasting successful and unsuccessful cases with varying profiles of matching can be a very fruitful method for finding general guidelines and strategies for enhancing the working relationship within any particular client-therapist match.

## WHAT IS THE IMPORTANCE OF COHORT?

Within racial and ethnic groups, there are often strong cohort effects, which are sometimes confounded with age. Furthermore, because heterogeneity is far-ranging in the older population, there are likely to be subtypes of older adults based on worldview. These are too easily ignored. It may not be sufficient to address cultural aspects without also taking cohort into account. For instance, Geoffrey was unaware of some of the popular culture references used by the therapist (e.g., a popular young African American singer’s ongoing problems with drug abuse, which were often detailed in the media), and the therapist was unaware of some of the cultural references made by Geoffrey (e.g., that in his youth in rural Pennsylvania, elementary school students were schooled in one-room schoolhouses despite being in different grades). Interestingly, Geoffrey initially assumed that he and the therapist were the same age, when the therapist was actually twenty years his junior. It was not entirely surprising that knowledge gaps based on cohort seemed to come up far more often than racial issues. Rectifying them was an enjoyable part of the therapy for both the client and therapist.

In a related example, a young African American female client seen by the first author during the 2008 presidential primary elections often remarked how surprising it was that an African American male and a female (who can be viewed as members of oppressed social groups) were vying for the democratic nomination. In a therapeutic exercise, the therapist subsequently used Shirley Chisholm (the first African American presidential candidate who also happened to be female) as an example of a courageous individual, but due to her young age and

different historical cohort, the client was unfamiliar with the exemplar. In the therapist's efforts to stay finely tuned to the cultural aspects of the case, the cohort effect was inadvertently overlooked. However, this afforded an opportunity for a brief discussion of a historical figure in African American culture, and allowed for construal of the therapy session as a forum for enhancing the client's and therapist's knowledge of each others' cultures, from the vantage point of a different historical cohort.

The importance of cohort effects also impinges upon actual versus subjective age. As noted by Dr. Hyer, Geoffrey is an example of a "young old" client. Despite the fact that he was born slightly before the "baby boomer" generation and was already 30 years old when he worked in Vietnam (as noted by Dr. Knight), he fit seamlessly into the baby boomer cohort based on his progressive and liberal worldview and his life experience (e.g., past drug use, divorce). We advocate the de-emphasis of chronological age, and support the use of the "acting as if" technique to help clients identify with the cohort that best matches their subjective age, regardless of their chronological age. This also minimizes the extent to which clients feel as if they are viewed in a stereotyped manner by the therapist. It may also increase clients' perception of versatility in issues of self-definition and social affiliation. Referring to a quote from David Burns (1991) in *Feeling Good: The New Mood Therapy*, we strive to show each of our older clients that he or she is "...more like a river than a statue" (p. 40).

## **MINIMIZING THE MEDICALIZATION OF THE TREATMENT**

We hypothesize that attending psychotherapy in a medical setting runs the risk of intensifying an aging client's perception of being "old and sick." Thus, we encouraged Geoffrey to come to the university setting for his sessions whenever possible. This was meant to increase his comfort level with utilizing the university's resources and reintroduce him into the academic environment, as well as minimize the medicalization of his mood problems. Attending sessions in a university setting was also a form of therapeutic exposure, given that Geoffrey had left the academic environment years earlier due to problems with social anxiety.

Dr. Hyer eloquently discusses the medicalization of mental health care in the U.S., and in particular, the tendency for older adults to seek treatment from a primary care physician in a medical setting. Although some have argued that older adults typically present to primary health care settings for treatment (Akkerman et al., 2001; Wetherell & Gatz, 2001), the current authors speculate that this trend may change. Some older adults have concerns with aspects of the current health care system (e.g., inadequate time for discussing mental health during appointments with physician, decreased continuity of care such as seeing different primary care physicians across visits, seeing unfamiliar physicians), also pointing to the benefits of a demedicalized approach to mental health care.

Although the notion of offering treatment in primary care is currently the gold standard for dissemination, we advocate a slightly different vision that construes mental health self-care as an academic endeavor. Our therapy was offered as a 'class' in a university setting, not a 'treatment' in a medical setting. We find that this appeals to many older clients who do not wish to spend more time in clinic waiting rooms, interacting with members of the medical staff, or on

the phone with representatives from their insurance companies. Moreover, in a recent government-funded study of cognitive behavior therapy for late life anxiety, 100% of the older sample opted to try a purely behavioral intervention before accepting anxiolytic medication (Papp, personal communication).

In strategizing with Geoffrey about his medical conditions, we assisted him with a medical referral to the diabetes clinic and encouraged him to become more proactive in his own medical care, as opposed to relying entirely on doctors for help. It was our goal to increase Geoffrey's sense of self-efficacy in managing all aspects of his health, physical as well as mental.

We urge psychologists to think creatively about alternative strategies for promoting and delivering services for older clients, such as through senior centers and meal delivery programs. The first author has also used educational settings such as the popular Oasis program located in 26 U.S. cities (<http://www.oasisnet.org/>) as a means of disseminating information about CBT and other evidence based therapies, teaching basic mood management skills, and offering referrals to CBT therapists in the community. Following a recent lecture on CBT and mental health delivered to over 200 older adults attending an upstate N.Y. Oasis facility, the first author received twelve phone calls from individuals seeking additional behavioral treatment for anxiety or depression, gave out ten referrals to practitioners in the community, and was able to track seven individuals through to their first therapy session. We advocate the use of such nontraditional and nonmedical approaches to disseminating information about psychotherapy, because these methods do not amplify the aging client's concerns about being "old" or "sick," they can empower the client in managing mood problems, and they integrate mental health care into an intellectually stimulating, school-like setting, an environment which is also likely to facilitate mental health.

## **CHANGING THE CLIENT TO FIT THE THERAPY: THE COGNITIVE TRAINING APPROACH**

In addition to emphasizing cohort over chronological age, another means of capitalizing on the subjective age of the client was to take the optimistic approach of cognitive training. This approach assumes that the brain retains its plasticity even into the later stages of life, a notion that is becoming more accepted in the mainstream. By engaging in repetitive rigorous exercise, the brain's integrity and cognitive functioning improve, sometimes dramatically. There are currently several effective training packages available developed for use with patients with traumatic brain injury, all of which involve repeated practice in sustaining and dividing attention, inhibitory control, logical reasoning, and holding stimuli in mind for complex mental operations. Although we do not yet fully understand the limits of plasticity with regards to brain integrity and corresponding cognitive functions (Mateer & Kerns, 2000), research suggests that through repeated practice, cognitive skills can often be substantially improved (Sohlberg & Mateer, 2000), even if biological insult has occurred or an individual is elderly. Recovery following brain injury is believed to work through behaviorally induced, experience-dependent changes in brain function, and to a lesser degree, structure (Mateer & Kerns, 2000). As noted by Mateer and Kerns (2000), "cells that fire together, wire together," implicating that "connectivity between

cells firing in synchrony are strengthened, whereas nonsynchronous firing inhibits connectivity” (p. 106).

The cognitive training approach has been successfully applied to the treatment of different types of brain dysfunction such as traumatic brain injury (Sohlberg, McLaughlin, Pavese, Heidrich, & Posner, 2000); [added semi-colon] the effects of cranial radiation therapy (Butler & Copeland, 2004) and stroke (Murray, Keeton, & Karcher, 2005); and psychiatric disorders such as schizophrenia (Bell, Fiszdon, Bryson, & Wexler, 2004; Bell, Bryson, Greig, Corcoran, & Wexler, 2001; Fiszdon, Bryson, Wexler, & Bell, 2003; Lopez-Luengo, & Vazquez, 2003; Silverstein et al., 2004), major depression (Siegle, Ghinassi, & Thase, 2006), substance abuse (Fals-Stewart, 2006), and generalized anxiety disorder in older adults with minor deficits in executive skills (Mohlman, in press).

Although cognitive training is effective in improving cognitive functions in these populations, with more severely impaired individuals benefits are sometimes limited in terms of generalizability. There is a negative association of impairment severity to amount of improvement following cognitive training: in patients who are relatively less impaired (e.g., those with mild brain injury who are living independently as compared to those with severe schizophrenia who require assistance with activities of daily living), cognitive training can lead to enhanced cognitive functioning and transfer of skills to new situations (Boman, Lindstedt, Hemmingsson, & Bartfai, 2004; Palmese, & Raskin, 2000). The largest study to date of cognitive training in healthy older adults (n=2,832) demonstrated that 10 sessions of reasoning, processing speed, or memory training led to an improvement in cognitive abilities equivalent to the amount of decline expected in nondemented elderly over a 7 to 14 year period. Although ceiling effects on measures of daily functioning precluded evidence for transfer of skills, cognitive benefits were durable over a two-year period (Ball et al., 2002). Green and colleagues (2000) argue that cognitive training techniques are best used as adjuncts to other psychosocial interventions, because improved cognitive functioning appears to help patients to benefit from subsequent skills training and psychoeducation. Also of potentially great importance is the fact that stabilizing or reversing cognitive decline in the elderly is an important step in preventing subsequent functional decline and caregiver burden (Tariot, 2001), therefore the cognitive training approach can be viewed as a preventative strategy as well as a remedial intervention.

Other means of achieving similar cognitive benefits might be explored in future trials with older patients. These include vigorous exercise (Colcombe & Kramer, 2003), and modafinil and other stimulant medications (Makris, Rush, Frederich, Taylor, & Kelly, 2007). However, these methods might be more difficult for older clients to utilize than cognitive training due to limits on mobility and drug side and interactive effects.

## **MISSING ELEMENTS**

Dr. Hyer discusses a number of therapeutic elements that were missing from the case of Geoffrey. We did not include a progressive muscle relaxation component in the intervention for several reasons. First, it is somewhat time consuming and would have required 20 to 30 minutes out of several sessions to complete the training, for the sake of what are often short-lived

palliative benefits. We felt that encouraging Geoffrey to increase his overall activity level (i.e., walk to his volunteer job) might be a sufficient alternative for reducing stress and enhancing his health. Second, relaxation is not always included as a major component of interventions for depression or social anxiety, which were Geoffrey's two primary diagnoses. Some list relaxation as an adjunctive method in depression treatment protocols for older adults (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003), and in some treatment protocols for social anxiety disorder (Heimberg & Juster, 1995), but not in others (e.g., Heimberg & Becker, 2002). In early studies of relaxation for treating subclinical anxiety and depression symptoms in healthy older volunteers, daily relaxation-meditation led to inconsistent results, with no significant reduction in depressive symptoms (DeBerry, 1982a), or trait anxiety levels (DeBerry, 1982b) reported in some studies, but reduced symptoms of anxiety and depression in others (e.g., DeBerry, 1989). Similarly, in younger adults diagnosed with social anxiety disorder, the use of a pure relaxation intervention led to minimal symptomatic improvement in a subset of investigations (e.g., Al-Kubaisy et al., 1992; Alstrom et al., 1984) but better outcome in others (e.g., Jerremalm et al., 1986; Ost et al., 1981). A recent meta-analysis showed that when paired with other CBT skills (e.g., exposure) in the treatment of social anxiety disorder, relaxation is associated with *reduced* effect sizes as compared to when such techniques are used alone (Norton & Price, 2007). Therefore, evidence as to the need for a relaxation component is mixed at best.

We did not include a measure of general psychological well-being. However, we did include as a secondary measure in our battery the Geriatric Suicide Ideation Scale (GSIS; Heisel & Flett, 2006), which includes a *Perceived Meaning in Life* subscale (PMIL). This subscale allows for the assessment of one important aspect of overall well-being, one's life orientation, or the extent to which an individual views his life as valuable, meaningful, and dignified. This subscale is also viewed by its authors as an index of psychological resiliency. PMIL has strong psychometric properties when administered to older adult samples, with test-retest reliability across a one to two month period of .68, internal consistency of .82, and mean corrected item-total correlation of .57. The items on the PMIL subscale are shown in Table 1.

Geoffrey showed an increase on PMIL from 17.00 at baseline to 29.00 at posttreatment. The items accounting for the score increase were: item 5 ("*I feel that I am needed in this world*"), item 13 ("*I have come to accept my life with all of its ups and downs*"), item 18 ("*I find joy and beauty in life*"), and item 31 ("*I believe that others need me*"), each of which increased from a response of '1' (indicating that the respondent "strongly disagrees" with the statement) to '4' (indicating that the respondent agrees with the statement).

As noted by Dr. Hyer, our study also lacked a measure of the therapeutic alliance. Measuring cognitive match might have been one important addition to the case of Geoffrey (Sue et al., 1991), given the differing ethnic groups of client and therapist, and might have served as a proxy for therapeutic alliance. It was a happy accident that in this case, based on discussions during sessions, the therapist and client appeared to have similar political views, attitudes about health, and goals for Geoffrey's treatment. Although there was no formal measure of alliance, review of two randomly selected therapy tapes (sessions 3 and 8) revealed positive statements uttered by the client throughout each session (e.g., "This is interesting," "you are knowledgeable," "this really works," "we make a good team"). The therapist also received a



thank you card (“thank you for caring”) and complimentary note after treatment ended, suggesting that the client perceived the therapist as competent and concerned with his welfare. It is also possible, however, that the very notion of alliance might be subject to cultural differences (Sue & Zane, 1987). Interestingly, we could find no measures of alliance that have been validated among minority samples. If such differences do exist, then a culturally sensitive measure might be a valuable addition, and could tap unique aspects such as, “The therapist respects my views on things, even when they seem to be different from his/her own,” or “The therapist shows an interest in my cultural background.”

## CLOSING

The complexities of patient presentation in late life – including neuropsychological and cognitive factors, a high frequency of medical comorbidities, and a range of age and cohort-related psychosocial stressors – demand a careful balance between empirically-supported methods and individualized treatment design. We are grateful to both commentators for their thoughtful reactions to the Case of Geoffrey. We hope that this case series will provide a useful didactic tool for clinicians wishing to engage with this unique patient cohort and will promote dissemination of treatment to a growing, under-served, yet exceptionally rewarding group of individuals.

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***Table 1.***  
***The Perceived Meaning in Life subscale items from the***  
***Geriatric Suicide Ideation Scale (GSIS; Heisel & Flett, 2006)***

- 1 Life is extremely valuable to me
  - 5 I feel that I am needed in this world.
  - 9 I feel that my life is meaningful.
  - 13 I have come to accept my life with all of its ups and downs.
  - 18 I find joy and beauty in life.
  - 22 I am certain that I have something to live for.
  - 27 I feel that my life still has dignity.
  - 31 I believe that others need me.
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