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CBT with Clients in Midlife and Beyond: A Clinician's Guide to Effective Practice.
By Ann M. Steffen. Copyright © 2027.
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CHAPTER 1

Come On In, the Water's Fine

Whether you are a psychotherapist or provide behavioral health consultations to individuals in a medical clinic, you are likely to have middle-aged and older clients. Most individuals in midlife and beyond who receive mental health care are treated by generalist clinicians, not aging specialists. Why include midlife in a work devoted to aging? Some individuals age rapidly due to chronic medical problems and limited access to health care, while "superagers" show minimal signs of cognitive aging even in their 80s and 90s. A client in their early 50s may benefit from the practices described in this book as much or more than a well-resourced client in their early 80s. With that reality in mind, this book focuses on working with clients age 50 and older.

Aging is a personal matter for each of us because we are all aging. A significant amount of your personal time may be spent caregiving for an aging parent or partner. You may be in midlife or older yourself and find a range of topics in this book relevant to you and those most important to you. You may wonder how your own experiences and interests regarding aging can benefit your clients. The final chapter of this book (Chapter 15) is specifically addressed to all of us (myself included) who consider ourselves living in mid- and later life.

A Thumbnail Sketch of the CBTs

My appreciation for the cognitive and behavioral therapies (CBTs) began with seeing their versatility in fostering well-being across many aspects of our lives, including physical, social, behavioral, and emotional domains.

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I also liked the therapies' emphasis on scientific evidence in selecting and systematically delivering interventions (Koerner, 2018). Making changes in how we feel, think, behave, and interact with others requires our brains to learn something new, at every age. CBT change strategies are thus conceptually grounded in learning theories (e.g., social learning, cognitive science, respondent conditioning, operant learning, information-processing models of behavior, behavioral and cognitive processes in emotion regulation) for good reasons. These foundations in learning theory are why CBT interventions emphasize skill development, repetition, and practice applying these skills between sessions (regardless of the specific skill being targeted). Insights gained during a session may be helpful, and providing emotional support to clients experiencing stressful life events is important. Neither insight-oriented treatment nor emotional support alone, however, leads to the lasting changes our middle-aged and older clients are looking for. More is required, as demonstrated across this book.

All CBTs share a deeply humanistic emphasis on transparency and collaboration between clients and us as mental health providers. The emphasis on collaboration is one of the reasons that we are so intentional in jointly setting specific treatment goals, agreeing on how session time is used, and checking in with clients for feedback at the end of each session. We also collaborate with our clients to identify what is contributing to their problems and which change strategies work best for their life circumstances (Padesky, 2022; Padesky & Kennerley, 2023). For CBT practitioners, clients (and their problems) are viewed through the lens of their unique histories and their current social, cultural, and physical environments.

In other words, CBT generally emphasizes individualized case conceptualization and personalized treatment planning. You and your clients reach a shared understanding of which factors maintain their presenting problems and which personal and environmental change strategies will be targeted in treatment, using a "one-step-at-a-time" approach. New habits of behaving, thinking, and feeling are developed and practiced that either align with clients' social and physical environments or help them effect meaningful changes in these environments (Padesky & Greenberger, 2020). We carefully monitor progress to determine whether a change in treatment approach is needed.

The CBTs are substantiated by science for a wide range of presenting concerns (Cuijpers et al., 2025), and there is strong empirical support for the use of CBT change strategies with middle-aged and older adults (Steffen & Schmidt, 2022). The literature on CBT with older adults has been dominated by research on treating later-life depression; large-scale meta-analytic studies demonstrate positive outcomes for older clients that are equivalent to those for younger adults (Cuijpers et al., 2018; Werson et al., 2022). As research with middle-aged and older adults has

extended to a broad range of mental health problems and life stressors, CBT has continued to be documented as effective and attractive to clients in midlife and beyond (Laidlaw et al., 2025).

Transdiagnostic CBT Change Strategies

This book provides research-informed recommendations for your clinical practice, but it will not be a deep dive into psychopathology and aging. There are helpful reviews of that literature (Edelstein et al., 2022), including for older adults with anxiety (Wuthrich & Chen, 2022), posttraumatic stress disorder (PTSD; Gómez-Bautista et al., 2026), depression (Steffen & Bergstrom, 2025), unhealthy substance use (Woodhead, 2024, 2025), personality disorders (Lederer et al., 2022), and schizophrenia (Harvey & Muralidharan, 2022). As therapists, however, we face significant challenges in using formal diagnoses to select therapy approaches for our clients, given the substantial variability in diagnoses (Dalgleish et al., 2020). Specific symptoms vary in intensity across clients, such that dimensional approaches to understanding clinical problems often perform better than categorical ones. Individuals with the same psychiatric diagnosis differ in the combination and strength of symptoms (i.e., intradiagnostic heterogeneity of symptom patterns). Within clinical depression, for example, younger individuals most commonly report dysphoria (i.e., feeling sad). In contrast, older adults report higher levels of anhedonia (i.e., lack of interest and pleasure in daily activities). Clinicians looking for sadness/dysphoria as a predominant symptom may fail to identify depression in older adults. There are common symptoms across a range of disorders, and diagnoses are often comorbid (Barlow et al., 2021). Treating anxiety disorders with CBTs, for example, also lowers depressive symptoms (Cuijpers et al., 2016). Single, uncomplicated clinical presentations are rare.

Considering these challenges, this book takes a transdiagnostic approach. Rather than treating each condition as a distinct problem area, we focus on common processes across mental health diagnoses (Moskow et al., 2022). Distinct processes that underlie various psychological conditions are then linked to our selection of specific change strategies. Many of our clients, for example, have strong negative emotional reactions to stressful life events that they consider unpredictable and uncontrollable. The experience of such negative emotions is aversive and seen by clients as something to avoid as much as possible. This pattern of high reactivity to, and avoidance of, negative emotions is a central feature of neuroticism (Barlow et al., 2021) and is seen frequently in clients with anxiety disorders, depression, PTSD, and substance abuse, among other presenting concerns (Sauer-Zavala & Barlow, 2021). The

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transdiagnostic mechanism of neuroticism that underlies so many emotional disorders, once identified, can then be targeted using a combination of specific treatment strategies that are supported by research (Barlow & Long, 2023).

Prioritizing Interventions: The 4Ms Behavioral Health Framework

Middle-aged and older clients present for treatment with a wide range of concerns. Compared to working with younger clients, aging brings increased comorbidity among medical, cognitive, and mental health problems and requires more communication with other providers. Behavioral health practitioners often tell me that the co-occurrence of physical, brain, and mental health conditions poses the most significant challenge to their clinical practice with clients in midlife and beyond. I believe that using the 4Ms Behavioral Health Framework (Emery-Tiburcio, 2024; see Figure 1.1) in your clinical practice will help you navigate these complexities and benefit your clients.

The 4Ms refer to key facets of a person's daily functioning and health: Meaning, Medication, Mentation, and Mobility. As we work with middle-aged and older clients, paying attention to these four facets becomes essential to clinical effectiveness. The 4Ms framework was first developed for use with older adults being treated for physical problems (Institute for Healthcare Improvement, 2020). The framework has now been expanded to serve as a unifying approach in behavioral health care as well (Emery-Tiburcio, 2024). We return to the 4Ms Behavioral Health Framework in some chapters of this book. I briefly introduce it here to highlight this research-informed approach to prioritizing among your clients' presenting problems and concerns.

Meaning, or What Matters

Research and clinical practice over the past several decades have increasingly recognized the importance of centering therapeutic interventions on each client's personal values and strengths (Lee et al., 2022). There are specific, concrete things we can do with all clients to foster this values-centered approach. Top among them is taking the time to identify and understand what matters to each client, both within their lives and for their physical and mental health care choices. Considerations such as selecting a health care proxy may feel beyond the scope of mental health care. These issues, however, reflect the quality of close personal relationships and our clients' self-efficacy for sharing their health care preferences. Thus, this Meaning or What Matters domain of the 4Ms

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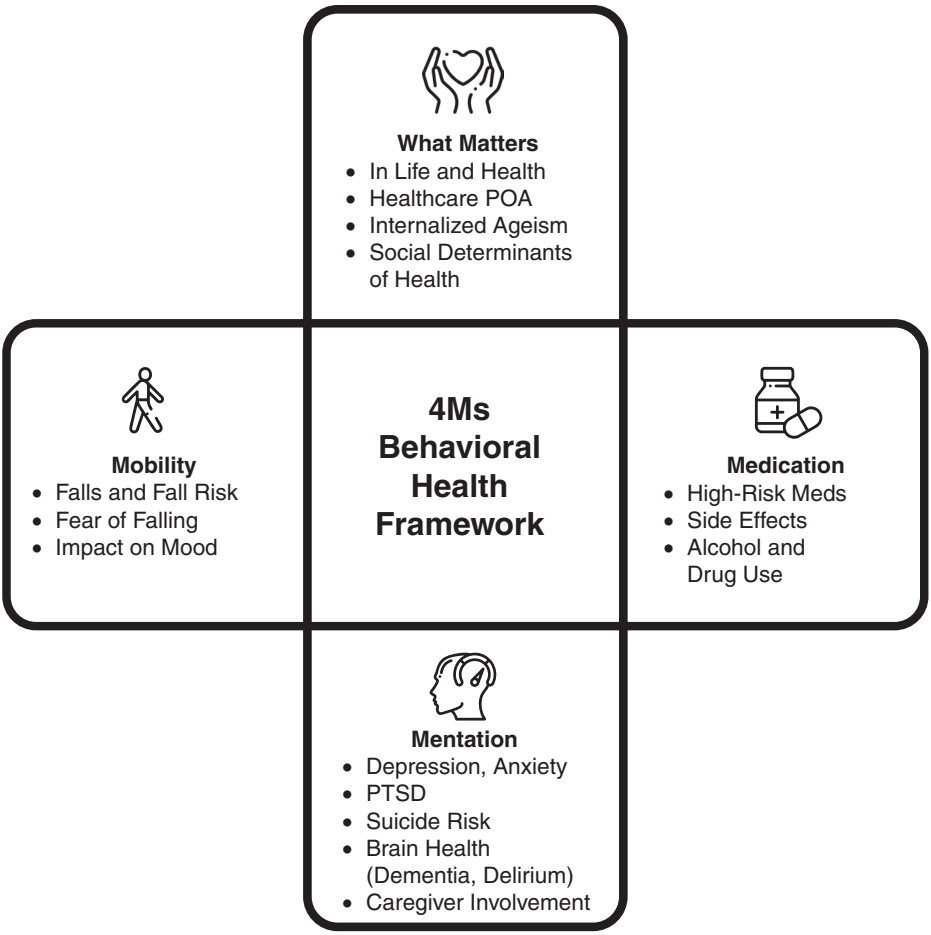


FIGURE 1.1. The 4Ms Behavioral Health Framework. Based on Emery-Tiburcio (2024).

framework emphasizes the role of personal values in daily life and health care. Because clients' health care preferences can be shaped by societal and internalized ageism, as well as by their cultural backgrounds, this book includes a chapter supporting anti-ageism efforts and another focused on cultural diversity among middle-aged and older persons.

Medication

Regardless of your prescription authority status, attend to how medications (including over-the-counter [OTC] medications, dietary sup-

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plements, alcohol, and other nonprescribed drugs) impact your aging clients' mental and cognitive health. We all need to become more knowledgeable about the influences of medications and other substances on the daily functioning of middle-aged and older adults (Levy, 2023). Polypharmacy and related complications increase with aging (Arnold, 2015). Some clients, for example, will need our help remaining adherent to complex medication regimens (Papus et al., 2022). Individuals who were young adults during the drug culture of the 1960s and 1970s are now in later life; you should be prepared to address alcohol and drug use problems in some of your older clients (Satre, 2015; Woodhead, 2024, 2025). All of these concerns are included in the 4Ms Behavioral Health Framework within the medication (and substance use) domain.

Mentation

Broadly speaking, "mentation" refers to using our minds to process experiences, solve problems, and manage daily life. Mentation thus encompasses basic cognitive processes (e.g., attention, memory, planning), brain disorders (e.g., dementia, delirium), and mental health concerns. Many of the areas of the 4Ms Behavioral Health Framework that are devoted to mentation may feel familiar to clinicians who routinely treat anxiety, depression, PTSD, and suicide risk. The additional contexts of family caregiving (as discussed in Chapter 8) and brain health (as discussed in Chapter 12) introduce new complexities that these chapters are intended to address. Organizing these topics together becomes especially helpful for clinicians working with individuals in midlife and beyond.

Mobility

Supporting physical mobility and addressing fear of falling can become central to helping clients improve the quality of their daily lives. Staying active with rewarding activities each day, along with maintaining as much independence as possible, plays a vital role in preventing and treating depression for older clients. In Chapter 10, I address specific ways to support your clients' physical mobility while remaining within your scope of practice.

Research-Supported Clinical Practice

Among the many gifts of being both a university professor and a psychotherapist in private practice has been the opportunity for continued learning. Sometimes I discover new research while updating material

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for an undergraduate or graduate course. Other times, I encounter new findings while working on a writing project or conference presentation. Having easy access and time to delve into the ever-growing scientific literature are luxuries you may not have. Thus, I have attempted to summarize the scientific findings central to my recommendations and present a few favorite studies as examples, while keeping each chapter practical.

In your clinical work, you are constantly holding multiple questions in mind—sort of like juggling at least three balls during your sessions: "What am I doing with this client?" (treatment planning; selecting specific interventions), "How am I doing this?" (actual implementation of these interventions), and "Why am I doing this?" (case conceptualization). Because of the emphasis on collaboration within the CBTs, we are also attending to our clients' daily experiences, preferences, and within-session reactions throughout this process. When we begin our journey as practitioners, we sometimes view psychotherapy as a linear process that moves from collaborative conceptualization to treatment planning to implementation. As we develop professionally, we increasingly see our work requiring us to shift back and forth among conceptualization, treatment planning, and intervention. These components continually inform one another while we stay true to CBT's practice of collaborative empiricism with clients. The interweaving of these three is depicted in Figure 1.2. Most of the chapters in this book include suggestions for

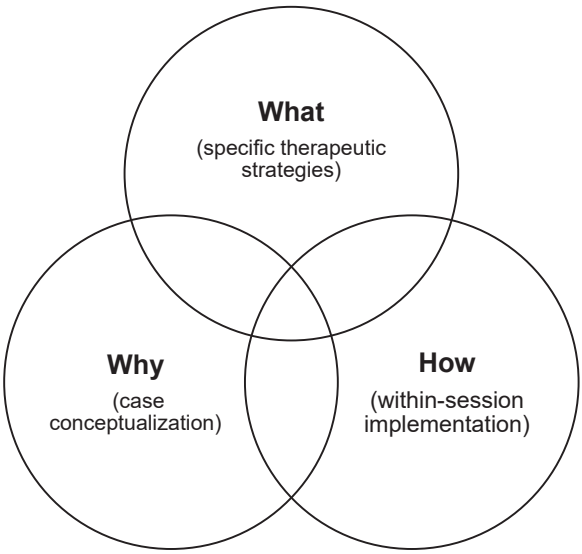


FIGURE 1.2. Three components of clinical decision making and competencies.

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working with that kind of recursiveness and flexibility. Background on the topic area is intended to help shape the way you and your middle-aged and older clients jointly think about (conceptualize) their daily experiences and presenting concerns. Practical suggestions then inform collaborative treatment planning with your clients. Because details matter, the section on common themes includes sample dialogue to support the choices we make as clinicians during treatment sessions.

Why I Love Working with Middle-Aged and Older Adults

Mental health clinicians attend my trainings from a wide range of disciplinary backgrounds, including psychiatry, social work, counseling, marriage and family therapy, mental health nursing, and clinical psychology (and probably a few others). Many of you are likely working in community outpatient clinical practices, while others may be providing services within an organization or in integrated behavioral health care (primary care, specialty services). Some of you are employed by a community agency, while others provide inpatient psychiatric care. This book is intended to be relevant and applicable across these various fields and in different practice settings. We all come to our work with individuals in midlife and beyond through different pathways. We also do not necessarily know where our careers will take us in the future.

The good news is that working with middle-aged and older clients can be deeply rewarding and often fun. Our Health and Aging research team at the University of Missouri–St. Louis studied psychologists who were all selected randomly from the professional license registries of the most culturally diverse counties in two U.S. states (California and Texas). We asked each provider about the age groups of the clients they saw in the previous year. Then we instructed them to "Please rate your experience with this population" on a scale of 1 to 5, with 1 being extremely negative and 5 being extremely positive (Band et al., 2025). Figure 1.3 summarizes their ratings for clients of different ages.

From this group of over 250 clinicians, we learned that about two-thirds of them work with older adults in their clinical practice and have favorable impressions of these clients. Although all ratings are positive, you can see that providers' ratings of their clients became increasingly positive the older the client group.

When asked, clinicians who work with older adults describe a range of personal benefits, including opportunities to reflect on personal values, increased attention to one's present and future, and a sense of inspiration to enjoy life daily. Practitioners can learn from their middle-aged

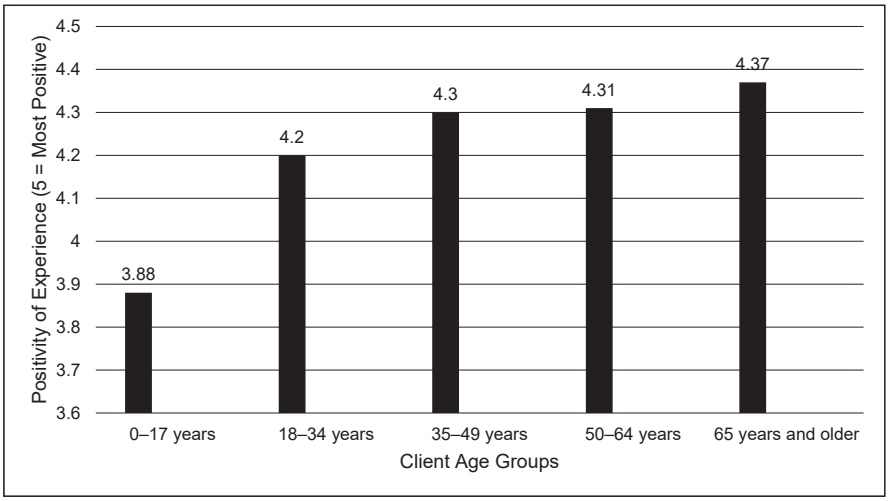


FIGURE 1.3. Behavioral health providers' ratings of experience with different-aged clients.

and older clients and develop a broader perspective, leading to vicarious wisdom. Other providers report an improved understanding of the wide range of aging experiences (Boschann et al., 2022), along with optimism about their own aging (Morante et al., 2020). I hope that you find the various chapters in this book useful over time as you embrace both clinical work with older adults and your own aging.

How to Use This Book

This book is intended to be useful for your clinical practice in concrete ways, with chapters that offer highly accessible, practical information and suggestions. The chapters that follow have been created to stand alone, meaning you can flip back and forth to specific topics as they arise in your work with middle-aged and older clients. I hope this book will become a familiar resource on your bookshelf—something that you return to as specific needs arise. Chapters 2–7 focus on themes that are common across your work with middle-aged and older clients; Chapters 8–14 are devoted to specific client concerns and problems. The final chapter offers opportunities for reflection as we become older clinicians and provides further recommendations for professional development.

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Each chapter also points to additional works I suggest you consult when you wish to delve deeper into specific topics. Supplemental online materials are available on Guilford's website (*www.guilford.com/steffen-materials*), including resources for further professional development and practice tools that I developed with busy clinicians in mind. In keeping with the principles of user-centered design (Lyon & Koerner, 2016), these client materials have been tested and revised based on feedback from practicing clinicians.

One other thing to bear in mind as you get into the rest of the book: While compassion-focused therapy is described as a specific intervention approach in Chapter 9, the work of self-compassion is also relevant for each of us (Gilbert, 2025). Incorporating new strategies into our clinical practice can be a stimulating challenge or, in times of additional stress, activate our threat systems, leading to self-criticism and discouragement. None of us needs that. Combine your reading with kindness and compassion toward yourself as you work to apply suggested intervention approaches and within-session strategies. Remember, all of the CBTs encourage breaking goals down into small, manageable actions, with progress occurring gradually. That is as true for us as it is for our clients.

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