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Does age matter? Initial treatment goals of older adults with major depression in outpatient cognitive behavioural therapy

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Abstract

Background: Personal treatment goals (PTG) are important means to tailor psychotherapy to the needs of the patient, leading to increased engagement and greater improvement in relevant outcomes. According to lifespan developmental research, motivational goals in old age differ from goals of younger people, with management of losses rather than growth becoming more prevalent. However, this study is the first to systematically investigate age-specific differences in PTGs.

Method: We used routine data from patients with major depression assessed at the beginning of outpatient cognitive behavioural therapy. Initial high-priority PTGs were assessed using the Bern Inventory of Treatment Goals (BIT-C). Older patients (≥ 60 years, $n = 52$) were matched to younger patients (< 60 years, $n = 52$) with regard to severity of depression, number of comorbidities, gender and level of education.

Results: Using a mixed method approach, high-priority PTGs of both age groups were focused most strongly on reducing depressive symptoms and, subsequently, anxiety. At the same time, older patients focused more strongly on PTGs related to well-being and functioning, while younger patients' emphasis was on personal growth. Furthermore, better coping with the ageing process and physical losses emerged as important PTGs for some older patients.

Conclusion: Initial PTG themes are specific to diagnosis, but also seem to differ in regard to age. Thus, it is important to develop age-sensitive measures that allow appropriate and efficient tailoring of psychotherapy to meet older patients' needs and preferences.

KEYWORDS

CBT, elderly, goal assessment, major depression, tailoring

1 | INTRODUCTION

Despite not being a typical age-related disorder, major depression is a common phenomenon in older populations with one in seven adults

older than 75 years meeting diagnostic criteria for a depressive disorder (pooled prevalence across countries; Luppá et al., 2012). Meta-analyses and systematic reviews have provided extensive evidence for the efficacy of standardized, disorder-specific

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psychotherapeutic interventions for treating older adults with depression (Cuijpers et al., 2014; Huang et al., 2015). However, on average, medium effect sizes and reports of a significant rate of non-responders (up to 58%) indicate that treatment manuals need to be improved (Korte et al., 2012; Wuthrich & Rapee, 2013).

Even more problematic are massive shortcomings in the provision of mental health care for older adults with depression under the current conditions of health care systems (Olsson et al., 2016). Taking Germany as an example for the international status quo, even though outpatient psychotherapy is an integral part of public and private health care utilization rates among older people are very low (Gellert et al., 2020). Among the group of very old and frail older adults, psychotherapeutic care is de facto non-existent (Tegeler et al., 2020). Reasons for those low treatment rates are diverse (see Bodner et al., 2018, for an overview), including patients not being able to access or enter mental health care facilities due to them being non-barrier, a shortage of psychotherapists qualified to work with older adults (Becker et al., 2021; Hinrichsen et al., 2018) and health care providers' pessimistic attitudes towards older patients' treatability (Kessler & Blachetta, 2020). In addition to that, the older population's low active demand for psychotherapy contributes to the little amount of provided treatments (Choi et al., 2011; Laidlaw & Pachana, 2009). This latter finding is especially critical, as the majority of older adults has positive attitudes towards psychotherapy or even prefers psychotherapy over pharmacotherapy (Luck-Sikorski et al., 2017), despite a strong desire for self-management of depressive symptoms among many older people.

The evidence-based need to optimize the efficacy of treatment manuals combined with low active demand for psychotherapy under naturalistic conditions highlight that older adults' motivational resources must be enhanced within the context of psychotherapy. In order to promote active participation in psychotherapy, treatment goals of disorder-specific therapies need to be aligned with the targeted patients' personal goals (Swift et al., 2018). A better understanding of *personal treatment goals* (PTG) of older adults with depression is thus urgently needed.

Treatment goals can be defined as changes of behaviour and experience that patients (in clinical practice: together with their therapist) intend on engaging in and which should be instrumental for successful psychotherapy (Grosse Holtforth & Grawe, 2002). Scientific knowledge of PTGs is important in order to tailor psychotherapeutic interventions to older people's personal mental health care needs and preferences. This can increase both the attractiveness and effectiveness of mental health care as well as older adults' compliance (Elkin et al., 1999; Swift et al., 2018). It is well-established that by tailoring psychotherapy according to a patient's individual concerns, their compliance and motivation can be significantly increased. Recent meta-analyses indicate an effect size of $d = 0.34$ for goal setting (Epton et al., 2017) across a range of behavioural outcomes. Furthermore, research indicates that agreement between patients and psychotherapists on the goals of therapy, which is likely to be enhanced by goal-setting procedures, is associated with positive outcomes, with a mean correlation of 0.24

Key Practitioner Message

- As well as younger patients, older patients with major depression define a broad spectrum of heterogeneous personal treatment goals (PTGs) for themselves at the beginning of outpatient psychotherapy, with a major focus on improving management of depressive symptoms and subsequently better dealing with anxiety.
- At the same time, older patients' PTGs reflect a greater focus on well-being and functioning, while younger patients' emphasis lies on personal growth. Furthermore, the themes of better managing physical losses and coping with the process of ageing appear to be relevant for some older adults, while typical themes related to family life may fade into the background.
- A "hybrid" instrument for PTG assessment, combining open format and age-sensitive checklists, has the potential to stimulate PTGs in the face of age-normative memory-retrieval decline, while allowing older patients to define their unique foci in psychotherapy.

(Tryon et al., 2018). Furthermore, goal setting is desired by a majority of patients, with approximately 60% expressing a preference for it, 20% not wanting it, and 20% having no a preference (Cooper et al., 2015). Goal attainment in relation to individual patients' treatment goals has become a central indicator of clinical significance in clinical research (Hurn et al., 2006; Kazdin, 1999).

While there is substantial evidence that PTGs differ between diagnoses, with (younger) depressed patients showing a more heterogeneous set of goals and a reduced focus on problem/symptom reduction compared with patients with other diagnoses such as anxiety disorders (Berking et al., 2004), so far nothing is known about age differences in PTGs. Up to now, only one Swiss study (Grosse Holtforth & Grawe, 2000) has investigated chronological age as a factor influencing themes of motivational goals in patients in outpatient psychotherapy and healthy controls. Findings suggested that older patients (more than younger ones) tend to strive towards altruism and spirituality, but want to avoid humiliation and weakness. Since general motivational goals, among other factors, influence PTGs (Grosse Holtforth & Grawe, 2002), similar age differences may also be found in PTG themes. Such knowledge about the content range of PTGs seems to be important to increase the efficacy of disorder-specific treatment.

In addition to age differences influencing the *content* of PTGs, the lifespan developmental literature on motivational development in the second half of life suggests age differences in the *number* of PTGs (Freund & Baltes, 2000). Accordingly, when a person's resources are insufficient to pursue all of their goals, they tend to focus on their most urgent goals (Freund, 2008). In line with this reasoning, older

patients may selectively prioritize a relatively small set of the most relevant PTGs in order to preserve resources. Furthermore, goals related to management of losses, rather than growth, have been shown to become more and more important when people reach old age (Schindler & Staudinger, 2008). For example, empirical research has shown that older adults show high levels of motivational energy in the life domains of health, cognitive functioning, and caring for well-being of family members and friends while occupation-like activities and sexuality were least important (Schindler & Staudinger, 2008; Staudinger et al., 1999). Going further, life reflection has been shown to represent a central domain of psychological investment in old age, in line with Erik Erikson's concept of integrity (Erikson, 1982). While no such empirical evidence exists for clinical contexts, it is worthwhile to consider this normative pattern of motivational developmental goals when investigating older patients' PTGs.

While research shows that patients, at the beginning of treatment, often define several heterogeneous goals, there is no established gold standard for assessing PTGs. In principle, two approaches have emerged from past research. One approach is to assess PTGs by presenting a predefined set of treatment goals to participants, with items that are consistent across patients (i.e., nomothetic approach; Sales & Alves, 2016). An example for the nomothetic approach is the personality disorder treatment goal checklist (Wood & McMurrin, 2013).

The alternative approach (i.e., idiographic) is that PTGs are assessed openly, consistent with the clinical reality of psychotherapeutic work (Lloyd et al., 2019, for an overview of ideographic measures). Specifically, patients construct their own items within a standardized questionnaire format, allowing them to establish their psychotherapy foci for themselves and to capture the broadest possible array of treatment goals (Jacob et al., 2018; Kiresuk et al., 1994).

While the idiographic approach makes it difficult to compare answers between individuals and/or groups of patients, the disadvantage of the nomothetic approach is that it may not capture highly individual goals that are of greatest importance to the individual patient. Furthermore, differences in subjective meanings that patients attribute to the same predefined goal are neglected. In case of older patients, an advantage of the nomothetic approach is that age-normative memory-retrieval problems (Cabeza et al., 2000) can be at least mitigated by presenting a predetermined set of treatment goals as memory cues to participants.

The present study used the checklist format of the Bern Inventory of Treatment Goals in order to assess PTGs from patient perspective at the beginning of outpatient psychotherapy (BIT-C; Grosse Holtforth, 2001). By combining the ideographic and nomothetic approach (using both answers to standardized and open-ended questions), the BIT-C allows both comparability between age groups and the inclusion of the subjective reality of PTGs to an adequate degree. The BIT-C has been shown to be reliable, valid and exhaustive in the context of treatment planning and outcome evaluation (Grosse Holtforth & Grawe, 2002), while it has been investigated merely in young and middle-aged patients so far.

1.1 | Aim of the present study

Knowledge of PTGs is important in order to tailor psychotherapy to depressed older people's personal mental health care needs and preferences, thus increasing both access to mental health care and efficacy of treatment. However, no study has yet systematically investigated PTGs of older patients with major depression. In order to address this research gap, the current study, conducted in a naturalistic setting, was driven by two aims. The first aim was to investigate the spectrum of thematic *contents* in depressed older patients' initial PTGs at the beginning of outpatient CBT treatment. Since research on motivational goals suggests age differences in the prioritization of contents, we were interested in thematic differences in PTGs between younger and older patients with major depression. In addition, we were interested in the *number* of formulated PTGs by older versus younger patients as existent research has suggested that older patients may seek to preserve restricted resources and therefore formulate fewer PTGs compared with younger patients.

Second, we were interested in age-specific aspects of the BIT-C (Grosse Holtforth, 2001), which is the instrument that was used to assess PTGs in the current study. The BIT-C is assumed to represent a vast range of PTG themes across different diagnoses besides symptom relief (Grosse Holtforth & Grawe, 2002). However, empirical evidence is only available for younger and middle-aged samples. Therefore, the second aim of this study was to investigate the representativeness of PTG themes of older depressed patients within the checklist format of the BIT (BIT-C, Grosse Holtforth, 2001).

2 | METHOD

2.1 | Design and sample

Data from archive files collected at the adult outpatient clinic of the University of Jena between October 2007 and October 2018 during routine psychotherapeutic treatment (CBT) were used. Data of $N = 394$ adult patients (≥ 18 years) diagnosed with major depression (F32.x, F33.x) were assessed for eligibility. This process resulted in $n = 74$ eligible older patients (≥ 60 years). To enable comparison with a group of younger adults, older patients were matched with younger patients (< 60 years) from the database. This was done using propensity score matching (PSM) to counter issues of selection bias. Specifically, patients were matched with regard to severity of depressive symptoms, number of comorbidities, gender, and highest level of education. Patients without a matching partner were excluded, resulting in a final data set of $n = 52$ younger ($M_{\text{age}} = 38.96$ years, $SD_{\text{age}} = 11.50$ years) and $n = 52$ older patients ($M_{\text{age}} = 68.67$ years, $SD_{\text{age}} = 6.40$ years). There were no exclusion criteria regarding comorbidity, severity of depression, or other patient characteristics such as physical conditions, which resulted in a naturalistic sample of patients attending outpatient CBT. Diagnoses were determined using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; Wittchen et al., 1997). Initial PTGs were assessed from patient

TABLE 1 Characteristics of the sample after PS-matching (N = 104)

	Younger patients (<60 years, n = 52)	Older patients (≥0 years, n = 52)
Age in years, M (SD)	38.96 (11.50)	68.67 (6.40)
Range	23–59	60–86
Gender (female), n (%)	41 (78.9)	38 (73.1)
State in therapy, n (%)		
Current	24 (46.2)	22 (42.3)
Completed	17 (32.7)	23 (44.2)
Dropout	11 (21.1)	7 (13.5)
Symptoms of depression (BDI-II), M (SD)	19.06 (9.76)	19.92 (11.28)
Primary diagnosis, n (%)		
Single episode (F32.x)		
Mild	6 (11.5)	4 (7.70)
Moderate	9 (17.3)	10 (19.2)
Severe	2 (3.8)	0 (0.0)
Other	1 (1.9)	1 (1.9)
Recurrent episode (F33.x)		
Mild	9 (17.3)	10 (19.2)
Moderate	22 (42.3)	24 (46.2)
Severe	1 (1.9)	2 (3.8)
Other	2 (3.8)	1 (1.9)
Number of diagnoses, M (SD)	1.58 (0.75)	1.44 (0.67)

perspective at the beginning of treatment together with sociodemographic data as well as severity of depressive symptoms.

All patients signed an informed consent form as part of the standard procedure at the outpatient clinic. Study procedures were performed in accordance with the Declaration of Helsinki. The study has been ethically reviewed and accepted at the Faculty of Social and Behavioral Science, Friedrich-Schiller-University Jena. Sample characteristics of the two age groups are shown in Table 1.

2.2 | Measures

2.2.1 | Bern inventory of treatment goals - Checklist format

Patient's PTGs were assessed using the BIT-C (i.e., a checklist including suggestions of possible PTGs, based on the taxonomy of the Bern Inventory of Treatment Goals [BIT-T] from Grosse Holtforth, 2001), which can be used as an assistive tool in the process of formulating PTGs (Grosse Holtforth, 2001). Completing the BIT-C takes approximately between 15 and 20 min.

Following the BIT-T (Grosse Holtforth & Grawe, 2002), the treatment goals in the checklist are organized in three levels of hierarchy and also presented in this way to patients: (1) goal types (top level), (2) goal categories (middle level) and (3) specific treatment goals (lower level). Specifically, the top level consists of the following five goal types: “coping with specific problems and symptoms” (P), “interpersonal goals” (I), “well-being and functioning” (W), “existential issues” (E) and “personal growth” (G). These goal types are further divided into 28 goal categories, such as anxiety, depressive symptoms, current family or exercise and activity (i.e., middle level). These categories are again subdivided into 64 specific treatment goals, which are formulated in plain and colloquial language. For example, “I want to overcome negative, ruminating thoughts and feelings of guilt” is an example of a specific treatment goal within the goal category “depressive symptoms,” representing the goal type “coping with specific problems and symptoms” (P).

The BIT-C (Grosse Holtforth, 2001) is presented to patients in two subsequent parts. In part 1 (i.e., preparatory step), patients are asked to screen the 64 pre-formulated treatment goals presented in the checklist (see Figure 1) for PTGs that represent their individual goals for therapy. In this step, patients can choose as many PTGs as possible without any prioritization. When patients are not able to find pre-formulated items matching their individual goals within the middle-level categories, there is also space for individual additions to these specific categories, (i.e., 24 open-ended questions, listed below the respective goal category). Four goal categories are represented by only one unambiguous specific treatment goal, thus making it unnecessary to leave space for open-ended questions. In part 2 (i.e., goal setting), patients are asked to review the treatment goals from the checklist and then formulate PTGs with the highest individual priority in their own words (hereafter referred to as “high-priority PTG”). This is done using a separate section where a maximum of five high priority PTGs can be written down (see Figure 2). The complete process of goal setting using the BIT-C is displayed in Figure 3.

2.2.2 | Beck Depression Inventory

Severity of depressive symptoms were assessed with the German version of the Beck Depression Inventory (BDI-II; Hautzinger et al., 2006). The BDI-II is a standardized, empirically validated self-report questionnaire, consisting of 21 items that represent typical depressive symptoms such as sadness, feelings of guilt or fatigue. Patients are asked to rate the severity of symptoms within the past 2 weeks on a 4-point scale (e.g., 0 = I do not feel sad, 1 = I feel sad, 2 = I am sad all the time and I cannot snap out of it and 3 = I am so sad or unhappy that I cannot stand it; Kühner et al., 2007). The highest possible score is 63 indicating severe depression.

2.3 | Analysis

Data analysis was performed using a combination of qualitative and quantitative steps of analysis.

I. Coping with specific problems and symptoms

With the help of psychotherapy, I want to

Depression	<input type="checkbox"/> ... overcome negative, ruminating thoughts and feelings of guilt. <input type="checkbox"/> ... overcome my bad mood, sadness or inner sense of emptiness. <input type="checkbox"/> ... cope with my mood swings. <input type="checkbox"/> ... regain drive and energy. <input type="checkbox"/>
Anxiety	<input type="checkbox"/> ... manage a specific fear or learn how to cope with it better. <input type="checkbox"/> ... cope better with panic attacks. <input type="checkbox"/> ... overcome anxiety and insecurity in presence of other people. <input type="checkbox"/> ... learn how to do things again that I avoid because of my anxiety. <input type="checkbox"/>

FIGURE 1 Excerpt from the Berner Inventory of Treatment Goals–Checklist format (BIT-C, part 1; Grosse Holtforth, 2001)

My personal treatment goals

1. Treatment goal (high priority personal treatment goal)
2. Treatment goal (high priority personal treatment goal)
3. Treatment goal (high priority personal treatment goal)
4. Treatment goal (high priority personal treatment goal)
5. Treatment goal (high priority personal treatment goal)

FIGURE 2 Excerpt from the Berner Inventory of Treatment Goals–Checklist format (BIT-C, part 2; Grosse Holtforth, 2001)

2.3.1 | Data preparation

In the initial qualitative analysis, participants' high-priority PTGs were analysed by conducting qualitative content analysis (Mayring, 2006)

using QDA software ATLAS.ti. PTGs were transferred to a text file and entered into ATLAS.ti. Sentences including more than one treatment goal were divided into single coding units by the first author of the study. A coding unit was defined to be constituted by a

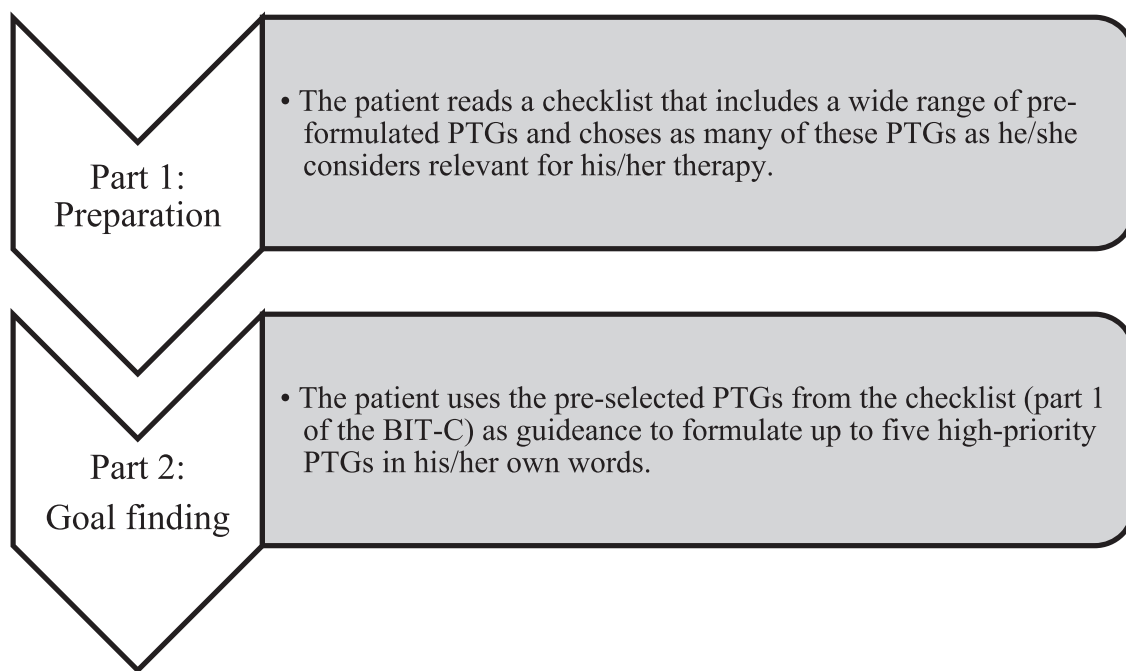


FIGURE 3 Personal treatment goal (PTG) selection process using the checklist format of the Bern Inventory of Treatment Goals (BIT-C, Grosse Holtforth, 2001)

treatment goal. A hybrid approach of inductive and deductive code development was then used to code the data. In a first (deductive) step, two independent raters (the first author of this study and a second rater, who was not involved in the project but familiar with the taxonomy) categorized content as represented in the respective coding units into to the best fitting lower level treatment goal in the checklist. For example, “I want to learn how to deal with the sadness and disappointment in my life” was coded as “to overcome my bad mood, sadness and inner sense of emptiness,” which is one of the 64 specific treatment goals in the goal category “depressive symptoms.” PTGs that could not be matched to the checklist’s treatment goals were assigned to an additional category (“further goals”).

In a second (inductive) step, participants’ PTGs in the category “further goals” were clustered into new (lower level) treatment goals using the systematic summarizing method (Mayring, 2006). Afterwards, these new treatment goal categories were integrated into the coding system used in the first (deductive) step. The reliability of coding was assessed by calculating kappa values for 20% of the material. The interrater reliability was substantial with Cohen’s $\kappa = 0.76$ (Landis & Koch, 1977).

2.3.2 | Statistical procedure—Research question 1

High-priority PTG themes identified within part 2 of the BIT-C (Figure 2) were analysed *quantitatively* using SPSS Statistics (IBM, version 25.0, Corp., Armonk, NY) to investigate possible age specific differences. We compared the *number* of high-priority PTGs (up to

five per patient) as well as the *frequencies of themes* formulated within the high-priority PTGs of older and younger depressed patients. For this purpose, we calculated *t* tests with age group as the independent variable. With regard to the *frequencies of PTG themes* as the dependent variable, we calculated a ratio of high-priority PTGs within each goal type/goal category to the total individual number of high-priority PTGs to control for possible differences in the number of formulated high priority PTGs in younger and older patients. The *t* tests were conducted separately for each goal type and goal category, resulting in 32 tests. Cohen’s *d* was calculated as a measure of effect size and is reported along with corresponding confidence intervals (CIs; Cumming & Finch, 2005). As the study is of exploratory nature, we will focus primarily on effect size to determine if group differences are meaningful.

2.3.3 | Statistical procedure—Research question 2

To investigate whether the checklist format of the BIT (BIT-C, Grosse Holtforth, 2001) is a valid and age-appropriate instrument for preparing and assessing PTGs of older depressed patients, *frequencies of high priority PTG themes* (part 2, see Figure 2) were analysed to identify the most relevant themes of PTGs as well as extraneous PTG themes of older depressed patients. On other words, if older depressed patients chose some PTGs very rarely or not at all, this would indicate that PTG themes in the BIT-C are not representative for the needs and wishes of older depressed patients. Furthermore, the *content* of PTG themes in part 2 that were not included in the BIT-C were analysed *qualitatively*. This was also done for the newly added PTG themes

TABLE 2 Differences in relative frequencies of high-priority treatment goals in older ($n = 52$) and younger ($n = 52$) patients (BIT-C, part 2)

	Younger patients M (SD)	Older patients M (SD)	<i>t</i>	95% CI ^a	<i>d</i>	95% CI ^b
Goal type						
(P)	0.41 (0.26)	0.42 (0.27)	-0.11	[-0.11, 0.10]	-0.04	[-0.43, 0.35]
(I)	0.17 (0.14)	0.14 (0.22)	0.69	[-0.05, 0.10]	0.16	[-0.23, 0.55]
(W)	0.07 (0.11)	0.17 (0.15)	-3.85	[-0.16, -0.05]	-0.76	[-1.15, -0.37]
(E)	0.06 (0.10)	0.05 (0.16)	0.30	[-0.05, 0.06]	0.08	[-0.31, 0.47]
(G)	0.25 (0.21)	0.14 (0.16)	2.83	[0.03, 0.18]	0.59	[0.20, 0.98]
Goal categories						
Depression	0.15 (0.14)	0.14 (0.15)	0.25	[-0.05, 0.07]	0.07	[-0.32, 0.46]
Anxiety	0.06 (0.16)	0.09 (0.18)	-0.82	[-0.10, 0.04]	-0.18	[-0.57, 0.21]
Compulsion	0.01 (0.06)	0.01 (0.04)	0.34	[-0.02, 0.03]	0.00	[-0.39, 0.39]
Coping with trauma	0.01 (0.05)	0.03 (0.07)	-1.04	[-0.04, 0.01]	-0.33	[-0.72, 0.06]
Difficulties in life	0.05 (0.11)	0.06 (0.12)	-0.54	[-0.06, 0.03]	-0.09	[-0.48, 0.30]
Sleep	0.03 (0.09)	0.03 (0.08)	0.64	[-0.02, 0.05]	0.00	[-0.39, 0.39]
Somatic problems	0.03 (0.15)	0.04 (0.10)	-0.29	[-0.06, 0.04]	-0.08	[-0.47, 0.31]
Stress	0.06 (0.10)	0.03 (0.07)	1.95	[-0.00, 0.07]	0.35	[-0.04, 0.74]
Eating behaviours	0.00 (0.03)	0.00 (0.00)	1.00	[-0.00, 0.01]	0.00	[-0.39, 0.39]
Addiction	0.00 (0.00)	0.01 (0.04)	-1.43	[-0.02, 0.00]	-0.18	[-0.21, 0.57]
Self-injury	0.01 (0.05)	0.01 (0.04)	0.41	[-0.01, 0.02]	0.00	[-0.39, 0.39]
Sexuality	0.00 (0.00)	0.00 (0.00)	-	-	-	-
Current relationship	0.01 (0.04)	0.04 (0.10)	-2.10	[-0.06, -0.00]	-0.40	[-0.79, 0.00]
Current family	0.00 (0.03)	0.00 (0.03)	-0.03	[-0.01, 0.01]	0.00	[-0.39, 0.39]
Family of origin	0.04 (0.09)	0.00 (0.00)	3.21	[0.02, 0.07]	0.62	[0.23, 1.01]
Other relationships	0.02 (0.06)	0.03 (0.15)	-0.59	[-0.06, 0.03]	-0.09	[-0.48, 0.30]
Loneliness	0.02 (0.06)	0.01 (0.05)	0.33	[-0.02, 0.02]	0.18	[-0.21, 0.57]
Assertiveness	0.05 (0.10)	0.03 (0.09)	1.09	[-0.02, 0.06]	0.21	[-0.18, 0.60]
Intimacy	0.03 (0.07)	0.03 (0.07)	0.49	[-0.02, 0.04]	0.00	[-0.39, 0.39]
Activity	0.00 (0.03)	0.03 (0.08)	-1.78	[-0.05, 0.00]	-0.50	[-0.89, -0.11]
Relaxation	0.02 (0.06)	0.10 (0.16)	-3.63	[-0.14, -0.04]	-0.67	[-1.06, -0.23]
Well-being	0.05 (0.10)	0.04 (0.09)	0.33	[-0.03, 0.04]	0.11	[-0.28, 0.50]
Past, present, and future	0.06 (0.10)	0.05 (0.16)	0.46	[-0.04, 0.06]	0.08	[-0.31, 0.47]
Meaning of life	0.00 (0.00)	0.00 (0.03)	-1.00	[-0.01, 0.00]	0.00	[-0.39, 0.39]
Attitude towards self	0.14 (0.15)	0.05 (0.11)	3.06	[0.03, 0.13]	0.68	[0.28, 1.07]
Performance	0.03 (0.07)	0.03 (0.08)	-0.35	[-0.04, 0.03]	0.00	[-0.39, 0.39]
Desires and wishes	0.06 (0.11)	0.02 (0.07)	1.80	[-0.00, 0.07]	0.43	[0.04, 0.82]
Emotion regulation	0.02 (0.07)	0.03 (0.07)	-0.15	[-0.03, 0.03]	-0.14	[-0.53, 0.25]

Note: (P) denotes specific problems and symptoms, (I) denotes interpersonal goals, (W) denotes well-being and functioning, (E) denotes existential issues and (G) denotes personal growth.

^aConfidence interval (CI) for the mean.

^bCI for Cohen's *d*.

within the open-spaced items in part 1 (preparation step, see Figure 1). Analysing their content was a crucial step in discovering the whole range of possible PTG themes older depressed patients may have. If older depressed patients formulated high-priority PTGs that are not yet included in the BIT-C, this would indicate that important PTG themes for older (depressed) patients are missing in the current version of this instrument.

3 | RESULTS

3.1 | Treatment goal themes of older versus younger patients (Research question 1)

There were no significant differences in the *number* of high-priority PTGs that older and younger patients formulated in part 2 of the

BIT–older patients: $M = 3.75$; $SD = 1.68$; younger patients: $M = 4.35$, $SD = 1.31$; $t(97) = 2.02$; 95% CI [0.01, 1.18]; $p = 0.05$. Considering the *relative frequency of themes* within goal types as well as goal categories (see Table 2), effect sizes indicate meaningful age differences for goal types (W) “well-being and functioning” and (G) “personal growth.” Specifically, compared with older patients younger depressed patients formulated more goal type (G) high-priority PTGs (Cohen's $d = 0.59$), while older patients composed more of goal type (W) (Cohen's $d = 0.76$). Corroborating these findings on the middle level of the goal taxonomy, in the sample of older depressed patients, effect sizes were largest for high-priority PTGs related to “activity” (Cohen's $d = 0.50$) and “relaxation” (Cohen's $d = 0.67$) whereas younger depressed patients were most strongly focused on “attitudes towards self” (Cohen's $d = 0.68$).¹

3.2 | Age appropriateness of the BIT-C for older depressed patients (Research question 2)

To evaluate how well the BIT-C covers initial PTG themes of older depressed patients, the themes of the high-priority PTGs were analysed ($N = 520$ codes). The PTG themes of older participants fit in all five goal types on the top level (goal types). On the middle level (goal categories), no PTG theme was formulated in the categories

“family of origin,” “sexuality” and “eating behaviour.” Furthermore, only very few of high-priority PTG themes pertained to the categories “addictive behaviour” ($N = 2$, 0.38%), “compulsion” ($N = 2$, 0.38%), “self-injury” ($N = 2$, 0.38%) and “current family” ($N = 1$, 0.19%). On the lower level, several specific treatment goals included in the BIT-C were not represented (e.g., “avoidance behaviour”, “divorce”, “physical self-injury”, and “identity”) or only mentioned very few times (e.g., “social phobic fears” [$N = 1$, 0.19%], “abstinence” [$N = 1$, 0.19%] and “housing situations” [$N = 2$, 0.38%]) within high-priority PTGs. In turn, there were PTG themes formulated by older participants that are not included in the checklist. As shown in Figure 4, the inductive categorization of these high-priority PTG themes resulted in additional PTGs on the lower level, encompassing “physical aging process” ($N = 5$, 0.95%), “widowhood” ($N = 2$, 0.38%), “health fears” ($N = 2$, 0.38%), “acceptance of old age and aging” ($N = 4$, 0.76%), “mental activity” ($N = 1$, 0.19%) and “illness of others” ($N = 2$, 0.38%).

Some of the older participants' PTGs added to the checklist (part 1, see Figure 1) could also be assigned to the inductively derived categories mentioned above. Older patients added PTGs to the checklist, introducing themes such as “health fears” ($N = 1$, 0.75%), “physical aging process” ($N = 2$, 1.5%) and “acceptance of old age and aging” ($N = 1$, 0.75%). There were also PTGs added to the checklist that were thematically not mentioned within the high-priority PTGs of older participants (“loss of social network,” $N = 2$, 1.5%).

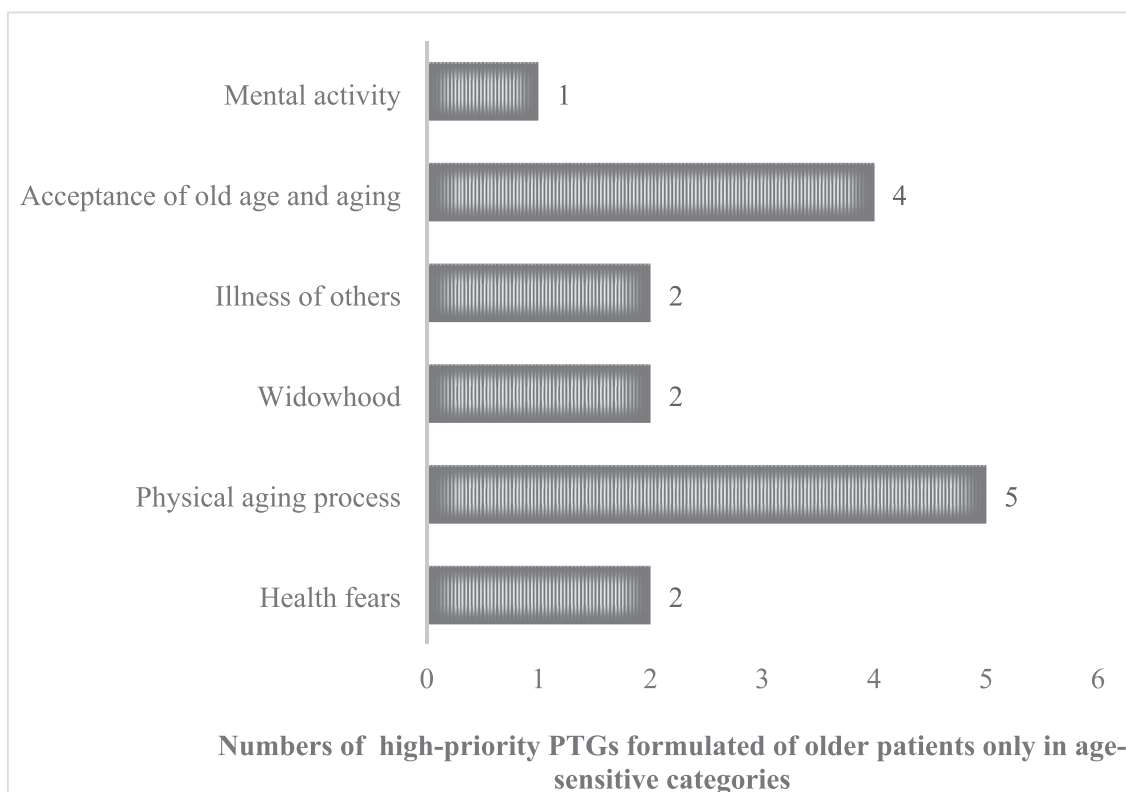


FIGURE 4 Numbers (i.e., absolute frequencies) of high priority personal treatment goals of older patients with major depression ($N = 52$) at lower level in accordance with the taxonomy of the Berner inventory of treatment goals (BIT-T, Grosse Holtforth & Grawe, 2002) that were not yet included in the checklist format (BIT-C, Grosse Holtforth, 2001)

4 | DISCUSSION

To the best of our knowledge, our study is the first to systematically investigate whether age matters when it comes to depressed patients' initial PTGs, using a naturalistic sample of patients with an age range of 23 to 86 years who were physically able to reach the outpatient clinic without help. Specifically, the aim of the present study was to investigate the spectrum of *contents* as well as the *number* of depressed older patients' initial high priority PTGs at the beginning of an outpatient CBT in comparison with younger depressed patients. Another aim of the study was also to examine how well PTG themes of older depressed patients are represented within the BIT-C (Grosse Holtforth & Grawe, 2002).

Contrary to the theoretical predictions of lifespan development theories, such as the SOC model (S = Selection of personally relevant goals, O = Optimization of resources for goal attainment, C = Compensation of declining health/loss of resources by building up goal relevant alternative resources; Freund & Baltes, 2000), we found no substantial age-specific differences in the *number* of initial high priority PTGs. One would have expected older patients to focus, consciously or unconsciously, on a smaller *number* of initial PTGs compared with younger patients, as indicated by smaller amount of high-priority PTGs in part 2 of the BIT-C. In contrast to this assumption, our findings provide preliminary evidence that, compared with younger patients, older patients do not limit their resources when it comes to their commitment to important self-defined goals in psychotherapy. In light of the present findings, it can be concluded that chronological age per se may at least not have a major impact on the *numbers* of high priority PTGs of older depressed patients, even if the general motive of loss management becomes more and more important in old age (Freund & Baltes, 2000). Our findings can be interpreted against the background of social-cognitive ageing research, which demonstrated that the meaning attached to a situation heavily influences the extent to which an older person is willing to engage his/her (limited) psychological resources (Hess et al., 2001). Obviously, older patients perceive psychotherapy as a highly meaningful context in which it is "worthwhile" to invest psychological resources. Restricting on a subset of life domains on which to focus one's resources may only apply when older patients perceive that their goals are unreachable or can only be achieved to significantly increased costs (Ennis et al., 2013).

With regard to prioritization of specific *contents* of high priority PTGs, the effect sizes indicate some difference considering goal types, with older patients being more focused on "well-being and functioning" and younger patients more focused on "personal growth." These findings are fully in line with the lifespan developmental research on self-regulation across the lifespan (Carstensen & Charles, 1998; Labouvie-Vief, 2003). Accordingly, self-regulation in old age calls for the preservation of resources, the avoidance of exhausting physical and mental resources and a "positivity bias" in memory and attention. In contrast, the developmental task of young adulthood is to explore environments and to acquire more knowledge about ourselves and the world. As a consequence of their distinct

contributions to adaptation, a focus on positive adjustment in the face of challenges has been shown to be most pronounced in old age, while striving for personal growth seems to be more important in young and middle adulthood (Kessler & Staudinger, 2010; Staudinger & Kessler, 2009). Our study suggests that this normative developmental pattern is also reflected in PTGs of patients with major depression.

Besides these preliminary findings on differences in initial high-priority PTGs, younger and older depressed patients both primarily focused on specific problems and symptoms within their high priority PTGs. Specifically, improving management of depressive symptoms was most prominent, followed by better dealing with anxiety, which is in line with existing evidence on frequent overlap of depression and anxiety in older adults (Prina et al., 2011). While these two PTG themes were most prominent, our study found that older patients with major depression define a broad spectrum of heterogeneous PTGs for themselves at the beginning of psychotherapy (including symptom-unrelated PTG themes), contrary to what is often believed. While some literature in the more distant past has suggested older adults to be more "symptom-fixated," our results suggest that they are not different from younger patients in this pattern of heterogeneous PTG themes (Grosse Holtforth et al., 2009).

Therefore, the *quantitative* results of our study have to be regarded jointly with results of our *qualitative* analyses of high-priority PTG themes. Specifically, the latter analyses indicate that high-priority PTG themes are by no way completely "age-neutral" and that it is worthwhile to further systematically investigate what older patients intend to engage in at the beginning of CBT. Specifically, a small, but relevant number of older depressed patients in our sample initially formulated high-priority PTGs related to better coping with age-related decline and physical illness. This finding at least indicates that the BIT-C is most probably not an exhaustive instrument, as it does not capture the whole spectrum of PTG themes relevant for older patients with major depression (even though it is described as such, see Grosse Holtforth & Grawe, 2002). This is important since recent research pronounces the importance of adequately tailored psychotherapy with depressed patients considering different patient characteristics (Maj, 2020). Especially during psychotherapy with depressed patients characterized by impaired neurocognitive functioning as well as by (serious) somatic comorbidities, as it is often the case in older patients (Fiske et al., 2009), patient-centred clinical assessment and conceptualization have been identified as important variables to predict (long-term) success of therapy (Laidlaw et al., 2004; Reynolds, 2020). If psychotherapists do not adequately address older patients' wishes to better deal with subjective and objective experiences of physical deterioration and illness, patients may lack motivation and compliance in psychotherapy. Nevertheless, based on our data, older patients' intentions to engage in PTGs related to deterioration and illness should also not be regarded as the norm, as suggested by the negative old-age stereotype of the vulnerable old person (Hummert, 2011). Complementary to missing PTG themes, the very low frequency or even non-occurrence of the BIT-C items "confidence in being a parent," "family situation"

and “divorce” indicate that the BIT-C (as an example of a treatment goal assessment instrument) is primarily tailored to the developmental tasks of young and middle adulthood than those of old age, suggesting the BIT-C to be an instrument with limited validity for older adults.

4.1 | Limitations

The main goal of this exploratory study was to provide a first and contextualized understanding of the needs and goals of older depressed patients at the beginning of CBT. As we used archive data from patients who attended psychotherapy in a natural setting, external validity can be considered high. It is, however, a downside of this approach that patients were not recruited systematically for the study and the relatively small sample size may have resulted in low statistical power. We therefore primarily inspected effect sizes which are, unlike p values, unaffected by sample size. Nevertheless, it should be noted that the findings provide a unique insight into the goals and needs of older depressed patients. Future studies need to be designed specifically for the purpose of replicating and extending these findings.

The sample size was further reduced as a result from the PS matching procedure that allowed us to account for some important third variables. Even if we tried to control for the most relevant third variables by using this procedure, not all sources of bias may have been diminished. For example, our findings could also be biased due to the nomothetic approach used within the BIT-C (Grosse Holtforth, 2001). With the presentation of a pre-defined set of treatment goals, standardized instruments to assess PTGs, such as the BIT-C, guide patients towards certain PTGs. It seems possible that larger differences regarding high-priority PTG themes would have resulted from using a checklist that does contain typical PTGs of patients from all age groups. Nevertheless, especially for older patients, instruments as the BIT-C are helpful in overcoming memory-retrieval problems. Using an exclusively idiographic approach may result in less specific high-priority PTGs, which would not represent the needs and preferences of the patient. Furthermore, another disadvantage of the idiographic approach is that high-priority PTG themes of older and younger patients would not have been comparable in numbers and frequencies of formulated themes.

The range of age is another limiting issue. In the present sample, most included patients were in the so-called third age (i.e., ages 60 years to 85 years). Older patients in the fourth age (85 years and older) were scarcely represented, in line with the heavy undersupply of this age group in terms of outpatient mental health services care across countries. In the fourth age, differences in successful ageing have shown to become more prominent than in the third age (Baltes & Smith, 2003). Our findings can also not be generalized to older patients with high levels of functional impairment and patients treated in inpatient settings, such as geriatric/geropsychiatric clinics. Therefore, it is still unclear if high-priority PTG themes of patients in the fourth age may differ from high-priority PTG themes of

younger patients. Due to the already small sample size, comparisons between younger, middle-aged and older patients were also not possible, but considering findings on motivational goals in lifespan developmental research, future studies should focus on these comparisons. Furthermore, our results are limited to patients with major depression, and no conclusions can be drawn for patients with other diagnoses, for example, anxiety disorders. Our findings can also not be generalized to other psychotherapeutic methods such as psychodynamic psychotherapy, interpersonal psychotherapy, and so forth. Finally, future research should include interesting and valuable analyses in regard to negotiating PTGs throughout the course of psychotherapy as well as goal attainment in dependence of content of older patients PTGs.

4.2 | Implications and conclusion

The need to optimize the efficacy of treatment manuals for depressed older adults combined with low active demand for psychotherapy under naturalistic conditions highlight that disorder-specific treatment goals need to be aligned with the targeted patients' personal goals (Swift et al., 2018). Results of our study suggest that older age may not fundamentally change what patients with major depression intend on when beginning a psychotherapeutic treatment. As well as with younger patients older patients with major depression define a broad spectrum of heterogeneous PTGs for themselves at the beginning of psychotherapy, with a major focus on improving management of depressive symptoms and better dealing with anxiety. At the same time, age differences in PTGs become visible in older patients' greater focus on well-being and functioning versus younger patients' emphasis on personal growth. Furthermore, improved coping with the ageing process and physical losses appear to be important themes for some older adults, while typical themes related to family life may fade into the background. Even if frequencies were small for age specific PTG themes in the present study, it may be possible that these themes are formulated more often when using a checklist including such PTGs. Thus, the results of this study can contribute to the development of age-sensitive instruments for the valid assessment of PTGs, which in turn allows for an appropriate and efficient tailoring of psychotherapy for older patients (Dwight-Johnson et al., 2000). A “hybrid” instrument for assessing PTG that combines open format and age-sensitive checklists has the potential to stimulate PTGs in the face of age-normative memory-retrieval decline while allowing older patients to define their unique foci of psychotherapy. Also modifications for patients with mild cognitive impairment, such as a reduced number of items and simplified language, deserve further study. The importance of a personalized conceptualization of psychotherapy with older patients has already been suggested in the literature (see, for example, Laidlaw et al., 2004), but is realized too little in practice (Renn & Areán, 2017). With appropriate PTG assessment, older patients may be able to better engage in and commit to therapy, thereby improving both access to and efficacy of outpatient psychotherapy.

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CONFLICT OF INTEREST

None declared.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval was obtained from the Ethics Committee of the Faculty of Social and Behavioral Sciences of the Friedrich Schiller University Jena, Germany (committee's reference number: FSV 19/32). All participants received information about the study and gave written informed consent. Approval for the informed consent materials was granted by the ethics committee.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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ENDNOTE

¹ Even if p values were not reported due to the exploratory character of this study, we want to note that the Bonferroni-adjusted p values correspond mainly with the results of effect sizes. Even when controlling for the number of tests ($N = 32$), we still found significant effects for the goal type (W), $p < 0.001$, and for the goal category relaxation ($p = 0.032$).

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