UNIT 3 PSYCHOTHERAPY WITH OLDER ADULTS

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3.0 INTRODUCTION

Psychological therapies with older people have traditionally held a lowly position in old age psychiatry and in psychotherapy generally. This is due to a number of reasons, particularly ageism, which has been a great hindrance to development of expertise and services in this area. Negative stereotypes about the treatability of older people and a lack of psychotherapy theory that can speak to later life still have a pervasive negative effect on expectations and expertise. With the current high demand on old age psychiatry services for the assessment and treatment of early dementia, developments in services are focusing on biological models of illness and pharmacological treatments, again at the expense of psychological therapies.

The aim of this unit is to give students an overview of the psychological therapies that have been applied to work with older people, in order to inform clinical work in old age psychiatry and to encourage interest, training and referral where resources and practitioners are available.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the background and different therapeutic approaches for older adults;

- Describe psychotherapy with dementia;
- Discuss the types of therapies used with specific problems; and
- Discuss the modification and adaptation of therapies for treatment with older adults.

3.2 BACKGROUND

Ageism, or the discrimination against people on the grounds of age alone, has been slow to gain public awareness in society. Although racism, casteism and sexism, for example, have been tackled in statute law around the world, ageism is just surfacing in the collective consciousness of policy makers and clinicians. It is interesting to consider the paradox that discrimination based on a universal experience(ageing and death) has been relatively slow to achieve public awareness compared with 'isms' that oppress minority groups in society. There may be many reasons for this: the prevalence of age is among older people themselves (discouraging the formation of a 'minority group'); our need for robust denial based defenses to protect against frightening existential uncertainties (death, meaninglessness); and the notion of the demise of 'elder hood' in Western society in the 20th century.

Even at the age of 49 himself, Freud considered older people (the over-50s by his reckoning) ineducable (Freud, 1905). This therapeutic nihilism has had a profound effect on the development of both psychotherapy theory and services for older people. Psychotherapy theory has tended to focus on childhood development and the developmental stages of infant, child and early-adult life, with later life being neglected as a developmental phase.

An exception to this has been the work of Erikson (1966),who identified 'eight ages of man' in terms of dichotomies, with 'generality *v*. stagnation' and 'ego integrity *vs*. despair' describing the developmental challenges of later life. The apparent linearity of this model, however, and the lack of elaboration of the nature of psychological development in later life over the 30 years since Erikson proposed it have left old age psychotherapy detached from the mainstream and without a firm theoretical base. In addition, the dominance of the biological or organic model in old age psychiatry and neuropsychology has tended towards 'brain-based' rather than 'psyche based' explanations for all illness and distress in later life, where the imaging and charting of deficits takes priority over any meaningful dialogue about shared existential fears between professional and patient.

Despite all these problems, many psychotherapists, psychologists and psychiatrists have used various psychotherapies with older people with success and enthusiasm. Of particular note is the work of Martin (1944) and Hildebrand(e.g. Hildebrand, 1990), who can be seen as pioneers in this field. Many others, who will be mentioned in the sections below, covering individual psychotherapies, have been determined to apply and develop different theoretical approaches in their work with older people and to share their experience and positivity. In contrast to the pessimistic starting point that psychotherapy with older people is 'too late' there is hope not only that it is not too late, but that for many it can be just in time.

3.3 COGNITIVE BEHAVIOURAL THERAPY (CBT)

Cognitive Behavioural Therapy (CBT) is the form of psychotherapy most often used with older people. In controlled clinical studies it has been shown to be efficacious in the treatment of depression, anxiety and problematic behaviours in the context of dementia. In a series of studies with older people in the USA by Gallagher-Thompson and colleagues (reviewed by Teri *et al*,1994) CBT has been shown to be highly effective with depressed patients in both hospital and community settings as well as in individual and group formats. A more recent trial (Barrowclough *et al.*, 2001) of the effectiveness of CBT *v*. supportive counselling on anxiety symptoms in older adults showed CBT to be both effective and superior to supportive counselling in terms of improvement in anxiety symptoms and self rating of anxiety and depression over a 12-month period.

Cognitive behavioural therapy focuses on negative thoughts and their reinforcing behaviours, attempting to identify dysfunctional cycles and to intervene with challenges to unhelpful thinking, the reduction of negative and avoidant behaviours and the introduction of positive behaviour patterns. Negative thoughts can be challenged by techniques that assess the evidence behind the thoug ht, the 'thinking errors' that are present, the pragmatic effect of negative thoughts on overall well being and the consideration of alternative viewpoints. The intensity with which thoughts are held can be rated and monitored through treatment, and the reinforcing avoidant behaviours can be tackled using a graded exposure model. In work with older people, writers in the field suggest some adaptations to CBT technique, including increased emphasis on maintaining the focus on the work, acknowledgement of feelings of guilt and helplessness following the onset of disability and other life events and an awareness of the interaction of somatisation and the physical symptoms of organic disease. Cognitive behaviouraltherapy offers a structured, collaborative, and brief and client centered approach.

3.4 COGNITIVE ANALYTIC THERAPY

Cognitive analytic therapy (CAT) represents a modern integration of analytic (object relations theory) and cognitive psychotherapy traditions to provide a brief, structured and collaborative therapeutic journey from past trauma into reconnection with dialogue and meaning. In existence for less than 20 years, the evidence base, although in progress, is yet to be established, but there is interest in applying the model to older people because of its emphasis on shared meaning in the context of the client's life story and the importance it gives to 'dialogue', both cathartic and reparative, in the therapeutic relationship. Traditional concepts from psychoanalytic theory and psychiatry (such as narcissism, borderline personality traits and post-traumatic syndromes) have recently been applied to later life from a CAT perspective.

Later life can be a time when coping mechanisms are challenged by losses, disability and changes insocial role. It is then that pre-existing trauma and low self-esteem can resurface to produce anxiety,depression and self-destructive behaviours, which need to be understood in terms of the person's wholelife story. Cognitive analytic therapy can offer a coherent way of linking past and present, and maybe well suited to work in later life because of its emphasis on the interpersonal and the need to find shared meaning and understanding in therapy across generational and cultural boundaries.

Self Assessment Questions

1) Discuss psychotherapy in regard to older persons. Give a background of the old persons.

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2) What is Cognitive Behavioural Therapy (CBT)?

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3) Discuss cognitive analytic therapy and bring out the difference between cognitive behaviour and cognitive analytic therapies.

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3.5 PSYCHODYNAMIC THERAPY

This broad range of therapies, stemming largely from the work of Freud, Klein and Jung, has been discussed widely in relation to later life. Some empirical evidence exists to suggest that psychodynamic work with older people is at least as effective as CBT in dealing with depression (Thompson *et al*, 1987).

Psychodynamic approaches often center on the development of insight into repressed unconscious material from earlier life experience and on the working through of this material in the therapeutic relationship. Experience has shown that the client's age can be an important factor in the nature of the transference and counter transference aspects of the therapy.

Therapists may be reluctant to acknowledge the infantile needs of an elderly client because of a subconscious fear of the perceived dependence and helplessness that they might themselves experience in old age. Erotic transference may be ignored or ridiculed in the counter transference, and the client's situation may elicit in the therapist idealised care fantasies resulting from the therapist's unconscious fears and concerns about their own older family members. The psychodynamic model, however, is likely to be well suited to working with

material derived from the client's 'feelings of abandonment and despair, intimacy and isolation, arrogance and disdain, stagnation and creativity as each of us struggles with the developmental task of "the third age" '.

3.6 INTERPERSONAL THERAPY

Interpersonal therapy is a practical, focused, brief, manual-based therapy that can be applied by arrange of professionals after a period of basic training. Its accessibility has generated considerable interest in its use with older people, and a reasonable evidence base exists to support its efficacy in the treatment of depression in older people, both in the acute phase and in relapse prevention (Reynolds *et. al*, 1999).

Interpersonal therapy focuses on disturbances relationships, categorized into four domains:

i) role transition,

ii) role dispute,

iii) abnormal grief and

iv) interpersonal deficit.

A range of therapeutic interventions aim to improve communication, express affect and support renegotiated role relationships, with the result of symptom reduction and improvement in functionality. Experience in applying interpersonal therapy to work with older people has suggested that it is directly applicable to the relationship and developmental issues relevant to people in later life.

3.7 SYSTEMIC (FAMILY) THERAPY

Although the evidence base for the use of systemic approaches in work with older people is sparse, a model that looks at individuals in the context of their wider family and social system seems to have wide applicability. A systemic approach may be particularly helpful in the context of communicating and processing the diagnosis of dementia in a family setting and also in unraveling the reinforcing factors in dysfunctional somatizing and sick role behaviour in older adults. Systemic approaches can be used pragmatically both in one time therapeutic assessments andin more formal therapy sessions following an established family therapy model.

The systemic approach recognises that presenting symptoms in the patient may result from dysfunctional dynamics in the wider matrix of relationships surrounding the individual. By using techniques such as circular questioning (e.g. 'what do you think X would say to that?'), positive connotation (e.g. 'you are such a close family that sometimes you care too much'), paradoxical intervention (e.g. 'So it seems that you have solved all your difficulties and don't need our help any longer'), reframing (e.g. 'It seems as if X is flagging up the distress on behalf of the whole family') and exploration of the shared genogram (family tree),therapy may tip the system into positive change. The availability of professionals skilled in system approaches is likely to be highly beneficial as a consultative tool for those working directly with clients in old age, who are well aware of the challenging family dynamics often uncovered by mental illness in late life.

3.8 REMINISCENCE / LIFE REVIEW THERAPY

Reminiscence Therapy (RT) involves recalling the past as a way to increase self-esteem and social connection. RT typically occurs in a group format in which individuals are encouraged to remember and share memories of the past, with personal artifacts, newspapers, and/or music often used to stimulate memories. These sessions are frequently structured with the therapist picking the topic. This very popular counseling tool is regularly used with elderly to gain perspective on their lives and thus is popular in senior centers, residential settings, and retirement communities rather than as clinical intervention for those older adults with major mental health or personality disorders (Thorton and Brotchie, 1987).

Life review therapy (LRT: Butler, 1963), a more intense type of RT, involves the reworking of past conflicts in order to gain a better understanding and acceptance of the past. These types of therapies are based on the work of Erik Erikson (1966) and his eight-stage model of psychosocial development. The underlying premise is that an older adult can be helped through the last stage of Erikson's model, ego integrity versus despair. It is thought that if older adults can satisfactorily formulate and accept personalised answers to existential questions such as, 'Who am I?' and 'How did I live my life? Etc., they may be able to achieve integrity.

Self Assessment Questions

1) Define and describe psychodynamic therapy.

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2) Discuss interpersonal therapy and how is it applicable in the adults group.

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3) What is systemic (family) therapy? Elucidate

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4) Put forward the reminiscence life review therapy.

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3.9 PSYCHOTHERAPY IN DEMENTIA

An important area in need of further investigation is the application and provision of psychotherapeutic services to those with cognitive impairment. A significant minority of the elderly population experience limitations in their cognitive abilities due to progressive dementia, and many of these individuals also experience co morbid emotional distress. Owing to their cognitive deficits, such as memory loss or decreased capacity for judgment and problem solving, persons with dementia are usually not considered to be good candidates for traditional psychotherapy. However, the symptoms and behaviours of persons with dementia should not be viewed solely as manifestations of biology, but rather, as being affected by social, psychological, and environmental contexts as well. Thus, patients with dementia are able to derive some benefit from psychological interventions. Various CBT, environmental, and supportive interventions may help cognitively impaired older adults reduce disruptive behaviours and excess disabilities, increase or maintain positive behaviours, improve memory or learn coping skills to manage loss of cognitive skills, increase quality of life, reduce excessive burden on health-care delivery systems, alleviate symptoms of depression or anxiety, or help adjustment to multiple losses.

Many psychosocial interventions currently in use with older adults with dementia are based on uncontrolled case studies and anecdotal reports. However, there are some studies examining the feasibility of conducting therapy or the effectiveness of therapy for particular purposes with older adults. Use of behavioural and environmental treatments for behaviour problems and memory and cognitive retraining for some forms of late-life cognitive impairment may be effective. However, there is much dispute about cognitive training, in particular. Support groups and CBT can assist those with early-stage dementia to foster coping strategies and reduce distress. RT may provide mild to moderate stage individuals with interpersonal connections. Behavioral approaches and memory training target specific cognitive and behavioural impairments and help to optimise remaining abilities.

3.10 THERAPIES FOR SPECIFIC PROBLEMS

The choice of psychological approach will largely depend on availability of expertise, which is often sadly lacking because psychotherapies are still regarded as being unnecessary or ineffective for older people. In an ideal world, however, a range of therapies would be available, and given that some require considerably more time and resources than others, the following is a guide to deciding what might be best for whom.

3.10.1 'Uncomplicated' Depressive Illness

Cognitive–behavioural or interpersonal therapy maybe offered in the first instance with or without pharmacological treatment. Both therapies may be useful in relapse prevention in those with recurrent depression. Interpersonal therapy may take preference where obvious tensions exist in current relationships, whereas CBT may suit a more cognitively minded patient. Cognitive behavioural therapy should also be the first line approach for pronounced anxiety symptoms and panic with avoidant behaviours.

3.10.2 Depressive Illness and Borderline or Narcissistic Personality Traits

Patients with depressive illness complicated by borderline or narcissistic personality traits often have a history of traumatic experience in childhood or earlier in their adult lives and exist either in a highly dysfunctional systemic context or in relative isolation following severing of close interpersonal links. Cognitive analytic therapy or psychodynamic therapy is the treatment of choice.

3.10.3 Depressive Illness in Dysfunctional Family Systems

Depressive illness in late life is sometimes complicatedby enmeshed and 'high expressed emotion'family or systemic relationships. Systemic (family)therapy is indicated if at least some of the systemcan be engaged in it.

3.10.4 Somatisation Disorders

Cognitive behavioural therapy is probably the first line approach, but if the somatic or dissociativesymptoms can be traced to earlier trauma a moreexploratory therapy such as CAT or psychodynamictherapy may be needed.

3.10.5 Psychological Approaches to Dementia Care

Insights from psychodynamic theory and CAT can contribute to an understanding of the role-play between the care giver and the person with dementia and help prevent interaction that reinforces the isolation and alienation experienced. Behavioural approaches may be helpful for clusters of repetitive behavioural disturbances in more severe dementia. Family and systemic approaches can be useful in exploring a diagnosis of early dementia. A general approach based loosely on the principles of validation therapy (Feil, 1982), with time for reminiscence and life review, is likely to provide a humane theoretical backdrop to dementia care in many settings.

Self Assessment Questions

1) Discuss the therapies suited to the following specific problems

   a) Dementia

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   b) Uncomplicated depressive illness

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   c) Depressive illness borderline disorder

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   d) Depression in dysfunctional family system

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3.11 MODIFICATIONS OR ADAPTATIONS OF TREATMENT

There are numerous physical, psychological, cognitive, social, developmental, and environmental factors that can impact the choice and delivery of psychotherapy to older adults. Older adults have at least one chronic medical illness, some degree of functional impairment/disability, an increasing frequency of loss events, and a decrease in controllability of these losses (e.g., financial limitations, diminished sensory capacities, decreased mobility, retirement, widowhood, and change in residence). The complexity of these intermingling influences often merit special therapeutic consideration.

Although some mental health interventions are comparable with those used with younger individuals, it is often necessary to adapt therapies to address special considerations unique to older adults. For example, psychotherapy with older adults often occurs at a slower pace due to possible sensory problems and slower learning rates. This means that repetition is very important in the learning process, and information should be presented in both verbal and visual modalities (i.e., on chalk boards and hand-outs) in order to help older patients encode and retain information. Older clients should also be encouraged to take notes to help aid memory retention and thus increase efficacy of therapy. Assignments may need to be in bold print or sessions tape-recorded for review. Additionally, psychotherapy with older adults often requires a collaborative style with few clearly outlined goals and a more active or task-focused approach.

The goals of psychotherapy with older adults should be continually highlighted to reinforce the purpose and facilitate the direction of treatment. It may also be necessary to facilitate therapy for those with sensory problems, particularly hearing and vision impairments. Thus, adaptations such as pocket talkers to assist in hearing or eliminating glare for the sight impaired should be made available. Rather than giving suggestions or expecting the client to infer answers, Knight and Satre (1999) suggest that as there is a normal age decline in fluid intelligence, therapists may need to lead the older adult to conclusions.

When determining if and which modifications are needed, it is important to separate the effects of maturation from the effects of cohort. Maturational effects include similarities that are developmentally common or specific to older adulthood, such as adjusting to chronic illness and disability, or loss of friends and family due to death. Cohort effects are specific to a certain birth-year-defined group. For example, in the USA, early-born cohorts have lower educational levels and less exposure to psychological concepts. Psychotherapists working with older people need to be aware of maturational and cohort differences in the expression and treatment of psychological problems. Additionally, therapists working with older adults should learn about chronic illness and its psychosocial impact, management of chronic pain, factors influencing adherence to medical treatment, rehabilitation methods, and assessment of behavioural signs of negative medication effects.

Assessment should always include current mental and cognitive status. A brief screen of cognitive functioning, such as the Mini-Mental State Exam (MMSE; Folstein et al., 1975), can measure suitability for treatment, as well as identify

patients in need of more extensive neuropsychological testing. It is also imperative to consider the medical status of and social support available to older adults, as these may affect presentation and treatment of pathology. Formal testing, such as the MMSE, requires normative data specific to older adults in the reference group of the person being tested (e.g., education, race, gender). Without such normative data, 'normal' aging processes are impossible to distinguish from pathology or impairment.

Providing psychological services to older adults often requires flexibility in scheduling, location and collaboration. Older adults often have a greater chance of hospitalisation or reduced mobility, responsibility to care for infirm relatives, or reluctance to travel in bad weather conditions, all of which may necessitate missed therapy session. Thus, brief, occasional hospital visits, telephone sessions, or letters may need to be made at times to maintain contact.

At times, when an older adult becomes temporarily dependent upon a caregiver for assistance, it may be crucial to engage the caregiver in aspects of the treatment. An example of this is the pivotal work by Teri et al. (1997) of treating depression in older dementia patients via training caregivers in behavioural interventions. Goals of that treatment, not uncommon to other caregiver stress experiences, included setting limits and making time for personal needs. Treating the caregiver in individual or group, dyadic or brief educational sessions can be directly beneficial to the caregiver and indirectly helpful to the care recipient. If a caregiver is taught to understand and more effectively cope with emotions such as frustration and anger, they may be less distressed and better able to provide effective care.

Because many older adults have experienced increased loss of family members or friends compared with younger individuals, clinical lore suggests that the therapeutic relationship becomes a vital source of support as well as information. For this reason, it has been suggested that rather than traditional termination, ending sessions be spread out and booster sessions be offered.

A suggested acronym to help therapists working with older adults provides respectful and appropriate therapy is MICKS:

a) use Multimodal teaching,

b) maintain Interdisciplinary awareness,

c) present information more clearly,

d) develop Knowledge of aging challenges and strengths, and

e) present therapy material more slowly.

Clinical findings also suggest that many older adults hold negative stereotypes about mental health and psychotherapy, which may result in reluctance to accept or engage in therapy, limitations in self-disclosure and endorsement of symptoms. Some of these myths follow: only crazy people seek mental health treatment; psychological problems indicate moral weakness; therapy constitutes an invasion of privacy; adults, especially men do not share their feelings or show weakness to strangers; adults do not need to ask for help; and therapy has no relevance. Thus, one additional adaptation for therapy with older adults may be to have an introductory orientation/socialisation into psychotherapy. Here incorrect assumptions or fallacies can be corrected, and roles and expectations established.

It is important to remember that there is much more commonality between the young and the old than there are differences, and that older people have a huge diversity of life experience having matured in a world of unprecedented change, where wars, mass migration, and rapid technological development changed many aspects of life beyond recognition for many individuals. Psychotherapists, although benefiting from the specialised skills and approaches utilised in work with older people, need to bear in mind that what is shared with their older clients is humanity and that what is different may take some understanding.

3.12 LET US SUM UP

Psychotherapies with older people have been slow to develop, both theoretically and operationally. This is due to ageism and the predominance of models of psychological development relevant to children and younger adults. Despite this, many have applied their practice and skills to psychological work in old age psychiatry, countering the dominance of the 'organic' model. An evidence and practice base exists to suggest that cognitive behavioural therapy, interpersonal therapy, cognitive analytic therapy, psychodynamic and systemic approaches can help in a range of psychiatric problems in older people, including affective disorders, personality disorders and dementia. The inclusion of older people in existing psychotherapy services and the development of networks of practitioners whose support and supervision are encouraged are likely to be positive ways forward.

3.13 UNIT END QUESTIONS

1) Discuss the various therapeutic approaches in therapy with older persons?
2) Write about psychotherapy in dementia?
3) "It is often necessary to adapt therapies to address special considerations unique to older adults". Discuss?
4) What modifications or adaptations do we make in treatment of adults?
5) Multiple Choices Questions
    1) Ageism:
        a) is a psychological disorder
        b) creates negative stereotypes of older people
        c) is mainly found among the young
        d) is an inevitable response to ageing
    2) Psychological therapy services for older people:
        a) are widespread
        b) attract high referral rates
        c) are disconnected from general psychotherapy services
        d) is offered at all clinical settings.
    3) CBT with older people:
        a) is an effective treatment for depression
        b) is an effective treatment for dementia

   c) is an effective treatment for bipolar disorder
   d) focuses on childhood experiences

4) The following are focuses for interpersonal therapy with older people:
   a) role transition
   b) normal grief
   c) reciprocal roles
   d) the 'wise old man'

5) The following have been used in dementia care:
   a) personal construct therapy
   b) behavioural therapy
   c) social role valorisation
   d) Gestalt therapy

3.14 SUGGESTED READINGS

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). *Oxford Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

Sommers-Flanagan, John., Sommers-Flanagan, Rita. (2004). *Counseling and Psychotherapy Theories in Context and practice: Skills, Strategies, and Techniques.* Hoboken, New Jersey: John Wiley & Sons, Inc.