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Practical Psychiatry of Old Age, Fifth Edition

### Original Citation

Wattis, John and Curran, Stephen (2013) Practical Psychiatry of Old Age, Fifth Edition. Radcliffe. ISBN 9781908911988

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# 1

## Setting the scene

### Introduction

This chapter sets the scene for the whole book. Those who are eager to address some practical problem such as what to do with a confused or depressed patient in the consulting-room can safely skip it and return to it later.

The pace of change in medicine and society is accelerating. We are in a period of confusion as the 'industrial age' gives way to the 'information age'. We may move into a period of *relative* stability once this has occurred. In the mean time, the busy clinician and the educated consumer have to learn to work *with* constant change. The following are among the most relevant:

- technical progress – molecular medicine, new scanning techniques, new drugs (medications) and new classes of drugs, and new information technology
- the need to develop good practice based on the best available evidence, meeting the challenge of changing the behaviour of clinicians and patients
- improving the interpersonal aspects of clinical practice
- Frequent reorganization as politicians 'modernise' the way services are delivered.

Our understanding of ageing and the issues that surround it has also moved on. In particular, our understanding of the dementing illnesses such as Alzheimer's disease has developed in a number of ways, from the molecular biology to the 'science of the art' of diagnostic practice<sup>1</sup> and interpersonal care.<sup>2</sup> Social and political trends are also influencing *how* services are delivered. These include the following:

- a move from quantitative to descriptive standards of service provision
- a move from public to private funding and provision
- a move from medical dominance to 'stakeholder' or even consumer power (potentially leading to neglect of weaker consumer groups such as old people)
- a move from hospital to community services
- rising inequality in Western societies (especially the USA and UK).

The changes in the population structure continue. These include not only the 'greying' of the population but also other social and cultural changes with regard to marriage, divorce

and parenting. The political context is also changing. In the UK we are moving away from the post-war welfare state, which was dominated by monolithic (some would say 'neolithic') public services, towards a 'mixed economy' of health and welfare provision. This is more able to cope with rapid change, but there may be more risk of vulnerable groups being neglected. Mental health services for older people are a relatively new development both around the world and in the UK.<sup>4</sup> They are children of change, and should be able to thrive in the changing world, though increased emphasis on private provision and consequent fragmentation of services may not serve old people well.

In this chapter we intend to give a brief overview of some of these issues. In particular, we hope to cover the following areas:

- what ageing is – a biological and psychological understanding
- ageing in society – social, cultural and political aspects
- a developmental viewpoint on ageing and its challenges
- the impact of technical advances and 'evidence-based medicine/evidence-based practice' (EBM/EBP)
- the epidemiology of mental disorder in late life
- the development of specialist services for old people with mental disorder and their interface with other services for old people, especially memory services.

## **What is ageing?**

Age can be measured in various ways, including the following approaches:

- chronological
- biological
- psychological
- developmental
- social.

A particular individual may well be at different stages on these and other dimensions. These various aspects of ageing are not independent of each other. Psychological and biological ageing interact with each other and with the social and physical environment to produce the complicated picture that we recognise as ageing. We shall now, for the sake of simplicity, describe some of these areas separately.

### **Biological ageing**

Biological ageing can be considered at the level of molecular, cellular, organ, organ-system or whole-organism ageing.

Despite the Bible's 'threescore years and ten', human life expectancy is scientifically indeterminate. We can discuss the average age of populations and the known limit of longevity, but individuals may (and probably will, in due course) survive beyond that apparent limit. However, we are here more concerned with present reality than with any theoretical limit. In the UK in 2011 a man aged 65 years could expect on average to live to 83 years, and a woman of the same age to 85.6 years (*see* Age-UK website). Even within the UK there are marked geographical differences in life expectancy<sup>5</sup>

What determines the age of death and what processes are important? Usually death occurs as a consequence of the inability of the body to deal with some disease process, rather than as a direct effect of ageing. Indeed, one definition of ageing is that it is a progressive change in the organism that leads to an increased *risk* of disease, disability and death. At the *genetic* level, some argue that lifespan is 'pre-programmed', although no direct evidence of this has yet been found. Others argue that errors in protein synthesis, damage to DNA (the genetic coding material of the cell) or chromosomal mutation in tissues that renew themselves may play a part. Certainly cell cultures grown in the laboratory seem to survive for a long but limited time unless they undergo a mutation (e.g. into cancer-like cells) whereby the normal cellular mechanisms that control growth and cell division are no longer active.

Another type of genetic mutation, in the immune system, might result in it starting to attack healthy cells. External factors such as ionising radiation may be responsible for damaging the DNA and producing mutations. Even at this level, attempts to separate internal and external factors may be in vain. At the *cellular and tissue* level some cells (e.g. nerve cells) are not replaceable if they die. However, even nerve cells are able to generate new connections and so, to a limited extent, 'bypass' problems caused by cell death. Other cells are replaced with varying degrees of rapidity in processes that are sensitive to internal feed-back mechanisms. Pigments and other products of metabolism may accumulate in cells and extracellular tissue and may potentially cause harm, as may certain heavy metals.

Whatever the underlying mechanisms, we know a great deal about the changes that normally occur in different *organ systems* of the body as they age. Heart disease accounts for most deaths over the age of 65 years. Muscle fibres in the ageing heart are reduced and the pigment lipofuchsin, which first appears in the heart at around 20 years of age, represents over 5% of the muscle fibres in those aged over 80 years. Within wide individual variation there is an average reduction in the pumping performance of the heart. Each individual contraction is slower, probably as a result of changes in the cellular enzymes that facilitate this action. The reserve capacity of the heart to cope with the stress of vigorous exercise is reduced with increasing age, but is generally still

considerable. Changes also occur in the blood vessels, with decreased elasticity in the vessel walls, compounded in virtually all cases by the deposition of fatty atheromatous plaques in the lining of arteries. This loss of elasticity may be one of the reasons why blood pressure tends to increase with increasing age. However, another reason may be only indirectly age related, as obesity tends to be more common in middle age, and is itself a risk factor for high blood pressure, and possibly for later onset of Alzheimer's disease.

In the digestive system, apart from wear and tear on teeth, there are no major consistent changes with ageing. The loss of neurones in the brain is probably only marginal and, although nerve cells do not generally regenerate in humans, they are capable of growing new connections to other nerve cells (synapses). Sensory input to the brain may be reduced by ageing and disease. The eye becomes less able to shift focus, and night vision declines with increasing age. High-frequency hearing loss develops gradually over the age of 50 years. Reflexes are more slowly reactive, and the capacity of the brain to make decisions in complex situations is slightly reduced, apparently largely as a result of intrinsic changes.

Skin shows reduced elasticity and adherence to subcutaneous tissues. With the exception of the female menopause, relatively few changes occur in the endocrine system. There is no decrease in thyroid activity, although there may be reduced utilisation of thyroxine by other cells. Corticosteroid hormones, produced by the adrenal cortex, may show a slight reduction in levels, but the adrenals retain their capacity to react to stress. The production of insulin by the pancreas is undiminished in health, but may be less reactive to changes in blood sugar levels. Male sex hormones gradually decline between the ages of 50 and 90 years, and male sexual activity decreases from around four episodes weekly at age 20 years to around once weekly at 60 years. The majority of this decline appears to occur by the age of 45 years. Of course, the extent to which this is hormonally determined and the extent to which it is a result of social and psychological expectations is not easily determined.

The *body as a whole* changes partly as a result of less effective feedback and control systems. It also changes in composition, with less lean body mass and relatively increased fat and fluid levels. Some of the loss of lean body mass may be due to reduced muscle mass resulting from reduced physical activity. This again emphasises the problems of distinguishing biological ageing from social and psychological factors.

Expectations about health have an important part to play in old people's satisfaction. For example, one study suggested that older people describe themselves as sufficiently fit if they can carry out the tasks of daily living, even though these may require minimal

activity. Levels of fitness in the general population may be much lower than optimal and many people may be accepting restrictions on their lifestyle unnecessarily.

## Psychological understanding of normal ageing

There are many false beliefs about the psychology of human ageing. However, there are some well-established facts. In the area of cognition, for example, research shows that response time slows – that is, it takes longer for older people to process new information. The size of the change is small, but in some circumstances even that may be critical, especially in combination with sensory or motor changes or stress, or when complicated decisions are involved. Many older people compensate by developing skills and strategies. For example, older typists look further ahead when typing and have extra time for processing, thereby maintaining their speed. The slowed reflexes and greater difficulty in decision-making in older people, coupled with sensory changes, should make older people less safe drivers. However, again they use experience to compensate (and more than compensate), as the actuaries who set insurance premiums so high for young people clearly understand.

The differences that are found between groups are *statistically* significant, but there are older individuals whose performance matches or exceeds that of younger people. Training older people to use their memories and asking them to perform in areas of special competence allows them to perform as well as younger individuals. Memory for events in the distant past is not necessarily better than memory for recent events, and some of the stories that are retained by individuals may be over-learned and told in an automatic, repetitive way. In normal ageing, the ordinary tasks involving memory (e.g. sending someone a birthday card or remembering that the bath is running) do not decline. Where levels of motivation are high, older people may be better at telephoning someone at a set time, for example, but apparently perform less well when tasks are not regarded as vital. Certainly older people have a tendency to complain that they are more forgetful, particularly of names and the last place in which they put something. Their ‘working memories’ often have less capacity than those of younger people. However, there is a suggestion that the thinking of old people becomes more context bound and more expertise related, and intuitive, because it is *more* efficient to proceed in this way, thus compensating for reduced capacity.

Chronological age is an inadequate but necessary marker for more important but less easily measured phenomena of biological and psychological ageing.

## Ageing in society

## Social and legal construction of ageing

In the UK, there was until recently a statutory retirement age of 65 years. This is still often seen as the age at which people are defined as 'old' in terms of public services. However, things are changing. Pensions are increasingly deferred to a later age and age discrimination has become illegal. 'Old' and 'young' are comparative terms, and individuals change their opinion about when old age starts as they themselves get older. Perhaps a better question to ask than 'When am I old?' is 'When am I too old for what?'. For everybody, getting older is an issue even during childhood, as it seems clear then that birthdays bring advantage and privileges. However, concerns about ageing start early in adulthood, with worries about reaching the milestones that we have planned. For example, ageing becomes a prominent issue for some women in their twenties and thirties when they try to balance the demands of relationships, career and children. Most people are taking active notice of the process of physical ageing by this point in their lives, and mid-life is an accepted point for review, if not crisis.

The National Service Framework (NSF) for older people in England and Wales<sup>6</sup> described three broad groups as follows:

- entering old age (which may be 'retirement age' or as young as 50 years)
- transitional phase – in transition between healthy active life and frailty (commonly in the seventh or eighth decade)
- frail older people – people who are vulnerable as a result of health problems, social care needs or a combination of both.

On average about half of life expectancy over age 65 fits into the transitional phase. The last years for men and women are often lived with significant disability<sup>5</sup>

## Demography: some key facts

At the start of the 20th century it was estimated that there were about 600 million people over 60 years of age alive, and about two-thirds of them were living in Third World countries. The UK now counts (or discounts, if you prefer) 16% of its population as elderly. This adds up to over 10.3 million individuals over 65 years of age, of whom around 1.4 million are over 85 years old.<sup>5</sup> The role of this group is therefore likely to have important implications for the whole of the population.

The increase in numbers of old people has been due to improvements in public health, reductions in the number of child deaths, and increased quality of life. Dementia increases almost exponentially with age, rising from less than 1% in the under-65 years

age group and doubling approximately every five years to 2–3% in the 65–70 years age group, 4–6% in the 70–75 years age group, 8–12% in the 75–80 years age group and over 20% in the over-80 years age group.

In 2002, almost two-thirds of people aged 75 years or over (and almost three-quarters of those aged 85 years or over) were female. At age 95 years or over there are about five times as many women alive as men. This, too, has implications for the possible contributions and needs of old people. At the most concrete end of the spectrum, the financial resources of women have historically been lower than those of men. They earned less when they worked, so they have less at retirement.

Overall 50% of people aged over 75 live alone<sup>5</sup> The Age-UK Factsheet referred to above<sup>5</sup> gives many more details about demography, poverty, housing and other issues that affect the quality of life in old age<sup>5</sup>. These issues directly affect all health and social services for old people. Increasingly there will be a need for support for old people suffering from dementia that cannot be supplied by the family. With rising standards of living and expectations among the population as a whole, and with the cohort effect as the ‘consumer generation’ grows old, there may be higher levels of dissatisfaction among old people and their younger relatives with regard to their life circumstances of health and social services provision.

## Politics, ageism and sexism

Service provision for old people is largely related to the needs of elderly women, many of whom live alone. Women have been relatively excluded from public life, and the current cohorts of elderly women include fewer highly educated and professional people than are found in their male peer group or among younger women. Many older women were brought up with an ideal of womanhood as passive or receptive. This suggests that at present some old people may be restricted in their expectations and capacity to campaign on their own behalf. This situation is changing, and it is likely to change ever more rapidly as younger women who have had greater access to education, careers and a range of role models grow old.

Pensioners who are mainly dependent on a state pension and who are living alone (mostly women) are much less likely to have a car or a washing-machine, and slightly less likely to have a telephone or central heating, than the rest of the population. Poor public transport selectively penalises this group. Yet decisions on public spending and service priority, many of which influence provisions for older people, are made by people under retirement age, even if the views of older people are (sometimes) researched and taken into account. Hopefully this imbalance of means and needs will not be tolerated by future generations of old people (by which we mean us!).

Images of old age have a continuity across recent history and Western culture. There is a balance between the value accorded to young and old, which shifted towards youth with the post-war baby boom, and which may return as that cohort ages. Whatever the particular images of old age, each contains an implicit comparison with youth, so that people are approved for ageing well (i.e. looking young), or castigated for impersonating youth ('mutton dressed as lamb').

Positive images of several types have been created as old people are developed as a consumer group. Commonly there are images of the 'youthful old person', linked to anti-ageing products and the image of retirement as leisure lifestyle, linked to leisure goods and activities. While these may raise the consciousness of both old and young, the risk would be an increase in dissatisfaction among those who see opportunities but cannot attain them.

Ageism is the expression of disadvantage due to age and it can be found everywhere, psychiatric services not excepted! Like sexism, it may be difficult to uncover and it is highly reinforced. It is reflected in the very language we use – for example, when general psychiatrists call themselves 'adult' psychiatrists, unconsciously implying that those over 65 years old are no longer adult! It is reflected in the ambiguous attitudes to older people of government documents such as the National Service Framework for Mental Health to older people.<sup>10</sup> It is built into the social networks and institutions in which we work and live, and its effects start in youth. In the UK, as in many other societies, images of beauty and goodness are associated with youth. Our definitions of old age are bound up with our views of other phenomena, including infirmity, dependency, aesthetics, moral and social ideals, gender attributes, independence, competence and employment. Culturally, younger people play a significant role in the definitions and experience of ageing. The healthy under-65s write the soaps and the newspapers, deliver conference papers, treat old people in hospital and serve them in shops. Despite this, old people are much more likely to exercise their democratic right to vote than younger people.<sup>5</sup>

To describe someone as 'old' is often regarded as abusive. The idea of old age as a handicap remains prevalent even among trained psychiatric staff. In a teaching exercise, nurses were asked to think of and describe an old person known personally to them. In each session, virtually everyone who described someone old in positive terms agreed that they thought that the individual was exceptional for their age.

## **A developmental viewpoint**

A helpful way of understanding individual ageing in an ageing society is the developmental approach. Development is a dynamic process, and may occur when an individual has to face a new situation and learn new skills, resolve internal conflicts or

take on a new role. Some of these are the normal transitions of life, such as retirement, while others are idiosyncratic changes, such as disability, divorce or loss of a child. The human potential for creative solutions to dilemmas and problems leads to wide variation in skills, lifestyles and coping strategies by the time people grow old.

The developmental approach sees each stage of life as having its own particular and appropriate aspirations and challenges, with none of these being intrinsically 'better' than the others.

## Life aspirations

The majority of people have a rough plan for their lives. Generally, they want a partner and family, friendships, productive and interesting work and leisure activities. These aspirations develop through childhood along with the characteristics and skills that may enable them to be realised. Fairy tales may owe some of their popularity to the reassurance they offer to children that they may reach adult goals. Some people's lives approach their aspirations, while others do not. Later opportunities and experiences depend to some extent on the degree of satisfaction with life in earlier stages, and the decisions that were made then.

## Developmental tasks of late life

Although there is immense variety, at a deeper level there do seem to be issues common to people of particular ages and generations. Erikson suggested that each developmental stage has a 'core conflict' to be resolved.<sup>9, 10</sup> He suggested that a dominant conflict for old people is that of 'integrity versus despair', as they struggle to come to terms with the limits of their existence, their achievements and the loss of a future. Erikson's model is based on psychoanalytic theory, and implies that personal growth is achieved through successful resolution of psychosocial conflicts which are brought about by maturational processes and external conditions. Our understanding of these 'core conflicts', based on Erikson's model, is summarised in Table 1.1.

Erikson's model suggests that all of the conflicts he defines are being continually renegotiated. For example, if in adult life someone is betrayed by a partner, the balance of trust may be changed towards mistrust. The degree of the change and its permanence will be dependent on past experiences. If the person's own background was stable and loving, this may allow for the repair of the relationship or reinvestment in another one. If, on the other hand, the person had been severely let down or abused by a parent, it might be difficult or impossible to overcome the adult trauma constructively. A supportive family or friends may help, as may therapy. If it is not overcome, such mistrust may

increase in old age as the person faces reductions in strength and independence while fearing that carers will behave in an untrustworthy manner.

**Table 1.1** Erikson's model of psychosocial development

<i>Developmental stage</i>	<i>'Core conflict'</i>
First year	Basic trust vs. mistrust
'Toddler'	Autonomy vs. shame and doubt
'Pre-school'	Initiative vs. guilt
Early school years	Industry vs. inferiority
Puberty and adolescence	Identity vs. role confusion
Young adulthood	Intimacy vs. isolation
Middle adulthood	Generativity vs. stagnation
Maturity	Ego integrity vs. despair

This theory may go some way towards explaining the occurrence of distress and severe symptomatology in late life. In younger adult life, people may not develop the skills necessary for intimate relationships and dependency, or for enabling them to act autonomously without excessive anxiety. The changes that are brought about by ageing, such as frailty or bereavement, may then bring them face to face with the problem and their failure.

## Personality development in late life

There is evidence for the importance of both change and continuity in personality throughout adult life. Although people's characters tend to remain stable over long periods, stressful life events may require adaptations and promote change. In particular, it seems that some events, such as separation by divorce or bereavement, may set in motion a series of changes and decision-making with long-term and profound effects. However, personality types seem to remain stable throughout adult life, while the level of life satisfaction is related to personality type rather than to age. Some researchers have sought to identify common strategies for dealing with ageing itself. One such strand is the reclaiming of opposite-gender characteristics.<sup>11</sup>

Adaptation to stress is important for life satisfaction and depends on the external stressors, the coping abilities of the older person and the social support that is available. Older people tend to view stress in a wider context, so are sometimes less bothered by minor stresses. Changes are often forced on the lifestyle of the older person by events

such as disability or bereavement. One change may precipitate others – for example, the death of a spouse may necessitate moving from the marital home.

## Wisdom and spirituality

Old people are sometimes said to develop wisdom. Wisdom can be defined as the capacity to exercise good judgement when important issues are complex and uncertain. Perhaps the relative slowness of older people's decision-making in complicated situations is actually *appropriate* learned behaviour rather than an inevitable concomitant of slower neural processing! Wisdom requires the integration of thought and emotion, and reflexivity, in order to take into account ambiguity and context. Wise people allow that there might be a number of possible solutions to a problem. For many people, interpersonal and spiritual concerns become more important in the second half of life, and this is partially recognised in Erikson's formulation of *ego integrity vs. despair*. However, this formulation does not emphasise the interpersonal aspects of spirituality.

The interface between science and religion is an uneasy one. There are fears about clinicians imposing their religious viewpoints on patients. A useful distinction in this area is that between spirituality, defined as the search for meaning in life, and religion, defined as *one way* of conducting that search. For some old people, spirituality, religion and prayer are important healing resources. Religious beliefs can provide a useful framework for important debates on ethical problems, such as the thorny issue of euthanasia. Some good work on interpersonal (spiritual) care for people with dementia comes from secular sources working in collaboration with religious organisations.<sup>12</sup> The churches are beginning to awaken to the spiritual needs of an ageing population,<sup>13</sup> and particularly the needs of people with dementia.<sup>14</sup> Interested readers are referred to the work of Tournier,<sup>15</sup> an early pioneer in this area, and of Koenig,<sup>16</sup> a more recent author who has attempted to bridge the gap between science and spirituality in relation to ageing.

## Transitions and stress

The passage into old age requires an individual to adapt to a number of transitions, which range from retirement or having grandchildren to taking an educational course post-retirement, or experiencing bereavement or late divorce. Many old people adapt well to these changes, whether they are crises or not. Others may experience difficulties even with the predictable events. Sometimes it is possible to see how the problems have arisen in retrospect. For example, a man who has difficulties with intimate relationships but who remains happily bound up with his work may retire to find that he and his wife have different expectations. If the couple cannot resolve these in a satisfactory way, it is

possible that one of them might present with symptoms of depression, anxiety or somatic complaints. Psychiatric services might in this case be called in to offer help in negotiating the transition. Bereavement counselling, groups for individuals suffering from isolation or interpersonal difficulties, family therapy and individual therapy may all be helpful to individuals who are coping with transitions.

One of the psychological tasks of old age is that of maintaining self-esteem in the face of the negative images of ageing that we all carry. The success with which an individual may achieve this task is related to earlier experiences of self-acceptance. If these have gone well, the old person will have developed sufficient confidence to enable them to adapt in a flexible and assertive manner. Without this confidence, individuals may resist changes even if this means suffering isolation or loss. An example might be the person who refuses a hearing-aid or a day centre place because this would be felt to be humiliating. One of the tasks facing the professionals in psychiatric services for old people is that of helping vulnerable people to accept help which in no way makes up for what has been lost, but which can make adaptation possible.

### Control, autonomy and power

Some of the changes that occur in old age make it more difficult for people to exercise choice or control over their lives, or even over themselves. Physical changes, institutional settings, dementia and restrictive beliefs can all have this effect, often impairing an old person's mental health as a result. Although it is sometimes impossible to proceed without reducing a person's choice, it is an important task within health and social services for old people to attempt to reverse this trend, enabling them to decide on their own lifestyle as far as is possible and appropriate. Langer showed that there were differences in several psychological dimensions and even rates of mortality between a group of old people in institutional care who were encouraged to take responsibility for their own lives and a group who were encouraged to look to staff for the satisfaction of their needs.<sup>17</sup>

Gender, racial, cultural and economic influences operate throughout life, and the resources and influence accrued over the years can buffer some of the effects of ageing. A small group of wealthy older women control a large proportion of privately owned wealth in the USA, often through having survived their husbands. Some senior positions in the professions and important social and political positions are occupied by older people.

As well as material constraints, there are psychological ones. Not only is there the view that old age is a time for leisure rather than for active involvement in social and familial activities, but many older people experience anxiety about becoming dependent

on others for help. When such anxiety is troubling, it may lead to inappropriate attempts at avoidance or control.

## Sexuality

Myths about sexuality and ageing abound. Older people are thought to be no longer interested in sex, post-menopausal women are believed to be incapable of sexual enjoyment, and old men are thought to be incapable of sustaining an erection. As we have seen, the frequency of sexual activity does decline with ageing, but older people can and do have active and enjoyable sex lives, albeit lived at a slower pace than when they were younger. Sometimes worries about sexual prowess and self-esteem lead to defensive manoeuvres. The middle-aged man who leaves his wife for a younger woman is an example of the abuse of sexuality for the maintenance of self-esteem and protection against anxieties (about failing powers and infirmity or eventual death). For women, sexuality in old age is not only affected by beliefs, but is also pre-dated by the menopause. The sexual politics of the menopause have been explored by Greer.<sup>18</sup> She suggests that HRT is offered, in part, as a 'cure' for ageing. Older women, perhaps unsurprisingly, view menopause more favourably than younger ones, and do not regard it as a major transition. In most cases where heterosexual couples give up sexual activity, such activity is stopped by the male partner. If this is seen as a problem, it may be amenable to pharmacological or psychological therapy. For many women there are difficulties in maintaining sexual activity, partly because of the substantial proportion who live without partners. Again it may be useful to have the opportunity to talk about this situation, and to consider the options. Unfortunately, however, the opportunities remain limited, partly because older men are often concerned to find younger partners. Some women, it must be said, welcome the freedom that living alone brings, and avoid relationships in case they are restricted or are required to provide care for an older man.

## Death and bereavement

Old age requires people to face death. It is in late adulthood especially that individuals have to come to terms with the meaning of their existence and decide for themselves whether their life has been worthwhile. This experience can be seen in Erikson's last stage. It is often presaged by an increased awareness of time limits and reduced opportunities. From the successful resolution of this evaluation emerges the traditional quality attributed to old age, namely wisdom. Fear of death seems to become less common as people age.<sup>19</sup> This is partly perhaps because they have survived frightening or stressful life events by which the experience of death can be estimated. However, preparation for death (e.g. leaving a will) is relatively uncommon, perhaps indicating a

more or less healthy denial. Kubler-Ross classically described a series of reactions that individuals tend to experience if faced with the prospect of their own death.<sup>20</sup> These include denial of death and isolation from others (due to difficulty in communicating meaningfully), depression and despair, anger, attempts to bargain and control, and acceptance and hope. It is difficult to predict which feelings a particular individual may experience, or in what order.<sup>31</sup>

Most older people find that their time is still meaningful, but a common clinical problem is that of the demoralised and desperate old person who seems to feel that life is already over or is passing them by. They have difficulty in finding a reason to carry on, or indeed any meaning for their experience. Retirement, losses and discontinuities can lead up to such states of mind, and bereavement can be a cause of such feelings for some. If clinical depression is present it should be treated (see chapter 5).

The impact of bereavement should not be underestimated in old age, even though it is an almost inevitable crisis. Loss through death may have various meanings, and the mourning process will be greatly affected by this. For example, loss of a spouse may bring about loss of a companion, loss or change in material resources and conditions, or even changes in self-definition. Beliefs about self may be important in surviving a loss. For example, if a person believes that they cannot cope without their partner, or that it is awful to be old and alone, there may seem to be no incentive to make new contacts or even to take on the household tasks that were previously done by the other person. People complain more to their doctors, and there is increased risk of mortality, after bereavement.

Models of grieving, like those of facing one's own death, have been conceptualised as stages. The perception of loss has to take place first, and is followed by protest or searching, despair and grief, and then evolves into detachment from the lost person and reinvestment in other relationships or activities. However, these models simplify the reality of a person's experience. In fact, it seems that individuals reiterate their grief with each reminder of their loss. Some individuals find their loss so painful that they protect themselves from grief in a variety of ways, which leads to prolonged states of depression or unconstructive action.

On the other hand, older adults are showing an increasing interest in psychological therapies, including psychoanalysis, and they may bring certain advantages to therapy. These include an awareness of the pressure of time (which can increase motivation), stability, and increased financial resources compared to younger adults. Some adults seek psychotherapy as they approach old age. They are concerned to make the best of their later years, after perhaps recognising the emptiness inside themselves, the failures they have experienced in developing their potential, or the difficulties they have encountered

in relationships. Such people wish for therapy to help them to make the best of the time and resources available to them, and they use therapy well. From a position where psychotherapy was perceived to be largely irrelevant to old people, we have moved on to a situation where it is viewed as increasingly relevant,<sup>21</sup> although still hard to access on the NHS.

## **Technical advances**

Technical advances in two fields can be described. The first is innovation in scientific understanding, including understanding of the basis of disease, its investigation and treatment. The second has been described as advances in the ‘science of the art’ of medicine, perhaps best understood through developments in clinical epidemiology and behavioural science related to medicine.

### **Innovations in technology**

So far, innovations in technology have borne relatively little fruit for old age psychiatry. However, the potential arising from a better understanding of human genetics and molecular biology is enormous. Limited gains have occurred in the diagnosis of the dementias because of advances in expensive imaging technology.<sup>22</sup> New classes of antidepressants and antipsychotics with different side-effect profiles (and often lower toxicity) have also had an impact on the management of depression and psychosis in old age. The arrival of the cholinesterase inhibitors for the management of dementia (principally Alzheimer’s disease at present) marks only the beginning of a long road to control or prevention of these disorders, although some potentially beneficial treatments have proved disappointing on further study.<sup>22</sup> At the same time, the new understanding of the genetics of Alzheimer’s disease and research on early detection<sup>22</sup> offer the hope that, when a more potent treatment arrives, we shall be able to use it at a very early, possibly pre-clinical stage.

Scientific advances have also enabled developments in information technology which offer hope of increased efficiency and effectiveness by making clinical information and the scientific knowledge base of clinical practice more readily available to both clinician and patient.

### **Advances in the ‘science of the art’ of medicine**

This term is used to refer to the way in which clinicians, sometimes unwittingly, use logical strategies to increase the probability of correct diagnosis and management of disease. Sackett and colleagues, in their extremely influential texts entitled *Clinical Epidemiology*<sup>1</sup> and *Evidence-Based Medicine*,<sup>23</sup> show how we can systematically use the

accumulated knowledge from scientific research to improve the diagnosis and management of disease. They warn us to be suspicious of dogmatic ‘authority’ and to be prepared to look at the evidence for ourselves. For many this will only be appropriate in a particular specialist field or with a particularly difficult patient. However, for all of us the rational application of scientific knowledge utilising guidelines reliably developed from the available evidence by experts using declared, open and valid methodologies will become an increasingly important part of practice. The development of techniques such as integrated care pathways<sup>24</sup> for the management of common conditions on a team basis will also encourage more rigorous application of the knowledge base in team clinical practice.

Qualitative studies of clinician–patient interactions also help us broaden the ‘science of the art’. This was memorably applied in a seminal study of psychotherapy which found that certain characteristics of the therapist predicted success regardless of the psychotherapeutic theory of the therapist.<sup>25</sup> These characteristics included the following:

- empathy
- respect (unconditional positive regard)
- concreteness
- genuineness (congruence)
- confrontation
- immediacy.

Much more recently, similar person-centred ideas have been very successfully applied to dementia care by Kitwood.<sup>2</sup> More recent work, addressing similar areas, is found in the values-based approach to clinical practice.

## **Epidemiology and classification of mental health problems in late life**

Epidemiology is the study of the distribution of disease and its management in populations. It forms the basis for assessment of population needs and the rational planning of health services. When its techniques are applied to individuals (clinical epidemiology), it forms the framework for evidence-based practice.

In order to describe diseases in populations and individuals, we have to be able to describe them in a valid and reliable way. Classification can be based on a knowledge of causative agents, underlying pathology or – more often in psychiatry – the symptoms and natural history of disorders. The science of naming diseases is sometimes called

nosology, and it is a bedrock on which both health service planning and the individual management of patients should be based.

Nosology in psychiatry has come a long way, and the World Health Organization's *International Classification of Diseases (ICD-10)*<sup>27</sup> and the related American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-IV)*<sup>28</sup> provide reliable and detailed descriptions of psychiatric disorders which will be discussed further in appropriate sections of this book. We will use ICD-10 mainly but a useful cross-tabulation is provided in Appendix H of DSM-IV.

The epidemiology of individual disorders will also be considered at an appropriate point. Here we shall describe the most prevalent psychiatric disorders in late life, and their influence on service planning. The mood disorders (ICD-10 F30-F39) are most prevalent in older people at least up to the age of 75 to 80 years, when the dementias take over as the commonest psychiatric disorders. Depending on the definitions used, depressive disorders sufficient to interfere with daily life affect perhaps 11–12% of the elderly population, with about a quarter of these being seriously affected, and a much larger group of older people experiencing transient depressive symptoms. Dementia of sufficient degree to come to clinical attention affects about 7% of the population over 65 years of age, but a much larger proportion of those who are even older. There is an association between chronic physical ill health and disability on the one hand and depressive disorder on the other. Depression and dementia were the main conditions considered in the NSF for Older People.<sup>6</sup> They are also more common in certain populations (e.g. elderly medical inpatients and residents of care homes). Other disorders, such as phobias, are relatively common in the elderly population but rarely come to medical attention. They form a hidden reservoir of disability and distress. One of the main serious psychiatric disorders of younger adulthood, namely schizophrenia, persists into late life, and new cases arise. However, because of the special needs of elderly depressed and demented people, schizophrenia forms a smaller proportion of the work of old age psychiatrists. Other conditions, such as alcohol and drug abuse and personality disorder, are relatively rare but still need to be recognised and managed when they occur.

## **Implications for services**

The last 30 years or so have seen the evolution of specialist multidisciplinary community-focused teams in the UK and elsewhere.<sup>29–31</sup> The previous sections of this chapter help us to consider how an ideal service might be designed. For example, the different ways of understanding ageing highlight the difficulties in defining a service or the target population by birth date alone. In recent years this has been recognised by old age psychiatrists increasingly offering services to younger people with dementia (who,

however, face special problems because of their relative physical fitness and family circumstances). It is also clear that expectations and beliefs about what is normal, desirable or pathological in terms of age may affect the nature and usefulness of any service. The philosophy of ageing that is held (whether explicitly or implicitly) by the developers, commissioners and providers of a service will affect its priorities, aims and the range of treatments offered. The initial refusal of some service commissioners in the UK to authorise the use of the anti-dementia drugs demonstrated the importance of these hidden prejudices. However, beliefs and attitudes can be discussed and revised in the light of evidence.

Those working in psychiatric services for old people need to take into account their own ideas and definitions of ageing. Often we, like others, may be satisfied with too little because 'after all, what else can you expect at this age?'. Research on normal ageing (e.g. on the nature and extent of cognitive change in late life, and on the life cycle) can give a more optimistic view of the potential of old people.

For many older people, their use of the services may be relatively straightforward. Physical illness and psychiatric conditions can be diagnosed, and some conditions treated successfully, while others, such as dementia, can be managed in order to improve quality of life. Even this requires a specialised knowledge of ageing, and of the issues relevant to coping with disability. These issues may be similar for people of all ages, but old people have to face a different set of implications and life circumstances. When a man's wife dies at 30 years of age, he will have to deal with an event that is unusual and unexpected among his peers, but he may have more opportunity to remarry than a man whose wife dies when he is 70 years old, even though this is a more 'normal' event. Under these circumstances, the young man might grieve and then seek a new partner, while the older man might have to adapt to living alone and satisfying his emotional needs through friendships and family. If they were referred for depression to a service, both might benefit from a range of approaches, ranging from cognitive behavioural therapy through antidepressants to bereavement counselling or social skills training. The older man will probably be provided with help in the home and day care, yet his problem is likely to be only partially practical. It is important to consider why both he and service providers consider practical support satisfactory. In fact, he may need help to develop new skills. These may be both practical (enabling him to run his own household and perhaps develop an interest in cooking) and psychological (enabling him to identify his needs for companionship and set about satisfying them).

The real needs of old people with mental health problems must be recognised. Recognition does not, of course, mean that we can always help, but this holds true for all age groups. It is better to try to meet real needs than to waste money on irrelevant

services that may even increase dependence and disability. Older people often face problems that cannot easily be solved, such as poverty and physical disability. Staff need support to understand and deal with tough situations, for without it they may end up discouraged and liable to avoid the patient's pain. Staff support and good training are essential parts of any service.

There have been massive changes in the way health Services are organized in the UK. Responsibility for health care has been devolved to Wales and Scotland and English health services are about to be reorganized in a way more radical than ever before. In the midst of all this change we do well to remember the importance of a culture of 'intelligent kindness'.<sup>32</sup> The full potential for general practitioners to shape services may at last be realised, and new ways of working at the primary/ secondary care interface need to be developed and researched, perhaps through the use of devices such as integrated care pathways for the more common conditions. Mentally ill old people are often unable to protest effectively and, in the absence of advocacy may suffer unnecessary hardship. Mobility, mental well-being and even mortality are affected by the milieu in which an old person lives.<sup>27</sup>

Opportunities abound for adventurous old age psychiatry services. This is a time of continued upheaval in the health service, and those who have the will also have the opportunity to shape emerging services. Some potential key areas include the following:

- developing the primary/secondary care interface
- agreeing integrated care pathways for common disorders in old age
- developing and quality assuring 'memory services' for the diagnosis and management of dementias
- adapting new ideas about how mental health services should be organized to the needs of older people
- making use of the opportunities arising from 'new ways of working' and changing roles.
- (in England) learning to work effectively in a service where private providers and social enterprises may take on some or all the work previously done by exclusively NHS organisations.

We can also expect changes in the ways in which ageing is seen to lead to an increase in the expectations of older people, so that they look after their own health better, feel more able to influence the communities in which they live, and assert themselves more. Under such circumstances they themselves will let service providers know more clearly what they need.

## Conclusion

These are exciting times for old age psychiatry services. The increasing knowledge base, technical innovations and political change all make it possible to achieve a great improvement in psychiatric services for older people. Political changes, especially the marketisation of health care, also carry risks for older people. We not only need to keep up to date with current knowledge, but we also need to apply it in well-designed services where patients are valued as individuals and to learn to influence service commissioners to purchase the best services for older people with mental health problems.

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