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Psychotherapeutic approaches to the elderly

For too long the psychological needs of older people have sat on the periphery of psychotherapeutic services, being seen by some as a luxury or a novelty, and too expensive with no productive outcome. Yet the stark fact remains, we will all one day become old and face our own end. Older people can derive huge benefit from psychotherapeutic approaches. Personal transformation may enable them to go on to enjoy meaningful and fruitful old and new relationships whether in the community or in a care home.

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It is not easy to come to terms with retirement, failing bodily functions, increased vulnerability, potential institutionalisation and inevitable death. For some this is a stage of life tinged with difficult memories of being cared for themselves when they were younger. It is not uncommon to see some older adults with a past history of childhood trauma and adversity develop new onset relationship problems having lost the containment of a career or a loved one.

Older people can derive huge benefit from psychotherapeutic approaches. Personal transformation may enable them to go on to enjoy meaningful and fruitful old and new relationships whether in the community or in a care home. Many continue to help as volunteers and many more continue as carers for their own families either as grandparents for busy children who are now parents or as carers for a frail or cognitively impaired loved one. Legislation such as the Equality Act

2010 should enable older people to strengthen their voice, and prompt commissioners of services to consider all needs irrespective of age.

Though cognitive behavioural therapy is often preferred as a first line psychological approach to specific psychological problems like depression or anxiety, psychodynamic insights are also important in approaching many of the problems of older people and this article will focus on the psychodynamic understanding of old age and its related problems.

The size of the problem

The majority of the nearly 11 million older (>65 years) people in the UK have good mental health but about three million suffer from psychological symptoms which affect quality of life. Studies estimate that about 25% of people over the age of 65 living in the community

have symptoms of depression around half of them severe enough to warrant some psychological or medical intervention, but only a third ever discuss these symptoms with their GP.¹

Age Concern estimates that the number of people over 65 years of age experiencing mental health problems will increase by as much as a third over the next 15 years.¹ For 10,000 people aged over 65 or over there are 2,500 people with a mental illness which includes 1350 people with depression of whom 1135 are not receiving treatment.¹

Psychotherapeutic interventions

“Securing better mental health for older adults” recognises that older people have not benefited to the same degree as younger adults from developments in mental health service provision.² The document describes the principle of age equality for future services,

Box 1: Summary of the evidence-base for psychological therapies in older adults⁴**Anxiety disorders**

Nordhus and Pallesen (2003) Meta-analysis of CBT vs control showed effect size of 0.55

Stanley et al. (1996) RCT of group CBT vs. supportive group therapy showed 6 month follow-up responses of 50% and 77% respectively

Wetherell et al. (2003) RCT of group CBT vs. supportive groups showed effect sizes of 0.97 and 0.51 respectively.

Benzodiazepine addiction

Jones (1990/1991) RCT in primary care of counselling and relaxation skills vs. control showed a response rate of 39% and 20% at 9 month follow-up.

Depression

Scogin and McElreath (1994) Systematic review of 17 trials showed effect size of 0.78 for psychosocial interventions and 0.85 for cognitive therapy.

Reynolds et al. (1999) RCT for relapse prevention of recurrent depression using nortriptyline vs interpersonal therapy vs combined treatment vs. control showed 3 year relapse rates of 43% vs. 64% vs. 20% vs. 90% respectively.

Thompson et al. (1987) RCTs of cognitive vs. behavioural vs. brief psychodynamic therapies vs. control. All showed significant improvements (response rate of 52%) with no differences between therapies. At 2 years 70% were not depressed.

Steuer et al. (1984) showed psychodynamic and CBT group therapies were equally effective with 40% in remission at 9 months.

Dementia

Many studies confirm the value of positive, personalised care environments using psychological principles in improving mood, behavioural symptoms and cognition.

Sensory stimulation using music, massage, pet animals and exercise have shown a 63% reduction in agitation (Goddaer and Abraham, 1994).

Burns et al. (2002) Systematic review of aromatherapy helping to reduce agitation.

Spector et al. (2000) Meta-analysis of reality orientation showed effect sizes of 0.59 for cognitive function and 0.66 for behavioural function.

Small numbers of trials exist for reminiscence therapy, validation therapy, psychotherapy, CBT and behavioural management for various symptoms associated with dementia.

supported by a service development guide *“Everybody’s Business”* intended to help commissioners to introduce mental health services with equity of access for older people.³

NICE guidance on the management of depression in primary and secondary care also recommends clear that the full range of psychological interventions should be available to older adults with depression.

To date the evidence base for the effectiveness of psychological

therapies in older adults remains sparse but it is growing as more therapy trials include older people. Box 1 provides a summary of such evidence.

Ageism

As shocking as it may seem now, in 1905 Sigmund Freud wrote, “Near or about the fifties, the elasticity of the mental process, on which the treatment depends, is as a rule lacking—old people are no longer

educable.”⁵

He considered that the sheer accumulation of material in a lifetime would contraindicate analysis as a useful form of therapy. Interestingly Freud himself revised his first statement 12 years later when he reached his sixties. Presumably the motive for this was the realisation that old age itself was not the desperate state of being he had first thought it to be, and indeed his writings continued until the end of his life.

Why do we have such an

Box 2: Suggested referral for older adult mental health services

- People of any age who have any primary cognitive disorder
- People who have mental disorders and who also have significant physical illness (e.g. stroke, Parkinson's disease, severe ischaemic heart disease or COPD) or frailty.
- People around the age of 70 or above with mental disorders and social or psychological issues relating to ageing or people approaching end-of-life

anathema towards being old? Images of health, beauty and youth are the new icons of our time. In today's consumerist society, youth, with its associations with activity and production, is held as the icon of our time. No longer are the elderly seen as the keepers of our memories and heritage, nor valued for their wisdom. The elderly are praised for looking young, not ageing well.⁶

Unconscious ageism has hampered the development of mental health services for older people, especially the provision of psychological "talking" therapies. Access to services can be a physical barrier for older people with restricted mobility and therapeutic approaches have to be tailored to the cultural attitudes of older people. Day hospitals which were seen by some as an ideal vehicle for delivering psychotherapeutic approaches, have often been closed

down in the name of "evidence-based practice" without giving clinicians the time to develop the evidence for their utility in delivering all forms of psychological therapy to older people.

When does old age begin and what does it mean?

The question of when old age begins and what it means needs to be considered. Mental health and social services in the UK both typically use 65 years of age as a transition point despite it no longer being lawful with the Equality Act 2010. Indeed most stereotyped views of old age have blurred in recent years. Some wish to work beyond 65 years old, while others chose earlier retirement. People tend to dress in less clear-cut fashions for their age than before. Some choose to divorce and marry again at later ages, and the issues of sexuality in older people are increasingly recognised. People are more able to talk openly about their sexual experiences than was ever possible until recently. Some even argue that the term old age should be dropped in preference for the less stigmatising term "The Third Age". Box 2 describes the referral criteria for older adult mental health services that are starting to be used as a way of moving away from age dependent cut-offs.

Psychological challenges of ageing

The individual older patient must learn effectively to manage ageing, illness and death and balance this

against maintaining hope and enjoyment of life. Taking this beyond the individual and into a relationship or a marriage, strains can then appear in being able to support each other's need for productivity and fulfilment in the face of these threats. Conflicts in the relationship are fuelled further by fears of abandonment, loneliness, sexual failure and a lack of intimacy. Fears of survival amplify the needs for control and dominance. If this fails, feelings of paranoia can develop.⁷

Taking this developmental viewpoint further, old age may be likened to the stage described by Erik Erikson in his description of the eight stages of man—that of integrity versus despair.⁸ The ability to cope with loss and death through acceptance and dignity must be considered fundamental to a "good ageing". The consequence of despair as a response to failing to achieve one's own goals when reflecting a life lived cannot be considered a healthy response. This may well also depend on how such an individual responded in the past to separation and loss.

Loss is a part of all aspects of life. As retirement approaches, loss is encountered in social status and perhaps financial freedom. Physical abilities gradually decline and, in the unfortunate few who develop dementia, cognitive abilities too. In what some characterise as the "fourth age" adapting to dependency becomes a challenge. The loss of the ability to lead an independent life, prized highly by those accustomed to such freedom, is devastating. The frustration of developing dependency on family and carers provides grounds for anger and even hatred of self or others. A sense of injustice may

fuel these feelings further. For a life well lived, to turn sour must be an embittering experience. Those facing these challenges often find relief in the containment of family, friends and carers including clinicians.

Somato-psychic challenges of ageing

Falls can become a devastating experience with loss of confidence and sometimes lead to institutionalisation. Falls often are significant as a reflection of change or significant shifts in the everyday. Our language uses numerous analogies to the idea of falling:

People fall in and out of love, fall for each other, fall pregnant, burdens fall onto shoulders, fall into depression, we fall from grace.⁹

The body especially provides that ultimate boundary between self and external reality. The skin, as it ages it becomes fragile both in an external sense and an internal one, revealing the fragility of the ageing body inside. Care often just focuses on the overt physical fragility. The body is there to be washed, fed and toileted. Urinary incontinence may evoke inappropriate feelings of shame. The emotional needs stemming from such changes are often neglected. The idea of emotional containment needs to be considered when rehabilitating an individual who has fallen, has fragile skin or some other physical disability.⁹

There is a need to recognise the vulnerability of the person with such boundary insults. If the body fails that boundary also starts to fail. Such shifts in equilibrium cause emotional pain in the form of shame and disgust: a narcissistic

injury stemming from the person's sense of pride and independence. After all, how many times have you heard an older person say in clinic that he/she does not need help as he/she has always managed in the past. It is very easy for any perception by the patient of the need to receive care to be lost in such emotional pain.

A specific fear that follows loss, whether of mental function or physical ability, is a fear of dependence. For many individuals, such need to rely on others is probably the first time in their lives since infancy they have needed support. Ageing and its vicissitudes reawaken infantile fears, brought forward to the here and now. During adulthood, such fears may be sealed off from the conscious mind, often by mature capacities such as mastery and independence, but sometimes as well by immature mechanisms such as denial and projection. Faced with the realities of ageing, these defences can become loosened.¹⁰

Fear of death, as with fear of loss and mourning, are again factors which can haunt us at any age; but, as Erikson's stages of man emphasise, it surely has more significance for the elderly. The fear of life ending without full resolution of goals and regrets can be motivational factors for improvement and may serve as a prompt for psychological intervention. The individual may see this time as a useful moment for recollection and reflection given the inevitability of death. This would depend on ego strength: an ability to accept failure by allowing the good internalised relationships and experiences significant for that person's psyche to shine through. As with mourning, those that

may face difficulty are those who have poor strength of internal relationships and experiences. Indeed, the aim of a reflection on a life lived, is to accept one's own mourning and death. The urgency of time becomes the motivator for psychological care.

The psychodynamics of caring for a person with dementia

The emotional welfare of staff and other caregivers must also be kept in mind. It is estimated there are six million carers in the UK looking after someone with illness or disability, one million of whom provide more than 50 hours of care per week.¹¹ Studies consistently demonstrate the impact of dementia upon family members. Without adequate support carers will experience stress resulting in their own deterioration in physical and mental health.¹²

However for the clinician such emotional reactions can be extremely useful if the clinician can manage to maintain a "third position" within the consulting room. Emotional reactions to the patient give useful clues about what it is like for that person right now, and what it must be like for families and staff trying to care for that person. Always ask yourself the question, "if I feel like this right now, what is it like for someone living with this feeling all the time?"

Such reactions become a principle form of communication for those whose verbal communication is impaired by dementia. Dementia patients are sensitive to such changes in their

carers and will quickly pick up on cues in tone and body language and yet not have enough cognition to understand the reasons for why their carer might be angry, or snappy with them.¹³ Frustration can soon follow resulting in behavioural and psychological disturbance in dementia patients, breakdown in placement and sometimes the misuse of psychotropic medications.¹²

Carers must carry the burden of feelings arising suddenly and unexpectedly from the encounter with the patient without identifying with them. This is a near impossible task to carry, and without adequate support can become overwhelming. Such feelings however will often 'hook' onto something unresolved for a carer from the carer's past and perhaps evoke similar feelings the carer might have towards parents or grandparents.¹⁴ This could be taken further as a means by which a carer could try to solve unresolved past issues. Sometimes this process can result in an extreme wish to please and not "let go" leading to over-dependency and malignant regression into a highly dependent and infantile state on the part of the patient.¹⁵ Sometimes the feelings are the opposite and result in neglect and aggression. Such feelings as difficult as they are need to be openly acknowledged as by doing so the risk of acting inappropriately towards the patient declines. The opposite strategy of ignoring such feelings increases risk and leaves the patient misunderstood and isolated. As Garner and Ardern describe, the consequences are as follows: "By denying an emotional life to the elderly the imagined pain and fear of old age and life's end can be conveniently denied for the rest of us."¹⁶ In other words by denying an

emotional life to our older patients we serve our own needs and not the needs of those who need our help.

Sometimes feelings in carers in response to the patient (countertransference) can become particularly aggressive resulting in resentful and even hateful feelings. Winnicott's discussions surrounding such feelings provide a model for thinking about the challenges of caring for someone with dementia when expected to hold onto the less pleasant aspects of human suffering.¹⁶ Although admitting to such feelings can feel shameful, they are normal and require a forum for discussion. There is a risk of such feelings interfering with the quality of care given if they are not discussed. Impatience with a patient's slowness of movements or repetition of language may lead to angry outbursts on the part of the carer, or lead to over-compensation of the patient's slowness or simply ignoring the patient's repetitions. Such responses may result in added shame and humiliation for the patient, further worsening their already impaired abilities.¹⁵

Sometimes counter-transference to the elderly and specifically to those with dementia, can become extreme. Staff and carers can become prey to "therapeutic nihilism or, conversely, embark on heroic treatments that cause pain and distress to all concerned."¹⁷ The tendency seems to be towards splitting in our attitudes, either annihilating the very existence of such people in our minds within institutions or even their own homes, or becoming grossly emotionally over-involved and emotionally over-whelmed.

The experience of the patient

and carer is often of social exclusion and social embarrassment. Dementia patients are notorious for being unpredictable, particularly within social situations where the multitude of stimuli to process can become too much. Social exclusion may protect the patient from embarrassment, but it may also protect our own embarrassments.¹⁸ It can be challenging to protect an often assumed need for dignity, especially when the dementia sufferer cannot communicate their own wishes, against the need to protect ourselves from unsightly eating habits, or incontinence. Behaviours can become less socially acceptable and more disinhibited, sometimes provoking anger and aggression in those on the receiving end of such behaviours and who do not understand the illness. This need to exclude continues even after the patient has become institutionalised. We do not wish to be confronted with neither the experience of being in a nursing home, nor the state of mind of the sufferer, as it reminds us of our own possible future.

Conclusion

The applicability of psychotherapy to the elderly, both as a treatment and an approach to care, is broad and useful. There is a wealth of opportunity for psychological approaches to the changing roles and transitions of old age as well as specific mental health problems. In contrast to this there is inadequate training in understanding the psychological challenges of ageing and inadequate provision of specific services. Some clinicians do apply these principles in day-to-day work. An understanding

of psychodynamic and family dynamic factors can sometimes be life-saving, for example in assessing suicide risk. Behavioural problems, particularly in people with dementia, are often a function of the interaction between the patient and those caring for them. Both psychodynamic and behavioural approaches can help family and professional carers to provide care which is both more effective and less stressful. In continuing care facilities, the work centres around the value of meaningful relationships, the therapeutic environment and supervision of staff to explore their reactions to patients in the day-to-day work of caring for older people.

Of course ageing is not all about dementia, and many suffer the consequences of transitions, role changes and loss. Currently we have a mix of older people who learnt to be stoical in adversity and consequently have often never worked through past difficult material with an increasing proportion of older baby-boomers with their post-1960s lifestyles and expectations. Personality disorder in older adults is being increasingly recognised particularly apparently late-onset personality disorder and its relationship to treatment resistant anxiety and depression. Taking a careful personal history in such individuals often uncovers untold stories of childhood trauma including physical and sexual violence, and of loss. Being cared for as an older adult in need can re-ignite old patterns of disturbed interpersonal relating and attachment established from childhood.

What is certain is that the elderly have their own unique anxieties and face a unique moment

in life—that moment when life will be no more. Freud wondered if the elderly should not be analysed as they carry with them too much life experience. Yet this should be considered in modern practice as a further unique and challenging attribute. The elderly carry a wealth of life-time experience and so a wealth of coping strategies and psychotherapeutic opportunity. They deserve our best efforts and we have much to learn from them. We need to make a reality of Improving Access to Psychological Treatments for older people.

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