

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. This is part one of a two part series.

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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 1,350 people with depression of whom 1,135 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, supported by a service development guide ‘Everybody’s Business’ intended to

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

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

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

Wetherell *et al.* (2003) RCT of group CBT versus 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 versus control showed a response rate of 39% and 20% at nine 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 versus interpersonal therapy versus combined treatment versus control showed three-year relapse rates of 43% versus 64% versus 20% versus 90% respectively.

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

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

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 clearly 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 50s, 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 60s. 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 anathema towards being old? 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 choose 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'.

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.

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.

Part two of this article will be in the next edition of GM

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References available online at www.gmjournals.co.uk