Developments in Clinical Interventions for Older Adults: A Review

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Older adults are increasing as a percentage of the population in many nations, including New Zealand (Statistics New Zealand, 1995). In response to this trend, world-wide research in health care has increased its focus on successful ageing as well as disorders occurring later in life. Clinical psychology is not exempt from this upsurge in gerontological research, and our knowledge of many aspects of the psychology of ageing has grown exponentially in recent years. Yet to a certain extent, the psychology of later life continues to be overshadowed by the more established literature on younger adults. Diagnostic categories and treatment approaches which are well-validated for younger populations remain under-researched or even wholly unexamined in older adults. Also, biases and assumptions about older adults can help instil a false sense of security in clinical work with older patients.

What follows is an attempt to highlight selected areas of new research as well as recent attempts to consolidate theoretical knowledge about diagnosis and treatment of older adults. Such a review cannot hope to be comprehensive in such a limited space. Topics were chosen to illustrate areas of new and innovative study (e.g. substance abuse, family therapy), areas in which much has been written but perhaps popular biases remain (e.g. bereavement, caregiving) and areas in which psychologists still have much to contribute (e.g. combined psychological and pharmacological approaches, dementia care).

Recent Empirical Research on Therapeutic Interventions

Treatment Protocols for Older Adults

Specific, empirically-validated treatment protocols have been developed for a range of psychiatric disorders, but the vast majority of these were developed either in adult populations or have only limited validation on older populations. In many instances, similar psychotherapeutic treatment approaches may be utilised with older adults as have been proven effective with younger adults. Several researchers, however, have suggested that therapists may wish to make minor modifications in assessing older adults for treatment, and in applying such treatments to older adults.

Sadavoy (1994) stresses the importance of gathering a thorough developmental history to gain insight into past behaviour patterns and coping styles, and to identify therapeutic issues. Bortz & O'Brien (1997) point out that the process of gathering such a developmental history helps to develop rapport and a productive therapeutic alliance. Cultural and cohort-based factors, along with the individual history and expectations of the older adult, should be taken into account, as these may affect later treatment decisions. Because older adults present with a rich history of psychiatric, medical, and social symptoms, patterns, relationships and beliefs, time spent gaining a solid understanding of how these interrelate will be time well spent by the clinician. In fact, in tapping into the rich experience of older adults, therapy may involve a "rediscovery" of skills by the patient rather than the teaching of new skills (Knight & Satre, 1999).

Interactive and integrative treatment strategies work particularly well with older adults (Sadavoy, 1994). In writing about interventions for late-life depression, Gallagher and Thompson (1983) offer specific suggestions to this end. The assumption of an active role by the therapist in socializing the older adult into treatment, the use of strategies in therapy to maximize learning and understanding by the patient, and the careful preparation for termination by a gradual tapering of sessions are described as means

to therapeutic success. The adoption of a relatively prescriptive, directive approach to therapy may be useful in working with older adults, who may expect the therapist to fill a role similar to that of their medical doctor. Such an approach may allay fears triggered by the therapy situation (Hersen & Ammerman, 1994).

In treating anxiety disorders in older adults, Acierno, Hersen, and van Hasselt (1996) recommend several age-related procedural modifications to treatment protocols. Increased treatment duration, particularly when new skills such as relaxation techniques are being taught, may be required, as a greater number of learning trials may be needed for the behaviour to be acquired. At the same time, treatment intensity (such as in exposure-based paradigms) may need to be reduced to gain optimum treatment effects. Intense anxiety-provoking interventions (e.g. flooding) may pose cardiovascular risks, and may lead to unacceptably high rates of treatment attrition (Janssen & Ost, 1982).

Older adults may experience several barriers to treatment. For example, therapists should be sensitive to the presence in older patients of sensory deficits, such as impaired vision or hearing, or cognitive impairments, which may have a negative impact on the therapeutic process if not taken into account. Practical problems such as lack of transportation, illness, or economic constraints may interfere with initiating or completing a course of psychotherapy. Finally, difficulty in convincing the older patient or his or her family of the benefits of psychological intervention may be a major stumbling block. (Lazarus & Sadavoy, 1996).

For some older adults seeking treatment is shameful or an admission of "craziness." They may feel, along with some health professionals, that particular symptoms (i.e. depression, anxiety, or memory difficulties) are an expected and "normal" part of ageing. Therapists need to balance the need to "normalize" older patients' experience of psychiatric symptoms so that they do not feel they are abnormal for seeking treatment, while at the same time not endorsing the fallacy that psychiatric symptoms are a normal part of growing older.

Comparisons between Therapeutic Modalities

Pairing of the most effective treatment with specific psychological disorders has been a focus for many years, with more attention paid recently to therapy modalities applied specifically to older adults. However, many such comparative studies (c.f. Thompson, Gallagher, & Breckenridge, 1987) have found no differences in efficacy between various forms or models of therapy. This literature has primarily been concerned with approaches to treat depression, but a few studies have compared treatments for other disorders including anxiety disorder.

Several comparative studies have examined efficacies in treatments for older adults. Gallagher-Thompson, Hanley-Petersson, and Thompson (1990) compared relapse rates of depression in older adults using cognitive, behavioural and psychodynamic interventions. No differences emerged between the treatment protocols. Time-limited psychodynamic therapy was compared with supportive interventions in acutely bereaved persons, many of whom were older (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984). Those with higher motivation and better ego functioning benefited most from the brief psychodynamic approach. In adults age 55+ meeting criteria for major depression, Arean, Perri, Nezu, Schein, Christopher & Joseph (1993) found significant reduction of symptoms in groups of older individuals in a primary care setting receiving social problem-solving therapy and reminiscence therapy compared to a wait list control group.

Relaxation methods are often employed to treat anxiety in the elderly, but methods such as progressive muscle relaxation may be contraindicated in older adults, particularly those suffering from arthritis. Scogin, Rickard, Keith, Wilson and McElreath (1992) compared the efficacy of progressive relaxation and imaginal relaxation in older adults; both methods were successful at reducing anxiety and related symptoms, with continued modest improvements at 1 month follow-up.

Finally, age itself has been examined as a factor contributing to the efficacy of various forms of therapeutic intervention. Teri, Curtis, Gallagher-Thompson, & Thompson (1994) reviewed 13 controlled studies looking primarily at cognitive-behavioural therapy (CBT) in the treatment of depression at various ages. In general, the various forms of therapy were equally effective in treating younger and older adults. This is further demonstrated in a study by Scogin and McElreath (1994), who found an effect size of .78 for psychotherapy with older adults, compared to Robinson, Berman, and Neimeyer (1990), who report an effect size of .73 for psychotherapy with adults of all ages.

Therapy Coupled with Psychopharmacological Approaches.

In the last 15 years there has been an increase in research systematically assessing the differential and combined effectiveness of interpersonal and pharmacological therapies in older populations. Some variations in the results of such studies may be traced to the particular diagnostic criteria or assessment instruments used.

Similar to the research comparing modalities of psychotherapy, studies looking at combinations of drug and therapy treatments have mostly dealt with depression. Beutler et al. (1987) assessed relative and combined effectiveness of cognitive group therapy, without medication, with medication and with placebo in older depressed adults. Interestingly, while patients in all therapy groups, regardless of medication status, indicated a reduction of self-reported depressive symptoms, psychiatrists' ratings of depressive symptoms on the Hamilton Rating Scale for Depression (HAM-D) did not change. This may be due to the HAM-D's heavy focus on physiological symptoms of depression, such as fatigue and reduced sleep and appetite. Such symptoms may be present as a result of other factors besides depression in older adults and may not have given a true picture of changes in depressive symptomatology in this cohort.

In another study measuring the efficacy of psychotherapy combined with medication, Reynolds (1992,

1994) examined response and relapse rates of older patients with recurrent depression treated with a combination of an antidepressant (nortriptyline) with interpersonal psychotherapy, compared with either treatment alone. Response rates were high in the group receiving the combined psychological/pharmacological intervention. This group's risk of recurrent depression was also less than that of the other groups. Similarly, a combination of CBT and an antidepressant (desipramine) was shown to be more effective than either alone in a large (N=102) clinical trial (Thompson & Gallagher-Thompson, 1993).

Several studies have reported positive benefits of combined pharmacological and psychological interventions for the treatment of anxiety disorders in older adults. Exposure and response prevention in conjunction with medications is cited as efficacious in the treatment for OCD in older adults (Calamari, Faber, Hitsman, & Poppe, 1994; Wise & Griffies, 1995). Likewise, cognitive-behavioural approaches augmented by pharmacological interventions are cited as the treatment of choice for generalised and specific social phobias (Sheikh, 1994). However, it should be noted that as possible side effects, drug interactions and potential for abuse are significant with most anxiolitics in older adults, and potential benefits and costs of their use should be carefully considered.

The efficacy of combined family therapy, cognitive-behavioural approaches and pharmacological treatment embedded in a comprehensive treatment programme for schizophrenia is well-documented for younger patients (c.f. Randolph et al., 1994; Tarrier et al., 1988). For older schizophrenics, a concern is the increasing incidence rate of tardive dyskinesia with increasing age, with estimates ranging from 26% to 45% (Jeste, Lacro, Gilbert, Kline & Kline, 1993), the lower estimate being six times the rate for younger schizophrenics (Kane, Woerner, & Lieberman, 1988). This must be balanced against the fact that increasing age is also associated with a decrease in symptoms of schizophrenia (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987), particularly positive symptoms of the disorder. Nevertheless, the research literature on older schizophrenic patients is limited (Belitsky & McGlashan, 1993), with the area of psychosocial treatments being almost completely lacking.

Although the number of studies directly comparing the therapeutic efficacy of psychotherapeutic interventions and pharmacological interventions in older adults is relatively small compared to those directly comparing alternative drug treatments, the bulk of the literature indicates such combinations can be effective with older adults. Moreover, often the differences in the efficacy of medication and psychotherapy interventions in older adults is relatively minor.

Therapy for Specific Diagnoses and Populations

Substance Abuse

Substance abuse and its treatment in older adults is an area of increasing research interest, but one which may be unfamiliar to clinical practitioners who see relatively few patients in this population. In general, research suggests that substance abuse declines with ageing (Fillmore, Hartka, Johnston, Leino, Motoyoshi, & Temple, 1991), with young-old patients (ages 60-74) having higher substance abuse rates than old-old patients (ages 75+) (Lichtenberg, Gibbons, Nanna & Blumenthal, 1993). However, it should be noted that such declines in diagnostic rates may reflect difficulties with diagnostic criteria, and an unwillingness on the part of both practitioners and older patients to explore substance abuse issues.

Older adults are at increased risk for both accidental or deliberate misuse of drugs and alcohol due to the high rate of prescribed medications, increased physiological sensitivity to drug effects, and the risk of drug interactions among multiple medications or adverse reactions to drugs taken with alcohol (DeVries & Gallagher-Thompson, 1994). A 1990 study by Kemp, Brummel-Smith, & Ramsdell of a US sample suggested that as many as 10% of older adults in the general population have a significant problem with substance abuse. Other studies produce prevalence rates as high as 25% among community dwelling older adults (Nirenberg, Lisansky-Gomberg, & Cellucci, 1998), 20% among geriatric outpatients (Holroyd & Duryee, 1997) and 60% among institutionalised older adults (Caracci & Millar, 1991). Generally, older men are at greater risk for substance abuse than older women. Establishing rates of drug use among older populations is hampered by factors such as the isolation of some older adults, and the tendency of older persons to drink alone and at home (Solomon, Manepalli, Ireland & Mahon, 1993). Cultural factors, of course, play a role in substance abuse, and very little research has looked at both Maori and Pakeha substance abuse incidence and prevalence in middle to late life.

In terms of diagnosis of substance use and substance-induced disorders, the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV; American Psychiatric Association, 1994) criteria may be less relevant for older persons as the criteria were based primarily on younger cohorts (King, Van Hasselt, Segal & Hersen, 1994). For example, older adults may have fewer daily community obligations (e.g. work, child rearing responsibilities) that would be interfered with by substance abuse. Stereotypes about aging and alcohol abuse may also lead to missed diagnoses. In one study, older substance abusers, particularly older women, were more likely to be misdiagnosed as not having a substance abuse problem than younger patients (Curtis, Giller, Stokes, Levine, & Moore,1989).

Older adults may suffer negative consequences of alcohol use while ingesting less than the generally recommended safe upper limits (Royal College of Psychiatrists, 1988). Also, medical and physical problems in older adults may obscure signs of substance intoxication and withdrawal (Nirenberg et al., 1998). Whereas delirium tremens is relatively rare in older alcohol abusers, falls, self-neglect and confusion are common in older alcohol and benzodiazepine abusers and can be easily mistaken for early signs of dementia. A variety of psychiatric and medical complications are associated with alcohol use in older adults,

including hypertension (MacMahon, 1987), delirium, dementia, urinary incontinence, and malnutrition (c.f. Atkinson & Kofroed, 1982), psychosis (Solomon & Stark, 1993) and depression and suicide (Blumenthal, 1988).

During clinical interviews, potential substance abuse issues as well as intentional or unintentional misuse of prescription medications should be explored. Few measures of substance abuse have been tested specifically on adults over age 65; one which has, the MAST (Moore, 1972) revealed good sensitivity and specificity (Willenbring, Christensen, Spring & Rasmussen, 1987). Knowing which prescriptions and over-the-counter (OTC) medications a person is taking can help with diagnosis and also give insights into poor test performance, complaints such as dizziness, sleeplessness, or impotence. All health care providers who treat older adults should have some knowledge of common adverse side effects and potential reactions to medications commonly used with this population (LeSage & Zwygart, 1988).

Generally, research has shown older adults to be less likely to seek out alcohol treatment (Brennan & Moos, 1991) and less likely to be referred for substance abuse rehabilitation (Moos, Mertens, & Brennan, 1993). Mulford and Fitzgerald (1991), in a study comparing profiles of early and late-onset older adult problem drinkers with a younger problem-drinker cohort, the older adults were found to be more heterogeneous as a group compared to the younger subjects. Also, the late-onset drinkers were much more likely to be light drinkers and less advanced in the alcoholic process.

A lack of treatment options other than traditional approaches and twelve step programmes has been cited as a hindrance to efficacious treatment of older substance abusers (Zimberg, 1995). Few studies have examined therapeutic outcomes using elder-specific treatment protocols. Kofoed, Tolson, Atkinson, Toth and Turner (1987) found that use of elder-specific peer groups in outpatient substance abuse treatment groups resulted in lower drop-out rates, lower drinking rates at discharge, and, at one year follow-up, higher programme compliance (Atkinson, Tolson, & Turner, 1993). In a study comparing more traditional confrontation and problem-solving therapy to an "older alcohol rehabilitation" (OAR) approach emphasising peer relationships and use of reminiscence therapy, several differences emerged (Krashner, Rodell, Ogden, Guggenheim, & Karson, 1992). At one year follow-up, OAR patients were significantly more likely to report abstinence; this difference also increased with increasing age. Other studies have shown behavioural treatments, group therapy and community outreach programmes to be successfully used with older adults (Nirenberg et al., 1998). However, where outcomes were most successful, both the context (e.g. running groups in community centres for older adults) and the processes used (e.g. a nonconfrontational approach) were designed specifically for the older adults targeted.

Use of adjunctive medications such as antabuse in the treatment of substance abuse in older adults, either alone or in conjunction with psychosocial therapies, is very poorly researched and may be contraindicated in older adults with co-morbid medical illnesses. However, Zimberg (1995) has emphasised the important role antidepressant medications can play in treating depressed older adults who are also substance abusers.

Bereavement

While bereavement is a normal response to loss, experienced by people of all ages, it is experienced perhaps more often and more regularly to older adults. Approximately 51% of women and 14% of men over age 65 have been widowed at least once (La Rue, Dessonville, & Jarvik, 1985). Reactions to bereavement differ among people, not only due to differences in culture or age, but also due to individual characteristics of the mourner, the deceased party, and the relationship between the two. While sadness and grief are possibly the most commonly accepted and expected emotions, normal responses to bereavement can be varied. Individual differences in response can make a diagnosis of pathological response to bereavement difficult.

The DSM-IV lists symptoms characteristic of an abnormal or complicated grief reaction as thoughts of death (apart from the survivor feeling he/she should have died with the deceased), feelings of worthlessness or guilt, hallucinatory experiences (other than seeing or hearing the deceased) and, perhaps most importantly, prolonged functional impairment. Several recent studies (c.f. Prigerson et al., 1995) have demonstrated that certain symptoms of grief (e.g. preoccupation with thoughts of the deceased) are distinct from symptoms of bereavement-related depression (e.g. worthlessness, psychomotor retardation, apathy) and anxiety (e.g. irritability, nervousness, diaphoresis). In research comparing grief reactions of older and younger adults, older adults are more likely to display flattened affect, have complaints of apathy and loss of purpose in life, and to idealise or even experience hallucinations of the deceased (Wisocki, 1998). By comparison, younger adults are more likely to have higher mortality rates and increased health problems after bereavement.

It is commonly assumed that the opportunity to grieve prior to loss, sometimes called anticipatory grief, may ease adverse reactions to loss. However, a number of studies have contradicted this assumption. For example, Hill, Thompson and Gallagher (1988) found that older women who had anticipated or spontaneously rehearsed their loss by discussing financial security or funeral arrangements were more poorly adjusted after their loss, reported significantly more health problems, and tended to show greater levels of depression than widows who had not engaged in such preparatory tasks.

Bereavement may also follow a different course in older adults depending on whether the death experienced was the result of natural causes or a result of suicide. Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson (1993), in describing results from two longitudinal studies of how adults age 55+ cope under these two different sets of circumstances. In general, while levels of distress did not differ initially, over 2.5 years after the death, distress in the suicide survivor group was more intense and had persisted longer than the natural death survivor group. The

suicide survivors also had a more variable pattern of change in grief reactions over time, and Gallagher-Thompson et al. speculate that this may put this group at increased risk for development of psychopathology. Farberow, Gallagher-Thompson, Gilewski, & Thompson (1992), found that older suicide survivors received significantly less emotional support for their feelings of depression and grief than natural death survivors.

A number of factors unique to the bereavement process in older adults have important implications for therapy. Loneliness has been cited as the single greatest difficulty for older bereaved spouses (Lund, 1989). This can be a difficult and painful issue to be resolved, requiring support, time and space for the bereaved. Another problem facing particularly older bereaved spouses involves lack of skills to deal effectively with problems of daily living. However, dealing with these issues in the course of therapy can have a great impact on psychological functioning. In one study, older bereaved adults reported feeling increased self-esteem, independence, capacity to get along with others and ability to deal with their grief after learning new life skills following the death of their spouse (Lund, 1989). In therapy, working on strategies to address problems of daily living can have an added benefit of allowing the bereaved to feel more comfortable and at ease with others, thus decreasing loneliness.

A problem often faced by older bereaved spouses is the pressure they feel from others to live their life in a certain way (Lund, Caserta & Dimond, 1993). When making decisions on their own, these spouses often feel torn between doing what they would like to do, and doing what they believe others would want them to do, or what they think their deceased spouse would want them to do. Agonising over decisions, feeling guilty about their own needs and desires and becoming frustrated or paralysed in their daily lives can all work to undermine successful coping with both grief and with gaining new coping skills. Such issues again provide a wealth of material to be tackled in therapy.

Finally, the resilience, resourcefulness and adaptability of older adults in the face of bereavement should not be forgotten. In one sample, despite the death of a spouse reported as the most stressful event of their lives, 82% of the sample were successfully managing their lives (Lund, 1989). Not only were life satisfaction, perceived health, self-esteem and social support relatively high, but these bereaved persons were resourceful enough to manage their grief and make satisfying adjustments to their lives.

Patients with Dementia

All too frequently, psychotherapeutic interventions are not considered for patients with dementia, despite high incidences of depression, anxiety, and neurobehavioural problems in this population. Depression, agitation, aggression and wandering may not only impair quality of life for the dementia patient, but may hasten institutionalisation. Treatment goals in psychotherapy with the dementia patient may include providing emotional support, maximising cognitive, psychiatric and behavioural functioning, and enhancing coping strategies.

Although specific interventions will be described, some general considerations in working with persons with cognitive impairments are also important. As memory and language impairments are typical features of dementia, therapists should make use of simplified language, clear directions and written recommendations whenever possible. As abstraction may be impaired, metaphorical language or illustrations should be avoided; clarity is the key to achieving fruitful verbal interactions and shared treatment goals. Bonder (1994) highlights the utility of frequent repetition, review and restatement for those patients with memory dysfunction. Shorter, more frequent sessions can help circumvent fatigue and decreased attention, and should be considered in planning both assessment and treatment sessions.

It is useful, before designing or implementing an intervention, to determine the nature, extent, and possible triggers or precursors of both positive and negative behaviours in the patient with dementia. Such behaviours may be obvious or quite subtle. For example, even simple repetitive movements may offer cues to mood or level of arousal. Both past habits and cultural norms can influence behaviour and should be considered when evaluating a situation, and information from friends and family may greatly influence a treatment strategy. The patient's level of neurological or physical impairment, his or her own needs and desires, or passive or active influences of the environment (both physical and interpersonal) may be causing or reinforcing a given behaviour, and such parameters must be considered across all settings in which the behaviours occur. When both professionals and caregivers have understood these dimensions of the behaviours as much as possible, decisions about methods of encouraging, accommodating, changing or restricting behaviours can be made.

Cohen-Mansfield (1996) suggests two dimensions for classifying inappropriate behaviours: aggressive vs. non-aggressive and verbal vs. physical. Research suggests aggressive behaviours are correlated with increased levels of cognitive impairment (c.f. Cohen-Mansfield, Culpepper, & Werner, 1995), with impaired ability to perform activities of daily living (ADL's) and poor quality of social interactions (Marx, Cohen-Mansfield & Werner, 1990), and with the premorbid personality of the older person (Ware, Fairburn, & Hope, 1990). In some studies a clear antecedent of aggressive behaviours was not found in the majority of cases (Cohen-Mansfield, Werner, and Marx, 1992), whereas Meyer, Schalock and Genaidy (1991) found most aggressive behaviours were preceded by some form of request. Cohen-Mansfield (1996) suggests that neurological damage associated with dementia, either directly or through increased disinhibition, may lead to aggressive behaviours. Such behaviour may be a response to perceived danger or discomfort, or may represent a frustrated attempt at communication. Cohen-Mansfield (1996) also suggests that verbally aggressive behaviours (i.e. screaming) are more associated with cognitive and functional impairments, while non-aggressive verbally disruptive behaviours (i.e. repetitive vocalisations) are not as clearly related to

cognitive impairment.

The most commonly cited interventions for inappropriate behaviours for dementia patients are cognitive and/or behavioural interventions, environmental design modifications, supportive and educational interventions, and pharmacological treatments. Often, some combination of these will be most effective for a particular individual. As individual rates of progression in dementia are highly variable, even the most successful interventions will have to be frequently re-evaluated.

Modifications to existing cognitive and/or behavioural therapeutic processes or specific treatment protocols, such as token economies, contingent positive reinforcement, social skills training programmes and relaxation with guided imagery may be of great benefit to older cognitively impaired adults. Teri & Gallagher-Thompson (1991) present evidence of the efficacy of both cognitive as well as behavioural strategies for treating depression in Alzheimer's patients. Cognitive interventions may be used to challenge patients' negative cognitions and beliefs about their diagnosis, allowing for more adaptive ways of viewing specific situations and events. Behavioural approaches may target person-environment interactions by increasing the level of positive activities and decreasing negative ones. The authors suggest that cognitive interventions may be more appropriate with mildly demented adults, and that clinicians may choose to blend the 2 strategies to suit the particular needs of patients, caregivers and their families.

Modifications to the environment may have particular impact on such behaviours as wandering, pacing, and becoming lost or disoriented. While locks and barriers may prevent unwanted exits, they may be a focus or frustration for patients. Innovative strategies such as visual cues or disguising exits and unsafe areas may be a successful alternative. Environmental enrichment, including increasing sensory stimulation with music or touch (Birchmore & Clague, 1983), has been used to combat verbally disruptive behaviours. Activities such as pet-assisted therapy (c.f. Batson, McCabe, Baun, & Wilson, 1998) and structured exercise and movement programmes (c.f. Mullins, Nelson & Smith, 1987) have been shown to ameliorate agitation, wandering and distress in dementia and long-term care patients, as well as increasing social interaction in these groups. While more controlled and careful research on the therapeutic effects of such activities is needed, such novel approaches offer other therapeutic avenues to explore with dementia and long-term care patients.

Agitation and aggressive behaviours are among the most difficult to manage in Alzheimer's patients. Pharmacological and physical restraints are one choice of treatment for such symptoms. Drug treatments alone are rarely adequate in the control of such behaviours. There is a large body of literature on the ill effects of physical restraints, including serious injuries, increased agitation, negative social behaviours, urinary retention, and muscle atrophy (c.f. Evans & Strumpf, 1989; Folmar & Wilson, 1989). Behavioural treatments are the treatment of choice for such difficult behaviours. Creative activity planning can channel excess energies, and ADL's can be modified to reduce as much as possible the fear and confusion they can provoke in advanced AD patients. Identifying antecedents, behaviours and consequences can assist in breaking cycles of disturbance (Teri & Logsdon, 1990).

Psychoeducation can be a prerequisite to the implementation of other treatment approaches or an intervention in and of itself. Ryden and Feldt (1992) describe a programme aimed at increasing dementia patients' feelings of safety and physical comfort, enabling them to experience a sense of control and to maximize pleasurable experiences. The Seattle Protocol for Behavioral Treatment of Depressed Demented Patients (Teri, 1994) involves both patients and their caregivers. In this approach ongoing psychoeducational instruction is combined with behavioural approaches targeting increasing pleasant experiences, decreasing behavioural problems, maximizing functional abilities and decreasing caregiver burden. As the severity of dementia increases, the focus may shift more prominently to the caregiver. Addressing caregiver burden and depression is important, as both have been identified as precursors to institutionalisation (e.g. Steele, Rovner, Chase, & Folstein, 1990).

Caregivers of Persons with Dementia

Providing care for dementia patients in their home, while having numerous advantages (i.e. familiarity of surroundings), may place family caregivers under stress, increasing physical and psychological morbidity. Research has shown caregivers to be more prone to physical and psychiatric illness (see Light, Niederehe & Lebowitz, 1994, for an excellent overview). For example, the stress of caregiving has been linked to undetected hypertension and cardiac problems, and immune system disorders (Kiecolt-Glaser & Glaser, 1989; Koin, 1989). Several studies have found that caregivers report a decline in their health since beginning caregiving, and most studies find elevated depression rates among caregivers compared to age- and gender-based population norms or non-caregiving controls (Schultz & Williamson, 1994). Gallagher, Rose, Rivera et al., (1989) found depression rates as high as 40-50% in a large caregiver cohort studied. In general, the more severely impaired the patient, the greater the depressive symptomatology of the caregiver. In addition, among caregivers females tend to be more depressed than males (Schultz & Williamson, 1994).

While the incidence and prevalence of caregiver distress have received much notice, this population's unique symptom profiles are also important. The nature of the previous relationship between the caregiver and patient has a direct impact upon both the care relationship as well as caregiver distress (Mui, 1995; Sharlach, 1987). In studies of caregiver well-being, aspects of the caregiving context (i.e. familial generation, living arrangements) were found to have a great impact upon both the health and well-being of caregivers (Cattanach & Tebes, 1991; George & Gwyther, 1986). In a large study comparing depressed caregivers to depressed non-caregivers, the former reported more positive perceptions of their personal interactions, and more frequent use of behavioural and cognitive coping

strategies than the latter (Stephan, Gallagher-Thompson & Thompson, 1997). These results highlight the importance of the relationship and situational variables inherent in caregiving and have implications for psychological interventions. It is suggested by Stephan et al., for example, that those treating depressed caregivers should take into consideration psychosocial strengths and utilise more practical interventions that reduce the severity of caregiving as a stressor.

While possible negative outcomes for caregivers have been identified, often caregivers are so focused on the needs of their charges that they do not seek help for themselves until problems are severe enough to interfere with daily living. Caregivers may feel a sense of failure if they seek help for themselves, and may feel ambivalent about a course of therapy where the focus of attention will be on them. It may be useful to remind caregivers that improving their own health and well being can enhance both their ability to continue caregiving and their time with the person they are caring for.

In a large meta-analytic review of the efficacy of interventions to alleviate distress in caregivers, Knight, Lutsky & Macofsky-Urban (1993) demonstrated a moderately strong treatment effect for both psychosocial interventions and respite care programmes, with more modest treatment effects for group psychosocial interventions. Toseland & Rossiter (1989) note, however, that caregivers that complete intervention studies are likely to be different than those studied in community surveys, and that the self-selection of caregivers into intervention studies introduces selection bias that cannot be ignored. Knight et al. (1993) comment that in many caregiver intervention studies the theoretical underpinnings of the intervention methods are not made clear, and that rarely are various "doses" of an intervention compared in order to ascertain their efficacy.

In one of the few controlled studies comparing effects of different types of therapy approaches with caregivers, Gallagher-Thompson and Steffan (1994) randomly assigned clinically depressed caregivers to either cognitive-behavioural (CBT) or psychodynamic (PD) individual psychotherapy. A 20 session brief format for both types of intervention was utilised. No differences were found between the two outpatient treatments. However, there was an interaction effect between length of time as a caregiver and treatment modality. Those who had been caregivers for less than 40 months showed more post-treatment benefit from PD, whereas those who had been caregivers for a longer time improved more with CBT. Although the authors do caution against over-interpretation, such an individual difference variable may prove important when choosing an appropriate treatment with older depressed caregivers.

In cognitive-behavioural approaches with caregivers, maladaptive thought patterns must be identified. Such "black-and-white" thoughts as "I am angry/upset with John, thus I am a bad person" or "Sarah is no longer really my wife" are examples of guilt-provoking self-statements. Caregivers may become unable to separate their own emotional state from that of the caregiving experience, which is understandable, given the constant nature of caregiving demands. Asking the caregiver to keep a record of such thoughts and feelings, with links to activities during the day, can help uncover negative thought patterns and anchor them to specific daily events. This will help the caregiver recognise such patterns and their triggers, so that they may begin to experiment with more adaptive self-statements. Later sessions may incorporate role-playing, relaxation exercises and strategies to increase the caregiver's own experience of satisfying and pleasurable activities.

One useful intervention with caregivers is to assist them in putting together a "Survival Guide" (Gallagher et al, 1989). This is a booklet which the therapist and the caregiver jointly compile, with helpful reminders, effective coping strategies learned, and any other useful materials produced from the therapy sessions. Such booklets may help prevent relapse (Gallagher et al, 1989).

Almost invariably, caregivers are referred to support groups. Such groups offer support, education, and a network of peers with which to discuss the caregiving role. However, conflict-laden topics such as sexuality, money management, and the right to die, have been shown to be rarely raised of discussed in much depth in mutual support groups (Hepburn & Wasow, 1986). Such issues may be better discussed within an individual or family therapy context.

New Areas of Development in Therapies for Older Adults

Family Therapy with Older Adults

Although many family therapy approaches are based on intergenerational relationships (i.e. Bowen, 1978), later life issues have not been prominent in the family therapy literature. A need for developing strategic interventions for older adults and their families, and for outcome research on such treatment models, were cited by Richardson, Gilleard, Lieberman, and Peeler (1994) in their recent review of the family therapy literature.

Roles within families continually change over time. Moreover, the character and process of such changes may differ depending upon a variety of factors including age. Families with older adults negotiate a number of age-specific developmental tasks. These may include coping with retirement, changes in health status, bereavement and caregiving responsibilities. Caregiving in particular may prove a heavy burden for family relationships. Although the popular stereotype is to view caregiving as a "role reversal," this idea has negative implications for older family members. Brody (1990) argues that adult children never become parents to their parents. Such changes in family dynamics do not have to come at the expense of the dignity and respect of older family members. As Hanna and Hargrove (1997) point out, members of families care for each other in various ways throughout the life cycle.

All families have history and traditions, legacies which members may accept or reject. Intergenerational giving and receiving vary across cultures, age cohorts, and the unique construction of individual families and extended families.

As one family member approaches death, this event affords the family an opportunity to work through issues, affirm legacies and negotiate changes (Hargrave & Anderson, 1992). With the combination of an ageing population and changing family structures, ageing issues have come to the fore in clinical work with ageing families. Hanna and Hargrove (1997) point out a pattern in the literature of family therapists' integration of political, behavioural and psychodynamic approaches in working with older adults. Problem-solving, developmental and educational approaches have been developed and refined to go beyond traditional family therapy models in order to address the specific concerns of such families.

Psychotherapy with Medically Ill Older Adults

Older adults over age 65 with at least one chronic illness range from estimates of 50-86% Boczkowski & Zeichner, 1985; National Center for Health Statistics, 1987). In New Zealand, in the Household Health Survey conducted by Statistics New Zealand between 1992 and 1993, 70% of persons over age 65 reported either a diagnosed or self-identified long-term illness or disability (Statistics New Zealand, 1995). Thus, co-morbidity of medical and psychiatric problems is fairly common in older adults. In fact, many older adults with psychological complaints first come to the attention of health care workers either in a medical setting, or in the process of having a physical illness treated.

Psychosocial and medical problems often act in 'vicious circles," with physical complaints exacerbating psychological problems and vice versa (Haley, 1996). Depression is often a common concurrent psychiatric condition with comorbid medical illness. Prevalence rates as high as 59% are reported in older medically ill adults (Finch, Ramsay & Katona, 1992). Older patients without significant depression were nine times more likely to regain full physical functioning after a hip fracture than those with persistent depression (Mossey, Knott & Craik, 1990). Likewise, a variety of illnesses (e.g. emphysema, congestive heart failure) and medications have been shown to have adverse effects on psychological status (Haley, 1996).

Several studies (c.f. Arean & Miranda, 1995; Lopez & Mermelstein, 1995) have shown cognitive-behavioural interventions to be effective in treating medically ill older adults with psychological distress, including chronic pain (Cook, 1998). Such patients have stressors in multiple areas, including behaviours (i.e. disability), cognitions (i.e. anxiety about the future) and emotions (i.e. depression). Thus CBT is particularly suited to address these concerns (Rybarczyk, Gallagher-Thompson, Rodman, Zeiss, Gantz, & Yesavage, 1992). Psychotherapy can have as its goal both the reduction of psychological symptoms as well as the reduction of excess disability from the medical conditions present. Even when a patient has considerable medical problems, neither depression nor poor quality of life should be accepted as inevitable or unavoidable in any medically ill patient, young or old (Haley, 1996).

Conclusion

Just as increased heterogeneity characterises increasing age, it also in a sense characterises the clinical literature on ageing. The ageing process encompasses biological, psychological and social aspects of being, and so by default must research on ageing. This makes for a vast and fascinating literature, but also one that remains far from complete, as well as in need of more integrative theories and greater cohesion. The breadth of psychological disorders encountered, the prevalence of co-morbid medical conditions, and the wide variety of settings in which older adults seek treatment all complicate research as well as challenge clinicians attempting treatment.

In this selective review of clinical interventions with older adults, familiar topics in ageing have been reviewed along with more innovative areas of exploration in diagnosis and treatment. While significant gaps in the literature remain, specific studies of the processes and outcomes of treatments with older adults have replaced the guesswork of extrapolating these for older adults. Newer attempts via meta-analytic techniques to increase understanding of efficacy and effects across treatment studies have a great deal to offer clinicians seeking to follow empirically validated "best-practice" guidelines in their work.

Psychologists have much to offer older adults, in terms of understanding and coping with the many facets of later life. Familiarity with the extant literature, combined with flexibility and creativity in approach, is the key to therapeutic success with older adults.

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