Psychotherapy Groups for Older Adults with Complex Depressive and Medical Illness

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Presenter Disclosures

No relationships with commercial interests
Learning Objectives

At the end of this session the participant will be able to:

- **Describe the benefits** of psychotherapy groups designed for older adults with complex depressive and medical illness

- **Identify the challenges** associated with conducting groups with this older adult population

- **Apply knowledge** of the integrated psychotherapy model to increase their comfort and willingness in working psychotherapeutically with this population
Mental Health in Late Life

- 1 in 5 Canadians - mental health/addiction problem per year
- 15-50% of older persons with mental health problem experience their first episode late in life
  - Depression (4-20%)
  - Alzheimer's disease (7-12%)
    (747,000 Canadians are living with a cognitive problem)
  - Substance misuse (5-9%)

(CDC 2006; Marcus 1996)
Suicide in Late Life

- 11 per 100,000 in general population
- 14.3 per 100,000 in people 65 or older
- 49.8 per 100,000 in non-Hispanic white men

**Suicide attempts and suicides:**

- Youth: 200+ attempts for every suicide
- General population: 100+ attempts for every suicide
- Older people (65+): 2-4 attempts for every suicide

CDC, 2006; Marcus, 1996
Prominence of Psychosocial Risk Factors for Suicide

Non-Modifiable: Age, gender, ethnicity

Modifiable:

• Suicidal ideation and or behavior
• Previous behavior of suicide
• Family history
• Personal history: any form of psychopathology (MDD, Affective d/o, Psychotic d/o)
  • Substance misuse
  • Personality factors: personality disorders, emotional instability, rigid personality, poor coping skills, introversion

• Medical illness:
  • Pain, chronic illness
  • Sensory impairment
  • Perceived or anticipated/feared illness

• Negative life events and transitions
  • Early life trauma, family discord, separation, death or other losses
  • Financial or legal difficulties
  • Employment/retirement difficulties
  • Relocation stresses

• Functional impairment
  • Loss of independence
  • Problems with activities of daily living

Heisel et al, 2006
Late Life Depression: Self-Perpetuating Cycle

Leszcz, 1990
Social Networks; Health Begets Position Hypothesis

Correlates of poorer health outcomes:
- smaller social circles
- Poorer quality of relationships
- Higher likelihood of elder abuse
- Enduring effect of adverse early childhood

Schafer, M, 2016; Litwin & Shiovitz-Ezra, 2010
Our Need for Interconnectedness

“Human beings are group oriented. We begin in small groups known as families and thereafter live our lives in various groups.”

(Rutan and Stone, 1984)
Group psychotherapy for patients with depression in late life: rationale for use

- Combination therapy: improved outcomes  
  (CANMAT 2009)
- Addresses psychosocial complexities
- Facilitates grieving (e.g. spousal bereavement)
- Combat social isolation (risk factor for GD)
- Growing empirical support: measuring treatment outcomes (Lambert, 2010; Schwartz, 2011)
Challenges of working with Older Adults

- Cognitive deficits
- Multiple medical comorbidities
- Sensory challenges
- Cohort specific factors
- Context: LTC vs. inpt vs dayprogram setting
- Thematic shift: existential vs developmental thematic focus

Knight, B. 2009
The Frame: What Makes a “Group”?

“An aggregate of individuals is not a group until there is a unique social system with its own boundary” (Mackenzie, 1990)
Structure of the Group System

Therapist tasks vary according to:
- boundary level
- timing

(Mackenzie, 1990)
Therapeutic elements of group

• Installation of hope
• Universality
• Imparting information
• Altruism
• Corrective recapitulation of primary family group

• Development of socialization techniques
• Imitative behaviour
• Interpersonal learning
• Group cohesiveness
• Catharsis
• Existential factors

(Yalom and Leszcz, 2005)
Stages of group development

1. Engagement/“Forming”

2. Conflict/Differentiation/“storming”

3 (b) Working Group: Mutuality & Cooperation/“performing”

3 (a) Working Group: Individuation & Intimacy/“norming” = “we-ness”

4. Termination/Separation

<- explore loss, allow group to end

= Cohesive group. Allow > group-leadership, ask about ways in which group deviates from its task (e.g., pairing)

Beginning of group cohesiveness —>

group members share responsibility of staying in the here and now. Therapist isolation. —>
Therapist Tasks: Tear & Repair

• Welcome conflict as an opportunity.

• Protect safety of individuals - fight/flight dynamics are common during conflict stage

• Alliance - creation of “holding environment” (Winnicott, 1960). (“It's okay to take risks here”)

• Maintain boundaries.

• Early in group life: focus on group boundary to disconfirm beliefs about reliability.

(Lambert, 2007; Yalom, 2005)
Therapist Tasks: Tear & Repair

• Use language based on mutuality (“us, we”, “together”)

• Mentalization

• Meta-communication: provides template for core beliefs
  • manifest vs. latent content: How “there and then” stories relate to the “here and now”.

• Note body language; who sits where, why? What does it suggest about subgrouping?

(Lambert, 2007; Yalom, 2005)
“I can be important to someone else”

“I can be seen for who I am by others”

“I can feel that I’m cared about”

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**Intimacy & Connectedness**

- Trust & Cohesiveness
- Feedback
- Self-disclosure

*TIGS, 2016*
Endings

• Dealing with death anxiety - Avoidance: us and them

• Reflections on death, dying and loss
  • Can use confrontation with death as fulcrum to help people change

• Compassion: we are all in this together. human connectedness. cycle of life alive in the group itself

  • “You became one of us”

• Yalom (2005): authenticity as the cornerstone of therapeutic relationship.
Pathogenic Beliefs (PB’s) as Drivers of Psychopathology

- The Plan Formulation Model (Curtis et al, 1994)

- misconstrual - misconstruction sequences:
  - beliefs about self are expressed interpersonally

Six core PB’s emerging from early life: Belief of danger or costs (to self/others) of achieving goal:

1. Self-doubt
2. Doubt of others
3. Anger/assertiveness
4. Fear of closeness
5. Fear/Guilt re: successes
6. Guilt & responsibility for others
An Old Fable:

• “A deeply religious man believes sooner or later he will win the lottery to pay off debts…”

• Week after week passes... and he prays and prays...

• Finally, he cries out “Lord, why have you not yet responded? I have such hope and faith.” Then he sees the skies part and hears a booming voice – “Max, meet me half way, buy a ticket.”
Message:

- Dealing with and adapting to complex medical and/or mental health issues both requires having hope and the capacity to take some form of action.

- Thereby increasing the individual’s self-efficacy and personal effectiveness.

(Leszcz, 2009)
Ways of Coping with Stress of Illness

• “Situations in which the person thinks something constructive can be done or that are appraised as requiring more information favor problem-based coping, whereas those that have to be accepted favor emotion-based coping”

(Folkman & Lazarus, 1980)
Problem-Based Coping

- Focus on practicalities (relaxation, exercise, rest)
- Imparting information (education) regarding illness and learning how to speak to health care workers
- “Doctor – one more question, it’s a few minutes of your time but for me it’s not waiting and worrying for an entire month.”
Emotion-Based Coping

- Social support of group promotes direct engagement with challenge of illness and its treatment.

- Mature groups provide a more hopeful, trusting and sharing environment where culture is to speak the unspeakable, rather than engage in maladaptive denial (elephant in the room)

- Feelings need to be effectively processed and worked through ("We all have feelings...It’s how we handle feelings")

- And keep in mind, “you can’t truly understand what a person’s illness means to them and to what degree they are able to participate in their own care without understanding their inner emotional environment and psychological vulnerabilities and strengths”. (Dr. J. Hunter, 2016)
Meaning-Based Coping

- The elderly’s awareness of the limits imposed by aging, loss, decline focuses attention on existential issues regarding death, meaning in life, and personal responsibility.

- Group therapy should support exploration of these concerns with a view to facilitating members meaningful engagement with life.

- The event of death obviously ends life, but the idea of death can vitalize life by focusing attention on both reducing regrets of things undone or unsaid and living life before time runs out.

- In other words, “it’s not just what aging (or illness) does to you, but what you do with aging (or illness)” (Atchley, 1972)
Mrs. X, a 84-year-old woman in a weekly aftercare group spoke of “how at memorials people often joked or were blocked from expressing their emotions.

She contrasted this with the group which allowed members to share their vulnerability.

Another member commented he used to think vulnerability was bad or a sign of weakness.

Mr. B agreed and went on to say he was once afraid of aging and his medical problems worsening. But was now helped by believing he was still growing because “I no longer get so angry and can now approach my children to talk. I’m having the best time of my life, but I’m still sad. Why? I don’t want my life to end as I’ve never had such good relationships before.”
Therapists and Attitudes

• Just as the challenge exists to help the complex geriatric patient not end up feeling hopeless, helpless, disengaged, and ineffective,

• A similar challenge exists for the therapist to not end up feeling hopeless and ineffective leading to disengagement,

• The therapist’s belief in the continued potential for change and personal growth in later life is critical and at heart of clinical effectiveness.

• There is no place for ageism in the therapist. (Saiger, 2001)
Group Therapist Reflective Questions on the Experience of Working with Aging Patients With Complex Medical and Mental Health Needs

Questions for Inexperienced or Younger Therapists

1. How do you feel working with older adults in a group?

2. How would you compare your feelings about working with older (or ill) adults to your feelings about working with younger adults? Do such feelings lead you to experience discomfort regarding your own aging or aging of family members (e.g. parents/grandparents)?

3. How do you anticipate that your feelings might change as you age if you continue working with older adults in group, or are you too uncomfortable now to work in the future with individuals who are ill, older, or disabled?

(Schwartz & Schwartzberg, 2011)
Questions

For Middle-aged, Older or Experienced Group Therapists

1. Do you think your feelings about working with an older adult population have changed as a result of your aging, personal illness or disability?

2. As you continue to age, do you anticipate working with these populations to become more or less of a challenge, and why?

3. Does your own health or health of family members at times influence your work with medically ill, disabled, or the aging elderly?

(Schwartz & Schwartzberg, 2011)
The Affect Education Model (Zeisel, 2009)
Seven Questions to Help Deal with Countertransference

1. What am I feeling?
2. Why am I feeling this way?
3. What would I like to do or say to a group member (or group) at this moment?
4. What would be the consequences?
5. What is the group member (group) feeling?
6. Why is the group member (group) feeling this way?
7. What would my ego (healthier mature self) like to do or say now?
Case Example from the Day Hospital for Depression

• An aftercare group began with the sad announcement of death of member, who had been ill for several months.

• Soon, another member spoke of worry about niece’s recent diagnosis of cancer.

• Another member interrupted, albeit in an attempt to help by telling about his similar upsetting news.

• A 3rd member, sensitive to the interruption, irritability informed this 2nd member of his interruption.

• A lively and heated interaction occurred soon involving more group members.
Example of Therapist’s Use of Seven Questions

1. What am I (as group therapist) feeling?
  Upset and irritated with group members

2. Why am I feeling this way?
  At how some members are interacting and the effect this has on the group (sadness to anger) – whoever said geriatric groups lack energy and vitality?

3. What would I like to say or do?
  Stop – Get along – Look at your behaviour and its effect on others and group – Act your age!

4. What would be the consequences?
  The most irritated of the group members would not thank me – Too caught up in moment to calm down, listen and reflect on own behaviour and effect on others.
5. What are the others (the group members) feeling?
   Irritated with each other in the here-and-now

6. Why are others feeling that way?
   Are hurt at being interrupted and not heard. Caught up in expressing judgment about who is right or wrong.

7. What would I now do as group leader upon calming down and reflecting:
   Address group to share understanding of what is happening and why, in an effort to increase their understanding and to get the many group relationships back on track.

   • Point out how expression of anger was overshadowing underlying sadness, fear and vulnerability.

   • Process versus content (who interrupted who and when).

   • Understanding connects/heals/repairs whereas not feeling understood disrupts relationships.
Conclusion: What groups can do!

- To help members retain hope and live life the best and for as long as they can rather than to fear death or to stop living before death occurs (engage vs. escape).

- Reinforce illness not just a curse, it’s an opportunity to get closer to oneself and others.

- (Long-term care homes no longer described as a waiting room for death as people come to live, not die).

- From group of breast cancer members, “I want to do more than survive form one day to the next“.
Thank you!

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