Chapter 1

BASIC GERONTOLOGY FOR COGNITIVE THERAPISTS

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INTRODUCTION

Working with older people presents many challenges, but to what extent should one expect older people to change their lifestyles as a result of therapy? With what changes in society do therapists need to acquaint themselves in order to have realistic expectations of this patient group? Before embarking upon therapy with older people, many considerations need to be taken into account, not least of which is an understanding of the realities facing the individuals with whom the therapist may be working. Many authoritative articles have been written about the process of working therapeutically with older people and it is often stated that knowledge of normal ageing is necessary for working with that age group. However, it is rare for guidance to be given on the aspects of knowledge of the ageing process that would be helpful to the psychotherapeutic process. This chapter aims to orient the therapist to aspects of ageing that are important and to provide affirmation of existing knowledge of good practice for the experienced clinician.

UNDERSTANDING DEMOGRAPHIC CHANGES IN SOCIETY

In the developed and developing world, people are living longer, and increasing longevity across societies is a major societal achievement, *and a*

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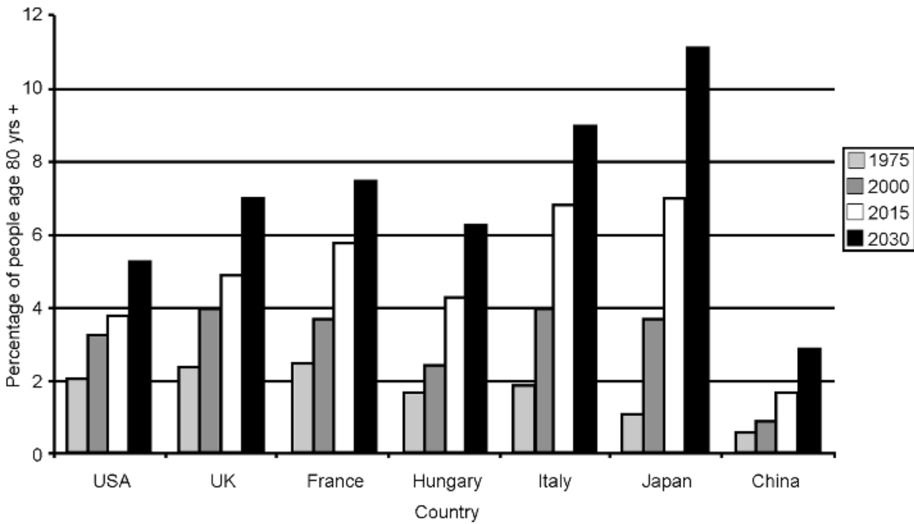

Figure 1.1 Percentage of oldest-old 1975, 2000, 2015, 2030 across countries (*source:* Kinsella & Velkoff, 2001)

challenge (WHO, 2002). A combination of low fertility rates and increased life expectancy has resulted in the relative ageing of societies world wide. According to recent statistics (UN, 2001), the world's older adult population is estimated to show a three-fold increase over the next 50 years, from the present population of 606 million people to 2 billion in 2050. In fact, given the increase in lifespan that is occurring world wide, this may require people to modify their notions of when old age is considered to have started (OECD, 2001). It is the oldest-old section of society (people aged 80 years plus) that shows the most dramatic increase with an almost five-fold increase from 69 million in 2000 to 379 million older people in 2050 (see Figure 1.1). It is estimated that, over the next 50 years, the numbers of people aged 90 and above will show an eight-fold increase, but the number of centenarians will show the greatest increase in numbers as the number of people aged 100 and above in 2050 will be 18 times greater than the numbers in 2000. Interestingly the growth of the oldest-old section of society is also a feature in developing countries and the absolute numbers of older people in developing countries is increasing markedly (WHO, 2002).

The ageing index and the dependency ratios are important indicators of how societies are ageing. The ageing index is calculated by comparing the number of people aged 65 years and over per 100 young people aged 15 years and younger. According to the latest figures, in the UK in 2000 the ageing index was 82, meaning that for every 100 youths there were 82 people aged at least 65 years. This figure is set to rise to 152 by the year 2030. In the USA, the

ageing index is currently 59, but is set to rise to 102 by the year 2030. By the year 2030, Italy, Bulgaria, the Czech Republic, Greece and Japan will all have age indices above 200, indicating that there will be two older people for every one young person in these societies (Kinsella & Velkoff, 2001; WHO, 2001a; OECD, 2001). The dependency ratio is also of interest to psychotherapists working with older adults as it may give a guide to the number of psychotherapists specializing in working with older people that will be needed in the future. The dependency ratio is calculated by dividing the total population over the age of 60 and of retirement age (the effective age of retirement in European Union countries is now 58; Anderson, 2002) by the total population aged 15–60, of working age. In 2002 in North America the dependency ratio was 0.26, and for the countries of the European Union, the ratio was 0.36. In 2025 it is estimated that the ratio will rise to 0.44 in the USA and to 0.56 in Europe. In effect, by the year 2025, there will be 56 people aged 60 years and over for every 100 people aged 15–60.

In the UK in 2000, older people accounted for nearly one-sixth of the population (16 per cent). It is estimated that by 2020 there will be twice as many people aged 60 and above living in the European community than there were in 1960. The recent US national census (Kinsella & Velkoff, 2001) revealed that people over the age of 65 years accounted for almost 13 per cent of the total population and it is estimated that by 2030 older people will account for about one-fifth of the total population. Since 1900, the percentage of Americans aged 65 years and above has increased more than three-fold and the increase in the numbers and percentages of older people living in the USA is higher than for any other age group (Administration on Aging, 2000).

Data published by the UK Office of National Statistics (ONS, 2001) for 1997 suggest that a man aged 60 years could expect to live for another 18.9 years and a woman aged 60 years could expect to live for another 22.7 years. In the UK in 1931, the life expectancy at birth for men was 58 years and for women it was 62 years (Help the Aged, 2000). In 2000 in the UK, life expectancy at birth increased to 75 years for men and 80 years for women. Over the period 1900–1990, the average gain in life expectancy at birth in developed countries was 66 per cent for men and 71 per cent for women (Kinsella & Velkoff, 2001). Accordingly there will be a greater need for psychotherapists to develop knowledge and expertise in dealing with older clients.

There is a gender gap in life expectancy resulting in large numbers of older women than older men in many parts of the world (WHO, 2002, 2001a, 1999). The gender gap is important for therapists to take note of, as women tend to report higher levels of depression than men and are more likely to come to the attention of the psychiatric services (Crawford et al., 1998). Men on average tend to die before women (WHO, 2002; Wood & Bain, 2001). The reality of this statement is brought out by the fact that in the UK in 1997 there were 5523 centenarians and only 580 of these were men (ONS, 2001). In 2000 in the USA, one in every eight American is over the age of 65 and three out of five of these

individuals are women (Kinsella & Velkoff, 2001). The mortality age gap between the sexes, however, has fallen over recent years and is now on average between 5 and 7 years. Nonetheless, as women on average tend to marry men older than themselves, older women are more likely to be widows, to live alone and to experience chronic ill-health. The likelihood of living alone increases with age; 19 per cent of men and 31 per cent of women aged between 65 and 69 years live alone, while 43 per cent of men and 72 per cent of women aged 85 years and above live alone (ONS, 2000).

The mental health needs of older people have often been neglected in the past. As people are living longer, pressures on services will increase to deliver the types of interventions that are required to meet the emotional as well as the physical health needs of older people. Greater numbers of older people will result in greater potential sociopolitical power and may influence the ways in which health services, particularly mental health services, are organized and resources allocated. The need for effective psychological treatments for older adults will become more important rather than less (Laidlaw, 2003).

WHO IS AN OLDER PERSON? WHEN DOES AGEING START?

In Europe and the USA, older people are most commonly defined by chronological age. For legal and occupational purposes an older person is generally defined as someone aged 65 years and older. It has become popular to characterize people as young-old (65–75 years), old-old (75–85 years), and oldest-old (85 years plus). In working with older adults, it is important to understand the individuality of each person you see. The age of an individual is more complex than chronological age (years since birth). In a sense, chronological age confuses the picture more than it clarifies it. To understand the individual capabilities of an older adult it may be more important to take into account biological, psychological and social factors rather than age.

An important concept, functional ageing, refers to the ability of people to perform activities relative to their life experience. Two exemplary individuals, one from the UK and one from the USA, are cited here as evidence that ageing does not automatically mean loss of abilities or poor functioning. In the UK, the late Sir Stanley Matthews continued to play professional football (soccer) at a high level until he was 50 years of age. When he was 41, Sir Stanley Matthews won the first-ever European Player of the Year award, an immensely impressive achievement since this is an age when most athletes have long since retired from any active sport. As Matthews grew older during his professional soccer career, his pace diminished but his skills remained and were augmented with years of life experience. Matthews had an American counterpart in the baseball player Satchel Paige who defied chronological age to continue his career until his retirement from sport at the age of 59 years.

When Paige was once asked by a reporter about his age, he replied, 'How old would you be if you did not know what age you was?' This is an important point to keep in mind when working with older people. Do not assume that older age necessarily means decrepitude (Midwinter, 1992) and do not assume that chronological age will tell you everything you need to know about an individual. Many people have a mental age that is years younger than their chronological age. Ask yourself, 'How old do I feel?'

Older adults are *the least* homogeneous of all age groups, and often have many more dissimilarities than similarities (Steuer & Hammen, 1983; Futterman et al., 1995). As Zeiss and Steffen (1996a) point out, at least two generations are contained within this age grouping. With the increase in longevity there can be four decades separating the youngest-old from the oldest-old.

The therapist also ought to bear in mind the importance of cohort (Knight, 1996a; Thompson, 1996). Cohort refers to the set of cultural norms, historical events, and personal events that occurred during a specific generation. For example, today's older people would be affected by great social upheavals such as the economic depression of the 1920s and 1930s. Tom Brokaw (1998) provides an insight into the cohort experience of the generation of adults who lived through World War II. Understanding older people in terms of their generational cohort allows therapists a way of gaining insight into the societal norms and rules that may influence an individual's behaviour. The therapist may need to take account of the different cultural expectations regarding health-seeking behaviour among older adults as compared to younger adults, especially with regard to views on the care and treatment of conditions such as depression and anxiety. Understanding cohort experiences and taking these into account when working psychotherapeutically with older people is no more difficult, and no less important, than when working with cohorts such as ethnic minority groups.

NORMAL AGEING, DISABILITY AND DEPRESSION

Old age is often characterized as a time of loss: loss of health, loss of income and loss of companionship through bereavement. While for many older people, bereavement and ill-health are unfortunately more common with advancing years, this is only part of the current picture of growing old in Britain, Europe or the USA.

Old Age as a Time of Loss of Income and Loss of Companionship

Today's older people face more challenges and opportunities from the increase in leisure time, as a result of increased life expectancy, than any previous generation. The change in number of lifetime hours devoted to paid

work has declined, but has not been replaced by an increase in time devoted to unpaid work or voluntary activities; unfortunately older people currently spend a lot of their retirement time in passive activities (Gauthier & Smeeding, 2001). In a report on attitudes of older people towards ageing, Midwinter (1992) provides evidence that many older people see retirement as a time of new challenge. Midwinter reports that 27 per cent of older people enjoy life more now, whereas 30 per cent enjoy life less. Thus while at least a third of older people find increasing age to be a time of great challenge, the majority of older people enjoy life as much as, or even more than, at any other time. Working therapeutically with older people means having to keep an open mind about the individual response to the stages of life. Of those enjoying life less there is an association between poor health, living alone and low income. Midwinter (1992) states that to characterize older age as a time of loneliness is overstating things. Even although 82 per cent of retired people sampled believed that loneliness was a common problem in older age, only 22 per cent of the sample stated this was a problem for them personally. Midwinter (1992) makes the point that, overall, one-fifth of the general population report loneliness as a problem, therefore, older people are not especially worse off on this issue than other sections of society.

In the UK General Household Survey in 1998 (ONS, 2000), four out of five older people reported having contact with relatives on a weekly basis. Indeed one out of four older people reported having daily or near daily contact with family. Of course, one ought to bear in mind that the quality of relationships and interactions are often more important than quantity. When working with older people it can be very important to enquire about the pre-morbid nature of familial relationships in order to determine the true nature of the supports available to the person you may be working with.

For many older people financial worries can make later life a time of stress. Older people's income comes from four main sources: social security benefits (state pension, income support, disability benefits), occupational pension, savings and investments, and employment earnings. Since 1974, the proportion of income gained from occupational pensions has almost doubled, from 15 per cent to 26 per cent, while at the same time the proportion of income from employment activities has halved, from 17 per cent in 1974 to 8 per cent in 2000 (Help the Aged, 2000). This trend indicates that many people are retiring earlier. In the late 1970s and 1980s, political pressures due to the reduction of employment opportunities in heavy industries contributed to large numbers of men and women taking early retirement.

Given the increase in longevity across developed societies this is likely to result in a reversal of the trend to retirement at an earlier age (OECD, 2001), and, consequently, there are calls to legislate against compulsory retirement in many countries. Many proponents of this approach point out that insurance schemes to support retirement at the age of 65 years were first set by the

Prussian leader Earl von Bismark between 1883 and 1889 shortly after the unification of Germany. The age was set at 65 purely for politically expedient reasons; in the late nineteenth century very few men or women were able to take advantage of State benefits as many people did not reach this age.

In the UK in 1997, 70 per cent of pensioner households were dependent upon State benefits for at least 50 per cent of their income, and 13 per cent received all their income from State benefits. In the UK, the current (2002) basic pension is £72.50 per week for a single person's pension, and £115.90 per week for a married couple's pension (ONS, 2002). Financially, increasing age results in increasing levels of relative poverty. Older people in the age bracket of 65 to 74 years are often more financially secure than older people in the age bracket 85 years plus. Many older people aged 85 years and above, particularly women, will be living alone and may have had to live on limited means for a number of years. The financial gap between the youngest-old and oldest-old sections of society gives the lie to the homogeneity suggested by the term 'older' people. However, when working with older people, a mindset expecting older people to be financially and interpersonally impoverished may be inaccurate for the majority, especially the youngest-old.

Old Age as a Time of Loss of Health

While older people are living longer they are generally remaining healthier with an increase in percentage of life lived with good health (Baltes & Smith, 2002; WHO, 2002). There has also been a change in the leading causes of death, with death occurring after chronic rather than acute disease. The three major causes of death are listed as heart disease, cancer and stroke (Sahyoun et al., 2001). Thus it is probable that when working with older adults they are likely to have at least one chronic medical condition and many will have multiple conditions such as arthritis, hypertension, heart disease, cataracts or diabetes.

Older people are more likely than younger people to have visited their family doctor within the previous three months, and are more likely to have received care at home by their doctor (ONS, 2000). Older people were also most likely to have attended an outpatient or casualty department of a hospital and to have required an inpatient stay in hospital (ONS, 2001). Despite the increased likelihood of chronic disease in later life, this does not equate with ill-health per se (WHO, 2002, 1999). An important point to bear in mind is that the majority of older persons report good health compared with others of their age (Midwinter, 1992). In the General Household Survey carried out in 1998 (ONS, 2000) in the UK, 60 per cent of men aged 65 years and over described their health as 'good' or very good, and 61 per cent of women aged 65 years and over described their health as 'good' or very good. Overall, 77 per cent of older people stated that their health was good or fairly good and only 12 per cent described their health as bad or very bad. Many chronic medical conditions will have developed

gradually over a number of years and therefore the person may have had time to adapt or compensate for the disability.

As the age of a person increases, so does the likelihood of developing a chronic medical condition. In 1998 in the UK, 20 per cent of people aged 44 years or less reported a longstanding illness, whereas 50 per cent of people aged 45 years and above reported a longstanding illness. In the General Household Survey carried out in 1998 in the UK, 59 per cent of people aged between 65 and 74 years and 66 per cent of people aged 75 years and above reported experiencing a longstanding illness and disability; 42 per cent of older people stated that their mobility was limited by their longstanding illness and 20 per cent reported no limitations. The most common longstanding conditions were either musculoskeletal conditions or conditions of the heart and circulatory system. The rate for developing medical conditions increases with age. Increasing age is also associated with larger numbers of people experiencing heart or circulatory system problems; 19 men and 13 women per 1000 aged 16 to 44 years of age, compared to 310 men and 299 women per 1000 aged 75 years and above, experienced cardiac problems. The UK has one of the worst rates for heart disease in Europe (TWG, 1999). While it is evident that with increasing age there are higher rates of physical ill-health, it is important to remember that the rates still indicate that *not every older person has a debilitating medical condition*. The rates for heart disease in men aged 75 years and above indicate that two-thirds are free from significant heart or circulatory problems.

Older people appear to accept longstanding illness as a normal part of ageing since a number of older people assessed as having a longstanding illness did not report any disability associated with their medically diagnosed conditions (ONS, 2000). Although poor physical health may be an important risk factor for the development of psychological distress (Kramer et al., 1992), symptoms of mental disorders are often undetected by health professionals treating older people for physical complaints. While it may be true that depression increases the risk of developing a disability, and that disability may increase the risk of depression (Gurland et al., 1988), the association between depression and disability is more complex than a single one-to-one correspondence.

Depression and Disability

In understanding the impact of longstanding illnesses in the context of ageing, psychotherapists working with older adults need to look beyond the medical model. The World Health Organization (WHO) in 1980 developed a disease classification[1] for differentiating between impairment, disability and handicap

[1]The World Health Organization has recently published an update and revision of this classification system. The updated classification system is discussed in more detail in Chapter 10. However, as the original classification provides a useful way of understanding disease in a psychological context it is retained for descriptive purposes in this chapter.

that is very helpful for identifying initiatives for the development of psychotherapy in the presence of physical conditions such as a stroke or Parkinson's disease. *Impairment* refers to the disease process itself, e.g. brain infarctions in a stroke; *disability* is the impact that disease has on the individual's ability to carry out activities such as dressing, walking or talking, e.g. following a stroke an individual may no longer be able to continue with previously pleasurable activities such as ballroom dancing; and *handicap* is the socialization of disability or impairment, e.g. following a stroke, an individual with left-sided paralysis may not be able to access social clubs or other places where social events were enjoyed previously.

Consistent with the WHO (1980) disease classification system is the concept of excess disability, i.e. the proportion of a person's disability that is not determined by the physical impairments of the condition. Excess disability, for example, is evident when a person surviving a stroke withdraws from activities prematurely because of embarrassment at the consequences of a stroke (e.g. a hemiparetic limb). In this instance, the cognitive therapist does not aim to reverse cognitive deterioration or to provide physical rehabilitation for the individual, but to target the psychological consequences of a physical condition as they impact upon the individual. In the case of embarrassment at a hemiparetic limb, the therapist works with the individual to understand the reasons for embarrassment and aims to develop interventions to enable the individual to maintain maximal levels of independence, given the circumstances. The self-imposed isolation given in the example above is not a direct consequence of the physical symptoms of a stroke, but is determined by the thoughts and feelings experienced by the individual concerning his or her body image. In other words, embarrassment rather than the stroke prevents the individual from socializing with friends. It is at the level of the excess disability that cognitive therapy can be very effective in tackling depression and improving the quality of life of individuals. Bearing this in mind allows clinicians to step back from fears about the applicability of psychotherapy when a patient presents with so-called 'realistic depression'.

PREVALENCE AND PROGNOSIS OF DEPRESSION IN OLDER ADULTS

Depression is generally considered to be the most common psychiatric disorder among older adults (Blazer, 2002; Ames & Allen, 1991), although recent evidence suggests that anxiety disorders may actually be more common (Blazer, 1997). Data from the Epidemiological Catchment Area Study (Regier et al., 1988) suggested that rates of major depressive disorder among older adults are lower than rates for younger adults (for a review see Futterman et al., 1995). A recent systematic review of community-based studies assessing the prevalence of

late-life depression carried out by Beekman et al. (1999) calculated an average prevalence rate of 13.5 per cent for clinically relevant depression symptoms.

Data from the UK suggests that major depressive disorder affects only a minority of older people, with Livingston et al. (1990) identifying an overall prevalence rate of 16 per cent for depression symptoms in their inner London sample. Consistent with other prevalence studies of depression in older adults, Livingstone and colleagues found that depressed older adults were more likely to be living alone and were more likely to have been in recent contact with GPs and hospital services. Lindesay, Brigs and Murphy (1989) report similar rates of depression in older adults living in the community, with 13.5 per cent of their sample identified with mild to moderate depressive symptoms and 4.3 per cent identified with severe depressive symptoms.

Katona et al. (1997) state that in younger people the comorbidity of depression with other psychiatric conditions has received a lot of attention and yet, in older adults, depression comorbidity has received relatively little attention. This would appear to be surprising as Katona et al. (1997) found very high rates of comorbid generalized anxiety in older adults diagnosed with depression. The association between depression and heightened levels of generalized anxiety was so great in their sample that they suggest that depression should be looked for whenever anxiety is present in older people. These findings correspond to reports by Flint (1999) that late-life generalized anxiety disorder is usually associated with depression. Lenze et al. (2001) comment that older adults with depression and comorbid anxiety are more likely to present with greater severity levels and are more likely to experience poorer treatment response.

Rates of depression in older people vary, depending upon the sample considered. For example, Katz et al. (1989) identified a prevalence rate of major depressive disorder among nursing home residents of 18 to 20 per cent, and up to 27 to 44 per cent overall for other dysphoric mood states. Likewise, Abrams et al. (1992) describe depression as being widespread in nursing home residents. Unfortunately, although nurses are good at detecting depression in nursing home residents, levels of treatment are low (Katz et al., 1989).

SUICIDE AND OLDER PEOPLE: ASSESSING FOR SUICIDAL INTENT

Older people are more likely to complete suicide than any other age group, resulting in relatively lower levels of suicide attempts in comparisons to younger age groups (Gallagher-Thompson & Osgood, 1997; Conwell et al., 1996). Suicide attempts by older people are more likely to result in a fatal outcome compared with younger age groups (Hepple & Quinton, 1997). While depression does not necessarily result in suicide, the majority of older people who attempt suicide are depressed. Among older people who make suicide

attempts, depression is the most frequent diagnosis (Conwell et al., 1996). Suicide rates for persons aged 65 years and older are higher than for any other age group, and the suicide rate for persons 85 plus is the highest of all—nearly twice the overall national rate. In the USA the suicide rate for older people is almost six times the rate of the age-adjusted suicide for all races and for both sexes (Center for Disease Control, 2001). Nonetheless the suicide rate of older people in the USA is average when compared with many countries in the developed world (see Table 1.1). Suicide rates for men and women tend to rise with age, but are highest for men aged 75 years and above (WHO, 2002; Kinsella & Velkoff, 2001).

The high suicide rate among older people, especially older men living on their own, may be partly explained by the fact that older people are more likely to use higher lethality methods of suicide and much less likely to communicate their intention beforehand. Sadly, however, although most older people who complete a suicide act visit their family doctor within one month of their act, this does not always result in recognition and treatment. For example, Caine, Lyness and Conwell (1996) carried out a review of the cases of 97 older people who had completed suicide and discovered that while 51 had visited their GP within one month prior to the suicide act, 47 had been diagnosed with a psychiatric problem, but only 19 had received treatment. Caine et al. (1996) reviewed the treatment received by these individuals and

Table 1.1 Suicide rates[1] among older men and women compared to suicide rates in young people (*source:* Kinsella & Velkoff, 2001)

Country	Men aged 15–24	Men aged 75+	Women aged 15–24	Women aged 75+
Australia	23	27	6	5
Bulgaria	15	116	6	50
Canada	22	27	5	4
Denmark	13	71	2	20
France	13	87	4	20
Germany	13	71	3	21
Hungary	18	131	4	50
Ireland (Eire)	25	22	5	2
Israel	9	41	2	15
Italy	7	43	2	8
Japan	11	53	6	33
Netherlands	11	34	4	12
Norway	23	24	6	5
Poland	17	31	3	6
Portugal	4	39	1	9
Russia	53	97	9	33
Switzerland	25	80	6	24
UK	10	17	2	4
USA	19	45	4	5

[1]*Note:* Rate per 100 000 in each age group. Data collected by different countries all within the last seven years.

concluded that only two had received appropriate treatment. The reality is that suicide rates for older people are probably underestimates as the true cause of death may not always be recorded on the death certificate either due to a reticence on the part of the family doctor to cause a family distress or because the means of death is uncertain (O'Carroll, 1989). There are two paradoxes when thinking about suicide in later life; older people are living longer and yet those surviving longer (especially older men) are more likely than ever to die by their own hand. The second paradox is that it is older women, especially those aged 85 years and above, who are faced with the greatest challenges of ageing and yet they have much lower rates of suicide than men of the same ages.

In the UK, drug overdose was the most frequent method of suicide among older people (Draper, 1996). For anyone working with depressed older adults a thorough evaluation of their suicide risk should be taken into account during treatment.

SUMMARY

Old age is certainly a time of challenge. Many older people will develop illnesses that may threaten their independence and quality of life; diseases such as stroke, Parkinson's disease, the dementias and arthritis are primarily diseases of old age. Nonetheless, to see older age as a time of decrepitude and melancholy is to miss the point completely. Even in circumstances where illness is present, this does not automatically lead to the development of depression and loss of independence. For many people, an adjustment to the reduction in their physical capacity may take place over many decades. To view old age from the perspective of younger age and as something to dread is to forget that in all stages of life we are faced with challenges that we may need to overcome (Knight, 1996b). In working with older people, a knowledge of normal age-related changes is necessary, but so too is an open-minded perspective that seeks to understand the individual's response to increasing age. While it may be a mistake to adopt a perspective on ageing that is too positive, a negative perspective is much more harmful and unhelpful, closing, as it does, one's mind to the possibility of change and learning at all ages.