Try Integrated Psychotherapy for Complex Issues

BY JEFF EVANS
Senior Writer

STOCKHOLM — Integrated individual psychotherapy may be the best method for addressing complex issues that are often unique to geriatric patients, Dr. Joel Sadavoy said at the 12th Congress of the International Psychogeriatric Association.

"The elderly often present to us with a confusing number of problems, and [these problems] originate from many different sources," said Dr. Sadavoy, president of the IPA.

Older adults are less likely than younger individuals to have support, since they may be no longer married, retired from the work that defined their identity and purpose, and have lower physical health and strength.

Psychopathology in geriatric patients may be more complex than in younger adults because of the interplay between the adaptive challenges of old age, such as illness or loss, and the individual's personality and psychological structure, such as the ability to maintain self-esteem and security in the face of adversity.

The psychological structure of an older adult will strengthen or weaken their coping capacities, according to the so-called diathesis-stress model described by Dr. Aaron T. Beck and Margaret Gatz, Ph.D., Dr. Sadavoy said.

Some clinicians suggest that the use of two or more interventions, such as combining medication and cognitive-behavioral therapy in the course of a single treatment is integrated therapy.

But a more focused definition of integrated psychotherapy is "the concurrent application of more than one psychotherapeutic technique to address symptoms that arise from different levels and sources, both from within a patient and from their environment and interactive surroundings," he said.

Dr. Sadavoy suggested that integrated psychotherapy works best if it addresses each of three sources of psychopathology in the patient:

- Lack of understanding and knowledge about illness and aging.
- Maladaptive thoughts and actions that originate from age-related cognitive distortions and perceptions, shifts in interpersonal relationships and identity, and a lack of problem-solving ability.
- Psychodynamically determined reactions and emotions that originate from lifelong, unconscious psychological conflicts and perceptions (Can. J. Psychiatry 1994;39:S19-26).

The third source "is of great importance but is probably the most difficult and subtle to deal with," Dr. Sadavoy said.

A psychotherapist must have broad training and sufficient practice in using the full array of interventions for these sources of psychopathology to implement an integrated approach successfully, he said.

Dr. Sadavoy uses psychoeducation to address misinformation and deficits in knowledge.

Maladaptive cognitive and interpersonal responses and difficulty in problem-solving are dealt with through clarification and modification of cognitive distortions, interpersonal coaching and training, and teaching of problem-solving techniques. "These are three types of therapy that have been shown to be effective in studies of younger and, in some cases, older patients," said Dr. Sadavoy, who is a professor of psychiatry at the University of Toronto.

He treats the unconscious conflicts and self-perceptions of older patients with psychodynamic therapies that employ interpretation and working within the transference in therapy.

The degree to which each intervention is used depends on which elements of psychopathology are most evident in a given patient, he said.

During treatment, the psychotherapist should undertake "some major history taking" to gather data on each of the three sources of impairment, organize the data, and develop an integrated intervention plan.

In an example of when an integrated approach works best, Dr. Sadavoy described the case of a 72-year-old woman who showed depressive symptoms, anxiety, and low functioning after a focal cerebrovascular lesion abruptly changed her husband's personality and cognitive function.

The woman's husband had agitation, severe paranoid depression, and executive dysfunction. The man developed new, bizarre behaviors and was unable to run the family business any longer. She felt abandoned. She believed that her husband's symptoms were the recurrence of a depressive episode that was associated with a business failure he had had many years before.

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At that time, she was very angry with him because she had to take over the business and rearrange her life in order to do so. Now she felt that she was going through the same thing again, and even though she was concerned for him, she could not shake the feeling of resentment, Dr. Sadavoy explained.

She was at a time in her life when she expected to feel more secure, but she was not sure about whether she could deal with the situation as she had done in the past because of her age, diabetes, and hypertension.

The woman was born into a business-oriented family that had no interest in the arts or intellectual pursuits, unlike her, and she had always thought that her parents were judgmental and rejecting of the things that differed from their perspectives on life.

She married to be rescued from her family, he said.

The woman was not demented and did not have a depressive disorder or any other Axis I disorders, according to Dr. Sadavoy.

He explained her husband's diagnoses and the reasons for his behavior. "She clung to her previous explanatory models but needed to understand in an entirely different fashion that this was not willful behavior but was a brain disturbance," he said.

They worked through her grief at the loss of the husband she once had, her lost sense of identity as a wife, her anger at his incapacity, and her fear of how she would survive by clarifying her role changes and reformulating her responses to interpersonal conflict. Dr. Sadavoy helped her to create a list of her interpersonal problems and then actively coached her in developing alternate behaviors and problem-solving skills.

At the psychodynamic level, the woman had a deep desire to be recognized as valuable and loved by her mother. They explored this in the context of her lifelong belief that "she was an alien in her own family."

Her feelings toward her husband's personality change paralleled those toward her family when she described her husband as being coarse, ungiving, unloving, and stupid.

"If she's truly going to be able to deal with what's happening to her husband, stop being angry at him, lose some of her anxiety, and begin to actually focus on problem-solving and dealing with the issues, she has to understand somehow why she is reacting the way she is," Dr. Sadavoy said. ■

Denial May Lead to Undertreatment of Fall-Related Injuries

BY KATE JOHNSON
Montreal Bureau

ORLANDO — Denial is a frequently used coping strategy in geriatric patients with fall-related injuries and is likely a risk factor for inadequate treatment, according to study findings presented at the annual meeting of the Gerontological Society of America.

"It is important for doctors to be aware that when they talk to geriatric patients, it is not always cognitive impairment that contributes to them forgetting about their falls; they may also simply repress it because they are so afraid to admit it," the study's principal investigator, Dr. Klaus Hauer, said in an interview.

"These patients need a person who knows this to approach them in a different way."

The investigation findings were based on 80 geriatric patients (average age 83 years) admitted to the hospital with serious injuries as a result of a fall.

Interviews using standardized psychological questionnaires revealed that patients frequently rely on "repressive coping," or denial, as a mechanism to defend against the threat of chronic impairment that is associated with falling.

Previous studies have shown that "when geriatric patients are asked what they fear most, many patients say they would prefer death to the consequences of a serious fall," said Dr. Hauer, a professor at the University of Heidelberg (Germany).

Patients who were in the highest tertile of repressive coping were significantly more likely to underreport falls, independent of depression, age, cognitive impairment, or education, Dr. Hauer reported.

Patients identified as relying on denial tended to report less fear of falling, fewer comorbidities, and less medication use, and they were less likely to regard a fall as a sign of 'terminal decline.'

Moreover, the charts of patients who used repressive coping documented significantly fewer diagnoses and less medication use, a finding that supports the association between denial and inadequate medical treatment, Dr. Hauer noted.

This population is in all likelihood undertreated, Dr. Hauer added, because they tend to downplay their symptoms and the severity of their falls, if they admit to falling at all.

Patients identified as those who rely on denial tended to report less fear of falling, fewer comorbidities, and less medication use and were less likely to regard their fall as a sign of "terminal decline," compared with less repressive patients, he said.

Although identifying patients who use repressive coping styles is not easily done in physicians' offices or emergency departments, Dr. Hauer said that awareness of the high prevalence of denial among geriatric patients is nevertheless important.

And when denial is identified, it may take extra motivational effort to get such patients to participate in fall prevention programs.

Dr. Hauer also offered strategies that might help these patients. For example, he suggested that it may be more effective to approach them with ideas aimed at improving physical conditioning, rather than strategies focusing on risk prevention, to emphasize a positive self-image, he said. ■