UNIT 1 PSYCHOTHERAPY WITH CHILDREN AND ADULTS

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1.0 INTRODUCTION

Psychotherapy refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with emotion and behaviour. Although there are different types of psychotherapy, each relies on communication as the basic tool for bringing about change in a person's feelings and behaviour. Psychotherapy may involve an individual child, group, or family. For children and adolescents, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems.

Psychotherapy helps children and adolescents in a variety of ways. They receive emotional support, resolve conflicts with people, understand feelings and problems, and try out new solutions to old problems. Goals for therapy may be specific (change in behaviour, improved relations with friends) or more general (less anxiety, better self- esteem). The length of psychotherapy depends on the complexity and severity of problems. In this unit we would be discussing the

different types of psychotherapies which have been found to be effective with children and adolescents. The first half of this unit will cover psychotherapy with children, which will include psychodynamic psychotherapy (such as play therapy, working with parents), cognitive-behaviour therapy (behaviour modification, individual therapy, etc.) and family therapy. The second half would discuss about the most effective psychotherapies with adolescents for disorders such as depression, anxiety and conduct problems.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the different types of psychotherapies used with children such as psychodynamic play therapy, cognitive-behaviour therapy and family therapy;
- Describe, understand and treat adolescent problems from developmental perspective; and
- Discuss the most effective psychotherapeutic methods for treating problems such as depression, anxiety and conduct disorders in adolescents.

1.2 PSYCHOTHERAPY WITH CHILDREN

In this section, we will describe and review three of the predominant approaches to working therapeutically with children: psychodynamic and play therapies, cognitive-behavioural therapy (CBT), and family therapy. Before dealing with each of these methods, however, it is important to realise that all psychosocial therapies with children need to be adapted to the context of maturational processes, and the social frame that supports or hinders them. Psychotherapy with children and adolescents, across orientations, aims to mobilise developmental processes appropriate to the child's age, replacing behaviours and other patterns typical of earlier development with more mature, adaptive capacities.

1.2.1 Psychodynamic Therapy with Children

Play and playing have always been at the core of psychodynamic approaches to working with children. The reasons for this are simple: the content, structure, and function of play are viewed as providing a window to understanding the nature of the child's anxieties and conflicts, and to assessing the internal and relational capacities he has available to organise and regulate his thoughts, feelings, and intentions. Psychodynamic child psychotherapy had its earliest beginnings nearly a hundred years ago, when Sigmund Freud used the principles of psychoanalysis to understand and treat (via the boy's father) the symptoms of Little Hans, a 5-year-old Viennese boy with a dread of horses. It was Hans's play, drawings, and fantasies that helped Freud uncover the conflicts and anxieties thought to lie beneath the child's fears, and that guided the interpretations of these fears that he passed along to the boy's father.

Freud's treatment of Little Hans was in essence the first psychodynamic child therapy, although his reliance upon verbal interpretation would differentiate his approach, derived directly from adult psychoanalysis, from that of psychoanalytically oriented therapy. Pioneered by his daughter, Anna, and another Viennese psychoanalyst, Melanie Klein, psychodynamic child therapy was

oriented around discovering the meaning and function of the child's play. Despite enormous differences in their view of early experience and psychic organisation, Freud and Klein together created the field of child psychoanalysis, and established it for a time as the primary means of treating children suffering from a wide array of psychological disturbances.

For both, play, like dreams, provided a window to the deepest parts of the child's soul, 'a royal road' to the unconscious. They and their followers were the first to fully recognise that children can express in play what they cannot express in words; indeed, until they are nearly adolescent, due to the constraints of development, and the nature of childhood defenses, play is their dominant mode of self-expression. Whereas words and insight were viewed as the primary agents of change in adult psychotherapy, the dynamic and therapeutic aspects of play were thought to be the dominant medium of change in child psychotherapy.

1.2.2 Psychodynamic Play Therapy

In the early days of psychodynamic child therapy, verbal interpretation of the unconscious meaning of the child's play was thought crucial to symptom remission and developmental advance. In this early view, resolution is only achieved via interpretation. But interpretation, per se, is no longer emphasised as the primary agent of change in child work; rather, what is thought to be curative is enhancing the child's symbolic, imaginative, and mentalising capacities by increasing the range, depth, and emotional richness of his play. This expansion of the child's capacity to acknowledge various aspects of his self-experience in the safety of play and fantasy is, many believe, what allows developmental progress. Mentalisation in play leads to the development of structures for containing feelings and understanding oneself and others.

The capacity to play is rooted in early relationship experience. Beginning with the earliest playful exchanges with the mother, the child slowly develops the capacity to recognise that he and she have separate and unique minds, and that ideas and feelings are not concrete realities, but rather states that, in play, can be reworked and transformed. The development of these capacities depends upon the establishment of intimate, secure relationships, which permit the discovery of the self and the other, and their separation. In relationships that are disturbed, however, these capacities are also disturbed; putting things into words and into play can be terrifying and disorganising.

It is for these reasons that the child's capacity to establish a relationship with the therapist (and, conversely, the therapist's capacity to establish a relationship with the child) is central to the treatment.

Play therapy is at the core two people, the child and the therapist, playing together. Children enter treatment with varying capacities to play, to talk, and to establish a relationship with the therapist. Most often these variations are linked to the nature and severity of developmental disruptions, emotional disturbance, and trauma. Sometimes the first job of the therapist is to help the child play, even a little. This may mean helping the child with the rudiments of telling a coherent story, it may mean helping him to imagine the inner life of the characters he has created, it may mean helping him find solutions in play that help to contain the intense feelings generated.

Because the relationship is so central to moving development forward, regularity is thought to be an especially crucial aspect of the process of play therapy. The processes inherent to the development of the capacity to pretend fully and imaginatively are complex, and require sustained periods of connection with the therapist. For this reason children are typically seen at least once a week, and many clinicians prefer to work with them twice or three times a week. In many clinical settings this may not be feasible, but there is evidence that increased frequency is critical to developmental change in seriously disturbed children. Equally critical to the child's progress is consistency. Children find change and disruption difficult, as their defenses are typically relatively tenuous or overly rigid; in either case, their capacity to engage in treatment is greatly helped by the therapist's sensitivity to the impact of these changes.

1.2.3 Working with Parents

Until recently, not much interest was taken in the psychodynamic child therapy of how to involve the parents in a child's individual treatment. Historically, the parent and his or her actual behaviour with the child were viewed as extraneous to the treatment process. While parents were typically seen occasionally for guidance and general 'catching up' on the child's home and school life, there was little conceptualisation of how to engage dynamically the parent in the child's treatment so as to change ongoing patterns of interaction and relatedness.

The first clinicians to work with the parents were Selma Fraiberg and her colleagues in their work on infant-parent psychotherapy (Fraiberg, 1980; Lieberman and Pawl, 1993). They were consulted by state welfare authorities to decide on troubled young mothers' capacities to care for their children, many of whom were showing signs of trauma and abuse at a very young age. Fraiberg and her colleagues were able to change the parent-child relationship in direct and dramatic ways by working with parents and infants together. They believed that the baby's presence in the room galvanised maternal affects and representations in ways that were transforming and healing, and allowed mothers to separate their own projections from the babies' affiliative and attachment needs. While this approach was virtually unheard of in the late 1970s, it has now become an accepted mode of working with parents and their infants and toddlers.

The aim of most parent work is to effect change in the dynamics and functioning of the actual parent-child relationship, as such changes are believed intrinsic to development in the child. One aspect of this work is to help parents understand critical aspects of their children's development; for example that a 4 year old's lie does not have the same significance or meaning as a 12 year old's. More importantly successful parent work involves engaging the parent's capacity for reflective functioning. Parent work helps a parent separate their own subjective experience of the child from the child's own thoughts, intentions and feelings. A parent's subjective experience of the child can be profoundly influenced by their own conflicts, or by the distorting effects of malevolent projections and representations. The work of the therapist is to help the parent hold the child and his or her subjective experience as separate in mind. This kind of work can powerfully help the parent to become better at managing the child's feelings and behaviour.

1.3 COGNITIVE BEHAVIOUR THERAPY WITH CHILDREN

CBT with children has its theoretical foundations in a number of related research traditions particularly behavioural science, social learning theory, cognitive developmental theory, and cognitive theory of emotional disorders.

In current practice, CBT with children and their parents has evolved from a loosely related set of theories, research findings, beliefs, and practice traditions, resulting in a diverse set of therapeutic techniques and practice. Some interventions emphasise the central role of children's cognitions in the etiology and maintenance of childhood disorders and thus aim to change cognitions, whereas others focus more on the behavioural mechanisms thought to be central to achieving change.

1.3.1 Behaviour Modification and Parent Training

Historically, techniques of change based on behavioural theory, such as behaviour modification, preceded more cognitive approaches. Behaviour modification applies the theory of classical and operant reinforcement to a wide range of childhood clinical problems such as anxiety disorders (phobias, obsessive-compulsive disorder) conduct problems and early developmental problems (sleep disturbance, enuresis). This approach is based on the notion that problem behaviours are likely to recur if the consequences of such behaviours are rewarding to the child. Formal treatments of this kind begin with a functional analysis, in which the antecedents and consequences of problem behaviours are systematically recorded so as to determine environmental and transactional patterns and responses that support these behaviours.

Interventions are planned to alter these behavioural patterns by focusing on reducing rewarding consequences, and increasing the positive consequences of pro-social behaviours. This approach is most commonly applied by working with the parent, using reported behaviour of the child in the school or home environment. Improvements with respect to reduced frequency or severity of problem behaviours are explicitly celebrated or rewarded. For example, parents are encouraged not to respond to angry outbursts or tantrums in young children with rewarding responses (attention, raised excitement) and to encourage more pro-social behaviours in achieving wishes or negotiating conflict.

Alternatively, treatment focuses on the behaviour and interactions taking place within the treatment session and explicitly structured sessions as opportunities to change the child's behaviour. For example in the Parent-child Game, therapist directly prompts parents (through a one-way screen using an earpiece) to follow behaviour modification principles in changing a child's behaviour.

Parent training has become one of the most widely used of the behavioural approaches. This method has been most comprehensively developed and evaluated by Webster-Stratton (Webster-Stratton and Herbert, 1993). The training can be delivered to parents either individually or in a group, and is typically brief (eight to 12 sessions) with a carefully prepared curriculum for each session. Video clips are used to illustrate common parent-child conflicts, and the emphasis is on structured homework exercises that facilitate the generalisation of skills

learned in therapy to the family environment. Initial sessions focus on positive interactions between the parent and child, particularly those that occur within the context of play. Behavioural principles of selective attention and reinforcement are illustrated and practiced through homework tasks, along with more cognitive components such as problem solving, negotiating turn taking and emotional recognition.

1.3.2 Individual Cognitive Behaviour Therapy

The CBT model is based on the proposition that childhood emotional disorders are maintained by cognitive biases which are manifested through fixed core beliefs, dysfunctional assumptions, and automatic thoughts about the world, self, or others and results in dysfunctional mood states, emotion or social interaction.

Typically there are four key components in CBT with children they are engagement, formulation, learning new skills, and applying change strategies. The construction of a shared, comprehensible formulation is central. Problems are defined in terms of a child's thoughts, feelings, and/or behaviour, usually linked to specific situations and rated by frequency and severity. This enables problems to be addressed sequentially and organised in a hierarchical way that allows the child (and parent) to determine what they are able to cope with. The person (child) in a more global sense is not the problem. This definition of the problem allows for explicit understanding about the solution that is being sought and allows the possibility of the child and the parent achieving success by reaching explicit targets of change. Behavioural techniques for noticing and rewarding positive change are usually integrated into this broader CBT approach.

In general, CBT sessions tend to have a more structured curriculum than nondirective therapies. The therapist is active, self-disclosing where appropriate, and adopts a psycho-educational, collaborative approach in which a range of activities within the session may be suggested. Kendall (2000) uses the metaphor of the therapist as being like a sports coach in which concepts of practice, preparation, and training are often referred to. The focus is on creating change both within the session but also more importantly in generalising change to the child's daily life. Practicing anger or anxiety management skills with the therapist in real life situations may be part of the treatment plan, as the intervention is not necessarily confined to the clinic room. In order to support the generalisation of new skills to the home environment, the curriculum often includes homework and record keeping tasks.

Initially activities may focus upon developing core skills such as: emotional recognition; separating thoughts, feelings, and actions; and activity monitoring and diary keeping. For example, poor discrimination between anxiety and anger feeling states may be more common in children with emotional behavioural difficulties. Similarly, improving a child's ability to regulate emotional states is likely to be dependent on their ability to monitor and notice internal states. Activities supporting strategies for change will be adopted depending on the formulation but may include a combination of behavioural and cognitive techniques such as relaxation training, problem solving, role playing, exposure, behavioural experiments, and testing the evidence for beliefs. Perhaps the most widely applied change technique is problem solving, in which children are guided to consider alternative options, to adopt a position of choice rather than powerlessness and to improve social perspective taking.

There are certain limitations to application of this approach. First, in contrast to adults, children are brought to therapy. Children may not collaborate if they perceive the reason for therapy as being critical of them, i.e., having a behaviour problem. Second, compared with adults, children's ability to make changes in their lives is restricted by their dependency on parents/caregivers. Third, children's interests and styles of interaction require that therapeutic methods not rely solely on verbal interaction. Some cognitive techniques for adults may be developmentally inappropriate and ineffective with children. There is a need to incorporate both the form and content of children's thinking for the cognitive components of CBT to become applicable. Thus, for younger children, their thinking and expectations of the world and others may be most readily revealed through symbolic play. Similarly, children may need narratives as a way of developing explanations about the world, rather than abstract ideas. Thus, for example, storytelling may have a greater role in cognitive restructuring than methods of Socratic questioning appropriate for adult CBT work. Finally, CBT interventions partly rely on the patient being able to report cognitive states in order that distortions can be effectively challenged. In general, children may have less practice (and less interest) in the recall of experience and monitoring internal states than adults. That is why such therapeutic tasks need to be carefully constructed to be within their cognitive developmental abilities.

1.3.3 Working with Parents

There has been a tendency in the child CBT literature to describe CBT independent of the role and relationship of parents and other family members. For example, Lochman et al. (1991) concluded that the "most striking deficiency in CBT programs has been the neglect of children's caregivers, especially parents". Working with the caregivers can be critical in strengthening treatment effects and in maintaining the generalisation of treatment effects over time. In addition, there is some suggestion that involvement of parents may increase treatment effectiveness.

Different CBT approaches with children have proposed different roles for parents that can be broadly identified as facilitator, co-therapist, or patient. As facilitator, the parent is predominantly involved in supporting the child's individual therapy and may meet with the therapist occasionally. As a co-therapist the parent may be actively involved in supporting the child in learning new skills and may be central to providing behavioural feedback and rewards.

In such instances, the parent is seen as closely collaborating with the therapist using agreed upon CBT technique. Alternatively, parents may be clients receiving treatment to cope with their own difficulties, which may be associated with the child's problem, either as part of a family approach or individually alongside the child's sessions. Typically, parents may be offered CBT to manage their own emotional and behavioural difficulties. In practice, parents may sometimes wish to move between these different roles during a child's treatment and, although some flexibility of relationship with the family is often essential, sudden changes in parental role can be disruptive for the child. In general, much work still needs to be done in developing models of CBT practice that are coherent with family roles, relationships, and individual differences.

1.4 FAMILY THERAPY

Family and systemic therapies believe that intervention must address the interactional patterns between people as well as their intra psychic processes. Gurman et al. (1986) have defined family therapy as any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family.

The last 10-20 years has seen a major change from individual to family systemic therapeutic approaches to children and families in clinical practice, within both the health and social services. However, it is important to recognise that family therapy is not about the creation, or maintenance, of traditional nuclear families. Family therapists have to recognise the diversity of configurations that families today bring to the task of rearing children and should strive to maintain a respectful and nonjudgmental approach to these differing choices.

1.4.1 Children and Young People in Family Therapy

Although family and systemic therapies have become one of the predominant forms of working with children's emotional and behavioural problems, surprisingly little has been written about children's perceptions of family work or about ways in which children might be more fully engaged in the therapeutic process. Most therapeutic models rely heavily on verbal communication and so might be seen to exclude younger children. In the past family therapy has been criticized for ignoring children and, in effect, conducting therapy in their presence without involving them. Children's worlds are often full of play, creativity, and activity and therapy must incorporate these concepts if it is to be meaningful to children.

Different schools of family therapy have addressed these concerns in different ways. These are:

Structural family therapy (Minuchin et al., 1967; Minuchin, 1974) assumes that problems in the child arise from underlying problems in the structure and organisation of the family. The therapist is interested in how the family makes decisions, and how the boundaries between individuals and subsystems within the family lead to relative engagement or distancing.

The therapist is often directive, attending to sequences and patterns of behaviour, and seeking to bring about change using techniques such as enactment and the encouragement of family members to practice new ways of behaving and communication in the session which ensures that all family members, including even quite small children are actively involved in therapy.

1.4.2 Brief Solution-Focused Therapy (Berg and de Shazer, 1993)

This therapy assumes that problems are maintained by the way difficulties are viewed and by the repetitive, behavioural sequences surrounding attempts to solve them. Families are seen as constantly changing and it is assumed that families will already have solutions to their own difficulties. The therapist sets clear goals with the family and focuses on solutions not problems. Underlying this emphasis on competence and solutions is a focus on challenging unhelpful

beliefs about the child and the problem as part of the process of generating new solutions. This focus on solutions can be helpful when working with children who are often worried that being brought for therapy is just another context in which they will be blamed for family difficulties. Solution-focused work is often active and, like structural therapies, can involve tasks and between session homework these practical activities provide a further opportunity for children to be actively engaged.

1.4.3 Narrative Therapy (White and Epston, 1990)

This therapy draws on the way that we all make sense of our experience by creating personal accounts or narratives. Therapy is a form of conversation that encourages reflection and can transform problem-saturated narratives into more positive accounts. The emphasis on language can be off-putting for children but techniques such as externalisation, which assist in separating the person from the problem, can help the child to feel less blamed and join the child with the family in fighting the problem. Narrative therapists also see those with problems as having expertise in solving them that may help children to feel engaged and less blamed, and the emphasis on narrative suggests the possibility of links with stories and storytelling ideas familiar to children. Narrative therapists also look for unique outcomes and positive exceptions concepts similar to the search for solutions and exceptions by solution-focused therapists, and this too may help children to feel less blamed.

There are a few recent studies looking at children's perspectives on therapy. Stith et al. (1996), for example, explored the experience of 16 children from 12 families in a qualitative study. Children, interviewed alone, wanted to be included in therapy and were keen to know more about their families, be involved in generating solutions and not feel blamed for problems. They did not want to be the sole focus of discussion. Even primary school children understood the purpose of therapy and found talking about problems helpful but their willingness to be involved increased with time and with the amount they knew about why their families were coming to therapy.

There are many important differences between approaches to the treatment of children. Treatments have been extended from traditional inpatient and outpatient settings to community contexts. There is an increased tendency, across orientations, to offer treatment in context: in relation to the family and perhaps the school, rather than focusing on the child alone.

Self Assessment Questions

1) Name the predominant approaches to working with children?

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2) What is the aim of psychodynamic child therapy?

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3) What is the goal of parent work in therapy with children?

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1.5 PSYCHOTHERAPY WITH ADOLESCENTS

Psychotherapy with adolescents differs in a number of substantive ways from psychotherapy with adults. Adolescence is a time of transition. Processes of cognitive, social, emotional, and physical maturation can affect the nature and course of symptoms. It is necessary to adapt our psychotherapeutic approaches in order to assist adolescents in managing such changes. There is a general consensus that it is important to adopt a contextual and developmental perspective for describing, understanding, and treating adolescents.

1.5.1 Developmental Considerations

Early research into the efficacy of psychotherapy for treating youth borrowed heavily from research with adults. Models, methodologies, instruments, and clinical techniques that had been found useful in clinical outcome research with adults were simply applied to a new sample: children and adolescents. It quickly became apparent, however, that processes responsible for the expression of behavioural and emotional difficulties among youth may differ from those of adults. Responding to this challenge, recent research has been more sensitive to developmental differences between children, adolescents, and adults.

A range of physical, social, cognitive, and emotional changes occur over the course of adolescence. These developmental changes and issues must be considered both when developing a clinical treatment plan, and when designing a clinical research project. Developmental changes include puberty, the emergence of formal operational thought, the emergence of an adult identity, increasing emphasis on relationships with peers, decreasing reliance on parents for guidance and support, the establishment of vocational goals, the emergence of sexual interests, and the consolidation of values, standards, and tacit beliefs.

1) **Puberty**

Puberty, for example, is accompanied by a range of changes, both hormonal and physical. The physical transformations that accompany puberty can be confusing,

exciting, and challenging. The effects of physical maturation on adjustment during adolescence, however, are complex. Significant individual differences exist in the age of onset of puberty and in the rate at which physical maturation occurs. Moreover, there can be asynchronies in development across physical, social, and emotional domains.

The effects of physical maturation on psychosocial development and adaptation appear to be mediated by a number of factors including gender, age of onset of puberty, the relative maturity of peers, and cultural, familial, and community beliefs about maturation. That said hormonal changes accompanying puberty appear to have broad effects on adolescent development. They have been associated with changes in expression of anger, oppositionality toward parents and other adults, sexual behaviour, aggression, mood, self-confidence, and level of psychopathology.

It is not clear, however, that relations between physical maturation and adjustment are direct. Rather, the effects of hormonal changes accompanying puberty appear to be mediated and moderated by psychological, familial, and social variables.

The effects of puberty on adjustment are clinically important for a number of reasons. Physical maturation during adolescence has significant effects on the social status of the individual, how they view themselves, how their peers see them, and how they are viewed by their family and the larger community. Others expectations for them will change as they mature. Teenagers who appear mature may not, however, be socially, emotionally, and cognitively mature, leading to confusion and conflict. Moreover, teenagers naturally experience a range of thoughts and feelings about their physical and sexual maturation. Their thoughts, fantasies, and expectations about these changes, and their effects on their life and relationships, are worthy of discussion during psychotherapy. This is particularly important when the teen is dissatisfied with the changes in their appearance or the ways that these changes have affected their relationships with others. Physical maturation and the social changes that accompany it have important effects on adolescent adjustment and can, as a consequence, complicate the practice of psychotherapy with adolescents.

2) **Cognitive Development**

Developmental changes in reasoning also influence emotional and behavioural adaptation during adolescence. As formal operational thought emerges, for example, adolescents may be better able to reflect upon their experiences and motivations, to develop and evaluate alternative interpretations of events, and to examine critically their beliefs and attitudes. As they develop hypothetico-deductive reasoning they will be better able to use insight-oriented and cognitive-behavioural interventions.

As formal operational thought emerges in adolescents, however, it may be applied in an egocentric manner. This may lead adolescents to believe that others are as concerned by their behaviour and appearance as they are (an imaginary audience) or that his or her emotions are both unique and significant (the personal fable). This can be accompanied by fluctuations in affect. Egocentric thought during adolescence can be associated with a tendency to personalise events, to magnify their significance, and to misperceive their consequences. Clinically, this can contribute to emotional lability as adolescents believe their emotional experiences

are more intense than those of their peers. It can also contribute to difficulties trusting others (including the therapist) based on the belief that no one really understands me. A central task in cognitive-behavioural psychotherapy (CBT) with adolescents, then, is to assist the individual to recognise these misperceptions and to develop more mature forms of reasoning.

3) **Autonomy and Independence**

Development of autonomy, a sense of personal efficacy, and an ability to function independently of one's parents and family are central tasks of adolescence. Peer support plays a critical role in accomplishing these tasks. Adolescents' sensitivity to the norms of their peer culture, as well as a desire for acceptance by their peers, can both assist with the process of becoming independent from ones family, and can lead them to become resistant to the authority of their parents and other adults. Moreover, it can lead them to question the beliefs, attitudes, expectations, and values of their families. Clinically disturbed adolescents may, as a result, show little concern for fitting their actions to the norms of adult society. Not surprisingly, such youth can find it difficult to form a trusting relationship with a therapist. This can be exacerbated by a tendency on the part of parents and adolescents to view their problematic behaviour as a normal part of growing up.

Adolescent oppositionality, resistance, and identification with negative aspects of their peer culture may be understood, then, within a developmental context. Difficulties becoming independent from one's parents can also be problematic. Insofar as anxieties and ambivalence about autonomy from one's parents, oppositionality, fluctuating self-image, and challenging of accepted beliefs are, in many ways, normal and adaptive parts of the adolescent experience, it can be difficult for clinicians to discriminate normal, healthy adaptation and problematic behaviour. The line between normative development and clinical disturbance is often a thin one.

Not all adolescents experience turmoil (most, in fact, are reasonably well-adjusted socially and emotionally), and not all turmoil is maladaptive. How therapists conceptualise turmoil can have important effects on how they develop clinical formulations and on how they approach treatment.

1.5.2 Depression

Studies suggest that several forms of psychotherapy can be helpful in treating clinical depression among adolescents. Two approaches that have received the largest amount of empirical interest and enjoy the strongest support are CBT and interpersonal psychotherapy for adolescents (also referred to as IPT-A).

A substantial body of research indicates that CBT can be effective for treating depression among adolescents. Although differences exist between cognitive-behavioural protocols, they tend to emphasise the development of specific skills that can be helpful for managing depressed mood. Skills addressed include developing a goal list, monitoring one's mood, engaging in pleasant activities, development of social skills, engaging in activities that provide a sense of accomplishment or mastery, relaxation, conflict resolution and negotiation, identification of cognitive distortions or biases, identification of maladaptive thoughts, rational disputation of maladaptive thoughts, and developing realistic counter-thoughts. Recently developed approaches to CBT tailor therapeutic

techniques to the specific needs of individual patients (Curry and Reinecke, 2003). A list of the specific cognitive-behavioural tasks used in CBT is presented in Table below

Table 1.1: Cognitive Behavioural Interventions for Depression

- Development of therapeutic rapport. Make adolescent and parents feel understood
- Develop shared problem list
- Develop and share rationale with adolescent and parents
- Mood monitoring
- Pleasurable events scheduling
- Mastery activities scheduling
- Rational problem-solving
- Realistic counter-thoughts (rational responding)
- Social skills/address social withdrawal
- Family communication (encourage expression of emotions, compromise)
- Assertiveness training (to address passivity)
- Review and consolidation of gains/relapse prevention
- Booster/follow-up sessions

1.5.3 Interpersonal Therapy

IPT, a form of psychotherapy developed by Gerald Klerman et al. (1984) for treating depressed adults, has been adapted for use with adolescents (Mufson et al., 1993). The approach focuses on addressing common interpersonal difficulties experienced by adolescents, including challenges associated with autonomy from parents, relationships with peers, and managing the loss of significant relationships. Explicit attempts are made to identify interpersonal factors that are associated with the cause and maintenance of the depressive episode. Information is gathered about the nature and quality of the adolescent's relationships, their expectations for the relationships, whether these expectations are being met, goals for their relationships, and how they have attempted to accomplish these goals. Particular attention is given to separations and losses, conflict, changes in roles, interpersonal deficits (including social withdrawal or isolation, social skills deficits, and social anxiety), and difficulties encountered in single family homes. Active attempts are then made to address difficulties identified in these domains.

To date, research on ITP-A has been positive. Completion of a 12-week ITP-A program has been associated with a significant reduction in symptoms of depression, improved social functioning, and an increased rate of remission from the depressive episode. Moreover, gains appear to be maintained over time. Although research is limited, ITP-A is a promising approach for understanding and treating depressed youth.

Apart from the above approaches, psychodynamic psychotherapy endeavors to treat depression by providing adolescents with insight into defenses used in coping

with the expression of drives, by identifying and rectifying recurrent relationships issues, by addressing feelings of narcissistic injury, or by establishing a more coherent, integrated, and authentic sense of self. Psychodynamic psychotherapy typically is nondirective, long term, and focuses upon the expression and interpretation of events within the therapeutic relationship as a means of bringing about clinical improvement.

Although it is widely used, little systematic research has been conducted examining the efficacy of psychodynamic psychotherapy with clinically depressed youth. No randomized controlled trials of these forms of psychotherapy have been published. Individual psychodynamic psychotherapy has not, then, been demonstrated to be an effective treatment for depression among adolescents. That said, preliminary evidence indicates that adolescents who receive intensive psychodynamic psychotherapy may benefit over time.

In conclusion, CBT and IPT appear to be effective in alleviating symptoms of depression among youth. Gains achieved appear to be reasonably stable over time. Evidence supporting the efficacy of psychodynamic and psychoanalytic psychotherapy is scant.

1.5.4 Anxiety

Several protocols have been developed for treating child and adolescent anxiety disorders. Controlled outcome studies completed over the past 15 years indicate that behavioural psychotherapy and CBT can be useful in treating generalised anxiety, school anxiety, specific phobias, panic, and obsessive-compulsive disorder among youth.

Based upon cognitive and behavioural models, these approaches help to alleviate anxiety by teaching children and adolescents to monitor their moods, anticipate situations in which they are likely to become anxious, identify specific distressing thoughts, and respond to these cues by actively using cognitive and behavioural coping strategies. Exposure and desensitisation, relaxation training, guided imagery, rehearsal of adaptive self-statements, and encouragement of adaptive coping attempts are frequently used.

Parent and family sessions are typically included in these treatment programs, both to address parental behaviours that may be maintaining the child's anxiety and to provide them with strategies for managing their child's anxiety at home. Cognitive strategies (which focus upon reducing cognitive distortions, developing coping skills, and enhancing perceptions of control or efficacy) and behavioural approaches (which emphasise desensitisation to anxiety-provoking stimuli and operant reinforcement of adaptive coping) are typically used together.

Types of anxiety experienced by children and adolescents vary with age. Forms of anxiety that may be normal at one age (such as a fear of separation from parents during the toddler years) may be quite inappropriate at a later age. The most common source of anxiety during adolescence is peer rejection, and the most frequent anxiety disorders are social anxiety, panic, and agoraphobia. As adolescents develop the capacity for hypothetico-deductive reasoning, they become increasingly able to envision a range of potential threats, dangers, and sources of social embarrassment.

Increasing rates of social anxiety among adolescents are due to the central importance given to peer relationships for negotiating independence from one's family and for developing mature sexual relationships. Cognitive-behavioural models suggest that anxiety disorders tend, as a group, to stem from unrealistic appraisals of threats related to normal fears. It is these appraisal processes that are the focus of treatment.

CBT has been found effective for treating school phobia, overanxious disorder, overanxious disorder and specific phobia, panic disorder, social anxiety, generalised anxiety, and obsessive-compulsive disorder. Although few long-term follow-up studies have been completed, those that have been published are promising. Results suggest, for example, that gains achieved in CBT may be maintained for up to 3 years.

Parents of anxious children and adolescents often experience high levels of anxiety themselves, and the possibility exists that this may lead parents to behave in ways that exacerbate and maintain their children's difficulties. At a minimum, clinicians should attend to the moods of their patient's caregivers and the ways in which this may affect the child's adjustment. If appropriate, parents might be referred for treatment to address their feelings of anxiety.

1.5.5 Conduct Disorders

Conduct problems, including aggressive behaviour, disobedience and defiance at home and at school, and major rule violations, are among the most persistent and difficult to treat clinical problems in adolescence. They are among the most common reasons for clinical referral, reflecting their high prevalence rates and the fact that they can be quite distressing to parents and school officials. Traditionally, serious conduct problems have been treated with long-term, dynamically informed psychotherapy aimed at low frustration tolerance, limited self-awareness, impaired empathy, compromised interpersonal relations, or a fragmented, non-cohesive sense of self.

Three treatments have been developed for and evaluated with conduct disordered adolescents.

The first is anger control training with stress inoculation (Feindler, 1991). At the core of this intervention is the view that youth with delinquent and aggressive problems have serious difficulties with the expression and regulation of anger. The treatment, then, principally aims at teaching youth a variety of coping strategies for reducing angry arousal. Therapy focuses on helping youth to identify anger provocation cues, to suppress immediate anger responses with self-instructions, to modulate arousal with relaxation or self-instructional techniques, and to consider consequences of aggressive behaviour or explosive anger. In addition, a portion of the treatment is directed toward training individuals to behave in an assertive rather than an aggressive manner. Treatment is offered in both individual and group formats, and typically is time limited (12-25 sessions). Although psychoeducation is given emphasis in this treatment therapists also model the components of anger management, and adolescents are made to role-play skills under varied conditions of anger arousal.

The second promising treatments for adolescent conduct disorder are family-based therapies. A growing body of research suggests that disrupted family

relations, poor parental monitoring, inconsistent discipline, and cross-generational continuities may contribute to aggressive and disruptive behaviour among youth. Based on these findings, family processes have been targeted for intervention.

Functional family therapy draws heavily on social learning formulations of noncompliance and aggressive behaviour. At the core of this intervention is the view that aggressive and disruptive behaviours are maintained through patterns of family interaction that unintentionally reinforce problem behaviours while failing to reward pro social behaviours. One recurrent pattern involves negative reinforcement. An adolescent may, for example, respond to limits or requests with aversive behaviours such as whining, arguing, or threatening.

His or her parent, in order to reduce the aversive interaction, responds by disengaging or withdrawing. The youth's aversive behaviour has been reinforced by the removal of the request, and the parents' disengagement is reinforced by the reduction in aversive interactions. Not surprisingly, over time, families with conduct-disordered youth appear to be quite disengaged and lacking in cohesion. Further, youth fail to comply with parental limits and requests.

1.6 FUNCTIONAL FAMILY THERAPY

This attempts to modify such dysfunctional family patterns by altering parental monitoring and disciplinary strategies. Parents are taught to use basic social learning principles for managing youth behaviour. Several additional components complement the core behavioural approach including family sessions designed to improve communication and increase family reciprocity, and sessions aimed at facilitating negotiation among family members.

1.6.1 Multisystemic Therapy (MST; Hengeler et al., 1998)

This is an integrative and comprehensive approach to treating youth conduct problems and antisocial behaviour. Unlike traditional, comprehensive treatments that remove the adolescent from his or her social environment through placement in residential treatment settings, MST aims at restructuring multiple levels of the youth's environment in order to promote pro-social functioning. Based on Bronfenbrenner's (1979) ecological model of development, individual behaviour is viewed within the context of multiple, nested contexts. Relevant context is not limited to the family, as in functional family therapy, but extended to the school, neighbourhood, peer group, and broader community, as well as to linkages among these systems.

MST draws upon methods from a number of empirically based treatments. For example, interventions at the family level might include communication training as well as methods from strategic or structural family therapy. Integration of specific interventions is guided by a core set of principles. MST begins with the assumption that the purpose of assessment is to understand the fit between identified problems and the functioning of multiple systems.

Psychiatric diagnosis is not the primary aim, instead MST therapists attempt to identify processes at multiple levels that support or impede adaptive functioning. In turn, therapeutic interventions attempt to use systemic strengths, for example, a committed extended family, as levers for change. All interventions are present

focused and action oriented. Typically, many interventions focus on specific contingencies that sustain problematic behaviours. Therapist and family agree upon specific, well-defined goals, and progress is closely monitoring, including family feedback on treatment fidelity.

Self Assessment Questions

1) What is interpersonal psychotherapy with adolescents?

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2) Name the three treatments which have been developed for conduct disordered adolescents?

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3) What is functional family therapy?

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1.7 LET US SUM UP

The three of the predominant approaches to working therapeutically with children are psychodynamic and play therapies, cognitive-behavioural therapy (CBT), and family therapy.

Psychodynamic child psychotherapy was the first psychosocial treatment specifically developed for mental disorders for children. Its aim is the developmental advancement of children whose symptoms are seen as an indication of a failure to progress socially, cognitively, or emotionally. While interpretation and insight represent an important feature of therapeutic process, more central are becoming able to play, and to establish a relationship with a therapist that is richly imbued with symbolic meaning, and aims to extend the child's capacity coherently to represent mental states. These representations allow the child to understand himself and others better, and to gain more control over what happens in his or her relationships as a result. For most child therapists, work with parents is important for both preschool and school-age children, its primary aim being to help parents understand their child's thoughts and feelings.

CBT with children currently encompasses a wide range of interventions to address childhood disorders and distress. In general, there is some evidence of the usefulness of CBT for a number of childhood disorders. More established behavioural approaches such as behaviour modification and parent training increasingly include cognitive factors for both parents and children, and the child is placed in a more central position in the therapeutic endeavor. This is ideologically welcome as it conveys respect for the child's perspective and experience. However, it remains unclear whether CBT is yet addressing critical cognitive factors that lead to childhood disorders.

There is evidence that family and systemic therapy is an effective treatment for some young people and systemic ideas can contribute to the delivery of other treatment modalities. The theoretical models and practical techniques of the current schools of systemic practice all acknowledge the importance of involving children and have all found creative ways of doing this. There is emerging evidence from qualitative research that even quite young children can understand, make sense of, and participate in systemic work. Careful explanation of the purpose and process of therapy, recognition of the expertise of the child and the provision of environments that are child friendly and promote play and creativity should maximize the involvement of children.

We can be optimistic about the benefits of psychotherapy for treating anxiety and depressive disorders experienced by adolescents. The treatment of conduct disorder remains a vexing problem, but the emergence of comprehensive and systematic interventions, such as MST, hold significant promise. The social environment (both family and peers) is important. It is important to attend to both stressors and social supports. Behavioral, emotional, and social difficulties experienced by adolescents can have pernicious effects that persist into adulthood. It is important, then, to include long-term assessments as a part of both clinical practice and research. We should, at the same time, attempt to insure that our interventions have broad, positive effects on adolescents' development.

1.8 UNIT END QUESTIONS

1) Describe the different psychotherapy approaches in treatment with children?
2) Discuss in detail the different developmental changes during adolescence?
3) Write about the psychotherapeutic approaches used for treating depression in adolescents?
4) What are the ways in which anxiety could be treated in adolescentgs?
5) Describe the different approaches used for treatment of conduct disordered adolescents?

1.9 SUGGESTED READINGS

Friedberg, R. D. and McClure, J. M. (2002). *Clinical Practice of Cognitive Therapy with Children and Adolescents: the Muts and Bolts.* New York: Guilford Press.

Plante, Thomas G. (2005). *Contemporary Clinical Psychology.* New Jersey: John Wiley & Sons, Inc.

UNIT 2 PSYCHOTHERAPY WITH ADULTS AND MIDDLE AGED PERSONS

Structure

2.0 Introduction

2.1 Objectives

2.2 Psychotherapy with Fledgling Adults

- 2.2.1 Life Stage Issues with Fledgeling Adults
- 2.2.2 Psychosocial Tasks of Middle Adulthood

2.3 Psychotherapy with Young Adults

2.4 Overview of Young Adult Issues

- 2.4.1 The Psychotherapy Model and Young Adult Issues
- 2.4.2 The Medical Model and Young Adult Issues
- 2.4.3 Therapy for Young Adult Issues

2.5 Psychotherapy with People in Middle Adulthood

2.6 Parallels and Distinctions

2.7 Let Us Sum Up

2.8 Unit End Questions

2.9 Suggested Readings

2.0 INTRODUCTION

Many micro skills are common to counseling or therapy with clients of all agesand many significant life events that might bring clients into therapy such as bereavement, illness, traumaticstress, for example have no special or very clear association with age or life stage. Nonetheless, if the differences between counseling children, adolescents and adults are ignored, the outcomes may be disappointing. The present block, therefore, addresses some of the specific issues concerned with counseling clients at different life stages. This unit will describe the issues and concerns related to psychotherapy in fledgling (18-25 years), young (25-40 years) and middle adulthood (40-65 years). Separated out for reasons of convenience and manageability, it needs to be remembered that these stages overlap chronologically and, to an even greater extent, psychologically and developmentally.

Many people feel themselves 'betwixt and between' different life stages, having a foot in two camps as it were. It must be remembered that while life stage labels have their use and their importance is overshadowed by the need to keep to the fore the individuality and uniqueness of each particular client. The goal is to help clients 'be themselves' rather than 'act their age'.

2.1 OBJECTIVES

After completing this unit, you should be able to:

- Describe the issues and life stage problems with fledgling adults;

- Discuss the typical issues and areas relevant for therapy with young adults; and
- Describe middle adulthood and issues important for counselling.

2.2 PSYCHOTHERAPY WITH FLEDGLING ADULTS

Although those between the ages of 18 and 25 are often referred to as young adults by implying that the status of adulthood has been reached but this may be somewhat misleading. If you think of the range of different minimum age legislation that exists (across countries) for voting, for criminal responsibility, for marriage, for joining the armed forces, for the age of consent, for obtaining a driving license etc., it is hardly surprising that the onset of adulthood is beset with confusion. It is a status acquired haphazardly and little by little. To be sure, young people in the 18–25-year age band are legally adults, but this does not mean that they feel 'grown up'. They move towards adulthood in the context of a diminishing support network, and this can leave them feeling isolated and vulnerable. Contact with parents and other relatives may diminish or be lost as family ties weaken or disintegrate through divorce, geographic dispersion and social diversity. Friendship networks may be unstable. They are less likely to have strong religious affiliation. Universities no longer operate *in loco parentis*.

The dynamic, fluid and transitional quality of this period is captured in such terms as emerging, threshold or fledgling adulthood. Like adolescence, it is a stage that is culturally constructed and during the last three decades of the twentieth century it became a period of increasing demographic diversity and instability. There are now no certainties, and ever fewer probabilities, in relation to likely occupational, residential, marital or parental status.

Thus, for example, while many 18–22 year olds are in fulltime higher education (allowing student counseling to become a distinct and well defined area of work) many others are not.

2.2.1 Life Stage Issues with Fledgling Adults

Life stage issues that fledgling adults may bring to psychotherapy or counseling (Thomas, 1990; Cooper, 2003) include:

- Difficulties occurring in relation to family and friends;
- Issues of sexual identity and development;
- Questions of morality in the face of an imperfect self and a flawedsociety;
- Problems of planning a career, finding satisfactory employmentand adjusting to job conditions;
- Financial difficulties.

While these difficulties and their manifestations are by no means unique to the period of fledgling adulthood, the developmental status and social demands of this stage lend them a particular quality and form. The shift in gaze from family to peers offers freedom, but can also create anxiety if such distancing from parents is perceived as risking the loss of their love and support. Furthermore, the independence that a job or full-time education away from home can bestow may

be compromised by continued financial dependence on parents, and by the need to return to the family fold if subsequent occupational opportunities fail to materialise, or the cost of housing outstrips their income.

This is the 'boomerang' generation which leaves home but (sometimes to the discomfiture of their parents) keep coming back. If, in contrast, their professional and/or financial success seems set to outstrip that of their parents, they may feel they are in some way being disloyal and be unable to grasp the opportunities before them.

Fledgling adults will often be concerned with establishing a workable and acceptable system of values. It is a time for putting into practice (or not) the idealism of adolescence. Awareness of the discrepancies between their own pretensions and performances can be acute, with assessment of their own and other people's moral standards being largely grounded in the quality of personal relationships.

The fledgling adult anticipates that, largely through various social and sexual experiences, the unstable and ill defined self concept of adolescence will become more clear and consolidated, and that a specific and fixed sexual identity will be established. While this may be true to some degree, the plasticity of human development including sexual orientation is easily underestimated. The myth of adulthood as a fixed and stable state is pervasive, and distorts both expectations and self-evaluations of personal success and failure.

As fledgling adults strive towards adulthood, the ripples of their struggle disturb the equanimity and sense of being 'in charge' of the generation ahead of them. It emphasises to parents that they are growing older, and that the society they created will eventually be supplanted and overtaken by this new generation. The majority of therapists will still be a good many years older than their fledgling adult clients, and so intergenerational dynamics will again be an issue in the client– therapist relationship. Therapists may at times find that their worldview more closely approximates that of the parents than of the fledgling adults themselves.

2.2.2 Psychosocial Tasks of Middle Adulthood

Erikson stated that the primary psychosocial task of middle adult hood ages 45 to 65 is to develop generatively, or the desire to expand one's influence and commitment to family, society, and future generations. In other words, the middle adult is concerned with forming and guiding the next generation. The middle adult who fails to develop generatively experiences stagnation, or self-absorption, with its associated self-indulgence and invalidism.

Perhaps middle adulthood is best known for its infamous midlife crisis: a time of reevaluation that leads to questioning long-held beliefs and values. The midlife crisis may also result in a person divorcing his or her spouse, changing jobs, or moving from the city to the suburbs. Typically beginning in the early- or mid-40s, the crisis often occurs in response to a sense of mortality, as middle adults realise that their youth is limited and that they have not accomplished all of their desired goals in life. Of course, not everyone experiences stress or upset during middle age; instead they may simply undergo a midlife transition, or change, rather than the emotional upheaval of a midlife crisis. Other middle adults prefer to reframe their experience by thinking of themselves as being in the prime of their lives rather than in their declining years.

During the male midlife crisis, men may try to reassert their masculinity by engaging in more youthful male behaviours, such as dressing in trendy clothes, taking up activities like scuba diving, motorcycling, or skydiving.

During the female midlife crisis, women may try to reassert their femininity by dressing in youthful styles, having cosmetic surgery, or becoming more socially active. Some middle adult women try to look as young as their young adult children by dying their hair and wearing more youthful clothing. Such actions may be a response to feelings of isolation, loneliness, inferiority, uselessness, non assertion, or unattractiveness.

Middle-aged men may experience a declining interest in sexuality during and following their male climacteric (male menopause). Fears of losing their sexual ability have led many men to leave their wives for younger women to prove to others (and to themselves) that they are still sexually capable and desirable. In contrast, middle-aged women may experience an increasing interest in sexuality, which can cause problems in their primary relationship if their significant other loses interest in sexual activity. This leads some middle aged women to have extramarital affairs, sometimes with younger sexual partners.

Happiness follows a U-shaped curve during a person's lifetime, according to research showing that middle-aged people are the unhappiest. Satisfaction with life starts to drop as early as a person's late 20s and does not begin to recover until well past 50, says Bert van Landeghem, an economist at Maastricht University in Belgium. While young adults are carefree and full of hope for the future and the over-50s have come to terms with the trials of life, the research indicates that those in the middle feel weighed down by the demands on them.

Studies around the world have shown that happiness tends to dip in midlife, van Landeghem said, and that this was not just a phenomenon confined to the Western world. Last month Lewis Wolpert, emeritus professor of biology at University College London, said happiness could peak as late as 80. In a book called *You're Looking Very Well*, Prof Wolpert said most people were 'averagely happy' in their teens and 20s, but this declined until early middle age as they attempted to support a family and career. He added: 'From the mid 40s, people tend to become ever more cheerful and optimistic, perhaps reaching a maximum in their late 70s or 80s.' An easing of the responsibilities of middle age, maturity and an increased focus on things we enjoy contributed to the trend, he said.

Timing of Events Model

The field of life span development seems to be moving away from a normative crisis model to a timing of events model to explain such events as the midlife transition and the midlife crisis. The former model describes psychosocial tasks as occurring in a definite age related sequence, while the latter describes tasks as occurring in response to particular life events and their timing. In other words, whereas the normative crisis model defines the midlife transition as occurring exactly between ages 40 and 45, the timing of events model defines it as occurring when the person begins the process of questioning life desires, values, goals, and accomplishments.

A long term study of over 3,500 adults revealed that self esteem ramps up as young adults progress to middle age, and then begins to decline around retirement

age. Researchers studied men and women ranging in age from 25 to 104. The study took place during the period 1986 - 2002 with researchers assessing self-esteem on four occasions. "Self-esteem is related to better health, less criminal behaviour, lower levels of depression and, overall, greater success in life," said the study's lead author, Ulrich Orth, PhD. "Therefore, it's important to learn more about how the average person's self-esteem changes over time." Self-esteem was lowest among young adults but increased throughout adulthood, peaking at age 60, before it started to decline.

2.3 PSYCHOTHERAPY WITH YOUNG ADULTS

By their mid twenties, most fledgling adults will have largely achieved the outer trappings of separation from their family of origin. Life will have lost some of its 'provisional' character and things are now seen as being 'for real'.

Occupation, lifestyle, friendships and relationships may all seem to be 'settling down', with young adults glimpsing a plateau ahead that is reminiscent of the growth, stability, decline model. After the turbulence of adolescence and fledgling adulthood, the period of early adulthood may seem more concerned with consolidation and incremental growth a structure building phase which is less demanding of the need for counselling or psychotherapy.

The losses of this life stage i.e. loss of youthful freedom from responsibilities and loss of such entwined relationships with parents and siblings may pass unrecognised by the young people themselves, by their families, by friends and even by therapists.

Normative pressures to establish an independent 'adult' lifestyle may encourage a denial of the importance of continued relationships with one's family of origin. Because leaving home is regarded as a ritual proof of achieving adult autonomy, we may underestimate the significance of what is lost. Young adults themselves may question and doubt any continuing attachments, accepting the dictum that by now they should have untied themselves from the apron strings of their childhood home. There is, however, evidence (Troll, 1989) that young adults typically keep in close contact with their parents, although this does not mean that things remain the same.

Intergenerational relationships within the family must shift from an adult child relationship involving dependency and control, towards a more equal relationship between adults. It is especially in families where relationships have been particularly close or characterised by intense conflict, that fear of sliding back into a previous dependency may lead young adults to severe, at least temporarily, all links with their family of origin. However, generally a state of 'intimacy at a distance' (Troll, 1989) is ultimately attained. While not many young adults live together with their parents, many do live fairly close and will visit frequently. If the distances are too great, then they will generally talk regularly on the phone, and undertake longer visits at less frequent intervals.

The paucity of attention given to the therapy needs of young adults may stem in part from wrongful assumptions about the nature of this life stage, but also from the fact that no longer are large numbers of the age group sharing similar educational experiences, as has been the case from entry into primary school

until graduation from higher education. Members of this age group are more widely dispersed across different institutions than has been the case in their lives till now. Lifestyles are becoming increasingly diverse. However, the boundaries between different life stages are blurred and over lapping, and the problems associated with employment, relationships and money that were identified as characteristic of fledgling adulthood may persist into this life stage. In addition, young adults may find themselves reluctant and hesitant to take on the responsibilities of adult life, wondering, perhaps, if they want to or are capable of really 'standing on their own two feet'.

2.4 OVERVIEW OF YOUNG ADULT ISSUES

Erik Erickson, noted developmental psychologist, described the period of young adulthood as being from age 20-45, and the task of the stage to be "intimacy vs. isolation". This seems too broad and simplistic in today's society. In 1970, Kenneth Keniston, a Yale Psychologist, described characteristics of youth as "pervasive ambivalence toward self and society", "having a feeling of absolute freedom, of living in a world of pure possibilities". He proposed that they have not settled the questions of relationship to existing society, vocation, social role and lifestyle.

A young adult in today's society faces issues and challenges that did not exist, or were unacknowledged, in previous generations. In 2000, Jeffrey Arnett coined the term "Emergent Adult" and identified changes that have occurred over the last several decades: more education is needed to survive in information based economy; fewer entry level jobs are available even after all that schooling; young people are feeling less rush to marry because of the general acceptance of premarital sex, cohabitation and birth control; young women feeling less rush to have babies given their wide range of career options and their access to reproductive technology if pregnancy is delayed beyond most fertile years.

Choices for both genders are more numerous. Expectations are less clear about what is one's next step after finishing school (whether it be high school, college, or graduate school). In times past, young adults' paths were more predetermined by role expectations, family expectations, and clearer gender expectations. The traditional cycle seems to have gone "off course". Young people remain unattached to romantic partners or permanent homes, are going back to school for lack of better options, traveling, avoiding commitments, competing for unpaid internships or temporary public service volunteer jobs. In other words, forestalling the beginning of adult life. Sociologists call it "the changing timetable for adulthood."

2.4.1 The Psychotherapy Model and Young Adult Issues

Psychotherapy with young adults may help the client explore their identity, including values, interests, and questions of who the person is in the world. Instability is addressed as clients deal with a feeling of being "in between" one stage of life and the next, often striving for independence from parents, but needing to depend on them for financial or emotional support. Clients are naturally very self focused at this time of their life, but may need help in seeing a bigger picture in terms of how they fit into the world and their relationship with others. Young adults' sense of possibilities can help to establish hope for the future, but can also hinder progress if the client is overwhelmed by possibilities and may need

assistance narrowing down choices. Some of these characteristics are part of adolescence but they take on new depth and urgency in the 20's.

2.4.2 The Medical Model and Young Adult Issues

A NIMH longitudinal study found that children's brains were not fully mature until at least age 25. Most significant changes after puberty were in prefrontal cortex and cerebellum, the regions involved in emotional control and higher-order cognitive functioning.

The limbic system explodes during puberty, but the prefrontal cortex keeps maturing for another 10 years. This is the part that allows you to control your impulses, come up with a long-range strategy and answer the question, "What am I going to do with my life?"

Many serious mental illnesses tend to appear in the late teens or early 20's *(bipolar, schizophrenia).* Other common problems may include *substance abuse*, *eating disorders, depression* and *anxiety*. These illnesses and issues complicate the already complex question of life choices and direction.

2.4.3 Therapy for Young Adult Issues

Clients of this population are frequently looking for an encouraging parental figure in a therapist, particularly if they were or are not so well supported by their own parents. Other times they are looking for the opposite of a parental figure, that is someone who sees them as capable and adult. Not an authority, just an older, wiser guide. If they come in with their parents, or are living with their parents, they are sometimes ambivalent about separation from them, and may need some help being launched. Therapy helps to establish where a young adult is in the separation process and how much autonomy he or she is feeling. What is keeping someone tied to his or her parents? Is it okay to be different from parents? What are fears/anxieties about independence?

Therapy also helps young adult clients to explore their identity or how well they know him or herself? What is one's personality type, one's values and goals, one's sense of him or herself in the world? Group therapy is a powerful intervention for this cohort, as many young adults are feeling isolated and alone, as if everyone else "has it together" except for them. Group therapy helps them to see that this is not the case, and gives them a place to feel less isolated and more supported, as they grapple with issues of what their life will be about.

At this stage they experience anxiety and uncertainty over child bearing decisions, or difficulties in relation to child rearing including problems of raising children as lone parents.

In previous generations, and especially for women, the prospect of reaching the age of 30 often signaled an increase in awareness of the ticking of the 'biological clock'. Twenty years ago, young women frequently wished, and believed it was necessary, either to have had their first child by the time they were 30, or, at least, to have clear plans about whether and when they would do so. However, demographics change, and the birth rate among women in their 20s continues to fall. It is predicted that the birth rate among women aged 25 to 29 years will soon be lower than the birth rate among women aged 30 to 33, meaning that the age 30 transition has largely lost its significance as a 'last chance saloon' for

motherhood. Nonetheless, miscarriage, stillbirth, abortion and infertility are losses that affect a significant number of women and couples, and issues around fertility and the transition to parenthood can be highly emotive concerns of clients at this stage.

By the end of their 30s, however, most young adults who are to become parents will have done so. A developmental task for this decade is frequently, therefore, the adjustment to parenthood, or, for those who, whether out of choice or not, do not become parents, managing the consequences of deviating from this social norm.

With the arrival of children, parents' developmental tasks become joined to those of their children, and the couple relationship has to be renegotiated. Parenthood frequently exacerbates the difficulties of achieving a satisfactory work home balance. Former leisure activities may be squeezed out, and friendships, particularly with friends who do not themselves have children, may fall by the wayside.

Stereotyping, and what Huyuk and Guttman (1999) describe as the 'parental emergency' of the child-rearing years, may increase pressure for couples to adopt role specialisation during the woman's 'window of fertility'. It is still mothers who overwhelmingly assume greater responsibility than fathers for childcare. Therapists may find themselves working with clients to help them prioritize roles, activities and relationships, and to find ways of responding to multiple, pressing demands. For some, coming to terms with 'non-events' may be an issue, that is the career path that did not materialise or proved disappointing, or the stable relationship that did not develop or did not last or the baby that was not conceived. In each case, assumptions, expectations and hopes largely socially constructed may be dashed.

2.5 PSYCHOTHERAPY WITH PEOPLE IN MIDDLE ADULTHOOD

For most clients, middle adulthood is a time of multiple and sometimes conflicting roles, demands and opportunities, making the resources a person has available for dealing with this complexity one of the key therapeutic issues of this life stage (Biggs, 2003). There have, historically, been several different interpretations of midlife as:

- **a*plateau* –** with, for example, mid career being seen as a time of 'maintenance';
- an overwhelming crisis, whereby a person's coping resources are severely stretched;
- a period of challenging change and transition, although not necessarily crisis; and
- a period of continuity involving more incremental than dramatic change.

Furthermore, midlife may be present either in positive fashion as 'the peak period of life', where people are 'wise and powerful that is, in charge of themselves and others or more negatively, as the herald of 'a downhill slide in energy, attractiveness, occupational performance, and happiness at home'.

These different interpretations will influence, perhaps unknowingly, both clients' and therapists' expectations about midlife and this may lead to difficulties in the therapeutic situation (Biggs, 2003). Seeing midlife issues as depressing and without solution may lead therapists to resist confronting issues of ageing. Seeing age as irrelevant i.e. being 'age blind' may create false expectations of what is possible, ignoring the need for developing resilience to the inevitable losses that accompany passage through the life course and the need to adapt to forms of decline.

Seeing midlife as inevitably a time of crisis may result in an exaggeration of the significance of everyday issues and problems, or by way of contrast ignoring them as intractable and unavoidable.

Life adjustment problems that clients in middle adulthood may typically bring to counselling coalesce around concerns regarding work and career, family commitments and health (including sexual potency). Specific concerns include (Thomas, 1990) the following:

- the need to change career or to retire, either because skills no longer fit the needs of a changing job market, or because the ability to cope with the demands of the job has diminished with age;
- stress at work, and the desire to resolve job dissatisfaction and/or conflict between job responsibilities, family commitments and diminishing energies;
- the need to renegotiate relationships with partner, with children (as they move towards and achieve independent adulthood) and with parents (who may be becoming increasingly dependent, vulnerable and demanding);
- the wish to find meaningful occupation and purpose, either within or beyond the workplace, as children grow up and leave home;
- concern about the physical changes often associated with midlife in terms of physical appearance, diminishing sexual desire and potency, and, for women, the approach, occurrence and implication of the menopause.

Grief following the death of a child, parent, partner or close friend.

These issues are often interrelated, rarely arising in isolation. Thus, middle adulthood is the life stage during which demands of both career and family may be at their peak. In the family arena, midlife often coincides with children's long passage from adolescence to adulthood. Not only does this serve as a reminder to the midlife adult of their own ageing, but also requires that the parent, as well as the child, is involved in the renegotiation of relationships that characterises this transition. Powerful feelings around autonomy and encroaching dependency may arise (Biggs, 2003). Furthermore, once children have left home, parents can no longer use their children to mask problems in their relationship with each other and this can lead them to seek help of a therapist.

Seeing offspring successfully take on the mantle of adulthood may lead parents to reflect on, and perhaps regret, the choices they have made in their own lives (Cooper, 2003). At work, the increasingly apparent presence and advancement of 'the younger generation 'serves' as another reminder of the passage of time. As a result of increasing life expectancy, midlife adults may also find themselves implicated in the transitions of their parents through late adulthood.

As children become more independent, so parents may become more dependent and needy. For much of middle adulthood the 'midlifer' may be part of a 'sandwich' generation that is caught it might sometimes feel, between the demands and needs of both those ahead and those following on behind in the human race.

While there are clear and observable physiological changes in both men and women during the middle years, it is the awareness and perception of these changes that is of prime importance. Thus, the menopause is a socially constructed as well as a physiological transition that, in contrast to its image as crisis, leaves many women feeling freer, more in control of their lives and enjoying improved communication (including sexual).

However, health problems or at least the possibility of them may become more apparent during middle adulthood, exacerbated by the illness or death of contemporaries. This can lead to an increased sense of physical vulnerability in men and preparations for widowhood in women, leading to a restructuring of life in terms of 'time left to live' rather than 'time since birth'. The awareness of mortality that this denotes is seen as the basis of the apocryphal midlife crisis.

2.6 PARALLELS AND DISTINCTIONS

The present unit has focused on the dissimilarities of different lifestages. However, while each life stage is *distinctive*, it is also true that life stages are not *distinct* in the sense of being separate and isolated. While it is important, when working with any age group, to be aware of their particular qualities and vulnerabilities, it is equally important to be aware of the connection between different life stages.

Although people of different ages differ, their concerns and preoccupations are not as different as perhaps they might appear. There are wide ranging and fundamental psychological themes that may appear in varying forms at any phase of life. These include attachment, loss, separation, hope, fear, anger, hostility and love. Many writers focusing on clients of a particular age or life stage reiterate this point.

There is interplay and interaction between the concerns and developmental tasks characteristic of different life stages. For example, the social network of parents with young children frequently comprises the parents of other children of a similar age to their own, irrespective of the age of the parents. Thus, the 20-year-old parent of a toddler and the 45-year-old parent of a toddler may see themselves at a broadly similar life stage – even though, by the framework adopted in the present unit, they would have been identified as being nonfledgling adulthood and middle adulthood, respectively. Another example is the interplay between the developmental preoccupations of adolescents and their parents. It is often the timing of the departure of adolescents or fledgling adults from their childhood home that determines to a significant extent when parents reevaluate their own future and confront issues in their relationship that have been masked by child rearing responsibilities.

While being of different ages, life stages and generations sometimes separates and distinguishes us, our position on this dimension of difference is continually changing. Although we may choose not to dwell on it, we either were or can anticipate reaching the age and life stage of those many years our junior or senior.

This points to a key distinction between ageism, on the one hand, and sexism and racismon the other.

Although sex change and skin pigmentation operations do exist, for most people the categories of sex and race are constants. Our age classification, however, is not static. While people who behave in a racist or sexist manner are unlikely ever to be members of the group that is the target of their discrimination, ageism is unique in that those who practice it were once a member of, or will one day join (if longevity is granted them), the group they presently discriminate against. Ageism identifies those of different ages as 'the other', and creates an artificial 'them' and 'us'divide between different life stages.

Self Assessment Questions

1) What are the life stage issues that fledgling adults may bring to therapy?

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2) Write about the problems which young adults are prone to bring to therapy?

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3) What is midlife?

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2.7 LET US SUM UP

Although those between the ages of 18 and 25 are often referred to as young adults, the dynamic, fluid and transitional quality of this period is better captured in such terms as emerging, threshold, or fledgling adulthood. Life stage issues that fledgling adults may bring to counseling include:

- difficulties occurring in relation to family and friends;
- issues of sexual identity and development;

- questions of morality in the face of an imperfect self and
- a flawed society;
- problems of planning a career,
- finding satisfactory employment and
- adjusting to job conditions and financial difficulties.

Persons belonging to 25-40 age range can be termed as young adults. This is characterised feeling of settling down in terms of occupation, lifestyle, friendships and relationships.

The mid-life paradox is that of entering the prime of life, the stage of fulfillment, but at the same time the prime and fulfillment are dated. Death lies beyond. Somewhere between 35 and 45 most of us begin to realise that half of life is over. Points of reference change with the individual's realisation that s/he has stopped growing up, and has begun to grow old. Taking stock we register unachieved youthful dreams and the unlikelihood of our anticipated outstanding contribution.

Mid-life reevaluation is precipitated by changing relationships to elderly or dead parents, to childlessness or self-reliant children. Shocked by illness or unexpected deaths we register signs of the biological clock's slowing down in our own bodies. Memory loss, discovery of one's ineffectuality at work or elsewhere, lack of influence over colleagues, politicians, or family members accompany growing awareness of one's own mortality.

2.8 UNIT END QUESTIONS

1) Describe and discuss the issues and life stage problems related to fledgling adults?
2) After the turbulence of adolescence and fledgling adulthood, the period of early adulthood may seem more concerned with consolidation and incremental growth. Discuss?
3) Write about middle adulthood in terms of issues relevant in psychotherapy?

2.9 SUGGESTED READINGS

Woolfe. R., Dryden. W., Strawbridge.S (2003). *Handbook of Counselling Psychology* (2nd edn). London: Sage.

Sugarman.L. (2004). *Counselling and the Life Course.* London: Sage.

UNIT 3 PSYCHOTHERAPY WITH OLDER ADULTS

Structure

3.0 Introduction
3.1 Objectives
3.2 Background
3.3 Cognitive Behavioural Therapy
3.4 Cognitive Analytical Therapy
3.5 Psychodynamic Therapy
3.6 Interpersonal Therapy
3.7 Systemic (Family) Therapy
3.8 Reminiscence/ Life Review Therapy
3.9 Psychotherapy in Dementia
3.10 Therapies for Specific Problems
  3.10.1 Uncomplicated Depressive Illness
  3.10.2 Depressive Illness and Borderline or Narcissistic Personality Trait
  3.10.3 Depressive Illness in Dysfunctional Family Systems
  3.10.4 Somatisation Disorder
  3.10.5 Psychological Approaches to Dementia Care
3.11 Modification or Adaptation of Treatment
3.12 Let Us Sum Up
3.13 Unit End Questions
3.14 Suggested Readings

3.0 INTRODUCTION

Psychological therapies with older people have traditionally held a lowly position in old age psychiatry and in psychotherapy generally. This is due to a number of reasons, particularly ageism, which has been a great hindrance to development of expertise and services in this area. Negative stereotypes about the treatability of older people and a lack of psychotherapy theory that can speak to later life still have a pervasive negative effect on expectations and expertise. With the current high demand on old age psychiatry services for the assessment and treatment of early dementia, developments in services are focusing on biological models of illness and pharmacological treatments, again at the expense of psychological therapies.

The aim of this unit is to give students an overview of the psychological therapies that have been applied to work with older people, in order to inform clinical work in old age psychiatry and to encourage interest, training and referral where resources and practitioners are available.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the background and different therapeutic approaches for older adults;

- Describe psychotherapy with dementia;
- Discuss the types of therapies used with specific problems; and
- Discuss the modification and adaptation of therapies for treatment with older adults.

3.2 BACKGROUND

Ageism, or the discrimination against people on the grounds of age alone, has been slow to gain public awareness in society. Although racism, casteism and sexism, for example, have been tackled in statute law around the world, ageism is just surfacing in the collective consciousness of policy makers and clinicians. It is interesting to consider the paradox that discrimination based on a universal experience(ageing and death) has been relatively slow to achieve public awareness compared with 'isms' that oppress minority groups in society. There may be many reasons for this: the prevalence of age is among older people themselves (discouraging the formation of a 'minority group'); our need for robust denial based defenses to protect against frightening existential uncertainties (death, meaninglessness); and the notion of the demise of 'elder hood' in Western society in the 20th century.

Even at the age of 49 himself, Freud considered older people (the over-50s by his reckoning) ineducable (Freud, 1905). This therapeutic nihilism has had a profound effect on the development of both psychotherapy theory and services for older people. Psychotherapy theory has tended to focus on childhood development and the developmental stages of infant, child and early-adult life, with later life being neglected as a developmental phase.

An exception to this has been the work of Erikson (1966),who identified 'eight ages of man' in terms of dichotomies, with 'generality *v*. stagnation' and 'ego integrity *vs*. despair' describing the developmental challenges of later life. The apparent linearity of this model, however, and the lack of elaboration of the nature of psychological development in later life over the 30 years since Erikson proposed it have left old age psychotherapy detached from the mainstream and without a firm theoretical base. In addition, the dominance of the biological or organic model in old age psychiatry and neuropsychology has tended towards 'brain-based' rather than 'psyche based' explanations for all illness and distress in later life, where the imaging and charting of deficits takes priority over any meaningful dialogue about shared existential fears between professional and patient.

Despite all these problems, many psychotherapists, psychologists and psychiatrists have used various psychotherapies with older people with success and enthusiasm. Of particular note is the work of Martin (1944) and Hildebrand(e.g. Hildebrand, 1990), who can be seen as pioneers in this field. Many others, who will be mentioned in the sections below, covering individual psychotherapies, have been determined to apply and develop different theoretical approaches in their work with older people and to share their experience and positivity. In contrast to the pessimistic starting point that psychotherapy with older people is 'too late' there is hope not only that it is not too late, but that for many it can be just in time.

3.3 COGNITIVE BEHAVIOURAL THERAPY (CBT)

Cognitive Behavioural Therapy (CBT) is the form of psychotherapy most often used with older people. In controlled clinical studies it has been shown to be efficacious in the treatment of depression, anxiety and problematic behaviours in the context of dementia. In a series of studies with older people in the USA by Gallagher-Thompson and colleagues (reviewed by Teri *et al*,1994) CBT has been shown to be highly effective with depressed patients in both hospital and community settings as well as in individual and group formats. A more recent trial (Barrowclough *et al.*, 2001) of the effectiveness of CBT *v.* supportive counselling on anxiety symptoms in older adults showed CBT to be both effective and superior to supportive counselling in terms of improvement in anxiety symptoms and self rating of anxiety and depression over a 12-month period.

Cognitive behavioural therapy focuses on negative thoughts and their reinforcing behaviours, attempting to identify dysfunctional cycles and to intervene with challenges to unhelpful thinking, the reduction of negative and avoidant behaviours and the introduction of positive behaviour patterns. Negative thoughts can be challenged by techniques that assess the evidence behind the thoug ht, the 'thinking errors' that are present, the pragmatic effect of negative thoughts on overall well being and the consideration of alternative viewpoints. The intensity with which thoughts are held can be rated and monitored through treatment, and the reinforcing avoidant behaviours can be tackled using a graded exposure model. In work with older people, writers in the field suggest some adaptations to CBT technique, including increased emphasis on maintaining the focus on the work, acknowledgement of feelings of guilt and helplessness following the onset of disability and other life events and an awareness of the interaction of somatisation and the physical symptoms of organic disease. Cognitive behaviouraltherapy offers a structured, collaborative, and brief and client centered approach.

3.4 COGNITIVE ANALYTIC THERAPY

Cognitive analytic therapy (CAT) represents a modern integration of analytic (object relations theory) and cognitive psychotherapy traditions to provide a brief, structured and collaborative therapeutic journey from past trauma into reconnection with dialogue and meaning. In existence for less than 20 years, the evidence base, although in progress, is yet to be established, but there is interest in applying the model to older people because of its emphasis on shared meaning in the context of the client's life story and the importance it gives to 'dialogue', both cathartic and reparative, in the therapeutic relationship. Traditional concepts from psychoanalytic theory and psychiatry (such as narcissism, borderline personality traits and post-traumatic syndromes) have recently been applied to later life from a CAT perspective.

Later life can be a time when coping mechanisms are challenged by losses, disability and changes insocial role. It is then that pre-existing trauma and low self-esteem can resurface to produce anxiety,depression and self-destructive behaviours, which need to be understood in terms of the person's wholelife story. Cognitive analytic therapy can offer a coherent way of linking past and present, and maybe well suited to work in later life because of its emphasis on the interpersonal and the need to find shared meaning and understanding in therapy across generational and cultural boundaries.

Self Assessment Questions

1) Discuss psychotherapy in regard to older persons. Give a background of the old persons.

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2) What is Cognitive Behavioural Therapy (CBT)?

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3) Discuss cognitive analytic therapy and bring out the difference between cognitive behaviour and cognitive analytic therapies.

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3.5 PSYCHODYNAMIC THERAPY

This broad range of therapies, stemming largely from the work of Freud, Klein and Jung, has been discussed widely in relation to later life. Some empirical evidence exists to suggest that psychodynamic work with older people is at least as effective as CBT in dealing with depression (Thompson *et al,* 1987).

Psychodynamic approaches often center on the development of insight into repressed unconscious material from earlier life experience and on the working through of this material in the therapeutic relationship. Experience has shown that the client's age can be an important factor in the nature of the transference and counter transference aspects of the therapy.

Therapists may be reluctant to acknowledge the infantile needs of an elderly client because of a subconscious fear of the perceived dependence and helplessness that they might themselves experience in old age. Erotic transference may be ignored or ridiculed in the counter transference, and the client's situation may elicit in the therapist idealised care fantasies resulting from the therapist's unconscious fears and concerns about their own older family members. The psychodynamic model, however, is likely to be well suited to working with

material derived from the client's 'feelings of abandonment and despair, intimacy and isolation, arrogance and disdain, stagnation and creativity as each of us struggles with the developmental task of "the third age" '.

3.6 INTERPERSONAL THERAPY

Interpersonal therapy is a practical, focused, brief, manual-based therapy that can be applied by arrange of professionals after a period of basic training. Its accessibility has generated considerable interest in its use with older people, and a reasonable evidence base exists to support its efficacy in the treatment of depression in older people, both in the acute phase and in relapse prevention (Reynolds *et. al*, 1999).

Interpersonal therapy focuses on disturbances relationships, categorized into four domains:

i) role transition,

ii) role dispute,

iii) abnormal grief and

iv) interpersonal deficit.

A range of therapeutic interventions aim to improve communication, express affect and support renegotiated role relationships, with the result of symptom reduction and improvement in functionality. Experience in applying interpersonal therapy to work with older people has suggested that it is directly applicable to the relationship and developmental issues relevant to people in later life.

3.7 SYSTEMIC (FAMILY) THERAPY

Although the evidence base for the use of systemic approaches in work with older people is sparse, a model that looks at individuals in the context of their wider family and social system seems to have wide applicability. A systemic approach may be particularly helpful in the context of communicating and processing the diagnosis of dementia in a family setting and also in unraveling the reinforcing factors in dysfunctional somatizing and sick role behaviour in older adults. Systemic approaches can be used pragmatically both in one time therapeutic assessments andin more formal therapy sessions following an established family therapy model.

The systemic approach recognises that presenting symptoms in the patient may result from dysfunctional dynamics in the wider matrix of relationships surrounding the individual. By using techniques such as circular questioning (e.g. 'what do you think X would say to that?'), positive connotation (e.g. 'you are such a close family that sometimes you care too much'), paradoxical intervention (e.g. 'So it seems that you have solved all your difficulties and don't need our help any longer'), reframing (e.g. 'It seems as if X is flagging up the distress on behalf of the whole family') and exploration of the shared genogram (family tree),therapy may tip the system into positive change. The availability of professionals skilled in system approaches is likely to be highly beneficial as a consultative tool for those working directly with clients in old age, who are well aware of the challenging family dynamics often uncovered by mental illness in late life.

3.8 REMINISCENCE / LIFE REVIEW THERAPY

Reminiscence Therapy (RT) involves recalling the past as a way to increase self-esteem and social connection. RT typically occurs in a group format in which individuals are encouraged to remember and share memories of the past, with personal artifacts, newspapers, and/or music often used to stimulate memories. These sessions are frequently structured with the therapist picking the topic. This very popular counseling tool is regularly used with elderly to gain perspective on their lives and thus is popular in senior centers, residential settings, and retirement communities rather than as clinical intervention for those older adults with major mental health or personality disorders (Thorton and Brotchie, 1987).

Life review therapy (LRT: Butler, 1963), a more intense type of RT, involves the reworking of past conflicts in order to gain a better understanding and acceptance of the past. These types of therapies are based on the work of Erik Erikson (1966) and his eight-stage model of psychosocial development. The underlying premise is that an older adult can be helped through the last stage of Erikson's model, ego integrity versus despair. It is thought that if older adults can satisfactorily formulate and accept personalised answers to existential questions such as, 'Who am I?' and 'How did I live my life? Etc., they may be able to achieve integrity.

Self Assessment Questions

1) Define and describe psychodynamic therapy.

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2) Discuss interpersonal therapy and how is it applicable in the adults group.

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3) What is systemic (family) therapy? Elucidate

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4) Put forward the reminiscence life review therapy.

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3.9 PSYCHOTHERAPY IN DEMENTIA

An important area in need of further investigation is the application and provision of psychotherapeutic services to those with cognitive impairment. A significant minority of the elderly population experience limitations in their cognitive abilities due to progressive dementia, and many of these individuals also experience co morbid emotional distress. Owing to their cognitive deficits, such as memory loss or decreased capacity for judgment and problem solving, persons with dementia are usually not considered to be good candidates for traditional psychotherapy. However, the symptoms and behaviours of persons with dementia should not be viewed solely as manifestations of biology, but rather, as being affected by social, psychological, and environmental contexts as well. Thus, patients with dementia are able to derive some benefit from psychological interventions. Various CBT, environmental, and supportive interventions may help cognitively impaired older adults reduce disruptive behaviours and excess disabilities, increase or maintain positive behaviours, improve memory or learn coping skills to manage loss of cognitive skills, increase quality of life, reduce excessive burden on health-care delivery systems, alleviate symptoms of depression or anxiety, or help adjustment to multiple losses.

Many psychosocial interventions currently in use with older adults with dementia are based on uncontrolled case studies and anecdotal reports. However, there are some studies examining the feasibility of conducting therapy or the effectiveness of therapy for particular purposes with older adults. Use of behavioural and environmental treatments for behaviour problems and memory and cognitive retraining for some forms of late-life cognitive impairment may be effective. However, there is much dispute about cognitive training, in particular. Support groups and CBT can assist those with early-stage dementia to foster coping strategies and reduce distress. RT may provide mild to moderate stage individuals with interpersonal connections. Behavioral approaches and memory training target specific cognitive and behavioural impairments and help to optimise remaining abilities.

3.10 THERAPIES FOR SPECIFIC PROBLEMS

The choice of psychological approach will largely depend on availability of expertise, which is often sadly lacking because psychotherapies are still regarded as being unnecessary or ineffective for older people. In an ideal world, however, a range of therapies would be available, and given that some require considerably more time and resources than others, the following is a guide to deciding what might be best for whom.

3.10.1 'Uncomplicated' Depressive Illness

Cognitive–behavioural or interpersonal therapy maybe offered in the first instance with or without pharmacological treatment. Both therapies may be useful in relapse prevention in those with recurrent depression. Interpersonal therapy may take preference where obvious tensions exist in current relationships, whereas CBT may suit a more cognitively minded patient. Cognitive behavioural therapy should also be the first line approach for pronounced anxiety symptoms and panic with avoidant behaviours.

3.10.2 Depressive Illness and Borderline or Narcissistic Personality Traits

Patients with depressive illness complicated by borderline or narcissistic personality traits often have a history of traumatic experience in childhood or earlier in their adult lives and exist either in a highly dysfunctional systemic context or in relative isolation following severing of close interpersonal links. Cognitive analytic therapy or psychodynamic therapy is the treatment of choice.

3.10.3 Depressive Illness in Dysfunctional Family Systems

Depressive illness in late life is sometimes complicatedby enmeshed and 'high expressed emotion'family or systemic relationships. Systemic (family)therapy is indicated if at least some of the systemcan be engaged in it.

3.10.4 Somatisation Disorders

Cognitive behavioural therapy is probably the first line approach, but if the somatic or dissociativesymptoms can be traced to earlier trauma a moreexploratory therapy such as CAT or psychodynamictherapy may be needed.

3.10.5 Psychological Approaches to Dementia Care

Insights from psychodynamic theory and CAT can contribute to an understanding of the role-play between the care giver and the person with dementia and help prevent interaction that reinforces the isolation and alienation experienced. Behavioural approaches may be helpful for clusters of repetitive behavioural disturbances in more severe dementia. Family and systemic approaches can be useful in exploring a diagnosis of early dementia. A general approach based loosely on the principles of validation therapy (Feil, 1982), with time for reminiscence and life review, is likely to provide a humane theoretical backdrop to dementia care in many settings.

Self Assessment Questions

1) Discuss the therapies suited to the following specific problems

   a) Dementia

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   b) Uncomplicated depressive illness

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   c) Depressive illness borderline disorder

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   d) Depression in dysfunctional family system

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3.11 MODIFICATIONS OR ADAPTATIONS OF TREATMENT

There are numerous physical, psychological, cognitive, social, developmental, and environmental factors that can impact the choice and delivery of psychotherapy to older adults. Older adults have at least one chronic medical illness, some degree of functional impairment/disability, an increasing frequency of loss events, and a decrease in controllability of these losses (e.g., financial limitations, diminished sensory capacities, decreased mobility, retirement, widowhood, and change in residence). The complexity of these intermingling influences often merit special therapeutic consideration.

Although some mental health interventions are comparable with those used with younger individuals, it is often necessary to adapt therapies to address special considerations unique to older adults. For example, psychotherapy with older adults often occurs at a slower pace due to possible sensory problems and slower learning rates. This means that repetition is very important in the learning process, and information should be presented in both verbal and visual modalities (i.e., on chalk boards and hand-outs) in order to help older patients encode and retain information. Older clients should also be encouraged to take notes to help aid memory retention and thus increase efficacy of therapy. Assignments may need to be in bold print or sessions tape-recorded for review. Additionally, psychotherapy with older adults often requires a collaborative style with few clearly outlined goals and a more active or task-focused approach.

The goals of psychotherapy with older adults should be continually highlighted to reinforce the purpose and facilitate the direction of treatment. It may also be necessary to facilitate therapy for those with sensory problems, particularly hearing and vision impairments. Thus, adaptations such as pocket talkers to assist in hearing or eliminating glare for the sight impaired should be made available. Rather than giving suggestions or expecting the client to infer answers, Knight and Satre (1999) suggest that as there is a normal age decline in fluid intelligence, therapists may need to lead the older adult to conclusions.

When determining if and which modifications are needed, it is important to separate the effects of maturation from the effects of cohort. Maturational effects include similarities that are developmentally common or specific to older adulthood, such as adjusting to chronic illness and disability, or loss of friends and family due to death. Cohort effects are specific to a certain birth-year-defined group. For example, in the USA, early-born cohorts have lower educational levels and less exposure to psychological concepts. Psychotherapists working with older people need to be aware of maturational and cohort differences in the expression and treatment of psychological problems. Additionally, therapists working with older adults should learn about chronic illness and its psychosocial impact, management of chronic pain, factors influencing adherence to medical treatment, rehabilitation methods, and assessment of behavioural signs of negative medication effects.

Assessment should always include current mental and cognitive status. A brief screen of cognitive functioning, such as the Mini-Mental State Exam (MMSE; Folstein et al., 1975), can measure suitability for treatment, as well as identify

patients in need of more extensive neuropsychological testing. It is also imperative to consider the medical status of and social support available to older adults, as these may affect presentation and treatment of pathology. Formal testing, such as the MMSE, requires normative data specific to older adults in the reference group of the person being tested (e.g., education, race, gender). Without such normative data, 'normal' aging processes are impossible to distinguish from pathology or impairment.

Providing psychological services to older adults often requires flexibility in scheduling, location and collaboration. Older adults often have a greater chance of hospitalisation or reduced mobility, responsibility to care for infirm relatives, or reluctance to travel in bad weather conditions, all of which may necessitate missed therapy session. Thus, brief, occasional hospital visits, telephone sessions, or letters may need to be made at times to maintain contact.

At times, when an older adult becomes temporarily dependent upon a caregiver for assistance, it may be crucial to engage the caregiver in aspects of the treatment. An example of this is the pivotal work by Teri et al. (1997) of treating depression in older dementia patients via training caregivers in behavioural interventions. Goals of that treatment, not uncommon to other caregiver stress experiences, included setting limits and making time for personal needs. Treating the caregiver in individual or group, dyadic or brief educational sessions can be directly beneficial to the caregiver and indirectly helpful to the care recipient. If a caregiver is taught to understand and more effectively cope with emotions such as frustration and anger, they may be less distressed and better able to provide effective care.

Because many older adults have experienced increased loss of family members or friends compared with younger individuals, clinical lore suggests that the therapeutic relationship becomes a vital source of support as well as information. For this reason, it has been suggested that rather than traditional termination, ending sessions be spread out and booster sessions be offered.

A suggested acronym to help therapists working with older adults provides respectful and appropriate therapy is MICKS:

a) use Multimodal teaching,

b) maintain Interdisciplinary awareness,

c) present information more clearly,

d) develop Knowledge of aging challenges and strengths, and

e) present therapy material more slowly.

Clinical findings also suggest that many older adults hold negative stereotypes about mental health and psychotherapy, which may result in reluctance to accept or engage in therapy, limitations in self-disclosure and endorsement of symptoms. Some of these myths follow: only crazy people seek mental health treatment; psychological problems indicate moral weakness; therapy constitutes an invasion of privacy; adults, especially men do not share their feelings or show weakness to strangers; adults do not need to ask for help; and therapy has no relevance. Thus, one additional adaptation for therapy with older adults may be to have an introductory orientation/socialisation into psychotherapy. Here incorrect assumptions or fallacies can be corrected, and roles and expectations established.

It is important to remember that there is much more commonality between the young and the old than there are differences, and that older people have a huge diversity of life experience having matured in a world of unprecedented change, where wars, mass migration, and rapid technological development changed many aspects of life beyond recognition for many individuals. Psychotherapists, although benefiting from the specialised skills and approaches utilised in work with older people, need to bear in mind that what is shared with their older clients is humanity and that what is different may take some understanding.

3.12 LET US SUM UP

Psychotherapies with older people have been slow to develop, both theoretically and operationally. This is due to ageism and the predominance of models of psychological development relevant to children and younger adults. Despite this, many have applied their practice and skills to psychological work in old age psychiatry, countering the dominance of the 'organic' model. An evidence and practice base exists to suggest that cognitive behavioural therapy, interpersonal therapy, cognitive analytic therapy, psychodynamic and systemic approaches can help in a range of psychiatric problems in older people, including affective disorders, personality disorders and dementia. The inclusion of older people in existing psychotherapy services and the development of networks of practitioners whose support and supervision are encouraged are likely to be positive ways forward.

3.13 UNIT END QUESTIONS

1) Discuss the various therapeutic approaches in therapy with older persons?
2) Write about psychotherapy in dementia?
3) "It is often necessary to adapt therapies to address special considerations unique to older adults". Discuss?
4) What modifications or adaptations do we make in treatment of adults?
5) Multiple Choices Questions
    1) Ageism:
        a) is a psychological disorder
        b) creates negative stereotypes of older people
        c) is mainly found among the young
        d) is an inevitable response to ageing
    2) Psychological therapy services for older people:
        a) are widespread
        b) attract high referral rates
        c) are disconnected from general psychotherapy services
        d) is offered at all clinical settings.
    3) CBT with older people:
        a) is an effective treatment for depression
        b) is an effective treatment for dementia

c) is an effective treatment for bipolar disorder

d) focuses on childhood experiences

4) The following are focuses for interpersonal therapy with older people:

a) role transition

b) normal grief

c) reciprocal roles

d) the 'wise old man'

5) The following have been used in dementia care:

a) personal construct therapy

b) behavioural therapy

c) social role valorisation

d) Gestalt therapy

3.14 SUGGESTED READINGS

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). *Oxford Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

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UNIT 4 PSYCHOTHERAPY IN TERMINAL ILLNESSES (AIDS, CANCER)

Structure

4.0 Introduction

4.1 Objectives

4.2 Terminal Illness and Psychotherapy

4.3 Goals of Therapy with Dying Persons

4.4 Therapeutic Approaches

- 4.4.1 The Psychodynamic Approach
- 4.4.2 The Humanistic Approach
- 4.4.3 The Behavioural Approach
- 4.4.4 Family Approach

4.5 Major Therapy Issues

- 4.5.1 The Psychology of Dying Person
- 4.5.2 Weisman's Four Stages of Dying
- 4.5.3 Emotional Reactions

4.6 Specific Illnesses and Psychotherapy

- 4.6.1 Cancer
- 4.6.2 Problem Focussed Psychotherapies
- 4.6.3 Supportive Expressive Psychotherapies
- 4.6.4 Integrated Approaches to Psychotherapy in Cancer
- 4.6.5 Aids
- 4.6.6 Interpersonal Psychotherapy
- 4.6.7 Exploratory Psychodynamic Treatments

4.7 Let Us Sum Up

4.8 Unit End Questions

4.9 Suggested Readings

4.0 INTRODUCTION

In this unit we are dealing with psychotherapy in terminal illnesses such as cancer and AIDS. We start the unit with an introduction to terminal illnesses and how psychotherapy could be used in a dying person etc. We then discuss the goals of psychotherapy with dying person. Then we take up the different therapeutic approaches and discuss them in terms of their important features and how the same could be used in the cases of dying persons. We discuss under this category the psychodynamic, humanistic, behavioural and family therapy. Then we dealt with the major therapy issues related to dying person. We discuss the psychology of the dying person and follow it up with the four stages of dying put forward by Weisman. Then we take up depression, anxiety and anger and discuss these emotional reactions as part of dying and how to handle the same in therapy. This is followed by psychotherapy for specific illnesses such as cancer and AIDS. Here we present the problem focused psychotherapies, supportive expressive therapies, integrative approaches to psychotherapy and interpersonal psychotherapy etc.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe terminal illness and psychotherapy in that context;
- Describe the goals of therapy with dying persons;
- Discuss the differences between typical therapy and therapy with dying persons;
- Explain the major therapy issues and the stages of dying and therapy at different stages;
- Elucidate the various psychotherapies for specific illnesses such as cancer AIDs etc.;
- Discuss the psychology and emotional reactions of the dying persons; and
- Analyse the issues and therapy for persons with cancer and AIDS.

4.2 TERMINAL ILLNESS AND PSYCHOTHERAPY

Terminal illness is used to describe patients with advanced disease and a drastically reduced lifespan, with perhaps months or weeks to live. Inevitably the range and severity of physical symptoms will have increased, and will be having a profound effect on how the patient lives his life. General symptoms such as fatigue, pain and sleeplessness will all be taking their toll, and even patients who have coped well find the final insidious decline taxing their psychological reserve.

How well a patient copes is dependent on a number of variables, age of patient, level of education, religion, previous experience of illness, social support, personality and medical factors such as pain to name but a few. An optimal adjustment also depends on how bad news is delivered, and how the various reactions to this are managed.

In many cases, but not all, the patient will only have reached the terminal phase of the illness after a period of declining health and failed treatment. Both the patient and his family may well be aware of the possibility that the prognosis is grave, but this is different to being told that death is certain in so many months. There are also cases where the patient may present with metastatic disease, and the diagnosis and prognosis may come as an enormous shock to patient and family alike.

Psychotherapy with dying patients shares many features with all other psychotherapy. However, the unique status of the dying person presents special problems for the mental health professional. Clearly, everyone will die, and in this sense all therapy is done with patients of a limited life span. The labeling of a person as a “dying patient”, identifies that person as belonging to a special category of humanity, and creates profound changes in the emotional, social, and spiritual climate of therapy. The dying person is one who is seen to be in a life-threatening condition with relatively little remaining time with little or no hope of recovery. This unique existential position of the dying person necessitates some adaptations of the typical psychotherapeutic attitudes and strategies. The goals, structure, and process of therapy must change to meet the special needs and circumstances of the dying patient.

There are several features which distinguish therapy with a dying person from "typical therapy". They are:

First, therapy is more time-limited and time-focused.

The dimension of time takes on special urgency with the dying patient.

While many therapies are time-limited, often they proceed as if time were an inexhaustible resource.

The brief remaining time for the dying patient intensifies the therapy process, and accelerates it.

Second, the goals of therapy with dying patients are often more modest.

Recognising the limits of possible change is an essential feature of therapy with the dying.

What can be accomplished is quite restricted by time, disability, and other aspects of the patient's condition.

Third, the treatment of the dying patient often requires careful coordination with a variety of medical, nursing, and religious professionals.

The physical condition, medical treatments, and institutional settings of the patient complicate the practical and psychological context of therapy.

4.3 GOALS OF THERAPY WITH DYING PERSONS

The major goals of therapy with the dying patient can be summarized in a few simple statements.

- To allow open communication with patients regarding their conditions, and to provide honest, factual information about those conditions.
- To facilitate the expression of important emotions and to help patients learn to manage these emotions as well possible under the circumstances.
- To provide a relationship in which patients can experience support in the confrontation with death.
- To intervene between patients and other significant people such as family, friends, and medical staff.

Self Assessment Questions

1) Explain psychotherapy with dying persons.

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2) Differentiate between typical therapy and therapy with dying persons.

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3) What are the goals of therapy with dying persons?

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4.4 THERAPEUTIC APPROACHES

Prior to Elisabeth Kubler-Ross' seminal work, "On Death and Dying", very little systematic attention had been given to psychotherapy with dying patients. One important exception to this neglect was the humanistic approach described by Bowers, Jackson, Knight, and LeShan in their book, "Counseling the Dying". The prime impetus, though, was certainly Kubler-Ross, who provided an integrated theoretical and therapeutic perspective for use with the dying patient.

Following her lead, hundreds of books and articles have appeared in the last decade. Reflecting the increased maturity of the field, there are presently many therapists and researchers focusing on this population, and in addition several scholarly journals which devote some attention to the care of the dying person. Psychotherapy is beginning to be incorporated into the more general and growing field of clinical thanatology, which is concerned with the overall care and treatment of the dying person - mind, body, and spirit.

Modern psychotherapies are divided into four main groups – psychodynamic, humanistic, behavioural, and family therapy.

The main features of these therapies as used with all patients are preserved in the treatment of the dying, but each has been modified somewhat to fit the unique needs of dying persons.

4.4.1 The Psychodynamic Approach

The psychodynamic approaches are primarily concerned with the emotional conflicts and defense mechanisms of the individual. Special issues of conflict and defense arise in the dying person, and this approach addresses them in the hope of resolving the psychic crisis to the fullest extent possible. Dying is the ultimate crisis of ego development, and as such is associated with intense intra-psychic turmoil. Psychoanalyst Erik Erickson labels the last stage of ego development, "ego integrity versus despair", and identifies it with the crisis

provoked by the confrontation with one's mortality. The fear of death may precipitate a breakdown of previously integrated ego functioning, and result in an attitude of despair and disgust.

In most people the threat of death generates powerful defensive reactions, and although these defenses provide some limited relief of emotional distress, in the end they prohibit the personfrom effectively coping with the death crisis. Common defenses which are found in the dying person include denial, displacement, projection, and regression. As Kubler-Ross pointed out, denial is a very typical reaction of the dying person. The refusal to accept the reality of death makes it impossible for people to prepare themselves and their families adequately for it.

Through the displacement defense the fear of dying is channeled into other, "substitute" fears. For example, one may become preoccupied with anxiety about family members, personal business, household jobs, or other matters, and, thus, obtain partial release of one's death anxiety. The dying person's projection defense typically expresses itself in hostility and resentment toward others, e.g., doctors, nurses, and family. The person may irrationally blame others for the illness, or accuse them of not doing enough to cure or help. Regression in the dying person is often manifested in increasingly immature, dependent, and occasionally self-threatening behaviours and attitudes. An example is the extremely helpless, "infantilised" position of the person who has completely given up and merely waits for death.

A major goal of dynamic therapy with the dying is to help the person recognise, confront, and replace the defenses which run counter to an emotionally healthy attitude toward death. In the process it may be necessary to try to work through some long-standing problems and fixations which are intensified by the death crisis. For instance, a patient with a history of anxiety over separation from family members may be more distressed over the issue of loss/separation than by other death-related concerns. Dynamic therapy with dying patients is not directed as much toward the goal of insight, as it is with others. Time limits the course of therapy with the dying, and the goals are therefore more short term changes; rather than long-term personality change. The strategy of Kubler-Ross is a good model of a dynamic approach to defenses and emotional conflicts in therapy with the dying.

"On Death and Dying" provides many wonderful examples of a therapeutic approach that begins by accepting the defensive position of the patient, and then proceeds to work with the patient to overcome the self-defeating results of those defenses. Below is an example of one of Kubler-Ross' cases:

Mr. R was a successful businessman dying of Hodgkin's disease. During his stay in the hospital he behaved like a tyrant with his family and the staff. He blamed his cancer on his own "weakness" and claimed that "it was in his own hands to get up and walk out of the hospital the moment he made up his mind to eat more." His wife consulted with Dr. Ross for help in dealing with his domineering behaviour.

"We showed her - in the example of his need to blame himself for 'his weakness' - that he had to be in control of all situations and wondered if she could give him more of a feeling of being in control, at a time when he had lost control of so

much of his environment. She did that by continuing her daily visits but she telephoned him first, asking him each time for the most convenient time and duration of the visit. As soon as it was up to him to set the time and length of the visits, they became brief but pleasant encounters. Also, she stopped giving him advice as to what to eat and how often to get up, but rather rephrased it into statements kike, "I bet only you can decide when to start eating this and that". He was able to eat again, but only after all staff and relatives stopped telling him what to do".

As Mr. R. began to regain a sense of control over his environment and his activities, his anger, guilt, and tyrannical behaviour decreased, and his relationship with his family improved.

Another significant concern which has been addressed by the psychodynamic approach is countertransference, the emotional reactions of the therapist. The therapist must be particularly careful to avoid letting personal fears and conflicts over death interfere with helping the patient.

The three potential negative results of countertransference are:

1) The therapist unwittingly supports the patient's denial of death by avoiding the issue.
2) The therapist regresses to a helpless position in doing therapy with the patient.
3) The therapist engages in an anxious avoidance of the patient and his concerns.

In order to minimize the effects of the therapist's own attitudes toward death on the therapy, the therapist should explore and confront personal death attitudes before initiating treatment.

4.4.2 The Humanistic Approach

More than other approaches the humanistic view of therapy clearly integrates a philosophy of human nature in which death plays an essential role. Existentialism is a philosophy which has had a significant effect on the humanistic approach, and in this philosophy living the "good life" demand a confrontation with the reality of death. Death awareness helps us to clarify our values and purpose in life, and motivates us to live our lives with fullness and meaning. Death is the absolute existential threat, and it forces us to acknowledge the limit of our life plans and face "nothingness".

Humanistic therapy aims to help the dying patient live as full a life as possible in the face of death. Without giving false hope or optimism, the therapist attempts to mobilise the patient's will to live, to encourage the expression and growth of the self, and to facilitate the patient's self-actualisation. LeShan, an advocate of this approach, expresses his view of humanistic therapy with the dying in the following remark:

"Help is really needed in terms of how to live, not how to die."

With the dying patient humanistic therapy is more intensely focused than with others. According to LeShan psychotherapy should "move strongly" with the dying patient. An example of his approach is given in this dialogue. (Given in the box)

Patient (P): "I'm afraid of my cancer. I want to live

Therapist (T): "Why? Whose life do you want to live?"

P: "I detest it! I've never lived my own life. There was always so much to do at the moment. So much to ...I never got around to living my life."

T: "You never even were able to find out what it was."

P: "That's why I drink. It makes things look better. Not so dark."

T: "Maybe the better way would be to find out what is your way of life and start living."

P: "How could I do that?"

T: "That's what we are trying to do here."

Feigenberg describes the main features of his humanistic, "patient-centered" approach in the following way:

1) It emphasises building a strong, supportive, and empathic relationship with the client.
2) It allows the client to set the pace of the treatment.
3) It enables the client to actively and positively participate in the process of dying.

4.4.3 The Behavioural Approach

The behavioural approach to therapy relies on educating patients about more adequate coping skills to help deal better with the death crisis. Impending death is a terribly stressful situation, and it produces extreme emotional reactions like anxiety and depression, which inhibit patients from living out the remainder of their lives in a satisfactory way. The symptoms of the dying patient are partially manageable through some standard behavioural techniques. For example, relaxation training and desensitisation can help to alleviate excessive fear and tension. Other self-management skills, like biofeedback and self-hypnosis, are also useful in controlling the distressing emotions of the patient.

One example of a valuable behaviour therapy technique is "stress inoculation training". With the dying patient this strategy may be used to help cope with the physical and emotional aspects of pain. In this approach the patient is taught how to employ cognitive and behavioural skills in preparing for pain and managing pain. Some of the "self-statements" learned in this technique for pain control are shown below. (In the box)

Preparing for Pain: "What is it I have to do?" "I can develop a plan to handle it." "Just think about what I have to do."

Confronting and Managing Pain: "I can meet the challenge." "Just handle it one step at a time." "Just relax, breathe deeply."

Self-Reinforcing Statements: "Good, I did it." "I handled that pretty well." "I knew I could get through it."

A basic goal of behaviour therapy is to provide some Coping skills so that the patient can reduce discomfort and gain a measure of control over life. The loss of control over one's body, one's actions, and one's future which is experienced by the dying patient can lead to emotional distress and to feelings of helplessness and passivity. The acquisition of productive coping skills will not only enable

the patient to manage negative feelings better, but can also improve self-esteem by providing a sense of competence and self-efficacy.

The behavioural approach to therapy tends to focus on specific and concrete symptoms. It does not directly attend to the developmental and personality issues which are so important in dynamic or humanistic approaches. The goal of the therapy is primarily to relieve negative emotions and to enable the patient to cope more effectively in the remaining time.

4.4.4 Family Approach

The impending death of a family member places the entire family in a state of crisis. Death presents a threatening situation for each member of the dying person's family. The degree of disturbance in the family depends on many factors such as the role of the dying member, the stage of development of the family, and the quality of relationships among family members. A family systems approach conceives of the entire family, not just the dying person, as the recipient of therapy. This approach seeks to provide the family unit the opportunity to learn to deal with the tragedy. Some therapists will continue treatment beyond the death, offering grief counseling for the survivors.

Though family therapy may be integrated into therapies of various types, there are several issues on which family therapists are more likely to focus. Dying patients often experience a need to feel the closeness and support of their families in facing the death crisis. In families where past conflicts have interfered with relationships between the patient and others, family therapy can facilitate more open and productive communication. This can benefit all members concerned in terms of finding closure for "unfinished business". The defenses of family members can make it very difficult for the dying patient to confront death. It often happens that family members share the defensive reactions of the dying person, such as denial of the facts and displaced anger.

An advantage of the family approach to therapy is that it offers an experience that may enable everyone to accept the facts and to work together to enhance the quality of life for the dying person. Families generally experience a range of intense emotions regarding the dying patient, including anger, guilt, fear, and depression. In family therapy members are encouraged to understand and express these feelings in anticipation of the death of their loved one.

As she was in many other areas, Kubler-Ross was a pioneer in involving families in the therapeutic process with the dying. The case below, from Kubler-Ross, illustrates some common emotional dynamics in families with a terminally ill member.

"I am reminded of an old woman who had been hospitalised for several weeks and required extensive and expensive nursing care in a private hospital...

Her daughter was torn between sending her to a nursing home or keeping her in the hospital, where she apparently wanted to stay. Her son-in-law was angry at her for having used up their life savings... When I visited the old woman she looked frightened and weary. I asked her simply what she was so afraid of ... She was afraid of 'being eaten up alive by the worms'. While I was catching my breath and tried to understand the real meaning of this statement, her daughter

blurted out, 'If that's what's keeping you from dying, we can burn you' by which she naturally meant that a cremation would prevent her from having any contact with earthworms. All her suppressed anger was in this statement."

Kubler-Ross encouraged the mother and daughter to communicate honestly for the first time about their individual concerns, and they were able to console each other and make arrangements for the mother's cremation. The mother died the next day.

Self Assessment Questions

1) Describe psychodynamic approach with dying persons.

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2) What is humanistic approach? How is used in dying persons?

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3) Describe the behavioural approach with dying persons.

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4) How do we help persons dying with family approach?

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4.5 MAJOR THERAPY ISSUES

4.5.1 The Psychology of Dying Person

The best known theory of the dying process is that of Kubler-Ross, who proposes that many dying people progress through five stages of dying, described below:

Stage 1: **Denial:** Initially the reaction is "No! Not me!" Though the denial is rarely complete, most people respond with disbelief in the seriousness of their illness.

Stage 2: **Anger:** In this stage the dying person expresses anger, resentment, and hostility at the "injustice" of dying, and often projects these attitudes onto others.

Stage 3: **Bargaining:** The dying person tries to "make deals" to prolong life, e.g., making promises to God.

Stage 4: **Depression**: Here the individual may become overwhelmed with feelings of loss, hopelessness, shame and guilt, and may experience "preparatory grief".

Stage 5: **Acceptance**: In the final stage one comes to terms with death, not necessarily happily, but with a feeling of readiness to meet it.

Some researchers have questioned the generality of Kubler-Ross' five stages, pointing out that they do not necessarily apply to all dying people and that the therapeutic implications of the theory are not necessarily appropriate for everyone.

An alternate view of the "trajectory" of the dying person is offered by the psychiatrist, Avery Weisman. He believes that Kubler-Ross' theory describes some common reactions to loss, rather than general stages of dying. Weisman proposes four very flexible stages:

4.5.2 Weisman's Four Stages of Dying

1) **Existential Plight:** The dying person experiences an extreme emotional shock at the awareness of his/her own mortality.

2) **Mitigation and Accommodation:** The individual attempts to resume a "normal" life after first learning of the terminal nature of the illness.

3) **Decline and Deterioration:** When illness and its treatment begin to take full control over one's life and normal living is no longer possible, this stage begins.

4) **Pre-Terminality and Terminality:** This final stage refers to the very end of life, when treatment is no longer helpful and the "death watch" begins.

Whether they accept stage theories or not, most researchers and practitioners recognise that there are many common features in the emotional reactions of dying people. The core emotions on which therapies focus include depression, anxiety, and anger.

4.5.3 Emotional Reactions

1) **Depression:** Depression is perhaps the most typical response of the dying person. Although they are not inevitable, feelings of hopelessness and powerlessness pervade the experience of most dying people. The physical impairments that result from terminal illnesses and the restrictions on hospitalised patients only add to these feelings. The mental and physical condition of the dying person fosters a sense of alienation and withdrawal.

   Patients may slowly become estranged from family and friends, and they begin to disengage from "normal" living at the point where death is the prognosis. Depression is also associated with the loss of control over life events experienced by the patient. As death nears it is easier to slip into a state of passive resignation and despair. The potential of suicide is also a matter of great concern. The demoralisation, hopelessness, and physical pain of the dying patient contribute to a greater risk for suicidal action. The relatively high rates of suicide among the elderly may reflect depression in this group because of the infirmities of old age.

2) **Anxiety:** For most people the thought of death provokes anxiety. In facing death people typically experience a wide range of anxieties and related emotions like fear, dread, and panic. An analysis of the anxiety of the dying person identifies several central concerns. Surely, everyone confronts death in a unique way dependent on one's individual needs, personality, culture, and social situation, but the majority of dying persons experience intense feelings of anxiety and associated emotional stress. Some of the common elements of this anxiety are described below:

   The physical condition of the patient is certainly an obvious and significant source of anxiety. Pain, suffering, and the physical debilitation of the terminally ill person contribute significantly to insecurity, stress and anxiety. In addition terminally ill patients whose medical treatments are painful or aversive, e.g., chemotherapy for cancer victims, may develop conditioned anxiety reactions to the treatment setting and anticipatory anxiety regarding further treatments. Anxiety and shame can also result from the physical changes which occur in the dying person. The patient who insists "I don't want anyone to see me like this!" may be expressing a fear of rejection by others because of unacceptable bodily alterations from the illness.

   The social dimension of anxiety is also an important issue with the dying. Many worry about the effects of their illnesses on family members and friends. For people whose social roles are critical to the well-being of others,this anxietymay be as pronounced as self-concern. For instance, a single mother with two young children is quite likely to experience great fear for the future and safety of her children. Another aspect of social anxiety in the dying - involves the fear of loss and disruption of relationships. As suggested above social anxieties may be due to anticipated rejection because of physical revulsion, or to other factors, e.g., the fear of not being needed or wanted by others.

   The spiritual and existential aspects of death anxiety are also part of the psychology of dying. Questions about the meaning of one's life and the possibilities of life after death are common concerns of the dying person. It

is not unusual for people to show sudden increases in religious feelings when facing the prospect of personal annihilation. In dealing effectively with these concerns psychotherapists do well to cooperate with the priests or clergy and pastoral counselors, who are proficient in helping people through religious crises.

3) **Anger:** In Kubler-Ross' model anger is an essential stage of dying. The disorganisation of and threat to life felt by the dying person generates frustration, resentment, and hostility. These emotions can easily be turned against others or turned in on the self. Family members, friends, hospital staff, and therapists are likely to bear the brunt of this anger. The reactions of the recipients of anger may include withdrawal, anxiety, defensiveness, and anger in return. This will only complicate an already tension-filled situation. When the patient's anger is internalised, it leads to self-recrimination, self-blame, guilt, and lower self-esteem. As many psychologists have pointed out, anger turned on the self often fuels depression. The anger of the dying person is not always focused on others or the self, but is for many a diffuse, untargeted feeling. The pain, injustice and absurdity of dying cannot always be blamed on anyone or anything but the human condition, and that cannot be changed.

A case reported by Kubler-Ross illustrates some of the common features of a patient's anger.

Bob, a 21 year old cancer victim, was troublesome with the staff and other patients. His intense hostility prompted Kubler-Ross' consultation with him. On seeing his collection of "Get Well" cards she asked him, "Bob, doesn't that make you mad? You lie on your back in this room for six weeks staring at this wall with these pink, green, and blue get well cards?"

"He turned around abruptly, pouring out his rage, anger, envy, directly at all the people who could be outside enjoying the sunshine, going shopping, and picking a fancy get-well-soon card. And then he continued to talk about his mother who spends the night here on the couch.

Big deal! Big sacrifice! Every morning when she leaves, she makes the same statements - "I better get home now, I have to take a shower!" 'And he went on, looking at me, most full of hate, saying, 'and you too, doctor, you are no good! You, too, are going to walk out of here again.'

What counsel and advice can be offered to the dying person who experiences these intense emotions, and the many associated problems accompanying them? Often, the answer depends on the theoretical orientation of the therapist. As discussed earlier, different theories recommend different strategies for treating emotional distress. Behavioral therapies can assist the patient to take some control over these feelings through techniques like desensitisation, stress management, and relaxation training. Even a small measure of control can improve the condition of the patient. Humanistic therapists seek to help the patient confront death in as active and positive a way as possible, relying on an exploration of the individual's values, goals and self understanding. Dynamic therapy attends to the defensive reactions of the patient, and attempts to overcome self defeating defenses in order to help the patient through the dying process.

Despite considerable diversity in theory, the practical demands on counselors of the dying have led to some common concerns. As a rule therapists working with dying people take an "eclectic" approach. That is they choose from various theories those ideas which are most applicable to the individual needs of their patients.

If there is one fundamental principle of therapy with the dying person, it is to facilitate communication about the person's needs. A primary task of therapists is to assist patients in meeting their individual needs in their remaining time. Of course, each one has different needs, depending on life history, personality, and many other factors, but there are some common needs shared by most dying people. These needs include, but are not necessarily limited to, security, affection, support, dignity, and self-expression.

Self Assessment Questions

1) What are the five stages of dying?

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2) What are the four stages of dying according to Weisman?

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3) Describe the three emotional reactions to dying.

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4.6 SPECIFIC ILLNESSES AND PSYCHOTHERAPY

In considering the treatment context of the dying person one factor of fundamental importance is the specific disease from which the patient suffers. Specific terminal illnesses create unique medical, psychological, and social problems for patients. Though there are obviously many diseases which kill people, only a few have

received special attention by those working with the dying. Two diseases and their implications for psychotherapy will be discussed here: cancer and AIDS.

4.6.1 Cancer

Therapists have attended to cancer victims more than any other terminally ill group. Some of the features of terminal cancer which set it apart from other illnesses are its prolonged course, periods of remission, and its stigma. Because cancer may be a progressively debilitating disease, the cancer victim can anticipate a long and often painful struggle, associated with aversive medical treatments. For many cancer patients the disease involves a rollercoaster ride from remission to relapse, which is enormously stressful.

i) **Cancer-Related Psychosocial Morbidity**

Faulkner and Maguire (1994) have suggested that psychosocial adjustment to cancer is associated with six hurdles: (1) managing uncertainty about the future; (2) searching for meaning; (3) dealing with a loss of control; (4) having a need for openness; (5) needs for emotional support; and (6) needs for medical support. They suggest that a failure to deal with these results in psychosocial problems. Increasing medical advances have meant that people with cancer are now tending to live longer than used to the case, a factor that means that cancer is increasingly being conceptualised as a chronic illness. Patients who are told that they havecancer experience distress, but some have a normal adjustment reaction with limited distress that does not cause lasting psychological problems. Others experience psychological problems that significantly interfere with their quality of life; some of these will develop symptoms of an adjustment disorder, major depressive disorder, or an anxiety disorder.

ii) **Cancer Treatment**

Cancer treatment is also associated with a number of psychosocial concerns, some of which comprise quality of life and contribute to anxiety or depression. Nonphysical treatment side-effects such as anger, anxiety, or apprehension are often rated by patients as being more severe than physical side-effects such as nausea or hair loss. Indeed, some patients drop out of chemotherapy because of psychological problems.

Some treatment procedures (e.g., bone marrow transplantation) result in psychological problems because of the particular demands that accompany them. Many patients have to face treatment regimens that are difficult to tolerate, may involve behavioural demands such as frequent hospital visits and levels of motivation that may be difficult to generate or sustain.

Advances in drug therapies have resulted in a reduction in the incidence of nausea and vomiting associated with chemotherapy. However, conditioned nausea and vomiting do still occur and aversions to food can also develop. Even after the end of treatment, patients' lives may be affected throughout the follow up period, as they attend appointments to determine whether the cancer has returned.

Some psychological problems are more commonly experienced at particular times during the patient's 'cancer journey': at diagnosis, during the early months of treatment, at the end of treatment, at the discovery that the cancer has spread, or at recurrence. Some patients find that they notice persistent negative psychological

consequences only at the end of treatment. Most, however, do not experience any lasting negative psychological consequences. Others develop an increased vulnerability to future psychosocial problems as a result of the impact of an episode of cancer and cancer treatments. Some become more avoidant in their thinking about illness, having greater illness concerns and diminished capacity to work.

4.6.2 Problem-Focused Psychotherapies

Psychoeducational and cognitive-behavioural interventions are the most commonly problem-focused therapies for cancer patients. Psychoeducational interventions are typically of short duration and concentrate on didactic teaching of skills and strategies. This is in contrast to cognitive behaviourally based therapies that include instruction in specific skills and strategies but that are based on a cognitive and behavioural conceptualisation of the individual patient.

These therapies typically seek to help patients reduce their emotional distress by fostering control and regulating affective responses via the application of behavioural strategies (e.g., activity scheduling) or cognitive strategies that address distortion in thinking and/or enable people to test and develop more helpful alternatives to their dysfunctional ideas.

4.6.3 Supportive Expressive Psychotherapies

Supportive-expressive therapy has been traditionally delivered in a group and in the context of research activity that has sought to evaluate the impact of participation in such groups on survival. One of the major goals of this modality is to enable individuals to express all emotions (negative and positive). Based on the premise that most people tend to avoid the fear and anxiety associated with the possibility of death, supportive expressive therapy enables someone to express and tolerate the affect associated with thoughts of death and dying. This has been referred to as 'detoxifying death'. It has been suggested that therapy with this focus may be more appropriate for patients with advanced cancer.

4.6.4 Integrative Approaches to Psychotherapy in Cancer

Kissane et al. (1997) have integrated elements of cognitive, supportive, and existential therapies in group therapy, including elements of Spiegel's work (i.e., the development of a supportive network and addressing issues of death) with an existential focus on the management of uncertainty and awareness of one's own mortality.

Supportive expressive work shares some similarities with other modalities. The 'detoxification' of death, for example, enables patients to express their feelings about death. It can also, from a cognitive perspective, provide patients with evidence about the impact and consequences of the expression of emotion. In practice, most clinicians tailor therapy to the individual, taking account of the presenting problems, and emphasise particular educational, supportive, expressive, or existential elements.

In conclusion, therapists working with cancer patients will focus on the cycle of optimism and despair which accompanies changes in the symptoms of the disease. In addition there are stress and pain management techniques that are helpful in enabling patients to get through the more noxious periods of medical treatment,

e.g., chemotherapy. Behavioral therapy techniques such as desensitisation and relaxation training have been useful to help cancer patients learn to control the anticipatory stress and nausea related to chemotherapy.

Self Assessment Questions

1) Name the six hurdles which are associated with psychosocial adjustment to cancer?

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2) What are three potential negative results of countertransference in therapy with a dying person?

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4.6.5 Aids

The past few years have seen an enormous amount of interest in AIDS (acquired immune deficiency syndrome). Some predictions indicate that AIDS will reach epidemic proportions in the next 20 years. For now though mental health professionals have begun to examine the specific therapeutic needs of AIDS victims. As great as the stigma of cancer may be, it pales in comparison with the stigma of AIDS. Several reasons for this stigmatisation are apparent. It is primarily transmitted through intimate sexual contact and sharing of needles by intravenous drug users. The prevalence of AIDS in homosexuals, prostitutes, and drug abusers gives it an association with "deviant" sexuality and antisocial behaviour.

Aside from its association with groups who are negatively perceived, the disease is typically fatal, thus allowing little or no hope for recovery on the part of victims. For now at least, a diagnosis of AIDS is equivalent to a death sentence, and the fear generated by this disease among the public has often been turned against its victims and those in high AIDS-risk groups.

Where most other terminally ill patients are pitied, AIDS victims are often shunned, rejected, and met with open hostility, even by those family members and friends who are most needed by the patient.

Psychotherapy with people with AIDS who are at the end stage of their illness generally occurs in one of two clinical situations. The first is where the individual has been in some form of on-going counselling prior to entering the final phase of life. In the other case, a client seeks out a mental health professional as a direct result of being diagnosed as HIV positive or as a result of having deteriorated

due to wasting or an opportunistic infection. AIDS has challenged psychologists in private practice as well as those who are employed in hospitals, nursing homes, hospices, community based AIDS organisation, and other home health care agencies to become prepared for working with people who are dying and their loved ones.

As people develop symptoms of advanced AIDS they increasingly lose control over their bodies and lives. One task of counselling is to help people living with HIV and AIDS recognise what they can control. An individual's physical and mental deterioration has an impact on his/herself as well as the people he or she lives with. Family therapy can be a valuable tool to help family members adjust to the changes that the progression of a loved one's illness has on the family structure and dynamics.

Clients living with a progressive disease like HIV/AIDS require help in planning for hospitalisations and debilitating illnesses. It is best for the clinician to raise the difficult and painful issues such as hospitalisation, care of dependent children, living will, medical proxy and issues to be taken care of after their death etc., long before there is any apparent need for them. The rationale for this is that when the client is still well he or she is more likely to have the necessary physical and psychic energy to plan for the ensuing difficult realities.

Therapists need to question and often challenge clients' unwillingness to discuss concrete plans or desires for a living will or treatment options. It is helpful to stress to the clients that by addressing these issues now they can insure that they will have a measure of control over what happens to them later. Obviously this has the potential to confront a client's denial, and thus the clinician must be prepared to be the target of the client's anger in response to initiating such necessary queries.

Negative core beliefs about the 'self' such as an HIV-positive patient's conception of himself as defective and unlovable can usefully be targets of cognitive approaches to case conceptualisation and treatment. The labeling of inaccurate inferences or distortions may help the patient become aware of the unreasonableness of such automatic patterns of thought.

Cognitive probes and questioning may be used to elicit automatic thoughts. Such automatic thoughts can then be tested with the therapist who carefully attends to the possibility of exaggeration and catastrophizing. Relaxation techniques can also be useful with patients who are anxiously worried about the impact of their diagnosis on various aspects of their lives.

4.6.6 Interpersonal Psychotherapy

Interpersonal psychotherapy has been shown to have particular advantages for HIV patients (Markowitz et al., 1998). Interpersonal therapy relates mood changes to environmental events and resultant changes in social roles. For example, the interpersonal therapist defines depression as a medical illness and then assigns the patient both the diagnosis and the sick role. She then engages the patient on affectively laden current life issues, and frames the patient's difficulties within an interpersonal problem area: grief, role dispute, role transition, or interpersonal deficits. Strategies then address these problem areas, focusing in the present on what the patients want and what options exist to achieve this.

4.6.7 Exploratory Psychodynamic Treatments

These treatments including psychoanalysis may be usefully employed with the HIV positive patient grappling with these issues. In patients with AIDS, evaluation and treatment should focus on helping patients receive life-enhancing medical care, resolving troubling psychological issues and making the best use of whatever time is left.

4.7 LET US SUM UP

Psychotherapy basically offers the dying person much the same that it offers anyone – a supportive relationship in which the individual has opportunities to work on significant personal concerns. The unique life situation of the dying person places limits on the process of therapy and demands greater modesty on the part of therapists regarding possible outcomes. Regardless of theoretical orientations therapists working with dying patients rely first and foremost on communication. Therapy is best used as a forum for exchanging information, educating, expressing fears, and discussing needs.

4.8 UNIT END QUESTIONS

1) Discuss in detail how the major therapeutic approaches have been modified to the unique needs of dying persons?
2) Discuss the psychology of the dying person?
3) Describe the core emotional reactions of a dying person?
4) Write about the psychosocial morbidity related to cancer? Discuss the therapy approaches with cancer patients?
5) Write about the issues and therapy with persons with AIDS?

4.9 SUGGESTED READINGS

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