Aging, with grace

With the world’s population living longer than ever before, psychologists are facing new challenges and opportunities. Here’s an overview of the key trends.

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Overview
CE credits: 1
Exam items: 10
Learning objectives:
1. Identify how the significant change in demographics affecting the United States is similarly affecting the world.
2. Discuss the relationship between life satisfaction, depression and old age.

The news is good: We are all living longer, and in better health, than any other time in history. With the growth in longevity especially affecting the oldest-old section of society, more than ever before psychologists will come in contact with older people who need psychological help.

But this good news comes with challenges: The aging trend will have far-reaching societal consequences. Psychologists are now more likely to work with more patients who develop dementia or those who care for them. Meanwhile, the baby boomer generation’s sophisticated understanding of health care may lead its members to expect better access to evidence-based psychological treatments.

To meet these challenges, mental health professionals...
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with the first of the baby boomers turning 65 this year (Wan, Segupta, Velkoff & DeLarrazo, 2005). Thus, psychotherapists are increasingly likely to come into contact with older people and geropsychology is likely to be a growth area for psychologists (Koder & Helmes, 2008). Since the psychological and physical health needs of a 65-year-old are markedly different from those of a 95-year-old (Wan et al., 2005), we must consider the potentially powerful implications of failing to train sufficient health-care professionals to work with older people (Knight, Karel, Hinrichsen, Qualls & Duffy, 2009).

Globally, the fastest growth in population is the “oldest old,” people age 80 and over. Projections call for a near quadruple increase, from 102 million in 2009 to 395 million in 2050 (UN, 2010). In 2009, there were 12 million older people age 80 and older in the United States. However, by 2050, that number will nearly triple to 32 million (UN, 2010). In the United States, the numbers of centenarians is expected to increase nine-fold, from 455,000 in 2009 to 4.1 million in 2050 (UN, 2010). While we may make distinctions — and assumptions — about adults who fall into young-old and old-old categories, older adults are a heterogeneous group and likely to be becoming even more so as longevity increases. Sadavoy (2009) notes that taking account of complexity, chronicity, co-morbidity, continuity and context may make it more difficult to know what is going on with older people.

Although there could be a difference of many generations between therapist and client, chronological age by itself is less relevant to the psychologist than understanding a person’s social-cultural and to biological circumstances. As a result, it’s important for psychotherapists to understand the gerontological theories of aging, rather than age per se (Knight et al., 2009). Longevity may be determined by genetics and heritability, but we ignore at our peril the effects that lifestyle choices, chronic illness and life events have on people’s physical and mental health and ultimate longevity (Kirkwood, 2002).

Psychologists should also be aware that aging is a gender issue. Women outnumber men at every age (Kinsella & Wan, 2008). Their longer lives mean they may face more of aging’s challenges, such as chronic illness and loss of spouses, than older men. Women are consequently more likely to be living alone, with 70 percent of men age 75-plus married, compared with only 20 percent of women age 75-plus (Kinsella & Wan, 2008). This is likely to affect the sorts of mutually supportive networks that the genders develop (Atrash, Blanchard-Fields, & Gray, 2009). As a result, psychotherapists who work with older people need to recognize that aging affects the sexes differently. Moreover, with life expectancy increasing and with multigeneration families becoming more multifaceted, we may need to consider a stronger role for family systems work (Qualls, 1999).

Overcoming aging stereotypes

To meet the needs of aging clients, psychologists will need to become knowledgeable about longevity statistics and demographic change (Knight et al., 2009). One valuable resource for practitioners is the practice guidelines developed by the APA Working Group on the Older Adult in 1998. These guidelines can help mental health professionals identify and challenge many erroneous age-related negative cognitions — for example, that growing older is depressing (Laidlaw et al., 2003). Some people find that the transitions that come with aging, such as retirement, are unwelcome and difficult and that many people do not recognize themselves as members of the “older” population and may reject this definition. Levy (2003) suggests that agent oriented attitudes are internalized from a very young age and negative age-stereotypes are reinforced by attention bias to negative information about aging. Aging stereotypes operate outside of awareness, leading to false and maladaptive schematic operata in depression. In addition, the losses associated with aging — such as bereavement or the development of a chronic illness — may activate negative age stereotypes, thereby generating an unhealthy self-fueling fallacy of prophecies that may be harmful to the individual (Levy, 2009). As a result, the older client may mistakenly attribute the cause of his or her problems to aging rather than depression and may become hopeless about the possibility for change. Unless psychotherapists are able to recognize that these beliefs are cognitive errors associated with the negative age stereotype, progress in treatment may be impeded.

Depression and anxiety are major causes of mental health problems in later life. However, while depression rates may increase with age, rates of depression and anxiety in later life are lower than rates reported for working-age adults (Blazer & Hybels, 2005). Echoing this finding, Sadavoy (2009) found that depression is surprisingly uncommon among older people considering the challenges some face as they age. The Centers for Disease Control and Prevention (2008) note that, contrary to popular belief, older people do not report experiencing frequent mental distress. In addition, their lifetime histories of depression and anxiety are low (10.5 percent and 7.6 percent, respectively) and lower than those reported for adults age 50 to 64 years (19.3 percent and 12.7 percent respectively).

Of course, medical conditions increase people’s chances of being depressed later in life, with a greater burden of illness resulting in an increased risk of depression (Alenpoulos, 2005). The good news is that most older adults who develop physical problems do not develop depression (Blazer & Hybels, 2005). Nevertheless, the presence of chronic health problems and more than one chronic health problem and up to 50 percent have two (Wan et al., 2000). The presence of demographic changes may be confronted with more medical issues with a complexity and chronicity attached to them that is rarely seen currently. Older people are also more likely to die because of non- communicable diseases, such as cancer, heart disease and stroke, rather than injury or infection. Thus, older people may be more likely to have lived with a number of chronic diseases for many years before their eventual demise. This is another complicating factor for the therapist who may need to reconcile with new or existing models of psychotherapy.

A model for optimal aging

Selective optimization with compensation (SOC) is a useful model (or meta-theory) that promotes optimal aging in the face of realistic challenges (Freund and Baltes, 1998). Research suggests that SOC, a life management strategy may buffer people against aging’s effects in later life (Jopp and Smith, 2009). In this model, selection (usually “loss-based selection”) and optimization (compensation) (Baltes, 1997, p. 371). He attributed his enduring level of prowess to restricting on achieving goals through practicing or relearning activities. It must be done in an intentional manner. Compensation requires that people seek other ways of achieving the highest possible level of functioning, thereby taking account of the reality of a person’s capacity and physical integrity.

Baltes (1997) illustrates SOC in action when he cites the example of the acclaimed pianist Arthur Rubinstein, who at age 80 was interviewed about his skill. (Rubinstein retired from performing at age 89 due to deteriorating eyesight.) He attributed his enduring level of prowess to restricting his repertoire (selection), which allowed him to practice more frequently (optimization) and, “He suggested that to counteract his loss in mechanical speed, he now used a kind of impression management, such as introducing slower play before fast segments, so as to make the latter appear faster” (compensation) (Baltes, 1997, p. 371).

SOC can be incorporated into psychotherapy, especially cognitive behavioral therapy (CBT), since its active self-directed, problem-solving orientation fits well with an aim of symptom reduction, enhanced resilience and positive affect.

The importance of support networks

Social capital is the amount of emotional and practical support one can draw upon from families and friends — and viewed in this way, social support is an outcome of social capital (Gray, 2009). Consistent with an emotional selectivity theory, which suggests that emotional regulation and emotional investment in close relationships become more important as people age (Carstensen, Isaacowitz, & Charles, 1999), people’s social support networks may become smaller in size and diversity as they age. This may be intentional as familial and other emotionally nurturing relationships are preferentially selected (Carstensen, 2006).

As a result, when psychologists work with depressed or anxious older people, it may be important to assess whether their accessible social capital has diminished. In addition, as a result of people’s increased longevity, psychologists should examine whether older couples’ relationships have become strained after retirement as they face more years together. For many couples, retirement can require a period of adjustment and many couples may find this time as a process rather than a state (Kim & Moen, 2002). Women appear to find the adjustment more difficult as retirees and as partners (van Solinge & Henken, 2005). Further complicating relationships for older people is the fact that families are becoming smaller and divorce rates, family break-ups and reunifications are increasing, all of which affect the potential pool of informal caregivers (Ajoyoth et al., 2005). When working with couples, the therapist is wise to remember that quantity is not equivalent to quality when it comes to relationships, and an emotional relationship does not mean that the partnership is successful.

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boomers) are likely to endorse radically different attitudes compared with previous elderly cohorts (Gilleard & Higgins, 2007). For example, while longevity may bring more loss for many people, aging overall will be a positive and happy time (Laidlaw, Power, Schmidt, & the WHOQOL Group, 2007). Living longer may mean experiencing more leisure time after retirement with unanticipated interpersonal and sociocultural consequences. If one is retired and in reasonably good health, without work or other commitments, then all aspects of life may be open to reappraisal in terms of the personal fit (Gilleard & Higgins, 2007). Thus, psychotherapy for this phase of life may afford a transitional period of reflection that helps an individual introspectively reappraise his or her lifestyle choices.

**Treatments that work**

Empirical evidence suggests that psychotherapy with older people, particularly CBT, is efficacious (Wilson, Mottram & Vassilas, 2008). Research has tended to evaluate outcomes of manualized nonmodified therapies using treatment models largely without considering life-span developmental theories of aging (Laidlaw & Alpin, 2008). Nonetheless, a persistent question remains regarding the adaptation and modification of CBT with older people (Laidlaw & McAlpine, 2008). Modifications to CBT with older people should be based upon good conceptual and scientific reasons and should only be considered to enhance an already efficacious treatment. Unfortunately, many recommendations appear to be no more than banal procedural recommendations that ultimately have little evidence for their necessity and efficacy (Laidlaw & McAlpine, 2008).

The need to consider whether modifications are necessary to enhance outcome may arise because it will become increasingly common for mental health professionals to have nonagenarian (age 90 to 99) and centenarian clients. This is largely uncharted territory with respect to both biological and nonbiological interventions to lessen psychological distress in later life, and certainly to the application of existing psychotherapy treatment models. Ultimately, current therapy models need to heed demographic changes to maximize therapeutic outcomes. Augmenting CBT outcomes with gerontological theory may offer rich possibilities. For example, wisdom is a commonly held positive attribute associated with aging and its enhancement may prove to be a legitimate goal of CBT when dealing with older people. CBT with older people may be at greater risk of developing negative attributions about aging than generalist psychologists. Since for most older people, aging is a positive experience and a satisfactory life stage (Laidlaw et al., 2007), there seems to be a mismatch between older adults’ reality and the attitudes of specialists who work with them. These specialists may be focused on the minority whose experience of aging is bound up with distress and loss and become biased by that. In summary, depression, anxiety and suicide are more common in the professional experience of the clinician than in the population at large (Knight, 2004). In the main, older people report high levels of life satisfaction, are better at emotional regulation (Urry & Gross, 2010) and report better emotional well-being and emotional stability than younger adults (Carstensen et al., 2011).

Thus, we need more research into cognitive and affective aspects of aging to improve the psychological treatments aging clients receive and at the same time educate our clinicians about what to expect when they work with older people.

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**Dementia is not an outcome of age**

Although it is often viewed as a subject of fear and concern, dementia is not an inevitable outcome of old age. As a result of demographic change, the relative number of people diagnosed with dementia will increase, but the relative proportion of the population of older people who develop dementia will not. Increased demand for psychological support for those with dementia and for caregivers is likely. In particular, psychosocial interventions may need to be developed specifically for people with depression and anxiety in dementia, since the presence of those two mental health challenges increases an individual’s disease burden.

Although an apparently vast literature has developed with respect to interventions for people with dementia, the amount of empirically validated and theoretically supported evidence is smaller than one might expect (NICE 2007). When Gallagher-Thompson and Coon (2007) reviewed evidence for caregiver interventions, they found only three categories of evidence-based treatments for caregiver distress to be efficacious: multicomponent programs, psychotherapy and symptom-focused skills-enhancing psychoeducation interventions. Individualized CBT caregiver interventions are most efficacious for caregivers who have significant levels of depression, and group-based CBT interventions are most efficacious for caregivers exhibiting high levels of stress but without overt symptoms of depression.

**Summary and implications**

Psychologists are likely to face more complex workloads as the population ages. If people live 20 or 30 years after retirement, it is entirely possible that many older people will seek psychotherapy to maintain their personal growth or to grapple with the challenges of aging. A U.S. survey of clinical psychologists found that most have worked with older people even though a minority had received supervised practice in working with this population (Qualls, Segal, Norman, Neiderer, & Gallagher-Thompson, 2002). Thus, training and education is fundamentally important in order to prepare practitioners to meet the needs of older people (Knight et al., 2009). Yet, to date few psychologists actually choose to specialize in working with older adults. This may be due to a fear of aging among psychologists themselves.

Paradoxically, when Koder and Helmes (2008) investigated this finding, they found that specialist psychologists who work with older people may be at greater risk of developing negative attributions about aging than generalist psychologists. Since for most older people, aging is a positive experience and a satisfactory life stage (Laidlaw et al., 2007), there seems to be a mismatch between older adults’ reality and the attitudes of specialists who work with them. These specialists may be focused on the minority whose experience of aging is bound up with distress and loss and become biased by that. In summary, depression, anxiety and suicide are more common in the professional experience of the clinician than in the population at large (Knight, 2004). In the main, older people report high levels of life satisfaction, are better at emotional regulation (Urry & Gross, 2010) and report better emotional well-being and emotional stability than younger adults (Carstensen et al., 2011).

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