Brief Psychodynamic Psychotherapy for the Elderly – a Case Series

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Abstract

Psychodynamic psychotherapy is an increasingly rare commodity to find in psychiatric practice, but has never been seen to have a prominent role with respect to the older patient. This presentation discusses the changing recent literature regarding this concept, and discusses a case study from the author's own experience demonstrating a successful outcome with limited-session psychodynamic psychotherapy for an older patient. Issues of patient selection, and why the older patient may in fact be more likely to benefit from this intervention, are also discussed.

A 74 year old woman was admitted following deteriorating suicidal ideation. This was her fourth admission for the year, preceding admissions each lasting for 2 months, each of those precipitated by overdoses on benzodiazepines and alcohol, with multiple failures in antidepressant trials. She was a survivor of multiple traumas including torture and attempted murder by her second husband, and had a long history of poor engagement with mental health services. The patient was discharged after a planned 2 week admission, but three days after discharge she drank a bottle of whisky and took several paracetamol tablets, then rang her daughter to let her know. This had been her pattern of suicide attempts for the preceding 3 years.

On return to the ward, the team changed tactics and instead had a visiting psychoanalyst assess her. It was decided by the visiting analyst that although she had obvious psychopathology, "She's not appropriate for psychotherapy as she's too old." Nevertheless, the team went on to trial thrice weekly inpatient dynamically oriented psychotherapy, by a registrar who was supervised by another senior psychoanalyst. Multiple early traumas were explored. On session 17, the patient discussed the death of her mother, stating that her first husband had refused to allow her mother to stay with them. Her mother then suicided. She then volunteered that her own daughter's husband refused to allow the patient to stay with them 3 years ago. She then realised her run of suicide attempts started after this.

"I couldn't say a word against [him], [my daughter] would never bear it. I don't blame my daughter for it, though. I don't think so. It'd be awful if I did, wouldn't it? But I do blame myself for my mother's death. Maybe I really do blame her."

There was no further suicidality. After six weeks of therapy, she had improved, but was also realistic, "I don't think I'll ever be normal, but I think I'm better able to deal with things." She was seen a month later after discharge and noted to be much brighter and socially engaged. She is now on no antidepressants or sedatives, and has not had a mental health admission for the last four years.

This case demonstrates an excellent outcome with limited psychotherapeutic intervention in an older person. It also raises several questions. Is psychodynamic psychotherapy an intervention that should be considered more often for older patients? Is it being underprescribed, or underresourced, or both? And what should be done about this?

Should Older Persons Not Have Psychodynamic Psychotherapy?

It has been claimed that older persons do not respond to dynamic psychotherapy. Freud, wrote in 1905, "Near or above the age of fifty, the elasticity of mental processes, on which the treatment depends is, as a rule lacking – old people are no longer educable."[i] Curiously, Freud wrote this at age 49.

Are there practical reasons not to proceed with psychotherapy for older persons? Freud considered that the older person would simply accumulate too much unconscious material for analysis to be practical. It could be argued that the nonprovision of dynamic interventions is a compassionate decision for the older person – the symptomatic elderly patient, already burdened with the pressures of age, should not have to "open old wounds"[ii]. However, Hildebrand noted greater emotional strength and self-reliance in older patients[iii]. For those able to access

psychotherapeutic help "the outcome is comparable, sometimes better, than for younger patients."[iv]

Cognitive impairment is often regarded as a logical contraindication. This does not necessarily extend to mild cognitive impairment however, with the literature citing a number of case studies and even a randomised controlled trial[v] demonstrating the benefit of interpersonal interventions for older patients. Garner considers that mild cognitive impairment (and other practical issues such as mobility and hearing), need to be carefully assessed as to "whether these are real external problems...or whether either patient or therapist is employing them as a defence."[vi]

Should Older Patients Receive Psychodynamic Psychotherapy?

The 1991 NIH review noted "There are no clear comparisons with placebo or pseudo treatment control groups, with the old-old, or with medically ill elderly."[vii] There has been minimal progress since that time. The reader is directed to the excellent summaries of Payman[viii] regarding the current evidence base, in particular regarding the Koder review[ix] which found five studies indicating brief psychodynamic therapy to be more effective than control.

Do Older Patients Receive Psychodynamic Psychotherapy?

A study of 94 depressed elderly inpatients on a Australian psychogeriatric unit found that only 12% were referred for psychotherapy, compared to 97% receiving an antidepressant.[x] A postal survey of 100 psychotherapy departments in the UK found 87% of respondents feeling that the psychotherapy needs of the elderly were not as well met as for younger patients.[xi] A U.K. study found 93% of general practitioners said they would consider referring elderly patients for psychological help, although only 44% had actually done so, with 33% unfamiliar with the psychological therapies available.[xii] There is only one study describing a dedicated geriatric individual psychotherapy clinic[xiii].

Summary

There is historical bias against psychotherapy for the elderly, maintained by a paucity of research leading to perpetuation of non-prescription. With sufficient research the cost-benefit qualities of these services can then be explored and perhaps thus encouraged. The cited case demonstrated a cost-effective intervention. The patient had had 9 months inpatient of stays over the preceding three years, and following 20 half-hour has maintained superior functioning for four years. This is arguably rare and shows the benefits of good patient selection. Nevertheless, this patient was almost denied a lifesaving intervention because she was "too old". This would be a laughable oversight if it were not so pervasive, and so indefensible an attitude.

One of the greatest joys of psychiatry is to listen to the stories of patients. What better stories could there be than with the older patient?

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