Psychotherapy with Older Adults: A Gap Between Theory, Research, and Practice

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Literature Review Abstract

For psychologists, working effectively with older adults (aged 65+ years) requires awareness of the nuanced aspects of psychotherapy with this group. These include the clinical effectiveness of modifying psychotherapy, the variables that influence treatment outcomes such as older adults' characteristics (e.g., physical comorbidities) or non-specific therapeutic factors (e.g., therapeutic alliance), and psychologists' own personal reactions towards older clients. This narrative review examined the current knowledge about these clinically-relevant factors. The findings revealed a gap between theory, research, and practice in terms of how psychotherapy fares with older adults in real practice. More extensive, targeted research exploring the nuanced aspects of working with older adults can advance understanding about what may promote or interfere with their therapeutic progress. Ultimately, this can improve the care provided for this growing client base.

The role and effectiveness of psychotherapy for older adults (aged 65+ years) is well established (Pinquart, Duberstein, & Lyness, 2007). In fact, as the ageing population grows, and as later-born cohorts of older adults gain increased access to information about the benefits of psychological intervention, they will become a growing client base (Karel, Gatz, & Smyer, 2011). As the proportion of psychologists specialising in geropsychology in Australia is low, all psychologists will need to prepare to work effectively with this group (Koder & Helmes, 2008; Laidlaw & Pachana, 2009). Importantly, this task requires understanding beyond how psychological disorders manifest in late-life and which psychotherapies are most effective for this group (Goldfried et al., 2015).

Although psychotherapy with older adults does not require a fundamentally different repertoire of clinical skills, it does need to be informed by what is known about ageing (Laidlaw & McAlpine, 2008). Maturation effects (e.g., cognitive/physical changes) and specific age-related challenges (e.g., chronic physical illness) sit against the backdrop of older adults' unique sociocultural environment (e.g., familial/societal roles) and generational context. Keeping in mind the heterogeneity of the ageing population, the intricate interplay of these factors can shape older adults' attitudes towards psychotherapy, how they present and engage in session, and subsequently, how psychologists respond (Knight & Poon, 2008). Given this, nuanced practical issues are likely to arise – and require consideration – when working with older adults (Kazdin, 2008). These include the clinical effectiveness of modifying psychotherapy, the variables that influence treatment outcomes such as older adults' personal characteristics (e.g., physical comorbidities) or non-specific therapeutic factors (e.g., therapeutic alliance, level of direction, or flexibility), and psychologists' own personal reactions towards older clients. Although these issues are not exclusive to this client group, they may manifest differently or be more pertinent.

Although the literature dedicated to geropsychology standards explains the importance of considering these nuanced issues (American Psychological Association, 2014), research regarding how to actually manage them in clinical practice is scant and limited by methodological weaknesses (Bauer, 2007; Greenwood, 2014; Laidlaw, Thompson, & Gallagher-Thompson, 2004). Thus, psychologists trying to inform their practice with older adults may have unique clinical questions that cannot be easily answered through the current available resources. Definitive guidelines are certainly not possible but, at the very least, greater awareness about the distinct aspects of working with older adults can advance clinicians' understanding of what may promote or interfere with the therapeutic progress of this client group (Bauer, 2007).

Against this backdrop, this narrative review outlines the current literature about modifying psychotherapy for older adults, the variables that influence older adults' treatment outcomes (e.g., their personal characteristics and non-specific therapeutic factors), and psychologists' own personal reactions towards older clients. The aim is to highlight the practical significance of these issues rather than provide an exhaustive review of relevant studies. Suggestions for future research are offered in relation to obtaining better understanding of how psychotherapy fares with older adults in clinical practice. The scope of this review is limited to community-dwelling older adults.

Literature Search Strategy

Published research and dissertations dating up to 2018 were identified using the electronic databases PsycINFO, Scopus, and ProQuest Dissertations & Theses Global. The exclusion criteria for articles and dissertations are listed in Table 1. To conduct the literature search, search terms were categorised according to themes and then three searches were conducted on each database using the following combinations: #1 and #3; #1 and #2 and #4; #1 and #2 and #5 (Table 2). The searches were consistent across databases with respect to the

field codes and proximity options used. The reference lists of selected articles were also examined for additional relevant articles. Consistent with the literature, 'older adult' was defined as being 65 years or over (American Psychological Association, 2014).

Table 1

Exclusion Criteria for Articles and Dissertations

Exclusion criteria	Rationale
Participants are below 65 years of age	'Older adult' is consistently defined by the literature as being 65 years or over.
Article or dissertation is *not* from the psychology, psychoanalytic, or counselling literature (e.g., empirical study does *not* include psychologists, psychotherapists, or counsellors in the participant sample)	"Talking therapy" is the primary service of the psychology, psychoanalytic, and counselling professions. Although the concepts mentioned in this literature review may apply to other health professionals working with older adults, their roles extend beyond this and thus the nature of the practitioner-client interaction may differ.
Participants in empirical studies are students	Due to a lack of clinical experience, students may have limited awareness of how psychotherapy fares with older adults in real practice. Their views may also differ after more clinical contact with older adults.
Article or dissertation concerns psychotherapy in aged care facilities	Contextual differences exist between psychotherapy conducted in aged care facilities and that in community settings. Excluding articles related to the former prevents unwarranted generalisations.
Article is not published in English	Illegible.

Table 2

Search Terms According to Themes (Using PsycINFO Searching Format)

Theme	Search terms
Older adults (#1)	(old* adult* or elderly or late* life or senior* or advanced age or geriatric*).ti,sh.[a]
Psychotherapy (#2)	(psychotherapy* or psychological therap* or geropsychol* or psychological treatment* or psychological intervention* or mental health treatment* or mental health intervention* or counsel* or gerocounsel* or cognitive therap* or behav* therap* or cognitive behav* therap* or CBT or ACT or dialectical behav* or DBT or psychodynamic or psychoanal* or interpersonal therap* or IPT or emotion focused* or schema therap* or person-centered therap* or client-centered therap* or narrative therap* or non-pharmacological).ti,sh.[a]
Modifying psychotherapy for older adults (#3)	((psychotherapy* or psychological therap* or geropsychol* or psychological treatment* or psychological intervention* or mental health treatment* or mental health intervention* or counsel* or gerocounsel* or cognitive therap* or behav* therap* or cognitive behav* therap* or CBT or ACT or dialectical behav* or DBT or psychodynamic or psychoanal* or interpersonal therap* or IPT or emotion focused* or schema therap* or person-centered therap* or client-centered therap* or narrative therap* or non-pharmacological) adj10[b] (recommend* or adapt* or modif* or guideline* or model* or standard* or procedur* or structur* or process* or mechanism* or enhance* or augment*)).ti,ab.
Variables that predict treatment outcomes of psychotherapy with older adults (#4)	((characteristic* or variable* or factor* or attribute* or trait* or personality or moderat* or predict* or challenge* or barrier* or obstacle* or common factor* or non-specific or therapeutic alliance or therapeutic relationship or therapeutic bond or working relationship or working alliance or therapist* effectiveness or therapist* competence or therapist personality* or empathy) adj10[b] (outcome* or effect* or affect* or influence* or recovery or effectiveness or efficacy or symptom reduction or relapse or dropout or satisfaction or enhance or augment)).ti,ab.
Psychologists' experiences of working with older adults (#5)	((psychologist* or therapist* or psychotherapist* or counsellor* or counselor* or mental health clinician* or mental health practitioner*) adj10[b] (work* or provide* or deliver* or experience* or expertise or view* or attitude* or perception* or feeling* or insight* or belief* or challenge* or reward* or countertransference* or death anxiety or fear of death or fear of mortality or ethic* or therapeutic process* or psychotherapeutic process* or therapeutic alliance or therapeutic relationship or therapeutic bond or working relationship or working alliance)).ti,ab.

Note. [a] Terms related to older adults and psychotherapy were searched for within titles and subject headings to hone in on relevant articles. An unmanageable number of articles was identified when these search strings were extended to abstracts, many of which were irrelevant. [b] 'adj10' was used to identify articles which contained search terms within ten words of each other in either direction. As the search terms were unspecific when standing alone, this provided more context to the search string.

Clinical Issues in Geropsychology

Modifying Psychotherapy for Older Adults

As psychotherapy with older adults can involve a unique interplay of factors, their clinical presentations can sometimes differ compared to younger adults (Knight & Poon, 2008). This has potential implications for the content and structure of psychotherapy (Secker, Kazantzis, & Pachana, 2004). Thus, numerous recommendations have been published regarding the modification of psychotherapy – especially cognitive-behavioural therapy (CBT) – so as to make it more suitable for older adults. Suggestions have largely concerned procedural modifications to accommodate age-related cognitive changes (e.g., using a slower pace), sensory changes (e.g., using a larger font), and generational differences (e.g., greater socialisation to psychotherapy; Evans, 2007; Laidlaw & McAlpine, 2008). Modifications to therapeutic strategies have been suggested when cognitive impairment is present (e.g., using more behavioural than cognitive strategies in CBT; Rehm, Stargatt, Willison, Reser, & Bhar, 2017). Several authors have also emphasised the use of gerontological ageing theories to inform additional interventions (Laidlaw & Kishita, 2015).

Although these recommendations certainly have their place, their clinical effectiveness is unclear. This is because most efficacy studies do not 1) examine whether modifications independently contribute to outcomes or 2) compare the modified psychotherapy with the standard equivalent (Gould, Coulson, & Howard, 2012; Greenwood, 2014). This makes it difficult to determine whether modifying psychotherapy enhances outcomes beyond the standard intervention's effectiveness. For these reasons, Greenwood's (2014) systematic review could not infer the effectiveness of particular modifications to CBT for late-life anxiety and depression. Similarly, Jayasinghe et al. (2017) noted that little information was available about the efficacy of modifying exposure therapy for late-life anxiety when physical or cognitive impairments were present. Isolated studies which have compared

modified CBT with the standard equivalent have found conflicting results (Bourgault-Fagnou & Hadjistavropoulos, 2013; Mohlman et al., 2003), likely due to differences in methodology and participant samples.

More broadly, older adults over 80 years of age are underrepresented in efficacy research samples (Wuthrich, 2017). Any conclusions drawn about the modification of psychotherapy for older adults may be skewed if, on average, modifications are more or less beneficial for this sub-group. Research examining the effectiveness of modifying non-CBT psychotherapies is also lacking, as is qualitative research capturing how psychologists integrate the literature's recommendations into their practice with older adults.

Although the effectiveness of modifying psychotherapy for older adults is yet to be clearly demonstrated by efficacy research, the sheer number of theoretical recommendations available suggests that modifications are a given aspect of psychotherapy with this client group. However, assuming that modifications are warranted, they should not be made according to age but rather individual need. Recent literature has begun emphasising this (Wuthrich, 2017), yet compared to the number of recommendations about modifying psychotherapy, there remains less information on how the therapeutic skills and techniques used with non-aged adults are applicable to older adults (Laidlaw, 2001). Given the complicated literature coupled with older adults' diversity, psychologists unfamiliar with this client group may question which modifications to implement (if any) and when (Laidlaw & Pachana, 2009).

Summary. Psychologists need to be prepared to modify psychotherapy for older adults on a case-by-case basis. Theoretical recommendations have been instrumental in informing psychologists' practice but many suggested modifications are not clear-cut, empirically validated, or clinically validated. Which recommendations "work", which are not so effective, and when? Research offering guidance around these questions is lacking.

Variables That Predict Treatment Outcomes

Although efficacy research can identify which type of psychotherapy best suits a clinical issue in late-life, it does not shed light on matching specific psychotherapies or therapeutic techniques to specific older clients. This is partly because efficacy research does not entirely capture how older adults' personal characteristics, or their receptiveness to non-specific therapeutic factors, influence treatment outcomes (Goldfried & Wolfe, 1998). However, as these variables can promote or interfere with psychotherapy in routine practice, they need to be considered in order for psychologists to work effectively with older adults (Kazdin, 2008).

Older adults' personal characteristics. Working with older adults involves consideration of their personality, cognition, medical health, generational context, family, and preferences and expectations about psychotherapy. Depending on the nature of these characteristics, therapeutic modalities or techniques assumed to be beneficial may actually have a varying impact (Llewelyn & Hardy, 2001). Some older adults, for example, may be hesitant to self-disclose, adopt a recipient role, find it difficult to associate experienced symptoms with psychological disorders, be unaccustomed to homework, express negative stereotypes about ageing (e.g., "depression is part of ageing"), or relate to younger psychologists as if they were their child or grandchild (Laidlaw & Baikie, 2007; Laidlaw & McAlpine, 2008; Morgan, 2003; Myers & Harper, 2004; Wetherell et al., 2009). At the same time, ageing can be associated with enhanced emotional regulation, attention to positive information, and ability to draw upon life experience to rediscover existing coping skills (Laidlaw & McAlpine, 2008; Pachana, 1999; Plotkin, 2000). Although personal characteristics such as these could feasibly interfere with or promote psychotherapy, efficacy research regarding older adults has aimed to minimise the impact of confounding factors

through random sampling, restrictive exclusion criteria, and standardised conditions (Knechel, 2013).

In reaction to this, some recent efficacy studies have begun investigating which personal characteristics are related to older adults' treatment outcomes. Variables consistently shown to predict less reduction of depression symptoms in older adults include physical and psychological comorbidities, comorbid personality disorders, and neuroticism (Hayward, Taylor, Smoski, Steffens, & Payne, 2013; Kiosses, Leon, & Areán, 2011; Veerbeek, Oude Voshaar, & Pot, 2014). A moderation analysis also found that homebound older adults who engaged in passive cognitive coping (e.g., rumination) benefited from problem-solving therapy for depression just as much as those who did not engage in passive cognitive coping (Choi, Hegel, Sirrianni, Marinucci, & Bruce, 2012). However, passive cognitive coping was associated with greater baseline depression scores, meaning that the group's post-treatment depression scores were still comparatively higher. Although psychologists can consider these characteristics when assessing older clients' prognoses, their clinical implications were not described (e.g., personality disorders can complicate treatment in various ways). Additionally, as participants across these studies were mostly white females, the generalisability of results is unclear. Given these research limitations, psychologists unfamiliar with working with older adults may have difficulty deciding how to manage these characteristics in psychotherapy.

The influence of other personal characteristics on older adults' treatment outcomes is not as straightforward. For example, whilst some research suggests that lower Generalised Anxiety Disorder (GAD) baseline severity predicts better treatment outcomes (Hundt et al., 2014; Kiosses et al., 2011), Wetherell et al. (2005) found that older adults with more severe GAD symptoms at baseline benefited more from CBT, possibly because they had more to "gain". Homework completion has also been associated with better depression and GAD

outcomes for Caucasian older adults undergoing CBT, although this was not found to be the case for a mostly Black American sample with anxiety (Conti et al., 2017; Coon & Thompson, 2003; Wetherell et al., 2005). The inconsistency between results likely reflects the different samples, therapeutic procedures, and measures involved. Furthermore, the impact of cognitive impairment on treatment outcomes is complicated (Wuthrich, 2017). For example, depressed and anxious older adults with poorer cognitive flexibility were found to learn cognitive restructuring (which requires cognitive flexibility) just as well as older adults with intact cognitive flexibility, but they reported less reduction in emotional distress from using the technique (Johnco, Wuthrich, & Rapee, 2014). Overall, these mixed findings may be difficult to integrate in a way that can meaningfully inform psychotherapy with older adults.

Regardless of whether the aforementioned literature is consistent or inconsistent, it does not necessarily reflect the personal characteristics that psychologists or older adults themselves perceive as clinically-relevant. For example, despite the complicated findings mentioned above about cognitive impairment and homework completion, psychologists in another study perceived executive dysfunction and homework non-completion as hindering treatment for older adults involved in a hoarding disorder CBT trial (Ayers, Bratiotis, Saxena, & Loebach, 2012). As only 12 older adults participated in this trial under restrictive inclusion criteria (e.g., no substance dependence), other characteristics that could potentially influence treatment outcomes may not have been observed. Regarding older clients with posttraumatic stress symptoms, psychologists have noted that the longer the period since the traumatic event or the more accumulative the trauma, the harder it was for them to link previous events with current distress and change maladaptive coping strategies (Billett, 2013). Both psychologists and older adults have also reported that generational influences (e.g., deferring to the psychologist or stoicism) can hinder conversation during session (Billett, 2013;

McIntosh, 2013; Rizopoulos, 2015). It was unclear from these studies as to how the reported effects of early trauma, accumulative trauma, and generational differences were managed. Further, psychologists in another study rated 'refusing to eat' as more critical in predicting older adults' suicide risk than other empirically supported risk factors (e.g., male gender and loneliness; Brown, Bongar, & Cleary, 2004). However, given the nature of surveys, the respondents could not contextualise this answer (i.e., older adults may also refuse to eat for non-suicidal reasons). Although these findings provide naturalistic insight into which personal characteristics can influence treatment outcomes in older adults, they are also based on individual interpretations and perhaps individual cases. Thus, they cannot serve as a prescriptive reference.

It should also be noted that there is little information available about managing logistical issues when working with older adults. Some older adults' engagement in psychotherapy may be hindered by their access to resources (e.g., reliance on public transport or the aged pension), their health status (e.g., hesitancy to complete an *in vivo* exposure exercise due to concerns about incontinence and not having access to a bathroom), or the office's accessibility (e.g., parking and ramps), but these issues have only been mentioned in passing in the current literature (e.g., Bush, 2012; Jayasinghe et al., 2017; Polenick & Flora, 2013).

Non-specific therapeutic factors. Non-specific therapeutic factors are elements common to most psychotherapies which can influence treatment outcomes. When working with older adults, the importance of these factors is amplified given the range of unique personal characteristics and comorbidities that may need to be accommodated. Theoretical reviews have stressed that, irrespective of the psychologist's therapeutic orientation, the therapeutic alliance is crucial for older adults and flexibility is needed regarding the psychotherapy's duration, organisation, and setting (Knight, Nordhus, & Satre, 2003). It has

also been suggested that psychologists should prepare to be directive in keeping older clients on track, and should engage in multi-disciplinary collaboration to provide more coordinated care (American Psychological Association, 2014; Gallagher-Thompson & Thompson, 1996). However, it is difficult to advance these assumptions without understanding what older adults actually respond to during psychotherapy. Research examining how non-specific therapeutic factors impact treatment outcomes for older adults is limited, and findings from broader populations are also hard to generalise because older adults are underrepresented or totally excluded in many study samples.

In contrast with theoretical literature, Bertoni (2008) found that the therapeutic alliance and level of direction did not predict quality of life and distress outcomes for older adults undergoing cognitive therapy. However, as external observers rated the therapeutic alliance, the relatedness between psychologists and older adults may not have been fully captured. Indeed, Mace et al. (2017) found that older adults' perceptions of the therapeutic alliance were pertinent to depression treatment outcomes, with their ratings predicting 21% of their symptom reduction. Furthermore, in terms of level of direction, Bertoni's sample excluded older adults with cognitive impairment. Directiveness is perhaps associated with therapeutic outcomes when cognitive impairment is present. Accordingly, psychologists in Billett's (2013) qualitative study reported being directive when helping older adults with cognitive impairment make decisions about therapeutic activities.

Beyond this, psychologists in Friedler's (2011) discursive study reported preferring a less structured, flexible version of CBT for older adults. However, discussion focused on how this was influenced by participants' social constructions of ageing, with less consideration for how flexibility may be a response to older adults' real needs. For example, flexibility may be crucial when psychotherapy is interrupted due to changes in older adults' medical health (Jayasinghe et al., 2014).

Summary of variables that predict treatment outcomes. Psychologists can better match psychotherapies or therapeutic techniques to older adults by being aware of how personal characteristics and non-specific therapeutic factors can promote or interfere with psychotherapy (Goldfried et al., 2015). Whilst the literature has identified several personal characteristics related to treatment outcomes, results lack elaboration, consistency, or clinical validity. There has also been little focus on how such characteristics can be accommodated or harnessed in sessions. Research regarding how non-specific therapeutic factors influence psychotherapy with older adults is even more limited. Thus, psychologists unfamiliar with working with older adults may have difficulty troubleshooting when psychotherapy is not "working" as anticipated.

Psychologists' Personal Experiences

During psychotherapy, psychologists can bring their personal attitudes, backgrounds, and sensitivities into session, resulting in subjective reactions to clients (Muslin & Clarke, 1988). For example, it is assumed that older adults can trigger personal rewards, age biases, death anxiety, and countertransference for psychologists (Kessler & Bowen, 2015; Koder & Helmes, 2008b; McKenzie, Brown, Mak, & Chamberlain, 2016; Webb, Chonody, Ranzijn, Bryan, & Owen, 2016). These private experiences may impact psychologists' professional conduct in session (Laidlaw & Pachana, 2009). Additionally, the theoretical literature suggests that psychologists can encounter unique ethical challenges when working with older adults (McGuire, 2009). Research across the talking therapy professions has provided some insight into the occurrence of these issues in real practice. Importantly, any findings mentioned herein are not definitive but rather highlight the range of possible reactions. Psychologists may also experience multiple reactions concurrently and in different combinations.

Perceived rewards when working with older adults. Some research suggests that working with older adults can be personally rewarding. According to psychologists who responded to open-ended questions following a survey, older adults can be a source of knowledge and learning, as well as a minority group to advocate for (Webb et al., 2016). Although the survey component in this study may have unintentionally primed participants' responses, other qualitative studies have produced similar findings. For example, counsellors have alluded to gaining vicarious wisdom from older clients (G. Smith & Pearson, 2011). Psychologists and psychotherapists have also noted that older adults are gratifying because they tell interesting stories and often show appreciation beyond that expressed by non-aged clients (Plotkin, 2000; Watts, 2006). Perceiving rewards when working with older adults may foster the therapeutic process. For example, Kurina (2013) found that psychologists' positive attitudes toward older adults predicted a stronger therapeutic alliance. Although these findings are encouraging, they are minimised by the literature's emphasis on the challenging aspects of working with this group (as demonstrated below). There has also been a large focus on psychology students' attitudes toward older clients and this potentially minimises the range of rewards that have been identified because some may only be realised once directly working with this group (Steffen, 2012).

Old age biases. In contrast to the above findings, other psychologists have rated hypothetical older adults as, on average, having poorer prognoses and being less suitable for intense treatment or any psychotherapy at all (Helmes & Gee, 2003; Shmotkin, Eyal, & Lomranz, 1992; M. M. Smith, 2014). Although this suggests that psychologists could show biased behaviour towards older clients (e.g., suggesting less aggressive goals), findings need to be translated cautiously. In these studies, participants' responses were based on hypothetical case vignettes which may not capture genuine attitudes, nor do attitudes necessarily predict behaviour (Koder, 2008). The latter was demonstrated in another study

where psychologists' attitudes towards older adults' sexuality only explained an extra 7% variance in their willingness to assess older adults' sexual health (although this was statistically significant; Flaget-Greener, Gonzalez, & Sprankle, 2015).

Even if some psychologists do hold pessimistic attitudes towards working with older adults, this could reflect a history of limited clinical contact with this group (Koder & Helmes, 2008a) or could be influenced by the older clients they mainly interact with (e.g., those with complex, treatment-resistant presentations). Overall, it is difficult to conclude from the current literature whether some psychologists hold biases against working with older adults and, if so, what the implications are for psychotherapy. It is likely that psychologists are more motivated to minimise biased judgements and actions in real practice, although it is unclear how they manage this.

Death anxiety. It has been hypothesised that characteristics of some older adults (e.g., ill health) may remind psychologists that their own lives are finite, thus triggering death anxiety (Laidlaw & Pachana, 2009). To reduce their anxiety, psychologists may disengage from or avoid older clients (McKenzie et al., 2016). Although this assumption is possible, a small amount of qualitative research actually suggests that when mental health professionals encounter death-related issues with older clients, the implications can be constructive for both themselves and their clients.

When older clients deal with death-related issues, psychologists have described experiencing sorrow but also the desire to advocate for and assist them with their end-of-life planning (Foster & Vacha-Haase, 2013). The death of an older client can create short-term grief and concentration difficulties but, in the long-term, psychologists and psychotherapists have also reported that it allows them to accept the inevitability of their own death (Atkins & Loewenthal, 2004; Foster & Vacha-Haase, 2013; Watts, 2006). Counsellors have even mentioned how this acceptance has motivated them to consider addressing their own

interpersonal issues (G. Smith & Pearson, 2011). Although these participants may have under-reported professionally undesirable reactions, the fact that they were middle-aged on average and had accumulated years of work and life experience perhaps enabled this pragmatic approach. Early career psychologists may have more difficulty dealing with older clients', and their own, approaching death (Bennett, 2002). Although these qualitative studies provide insight into how psychologists have responded to death-related issues when working with older clients, only Foster and Vacha-Haase (2013) identified relevant self-care strategies (e.g., peer supervision).

Countertransference. Countertransference refers to psychologists' conscious and unconscious reactions toward a client which may occur in response to the client's transference or stem from feelings toward other people. Although countertransference may not be overly interpreted in short-term psychotherapies, it is still relevant to all psychologists as it can impact their in-session behaviour when unrecognised (Kennedy & Tanenbaum, 2000). Countertransference issues may be particularly relevant when working with older adults because they can remind psychologists of their parents or grandparents (Plotkin, 2000). Importantly, countertransference reactions will differ according to each psychologist and each client.

Countertransference research relating to older clients largely consists of psychoanalytic psychotherapists' case studies. Consistent with theoretical assumptions, Yu (2007) described relating to an older male client as her grandfather, acting passively when he undermined her knowledge, and also feeling irritable towards him when her own grandfather passed away. Poggi and Berland (1985) reported feeling cherished like children when older clients called them "boys", although at other times this denial of their maturity left them frustrated and overcommitted to making a point. Other cases of countertransference are found in Martindale (1989) and Semel (2006). Although these accounts may be ungeneralisable, case study

research complements and highlights the complexity of countertransference reactions, for psychoanalytic psychotherapists at least. Due to a lack of psychologist-specific research, it is unclear how psychologists with other theoretical orientations perceive countertransference in relation to older clients and how they manage or utilise it.

Ethical issues. The theoretical literature asserts that working with older adults can present unique ethical challenges for psychologists. Depending on the older adult's circumstances, issues can arise around informed consent, decision-making capacity, confidentiality, and psychotherapy in home settings (Bush, 2012; McGuire, 2009). While psychologists may encounter these issues at times, the theoretical literature does not provide information about their nature and management in real practice. Psychologists may also experience less predictable ethical challenges.

In an isolated study, three psychologists wrote about ethical challenges when working with older adults. Although their written responses were inevitably constrained, they offered unique clinical insight into how psychologists experience tension between respecting older clients' autonomy and having to make decisions to support their welfare (Bush, Allen, Heck, & Moye, 2015). Whilst this is consistent with theoretical literature, other research involving non-psychologists has produced novel findings. Psychotherapists across multiple qualitative studies have emphasised issues around managing professional boundaries when working with older adults. They reported instances of seeing older clients out of office hours, wanting to be a supportive friend rather than analysing their issues, and avoiding psychotherapy termination (Atkins & Loewenthal, 2004; Plotkin, 2000; Terry, 2008; Yu, 2007). Older adults have also described instances of not paying for their counselling session and going to a counsellor's home to talk (Hunter, 2011). Reasons for these occurrences were not provided but they could have been linked to the mental health professionals' countertransference or beliefs about ageing. Given these findings, it is possible that psychologists working with older adults may

face boundary issues whereby the therapeutic relationship is at risk of manifesting as a friendship. Nonetheless, clarification is required given the lack of psychologist-specific research. It would be particularly important to distinguish how psychologists reconcile their understanding about the importance of professional boundaries with their own, or their older clients', wishes for the interaction.

Summary of psychologists' personal experiences. To work effectively with older adults, psychologists need to be mindful of how they personalise and reflect on what is taking place in session (Kottler & Carlson, 2016). Every psychologist's experience of working with older adults will be distinct, yet highlighting the range of possible reactions can assist with identifying areas for self-reflection and professional development. Related research has supported and contradicted theoretical assumptions, as well as identified novel issues. However, some research is outdated and lacks elaboration, and much concerns non-psychologists.

Psychotherapy with Older Adults: A Gap Between Theory, Research, and Practice

Based on this review, a gap between theory, research, and practice exists in relation to psychotherapy with older adults. Theoretical assumptions and efficacy research have initiated understanding about what constitutes effective psychotherapy with older adults, but they have not fully captured the intricate happenings, practices, and workings of clinical practice. This means that there is less opportunity for psychologists unfamiliar with this client group to become attuned to, and prepared for, a growing older client base. Although the research presented in this review has begun to highlight more nuanced, clinically-relevant issues, it is piecemeal. Findings are largely by-products of wider research aims, extracted from multiple studies with different research designs and participant samples, not elaborated on, or not readily applicable to clinical settings. Older adults' perspectives of psychotherapy are also noticeably underrepresented (Rizopoulos, 2015). However, what still resonates from the

presented research is how working effectively with older adults requires more than just understanding how psychological disorders manifest in late-life and which psychotherapies are empirically supported for this group (Blair & Bird, 2016). Older adults need to be considered in their entirety, with knowledge about ageing applied to psychological methods. More organised, targeted, and extensive research regarding the nuanced aspects of working with this group can supplement theoretical perspectives, efficacy research, and the presented findings (Elliott, 2010).

Closing the Gap: What Else do Psychologists Need to Know?

The following research recommendations highlight gaps in the current literature which, when filled, can inform psychotherapy with older adults. Future research could explore:

- Whether procedural and content-based modifications to differing psychotherapies contribute to treatment outcomes for older adults of varying age and with varying presentations. More guidance could be provided about which clinical features necessitate modifications and, in turn, which modifications may be suitable (Johnco et al., 2014).
- Whether, and how, personal characteristics and non-specific therapeutic factors influence older adults' treatment outcomes across differing psychotherapies (Knight et al., 2003). Suggestions on how to manage or harness these variables could be described.
- The nature and significance of psychologists' personal experiences when working with older adults. Focus could lean towards the influence of psychologists' characteristics (e.g., age), as well as how they manage their reactions.

Importantly, such research cannot provide an exact model of how psychotherapy fares with older adults, or how psychologists should work with them. Rather, it can highlight

factors that may promote or interfere with older adults' therapeutic progress, thus serving as a broad reference for psychologists.

Closing the Gap: How?

Several authors have advocated that psychologists can close the gap between theory, research, and practice by participating in more qualitative research (Bauer, 2007; Kazdin, 2008). Whilst they can certainly contribute unique, clinically-relevant insight into psychotherapy with older adults, there are issues to consider. Psychologists may be susceptible to attributional errors (e.g., "I know X works because the older person improved afterward") or they may not be the best communicators of what older adults need in psychotherapy (Elliott, 2010). Some of the aforementioned research recommendations may also suit quantitative analyses. It follows, then, that future research on the nuanced aspects of psychotherapy with older adults may be most informative if it includes both psychologists' and older adults' perspectives, as well as both qualitative and quantitative methods (Llewelyn & Hardy, 2001). With a greater array and balance of research approaches, results can be triangulated to gain a more multilayered, clinically-valid understanding of how psychotherapy fares with older adults in real practice.

Conclusion

To work effectively with older adults, psychologists need to be familiar with the nuanced aspects of psychotherapy with this client group. This involves awareness of whether modifications to psychotherapy are actually useful and when these should be applied, how various variables may influence treatment outcomes, and how their own reactions towards older clients may impact their presence in session. Despite the importance of this, a gap between theory, research, and practice has left these clinically-relevant issues somewhat unclear. This means that there is less opportunity for psychologists unfamiliar with working with older adults to become attuned to, and prepared for, a growing older client base. The

research presented in this review has indeed begun filling this gap but there is room for further exploration. More targeted, extensive research involving both psychologists and older adults, as well as both qualitative and quantitative approaches, can offer more comprehensive understanding about what may promote or interfere with the therapeutic progress of older adults. Ultimately, care for this client group can be advanced by considering the perspectives of those that are most familiar with it (Hunter, 2011).

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How do you Teach an Old Dog New Tricks? Psychologists' Experiences of Working with Older Adults

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Abstract

As older adults (aged 65+ years) become a growing client base, all psychologists will need to prepare to work effectively with them. Those unfamiliar with geropsychology may be able to bolster their knowledge and confidence by accessing the clinical insight of psychologists who are experienced with this client group. Thus, this qualitative study explored psychologists' experiences of working with older adults. Participants were 13 clinical psychologists ranging in age from early 30s to late 60s. They worked in various private and public settings and reported familiarity with working with older adults as per pre-defined criteria. Individual semi-structured interviews were conducted and data were subsequently analysed using thematic analysis. Three overarching themes were identified concerning the commencement or continuation of psychotherapy (e.g., assessing older adults' suitability for psychotherapy), practices in psychotherapy (e.g., considering older clients' histories), and more personal matters for psychologists (e.g., managing ethical issues). The findings overall highlight that variations to the structure or content of psychotherapy may be necessary according to older adults' life experience, their experience of ageing, and their broader environmental context. Therefore, to work effectively with older adults, psychologists must be prepared to skilfully apply knowledge about ageing to psychological methods. The current findings can serve as a broad reference for psychologists unfamiliar with working with older adults, helping them to identify their training needs and become better attuned to this growing client group.

Key words: Older adults, geropsychology, psychotherapy, professional development, psychoeducation

The role and effectiveness of psychotherapy in later-life (65+ years) is well established (Pinquart, Duberstein, & Lyness, 2007). In fact, as the ageing population grows, and as later-born generations of older adults gain increased access to information about the benefits of psychotherapy, they will become a growing client base (Karel, Gatz, & Smyer, 2011). As the proportion of psychologists specialising in geropsychology in Australia is low (Koder & Helmes, 2008a), all psychologists will need to prepare to work effectively with this group.

Although psychotherapy with older adults does not require a fundamentally different repertoire of clinical skills, it does need to be informed by what is known about ageing (Laidlaw & McAlpine, 2008). Maturation effects (e.g., cognitive and physical changes) and age-related challenges (e.g., increased bereavement) sit against the backdrop of older adults' current sociocultural environment (e.g., familial roles) and generational context (Knight & Poon, 2008). Keeping in mind the diversity of the ageing population, the intricate interplay of these factors can shape how older adults present and engage in psychotherapy, and subsequently, how psychologists respond (Knight & Poon, 2008). Therefore, nuanced clinical issues are likely to arise – and require consideration – when working with older adults. Although the literature dedicated to geropsychology standards and frameworks attests to this and provides conceptual understanding (Knight & Poon, 2008; Salaz, Gutierrez, & Dykeman, 2016), guidance for actually managing these issues in clinical practice is piecemeal. Psychologists wanting to advance their practice with older adults may thus have unique clinical questions that cannot be easily answered through the current available resources.

For example, numerous recommendations exist about making procedural or content-based modifications to psychotherapy for older adults (e.g., Evans, 2007; Rehm, Stargatt, Willison, Reser, & Bhar, 2017). Although these recommendations are warranted under given circumstances, their clinical effectiveness is unclear because most efficacy studies do not compare modified interventions with the standard equivalent to establish whether outcomes

are enhanced (Greenwood, 2014; Jayasinghe et al., 2017). Isolated studies which have done this in relation to Cognitive-Behavioural Therapy (CBT) have reported conflicting results (Bourgault-Fagnou & Hadjistavropoulos, 2013; Mohlman et al., 2003). This highlights a related issue whereby, depending on their individual circumstances, not all older adults will require modifications to psychotherapy. Overall, the incomplete literature and diversity of older adults makes it difficult to decide which modifications to implement (if any) and when.

Older adults' psychological symptoms can often be linked to age-related challenges such as chronic illness, disability, or bereavement (Knight & Poon, 2008). Although these issues are not unique to older adults, they can manifest more commonly. Age-related challenges may create difficulty in identifying cause and effect or in disentangling psychological and medical issues (Pachana, Mitchell, & Knight, 2015). They may even necessitate an eclectic approach; however, it is unclear which variables to consider when implementing this with older adults (Cloosterman, Laan, & Van Alphen, 2013; Hillman & Stricker, 2002). Age-related challenges can also create logistical issues that can interfere with older adults' engagement (e.g., transport), yet this has only been mentioned in passing.

A systemic approach is encouraged in geropsychology because sociocultural environments, including family units, residential care settings, and healthcare systems, can exacerbate, maintain, or minimise older adults' presenting problems (Hillman & Stricker, 2002). However, psychologists unfamiliar with systemic work may feel uncertain about how to navigate different environmental and interpersonal structures or how to remain aligned with confidentiality responsibilities (Knight & Poon, 2008). Indeed, Hudgson, Rycroft, and Giri (2012) found that health professionals (including psychologists) valued family work with older adults but found it anxiety-provoking; this was partly attributable to a lack of training.

Working with older adults requires understanding of how the experiences, attitudes, values, and valued abilities characteristic of the time they grew up in (i.e., generational

factors) can shape how they engage in session (Knight & Poon, 2008). For instance, some older adults may be less willing to self-disclose as society historically encouraged stoicism (American Psychological Association [APA], 2014). It has also been suggested that, on average, later-born older adults may more easily identify with psychological explanations than earlier-born older adults (APA, 2014). Overall, generational factors may necessitate certain therapeutic strategies but such recommendations are scarce; currently, the only well discussed recommendation is to incorporate greater psychotherapy socialisation into sessions.

Depending on older adults' individual circumstances, the interplay of the aforementioned factors can result in various ethical challenges for psychologists (e.g., informed consent, confidentiality, elder abuse, and euthanasia; Bush, Allen, Heck, & Moye, 2015). As ethical principles occasionally conflict (e.g., respecting older adults' autonomy and making decisions to support their welfare), deciding on an appropriate course of action can be challenging despite the various resources available (Bush et al., 2015). Furthermore, psychologists bring their own attitudes, backgrounds, and sensitivities into session, resulting in subjective reactions to clients. They may perceive older adults as a source of wisdom, learning, and interesting stories (Smith & Pearson, 2011; Webb, Chonody, Ranzijn, Bryan, & Owen, 2016). Simultaneously, psychologists may encounter personal challenges such as pessimism about psychotherapy, countertransference, difficulty discussing sensitive topics (e.g., an older client's sexual health), or dealing with an older client's death (Flaget-Greener, Gonzalez, & Sprankle, 2015; Foster & Vacha-Haase, 2013). Highlighting the range of reactions perceivable when working with older adults can allow psychologists to identify areas for self-reflection and professional development.

Overall, information about managing nuanced clinical issues in geropsychology is largely a by-product of wider research aims and extracted from multiple studies; thus, it is not easily accessible for clinical use. In the current Australian milieu where geropsychology

coursework and placements are scarce, this makes it difficult for psychologists to become better attuned to, and prepared for, a growing older client base. Greater applied understanding about geropsychology is perhaps one factor that could contribute to fostering psychologists' interest and confidence in working with older adults. One way to achieve this may be through accessing the perspectives of psychologists who have experience with this client group (Kazdin, 2008). Their first-hand insight can serve as a broad reference, helping psychologists unfamiliar with geropsychology to identify their ongoing education needs.

Against this backdrop, this qualitative study explored how psychologists perceive psychotherapy with older adults. The intention was not to provide a model of how psychotherapy fares with this group, but rather a realistic account of clinical issues that may arise. Although geropsychology frameworks inform the introduction (Knight & Poon, 2008), an exploratory approach was adopted to enable a rich understanding of the research foci from psychologists' perspectives.

Method

Participants

Ethics approval was provided by the Human Research Ethics Committee at the relevant institution. Purposive sampling was implemented to source participants who could provide significant understanding of the research foci. This involved advertising the study Australia-wide on three online forums moderated by professional psychology bodies in Australia. Those who were interested in participating then contacted the author through private e-mail.

Participants were four male and nine female clinical psychologists (N=13) ranging in age from early 30s to late 60s. The proportion of participants below and above 50 years of age was approximately equal. As per the eligibility criteria, participants reported familiarity with working with older adults, defined as 1) on average, having 25%[1] of clients who were

[1] Australia has a shortage of geropsychology specialists who have caseloads of more than 50% older clients (Koder & Helmes, 2008a).

aged 65[2] years and over and 2) having delivered psychological interventions to this client group for approximately two years or more. This definition maximised the number of eligible psychologists with relevant experience and ensured that early career psychologists were represented in the sample. Participant demographics are detailed in Table 1.

Table 1
Participant Demographics

ID	Sex (F/M)	Age range	Total years practicing	Years working with clients 65+ (approx.)	Primary work setting	Average proportion of clients 65+ in this setting (approx.)
1	M	31-35	7	6	Community mental health	100%
2	F	31-35	6	4.5	Justice/corrective	25%
3	M	66-70	33	12+	Private practice	26-50%
4	F	56-60	19.5	19.5	Hospital (inpatient)	100%
5	F	56-60	20	20	Private practice	26-50%
6	F	36-40	10	10	Hospital (inpatient)	100%
7	F	31-35	2	1.5	Community mental health	100%
8	F	56-60	20	20	Community mental health	100%
9	F	31-35	6	4	Hospital (inpatient)	> 50%
10	M	41-45	18	10	Community mental health	25%
11	F	36-40	9	8	Hospital (inpatient and outpatient)	100%
12	M	61-65	21	6	Private practice	25%
13	F	56-60	8.5	8.5	Community mental health	100%

Note. All participants reported that their primary role was delivering psychotherapy.

[2] "Older adult" is widely defined in the literature as a person who is 65 years of age or over (APA, 2014).

Data Collection

Individual, semi-structured interviews were conducted between February and April 2018. Seven interviews were face-to-face at the participant's respective workplace and the remaining six participants were interviewed via telephone. Although the nature of telephone and face-to-face interviews differs (e.g., lack of non-verbal cues with telephone interviews), extant research does not suggest that data obtained from telephone interviews are of lesser quality or that multiple interview modalities should not be used (Novick, 2008).

Qualitative data is co-created between an interviewer, the participant, and their relationship. As the author is a provisional psychologist with a personal interest in geropsychology, it is possible that participants could have felt uncomfortable disclosing sensitive information given the possibility of future work-related interactions. Alternatively, participants could have provided less detailed responses if they thought that the author easily related to their experiences. To minimise this, the interview preamble emphasised the terms of confidentiality, that the aim was to capture participants' clinical experiences rather than assess their clinical competence, and that the author had foundational geropsychology knowledge.

Demographic information was collected and then discussion was guided using pre-devised, open-ended questions. The interview schedule was pilot tested with a psychologist familiar with working with older adults. The resultant interview questions encouraged participants to consider their older clients in relation to the therapeutic approaches used, factors that interfere with or promote therapeutic progress, non-aged clients, and personal challenges or rewards. Relevant issues unanticipated by the interview schedule were also explored. A copy of the interview schedule may be obtained from the author upon request. To minimise any author bias, conscious effort was made to clarify participants' responses, and participants were also encouraged to raise relevant issues which the author had not asked

about (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017). Interviews were audio-recorded and took 60 minutes on average. To determine the sample size, interviews were conducted sequentially and transcripts constantly compared until no new information was generated (i.e., data saturation; Braun & Clarke, 2013).

Data Analysis

After transcribing and de-identifying the audio-recorded interviews, thematic analysis was employed to identify and analyse themes within the data that captured some shared understanding relative to the research foci (Braun & Clarke, 2013). A semantic approach was adopted whereby themes aligned closely with participants' accounts. It was also recognised that participants' perspectives, and the author's subsequent interpretations, were situated within specific contexts that informed their understanding (e.g., environment, attitudes, and prior experiences; Levitt et al., 2017). Thematic analysis was conducted according to the six phase process proposed by Braun and Clarke (2013): 1) familiarisation with the data, 2) complete coding, 3) identifying themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the written report. Progression through phases was iterative, resulting in a rich, contextualised account of participants' perceptions.

Validation techniques were used to enhance the integrity of themes. An audit trail was maintained to document the rationale behind decisions made during the research process. An independent qualitative researcher reviewed three uncoded transcripts, coding them and identifying tentative themes. No discrepancies were found between this and the author's respective interpretations. Five participants also reviewed and provided feedback about preliminary themes identified within their transcript.

Results

The resulting themes related to various stages of the therapeutic process with older adults. Specifically, they concerned the commencement or continuation of psychotherapy

(*The First Question: Whether to Conduct Therapy or Not?)*, practices in psychotherapy (*Therapy with Older Adults is the Same but Different)*, and more personal matters for psychologists (*The Highs and Lows of Working with Older Adults*; Table 2). Notably, the majority of participants reported "falling into" geropsychology rather than having set intentions to work in this field.

Table 2

Identified Themes

Superordinate theme	Sub-themes
The first question: Whether to conduct therapy or not?	• Determining suitability • Advocating for the role of psychology
Therapy with older adults is the same but different	• It's not how old you are, it's how you are old • Work systemically • Consider older clients' histories • Talkin' 'bout [their] generation
The highs and lows of working with older adults	• The best classroom is at the feet of an older adult • Managing ethical issues

The First Question: Whether to Conduct Therapy or Not?

There were instances in which participants deliberated on whether to initiate or continue psychotherapy with older adults.

Determining suitability. Several participants referred to the notion of 'suitability' whereby older adults were perceived as more or less compatible with psychotherapy depending on certain characteristics. One factor contributing to perceived suitability was 'psychological-mindedness' which was coined as older adults' capacity for introspection and willingness to consider other perspectives. Psychological-mindedness was perceived as necessary for therapeutic change, although not all older adults were perceived to possess it.

> *sometimes we'll get referred a patient and the referral person says '… can you assess them for suitability?' and the first thing we look for in the assessment is the person's psychological-*

> *mindedness i.e., are they able to talk about thoughts, feelings, behaviours? Do they have insight into their experience and situation? … that's kind of a fundamental aspect that you need in order to engage well with psychotherapy (Participant 6).*

Notably, psychological-mindedness was a lesser issue for participants in private practice compared to those in public settings.

> *… what you find is those [older adults] that come along are the ones that are adapted partially already so that's why they come to therapy uh they have some knowledge or some willingness to test things out (Participant 3).*

Cognitive functioning was also considered when determining older adults' suitability. Whereas mild cognitive impairment could be accommodated, moderate-severe impairment was perceived as hindering older adults' engagement in psychotherapy. In such instances, participants used clinical judgement to determine if psychotherapy would be viable, although there was some uncertainty around what subjective criteria to use.

> *… it's too much cognitive impairment if they don't remember who you are … I guess that sounds really obvious I mean maybe at an earlier point um (.) yeah if there's (.) or it really depends on the case … (Participant 11).*

Generally, participants trialled psychotherapy with older adults whose suitability had been questioned (provided their work resources allowed for it) because they believed that there was capacity for some form of modified therapeutic intervention. A creative and resourceful approach was adopted to accommodate older adults' needs, and it was apparent that participants perceived some responsibility in achieving therapeutic change.

> *… you can have a person with a neurocognitive disorder, not going to be amenable to psychological therapy, and you go "there's still some things we can do here" so we may not be doing formal CBT we may not be going to the depths of schema therapy but there's still some behavioural interventions we can implement with the support of the person's networks … [if therapy is not working] just try something else … I'd have to just go back to the drawing board, look at my formulation and find a different point of intervention … (Participant 1).*

Advocating for the role of psychology. For participants working in multi-disciplinary settings, conducting psychotherapy with older adults sometimes meant promoting psychology to other health professionals with differing case formulations and treatment approaches.

> *… chronic pain was a huge trigger for [an older client]and I started doing some work around pain management strategies … but only being about two sessions in the doctors were really concerned about her level of suicidality and they wanted to start ECT so it became a*

> *negotiation around "well in my formulation I see pain as being the crux of all of this and we can get to the end of ECT, discharge and still no strategies to deal with the pain, so why don't you give me another fortnight?" … I did get my two weeks and then some more and she didn't end up having ECT (Participant 1).*

Participant 4 – whose secondary job was in private practice – needed to communicate with medical professionals so as to enhance referrals.

> *… I'll provide bulk-billed home visits for older clients and I've only got a handful of those and I'm forever writing to GPs saying I'm here for them [older clients] … there's still a lot of change [in education] needed within our medical system (Participant 4).*

Therapy with Older Adults is the Same but Different

Participants asserted that psychotherapy with older adults was fundamentally the same as that with non-aged adults because the underlying repertoire of clinical skills and principles used are alike. Rather, what distinguished working with older adults was the distinctive ways in which psychotherapy was commonly tailored. Whilst these modifications were not implemented in every case or specific to just older adults, they did manifest more frequently or were considered more imperative.

It's not how old you are, it's how you are old. Participants asserted that, given the heterogeneity of the ageing population, assumptions about older adults' therapeutic needs could not be made according to age. Rather, having an intimate understanding of each client's individual developmental issues (e.g., physical, cognitive, and social/lifestyle status) was considered essential to optimising treatment. Developmental factors were perceived as often tied to older adults' presenting issues; Participant 8 explained that "some of them they've got major depression and are having trouble adjusting to what being older means, or getting health diagnoses and what does that mean about mortality?". Many participants preferred an acceptance approach when older adults' developmental concerns were perceived as realistic. Participant 2 stated that she used "a lot of Acceptance and Commitment Therapy because generally speaking it's about acceptance of what's happening to their body, their mind, the grief and loss; there's no way around changing that".

Concurrently, some older adults held unhelpful assumptions about ageing. Here, participants used traditional cognitive techniques to help restructure their self-appraisals.

> *I've seen an 'an old dog can't learn new tricks' type attitude or 'it'll take too long, I don't have that long' … a practical response might be "when have you learnt something else new? When have you had a new experience in the last few years and how did you go?" (Participant 10).*

Logistically, accommodations were sometimes made for older adults' physical or educational needs.

> *I run a mindfulness group and probably the next round I'll make it shorter, lasting 1.5 hours instead of 2 hours, just because it's too much for them especially if they have physical frailties and if they have to sit still and if they're in pain … and currently I have two people who don't write at all so I'm saying that the primary home practice is listen to some recordings and then people have the option of doing some written work and readings … (Participant 13).*

Naturally, participants also modified psychotherapy to accommodate older adults' cognitive needs if necessary. Modifications for memory decline were consistent with the literature's recommendations (Rehm et al., 2017). Greater use of behavioural than cognitive strategies was also preferred when cognitive impairment was more significant.

Work systemically. Several participants working in the public sector adopted a systemic approach when working with older adults.

> *Older adults might bring an isolated list of symptoms but there may be things creating barriers to change that are outside the person and enablers, so things that um perhaps reinforce assumptions of why someone might stay the way they are, but also exceptions like things in their environment that actually encourage other ways of being and that's really helpful to know that (Participant 8).*

Working systemically could lead to confidentiality issues. When family or caregivers requested information, participants described having to strike a balance between following their ethical responsibilities and offering information that would be beneficial for the person's care.

> *… especially in an aged-care facility or hospital you lose a lot of privacy and so it was really important that I kept a lot of the stuff they said private so I'd have my own psychology files and then information I put into an aged-care facility computer was very minimal like 'worked on this strategy, please encourage them to use it to help reduce panic', we just translated what was important for staff to know … that's a really important ethical issue, that the psychologist doesn't pass on information that will be misinterpreted by the nursing staff (Participant 11).*

Consider older adults' histories. Most participants drew upon older adults' life experience in an attempt to make psychotherapy resonate more strongly with them. Recalling previous successes and difficult situations reportedly helped older adults to restructure their perceptions about their current situation and to generalise existing coping strategies to novel challenges.

> *... older people have a wealth of experience and that should not be dismissed, so listening to their story, looking at how they've dealt with difficulties in their life ... they can't get to the age that they have and not have built up resources ... you do this with younger people but with older people there's probably more breadth of experience to draw from (Participant 5).*

Younger participants constructed this approach as a way to build trust. Apparent in their responses was a humbleness that they were not the "expert" within the relationship.

Talkin' 'bout [their] generation. Many participants emphasised how older adults' generational factors shaped the course of psychotherapy. For example, older adults reportedly had "old-fashioned" manners characterised by appreciation for the psychologist. This was not as commonly perceived with non-aged clients.

> *... young people they don't turn up to appointments on time or at all, they don't understand the effort that's going into it, whereas older people are much more socially astute so they're really pleasant to work with in that way ... [older people] recognise you know you're lucky to get someone's time of day in this world ... they appreciate it (Participant 11).*

At the same time, some participants noted that older-old clients (approximately 75+ years) occasionally expressed less formality and less therapeutic distance in session (e.g., being verbose) compared to younger-old clients (approximately 65-74 years) and non-aged clients. This was attributed to older-old adults growing up with less access to information about the nature of psychotherapy. When this occurred, participants reported that they had to reorient the older-old client back to the purpose of psychotherapy.

> *A 65 year old feels, there's obviously variation, but more adult-like in that they understand what a therapist is and there's a professional element ... versus someone who's 80 let's say, it feels like if you structure something that's not necessarily the most effective thing for them, they'd be very happy if you would accept a cup of tea and have a chat ... for many [older-old] people I guess they didn't grow up with it [psychology], they don't really see it as these professional divides ... they're surprisingly gregarious in their conversation ... it's about slowly providing that psychoeducation as to what we're there for and certainly you're*

interested in what's going on in their life but "these are the things we're working on right now" (Participant 7).

However, for other older-old clients, this unfamiliarity with psychotherapy could initially create apprehension. Here, participants acted less formally so as to normalise the therapeutic process. This was described as encouraging the human-human connection while also acknowledging one's professional responsibilities.

I give them the clear message that we are on this planet together so turning up to therapy is like going down and getting their hair cut, like getting the bus and buying a few things for dinner, there's nothing terribly out of the ordinary, "we're just doing something extra because I'm not coping" ... that's not flippant, that's keeping in mind I have a responsibility to you as my client to help you get better and I've got a responsibility to you of respect (Participant 12).

Participants noted that older clients commonly medicalised their psychological issues in line with the historically predominant medical model. This could be counteracted by socialising them to psychological concepts, although it required sensitivity toward their medical interpretations and a graded treatment approach.

... you're asking them to consider that maybe these gastrointestinal issues are due to their mood disorder and that might get their back up a bit because "you're saying it's all in my head" so you need to be tactful around how you deliver that ... I think you need to validate their [physical] experience, do a lot of education around the way our body works so "yes you're feeling it here in your gut but it's also related to what's happening in the brain and we need to work on both" ... if they're not as convinced by what psychology can offer I start by trying to get them to address the physical symptoms first and work outwards ... (Participant 1).

Participants also highlighted that older clients had often experienced trauma and grief throughout their life stemming from historical events (e.g., World War II), or they were more likely to have experienced adversity simply because of the length of time they had been alive. However, participants noted that because stoicism was historically reinforced, older adults often lacked emotional expression around their experiences. Consequently, the pace of therapy was slowed to offer them space to connect with their emotions and express vulnerability.

I find it more so with older generations they don't know how to express emotions ... generally speaking emotions weren't really discussed you know, they didn't get as much validation ... I find that theme of 'I must not show my emotions', 'I have to be the strong person' ... I have to be very gentle and not go places too quickly yeah so just opening up a dialogue um the first thing I would generally do is just psychoeducation on emotions ... (Participant 2).

As well as a slower pace, simply listening to older clients was perceived as valuable because they had had minimal opportunities to process their traumatic experiences or grief.

> *… she shakes and jumps around in the office chair when we talk about her past and I ask her to tell me all about it; the interesting part is she settles down, it's almost as if getting it out is a relief for her because this means that somebody else is listening … (Participant 12).*

The Highs and Lows of Working with Older Adults

Participants perceived several rewards and challenges when working with older adults.

The best classroom is at the feet of an older adult. The majority of participants who ranged in age from 31-45 years alluded to gaining greater self-awareness of their own present and future lives. Access to older adults' stories – which they otherwise would not have – enabled insight into the importance of meaningful relationships as one ages. These participants subsequently reflected on their present values.

> *It's sort of changed my relationship with understanding values and priorities, seeing when someone reaches this age the things that really do matter to them might be really different from what I would have necessarily thought my future would look like … various achievements will certainly comfort someone to an extent and bring opportunities but it does seem that relationships really do sustain most strongly … in our society we are becoming very nuclear and so working with older adults challenges that (Participant 7).*

Again, for participants ranging in age from 31-45 years, working with older adults offered an increased sense of optimism about their own ageing.

> *[I've learnt] not to view age as an inadequacy or as a barrier because I've seen that hasn't been the case for a lot of people and it's not a time when you become stuck or start to close off but actually it can be a time that you can open yourself up to things more … I've learnt that ultimately you make of it [ageing] what you put into it … (Participant 10).*

Several participants of varying age also felt privileged listening to older adults' personal stories and gaining insight into a different historical period.

> *… it's almost endless where you go with someone who's been on this earth for 80 years and you're kind of torn because you have this acute problem that you're dealing with but "let's talk about all this other stuff that's happened and how did you get through that and what was that like for you and what was it like growing up in a time when psychology wasn't really a thing?" … delving into their life and pulling out all of the dark and twisted bits and all of the interesting bits, that's what I find most rewarding (Participant 9).*

Managing ethical issues. In addition to confidentiality issues when working systemically, several participants identified receiving gifts or hugs, elder abuse, and

euthanasia as other distinctive ethical issues that could arise when working with older adults. These had to be managed cautiously due to the seriousness of the potential consequences and the limited formal guidance available.

Participants noted that older clients occasionally demonstrated their appreciation by offering gifts or initiating hugs, thus moving away from typical boundaries within a professional relationship. When responding to this, participants reconciled their ethical responsibilities with the magnitude of the gesture, the client's presentation, and the impact their actions would have on rapport. Participants justified accepting tokenistic gifts or hugs if it was appropriate within the therapeutic context and in the best interests of rapport.

> *... these few times [receiving hugs] have been older women at the end of therapy where it didn't have any flavour that I felt was blurred lines ... framed in a schematic perspective if it is this limited re-parenting context then if someone makes this sign of connection then in a way it would be appropriate to give that hug back because that would be within the bounds of the therapist's role ... if I said "oh don't hug me I'm your therapist" would that challenge that relationship that in and of itself can be really therapeutic? It's kind of weighing up what's the cost and what's the benefit ... if it was an older gentleman who had some inhibition issues it might be a very different conversation and reaction (Participant 7).*

When responding to elder abuse, participants considered the imminent risk to the older client, the older client's perception of the situation, and their own legal and ethical responsibilities. Decisions were made pragmatically and in conjunction with peer supervision.

> *... unless it's an imminent risk like the person is at risk of being homeless or their lives are in danger you aren't going to go straight to the police ... it's often about that advocacy and working with the person "what do you think is going on? Are you ok that your child takes your credit card and buys groceries?" because some of them will say it's fine and that they like to help their child so it's kind of checking in with them and if they were to act how would they go about that? ... you're getting the team's advice constantly (Participant 9).*

When older clients with chronic or terminal illness were considering euthanasia, Participant 10 alluded to an intricate juggle between managing his own attitudes, respecting the client's right to autonomy, and managing his own ethical and legal responsibilities. If immediate intent to act was not identified, Participant 10 limited his role to exploring the older client's rationale for euthanasia, informing them of the alternatives to euthanasia, and

helping them to understand the euthanasia process, including medico-legal and relationship implications.

> *… the challenge was trying to put aside my approval or disapproval [of euthanasia] and just work with her around what she wanted to do and why and helping her think through the ramifications for her family and potential legal ramifications … rather than talking about how it was going to be done, it was really thinking about her own understanding and making sure she was clear about that, and that way it wasn't for me to judge in any way or get into the ins and outs and what that meant for me in terms of any ethical or legal issues … (Participant 10)*

Discussion

Overall, this study highlights that although psychotherapy with older adults does not require a fundamentally different repertoire of clinical skills, adjustments to the structure or content of psychotherapy may sometimes be necessitated according to their life experience, their experience of ageing, and their broader environmental context (Table 3). This is consistent with geropsychology frameworks (Knight & Poon, 2008). Participants used knowledge about ageing and clinical judgement to accommodate nuanced clinical issues, otherwise therapeutic progress may have been impeded. Certain aspects of participants' experiences depended on their work setting and age.

Older adults' suitability to psychotherapy is often questioned on the basis of their psychological-mindedness and cognitive functioning (Lee, Volans, & Gregory, 2003a, 2003b). Rather than this prematurely restricting older adults' access to psychotherapy, participants demonstrated that such an assessment can be constructive if it informs how psychotherapy can be tailored to older adults' needs. Indeed, appropriate psychological intervention can be effective for older adults with cognitive impairment (Orgeta, Qazi, Spector, & Orrell, 2015). The effect of psychological-mindedness on treatment outcomes is less clear (Boylan, 2006), although some participants suggested that it may not be a frequent issue in private practice. If older adults who access private psychologists tend to seek help autonomously, they may be predisposed to a psychological world view. Overall, in contrast to common notions that older adults are not suited to psychotherapy, it is worth at least

trialling psychotherapy if resources allow for it. To realise this, the findings suggest that psychologists become adept at collaborating with other care providers and managing disagreements across care teams. The identified issue of under-referral by doctors also highlights the need for outreach and the provision of educational programs to medical professionals (APA, 2014).

Consistent with some literature (Lunde & Nordhus, 2009), the findings support using an eclectic approach with older adults, particularly the combination of acceptance and traditional cognitive techniques. Given the breadth of what older adults can present with, offering a broad range of strategies can complement their varying needs. It is intuitive that acceptance approaches could help manage distress resulting from age-related challenges (e.g., physical illness), whereas traditional cognitive restructuring could help counteract unhelpful self-appraisals which undermine one's sense of self-efficacy (e.g., "I'm too old to change"). The effect of cognitive restructuring may be enhanced if combined with statistics about longevity and ageing. Importantly, older adults will require guidance around deciding which approach to use for a given situation. Studies combining acceptance and traditional cognitive approaches for older adults are scarce and based on individual cases, although the results have been positive (Lunde & Nordhus, 2009; Marino, DePasquale, & Sirey, 2015). Thus, further research with larger samples and comparison treatment groups is warranted.

The way in which participants harnessed older clients' life histories is akin to reminiscence therapy. Reminiscence has proved effective when used independently with older adults (Elias, Neville, & Scott, 2015), and this study suggests that it can also be integrated into a broader therapeutic approach. Using reminiscence techniques may especially benefit older adults with cognitive impairment as tapping into their intact memories may help them to express their strengths and communication skills (Woods, Spector, Jones, Orrell, & Davies, 2005). Younger participants also suggested that reminiscence techniques may aid the

therapeutic alliance – as well as minimising the effect of any generational differences, they may also satisfy older adults' need for generativity (i.e., mentoring younger generations; Ehlman & Ligon, 2012). Older adults' perceptions of the alliance are pertinent to treatment outcomes (Mace et al., 2017). Further, as physical comorbidities predict worse treatment outcomes for older adults (Veerbeek, Oude Voshaar, & Pot, 2014), this study reinforces the need to consider logistical issues (e.g., duration, homework, seating, and office accessibility).

When managing confidentiality within a systemic context, this study reinforces how psychologists can offer the least amount of information necessary to achieve the purpose of the disclosure (Bush et al., 2015). Caution is required with information that could be misinterpreted (e.g., disclosure of a Borderline Personality Disorder diagnosis to aged-care facility staff may result in the older adult being treated differently). Notably, only participants working in public settings discussed systemic work, perhaps because private practice offers less opportunity to work systemically. Alternatively, older adults who independently seek private psychologists may have greater control over their lives, thus not requiring a systemic approach. Irrespective of workplace, all psychologists should assess the degree of systemic work needed as, for families in particular, greater caregiver burden is associated with less response to intervention among older adults (Martire et al., 2008). Family practice frameworks may offer guidance around family work (e.g., Mottaghipour & Bickerton, 2005).

This study extends theoretical assumptions by offering insight into how generational factors can manifest in session. As literature suggests (Laidlaw & McAlpine, 2008), participants emphasised the value of socialising older adults to psychological concepts; although, it is important not to invalidate any alternative understanding older adults may have of their symptoms as this may rupture rapport. Findings also align with the notion that earlier and later born cohorts of older adults can present differently (APA, 2014). Participants attributed older-old adults' verbosity to their limited understanding of the nature of

psychotherapy, although social isolation or age-related neuropsychological factors may also contribute (Clarke, 2009). Discussing what constitutes relevant discourse at the onset of psychotherapy may help if re-orientating older adults during later sessions, keeping in mind that "off-topic" stories can offer insight into their cognitive styles (Clarke, 2009). Overall, identifying which sub-group older clients belong to may be useful within a broader evaluation of their therapeutic needs.

Whereas a slower pace in psychotherapy is typically attributed to older adults' cognitive changes, participants suggested that it was sometimes necessary to accommodate inhibited emotional expression (related to stoicism). In a non-clinical population, greater emotional control may be part of older adults' tendency for enhanced emotional regulation (Urry & Gross, 2010); although, in a clinical population it may impede insight and the cognitive integration of experiences (Suedfeld & Pennebaker, 1997). Yong (2006) relatedly found that stoicism delayed older adults from reporting physical pain and receiving appropriate treatment. If emotional inhibition interrupts psychotherapy, psychoeducation and validation can encourage emotional self-disclosure. Gender and culture may also influence emotional expression but this was not explored in the current study.

This study found that, for psychologists in the younger to early middle age bracket in particular, working with older adults can aid personal development and challenge one's ageing stereotypes. Perceiving such rewards may foster the therapeutic process. For example, Kurina (2013) found that psychologists' positive attitudes towards older adults predicted a stronger therapeutic alliance. Although health professionals in other studies similarly reported learning from older adults' stories (Lee et al., 2003a; Smith & Pearson, 2011; Webb et al., 2016), this study suggests that this learning surrounds values. Further, increased optimism towards one's own ageing is inconsistent with hypotheses that exposure to older adults can trigger anxiety about ageing (Laidlaw & Pachana, 2009). Participants' positive stance

towards geropsychology may have contributed to this (Koder & Helmes, 2008b). The personal rewards identified in this study may have been less salient for older participants given that they may have already attuned their values and attitudes towards ageing within the context of their own life experience.

This study demonstrated that older adults may divert from professional boundaries by offering gifts or initiating hugs, and ethical dilemmas concerning elder abuse and euthanasia can arise. The clinical insight offered in this study helps to reconcile the ethical resources available with the nuances of practice (Bush et al., 2015). Reasons for older adults offering gifts and hugs may include their assumptions about the therapeutic relationship, generational or cultural factors, or even the intimacy of providing psychotherapy in home settings (Yang, Garis, Jackson, & McClure, 2009). As highlighted, accepting gestures depends on the context in which they are given. Factors to consider include the magnitude and intent of the gesture, the client's presentation and culture, the length of treatment, and the impact on rapport. Flexibility in accepting tokenistic offerings may ultimately aid the therapeutic alliance.

Without any current legal reporting requirement for elder abuse in Australia, the findings suggest that psychologists balance their ethical responsibilities with the welfare and wishes of the older client when responding to suspected or actual elder abuse. As every case will require a different course of action, supervision and advice from elder abuse agencies may prove useful. Guidelines from the medical literature may also serve as a reference (e.g., Aravanis et al., 1993). Overall, with 2.5-5% of the Australian ageing population estimated to experience elder abuse, screening for it constitutes good practice (Kurrle & Naughtin, 2008).

Further, until euthanasia is legalised in Australia, questions exist about psychologists' ethical and legal responsibilities around reporting. As highlighted, if older adults are considering euthanasia, their rationale and understanding of the process and implications should be explored (for example questions see Hudson et al., 2006). If intent to act and

available means have been identified, supervision and legal advice should be sought. If euthanasia is legalised in Australia, psychologists can play a meaningful role in assessment and psychosocial support procedures (Australian Psychological Society, 2008). Training in end-of-life issues will be beneficial here.

This study assists in closing the gap between geropsychology research and practice. Important clinical information has been extended and collated in an easily accessible manner, offering practical guidance that can be meaningfully integrated into practice (Table 3). The recruitment of participants nationally and from diverse workplaces enabled access to the breadth of this field; albeit, the existence or influence of inter-state differences was not explored. Further, the findings anecdotally demonstrate the utility of extant geropsychology frameworks. They also warrant further research about the effectiveness of modifications (e.g., considering history, greater socialisation, and slower pace) and non-specific therapeutic factors (e.g., listening) on treatment outcomes for older adults. Conversely, the mostly self-referring sample may have minimised certain issues so as to not negatively portray geropsychology. As only clinical psychologists partook, the views of general psychologists or those with other specialisations (e.g., forensic) are also unrepresented, and thus, are an avenue for future research. Additionally, the role of older adults' culture within the current findings was not explored despite it likely shaping how they engage in psychotherapy.

Conclusion

When working with older adults, psychologists must be prepared to skilfully apply knowledge about ageing to psychological methods. However, becoming proficient in geropsychology may be difficult because extant relevant literature is piecemeal and geropsychology coursework and placements in Australia are scarce. Thus, one way in which psychologists can bolster their knowledge and confidence about geropsychology may be by accessing the clinical insights of those familiar with working with older adults. In this way,

this study highlighted a range of nuanced clinical issues which may arise – and require consideration – when working with older adults. Although older adults represent a diverse population with treatment decisions ultimately requiring clinical judgement, the current findings can serve as a broad reference for psychologists unfamiliar with this group, helping them to identify their training needs and become better prepared for a growing older client base. Overall, working with older adults requires nuanced knowledge about ageing, and it can also be a personally fulfilling experience.

Table 3

Practical Ideas for Working with Older Adults Based on the Current Findings

- Consider older adults' psychological-mindedness and cognitive functioning when tailoring psychotherapy to better suit their needs.
- Offer outreach and education to local health care providers to advocate for the role of psychology with older adults.
- Assess suitability of an eclectic approach based on older adults' presentation.
- Accommodate logistical and physical barriers to older adults' engagement.
- Work systemically if indicated and consider older adults' rights to confidentiality.
- Draw upon older adults' histories as a therapeutic technique.
- Accommodate generational factors as required (e.g., re-orientating back to the purpose of psychotherapy, normalising the therapeutic process, socialisation to psychological concepts, slowing the pace of sessions, or active listening).
- Consider accepting tokenistic gestures if it is appropriate within the therapeutic context and if it is in the best interest of rapport.
- If responding to elder abuse, consider the imminent risk to the older adult, the older adult's perception of the situation and their wishes, and your own legal and ethical responsibilities. Seek advice through supervision and formal elder abuse agencies.
- If older adults are considering euthanasia, explore their rationale and understanding of the process. If an imminent risk of action is identified, seek formal supervision and legal advice in regard to mandatory reporting requirements.

Note. Implementing these ideas requires clinical judgement and consideration of each older adult's needs and circumstances.

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