Adultspan Journal

Volume 15 | Issue 1 Article 5

4-1-2016

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Received 01/15/15
Revised 10/28/15
Accepted 10/29/15
DOI: 10.1002/adsp.12019

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Counselors who work with older adults with bipolar disorder are in a unique position to help them navigate their challenges. Older adults with bipolar disorder have lived decades with mental illness and also face the regular aging process. Narrative therapy provides counselors with a framework to deal with these issues.

Keywords: narrative therapy, bipolar disorder, older adults, guided autobiography

According to the Institute of Medicine (2008), the number of adults age 65 and older in the United States totals more than 70 million, making up about 20% of the entire U.S. population. Additionally, the average life expectancy in the United States is predicted to increase to 84.5 years in 2050 (United Nations, 2011). As the number of older adults increases, so will the number of individuals who are living with severe mental illness, making bipolar disorder (BD) in older adults a growing public health concern. According to the National Institute of Mental Health (2014), the 12-month prevalence rate of adults living with BD is 2.6%. Furthermore, Depp and Jeste (2004) found that the proportion of individuals admitted to inpatient facilities diagnosed with BD remains the same between the under-65 and over-65 age groups.

Thus, it is imperative we expand our understanding of how to best serve the growing population of adults age 65 and older. There is a large gap in knowledge about the presentation and treatment of clients 65 years and older living with BD. Extensive research and literature exist about the symptoms, course, and treatment of BD in young adults (e.g., Doherty & MacGeorge, 2013; Proudfoot et al., 2012; Scott et al., 2013); however, few studies provide

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parallel information for older adults. Additionally, the counseling field is unprepared to serve this population because professionals have relied, in general, on genetic explanations of etiology and the use of psychopharmacology to treat the disorder (Miklowitz & Scott, 2009).

One treatment approach used to treat multiple mental health concerns in older adults is narrative therapy (Bohlmeijer, Kramer, Smit, Onrust, & van Marwijk, 2009; Kenyon & Randall, 1999; Korte, Bohlmeijer, Cappeliez, Smit, & Westerhof, 2012; Kropf & Tandy, 1998; Morgan, Brosi, & Brosi, 2011). Because of its demonstrated utility with older adults, narrative therapy should be considered as an appropriate method to use with older adults living with BD.

The purpose of this article is to examine challenges encountered by older adults living with BD and to discuss ways narrative therapy may be effective with these clients. To this end, we explore characteristics of clients living with BD later in life, review the literature on narrative therapy, and apply the narrative therapy approach in a case illustration of an older adult living with BD.

BD IN OLDER ADULTS

BD is typically diagnosed during young adulthood; the mean age of onset for Bipolar I is 18 years according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. [*DSM-5*]; American Psychiatric Association, 2013). Although the onset for BD can occur in individuals in their 60s or 70s, our focus is on those initially diagnosed earlier in life. No matter the age of diagnosis, BD is characterized in the *DSM-5* by depressive and manic episodes, poor judgment, grandiosity, disruptions in sleep and appetite, and fatigue, among many other possible symptoms (American Psychiatric Association, 2013). Bipolar I co-occurs with anxiety disorder in nearly three fourths of diagnosed individuals; substance abuse also is a common comorbid illness (American Psychiatric Association, 2013).

The reported prevalence of BD in older adults varies, from as low as 0.1% in adults older than 65 years (Sajatovic & Chen, 2011) to closer to 2.6%, matching the prevalence for all adults with BD (Depp & Jeste, 2004). However, Depp and Jeste (2004) stated that the prevalence of BD was 6% in geriatric psychiatric outpatients and noted that older adults with BD account for 8% to 10% of late-life inpatient admissions. In another study of older adults with BD, Depp et al. (2005) found that 17% of older adults reporting to the emergency department have BD. Their meta-analysis showed that the proportion of individuals diagnosed with BD admitted into inpatient care might be similar to younger patients, because 9.6% of inpatient individuals over 65 years of age and 11.5% of the under-65 age group have a BD diagnosis. It is often in these medical settings—inpatient, outpatient, and emergency room—that researchers have been able to get the clearest picture of older adults living with BD.

A CLINICAL PICTURE

Research has shown that the longitudinal course of BD is heterogeneous (Depp & Jeste, 2004; Goldberg, 2010), meaning there is multifinality in the outcomes of the disorder in older adults. For example, Sajatovic and Chen (2011) pointed out there often is a difference in illness polarity, symptom severity, and phase (acute vs. stabilization). Risk factors influencing the prognosis of BD include stressful life events, severe childhood abuse, family history, substance abuse comorbidity, and many other variables (Goldberg, 2010). According to Tohen et al. (2003), although some older adults with BD show improvement in symptoms, few achieve full recovery. Tsai, Kuo, Chen, and Lee (2002) found that although older clients are at higher risk for suicide in general, there is no additive risk for BD clients. Although the outcomes for individuals with BD might differ greatly for each individual, some researchers are trying to capture the clinical experience for older adults with BD.

Depp and Jeste (2004) conducted a meta-analysis of studies looking at older adults (age 50 and above) with BD. They found a lack of information concerning prevalence, etiology, or clinical features of BD late in life. Overall, Depp and Jeste stated there was little consensus about the presentation and symptoms of the illness later in life. Because of this, there is disagreement in the literature about what BD looks like late in life.

Commonalities in BD

What is even more unclear are the differences, if any, between the older population and younger individuals with BD. In adults in general, BD is a mood disorder that includes many symptoms of depression in addition to cycling into episodes of mania or hypomania. The *DSM-5* (American Psychiatric Association, 2013) stated that although many individuals return to a fully functioning level, many also struggle to return to their premorbid functioning; this often means individuals are impaired in their work role, which results in lower socioeconomic status compared with the general population. Also, individuals with BD perform worse than the general population on cognitive tests, and the result of these impairments might increase vocational and interpersonal difficulties that persist even when the person is in recovery (American Psychiatric Association, 2013).

In terms of presentation of BD in older adults, Depp and Jeste (2004) found several studies that reported rapid cycling patterns of mood episodes within geriatric patients, but the difference between these patients and younger rapid-cyclers is unknown. In one of the more recent studies comparing age groups with BD, Al Jurdi et al. (2012) compared younger and older patients with BD and found no differences in the frequency of acute depression or manic symptoms between the two groups. However, Nivoli et al. (2014) analyzed the differences in clinical characteristics between older and younger BD patients and found older patients presented predominantly depressive polarity, compared

with younger patients who presented mostly manic symptoms. Nivoli and colleagues claimed theirs was the first study reporting a difference in polarity of BD symptoms based on age, suggesting that older BD patients might be a subgroup with specific clinical needs.

Unique Factors in Older Clients With BD

The issues that plague older adults rather than younger people with BD seem to be common to the aging process. Lala and Sajatovic (2012) conducted a meta-analysis focused on comorbidities in BD with patients 50 years or older. They found 12 studies that gave the following picture: Older adults with BD appeared to experience significant rates of cardiovascular disease, Type 2 diabetes, and endocrine abnormalities. Although analysis showed no difference in the prevalence rates for comorbidities between older adults with BD and the general geriatric population (Lala & Sajatovic, 2012), Fenn et al. (2005) found that the number of comorbid medical conditions among patients with BD increases with every decade of life, with an average of 11 conditions in patients 70 years or older. Older adults with BD also may have increased physical health issues compared with other older adults (Fenn et al., 2005; Tsai, 2015).

Furthermore, there is a substantial amount of correlational research linking BD and cognitive impairment in older adults (Aprahamian, Nunes, & Forlenza, 2013; Delaloye et al., 2009; Gildengers, Chung, Huang, Aizenstein, & Tsai, 2014; Schouws, Stek, Comijs, Dols, & Beekman, 2012). For example, compared with a healthy control group, older adults with BD performed worse at tasks that measured cognitive functioning (Schouws et al., 2012). The findings caused researchers to hypothesize there is something about BD that results in cognitive impairment over time. Aprahamian et al. (2013) stated that cognitive deficits might be due to the long-term burden of mood episodes, adverse effects from years of taking medication, and common comorbidities associated with BD such as substance abuse.

Finally, Dautzenberg et al. (2015) conducted a needs assessment among patients age 60 years and older who were receiving services for BD. They found that, overall, needs were low; however, the most common unmet individual needs included household skills, physical health, medication, and psychological distress. This and other research show there are special considerations for people who have been living with BD for a long time, but the treatment modalities, as outlined in the next section, have remained the same for most individuals with BD, regardless of age.

COMMON TREATMENT MODALITIES

Although much is known about treating BD in general, there is little in the literature about how to treat BD in older adults, so they are typically treated the same as the younger population. There is much discussion about medication

treatment, which is as common among older BD clients as their younger counterparts (Sajatovic & Chen, 2011). Besides medication, electroconvulsive therapy (ECT) continues to be used to treat both the manic and depressive symptoms of BD (Kennedy, 2008; Sajatovic & Chen, 2011). Van der Wurff, Stek, Hoogendijk, and Beekman (2003) conducted a meta-analysis investigating the efficacy of ECT with older adults and found that not only is ECT generally effective against severe depression, but in some studies it improved cognitive functioning in older patients.

Psychosocial intervention is considered to be an essential part of the treatment of clients with BD. However, as Bartels, Forester, Miles, and Joyce (2000) discovered, older BD clients seek psychotherapy less frequently compared with clients with other disorders. Bartels et al.'s study compared the use of mental health services between older clients with depression and older clients with BD. Findings revealed that BD clients were more likely to use case management, outpatient, skills training, partial hospitalization, and psychiatric hospitalization services rather than psychotherapy during the course of the study.

Other interventions commonly used with clients with BD include cognitive behavior therapy (Searson, Mansell, Lowens, & Tai, 2011), interpersonal and social rhythm therapy (Frank et al., 2005), and family-focused therapy (Miklowitz & Scott, 2009; Sajatovic & Chen, 2011). Patients receiving psychotherapy stemming from these three intensive approaches had significantly higher recovery rates after 1 year than clients receiving treatment as usual (Miklowitz et al., 2007).

Although all the aforementioned treatments appear valid, they do not specifically account for the unique issues present in older adults with BD. For example, Schouws, Paans, Comijs, Dols, and Stek (2015) found that older BD patients demonstrated a more passive coping style compared with healthy older patients. Schouws et al. explained that the main coping strategy for their participants was to accept the situation. They called for therapeutic interventions that focused on helping older BD patients demonstrate a more active coping style, which is thought to lead to better psychological outcomes (Jeste et al., 2010). One approach that has been used minimally with the entire BD population, but might be well received by older adults especially, is narrative therapy, which we outline in the next section.

THE PROPOSED APPROACH: NARRATIVE THERAPY

It is through the humanistic approaches that mental health counselors can contribute to the well-being of older adults who are living with BD who likely have lived a lifetime plagued with instability and stigma because of their diagnosis. Narrative therapy is a form of psychotherapy founded by Michael White and David Epston in the 1980s. They developed an approach that addresses the damaging effects society has on the individual. In their book, *Narrative Means*

to Therapeutic Ends (White & Epston, 1990), they explained the dominant story created by society for an individual is often oppressive, and the solution to this is opening space for the authoring of alternative stories. Additionally, narrative therapy uses language to attach meaning to the self and one's lived experience (Neimeyer & Stewart, 2000).

In narrative therapy, counselors help clients step outside of their selves and see how they are constructing their narrative, or dominant life story. Clients progress through narrative therapy in four distinct steps (Morgan et al., 2011; White & Epston, 1990). The first step is to identify and deconstruct the dominant narrative in an effort to identify the effects, dangers, and limitations of one's own ideas and practices. The second step is externalizing the problem, encouraging clients to objectify the problem they experience as oppressive. In the third step, clients identify instances that fall outside their dominant story, known as "unique outcomes" (White & Epston, 1990, p. 15). These occurrences show clients they can reach back and revise their own life narrative; for example, a person who is usually isolated from strangers recalls one time when she greeted a man on the street. Using unique outcomes allows clients to create new meanings in the present. The final step, reconstruction, flows naturally from the discovery of unique outcomes. Clients are encouraged to "re-author" (White & Epston, 1990, p. 17) their lives, inviting new descriptions of self, others, and relationships that reflect the new information.

Because narrative therapy does not focus on specific types of problems, it can be used with a broad range of clients. Research has demonstrated narrative therapy's success with people with eating disorders, attention deficit/hyperactivity disorder, and posttraumatic stress disorder (Madigan, 2011; van Emmerik, Reijntjes, & Kamphuis, 2013; Zang, Hunt, & Cox, 2013). Narrative therapists also work extensively with clients age 55 and older.

USING NARRATIVE THERAPY WITH OLDER ADULTS

Older adults face unique challenges during the ending phase of life. Kropf and Tandy (1998) outlined two types of changes in the lives of older adults that could make narrative therapy especially meaningful to this population. The first is the change in functioning caused by the loss of a life partner or self-care after an illness or injury; the second is the change in social experience as older adults engage in normative behaviors for this age group, such as retiring from work and abstaining from sexual relationships. Because later life is a time of tremendous change and loss, counselors can assist these clients in meaning making of past and present experiences.

There is an entire field devoted to using the narrative approach with older adults, called *narrative gerontology*, which explores the numerous ways stories function in people's lives and, conversely, how people function as stories (Kenyon & Randall, 1999). This differs from narrative therapy because it emphasizes

the "inside" of the aging process and assumes people do not merely have stories but, in fact, *are* their stories (Osis & Stout, 2001). However, the emergence of such a field underscores the utility of a narrative approach with older adults.

Aligned with this point of view, some researchers and scholars have explored the use of narrative therapy with older adults who have a lifetime of stories to share. Morgan et al. (2011) explained that using narrative therapy with older adults gives them a space to tell their stories about their relationship with substance abuse. Furthermore, a quasi-experimental study by Bohlmeijer et al. (2009) showed that older adults with depressive symptoms displayed significantly less depression symptoms and higher levels of mastery after participating in a narrative therapy intervention. Additionally, in a large randomized control trial that evaluated a narrative therapy intervention, known as *life review*, Korte et al. (2012) demonstrated that looking back was effective in decreasing depressive symptoms in adults age 55 years or older. Narrative therapy appears to have a place in clinical work with older adults.

Although there is considerable literature detailing narrative approaches with older adults, there is virtually no literature on using this approach with older adults with BD. Neto et al. (2012) used a narrative technique to gain insight into BD clients' actions, behaviors, and emotions, but no literature was found detailing use of narrative therapy with similar clients. A case illustration is presented next that demonstrates the application of narrative therapy with an older adult who has been living decades with BD. Julia (pseudonym), a 61-year-old unemployed artist and mother, has been battling interspersed major depressive episodes and hypomania. Her counselor uses the narrative approach along with some expressive activities that facilitate the storytelling process as Julia seeks help managing her illness while she deals with the issues inherent in aging.

A CASE ILLUSTRATION

Julia is a 61-year-old Caucasian client who has been coming to her local community mental health clinic for a little more than a year. She was originally from the West Coast but moved to a small suburban city in the South to be closer to her two daughters. Julia likes to spend her time watching music programs on television, creating art, and visiting with her granddaughter. Julia used to have a lucrative career painting murals and portraits for people but has been unemployed since she moved to the South.

Julia was first diagnosed with BD when she was 21 years old after a particularly self-destructive manic episode that landed her in a psychiatric hospital. During the past few years, Julia suffered mostly from several depressive episodes interspersed with occasional hypomania. Julia recalls having a handful of manic episodes throughout her life. When she is depressed, she comes to the clinic looking disheveled and often in mismatched clothes. She complains of not being able to keep her house clean (e.g., take out the garbage, organize her craft

room). Also when she is depressed, Julia finds it difficult to get the energy up to visit her granddaughter and often misses her granddaughter's dance recitals and gymnastic meets.

Medically, Julia suffers from Type 2 diabetes and high blood pressure. She is overweight and reports not being able to fall asleep most nights. When she does not sleep, Julia reports spending money she does not have on the Home Shopping Network, buying pieces to make jewelry and gifts for her family. She previously had to declare personal bankruptcy because, during a manic episode, she bought three or four houses on her good credit with the intention of fixing them up and selling them. This means money is constantly tight for Julia, and she relies on her Social Security check every month. In addition to her physical ailments, Julia reports mild cognitive impairments that make it difficult for her to remember things if she does not write them down and lose her train of thought during conversations.

The counselor tells Julia they will be working together to look back at her life in an effort to ascribe meaning to both her past and her future. Julia is resistant at first, stating she does not want to remember all her mistakes and bad decisions. The counselor describes narrative therapy's emphasis on strengths and deconstructing the dominant story so Julia can start seeing herself in a new light and see a journey "to more life, not less" (Kenyon, 2011, p. 239). This journey starts through a personal written reflection, similar to the ones suggested by de Vries, Birren, and Deutchman (1990) in their guided autobiography (GAB) process. The counselor chooses this narrative approach because it allows Julia to have a written record of her work, which will help her keep track of her progress despite her cognitive symptoms. In the GAB, individuals are meant to write on selected topics; with Julia, the counselor selected from a group of suggested questions for individuals who have lived with mental illness (Vassallo, 1998). These guiding questions included the following: What restrictions did BD place on your life? What was the impact of the label of mental illness or BD? What parts of your life did BD or the label affect? What were the first signs that you challenged your illness? How did you take this step? What did you discover about yourself? What did others notice about you?

Julia brings her GAB assignment back to the counselor and again expresses frustration with the assignment. Through her writing, she realized how much of her life had been defined by her label of BD. Her dominant narrative had been that of a "mental health patient," and she says writing about her experiences helped her understand how she played this role with amazing precision as she was wheeled in and out of inpatient facilities throughout her life. She expresses anger toward the stigma attached by society to those who are mentally ill and guilt over "passing on" this burden to her children. Julia discloses one of her adult daughters recently was hospitalized for overdosing on drugs; Julia speculates the daughter also suffers from BD because Julia also was addicted to

alcohol while she was in the worst throes of her mental illness. Julia shares her guilt stems from the idea that her legacy in this world was going to be more people suffering from BD.

To work with Julia through this, the counselor encourages Julia—an artist—to draw an "emotion monster" that depicts BD. Julia draws a two-headed dragon-like creature and talks extensively about how she feels like the creature's two heads are constantly battling for control over her mind and body. This exercise helps Julia to externalize her BD and to express she is an entity separate from her illness. The counselor intended this expressive arts activity to be client centered—because Julia is an artist—and to help her go through the narrative phase of externalization of the problem.

In the next session, the counselor asks Julia about times in her life when there were exceptions to the chaotic life she described in their initial meetings. Julia describes spending time with her granddaughter, who is now 8 years old. When she is with her granddaughter, Julia feels the most alive and happy; however, because of her poor sleep schedule and declining health, she misses out on a lot of her granddaughter's recitals, soccer games, and school plays. The counselor helps Julia write a letter to her granddaughter at 18 years old describing what it is like to live with BD. The counselor explains Julia could choose to give this letter to her granddaughter or not. Julia states the letter helped her express how she wants her granddaughter to view her, as full of love for her despite not being able to be with her all of the time.

As the counseling relationship continues, the counselor and Julia revisit the GAB process and explore several topics through written reflection and processing: Julia's family history, the role of money in her life, and the history of her life goals. Through these narrative exercises, the counselor and Julia co-construct a reality for Julia that remembers her as someone who has encountered a lot of hardships in her life and has used the lessons from those to dig herself out of her BD. Additionally, Julia finds a way to value herself for her artistic accomplishments and the love she has for family instead of how much money she has in the bank. In the end, Julia discusses her disappointments in life—the ending of her marriage, the stall in her career—but is able to focus on her strengths and how these will help her enjoy the remaining years of her life.

Later in the counseling relationship, Julia and the counselor revisit the drawing of the two-headed BD monster; the counselor asks Julia if she would like to make any alterations to the drawing. At this point, Julia draws chains made of pearls around the emotion monster, explaining these chains are valuable and precious to her because they symbolize her commitment to treatment. Julia explains that she spent most of her life battling this dragon, and it was only when she was older that she devoted herself to getting better. She cites exhaustion and guilt as the previous main drivers in her recovery. Like her path to recovery, the pearl chains Julia draws are fragile and can be broken if she is not careful. From this exercise, Julia says she is beginning to re-vision her life as a successful one and is developing a sense of

recommitment to her recovery, focused on wellness—instead of exhaustion and guilt—into her old age.

DISCUSSION AND IMPLICATIONS

Counselors who work with older adults with BD should be aware of the special issues surrounding this population. These include the idea that individuals with BD might maintain their illness but they never fully recover; many of them are experiencing failing health and might be susceptible to cognitive impairments (Depp & Jeste, 2004; Sajatovic & Chen, 2011; Schouws et al., 2012). All of these struggles combine to create rich areas in which counselors can work with older clients to make sense of and create meaning during the latter part of their lives.

Narrative therapy is an ideal way to assist older adults with BD in achieving an increased sense of power and importance, reconciling past negative feelings, and rediscovering interest in past activities or hobbies (Kenyon & Randall, 1999). It focuses on strengths instead of pathology, thus helping to change the ingrained narrative older adults with BD might have been telling themselves for a long time (Kenyon, 2011). Additionally, it eschews explanations based on theory, instead letting individuals create their own language for their situation. In particular, the GAB technique is meant to facilitate growth and awareness and can be used in groups as well as with individuals (de Vries et al., 1990). The process can be used to help understand clients' development within targeted areas or all domains of their lives.

In the case of Julia, narrative therapy facilitated a greater sense of meaning and helped her plan for the rest of her life with a renewed vision. Combined with expressive activities, such as the emotion monster creation and writing unsent letters, reauthoring her life through a multifaceted process helped Julia pull herself out of the hole in which she had pegged herself. Additionally, she was able to face the twilight years of her life with the newfound identity of an accomplished artist, mother, and grandmother.

Narrative therapy does have several limitations. First, this approach takes longer than a single session. Even older adults who are in the maintenance phase of BD sometimes experience major depressive or manic episodes, which disrupt the flow of individual therapy (Kennedy, 2008). Second, the use of the techniques mentioned in this article require client commitment both to working outside of the therapy session and to the task of reflective writing (de Vries et al., 1990). Here, Julia was hesitant and required a thorough explanation of the process before committing to the method. Finally, to assume that reflecting on the value of one's life can only be accomplished through this one path would be counter to the humanistic core of narrative therapy.

The literature clearly calls for more investigation into the physical, mental, and social reality of individuals with BD. Using the narrative technique

described here can be a good start for anyone who wants to gather qualitative data about this population. Additionally, further information is needed regarding the cultural differences among older adults with BD, as there is scant literature addressing this. Overall, more work is needed as the U.S. population ages and the number of older adults with BD and other severe mental illness increases.

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