Reflecting on the UK's ageing population: Perspectives from a psychologist

Foreword

by **Emily Savage-McGlynn,**

Head of Research & Development

In the UK, we currently have a greater proportion of older adults that ever before. We can attribute this to advances in healthcare and social care alike, but with the great achievement comes its own challenges. It is vitally important that we consider not only physical concerns of the elderly, but mental health and cognitive changes they experience. The concerns are brought into greater focus with the current Covid-19 pandemic, which is overwhelmingly affecting older people and can only exacerbate the stress associated with long periods of isolation and loneliness, chronic illnesses and loss of mobility.

During this challenging time, it is crucial that psychology professionals are provided the tools they need to be able to help and support the most vulnerable in our population. We also need to be caring for the carers within our communities who are often overlooked and will also be suffering from the increased stresses and strains of their current day-to-day.

In this document we have compiled some insights from Clinical Psychologist Dr Reena Vohora, who has worked extensively with older patients and their carers. We hope you enjoy reading her thoughts and experiences of supporting those with pressing mental health and cognitive difficulties.

With warm wishes,

Emily

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Case Study 1

Psychological support and considering the mental health needs of carers


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Recognising the needs of carers

It is imperative to ensure that stroke survivors and their families are provided with the appropriate level of support in a timely manner given our knowledge on the psychological sequelae post-stroke. When planning how best to support stroke survivors, it is important to consider the prevalence of post-stroke anxiety and depression as well as findings from studies that have considered psychological well-being after a stroke and association with outcomes for recovery. It is also crucial that health professionals acknowledge that there are a significant number of unpaid carers that play a vital role in looking after partners, friends and family members who have had a stroke.

Carers often describe wanting to do as much as they can for their loved ones, sometimes without appropriate consideration of their own needs. There can also be a significant change in role for some individuals taking on the role of a carer (e.g. taking on personal care, having to navigate a range of services or having to get to grips with financial affairs).

A stroke is an unexpected occurrence and therefore associated with feelings of shock. It is understandable that the initial concern is trying to understand more about why a stroke may have occurred and trying to come to terms with it. Due to this, carers tend to be provided with information on how to care for their loved ones but not always with advice and suggestions on how to maintain their own well-being. It is important to acknowledge that caring for a loved one can be associated with a range of positive factors such as being in a position to demonstrate love, kindness and spending time together, however providing prolonged periods of care may also lead to exhaustion and feeling overwhelmed or frustrated.

Caring for loved ones can impact on the lives of carers in many ways, including emotionally, socially, financially and practically. I have noted that carers may discuss their physical health needs with health care professionals, but may not be aware or feel able to consider their own emotional wellbeing. It is important that services consider the impact of caring and possible difficulties with managing anxiety, depression, stress, and both psychological and social isolation.

> *“Caring for loved ones can impact on the lives of carers in many ways, including emotionally, socially, financially and practically.”*

Psychological support for carers

I have provided psychological support for carers as part of my role as a Clinical Psychologist within a range of neuro-rehabilitation teams. This has sometimes included working with patients and carers together or carers alone.

Feedback from individual carer support sessions indicated that carers have found it useful to have a space in which to reflect on their own needs, as well as learn more about the impact of a stroke and consider the practical aspects of caring. Several carers also described feeling isolated and lacking social support or contact with peers. Based on the feedback received over several years of working with carers, I have offered group-based carer support sessions drawing on both Cognitive Behavioural Therapy (CBT) and Compassion Focused Therapy (CFT).

Attendees for both types of groups were asked to complete pre-group questionnaires to explore personal hopes for the group and their views on self-care. Responses indicated that carers hoped to improve their understanding of what recovery from a stroke may involve and to build confidence in their ability to care. The majority of carers attending the groups stated that they had not always considered self-care and certainly did not prioritise their own well-being at the initial point of contact with the service.

Key elements of CBT group sessions

Group sessions began with a period of psychoeducation and support to introduce an activity schedule (with an emphasis on including pleasant and/or previously enjoyed activities). Several carers reported experiencing sleep disturbance, therefore sleep hygiene and relaxation techniques were considered as a theme throughout the group intervention.

Time was spent exploring the presence of negative automatic thoughts and associated feelings before moving on to challenge, where appropriate, thoughts in relation to understanding, self-identity and sense of coping. A focus of sessions was also on how to address stroke-related difficulties effectively (e.g. how to support changes in cognition or mood) whilst also maintaining their own well-being and sense of individual identity.

Key elements of CFT group sessions

Attendees were encouraged to reflect on the three key emotional systems identified in CFT (threat, drive and soothing) and to consider how this was associated with their overall emotional well-being and role as a carer. We spent time discussing triggers and behaviours associated with each system and, importantly, considered how to develop capacity of the soothing system whilst identifying ways to reduce the predominance of the threat system (this was the pattern that the majority of carers had described experiencing). Balanced ways of obtaining a sense of achievement and activating the drive system was also discussed.

Carers worked together to support each other to develop their own ‘compassionate toolkits’ and collaboratively set each other goals to engage in a self-compassionate act between group sessions. Other skills practiced within sessions included soothing rhythm breathing, safe place imagery and compassionate letter writing.

Feedback from carers

Particular themes were consistently noted in feedback following group sessions. These included the importance of meeting other carers, receiving peer support in addition to professional advice, and being able to share personal experiences (including feelings and areas of difficulty that they had not been able to share with others previously).

Key themes appear to be consistent with previous literature on the value of carer support groups, particularly the importance of carers feeling listened to and not feeling that they were on their own. Carers reflected on placing more importance on personal self-care and their own well-being at the end of the final group sessions. Several carers also described a reduction in feelings of guilt when taking time out for themselves and feeling able to ask for help from services if needed.

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Case Study 2

The use of Compassion Focused Therapy with a stroke survivor

Key ideas from Compassion Focused Therapy

Compassion Focused Therapy (CFT) is an approach developed by Paul Gilbert that draws upon key ideas and understanding from several areas (e.g. evolutionary, social, developmental psychology and cognitive behavioural therapy). Importantly, CFT acknowledges the stresses and strains of life that we are all likely to face and the notion that we are all trying to do the best that we can, based upon our current circumstances and the resources that we have access to (Gilbert, 2010).

> *“Compassion Focused Therapy has been particularly useful in instances where patients and carers describe being able to intellectually connect with other therapeutic approaches whilst simultaneously experiencing an emotional delay or block.”*

My clinical experience from working in a range of older adult community teams and neuro-rehabilitation teams has been that CFT has been particularly useful in instances where patients and carers describe being able to intellectually connect with other therapeutic approaches whilst simultaneously experiencing an emotional delay or block (e.g. a head and heart lag). I have found that it has also been helpful to support patients and carers who present with a high level of self-blame or self-criticism (e.g. patients blaming themselves for pursuing particular lifestyle choices which they then associate with having had a stroke).

The CFT approach describes the evolution of the human brain over time as being helpful in many ways (e.g. affording us the ability to engage in complex decision-making, planning and reasoning), although the added ability to engage in self-introspection and rumination can be problematic in some instances (e.g. becoming ‘stuck’ in this phase). I have found that patients have found the idea of our ordinarily ‘tricky’ human brains (as termed by Gilbert in CFT) becoming ‘trickier’ following a stroke extremely helpful, and being able to explore this via use of a compassion-focused approach.

Description of role

I am a Clinical Psychologist working within a multi-disciplinary team with input provided from physiotherapy, occupational therapy, speech and language therapy, and dietetics. My clinical input with patients post-stroke is typically over a period of several weeks, as the focus of the service being is on the early phase of rehabilitation following discharge from acute hospital. I have found it helpful to draw on several components of CFT within my relatively short period of input and have noted positive outcomes via self-report and pre- and post-scores on a range of relevant measures.

Brief history and assessment of 'Gerald'

I was referred a male in his mid-seventies (name changed to 'Gerald'). Following a recent stroke, Gerald had withdrawn from all social contact with friends, family and social groups due to post-stroke changes to cognition. A high level of self-criticism was evident and it was clear that activation of the 'threat system' was leading Gerald to avoid all social interaction in an attempt to reduce feelings of anxiety.

Following discussion of feedback from the assessments completed with Gerald, key principles of compassion and the different flows of compassion were discussed. It was identified that Gerald had always set himself extremely high standards and did not believe that he should approach a task if he thought he would be unable to complete it in a way that he deemed to be perfect.

Gerald had previously struggled to consider goals for rehabilitation with our team, however spending time considering each of the key emotional systems (i.e. threat, drive and soothing) enabled Gerald to engage in a personally meaningful goal-setting phase. He identified a key goal as being able to return to leading a social group that he had set up which involved public speaking and therefore drew upon skills relating to memory and higher-level executive functioning abilities that had been impacted by his recent stroke. In order to support Gerald to achieve his goals, he received support from a Speech and Language Therapist, an Occupational Therapist, and myself.

Neuropsychological assessment

It is important to consider both emotional adjustment and cognitive abilities following a stroke.

A range of assessments were used to provide a snapshot of Gerald's cognitive profile following his stroke. Tests included the Test of Premorbid Functioning (ToPF), the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) and subtests from the Wechsler Memory Scale (WMS).

The estimate of Gerald's pre-morbid level of functioning fell within the 'high average' to 'superior' range. Whilst Gerald presented with mild to moderate post-stroke changes to cognition, his perception of the extent of these changes were much more severe than neuropsychological assessment had indicated.

Time was spent discussing the use of compensatory strategies based on findings from neuropsychological assessment in order to support Gerald with achieving his main therapy goal as well as to support engagement in everyday tasks around his home. The suggestion of practical strategies formed part of the intervention, however it was also essential to consider and support the process of emotional adjustment in both accepting the need to implement the strategies discussed and to consider his response to having had a stroke and the subsequent process of recovery.

Introducing CFT principles and skills

Skills that Gerald appeared to benefit from included the introduction and regular practice of soothing breathing exercises, developing a 'compassionate toolkit', considering qualities associated with being at his 'best', considering a compassionate figure, and compassionate letter writing. An important part of this work involved considering how to accept compassion from others and beginning work on allowing self-compassion.

Enabling Gerald to step back and reflect on how the extremely high standards that he set for himself were associated with feelings of anxiety, reduced productivity and social withdrawal was key when considering the importance of self-compassion and allowing himself to begin to accept acts of care and compassion from others. Skills training was combined throughout with emotional support and use of compensatory strategies (based on the findings from neuropsychological assessment) to support a gradual return to social engagement.

Outcomes following psychological input

Importantly for Gerald, input was tailored to support him with his rehabilitation goal to successfully return to delivering a 10-minute talk as part of the social group that he led. Whilst Gerald was still keen to work on developing his confidence with public speaking at the point of discharge from our team, he described a significant increase in his level of confidence, ability and willingness to engage in rather than avoid social activities. He rated his confidence as being 2/10 at the outset of psychological intervention and increasing to 8/10 following input. Gerald also reported increased engagement in activities at home, such as cooking for himself, and he had returned to managing his own financial affairs and shopping by using the compensatory strategies suggested from neuropsychological assessment. Moving to a position of accepting social support from others was a further positive outcome indicated at the end of therapy as Gerald opted to attend a peer support group following discharge from our team.

References

Gilbert, P. (2010). Compassion focused therapy: Distinctive features (first edition). Taylor and Francis: London.

Gilbert, P. (2010). The compassionate mind. Constable.

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Case Study 3

Considering mental health needs and cognitive changes after a stroke

Experiencing a stroke is an unexpected occurrence, and consequently is often associated with a range of emotions. Given the nature of a stroke, it is vital that stroke survivors are provided with appropriate mental health support (e.g. considering anxiety and depression), as well as taking possible changes to cognition into account.

> *“There are also instances whereby patients may not be aware of post-stroke areas of cognitive impairment.”*

Relevant background information on ‘Brenda’

‘Brenda’ (name changed) was an independent lady in her early sixties who lived alone, with a large network of friends and family. She valued her roles as a mother, sister, grandmother and friend immensely and enjoyed socialising and cooking a roast dinner each week for her family.

Brenda was in her bedroom when she had her stroke and used her mobile phone to call for medical assistance. Following a short inpatient stay in hospital, Brenda was discharged home and seen on the day of her return home by the Early Supported Discharge (ESD) team. It became evident that whilst she required physiotherapy and occupational therapy input for changes to mobility and limb weakness, changes to cognition and mood were also noted.

Initial assessment information

Initially, Brenda described being very doubtful of the need for input from a psychologist, however she consented to initial joint visits with my occupational therapy colleague. Over the period of several weeks, Brenda began to acknowledge the presence of fears related to having another stroke and anxiety when considering returning to previously enjoyed social activities. She described feeling ‘different’ and missing her ‘old self’, contributing to low mood, which was then maintained due to not seeing her loved ones as she had started to withdraw. Brenda also described difficulties with being able to concentrate on television programmes and recalling details of telephone conversations with friends and family, and also finding it more difficult to prepare a cooked meal for herself.

Goal setting

A multi-disciplinary approach was taken to elicit meaningful rehabilitation goals with Brenda and, crucially, to consider both the emotional and cognitive impact of a stroke. With regards to psychological input, Brenda consented to engage in neuropsychological assessment and a phase of adapted Cognitive Behavioural Therapy (CBT) to support changes in cognition. Goals to increase mobility and to support practice of activities of daily living were agreed with my physiotherapy and occupational therapy colleagues.

Post-stroke changes in cognition

Changes to cognition are commonly reported following a stroke. This can include changes within one or several cognitive domains (i.e. memory, language, visuospatial functioning, attention and concentration, and executive functioning).

Working as a Clinical Psychologist within a multi-disciplinary stroke ESD team means that patients can be referred for neuropsychological assessment at any time during their rehabilitation period. Although there are some instances in which it is helpful to wait before carrying out neuropsychological assessment, there are times when it can be helpful to ascertain a patient's cognitive profile earlier on during the recovery process, for example when patients and/or their family members become aware of a change in post-stroke ability to either engage in or complete a task (e.g. attending to personal care, cooking, managing finances, shopping). There are also instances whereby patients may not be aware of post-stroke areas of cognitive impairment, which are detected by members of the ESD team during the rehabilitation period (e.g. noting difficulties with encoding and retrieving information relating to exercises). Patients may also be referred for neuropsychological assessment when there appears to be a 'block' in therapy. An example of such a 'block' or halt in therapy is where a patient may seem keen to be set therapeutic exercises but then fails to carry these out in between sessions due to queries regarding attention, memory or executive functioning (difficulties with initiation, planning and problem solving) abilities rather than not wanting to do them or this being related to low mood.

Neuropsychological assessment

A range of assessments were used to provide a snapshot of Brenda's cognitive profile following her stroke. Tests included the Wechsler Test of Adult Reading (WTAR), the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), and more in-depth testing of executive functioning abilities.

Results from the assessment were indicative of post-stroke impairment in the areas of attention and concentration, immediate and delayed memory, and executive functioning. The results of the assessment were shared with Brenda and key members of her family, as well as other members of the ESD team for holistic consideration of the most helpful compensatory strategies to support Brenda, and to ensure a consistent approach in Brenda's treatment and support network.

Findings from the assessment were also important in informing how to present information to Brenda as part of her rehabilitation and optimise her ability to engage in and benefit from rehabilitation – for example minimising other distractions in the environment, planning sessions earlier in the day to avoid cognitive fatigue, supporting processing of information, and helping to plan clear daily schedules of which physical exercises to practice and when.

Consideration of mental health needs

Mood measures were completed with Brenda during the assessment phase that indicated she was scoring in the 'clinical' range for both anxiety and depression. The psychological impact of having a stroke was acknowledged and recovery was discussed as being a journey that was likely to entail both 'good' and 'bad' days as part of the natural course. Brenda seemed to find this extremely helpful and often referred back to the 'ups and downs' of recovery instead of berating herself if finding a task particularly difficult as she described in her initial assessment. Brenda found it helpful to collaboratively identify factors contributing to and maintaining low mood.

Brenda described experiencing disturbed sleep (difficulties with falling asleep and staying asleep) due to having had her stroke upon waking in her bedroom. She told me that she felt too anxious to return to sleeping in her bedroom since being discharged from hospital and had instead been napping on her sofa during the night. Brenda was supported to explore the presence of negative automatic thoughts and to gradually develop a routine that was more conducive to sleep based on principles of sleep hygiene. The presence of fears related to having another stroke were normalised and she was supported to learn more about the nature of her stroke and to implement small lifestyle changes that have been suggested to reduce secondary risk factors in relation to having another stroke. Brenda described it helpful to practice deep breathing techniques and was supported to engage in a wind-down routine before bedtime, in addition to being able to verbalise and challenge anxious thoughts.

Brenda described avoiding several social events that she would have otherwise enjoyed attending, because she was worried that she wouldn't be able to follow conversation between friends, and was also worried about 'seeming different to others'. We discussed identity and personal qualities pre- and post-stroke and applied a value-based approach. Practically, Brenda was encouraged to use compensatory strategies to help her to sustain attention in busier environments, and ways of processing information that would be more likely to support recall (e.g. chunking information, creating associations, multi-sensory processing). We also discussed internal and external memory strategies that Brenda could use in a range of situations both inside and outside of the home.

Brenda identified a goal of being able to return to cooking a roast dinner for her family and reported feeling overwhelmed and burning the dinner when she had tried to do this. Strategies to support executive functioning abilities were suggested on the basis of findings from neuropsychological assessment and Brenda's self-report. Brenda was supported to break tasks down into smaller, manageable steps and to write out recipes with key instructions and timings of when to start and complete each element clearly highlighted. A graded approach to achieving this goal was employed, whereby Brenda practiced an easier meal with the occupational therapist, then practiced a slightly more complex meal with her sister before proceeding to prepare a roast dinner for three family members (instead of eight as she previously had done), and then gradually building this up over time.

Outcome of psychological support

At the point of discharge from ESD, Brenda reported an improved understanding of the cognitive and emotional impact of her stroke and how to manage this using the strategies provided. The presence of stroke-related thoughts and fears were normalised (where appropriate) and Brenda described feeling much less anxious and brighter in mood.

Although Brenda consented to psychological input, she did not seem very keen on this idea at the outset. On a professional and personal level, therefore, it was extremely rewarding to hear Brenda describing psychological input as having been an essential factor in supporting her to feel 'much more like [her]self' and feeling hopeful about the future again after her stroke.

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About the author: Dr Reena Vohora, BSc (Hons), MRes, DClinPsy, CPsychol

Dr Vohora is a Chartered Clinical Psychologist and Academic and Course Tutor at the Oxford Institute of Clinical Psychology Training and Research, University of Oxford. She is HCPC registered and has 15 years' experience of working in a range of mental health settings both in the NHS and private sector. Her specialist interests relate to ageing, neuro-rehabilitation and well-being. This includes working with older adults with cognitive and/or neurological impairment and supporting families and carers. As part of her academic role, Dr Vohora teaches on a range of topics including issues relating to clinical skills, resilience, working in rehabilitation services, evidence-based psychological interventions, and cultural considerations in assessment and therapy.

email: **enquiry@doctorreena.com**
Twitter: **@ReenaVohora**

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