

# Supportive psychotherapy in dementia

Ola Junaid & Soumya Hegde

**Abstract** The role of psychotherapy for elderly people is the subject of much debate. Yet this has not resulted in a shift of resources towards increasing its availability within the UK's National Health Service. Over the past decade the pessimistic view of psychotherapy for elderly people has diminished owing to the growing evidence base and the commitment of champions in old age psychiatry and psychotherapy. However, there is still very little structured research into psychotherapy in dementia. Supportive psychotherapy is a poorly understood but very practical means of helping people with dementia to adjust to the effects of their illness. Its inherent flexibility enables individual sessions to be tailored to the patient's needs and deficits. An understanding of supportive psychotherapy and its benefits could enable clinicians to improve the quality of life of people with dementia and their carers within the ever-present constraints of limited time and resources. This article explores the use of supportive psychotherapy as a treatment option in dementia.

Dementia care is quite rightly the focus of much attention. Guidance on the treatment and care of people with dementia has recently been jointly agreed by the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence (National Collaborating Centre for Mental Health, 2006). This recommends as a key priority for implementation that 'Carers of people with dementia who experience psychological distress and negative psychological impact should be offered psychological therapy' (p. 9). The care of people with dementia has changed considerably over a relatively short period of time. Managing dementia has become a complex process: it is perhaps not an exaggeration to liken it to a sophisticated art. Advances in science have added useful pharmacological weapons, and there is a small but growing evidence base for non-pharmacological interventions. Unfortunately however, the emphasis is far too often one of exclusion. Access to antidementia drugs is under threat, psychological services are restricted and resources are often constrained by annual 'cost improvement' cycles. It is therefore imperative to identify, understand and utilise cost effective evidence-based interventions.

Although it is widely recognised and accepted that non-pharmacological interventions should always be considered as a first-line approach, there appears to be a distinct lack of enthusiasm for increasing the use of psychological treatments in dementia care (Douglas *et al*, 2004).

Public opinion on the value of psychotherapy for elderly people is disheartening. When 414 individuals (aged 17–81 years) were asked their opinion on psychotherapy for elderly people, participants of all ages were strongly biased against psychotherapy for older adults and felt that the benefits that clients could derive from it decreased steadily with increasing age (Zivian *et al*, 1994).

Murphy (2000) drew attention to the poor provision of psychotherapy services for older adults in the UK. Her study found overwhelming evidence of an ageist approach. She felt that all professionals should 'hold in mind' this group of people and should be educated about the availability and applicability of the psychotherapies for older individuals.

Garner (2002) reported that, although older people are less likely to be referred for psychological interventions, perhaps because they rarely have critical social or work roles so treatment to keep them functioning is not a priority, there is no evidence that these treatments are less effective in an older age group.

Hepple (2004) has written a very useful overview of psychotherapies with older people, again drawing attention to the slow development in this area and suggesting possible reasons. He reviewed the evidence base, which suggests that cognitive-behavioural therapy, interpersonal therapy, cognitive analytic therapy, and psychodynamic and systemic approaches can help in a range of psychiatric problems in older people, including dementia.

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Hepple advocates opening up access to psychological services to all adults, irrespective of age. This could be achieved by establishing psychological therapies networks within provider organisations, with professionals in old age and general adult psychiatry working collaboratively. He reminds us that a psychological perspective is a key part of the biological, psychological and social triad underpinning good psychiatric treatment and challenges mental health professionals to ensure that the psychological dimension does not continue to take a back seat to biological and social models of care.

## The evidence base for psychotherapies

People with dementia more often than not have impairments in language function and are therefore considered unsuitable for psychotherapy (Duffy, 2002). It is all too common for clinicians to accept the negative attitude reported by Duffy. Fortunately, clinicians are well aware that a majority of people in the early stages of dementia are able to communicate effectively. These individuals not only strive to maintain continuity but also want to understand their situation (Menne-Heather *et al*, 2002).

Cheston *et al* (2003) evaluated six 10-week psychotherapy groups for people with dementia and found significant improvement in scores for depression and marginal benefits in anxiety symptoms which were maintained at follow-up.

Burns *et al* (2005) have shown that it is possible to apply randomised controlled trial methodology in assessing the impact of a psychotherapeutic approach in people with Alzheimer's disease. Although they found that brief psychotherapy (psychodynamic interpersonal therapy) did not improve scores on any of the key outcome measures, qualitative assessments reported trends towards a subjective benefit for both patients and carers.

Fossey and colleagues (2006) went a step further, demonstrating that enhanced psychosocial care can reduce antipsychotic use in care home residents with dementia without worsening behavioural symptoms.

A recent randomised controlled trial examined the cost-effectiveness of a programme of cognitive stimulation therapy for people with dementia (Knapp *et al*, 2006). The authors found that it was of greater benefit, and might prove to be more cost-effective, than treatment as usual.

A decade ago the American Psychiatric Association (1997) produced practice guidelines for the treatment of dementia. These acknowledged that some clinicians find supportive psychotherapy useful in

helping people with mild impairment to adjust to their illness, although there had been little research into its effectiveness.

Supportive psychotherapy remains widely practised but seldom studied. Rosenthal *et al* (1999) undertook a 6-month follow-up study to measure changes in interpersonal functioning following brief supportive psychotherapy. This was a small study in an adult psychiatric population, but the results provide preliminary experimental evidence for significant and lasting improvement in interpersonal problems after the intervention.

In a comparison of supportive psychotherapy and cognitive-behavioural therapy the latter improved symptoms of anxiety in older adults at baseline and 12-month follow-up, but there was no difference in functional ability (Barrowclough *et al*, 2001).

## Providing information

One of the first challenges in the management of dementia is informing the patient of their diagnosis. There continues to be widespread disagreement among physicians and psychiatrists on what the patient should be told. A pilot study undertaken by Johnson *et al* (2000) found that only 40% of medical professionals regularly disclosed a diagnosis of probable Alzheimer's dementia and only 25% reported always using a clear terminology. It is difficult to understand the reluctance to allow autonomy to take precedence over paternalism. It is clear from the work of Pinner & Bouman (2003) that people with dementia want to have all the information regarding their diagnosis. In their study they found that 92% of patients with early dementia wished to be fully informed.

The practice of any form of psychotherapy is based on truth, a clear understanding of the illness, its prognosis and management. Clinicians who are responsible for disclosing and discussing the diagnosis may well find that the principles of supportive psychotherapy provide a very helpful framework for therapeutic discussion.

## What is supportive psychotherapy?

Supportive psychotherapy is a rather neglected aspect of psychotherapy, but we believe that it is a particularly useful strategy that can play an important role in positively influencing the quality of life in those affected by dementia. Supportive psychotherapy is not easy to define. In essence, the therapist 'carries' the patient, helps to sustain them, bolster them.

In his *Introduction to the Psychotherapies* (1979; now in its fourth edition) Bloch describes supportive psychotherapy as a form of psychological treatment given to people with chronic and disabling psychiatric conditions for whom fundamental change is not a realistic goal. This, of course, suggests that supportive therapy is one of the most commonly practised types of psychotherapy. It is a form of treatment in which therapist support is a core component. Gilbert & Ugelstad (1994) believe that the therapist's primary role in supportive psychotherapy is to support and strengthen the individual's potential for better and more mature ego functioning in both adaptational and developmental tasks.

It is important to distinguish between the supportive component of all psychotherapies and supportive psychotherapy as a specific mode of treatment for a particular group of patients (Holmes, 1995). Support is fundamental to all psychotherapies and is characterised by regularity, reliability and attentiveness of the therapist towards the patient.

Supportive psychotherapy is a concept that has been and perhaps still is evolving. In their concise review of what they saw as the more important conceptions of supportive psychotherapy, Novalis *et al* (1993) put forward Knight's (1954) description of it as 'superficial psychotherapy' that uses techniques such as inspiration, reassurance, suggestion, persuasion, counselling and re-education with people who are too psychologically fragile, inflexible or defensive for exploratory therapies.

Bloch (1979) stresses sustenance and maintenance rather than suppression and repression as the focus of supportive psychotherapy. Werman (1984) sees supportive psychotherapy as a substitutive form of treatment that equips patients with the psychological functions that they either lack or possess insufficiently. Wallerstein (1988), following Gill (1951), defines supportive psychotherapy as an intervention that strengthens defences and represses selected symptoms, using means other than interpretation or insight to achieve these goals.

Rosenthal and colleagues (Pinsker & Rosenthal, 1988; Rosenthal *et al*, 1999) have described individual supportive psychotherapy as a conversation-based 'dyadic treatment', whose focus is the maintenance or increase of patients' self-esteem, adaptive skills or psychological function by direct methods. The therapist may examine relationships (real and transference), patterns of emotional response and behaviour. Because the process is based on conversation, the therapist tends to respond more frequently in supportive psychotherapy than in typical expressive therapies.

In supportive psychotherapy the therapist plays an active and directive role in helping the patient to improve their social functioning and coping

### Box 1 Aims of supportive therapy

- To promote patients' best possible psychological and social adaptation by restoring and reinforcing their abilities to cope with the vicissitudes and challenges of life
- To bolster self-esteem and self-confidence by highlighting assets and achievements
- To make patients aware of the reality of their life situation, e.g. of their own limitations and those of treatment, and of what can and cannot be achieved
- To forestall a relapse of their clinical condition and thus try to prevent deterioration or re-hospitalisation
- To enable patients to require only the degree of professional support that will result in their best possible adaptation, and so prevent undue dependency
- To transfer the source of support from professionals to relatives or friends

(Bloch, 1979)

skills. The emphasis is on improving behaviour and subjective feelings rather than achieving insight or self-understanding (Novalis *et al*, 1993). Thus, supportive psychotherapy is not based on a singular theory or construct, but is drawn from a considerable body of literature describing the factors that influence change in people.

Bloch's summary of the aims of supportive psychotherapy are summarised in Box 1.

## Psychodynamically oriented supportive therapy

In 1989 Rockland introduced the concept of psychodynamically oriented supportive therapy. As the name implies, it is supportive psychotherapy of an individual patient carried out according to psychoanalytic understanding and psychodynamic principles, by a therapist trained in dynamic psychotherapy. Its immediate goal is to improve ego functions, either directly, for example by strengthening reality-testing or the ability to delay gratification, or indirectly, by reducing the strain on the ego from the id, superego and external reality. All of this is in the service of promoting better adaptation to both inner and outer worlds.

Rockland suggests that this type of therapy is supportive because its main goals are the strengthening of ego functions and the improvement of adaptation, not the exploration of unconscious conflict with subsequent insight.

## Components of supportive psychotherapy

Rather than merely considering the theoretical framework underpinning supportive psychotherapy it may be helpful to look at what is actually done in such psychotherapy.

Bloch (1979) gives a useful analysis of the key components of supportive psychotherapy.

- Reassurance is critical. It is necessary to remove doubts and misconceptions, and focus on assets. If reassurance is to be effective it must be realistic. The aim is to create a climate of hope and positive expectation.
- A thorough and detailed explanation of the illness should be given, focused on the here and now. The emphasis is very much on the external reality the patient faces. The overriding aim is to improve the individual's coping ability rather than enhance self-awareness. Repeated reality-testing is the key.
- Direct advice is acceptable and indeed desirable. The ultimate aim is to produce transferable skills. The individual should not only develop improved coping skills but also know when to seek help.
- Suggestion by the clinician can result in change by influencing the patient both implicitly and explicitly.
- Encouragement can promote self-esteem, prevent feelings of inferiority and facilitate more appropriate patterns of behaviour.
- Environmental change may often be necessary in order to effect significant change.
- Sympathetic active listening, unconditional acceptance and allowing catharsis ensure the patient a safe and secure environment, thereby facilitating full and frank disclosure.

Alternatively, it might be more helpful to group the techniques under two categories: explanatory and directive (Box 2).

## Psychotherapy in dementia care

There is a growing awareness that the organic pathology in dementia is but one aspect of the individual's situation and disability, and distress can often be understood in terms of psychological models (Hepple, 2004). Psychodynamic theory can help us acquire a greater understanding of the disintegration of the relationship between people with dementia and their carers.

Psychotherapeutic interventions may be beneficial for patients in the early stages of Alzheimer's disease,

### Box 2 Techniques of supportive psychotherapy

#### *Explanatory*

- Empathy
- Encouragement and reassurance
- Praise
- Enhancing the patient's self-esteem
- Building a healthy alliance
- Reality-testing
- Instilling hope
- Containment
- Interpretation
- Managing the transference

#### *Directive*

- Advice
- Education
- Environmental change
- Cognitive restructuring
- Problem-solving
- Modelling (by revealing more of themselves, the therapist increases the likelihood that the patient will identify with them)

as insight is often well preserved and psychological adjustment is difficult for individuals who assume that they face a future of inevitable decline (Burns *et al*, 2005). Denial is a common defence mechanism for patients and their relatives (Bahro *et al*, 1997). It is well established that psychological support also reduces carer stress (Mittleman *et al*, 1996; Donaldson *et al*, 1997).

The basic techniques of supportive psychotherapy can be readily applied to elderly people, provided the therapist is aware of the special attitudes and adjustments needed to make it more effective for this population. Certain adaptational responses (Box 3) are common in dementia, and these must be accommodated. An important aspect of support is to encourage the individual to focus on past successes and to limit social contacts to those that are reinforcing (Novalis *et al*, 1993).

Robie (1999), exploring how the process of psychotherapy is affected when the patient has concomitant dementia, highlighted appropriate adjustments in the therapeutic approach, methods and interventions. Modifications to the therapeutic process affect three primary areas: the therapeutic relationship, therapeutic contact and therapeutic operations. Among the suggested adjustments are slowing the pace of therapy, reducing the demands on the individual, simplification of patient-therapist communications and expanding the repertoire of techniques used to achieve goals.

**Box 3 Common adaptational responses in elderly patients with dementia**

Therapists should allow for elderly patients'

- withdrawal
- physical and affective isolation
- somatisation and/or hypochondriasis
- obsession with past memories and lost opportunities

(Novalis *et al*, 1993)

## Supportive psychotherapy in practice

With limited and often reducing resources within the National Health Service (NHS), mental health services may find it hard to provide an expensive psychotherapy for patients with dementia. So extending supportive psychotherapy to include these patients' carers might seem to be out of the question. However, the following anonymised example from my (O.J.) own clinical work shows its benefits to both parties. The NHS would do well to take into account this important but neglected area in its resourcing of services.

### Case vignette: Mary and James

Mary had endured with considerable dignity significant disability consequent on severe cerebrovascular disease. A referral to psychiatric services followed the onset of a severe depressive episode. This responded well to a course of antidepressants closely monitored by a member of the multidisciplinary team. It became evident over the course of her treatment that significant cognitive impairment was also present. Over the next couple of years the focus shifted from managing depression to managing dementia.

Eventually Mary developed severe vascular dementia. She has now lost the ability to communicate, and is completely dependent on others for all her needs. She has lived in a nursing home for several years and is now confined to bed. Her husband James is a retired professor who visits twice a day without fail. Unfortunately, his memory is beginning to fail and he is finding it hard to negotiate the 10-mile round trip.

During a regular review he told me how they met and how she gave up everything for him when things were very hard for him. He said, 'She saved me and now I can't save her'.

There are three distinct stages in the relationship between Mary and psychiatric services. At the start of the therapeutic alliance the emphasis was medical. Make a diagnosis, agree on a suitable pharmacological treatment and monitor response. However, success very much depended on the establishment of a

therapeutic alliance. The key individual was her community psychiatric nurse, who worked hard using the principles of supportive psychotherapy. Thus, much time was spent in ensuring that both Mary and James received repeated and reinforcing reassurance and explanation. This meant that they both cooperated with the treatment team as Mary's condition deteriorated. A key strategy was addressing environmental issues, and modifications were made to the home environment to minimise the impact of Mary's physical disability.

In the second stage the depression had become less of a problem than the consequences of the dementia. The focus of the therapeutic intervention necessarily changed. Teaching both Mary and James appropriate coping strategies, education about dementia and providing practical support to relieve the burden of care became the key objectives. Managing the transition to institutional care marked the entry into stage three.

It is easy to feel helpless in the face of this degree of despair. Mary is well cared for and not in any physical discomfort. It is undeniable that she benefits from James's visits. His distress is understandable in the context of his sense of impotence. Yet doing nothing other than sympathetically listening to him is, we think, a missed opportunity. Applying the principles of supportive psychotherapy will sustain James and ensure that he continues to provide the all-important emotional support to his wife. A secondary gain is, of course, that through him Mary's professional carers continue to be reminded to treat her as a person rather than problem.

Supportive psychotherapy provides a framework that ensures that mental health professionals give effective support to carers and therefore indirectly contribute to enhancing the quality of life of the patient. The therapeutic interaction inevitably shifts over the course of the dementia from the patient to the carer. But the focus should always remain firmly on the patient.

In caring for Mary and James I found the techniques outlined by Rockland (1989) particularly helpful. A first step is encouraging a therapeutic alliance. Ensuring that treatment is a joint endeavour can often be achieved simply by the frequent use of the word 'we'. Conveying hope and reassurance can be beneficial only if they are founded on a true understanding of the patient and are based firmly in reality. I was able to reassure James that modern pharmacological approaches meant that could keep Mary pain-free and comfortable despite her deforming contractures and disease progression.

Providing advice, suggestions and education is part of routine clinical practice. But do mental health professionals give sufficient thought to the impact of their advice from a psychotherapeutic position?

**Box 4 Suggested further reading**

- Bloch, S. (2006) Supportive psychotherapy. In *An Introduction to the Psychotherapies* (4th edn) (ed. S. Bloch). Oxford University Press.
- Hepple, J. (2004) Psychotherapies with older people: an overview. *Advances in Psychiatric Treatment*, **10**, 371–377
- Novalis, P., Rojcewicz, S. & Peele, R. (1993) *Clinical Manual of Supportive Psychotherapy*. American Psychiatric Publishing.
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It is easy but hazardous to resort to medication to deal with behavioural problems; supportive psychotherapy provides a framework for using psychotherapeutic approaches to reducing these problems, thereby minimising subjective mental distress.

Autonomy is a key aim of all therapeutic intervention. The principles of supportive psychotherapy, if properly applied, can help enhance the strengths and coping skills of both patients and carers. Ultimately, given space and time, supportive psychotherapy can help improve insight and self-understanding for people with dementia and their carers.

## Conclusions

All psychiatrists practice supportive psychotherapy some of the time. However, many might not have considered the principles underlying this very important aspect of clinical practice. Psychiatrists need to develop a better understanding of this tool. They need to improve their techniques and teach others.

Do not be put off by the jargon. The literature is accessible and not voluminous: for those who can create a little time we suggest that it would be a wise investment to explore it (Box 4).

The next step for the brave few might be initiating a friendly discussion with local psychotherapists. Regular supervision from a psychotherapy unit might be a cost-effective and highly efficient use of a scarce resource to disseminate knowledge and expertise in what is a key area for all psychiatrists, but a much neglected area for old age psychiatrists. It is no longer enough to hold in mind patients with dementia; psychiatrists have a duty to bring to bear all the resources available to ensure that they make a significant difference to the quality of life of these individuals.

## Declaration of interest

None.

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## MCQs

- 1 In managing dementia in elderly people:**
- a non-pharmacological interventions should be the last resort
  - b psychotherapy services are easily accessible
  - c cognitive-behavioural therapy does not allay symptoms of anxiety
  - d psychiatrists are sufficiently aware of existing psychotherapeutic services
  - e psychotherapeutic approaches can help reduce anti-psychotic use.
- 2 In the practice of supportive psychotherapy:**
- a fundamental change is a realistic goal
  - b therapist support is a core component
  - c focus is on suppression and repression
  - d patients' awareness of their clinical condition is not enhanced
  - e assets and achievements are minimised.

- 3 The components of supportive psychotherapy include:**
- a goal-setting
  - b decreasing awareness of external reality
  - c offering encouragement to promote self-esteem
  - d discouraging environmental change
  - e conditional acceptance to facilitate disclosure.
- 4 Regarding psychotherapy in dementia:**
- a withdrawal is a common important adaptational response in patients
  - b denial as a defence mechanism is rare in patients and carers
  - c insight is rarely preserved in the early stages of Alzheimer's dementia
  - d psychological models are ineffective in alleviating patients' distress
  - e adjustments in the therapeutic approach are not necessary.
- 5 When considering practical application of supportive psychotherapy:**
- a focus is initially on the carer
  - b listening sympathetically will not help
  - c the literature is extensive
  - d better understanding and more research are needed
  - e the out-patient setting is inappropriate.

### MCQ answers

1	2	3	4	5
a F	a F	a F	a T	a F
b F	b T	b F	b F	b F
c F	c F	c T	c F	c F
d F	d F	d F	d F	d T
e T	e F	e F	e F	e F