

17 Psychological treatments

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The emergence of psychiatry of old age as a speciality has been paralleled by a rapid growth in the application of psychological treatments for the elderly. This chapter offers guidance to adapting treatments to meet the particular needs of older people. While it is necessary to sound a note of caution in case the gains sought are too great, on the whole the problem is overcoming resistance, not least among older people themselves, to the idea that psychological treatments are relevant and effective.

Practical applications

In some cases a psychological treatment may be the treatment of choice and the only treatment required. More often older people, especially those with serious psychological disorders, have a number of current problems. Psychological treatment then involves working in an orchestrated way with several other professionals, whose skills are also required. This is not always quite as good for the therapist's kudos as playing the solo part, but is generally better at meeting the patient's needs.

Psychological treatments may require adaptations for older clients (Box 17.1). Most of these are self-explanatory and allow for the effects of normal ageing and physical change. It is worth emphasising the importance of experience. The patient usually has more than the therapist! Rather than

Box 17.1 Adaptations for older clients

Take the therapy to the patient
Keep the session length flexible
Ensure achievable goals
Keep groups small
Allow for sensory impairment
Incorporate individual experience

teaching granny (or grandad) to suck eggs, it may be possible to help them rediscover a skill, and learn something yourself in the process.

Psychotherapy

Psychotherapy for older people has thrived despite the now famous statement by Sigmund Freud that older people are not amenable to psychoanalysis. He considered anyone over the age of 50 years as lacking “the elasticity of the mental processes on which treatment depends... old people are not educatable” (Freud, 1905). Thankfully, such overt ageism has largely been overcome, and psychotherapy is offered to older people and their carers. Psychotherapy covers the whole range of psychiatric problems, from adjustment disorders to Alzheimer’s disease (see Box 17.2).

Dynamics

Psychotherapy is largely based upon a dynamic view of psychiatric (and some physical) illnesses. Although the word dynamic suggests activity where psychiatric symptoms arise, conflict often leads to a stalemate. Such a conflict might be between the drive to assert oneself and to make no trouble. The object of psychotherapy is to resolve the conflict and, in doing so, relieve symptoms and help the person function more effectively. This is achieved through words exchanged between the patient and the therapist, and the relationship which forms between them. Dynamic factors are important in old age psychiatry. Pitt (1982) identified dynamic factors in three-quarters of consecutive referrals to an old age psychiatric service.

Transference

The dynamic view is that disturbed relationships, past and present, contribute to illness. Psychotherapy seeks to improve these relationships by counselling, support and the use of transference. Transference occurs when the patient reacts to the therapist as a key figure from their past, such as a parent, sibling, child or spouse. The therapist can use transference by helping the patient become aware of subconscious feelings to these important figures. Although the patients are usually older than their therapists, this does not prevent them from being regarded as parent figures, as well as child (or grandchild) figures.

Dependency

One dynamic factor which may occur more commonly in later life is dependency. This may occur, for example, in people emotionally deprived

in early life, who coped well as adults but in older age fear being neglected and unloved as they see their useful role slipping away. Goldfarb (1965) described the frantic search for help from a strong parent figure, which is frustrated because the demands are too clamorous.

In a colluding partnership, usually husband and wife but sometimes child and parent, one is seen by the other as strong but each is, in fact, dependent on the other. The 'strong' partner preserves an illusion of mastery through the weaker's reliance on them. A husband who finds a *raison d'être* in retirement in caring for his sick wife, may be threatened when she requires help from doctors. He may have a vested interest in her invalidism.

In these cases the therapist tries to establish a supportive relationship to meet the dependency needs of the patient, without being taken over, or turning the patient into a child. For some very old patients, supportive therapy may mean an involvement for life.

Confrontation

There is a place for pleasant personal remarks, warmth and friendliness in the therapist's approach to older patients which would be less appropriate with younger patients. Nevertheless confrontation may play an important part in therapy. Negative reactions to the therapist such as plaintiveness; exaggeration of symptoms; seeking help elsewhere; or lateness for appointments, should be explored. Skilfully handled these confrontations allow the patient to acknowledge resentment and aggression, and find relief that therapy can continue.

Life review

When the recital of symptoms becomes tedious and repetitive, it can be useful to move away from the illness to a consideration of the patient as

Box 17.2 Psychotherapy in later life

Psychotherapy in older age

Dynamic factors are usually identifiable in referrals

Resolution of conflicts may resolve symptoms

Transference may be altered as therapists are usually younger

Dependency, loss of sexuality and fear of death are important factors

Lifelong defences may decompensate with changes such as retirement

Confrontation may be a useful part of therapy

A 'life review' can help older patients integrate their experiences

a person with an interesting life history. Memories of the war are often evocative and revealing. Butler (1968) advocated a 'life review' to help older patients function by gaining strength from memories of adaptation and survival. The last of Erikson's (1959) eight stages in life, is the identity crisis of old age. Integrity (the capacity to value one's life experiences and oneself) is an antidote to despair.

Group therapy

For some patients group support, often in the setting of a day hospital, is a good means of meeting and working through problems including dependency needs. It is often less intense than one to one therapy, and less likely to lead to regression. Groups can help some older people with social functioning, especially those who have been isolated. Some special difficulties with group therapy in the elderly include deafness and somnolence. Avoiding meeting after heavy meals; using comfortable but supportive chairs; a well ventilated room; and a minimum of extraneous noise, help to keep everyone awake and able to hear. Meetings should not run for longer than half an hour.

Dobson & Culhane (1991) describe a therapeutic group run for older women. They emphasise the importance of having a clear purpose for a group and considering selection criteria carefully. In the early stages, rules such as not talking while others do, and valuing others' contributions, helped to harness good intentions. Finances, losses and reminiscences were powerful themes. The group ended after plenty of notice had been given, and a photograph taken on the penultimate session. The leader's responsibilities are defined in Box 17.3.

Family therapy

Most informal carers are close family members, and the problems shown by an older family member may reflect family pathology. Family therapy remains primarily associated with helping children, but there are now a

Box 17.3 Running a group (adapted from Dobson & Culhane, 1991)

Practical organisation: recruitment, starting, ending
Listening and encouraging
Protection from scapegoating
Focusing on common themes
Involving all in the group

number of established examples of its application to older people (Brubaker, 1985). The adaptations required are relatively minor, although they include all the general rules for involving older people in psychological treatments (Box 17.1). There may be problems with communication, for example deafness or poor vision, which can compound the effects of ageing in reducing information processing capacity. The overall effect is to make demanding tasks such as therapy very difficult. Physical or mental illness can be used to scapegoat the older person. Conversely, symptoms of physical illness can be accentuated or become an important vehicle for the older person's status and power (West & Spinks, 1988) (Box 17.4).

Benbow & Marriott (1997) listed the following ideas as being useful in family therapy with older adults:

- (a) The family life cycle – looking at how families evolve. Key issues in later family life include retirement and becoming a grandparent.
- (b) Cross-generational interplay – life cycle changes in different generations may not 'fit'. One generation may be more family orientated (e.g. during childbirth) while others are more outward looking (e.g. early retirement). Expectations may vary across the generations.
- (c) Genograms – drawing a family tree is a useful way of collecting, organising and considering family information.
- (d) Circular questions – these are in terms of relationships. Examples include, "If your mother says this, what does your brother do?" or "who in the family would this affect?"
- (e) Reflecting teams – members of the multi-disciplinary team talk about the family while they listen, offering different perspectives.

The systemic approach derived from family therapy can also be applied to the care of older people in institutions (Jeffrey, 1986). Sometimes the

Box 17.4 Family therapy

Family problems are common in the elderly
Serious illness and impending death have major effects on the family
Carer stress is very common
Responsibility for older members can cause guilt in those not caring
Family myths may need to be explored
Illness can be used to bond the family together
Low key family meetings can be very useful
High expressed emotion includes criticism and overinvolvement

problems attributed to one or more residents are better addressed by looking at the social network and relationships in the home as a whole. Such networks are just as important in the community, and this approach can benefit older people and their carers (Pottle, 1984). It is certainly always worth considering family systems when dealing with complex problems in the elderly.

Marital therapy

“We’ve been together for 40 years and it doesn’t seem a day too long” is, alas, not always the case. Couples who have barely tolerated each other during working life may find each other’s company very difficult after retirement. Illness in one partner may result in guilt in the other. Marital therapy should not ignore the continuing sexual needs of many old people.

Cognitive and behavioural therapies

These approaches have aroused considerable interest in recent years. The most frequently reported developments have been with younger people (Williams, 1984), but there have been examples of applications to older people. These have been well reviewed, at least in relation to depression, and there is evidence that these approaches are effective (Morris & Morris, 1991). However, outcome studies have not indicated which particular forms of cognitive or behavioural therapy are most effective. Moreover there remains a lack of studies comparing these therapies with drug treatments or with combinations of approaches.

There is also a problem with generalising results. It is unlikely that a sample of elderly people with a history of at least four years of depression (Steuer *et al*, 1984) is the same as one recruited by media announcements and followed-up over the telephone (Scogin *et al*, 1989), or a group of depressed nursing home residents (Hussain & Lawrence, 1981). These groups may only have their ages and depression scores in common.

There are three reasons why cognitive and behavioural therapies are particularly suited to the elderly:

- (a) Depression in later life is prone to relapse and there is evidence that cognitive and behavioural approaches have longer-term benefits. Patients may develop preventative skills.
- (b) Older people are more susceptible to adverse side-effects from drug therapy, especially those who are physically ill or taking medications for other illnesses.
- (c) Spontaneous remission is less likely in older depressed people (Lambert, 1976; Thompson *et al*, 1987).

Evidence suggests that depression often goes unrecognised or untreated when it occurs with physical illness (Koenig *et al*, 1992). Only 10% of their sample of depressed older men in hospital received some form of psychological therapy, and 44% received no treatment at all. They suggest that behavioural and cognitive techniques are a viable therapeutic option for the 50% of patients or more who have medical contraindications to antidepressants.

Anxiety management

The prevalence of phobic disorders is higher than might be expected, with a one month prevalence of 10% (Lindesay, 1991). Disability from phobias can be significant but specific treatment is rare. The majority of these patients suffer from a late-onset agoraphobia following a traumatic experience, typically an episode of serious physical illness. They have a higher than average contact with primary care services but tend not to be referred for specialist treatment (see Chapter 9).

While it may be necessary to adapt anxiety management for older people, it is just as effective as in younger patients. Older people may benefit from anxiety techniques such as relaxation therapy with tapes. By using headphones it is possible to deliver soothing instructions loudly, so overcoming all but the most severe hearing loss (Box 17.5).

Grief counselling

Although bereavement is not exclusively a problem of later life it is more common, and can mean the loss of an intimate relationship which has lasted many years. One ageist stereotype is that older people are better

Box 17.5 Anxiety management

Full assessment

Treat depression, or underlying physical cause

Identify when symptoms occur, precipitants and consequences

Educate the patient about anxiety, the physical manifestations and the treatment

Take baseline measurements

Identify contributing cognitions and challenge them

Identify contributing behaviours such as avoidance and plan exposure

Breathing exercises

Relaxation therapy

Box 17.6 Bereavement reaction (adapted from Viederman, 1995)

Stunned phase: lasting a few hours to several weeks

Mourning phase: intense yearning and distress; futility; anorexia, restlessness, irritability; preoccupation with the deceased; transient hallucinations; guilt denial

Acceptance and readjustment phase: may take several weeks to a year or more

at handling loss because it is expected, or because they have had more practice. In fact older people are not only more likely to experience loss, but the effects are cumulative in terms of risk for depression (Murphy, 1986). Being recently widowed is a major risk factor for mortality (Rees & Lutkins, 1967). Box 17.6 lists the phases of an uncomplicated bereavement (Viederman, 1995).

Losses can also reduce social support, either because friends and family have died, or because physical illness enforces isolation. Appropriate interventions include bereavement therapy and practical help to improve social networks. Important steps are recognising that something is wrong and encouraging the older person to accept help. Some of the principles of grief counselling are listed in Box 17.7 for a fuller text see Worden (1991).

Therapies for dementia

Reality orientation

Reality orientation is perhaps the best known specific psychological treatment for older people (Holden & Woods, 1988). Reality orientation aims to help patients with dementia by directly focusing on some of the deficits of the disorder, including disorientation and impaired short-term memory. It also helps to preserve skills.

Box 17.7 Principles of grief counselling

Offering support

Giving time to grieve

Help to express feelings

Reassure that feelings are normal

Identify abnormal coping

The approach can be divided into brief sessions (classroom reality orientation) and a pervasive approach influencing staff–patient interactions throughout the day (24-hour reality orientation).

Underlying both of these types of approach is the principle that staff enhance orientation by using identifying names and other information. This is supported by cues such as the commonly used reality orientation board, showing the date, weather, etc. (providing it is kept up to date!) and cues to everyday behaviour such as making tea or visiting a pub. Activities within formal reality orientation sessions include prompting basic information such as the names of group members; looking at current events; and using tactile, olfactory and other stimuli to encourage active cognition.

The enthusiasm with which reality orientation has been embraced by staff has sometimes exceeded the evidence for its effectiveness (Powell-Procter & Miller, 1982). There is evidence that reality orientation is beneficial, but the benefits tend to be modest, and only sustained with continued effort. There is little evidence to suggest that generalisation occurs (i.e. encouraging orientation for time does not lead to gains in orientation for place). There are also doubts about the suitability of reality orientation for use by informal carers at home.

Perhaps the biggest impact of reality orientation has been on staff attitudes, where it has resulted in staff improving the environments in which they work. When you orientate someone to their environment you become more aware of it yourself. There is little point in orientating someone to the day if all days are the same.

Reminiscence

Thinking about the past is not exclusive to older people. Younger people reminisce, although their memories may not extend back so far. Similarly, older people are not always reminiscing. Some avoid doing so because it is painful, others because they prefer the present. Nevertheless for many older people looking back is an important part of making sense of themselves and their lives. It allows the kind of integration that Erikson (1959) suggests is important as a developmental task of later life.

The ability to reminisce is preserved in early dementia. People with dementia are better at remembering what happened many years ago than what happened this week or earlier this morning. The act of reminiscence therefore offers a good way of engaging people with mild to moderate cognitive impairment without reminding them of their cognitive shortcomings. It is quite possible to use reality orientation and reminiscence in combination. Starting with reality orientation before progressing to reminiscence appears to offer better results (Baines *et al.* 1987).

Whether the activity of reminiscence, per se, can be considered a ‘therapy’ is open to question. Certainly reminiscence can have powerful

emotional consequences and may be used with specific therapeutic targets in mind. However, it is neither a panacea nor is it always appropriate for older people. The overlap between reminiscence and post-traumatic stress disorder, requires more careful study. Certainly there are older people whose problem is not how to remember but rather how to forget memories from wartime or other past trauma. The effects of reminiscence, like reality orientation, are dependent on the environment. There is a more obvious effect in a less interactive environment (Head *et al*, 1990).

Validation therapy

Concerns about the specific effects of reality orientation in confronting dementia sufferers with their failings have crystallised around the development of an alternative therapy which is directed at emotional needs. There can, not surprisingly, be problems in reorientating people when the reality is upsetting. A common example given is of a disoriented person who wants to go home to his or her spouse, not remembering that they have died. Is reorientation the best solution in this situation?

Validation therapy focuses on the phenomenology of dementia at an emotional, rather than a factual level. It views the disoriented person as struggling to cope with a complex and confusing world. It is hypothesised that the content of 'confused' talk reflects the emotional meaning of past events. For example, worrying about getting home in time to meet the children may reflect that parenting was a time of reward and security. The response to the disorientation is directed at exploring what things were like for that person, and how this relates to how they are feeling now. It is suggested that even the most confused behaviour has some meaning for that person.

Validation therapy has begun to be reported but more investigation is needed (Jones, 1997). It remains to be demonstrated how validation therapy and reality orientation differ. Of course bad reality orientation can certainly be frustrating and even unkind. However, closer scrutiny of the practice of experienced therapists suggests that they are sensitive to the emotional content of 'confusion', and avoid inappropriate confrontation. We need to find the best responses to people with dementia.

Memory therapy

The emergence of specific approaches aimed at helping those with memory problems would seem to be of particular interest to those treating the elderly. On the whole, however, the work has been directed at younger brain damaged patients. This is because the conditions for memory therapy are not met so well in dementia. In particular the use of mnemonics or memory aids require insight into memory loss, as well as preserved language and psychomotor skills.

Older people with mild memory problems can make use of simple aids such as lists, alarms and placing notices and instructions in key areas. A useful list of such aids is given by Burnside (1988). However, these are of major significance in only a few cases. These tend to involve people with mild or relatively static memory problems, such as following a stroke. For those with progressive dementia prompts supplement, rather than replace, the presence of an alert carer.

Resolution therapy

Resolution therapy has been introduced as a companion to reality orientation (Stokes & Goudie, 1990). It shares with validation therapy the assumption that there is meaning in the behaviour and confused talk of patients with dementia. But, unlike validation therapy, it looks for that meaning in the 'here and now'. In other words it sees such behaviour or speech, as an attempt to make sense of what is happening now, or to communicate a current need. In order to try and understand these hidden meanings, the therapist must use reflective listening, exploration, warmth and acceptance.

Carers and stress

The carers of those suffering from dementia are often put under considerable strain (see Chapter 18). A third of relatives caring for someone with dementia show significant distress (Levin *et al*, 1989), and even higher rates than this have been reported. Distress is also found in those caring for an elderly person with a physical illness such as a stroke.

There is plenty of scope for improving the psychological well-being of carers and a genuine opportunity for primary prevention (George & Gwyther, 1988). This includes local support groups, individual therapy, education, practical advice and stress management. The Alzheimer's Disease Society and other organisations (see Appendix for a list of useful addresses) are very active in this area. Specific problems include

Box 17.8 Psychological therapies used in dementia

Reorientation therapy
Reminiscence
Validation therapy
Memory therapy
Resolution therapy

anticipatory grief and living bereavement. Living bereavement attempts to describe the difficulty of caring for someone whose personality has largely been lost.

Conclusion

More studies are needed to establish which patients benefit most from psychological treatments. It is difficult to generalise from research with selected older subjects with psychological problems in the absence of physical illness or social need. Such studies need to be complemented by naturalistic trials evaluating multi-disciplinary treatment. New pharmacological treatments for older people have to be evaluated, however it is equally important to evaluate psychological approaches.

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