# "Resilience in the face of change" – 23rd National ACAT Conference, the benefits of working with over 65s – our reflections on why the evidence base is so limited

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Having recently returned from presenting at the 23rd National ACAT conference we were left with many reflections we wished to share. We were privileged to have met with other CAT practitioners specialising in working with older adults. While our presentation focused on sharing our recent study, which highlights the efficacy of CAT in older adults (Williams and Craven-Staines, in press), we spent time having a shared group dialogue reflecting on why the evidence base for CAT, and more specifically CAT in older people, is limited.

Limited research in CAT is not specific to the area of older adults alone. Other authors have highlighted that single case design studies are frequently used to inform the evidence base for CAT, Lloyd (2016). Calvert and Kellett (2014) clearly described that 'cognitive analytic therapy is a popular and promising intervention for complex presentations'. However, they go on to point out that there is a need for more research in CAT which incorporates 'the rigors of the controlled phase of the hourglass model'. The 'hourglass model', according to Salkovskis (1995, in Feltham and Horton, 2012) proposes that the evidence base for new therapies usually follows a three stage trajectory. The stages include: case reports and single case designs; the use of randomised controlled trials (RCTs) and finally service evaluations and field experiments. Whilst CAT has a wealth of case reports and service evaluations, the number of published RCTs continues to be limited.

This article aims to highlight our considerations of the problematic patterns we fall into as practitioners in an older adults setting and also the position in which we find ourselves within the wider organisational or systemic context of the NHS. In addressing such matters, we endeavour to provide exits and, in so doing, promote hope for the future.

A key point raised among our colleagues at the workshop was the degree of discrimination felt against older people within an organisational context. There was a shared sentiment that this may have originated, at least partly, with Freud. Freud is quoted as saying: "near or above the age of fifty the elasticity of mental processes on which the treatment depends, is as a rule lacking – old people are no longer educable" (Freud, 1905, in Hepple, Pierce, and Wilkinson, 2002). This statement likely did little to help the psychiatric and psychological communities' view of older adults. Such comments suggest that older people are somehow less worthy of psychotherapeutic support than younger clients. Though much has changed for the better for our older adult patients since Freud's comments, ageism within the NHS is still, unfortunately, present.

When surveyed, 87% of staff working in a psychotherapy service said that they felt the provision of services for older people was limited in comparison to the provision for those of a younger age group (Murphy, 2000). As we reflect on this figure we query why this should be the case.

While out-dated views questioning the applicability of therapy for older people continue to prevail within the organisational context of the NHS, there are also generational and cohort factors which may affect the patient's own motivation for change. Furthermore, the discussion within the workshop identified a subset within the over 65s (e.g. the old-old a classification first described by Neugarten, 1974) whereby the hierarchical doctor/patient relations are particularly ingrained thus resulting in a tension between limited provision of support for mental ill health in the old-old populations versus the old-old population's conflict of feeling worthy of and able to ask for help. Such issues have been highlighted in current literature: Morichi et al. (2015) states that factors such as inadequate diagnostic tools, cognitive decline, and systemic prejudice were the main culprits in denying the over 80s access to support for depression. Morichi et al. (2015) continue, proffering a lack of confidence in treatments and the underrepresentation of older people in clinical trials as internal reasons for the over 80s feeling unable to seek support for low mood. The findings mirror the sentiments raised at the workshop and serve to reinforce our own experiences in our respective services. We also acknowledged that, as the years pass, a new generation will emerge which will recognise the benefit of CAT and

the societal acceptance of the over 65s asking for help from services.

We recognise that we are often challenged by our professional desire to meet the needs of a patient (which truly reflects a sense of their personhood) versus the need to underpin this with a sound evidence base in order to adhere to NICE guidance. We are faced, then, with a conflict which transposes as a tension between evidence-based practice versus practice-based evidence. We reflected, within the dialogue of our conference workshop, that the evidence base for CAT in older adults is likely to be lacking because the use of CAT itself within the NHS is still in its infancy. Moreover, given that the resources available to provide CAT to older people is rarer still, it is therefore understandable that the current evidence base exploring the efficacy of CAT in older people is limited. Consequently, we find ourselves in a situation whereby CAT practitioners on the ground are aware of the benefits of CAT for older people but have limited time and resources to empirically evaluate their work. This lends itself to a smaller evidence base which, therefore, makes it difficult to argue the case for management support in the commissioning of additional CAT resources and skills promotion.

The limited resources that we do have across the country lead to older adult CAT practitioners working in isolated pockets, restricting access to peer support and development. We recognised that while people had the drive and passion to develop CAT services for older people, practitioners are often left in the difficult position of championing CAT alone.

We were heartened by the delegates' recognition of the benefits of our research to date and motivated by their suggestions in terms of promoting hope for the future. First and foremost, we considered raising the profile for CAT and older people within a service user advocacy context. In providing a platform from which service users can vocalise their experiences of the benefits of CAT we felt that the valued opinions of patients may provide impetus to influence managerial decisions regarding clinical provision. Secondly, having met CAT practitioners who are as motivated to fly the flag for OP CAT as much as we are, we discussed together the benefit of creating a nationwide older persons CAT special interest group to share experiences and ideas regarding how CAT is used across services. This would also allow us to collaborate on collating CAT outcome data on a grand scale, in the hope of increasing the evidence base further, thus building upon the tentative findings of our own research. Such a collaboration could make way for the collation of data from several NHS trusts, serving as an ideal platform on which to develop quantitative studies using the larger sample sizes so greatly needed to explore the efficacy of CAT and older people. We recognise that CAT special interest groups have been found to be beneficial in other specialty areas such as learning disabilities (LD). As a result of this, to date, by pooling both forensic and community learning disability resources together, over 20 studies have been published which significantly contributes to the evidence base of CAT in LD (Lloyd, 2016).

The links between the aptly titled conference 'resilience in the face of change' and its subsequent applicability for our own clinical population were not lost on us during our discussion. Transition and change is inevitable for our patients and whilst we mirror this experience in services, we remain enthusiastic that we can create a culture of resilience and hope from an organisational and clinical perspective. The ideas and suggestions gleaned from our workshop have left us with an ongoing sense of optimism with regards to the future of CAT and older people in the NHS. We would, therefore, like to take this opportunity to thank the delegates who chose to attend our workshop, for their participation, their ideas and shared experiences.

## References


Calvert, R. & Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. Psychology and Psychotherapy: Theory, Research and Practice 28(3) 253-277 DOI: 10.1111/papt.12020

Feltham, C., & Horton, I. (2012). Handbook of counseling and psychotherapy, third edition. London: Sage

Hepple, J., Pearse, J., & Wilkinson, P. (2002). Psychological therapies with older people: developing treatments for effective practice. Routledge: London.

Lloyd, J. (2016, August 22nd). CAT with people with a learning disability. Retrieved from http://www.easybib.com/reference/guide/apa/website

Morichi, V., Del'Aquila, G., Belluigi, A., Lattanzio, F., & Cherubini. (2015). Diagnosing and treating depression in older and oldest old. Current Pharmaceutical Design 21(13) 1690-1698.

Murphy, S. (2000). Provision of psychotherapy services for older people. Psychiatric Bulletin 24 181-184.

Neugarten, B. L. (1974). Age groups in American society and the rise of the young-old. The Annals of the American Academy of Political and Social Science 451(1) 187-198.

Williams, T., & Craven-Staines, S. (In press). Exploring the efficacy of Cognitive Analytic Therapy (CAT) in reducing anxiety and depression in older adults. International Journal of Cognitive Analytic Therapy and Relational Mental Health.