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## Experiential psychotherapy in geriatric groups

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### Abstract

Depression and anxiety are emotional disorders frequently encountered at geriatric patients. Their causes can range from purely psychological (i.e. elderly people cannot or do not know how to handle the social changes that accompany old age) to physical ones (i.e. elderly people become physically weaker and sometimes they get chronic diseases), or a blend of both. This research has tried to see whether creative and visual-plastic methods of experimental psychotherapy can yield a positive response in the treatment of geriatric patients diagnosed with depressive and anxious disorders involved in group therapy. Thus, it proposes a new method of treatment for this specific type of patients, describing its advantages triggered by its holistic nature.

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### 1. Introduction

Geriatric patients with depressive and anxious disorders are difficult to treat as their psychological problems are accompanied by physical and social troubles. Different authors (Bleandonu, 1991, Morrin, 1988, to name but a few) made appeal to group therapy. The psychodynamic and cognitive-behavioural methods do yield the same treatment results; though, they tend to see the patient's mental problems in isolation. This is why the present study turned its attention to creative methods and visual-plastic expressions of psychotherapy.

Its main objective was to validate an experiential psychotherapeutic model for elderly people diagnosed with depressive and anxious disorders. More specifically, it aims to see whether Gestalt and expressive-creative methods used with geriatric patients may yield positive results, as they have not been used with such patients before. This study also tested whether geriatric patients undergoing this treatment

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would present any improvement of their symptoms, of their global functionality or of their interactional behavior.

## **2. Theoretical background.**

Due to their age, elderly people are faced with a number of problems such as poorer social relationships, physical illnesses, lack of sensorial vitality, or loss of physical and social autonomy. These and other similar symptoms may lead to an impaired self-image that sometimes is correlated with lack of self-esteem and psychological disorders. On this fertile ground, depression and anxiety can develop freely. In this context, psychotherapy should tackle all these aspects, and whatever psychotherapeutic method the therapist may choose it should trigger an overall improvement of the patient's condition.

Expressive group psychotherapy is a very suitable method of treatment for elderly people diagnosed with depressive and anxious disorders as it sees the patients from a holistic perspective. Drawing as a therapeutic and psycho-diagnostic method can be used both with individuals and groups. Different expressive and creative therapies may help elderly people to rediscover and express their Self. Such psychotherapeutic methods may give them the possibility to live a new life and give them a sense of well-being (Saul, 1988). The psychotherapist is the one to decide which particular expressive method is suitable for each individual or group, be it drawing, painting, modelling, or collage. Drawing may represent a challenge for patients, but they are not investigating their Self alone, but accompanied each step by the psychotherapist. Moreover, drawing allows patients to be faced with a real situation and give them the possibility to talk about it, to express their feelings, emotions and inner turmoil. Taking as the starting point whatever seems more salient for the patient in that particular moment, the psychotherapist can begin the therapeutic process.

Based on the assumptions discussed further on, group therapy has been chosen as the most suitable therapeutic method for elderly people diagnosed with depression and anxiety disorders.

First of all, according to Hunter (cited here from Bleandonu, 1991), irrespective of the type of psychotherapy applied, a group is always a miniature society, a micro-cosmos with a very operational role. Secondly, group therapy is suitable for elderly people because it offers them the opportunity to talk about themselves, about their problems and to see that they are not alone, thus making them more open and receptive (Bleandonu, 1991). Thirdly, as compared with individual therapy, group therapy presents financial benefits, but also it offers patients support and understanding that allow elderly people to strengthen their coping mechanisms and resolve their (inner) conflicts. Last, but not least, many people with emotional disorders feel attracted to this type of therapy hoping to get over their state of isolation and difficulties, and to get closer to other people.

## **3. Experiential Psychotherapy in Geriatric Groups. A case study.**

Since such a psychotherapeutic method has not been employed before with elderly people, the main objective of this research was to validate a model of experiential group psychotherapy for elderly people diagnosed with depressive and anxious disorders (Drăghici, 2010).

From a psychotherapeutic point of view, this research was meant to make patients behave as they felt, not live on dissonance, to make them have more options to choose from, and be more autonomous. Moreover, patients were expected to show improvement of their depressive symptoms (of their mood, of their cognitive mechanisms), and of their interactional abilities. Overall, patients were expected to exhibit a higher global functionality.

### 3.1. Research methods

The following criteria were used to select the members of the groups:

(i.) cooperative patients over 65 (with reduced hearing or visual/sight deficiencies); (ii.) depression and anxiety disorders without psychotic or suicidal tendencies); (iii) affective disorders with no association with severe somatic polypathology (with no severe kidney failure, no severe heart or lung deficiencies).

Initially, patients were screened by means of a psycho-gerontological assessment that consisted of an interview, direct observation and psychometric testing. The Geriatric Depression Scale, GDS-30 items and the Mini-Mental State Examination, MMSE-30 items were used as screening tests. The criteria of selection for psychotherapy were the severity of the affective disorder (cut-off score GDS  $\geq$  15) and of the cognitive efficiency (cut-off score MMSE  $\geq$  24).

The Lauretta Bender Visual Structure Test and Wechsler Memory Scale – Digit span, 5-WMS were used to further refine the assessment of the patients' mental states. The Clock Drawing Test and Bender-Gestalt Test - copy phase (Lacks, 1999) were means to differentiate between depression and cognitive disorders on the one hand, and to familiarize the patients with and to smooth their way towards visual-plastic expressive methods of psychotherapy.

Patients were grouped according to the severity of their affective disorders, which were tested in accordance with the scales of assessment and quantification of depression and anxiety, the Hamilton Depression Rating Scale, HDRS – 21 items, and the Hamilton Anxiety Rating Scale, HARS – 14 items. During baseline testing, the patients' overall health was tested using the General Health Questionnaire, GHQ-12 and Social Dysfunction Subscale, SDS – 6 items.

Drawing, an expressive-creative method was used with four groups (two open and two closed) made up of 30 geriatric patients (age 65 to 79) with depressive and anxious disorders. The experiment was carried out along eight sessions. Besides testing-retesting (HDRS, HARS, WMS, GHQ, SDS) and observational procedures, patients were asked to draw specific topics such as a tree, their house as they perceive it, silence, a rose bush, the ideal season, the colours of life and they were asked to talk about their feelings. The drawing in itself is the basis on which the psychotherapist can work, the element that was further explored.

There were two periods during which this research took place: March-April and September-October. Two groups were studied during each period. During March-April, I studied a closed group made up of 6 people and an open group made up of 9 people. During the second period, the closed group was made up of 7 people and the open one of 8 people. The experiments took place during these periods because close attention was paid to the needs of the elderly patients, thus taking into account the climacteric conditions.

### 3.2. Data analysis

In one session (different for each group), patients were asked to close their eyes and to imagine that they were a rose bush. To stimulate free associations, the patients' imagination was directed towards the topic at stake by means of constructive questions. For example, they were asked to imagine what kind of rose they were, where the rose bush was situated, how the weather was, etc. To create a relaxing atmosphere an orchestral tune was played in the background. Then, they were allowed to draw the rose bush for as long as they wanted. They were asked to talk about what the rose bush felt, i.e. what they felt, how they felt about the experience itself, what feelings and emotions they experimented during the drawing itself and what memories were brought back to life.

The connection between their inner turmoil, their drawing and the real life was discussed making it possible to bring to light different aspects of the patients' personality and of their Self, elements that were further used in the psychotherapeutic process. Moreover, sometimes even other members of the group

stepped in and realised that some elements of another group member resembled something that particular person mentioned earlier. More specifically, drawing helped the patients express symbolically their strengths, but also their weaknesses and blockages.

Mrs. P. M., age 73, moderate anxious depression. She said that her rose bush was in a pot. When asked what the rose felt, she said the rose felt protected! She said that it resembled the rose bush existing outside her apartment. She took care of that rose, but, because people stole the buds, she had never had the chance to see them bloom. Nevertheless, she knew they were yellow. Mrs. M. P. had a broken hip, she could hardly move or walk by herself, she was abandoned by her son as he would not visit her. Her husband was hearing impaired and had moderate dementia. So she felt alone and she needed protection! Later on when she was asked to draw her house as she felt it, she said it was an open house, with happy people. Mrs. P. M. needed affection, support and companionship. Although she did not like very much when she was asked to draw and to talk about what she drew, she did not give up and, sometimes 'forced' by her group members, she continued to come and finished the therapy sessions.

As it can be seen from Table 1, a comparison of the results P.M. got during baseline testing and during retesting at the end of the psychotherapeutic process shows a clear improvement of her depression and anxiety. M.P. was moderately depressed. Thus, she initially scored 24 at HDRS and 14 at HARS, whereas at the end of the sessions, her HDRS score was 9 and her HARS was 10. After taking part in eight sessions of expressive and creative psychotherapy, P.M. scored as a non-depressed person. After six months, her HDRS score was the same.

Tables 1 and 2 describe the results all patients got during screening, at baseline testing, retesting and at 6 months follow-up retesting.

Faced with tasks involving expressive-creative elements, patients showed improvement at all levels as shown above. At the end of the therapeutic process, it was observed that patients' need of assistance when facing the world can be fulfilled by means of supportive and relaxing methods. During treatment they became aware of the need to resolve their old conflicts and they even tried to. This therapeutic approach also showed that the restoration of patients' confidence, of their communication abilities and feelings of group membership were clear benefits.

Table 1. Closed groups – psychoclinical data (first period – a. March–April, second period – b. September–October).

Patient	Sex	Age	Screening testing		Base line testing					Retesting					Follo w-up
			MMSE	GDS	HDRS	HARS	5-WMS	GHQ-		HDRS	HARS	5-WMS	GHQ-		
								12	SDS				12	SDS	
a. O.G.	M	73	30	16	16	17	11	7	2	8	12	12	1	0	6
a. O.V.	F	69	29	20	23	20	7	10	3	10	14	9	3	1	9
a. P.E.	M	79	27	15	16	20	8	6	2	7	12	9	2	0	5
a. P.M.	F	73	28	20	24	14	7	8	4	9	10	8	3	1	9
a. M.Ş.	M	72	29	17	18	14	9	6	2	8	9	10	1	0	6
a. M.N.	F	65	28	18	20	29	8	7	2	10	17	10	2	0	9
b. V.O.	F	69	29	20	23	20	7	10	3	10	14	9	3	1	9
b. M.P.	M	79	27	15	16	20	8	6	2	7	12	9	2	0	5
b. E.P.	F	73	28	20	24	14	7	8	4	9	10	8	3	1	9
b. S.M.	M	72	29	17	18	14	9	6	2	8	9	10	1	0	6
b. N.M.	F	65	28	18	20	29	8	7	2	10	17	10	2	0	9
b. M.M.	M	72	29	17	18	14	9	6	2	8	9	10	1	0	6
b. P.S.	F	65	28	18	20	29	8	7	2	10	17	10	2	0	9
Mean		71,23	28,38	17,76	19,69	19,53	8,15	7,23	2,46	8,76	12,46	9,53	2,00	0,30	7,46

Table 2. Open groups – psychoclinical data (first period – a. March–April, second period – b. September–October).

Patient	Sex	Age	Screening testing		Baseline testing					Retesting					Follow-up
			MMSE	GDS	HDRS	HARS	5-WMS	GHQ-12	SDS	HDRS	HARS	5-WMS	GHQ-12	SDS	HDRS
a. M.I.	F	69	28	19	22	21	8	8	2	11	14	10	3	1	10
a. G.G.	M	77	28	18	19	20	10	8	2	10	16	12	2	0	9
a. G.M.	F	79	28	20	21	15	7	8	2	11	9	8	3	1	10
a. R.G.	M	65	30	18	20	14	11	7	2	11	14	11	3	0	-
a. V.E.	F	65	29	18	23	16	8	8	2	10	12	10	2	0	9
a. E.M.	F	66	28	15	16	19	8	7	2	9	14	8	2	0	-
a. P.G.	M	72	28	16	17	18	10	6	2	9	12	10	1	0	7
a. P.V.	F	68	27	19	20	21	8	10	4	9	10	9	2	0	-
a. P.L.	M	79	27	20	24	14	8	8	2	10	8	10	2	0	7
b. S.G.	M	77	28	18	19	20	10	8	2	10	16	12	2	0	9
b. S.M.	F	79	28	20	21	15	7	8	2	11	9	8	3	1	10
b. T.G.	M	65	30	18	20	14	11	7	2	11	14	11	3	0	8
b. E.E.	F	65	29	18	23	16	8	8	2	10	12	10	2	0	9
b. L.M.	F	66	28	15	16	19	8	7	2	9	14	8	2	0	7
b. P.E.	M	65	29	18	23	14	8	8	2	10	12	10	2	0	9
b. U.M.	F	66	28	15	16	19	8	7	2	9	14	8	2	0	-
b. L.G.	M	72	28	16	17	18	10	6	2	9	12	10	1	0	7
Mean		70,29	28,29	17,70	19,82	17,23	8,70	7,58	2,11	9,94	12,47	9,70	2,17	0,17	8,53

#### 4. Conclusions

Gestalt and expressive-creative methods used in treating geriatric groups have shown that experiential psychotherapy in small groups reduces depressive and anxious symptoms, personal or relation difficulties as it is a form of supportive therapy that could increase patients' adaptation to a new phase of their life. Although it may be thought that a closed group would yield better results, this research showed that open groups, easier to form with geriatric patients (as their age and physical problems may prevent them to attend each session or to follow the entire treatment) produced the same results as the closed ones, showing that there is no real difference between the two. Such a holistic approach is suitable to most hospitalised patients usually isolated and involved into fewer communicative environments.

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