Commentary

The potential for pharmacological treatment of unpleasant psychological symptoms to increase personal fulfillment in old age

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Summary

As some people get older, they experience a decline in their subjective sense of fulfillment. Life may become less rewarding, happiness diminished in intensity. This is usually regarded as an inevitable consequence of the ageing process: regrettable, but a circumstance to which stoical endurance is the only constructive response. This situation is potentially avoidable, for some individuals at least; not at some indefinite point in the future, but now. By using existing and available drugs in a novel fashion to treat the unpleasant psychological symptoms associated with ageing, a substantial improvement in the quality of life may be obtained.

Age-related decline in personal fulfillment

Why do some people get less out of life as they get older? There are social and personal reasons in some instances, but most of the commonest serious and debilitating diseases—such as cancer, heart disease, strokes—are commoner with increasing age. Injuries take longer to mend, degenerative disorders are progressive—consequently pathologies accumulate.

Unpleasant symptoms of ageing may also occur even in the absence of diagnosable pathology. The causes of these problems are quite likely to be subclinical or milder forms of the same kinds of pathology that lead to disease and degenerative changes. Even if optimal health care were universally available (which is far from the case) the pathologies underlying unpleasant symptoms may not be preventable or treatable—at least not by medical science at its current level.

Therefore, many elderly people experience aches, pains, heaviness, fatigue and many other unpleasant symptoms on a daily basis. And when someone is experiencing unpleasant symptoms, they are less likely to experience pleasure. Furthermore, with increasing age, even positive events in life may elicit diminished levels of pleasure: people still enjoy things, but their enjoyment is not so powerful as it once was. From this combination of unpleasant symptoms and emotional blunting, elderly people may feel less motivated to make the extra effort required by creative activity or a busy social life, since extra effort is not rewarded with extra satisfaction.

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Symptomatic treatment

The Hospice movement has shown us that, even when underlying pathologies are incurable, there may be considerable scope for providing symptomatic relief through optimal use of pharmacological agents. Symptomatic treatment has revolutionized terminal care, especially the management of severe pain. I am advocating that this principle could equally be applied to the mundane and everyday sources of low-grade misery in old age.

The concept of symptomatic treatment is already familiar with respect to over-the-counter drugs. A person taking ibuprofen for backache, or cimetidine for indigestion, is seeking symptomatic relief from unpleasant symptoms, and the success or failure of this treatment is self-evaluated. The need for medication, when to treat and when to stop, are all decisions made by ‘the patient’, not by professionals. The individual who is taking the drug is the arbiter, and the doctor’s role is mainly to give advice about the probability of risks and benefits.

Many of the drugs which would be most useful for the alleviation of the unpleasant psychological symptoms of old age are at present available only on prescription. However, in principle, prescriptions for such agents could be provided by doctors on request, in response to patient demand. This pattern of prescribing is familiar for reproductive technologies such as the contraceptive pill or ‘morning after’ pill. Such drugs may therefore be made available to anyone who wants to use them, so long as the drug is not medically contraindicated.

Which drugs might be useful?

What follows is a list of some of the frequently experienced unpleasant psychological states typical of old age, and some suggestions as to the kinds of agents that might be useful in alleviating them.

Aches, pains, heaviness and fatigue

The increased prevalence of age-related pathologies and degenerative disorders may explain why elderly people are more likely to experience aches, pains, heaviness and fatigue. Such malaise states may be a consequence of immune activation (due to infection, autoimmune disease, or subclinical neoplastic changes). The most obvious treatment of malaise is the use of analgesics titrated against symptoms. Regular dosages of ‘simple’, relatively safe, over-the-counter painkillers such as paracetamol, aspirin, ibuprofen and codeine might be effective in improving the quality of life for many people. Tricyclic antidepressants with strong analgesic actions, such as amitriptyline, can also be used—indeed, some elderly patients who are currently diagnosed as suffering from ‘depression’ might better be seen as suffering from a physical state of malaise, with the mood change as a secondary consequence. Unfortunately, tricyclic side-effects (including confusion) are common in the elderly, and lower-than-usual starting doses are indicated.

Lack of intensity in emotions

If the ability to experience powerfully rewarding emotions could be enhanced, this would count as an improvement to the quality of life. For emotions to be experienced intensely requires that they be enacted by muscle: especially smooth and cardiac muscle under control of the autonomic nervous system, but also the voluntary skeletal muscles. For example, emotions such as fear and or sexual desire involve characteristic physical changes to the body that are substantially mediated by the musculature, and patients suffering from paralysis have been found to suffer emotional blunting roughly proportional to the degree of paralysis. Drugs which cause muscular rigidity or insensitivity tend to blunt emotions (e.g. the neuroleptic drugs such as chlorpromazine or haloperidol), and conversely drugs which are muscle relaxants—such as alcohol and the benzodiazepines—seem to produce greater intensity of emotions. This implies that moderate and occasional use of muscle relaxants such as alcohol or, more safely, benzodiazepines may allow older people to experience events with greater intensity. Indeed, this may be one unacknowledged reason for the popularity of these agents.

Lack of drive

Another factor behind the reduction of motivation with age may be lack of ‘drive’, due to brain changes. Creative energy often falls off with age, and some people lack the inner vitality to engage in activities such as art, sport, music, drama, and other things which they found stimulating and rewarding in their youth. It has been argued that age-related decline in drive may be a consequence of progressive degenerative change in dopaminergic systems in the brain. When this degeneration is extreme, Parkinson’s disease is the result. But many more people will have earlier stages of this decline, and experience milder degrees of emotional flattening and lack of vitality. Anti-parkinsonian drugs may be able to delay or temporarily reverse these changes. Although not conclusive, there is a body of suggestive evidence in the
literature to suggest that taking selegeline/deprenyl in smaller doses than for Parkinson’s disease may have powerfully beneficial subjective effects on drive and the ability to enjoy life in some people.

Reduced social activity

Humans are social animals, and most people require regular social interactions in order to enjoy life. However, elderly people often lead a restricted social life—perhaps due to death of spouse, friends and relatives, physical restrictions on activity, or social isolation. But psychological factors may also be important: including fear of strangers, shyness, panic, feelings, and other potentially treatable symptoms of anxiety. Social phobia is an extreme form of this problem, but the same drugs that are effective in social phobia also work on some people who do not fulfill these diagnostic criteria. The SSRI, for instance, may have a general effect of increasing confidence, which leads to a substantial improvement in rewarding social interactions. These effects (when they occur) mean that SSRI can be described as emotional buffers, since they act like a safety net to prevent large swings in emotion, while leaving normal emotions pretty much unaltered. This emotional buffering may be experienced as unpleasant; on the other hand, those who are excessively emotional, and especially inclined to suffer negative mood swings, may find their lives transformed for the better.

Sleep problems

With increasing age, many people find that the night’s sleep is shorter, the sleep is more disturbed (exacerbated, in some men, by the need for frequent micturition), and they awake feeling unrefreshed. Daytime drowsiness may be a problem, and frequent napping may become a nuisance. Too often, complaints of poor sleep from the elderly have been put down to a ‘natural’ process of ageing. However, it is possible that poor sleep may itself exacerbate or cause some of the negative cognitive effects of ageing. If so, pharmacological assistance in sleeping may be appropriate, if a suitable agent can be found. Unfortunately, most hypnotics do not provide ‘natural’ sleep (according to EEG measurements), hence drug-induced sleep is often subjectively unsatisfying and probably functionally less effective. At present, the most helpful approach to pharmacological sleep promotion would appear to be cautious individual experimentation. Melatonin has its advocates, sedative antihistamines appear to suit some people (although hangover may be a problem), and it may also be worth looking at those drugs that are currently classified as ‘antidepressants’. For instance trazodone (anecdotally) has an excellent reputation as a hypnotic.

The need for individual drug trials

As things stand, we do not know how much scope there is for improving the well-being of elderly people by greater use of psychopharmacological agents to treat psychological symptoms. Current evidence on drug effectiveness very seldom incorporates detailed information on subjective wellbeing; and anyway, there are large individual differences in the acceptability of drugs. Perhaps it may be possible to use smaller doses for symptomatic treatment than when treating formally diagnosed pathologies.

Each attempt at symptomatic treatment should therefore constitute an experiment, with the patient acting as their own control. In other words, the patient and doctor together conduct an informal ‘n = 1 crossover trial’ comparing life-taking-the-drug vs. life-without-the-drug. Drug choice, dosage and regimen would need to be adjusted against both symptoms and side effects.

It would be helpful to document and share the information generated by such experiments, and already the internet is proving a useful repository of this new kind of psychopharmacological knowledge, with web sites devoted to collating, describing, interpreting and critiquing patient- and doctor-generated case reports alongside more conventional published papers.

Risks and benefits

My message is positive. The decline in well-being that many people experience with age may be neither inevitable nor intractable. A greater willingness to embark on the psychopharmacological treatment of unpleasant psychological symptoms might help old age to become a time in which personal fulfillment is commoner, more intense and more pervasive.

I am not suggesting that using drugs to treat unpleasant symptoms of ageing will itself bestow the gift of a fulfilled life. Fulfillment still requires hard work and luck. But, in some instances, drugs can remove obstacles to a rewarding life, making it both easier and more probable. This should not be controversial: it is what we do when we treat a headache with paracetamol. A headache does not necessarily prevent someone being happy, but it is easier to be happy without a headache. A drug like paracetamol is obviously not a ‘happy pill’, but it may nonetheless make the difference between
subsisting in a state of pain and an active life which provides personal fulfillment.

The suggestions made above are necessarily speculative, and intended to emphasize the principle of symptomatic treatment of unpleasant psychological states in old age, rather than providing a precise recipe. Moreover, I have not dwelled on the dangers of drug taking. When treating relatively ‘mild’ symptoms with powerful drugs, the probable balance of possible risk to benefit may not be favourable, especially considering that elderly people are often especially sensitive to side-effects. There may be problems of polypharmacy and drug interactions when people are already being treated. Some people prefer to avoid taking medication, if at all possible. Others, believe that it is wrong to take drugs ‘just’ to feel happier: that this is only one step away from drug abuse and addiction. Others, despite their age, feel fine, lead sociable and creative lives, and may regard this essay as insultingly stereotyped in its view of the old. And there is always the problem that when treatment fails, the process of having hopes raised and then dashed may leave people feeling worse than before they started.

All these objections are reasonable. Success is by no means guaranteed, and non-ill people should not be pressurized to take drugs against their wishes. But my point is that treatment of this sort should be the patient’s decision, not the doctor’s. Those individuals who are suffering unpleasant psychological symptoms, and who wish to try psychopharmacology, should be able to do so, as effectively, safely and conveniently as possible. As long as there is a realistic hope of significant subjective benefit, then some individuals will be prepared to accept the risks and problems of taking powerful drugs. The goal of achieving a more rewarding life is not an insignificant one.

Acknowledgements

Thanks are due to Gillian Rye, James Willis, and Dave Pearce for help and advice.

References

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