Milieu therapy for hospitalized patients with late-life anxiety and depression: a qualitative study

Nåvik, Marit[1,2]; Hauge, Solveig[3]; Sagen, Ulrike[2]

[1] Nasjonal kompetansetjeneste for aldring og helse - Sykehuset i Vestfold HF
[2] Psykisk helsevern og rusbehandling – klinikk - Sykehuset Telemark HF
[3] Institutt for sykepleie- og helsevitenskap - Universitetet i Sørøst-Norge

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Authors:

Marit Nåvik, OT, MPH.[1, 2]

Solveig Hauge, RN, PhD [3]

Ulrike Sagen, M.D, PhD.[1]

Affiliations and addresses

[1] Department of Psychiatry, Telemark Hospital, 3710 Skien, Norway

[2] Norwegian National Advisory Unit on Ageing and Health, Vestfold Hospital Trust, Postboks 2168, 3103 Tønsberg, Norway

[3] Faculty of Health and Social Sciences, Department of Nursing and Health Sciences, University of South-Eastern Norway, Kjølnes ring 56, 3918 Porsgrunn, Norway

Correspondence to:

M Nåvik, Department of Psychiatry, Telemark Hospital, 3710 Skien, Norway

e-mail: naam@sthf.no

fax: +47 3500 3785

telephone: +47 92246004

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Abstract

Background:

Milieu therapy (MT) is an important interprofessional part of therapy for persons with late-life anxiety and depression in psychogeriatric inpatient units. Research on how this is conducted is scarce.

Aim

To explore nurses' and nurse assistants' experience regarding MT interventions for persons with late-life anxiety and depression and how this is applied and conducted in the everyday life in a psychogeriatric inpatient unit.

Method

Four focus group interviews with nurses and nurse assistants were conducted. Systematic text condensation was used for analyzing and interpreting the data.

Results

MT was described as a dynamic and active process. Conscious individualized cooperation and communication day and night emerged as overarching theme, with following categories: 1. Collecting clues about the patient's history, challenges and coping strategies. 2. Active use of these clues. 3. Active use of the ward setting as arena for staff to learn from each other, for patients to learn from other patients and as frame for MT in general. Strategies from both psychiatric and dementia care were used in MT interventions.

Conclusion

Results from this study describe content and complexity of MT strategies that can be supportive in everyday practice in psychogeriatric inpatient units and nursing homes, and have the potential to facilitate teaching, supervision and counseling of health professionals, caregivers and patients

Key words: Anxiety, Depression, Psychogeriatric, Milieu Therapy

Introduction

For patients with late-life anxiety and depression hospitalized in psychogeriatric inpatient units in Norway, milieu therapy (MT) is an important part of therapy (1). Research on this topic is scarce.

Background

International studies show that anxiety andl. depression in late life are common with a high co-morbidity rate of 35%-52% (2). The prevalence of anxiety disorders in the elderly is 1.2% - 15% (3). Among patients admitted to psychogeriatric departments in Norway, symptoms of anxiety were found in 28% to 65%, depending on the underlying diagnosis (4). Anxiety may be underreported, and the risk of chronic course increases when anxiety co-exists with physical illness and/or depression (5). Symptoms of anxiety and depression interfere with each other (6) and suicide risk is increased in patients with co-morbid anxiety and depression (7, 8) as well as in patients with increased psychological distress and cognitive decline, and poorer social and physical functioning (2). There is plenty documentation of the negative

consequences of late-life anxiety and depression for health, functioning, use of health-care services and quality of life (9). Due to the demographic change to older populations in industrialized countries, the number of patients in need of treatment for anxiety and/or depression will increase. This puts great demands on health care. Hospitalization of elderly patients with severe depression and co-existing high risk of suicide, self-harm, self-neglect or complex problems is recommended (1, 10-13). These patients are often in need of individual approaches that take into account their declining general resources, cognitive decline and psychiatric or physical co-morbidity. Medication is often challenging due to physical illness, age-related changes in pharmacokinetics, drug interactions, drug intolerance and frailty (14). Furthermore, impaired cognitive function makes psychotherapy difficult. Therefore, treatment recommendations for psychogeriatric inpatient units in Norway include individual plans for every patient, with MT interventions in addition to individualized medication regimens and various psychotherapeutic approaches (1).

Milieu therapy

MT is complex and comprises the strategic use of the psychosocial milieu in institutions, communication and relations to therapist and staff, but a standardized definition of MT does not exist (15-17). In Norway, MT is recommended as part of interprofessional treatment in all kinds of psychiatric units (11-13) and is mainly based on Gunderson's framework for therapeutic processes in psychiatric milieus (16, 18): an ideal milieu would incorporate containment, support, involvement, validation and structure (*Table 1*). During stay in hospital, the patients' needs and the therapeutic approach will change. As Gunderson puts it: *"…no single type of therapeutic activity is ideal for all patients or at all times for any given patient"*

(16, p.327). Gunderson's concepts are meant to be useful in the process of selecting MT approaches (table 1) to meet the individual patient's needs and treatment goals (16).

Table 1. Gunderson's five major therapeutic concepts in milieu therapy

	Focus on
Containment	• Physical wellbeing • Stress reduction • A safe environment • Reality testing • Reinforce internal control
Support	• To make the patient feel better, comfortable and secure • To reduce distress and anxiety
Structure	• Promoting changes in maladaptive patterns • Planning together with the patients • Predictability, social rhythm
Involvement	• Interaction with social environment • Patients involvement regarding goals, control and responsibility • Modify aversive interpersonal patterns
Validation	• Affirming the patients individuality • Respect and acceptance of the patients choices • Meeting the patients with empathy, sensitivity and tolerance.

Research on MT for ospitalized patients with late-life anxiety and depression is scarce. We searched PubMed, EMBASE, PsychINFO, MEDLINE, OT Seeker with the search words anxiety and/or depression, elderly or old age or geriatric, milieu or psychosocial intervention or non-pharmacologic or activity. Previous studies have focused on specific, one-at-a-time

MT interventions, e.g. music (19), reminiscence (20), physical activity (21, 22) and gardening (23), and report beneficial effects, such as improvement of depressive symptoms, reduced rumination and increased well-being. Cognitive MT for depression has shown to be beneficial for in-patients (24), but has not been explicitly studied in older patients. In patients with dementia, patient centered care (PCC) has shown good results in reducing neuropsychiatric symptoms and depression (25), but we could not find any study that has investigated PCC for hospitalized patients with late-life anxiety and depression. To our knowledge, no study has examined the content and complexity of MT approaches in the everyday life in a psychogeriatric ward, even though hospitalized patients spend most of the time in a ward milieu, together with their fellow patients and the staff. This knowledge gap is the rationale for this study. Delaney demanded already in 1997 that "*nursing should focus explicitly on explaining the clinical functions of inpatient treatment and nursing's role in operationalizing these functions*" (15, p.19). Two of the authors (MN and US) teach, supervise and counsel health professionals, nursing homes and caregivers in line with Norwegian recommendations for psychogeriatric health service (1). However, knowledge of what is useful in everyday practice is often implicit and a standardized concept of MT for patients with late-life anxiety and depression in psychogeriatric wards is lacking. Thus, there is a need to explore the concrete MT approaches for these patients.

Aim

The aim of this study was to explore nurses' and nurse assistants' experiences regarding MT interventions for persons with late-life anxiety and depression and how this is applied and conducted in the everyday life of a psychogeriatric inpatient unit.

Method

A qualitative study was designed to address the research questions, using a qualitative, interpretative approach described by Malterud (26). Focus group interviews were conducted to explore the staff members' experiences. This design can encourage informants to interact, share and clarify their experiences and perspectives (27). The interviews were conducted in the meeting room of the ward by two of the researchers, one of whom (US) is senior psychiatrist at the inpatient unit and the other (MN) is occupational therapist working in the same psychogeriatric department. The third author (SH) is registered nurse and professor and participated in planning and analyzing the interviews.

Sample and setting

All nurses and nurse assistants who work shift in a psychogeriatric inpatient unit were invited to participate in the study by the leader of the unit and the researchers who gave oral and written information in meetings and posters. Twenty-one (70%) agreed. The informants are familiar with Gunderson's MT framework. Table 2 shows the informants' characteristics.

Table 2. Focus group participants (*n*=21)

	n	%
Female	20	95
Years in current job		
1-5 years	6	29
6-15 years	10	48
16-20 years	3	14
>20 years	2	9
Occupation		
Psychiatric nurse specialists	5	24
Nurses	10	48
Nurse assistants	6	29
Working hours as % of full time		
60-69%	2	9
70-79%	3	14
80-89%	7	33
> 90%	9	43

The study was conducted in a psychogeriatric inpatient unit at a medium-sized hospital in eastern Norway. The unit consists of two wards: an open ward for nine patients with anxiety, depression, psychosis, about half of whom usually have co-morbid cognitive impairment, and

a sheltered ward for six patients with dementia and neuropsychological symptoms. In 2016, the mean length of hospitalization was 43 days. Of 93 admissions, 72 were voluntary and 21 compulsory. The participants work in both wards.

Data collection and material

Four focus group interviews were conducted in June 2016 in the meeting room of the unit. The interviews involved three to eight participants and lasted one hour each. Every participant attended only once. Each group consisted of nurses and nurse assistants with a variation in experience, duration of employment and education.

The interviews were based on an interview guide (28), with open-ended questions focusing on different aspects of MT for persons with anxiety and depression. Examples: *Can you describe MT in the unit, as you understand it? What do you need to know / take into account? What do you do / say? Are there things you should not do or say? How do you perform MT in everyday practice?* The interviewer (MN) asked follow-up questions in order to clarify informants' statements and group discussions. The facilitator (US) summarized the main impression at the end of the interview, to open up for clarification and complementary comments. After the third interview little new came up, after the forth interview the material was considered saturated.

The interviews were audio recorded and transcribed word by word by a professional typist. Researchers (US) and (MN) performed independent quality controls, reading the transcribed material and listening to the tapes. Different understandings of the transcriptions were discussed until consensus was achieved. The four interviews gave 78 pages of transcript.

Data analysis

Systematic Text Condensation was used to analyze and interpret the data, following Malterud's description of the four steps procedure (26). All interviews were read by researchers (US) and (MN) separately to get an overview and to look for the essence of the total material. Preliminary themes were developed by the two researchers individually. Common themes were formulated through a process of discussion (MN, US, SH). Similar and different opinions were discussed and this generated new perspectives and themes.

Meaning units relevant to the research questions were identified. The transcribed interviews were read line by line and meaning units were withdrawn from the text by researchers (US) and (MN) separately and then compared and discussed. Meaning units were sorted, compared, discussed and coded into sub-categories. All three authors discussed sub-categories, organized and reorganized them in categories until consensus was achieved. During the process, five preliminary themes were reduced to one overall theme, three categories and seven sub-categories (table 3).

Table 3. Theme, categories and sub-categories

Theme	Conscious individualized cooperation and communication day and night		
Categories	Collecting clues	Active use of clues	Active use of the ward setting
	Seeking for the person	Balancing support and pressure	Patient helping patient

Sub-categories	Exploring challenges and coping	Changing focus	Framing the milieu therapy approaches Learning from each other

Ethical approval and consent to participate: The study was approved by the Norwegian Center for Research Data. Trail registration-number: 47634. Written and oral information about the study (purpose, plan for publishing and information about the right to withdraw from the study at any time) had been presented by the researchers and the leader of the unit in meetings and as a poster approximately two weeks prior to the first interview and was repeated at the start of each interview session. Written informed consent was obtained from all informants. It is not possible to recognize individuals from the quotations.

Results

The informants described MT as a dynamic process in which they use observation, knowledge and experience in their everyday meetings with the patients. Our analysis identified one overarching theme for how informants perceived and described milieu therapy in their interactions with patients: conscious individualized cooperation and communication day and night. Three underlying categories and seven sub-categories are presented in table 3.

In the following, the term “anxiety” will be used for the psychological and physiological state characterized by fear or worry and uneasiness based on emotional and somatic components. “Depression” will be used for depressive symptoms, such as low mood, sadness, hopelessness, negative thoughts, worry and low self-esteem. Quotations are used to highlight the results.

Collecting Clues

Informants described a continuous, systematic, round-the-clock search for information about the patients' history, function, symptoms, coping strategies, resources, reactions and receptivity to interventions:

They collect clues through verbal and non-verbal communication, structured interviews and interaction with patient and relatives. They observe while interacting with patients during daily activities such as meals, getting dressed, individual and group activities in the ward setting, in the garden, in the kitchen, in the dayroom or the patient's room.

Seeking for the person

The informants presented that they focus on each patient's life story, family relations, working experiences, interests and current situation: They search actively for clues, trying to understand the patient's experiences, point of view and perspective here and now.

> *"That's what it is all about, to get to know the person, and then you learn how the person reacts. We are striving to learn to know the patient as a person."*

> *"I think the point of being understood is important, that we do not trivialize the situation or tell the patient to pull himself together, without having tried to understand him first."*

Exploring challenges and coping

The informants described seeking insight into the patient's everyday challenges (e.g. what can generate or increase anxiety or depression), the patient's individual experience of his/her present situation, anxiety or depression (e.g. thoughts, emotions and behavior related to symptoms), coping strategies (e.g. what can prevent or reduce anxiety or depression),

previous experiences (e.g. what has helped or made things worse) and resources in general (e.g. can activities or interests be used as motivational factors).

> *"We search for the patients' experiences: What made a difference in a given situation? Do you recognize anything that worked before? Can we try the same strategy?"*

> *"We try to make the patient aware of his thoughts or feelings in a given situation, to make him recognize when and how anxiety occurs and try to help him use this knowledge to cope."*

Active use of Clues

Informants presented knowledge of individual clues as important for planning, adjusting and facilitating the MT interventions: A strategy can work well for one person, but be wrong for another. Moreover, the individual's symptoms, coping and function vary during the day, from day to day and throughout hospitalization. This necessitates flexible, individualized approaches. Informants described that goals, focus, intensity and frequency of interventions are selected based on the collected clues and are described in detail in the patients' individual treatment plans.

Balancing support and pressure

Informants reported that they use and share knowledge about individual patients' resources, triggers and coping strategies in order to continuously adjust the balance between exposing the patients to challenges, demands and pressure and the amount of support required to make the patients feel safe, comfortable and protected.

"Sometimes you need to put pressure on the patient to start a change process. However, you need to ask yourself: When do we give the patient backup, help and support and when do we try to give more responsibility? Where do we draw the line? When is it too much pressure? Was I too tough or was this okay?"

Balancing the MT interventions is, according to the informants, a matter of constant evaluation and discussion. Meeting the patients at their own pace, listening to and responding seriously to the patient's statements were described as important when supporting and facilitating the process of coping with everyday challenges, e.g. by reducing an activity into single tasks.

"….One step at a time. Because the whole process of getting out of bed, getting dressed, performing the morning toilet and entering the dining room can be overwhelming, I start with: '... you can start by going into the bathroom, now you can grab the soap, next you can…' "

Changing focus

Informants reported that the strategy of changing focus is used to prevent, reduce and/or confront anxiety and depression symptoms: Being present in the ward setting gives informants opportunities to observe and react to signs of anxiety and uneasiness. They described that they take action by participating in a conversation, introducing positive topics, regulating accessibility to dramatic news or by suggesting various activities e.g. listening to music, physical activities. In addition, they can offer the patient something to eat or drink, suggest a walk in the garden, board games or breathing exercises, invite the patient into a separate room for a chat, or simply offer body contact as nonverbal support.

"…to be able to prevent, to be ahead of…., sensing if a patient is getting worried, anxious…. we can introduce something that can shift the patient's focus and make the

patient feel safe and calm, for instance to sit and read a book, look at pictures or talk about old days or workplaces. But we need to consider what is appropriate there and then."

Further, changing focus from hopelessness into hope, focusing on that things can change, was described as important.

"Facing depression, you support, focus on coping and self-esteem and communicate hope. You do that with anxiety as well. You can use a lot of words talking with depressed patients. But facing anxiety, I think that words can be very disturbing, especially during panic attacks. They can't take it all in. It is more important to be present and communicate with body language."

Informants also highlighted the importance of helping patients to recognize and describe the occurrence of symptoms to enable them to think and act differently. Informants also described that trying out different strategies and interventions can give patients useful experiences regarding coping strategies. Informants emphasized that they could observe and verbalize changes and recovery processes, sometimes before patients recognize it themselves.

Active use of the Ward Setting

The informants described different aspects of how the ward setting can be an active agent in the MT approach, for staff interacting with patients, patients helping each other and as a learning area for both patients and staff.

Patient helping patient

Informants described that the ward setting gives them an opportunity to help patients to share experiences, to support and encourage each other. Talking about everyday life and common histories was presented as important.

> *"When the patients get to know each other, a dynamic group process arises where they can talk about topics, things they recognize, and after some time they can use each other's experiences and resources as support and backup. The staff then needs to facilitate this and press the right buttons… Patients can benefit from each other, take a walk, talk about common experiences, also focusing on healthy aspects and coping…"*

Framing the milieu therapy approaches

Informants described how facilities of the inpatient unit, its structure and activities on individual and group basis are actively used as a framework for planning, carrying out and evaluating the individual MT approaches: Nurses and nurse assistants are present, available and, while they participate in the ward setting, interacting with the patients. This was described as useful to facilitate good processes and to create a ward atmosphere with high predictability, as the ward milieu gives room for both planned and improvised approaches.

> *"One of the staff is always present in the dayroom, like an anchor. If anything happens, it does not need to affect all the patients. The staff keeps control and regulates the ward atmosphere."*

> *"We need to be focused, to observe, read the signs from the patient and be ready to intervene."*

Learning from each other

Informants described organization and daily routines in the unit as important for the staff in order to share knowledge and learn from each other: Regular meetings ensure that information, such as clues and approaches, are discussed, evaluated and documented in the electronic medical record.

> *"There is no recipe; you need to use what you can. We discuss this all the time. You learn from each other, learn by watching and observing what your colleague does."*

Discussion

The purpose of this study was to explore nurses' and nurse assistants' experiences regarding MT interventions for persons with late-life anxiety and depression and how these are applied and conducted in the everyday life in an inpatient unit. The overall interpretation of our findings is that MT is an active, constantly ongoing process of seeking for and making use of each patient's history, experiences, resources and challenges within the framework and the possibilities a ward setting can offer.

MT was described as a nonlinear dynamic process where the staff needs to consider every situation, adjust their communication, interventions and actions, to use all their knowledge and experiences in every meeting with the patient. The process is going on day and night, from admission until discharge. It requires an exploratory and creative attitude, willingness to learn from each other, and to make and to learn from mistakes made in interaction with the the patients. The interventions offered are systematic, planned and individualized based on observations, evaluations, reflections and documentation. On that background, individual treatment plans are made to help patients attain goals and coping, and provide them with both challenges and support.

Our informants highlighted the importance of sensitivity to the patient's response and searching for triggers that increase or reduce anxiety and depression. The staff needs to consider situations from moment to moment, simultaneously keeping the patient's individual plan and goals in mind. This is in line with the findings of Goyal, which highlight the importance of "reading" the patient, observing verbal and nonverbal cues (6). Similarly, a study by Helleberg and Hauge addressing what characterizes good care for persons with dementia in nursing homes, emphasized staff willingness to act in harmony with the patient's current state, including an awareness of the optimal tempo and timing for when to intervene (29).

Our informants describe an active seeking for the patient's history, experiences and perspectives. This is in line with the National Institute for Health and Care Excellence (NICE) guidelines for depression in adults (10), that point out the importance of psychological and social factors such as the patient's personal and family history. The same focus is, in dementia care, found in the framework for PCC (30), and in the VIPS practice model, where the central principles are to Value the person, to assess the unique needs of the Individual, to take the Person's perspective and to meet the person in a positive Social environment (31). While PCC for persons with dementia focuses on wellbeing and quality of life, our informants describe how the collected knowledge about a person is used actively in MT of anxiety and depression. Our findings show that Gundersen's five concepts of containment, support, involvement, validation and structure, alone and in combination, are used in different phases of treatment, tailored and individualized to the patient's goals and functional capacity; for example, when staff members plan a strategy to help a patient confront, learn from or cope with anxiety and depression (16). Elements of music therapy, reminiscence and gardening, and physical activity complete the palette of milieu therapeutic approaches in our unit.

Thus, although Gunderson's principles are a recommended and frequently used MT framework in psychiatry (17, 18), our informants also report using other theoretical frameworks in their approach. Why is that? Patients admitted to an old age psychiatry inpatient unit are often cognitively impaired. The informants are familiar not only with patients with anxiety, depression and psychosis, but also with patients with mild cognitive impairment or mild to severe dementia. When planning strategies to meet their patients' needs, they make use of their knowledge and experience from both areas. Twenty-four percent of our staff members are specialist nurses in psychiatry, geriatrics and/or educated in cognitive behavioral therapy (CBT), including exposure therapy (32) and psychoeducation (33), PCC and dementia care mapping (DCM) (30, 31). CBT in anxiety disorders has shown to be superior to other treatments (34), PCC and DMC give high observation competence (30, 31). Daily meetings and routines frame and facilitate that staff without can learn from staff with competence in CBT, exposure therapy, psychoeducation, PCC and DCM. By learning from each other, the staff members' collected knowledge of different frameworks and techniques and of what works for the individual patient increases and stays explicit, which again facilitates communication within the patient's interprofessional therapist-team consisting of nurse, nurse assistant, psychiatrist, psychologist and medical doctor, as well as communication with patients, relatives and caregivers. Given the staff members' formal competence and education, this contributes to a systematic and individualized milieu therapeutic process for every patient.

Methodological discussion

The use of focus groups was considered a useful design. The informants were experienced nurses and nurse assistants, recruited from one psychogeriatric inpatient unit. Each focus group was heterogeneous and consisted of informants with different professional background, professional roles, responsibility and work assignment. MT is conducted by this

heterogeneous team, and the team's experience was focus of interest. Heterogeneity can be a barrier for participants to speak freely, feeling a group pressure. Our participants knew each other well and obviously felt confident together. For a broader exploration of the concept of MT, additional informants could have been recruited from other professions, such as physicians and psychologists from the same unit, staff members from other psychogeriatric hospital units or nursing homes, patients and relatives or caregivers. Individual interviews could have given more depth exploration of individuals' experiences, including views deviating from the group's common viewpoint. Observations could have revealed what staff members do, not what say they are doing. Recruiting informants from several settings or using several data collecting methods could have given a broader perspective to the research question. This can be topic of further studies but was beyond the scope of this study.

Strengths and limitations

As strengths could be considered that the researchers have different professions (occupational therapist, nurse and senior psychiatrist) with different pre-understandings and assumptions and that two of the authors were familiar with context and informants. Knowledge of ward unit, patient group and organization could heighten the researchers' ability to understand and interpret the data in the analytic process. However, if researchers do not have the necessary distance to the phenomenon explored, it can affect objectivity in data collection and analytic process. To compensate for this, the researchers' pre-understandings and assumptions were addressed explicitly during the research process and a supervisor (SH), without connection to the unit or experience from old age psychiatry was engaged.

Working together with the informants might be considered a strength giving the researchers the advantage of knowing the study subjects well. However, the informants might have felt pressure to participate and to express their opinions in a pleasing manner. This was addressed

in written and oral information emphasizing that participation was voluntary and that the participants could speak freely, and during the interviews with follow–up questions about unsuccessful examples.

It was made clear that their meanings and understanding never would influence the informants' employment or work conditions.

Conclusion and Relevance for clinical practice

To our knowledge, our study is the first to explore and describe MT for patients with anxiety or depression admitted to a psychogeriatric inpatient unit. Our study shows that experienced nurses and nurse assistants use theories for psychiatric in-patient treatment, such as Gunderson's principles of MT and various psychotherapeutic approaches, but also skills from dementia care. These different approaches are combined in a dynamic, interwoven process of individualized cooperation with patient and relatives. The ward setting was described as an ideal frame for this: daily routines and meetings facilitate good interprofessional communication, teamwork and sharing of explicit knowledge that makes MT a potent means in treating hospitalized patients with late-life anxiety and depression.

Results from this study describe MT strategies that can be supportive in everyday practice in psychogeriatric inpatient units and nursing homes, and have the potential to facilitate teaching, supervision and counseling of health professionals, caregivers and patients. Further studies are needed to shed light on facilitators and hinders, and to investigate the generalizability of our findings. Since a standardized concept of MT does not exist, neither in general, nor for the target group of this study, re-producing of our findings could contribute to a MT-standard for patients with late-life anxiety hospitalized in psychogeriatric units. Investigation of transferability to other contexts would also be of great interest.

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