ANXIETY IN OLD AGE

ROBERT J. KASTENBAUM, PHD

ANXIETY AND RELATED DISORDERS

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ROBERT J. KASTENBAUM, PhD

e-Book 2015 International Psychotherapy Institute

From *Anxiety and Related Disorders* edited by Benjamin Wolman & George Stricker

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Orig. Publisher: John Wiley & Sons

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Author

Robert J. Kastenbaum, PhD
Professor of Communication
Arizona State University
Tempe, AZ

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ROBERT J. KASTENBAUM, PhD

Researchers have known for some time that introducing the term "old" has a marked and predictable attitudinal effect (Tuckman & Lorge, 1953; Kogan & Shelton, 1962). Consider, for example, the following sentence-stems:

Most people become anxious when . . .

Most young people become anxious when . . .

Most old people become anxious when . . .

The most salient finding from attitudinal research is that adult age is perceived as a powerful variable both by the general population and by professional service providers (Palmore, 1990). The specific attributions and expectations are secondary to the predisposition to utilize "old" as a basic discriminant category. This predisposition could introduce inadvertent bias into the examination of anxiety in old age. Simply by identifying old age as a separate domain we risk the perpetuation of age stereotypes. It might be useful, then, to begin by reminding ourselves that age is but one contributing factor to anxiety and related disorders. We will take five examples: gender,

race, health, personality, and cohort. Each of these sources of influence interact with age and often provide more useful cues for assessment and management of anxiety than does age taken by itself.

SOME CONTRIBUTING FACTORS TO ANXIETY IN THE LATER ADULT YEARS

Gender

Many sources of anxiety in the later adult years are mediated by gender-related experiences. Survival is itself correlated with sex/gender: the differential survival gap favoring females increases with advancing adult age (Gee, 1989). This means that elderly females are more likely to face anxieties related to (a) caring for a terminally ill spouse, (b) grieving his death, and (c) adjusting to postmarital life over an extended period of time. Although fewer elderly men survive their wives, those who do tend to have more difficulty in sharing their grief and seeking social support (Stroebe & Stroebe, 1990).

Gender is also a significant factor in many other types of vulnerability to anxiety in the later adult years. Elderly women tend to have fewer economic resources than men (Torres-Gil, 1992) and, as a result, have more reason to be concerned about basics such as food, transportation, home repairs, heating and telephone bills. In turn, a precarious financial situation is likely to arouse anxieties about losing one's own home and therefore also losing the sense of

independence that is so highly valued in our society.

Major gender differences also exist with respect to the sense of usefulness and social integration. Retirement from full-time, long-term occupational activity is still predominantly a challenge for men (although an indirect challenge, for their wives). It is more often the man who is faced with anxiety-arousing questions about personal identity, continued usefulness, and related issues. The much higher suicide rate for elderly men vis a vis women is seen by some researchers as an outcome of the male's greater loss of identity and perceived self-worth upon retirement (Canetto, 1992). Suicide and other self-destructive acts (e.g., drinking binges) may be panic responses to the perceived sudden loss of status and value. On the other hand, women are likely to face job discrimination at an even earlier age than men, especially for positions that are above the entry level or minimum wage category (Christy, 1990). Women tend to be penalized both by the "glass ceiling" obstacle to advancement in midcareer and by societal attitudes that consider females to lose their value more rapidly than men after young adulthood. Aging, then, seems to present somewhat different anxiety-arousing signals in the occupational realm according to one's gender.

Elderly women are more likely than men to experience a sense of personal powerlessness (Degelman, Owens, Reynolds, & Riggs, 1991). Therefore, aging females may become relatively more vulnerable to anxiety

that is related to lack of efficacy and control. Aging tends to challenge the sense of empowerment for both men and women, but gender-linked differences could be as significant as the shared age-related effects.

Race

Hardships, deprivations, and unequal access to social resources show race-linked patterns from infancy onward. Differential risk factors can both reduce the chances of surviving into old age (Gee, 1989) and contribute to unfavorable economic and health status in old age. An elderly African-American, for example, may experience anxiety as the result of a lifetime of prejudice and discrimination, but also because of stress and deprivation in the immediate situation (Barresi, 1987).

As Jackson (1993) suggests, socioeconomic class may be the major determinant of the risk factors that have been found associated with race. People in the lower socioeconomic brackets are at greater risk for health and other problems whatever their race. Furthermore, it is not only the differential sources of anxiety that seem to be race-linked, but there is also a tendency to focus on middle-class whites in research, educational, and clinical contacts.

For example, an elderly African-American man of rural Southern origins was a candidate for independent living after several years in a New England

geriatric facility. He was seen by a psychologist who recognized that some of Mr. S.'s concerns were identical with those of other (white) residents who had faced the same challenge. However, Mr. S. also had a more distinctive source of anxiety. He was alarmed at the prospect of stepping out of his life-long role as a compliant and subserviant individual. (This anxiety first came to light when he insisted on sitting in the back of the bus when he joined a number of other residents in an outing.) Mr. S. readily accepted help in preparing himself to cope with some of the specific tasks and problems he would be encountering in the community, but he became paralyzed with anxiety whenever he sensed that he might be crossing the line to the kind of independence and privilege he associated with whites. Mr. S.'s age itself had very little to do with this reaction, which was not seen among white residents of his age and older. It would have been a mistake to interpret this reaction as the anxiety of old age when it was the unfortunate residue of a lifetime of mistreatment.

Health

It is easier to describe an individual's functional status, than to ascribe this status confidently to "aging." Gerontologists have learned to be cautious in offering such interpretations because an observed deficit or impairment can arise from a variety of sources. The tremor in an old person's voice, for example, could well be a symptom of neurological disorder rather than a just-

to-be-expected correlate of the aging process (Case, 1993). Another elderly person's psychomotor retardation and confusion could prove to be the result of overmedication. For example, it was common to see significant improvement in mental status within a few days after admission to the geriatric facility in which Mr. S. resided, simply because the aged men and women were liberated from the mind-dulling medication they had been receiving in nursing care facilities.

People with limited experience in gerontology and geriatrics are more likely to assume that problems experienced by elderly people are part and parcel of old age. Unfortunately, this assumption too often eventuates in a self-fulfilling prophecy. A medical problem that might well have responded to treatment becomes chronic and recalcitrant because of misplaced therapeutic nihilism. An anxiety reaction that has been precipitated by potentially identifiable events and amenable to intervention may be dismissed as "senile agitation." At its worst, this assumption becomes a justification for withholding competent assessment and treatment opportunities from elderly men and women.

Aging adults themselves often have difficulty in distinguishing between "normal" changes and acquired disorders—made all the more complicated by such lifestyle factors as repeated dieting, over or under exercising, careless use of prescription or nonprescription drugs, insomnia secondary to

depression, and so forth. A well-trained geriatric diagnostician will also have difficulty at times in distinguishing more or less expected age changes from symptoms of illness or other disorder.

The person experiencing these changes may be at risk for increased anxiety either through misinterpretation or uncertainty. For example, Mrs. D., a woman in her late seventies, fractured her hip in a fall. Mrs. D. (uncharacteristically) became so anxious that hospital staff as well as family had difficulty in dealing with her. As it turned out, Mrs. D. had put together bits of information she had heard or read to conclude that she was suffering from bone cancer—a disease that had painfully ended her mother’s life. The anxiety quickly subsided when Mrs. D. accepted the medical evaluation that she was free of cancer but did have a problem with osteoporosis. Other elderly men and women have brought themselves to a state of anxious exhaustion by trying to understand the nature of their problems.

From a pragmatic standpoint, it may not seem to make much difference whether an elderly person’s physical problems are related primarily to intrinsic aging or to a genetic or acquired disorder. Painful is painful; fatigue is fatigue. However, it does make a difference if we look at the whole picture over a period of time. People tend to be less anxious when they have a coherent explanation for their difficulties and an active course of action that has some potential to provide relief. There is a need for caution in

interpreting a presenting picture of impairment and distress as "just what one might expect in a person of that age." It was not long ago that anxiety and confusion on the part of an elderly patient was often dismissed as senile agitation. Today, geriatricians are more likely to explore the sources of expressed anxiety with an open mind. (This writer's father would not have enjoyed his 90th birthday had not an older physician taken "vague complaints" seriously and discovered a gall bladder on the verge of rupture.)

Personality

Stereotypes about "the old person" perhaps misrepresent reality most enormously with respect to personality. Attitudinal studies such as those cited earlier have found that elderly people as a class are regarded as rigid, past-oriented, judgmental, asexual, and so forth. These stereotypes are not supported by direct studies of personality in the later adult years. What we find instead is a great diversity of personality types or lifestyles (e.g., Costa & McRae, 1984; Kogan, 1990). Although gerontologists disagree with respect to specific approaches to personality (e.g., trait vs. contextual models), there is fairly strong consensus regarding the fact of diversity. It is commonly noted that people become more rather than less individualized as they move through years of unique experiences.

There is no need here to survey the many competing models of

personality that continue to contend for the support of clinicians, educators, and researchers. Partisans of a particular theory or classification system can determine for themselves how well their favored approach works when applied to elderly adults. One does not have to abandon all that one has previously learned and invent entirely new models. For example, trait theorists who have focused on extraversion-introversion in young adult populations might well be proficient in identifying differential sources of anxiety and differential coping strategies in elderly adults based on this salient dimensions.

Similarly, clinicians who draw upon the psychoanalytic tradition will find many clues to understanding problems experienced in the later adult years. For example, a fashion buyer for a major department store was so valued for her skills that the organization asked her to continue to work past the usual retirement age. Some of her colleagues protested vigorously against keeping her on, however, pointing out that she was a constant source of tension and conflicts in her relationships with them. In this instance, a psychoanalytically-oriented counselor helped the elderly woman reconstruct a long-term pattern of developing masochistic and competitive relationships, the only type of relationships she could trust. (The “oppositional dualism” dynamics of this type of case are described by Panken, 1973, especially pp. 139 ff.)

The point here is not to endorse any particular personality theory, but simply to note that in approaching the anxiety disorders experienced by elderly adults, one can glean insights and leads from a variety of theories. It is probable that theories with a strong developmental component will be more useful. Although trait theories often are favored by mainstream personality researchers and provide convenient ways to describe and classify, we are likely to find more substantive value in theories that emphasize time, change, and context. As always, however, the skill of the particular clinician, researcher, or educator is a major variable in determining a theory's usefulness.

A central controversy in the study of personality across the adult years could have significant bearing on anxiety. This is the question of *continuity vs. change*. There is now fairly broad agreement that the personality patterns established earlier in life remain salient throughout the adult years, although modified to some extent through by experience and changed circumstances. And, as already noted, there is also agreement that a variety of personality types can be observed in the later adult years both because diversity is evident from the start and because people tend to become even more individuated through their distinctive life experiences. The question at issue is whether or not there is a transformation process that operates across the observed diversity and continuity. Is there something about "aging" that introduces systematic change within all the enduring personality types?

One possibility here may have particular relevance for understanding anxiety in the later adult years: the Jungian-flavored, cross-culturally-researched theory proposed by David Guttmann (1987; 1993). He suggests that there is a systematic change in *mastery styles* from youth through old age. This theory will be considered in a little more detail later in this chapter. What is important for the moment is the recognition that the personality characteristics of elderly people might be more complicated than previously supposed: a variety of lifestyles, each enduring with some modifications within its own frame of organization, but all perhaps being subjected to a general process of change.

Cohort

Why is this octogenarian so preoccupied with even very small financial matters and such a penny-pincher when there seems to be no need for being so? A "fancy" interpretation might dwell on biological changes with age and the hypothetical recrudescence of anal-retentive features. Most gerontologists, however, would probably go first with a simpler interpretation: This person's coming of age occurred during the Great Depression. He or she may have seen anxiety, confusion, anger, and deprivation on all sides. Perhaps he or she personally missed out on educational or career opportunities that never came around again. The possible influence of the Great Depression on personality and adaptation in

the later years of life is one example of the role of cohort effects. What might be mistaken for the consequences of aging or the expression of a particular personality type might instead by more cogently understood as the response to sociohistorical circumstances encountered because of one's membership in a particular birth cohort.

Several other examples were implied earlier in this chapter. For example, expectations and opportunities for women have varied significantly from generation to generation in the course of this century. These differences encompass the entire range of life activities, from careers to community service, from political involvement to sexuality. In an intergenerational group meeting, one elderly widow observed that "I'll tell you what my sexual anxiety was—seriously. It was not wanting to hurt my husband's feelings by turning him down, but not wanting to get pregnant again. . . . Oh, well, listen! We didn't talk about those things like you do today, not even in the bedroom. Now couples talk about sex and birth control like they talk about what to have for supper! . . . Yes, I think it's better today, much better!" When a few minutes, the discussion turned to AIDS, the elderly widow somberly agreed that not all the changes were for the better.

Cohort effects are also strong and varied along the dimensions of race and ethnicity. Think, for example, of the differential expectations and opportunities experienced by elderly African-Americans in their youth— and

compare this experience with the prospects that motivate and frustrate their grandchildren today. Specific historical events can also have differential impacts on people of varying cohorts. For example, the sudden rise in discrimination against Japanese-Americans during World War II resulted in heightened stress and, for some, significant loss. This experience took markedly different forms, however, for young and old. Senior adults had to cope with such feelings as surprise, anger, and disappointment that they would be treated as though disloyal to America, and the fear that all they had worked for over the years was now in jeopardy. However, they also had the resources of experience and maturity to call upon in coping with this crisis. By contrast, children also felt the sting of discrimination and the sense of stress and anxiety that enveloped their families—but they did not have a fully developed perspective within which to contain and cope with this situation. Therapists interested in ameliorating the anxiety of elderly Japanese-Americans would have had markedly different situations to deal with in the mid-1940s as compared with today: a person whose well-established life pattern had been disrupted and assailed by his or her host society, or a person who carries forward from childhood the memories of discrimination, trauma, and distrust.

It would be simplistic to proceed on the basis of a prototypical elderly person who has a particular kind of anxiety and a particular way of dealing with this anxiety. Gender, race, ethnicity, health, personality, and cohort

membership all contribute to who this particular person is and how he or she attempts to cope with anxiety in the later years of life. Furthermore, these influences are interactive at all points in the total life course. Mrs. P., for example, cannot be understood adequately in terms of her 87 years. We must take into account the role of the female as expected within first generation Polish-American culture and modified to some extent over the decades, a competitive personality that helped her to advance her own claims within a large family network, and a double-hip fracture that has severely restricted her mobility and independence in her old multilevel home. Moreover, we still would be ignorant of some of the most powerful influences and resources in her life if we did not take into account the ethnic neighborhood in which she resides—and the social and economic pressures that this traditional conclave is now facing itself. As it happened with Mrs. P., her intensified anxiety centered on an impending marriage that, to her way of thinking, would leave her in a socially isolated and less empowered position. She could cope with this and she could cope with that—but not with the threat of losing power within the family and neighborhood social structure.

OVERVIEW: GENERAL CHARACTERISTICS OF ANXIETY IN OLD AGE

It is helpful to identify several of the most salient age-related themes, contexts, and expressions of anxiety in the later adult years. As might be expected from the preceding discussion, these age-related phenomena are

mediated by all the factors that contribute to making a particular individual that particular individual.

The following characteristics tend to be more common and salient among older adults:

1. *Anxiety* frequently *arises from realistic concerns*. Clinicians who are primed to recognize and treat neurotic disorders in younger adults have sometimes felt powerless as well as disoriented when first called upon to work with elders. Although neurotic men and women grow older and take their anxieties with them, there are also many people whose sense of security has been challenged by emergent circumstances. In such instances, it is neither accurate nor useful to see them as tilting with windmills of their own devising or merely stewing in long-term conflicts. They are facing genuine threats (or, at least, the plausible "threat of a threat") to their health, independence, self-esteem, and so forth.

There are many implications. For example, in a study of more than a thousand male veterans (aged 25 to 90), it was found that there were some men with high, moderate, and low levels of expressed anxiety at every age level (McRae, Bartone, & Costa, 1976). A provocative difference showed up when highly anxious men of various ages were compared with each other on their reporting of physical complaints. Young and middle-aged anxious men

reported more physical symptoms than adjusted men of the same age. But anxious elderly men reported fewer physical symptoms than less anxious men of the same age.

The investigators then constructed a discrepancy index that compared the number of complaints reported by the men with the actual findings of very thorough medical examinations. The age-anxiety pattern again showed a reversal. Young and middle-aged men with high anxiety reported more illnesses than their physicians could find, but in old age, the less anxious men reported more illnesses. The anxious elderly men underestimated and underreported the actual hazards to their health, while anxious young men could afford to focus on symptoms because they did not truly think their lives were in danger. The adjusted elderly men seemed to be actively monitoring their own physical status in a realistic manner, while elevated anxiety in old age seems to interfere with attending to realistic health problems.

This is but one illustration of what one might discover when starting with the recognition that there are realistic emergent sources of anxiety in the later adult years, along with the perpetuation of neurotic conflicts. Furthermore, there can be a variety of interactions between realistic age-related concerns and pre-existing neurotic patterns. For example, the realistic threat of reduced financial circumstances can unmask or intensify earlier fears such as being exposed as a failure or “losing one’s substance.” An elderly

woman living alone with some difficulty may be alarmed when a neighbor of the same age is admitted to a nursing home— an alarm that has one foot in reality and the other in a lifelong hypersensitivity to being unloved and abandoned.

2. There is *often a reduction in the resources available to cope with anxiety*. Many people deal with stress, threats, and conflicts by moving away from them, exhibiting avoidant behavior. A hassled teenager runs away from home, a quarreling lover drives off, a pressured employee quits his or her job. This strategy may have paid off many times, not necessarily by solving problems but by providing time outs and preventing more extreme behaviors. Elderly adults tend to have fewer opportunities to move away from sources of anxiety. Limitations on physical mobility and finances often reduce the ability to put distance between oneself and a frustrating or abusive situation. Furthermore, a complex web of mutual dependencies may keep people together in stressful and destructive relationships. Forced proximity, especially without the opportunity for respite, can intensify anxieties around privacy, empowerment, and a variety of other issues that mediate quality of life.

An extreme example came to public attention recently in Arizona when a 94-year-old man shot and killed two of his mobile home park neighbors. Other neighbors reported that the two victims were unpleasant people who

had enjoyed tormenting the old man by playing music at a very high volume despite his continual protests. The old man himself was seen as a “crusty” fellow. Feeling that he could neither tolerate the abuse nor move away from it, he armed himself and shot them dead. Less extreme and violent, but also highly stressful, examples can be found in many geriatric facilities where elderly residents may be forced into close and regular contact with people they dislike or fear.

Within the family circle, a senior adult may feel stressed and outraged by the behavior of others, yet consider that he or she has no viable residential alternative. Mrs. L., a woman recovering from a stroke accepted her daughter’s invitation to move in with her. From the older woman’s standpoint, the situation soon became a living hell as “two bratty kids” did whatever they wanted, and she herself was treated like a child. Worst of all, her daughter, still legally married, would bring men home and disappear behind the bedroom door with them. Mrs. L. wept tears of anger at her perceived helplessness to do anything about the situation.

One does not have to assume that there is anything fundamentally different about the elderly person whose high level of anxiety has been provoked or maintained by constant exposure to stressful people and circumstances. Young people feel pretty much the same way when they can neither readily resolve nor escape from a problem.

3. *Normative transitions and uncertainties tend to keep people on an anxious footing*. Again, the basic phenomenon here is one that can be experienced by people of any age. We tend to feel most secure (least anxious) in familiar and stable situations, and when we can predict future developments and outcomes with a sense of confidence. The anxieties of adolescence have often been interpreted within the context of the transitions and uncertainties that tend to become salient as one attempts to establish an individual and adult identity. Although the particulars differ markedly, elderly adults also tend to find themselves in a transitional situation which, in this case, challenges the identity and security that had previously been achieved.

For example, people in their sixties face such normative transitions as:

- From career to retirement
- From relatively high to relatively low empowerment
- From marriage to widowhood
- From independent to assisted living.

Each of these transitions involves a set of more specific challenges and decisions. Anxiety may be even higher when these transitions are in prospect than when one is facing them directly. For example, the wife of a "workaholic" public agency administrator feared that her husband would go "looney-tunes

—and take me with him" when forced to retire. In her own words, "I made myself a nervous wreck worrying about becoming a nervous wreck!" As it turned out, however, the workaholic "sobered up" spontaneously after he drew his final paycheck and did not seem to miss either his previous busywork or authority. The couple felt less anxious "when retirement actually struck" than the wife had when anticipating the dreaded day.

Uncertainty tends to intensify apprehensions regarding health, independence, and survival. One cannot predict when significant problems will arise in these spheres. For example, people entering their seventh decades in good health could be continuing to enjoy independent living a decade later, or develop a serious ailment or impairment within a short time. Some people respond to this normative situational uncertainty with a perpetual bubbling of anxiety. Others, however, just stop scanning the future and take life day-by-day. An interesting study by Kulys and Tobin (1980) found that intellectually competent elderly adults who did not project their thoughts forward into the remote future were adapting this strategy of not burdening themselves with uncertainties. Those with low future concern were also less anxious and less hostile than those who were inclined to scan the temporal horizon for the disasters that might lie ahead.

To some extent, then, anxiety in later adult years can be conceptualized as part of a lifespan developmental story that has always featured

developmental challenge, hazard, and opportunity. When society as well as the individual is changing, the sense of instability and unpredictability is exacerbated. For example, a middle-aged adult who expected this to be a settled and prosperous time of life may be more anxious than ever because his or her job is jeopardized by corporate failure or downsizing. This person now must cope not only with sources of anxiety that are more or less normative in middle adulthood but also with dislocations and dangers introduced by socioeconomic forces. Similarly, elderly adults today must cope not only with the universal sources of concern associated with advancing age, but also with technological change and the destabilizing effects of postmodernism on those who grew up with more traditional views of self and society (Kastenbaum, 1993). The ailing old woman who is being asked to complete baffling bureaucratic forms by a stranger at the admissions desk of a hospital is not just experiencing her own idiosyncratic anxiety, but the anxiety of a generation.

4. *Elderly people tend to be anxious about dying, not death*. The three themes already mentioned all converge here. Dying and death are realistic concerns in later adult years; one can no more escape from mortality than one can escape from one's own skin; and the process of departing from this life to the unknown is as universal and normative a transition as birth.

There is no firm evidence for the proposition that elderly men and

women are more anxious about death than the general population. In fact, the available data suggest that younger adults have higher levels of everyday death anxiety than do healthy senior adults (Kastenbaum, 1987; 1992a). Peaks of death-related anxiety usually are seen only in elderly adults who are having a psychotic or trauma-evoked reaction, or as a fleeting reaction to an emergent situation (e.g., learning that one has cancer). Studies usually find that age itself explains relatively little about an individual's anxiety or other attitudes toward death.

Death-related anxiety is quite different, however, from fear or anxiety regarding death as such. For example, many people at any age have life concerns that are exacerbated by the prospect of death. An elderly woman who has lived for many years with a variety of painful and disabling conditions may be ready to see her life end, but anxious about who will look after her "old man." Another elderly person may be more concerned about what will become of the family estate when it falls into squabbling hands after his death. Would-be counselors or other service-providers will be more useful if they learn to distinguish between existential anxiety regarding death and the variety of life-oriented concerns that can perturb people who are nearing the end of their lives.

Dying is perhaps the most salient of all death-related issues. Anxiety in the last phase of life often arises from dread of prolonged suffering and

helplessness, feeling burdensome on others, and draining the family's financial resources. Again, a distinction must be made between how a person copes with the problem once it is directly at hand, and the fears and apprehensions that one may have lived with when thinking about a final ordeal. Experience with hospice care (e.g., Mor, 1987) has found that many elderly adults cope very well with their terminal illness, or serve as effective caregivers for a dying spouse. With competent and caring support from others, including state-of-the-art symptom relief, elderly men and women often can remain comfortable and secure, still a valued part of their families, until their last breath. Anxiety-reduction approaches, then, can take two general forms: relieving apprehensions about the dying process in advance through emotional support and information-giving, and preventing or ameliorating suffering and isolation during the dying process by competent and sensitive care. Counselors or other caregivers who are themselves highly anxious about their own mortality may not be in a position to provide either of these services.

ASSESSMENT AND INTERVENTION: A FEW SPECIFICS

In conclusion, we will look briefly at a few selected topics that may be of interest for those conducting anxiety disorder assessment, intervention, or research in later life.

The Cognition-Anxiety Link

Many associations are found between cognition and anxiety at all age levels. This linkage may be especially salient among elderly adults. For example, memory lapses may induce anxiety that is out of proportion to the incidents themselves. Furthermore, the increasingly widespread awareness of Alzheimer's disease has so sensitized some middle-aged and elderly adults that they may interpret "garden variety" forgetfulness as a pathognomic sign of a progressive dementing disease. In helping people cope with this source of anxiety, one should not underestimate the difficulties involved in making accurate assessments of Alzheimer-type disorders early in their course, nor be unaware of the variety of other organic and functional explanations for memory lapses.

Withdrawal from activities and relationships may also be consequences of anxiety about one's ability to perform cognitive tasks. Elderly people may fear humiliation or failure because they no longer trust their ability to learn new names and other facts, process information rapidly and reliably, and retrieve knowledge from memory on demand. One or two adverse experiences may lead to a loss of self-confidence and start a cycle of withdrawal and depression. "Test anxiety" is a variation of this concern.

"Flights into senility" may occur when an elderly person feels unable to cope with change, stress, and threat. The apparent inability to *comprehend*

reality proves at times to be a strategy intended to *protect* one from a hostile or overwhelming reality.

Loss of Efficacy, Control, and Confidence Are Primary Sources of Anxiety

Early in life one must often work to achieve efficacy, control, and confidence. "I can accomplish; I can manage; I can do" are self-judgments that are earned only after many attempts, some of which are miserable failures. Circumstances often compel elderly adults to ask themselves, "Can I still accomplish? Can I still manage? Can I still do?" Some older men and women seem to have an inexhaustible personal account to draw upon to maintain their confidence; others are more easily made to feel insecure when they encounter situations where their efficacy and control seems unequal to the task. Anybody might have a particular experience in which "the old touch" doesn't seem to work. It is when one starts to doubt his or her general ability to influence the world and exercise a reasonable amount of control that the danger of catastrophic anxiety arises.

The efficacy/control/confidence issue has its interpersonal and objective as well as its subjective side. One's success in continuing to live a confident and competent life may depend much on how others cooperate. A supportive "convoy" of friends and relations (Antonucci & Akiyama, 1993) can provide just enough help to make up for possible age-related decrements

in efficacy and control. The loss of significant others and the indifference of strangers can lead to a series of disappointments and frustrations that contribute to a loss of self-confidence.

The objective side is now the subject of intensified study of lifespan developmentalists and gerontologists (e.g., Baltes & Baltes, 1986; Langer, 1989). Studies conducted in field situations (e.g., nursing homes), as well as the laboratory, are exploring the limits and potentialities for maintaining control over one's own life in the later adult years. It would be premature to draw conclusions either about the nature and extent of age-related decrements in control or the possibility of compensating for deficits. For now it may be enough to note that objective control and the sense of control both are gaining recognition as major factors in adjustment to the challenges of aging. Anxiety disorders should be less common, intense, and enduring among those elderly men and women who can continue to feel confidence in their ability to influence the world around them.

"Opening Up" Can Liberate Energy and Reduce Anxiety

Here is one of the more significant emergent areas in gerontology. The basic thesis is that people often must "plow under" some of their creative potential in order to fulfill their obligations in the family and the workplace. This chronic suppression of interests and talents may contribute to a vague

sense of dissatisfaction. Despite health, financial stability, and supportive relationships, they feel somehow unfulfilled and thwarted. This might be termed the anxiety of the unfulfilled.

One specific theory has been offered by David Gutmann (1987), whose work was mentioned briefly earlier. His cross-cultural research seems to support Jung's conception that females and males each tend to suppress the other-gender side of their nature throughout the first half of their lives. The challenge of the second half of life, then, is to actualize the other side of our natures and, in general, open ourselves to the creative potentials that previously lay dormant. For men, this process involves moving from an active mastery to a symbolic mastery orientation; for women, the movement is in the opposite direction. Guttmann's theory also takes social change factors into account, especially the tendency of mass, high-tech societies to treat elders as useless rather than provide them with places of honor and respect. Maduro's (1974) research in Northern India has demonstrated that society can also encourage and support creativity in old age.

Academic studies of creativity (e.g., Simonton, 1991; Kastenbaum, 1992b), clinical reflections (e.g., Carlsen, 1991) and applied programs to encourage expressive activities (e.g., Goff & Torrance, 1991) are starting to make it clear that anxiety can be reduced and latent energies liberated when elderly men and women open themselves up to their creative potentials. This

itself is not entirely an anxiety-free enterprise because risk-taking is inherent in all creative activity. There is the immense advantage, however, of feeling oneself to be the source of impulse, idea, and activity rather the pawn or victim of forces outside one's control.

CONCLUSION

It may be suggested in conclusion that although many elderly men and women experience anxiety (e.g., MacDonald & Schnur, 1987), this does not necessarily signify that anxiety disorders are rife. There are many realistic sources of concern in the later adult years, so the frequent sounding of the anxiety alarm can be an adaptive function that speaks well of the individual's situational awareness. Elderly people are survivors. They have many resources of skill, character, and experience that can continue to benefit themselves and others. Competent service-providers need not develop their own anxiety disorders in contemplating preventive and interventive activities.

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