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PSYCHOTHERAPY IN OLD AGE

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Psychotherapy In Old Age

There are possibilities for growth and change throughout life, including old age.[1] Therefore psychotherapy is useful with older people, although it is less commonly practiced than would be appropriate. It is also a valuable part of the general treatment program for a variety of emotional and mental conditions among the elderly, not excluding those with varying degrees of organic brain disorder. Unfortunately, many psychotherapists resist undertaking psychotherapy with older people, and many older people themselves look upon their situation as futile. Consequently, in this chapter, these obstacles to treatment must be considered in addition to general therapeutic principles and common themes.

Is There a Psychotherapy of Old Age?

Is there justification for a psychotherapy directed specifically to older people? (Psychotherapy is here distinguished from environmental manipulation, behavioral modification, reality orientation, or other techniques *applied to* the person.) Should there be a geriatric or gerontological psychiatry (Butler, 1970)? Are the circumstances of old age so unique that special forms of psychotherapeutic treatment are necessitated? Do emotional and mental reactions occur in old age with sufficient frequency or intensity to warrant special consideration? Should not therapists be willing

to undertake psychotherapy for patients of all ages and diagnostic categories —with, of course, the proper training? In short, should not therapists operate from the perspective of the life cycle (Aries, 1962; Benedek, 1950; Benedek, 1959; Butler, 1968; Erikson, 1963) as a whole?

The number of actively practicing psychotherapists with respect to older people of the United States is extremely small. In 1959 a study (Bowman) showed that less than one percent of American psychiatrists spent any substantial amount of their time working with older people, in terms of any method of treatment. Studies of public clinics (Bahn,1950) and individual private practice (Butler, 1963) showed that the amount of contact between psychiatrists and persons over 65 approximated two percent of the total, although older people make up ten percent of the American population and perhaps as much as twenty-five percent of the psychopathology. Studies made in 1971 of community mental health centers (Dovenmuehle, 1971) revealed that only approximately five percent of those using the centers were older people. Nor are they seen in any greater frequency in research and training centers. Despite the introduction of limited Medicare coverage for emotional and mental disorders in 1965, the utilization of psychotherapy with older patients has remained about the same.

Crude estimates suggest that some three million of the approximately 19 million older people residing in the community (as of the mid-1970s) have

varying degrees of emotional and mental disorders, most of which go untreated. Another one million older people—five percent of the rough total of 20 million—reside in nursing homes, mental hospitals, chronic disease hospitals, and a variety of other care facilities where they customarily receive custodial care and very little active psychiatric support. Indeed, they seldom receive a comprehensive diagnostic evaluation, let alone a trial of treatment.

Psychiatrists, psychologists, social workers, and other mental health workers should receive adequate training with respect to those features that are particular to old age. (See the author's chapter on "Old Age" in Vol. 1 of the 2nd edition of this *Handbook.)* They must have sufficient experience with older patients to be prepared to work effectively with them. Therapists should have personal empirical validation of the effectiveness of therapy with older people. They should observe the reversibility of such emotional and mental states as depression and paranoia and the amelioration of organic brain disease.

Private mental hospitals, in particular, demonstrate a correlation between financial capacity and reversibility of illness. In studies done in private institutions, Gibson (1970), Myers, and others have stressed the reversibility of the psychiatric conditions of old age: 54 to 75 percent of the patients over 65 were able to be discharged to their own homes in two months. Thus if one can afford private care, the chances are much greater for

improvement and eventual discharge to home. At any rate, it is possible to bring comfort and support to the elderly who must grieve the loss of loved ones, and to those who, because of extreme brain damage, may not have the capacity to change.

With positive clinical experience, therapists are willing to work with older people. The intellectual stimulation of the work derives partly from the unexpectedly high success rates, indicating that old people are particularly susceptible to change. Moreover, the opportunity to study "lived" lives and to follow the course and observe the denouement of various aspects and kinds of human character is most rewarding. Such an opportunity provides a kind of "control" group against which to measure one's work with other, younger patients.

There is the further value of unraveling long lives in depth. As Proust said in *Remembrance of Things Past:*

> People foolishly imagine that the vast dimensions of social phenomena afford excellent opportunities to penetrate farther into the human soul; they ought, on the contrary, to realize that it is by plumbing in depths of a single personality that they might have the chance of understanding those phenomena.

The same general principles of psychotherapy apply to old age as to other age groups: the importance of listening; of observing and interpreting reactions of the patient to the therapist; of uncovering and exploring

motivation; of understanding dreams and language; of working through dependency. The traditional routes of intellectual insight and emotional working-through can be effectively reinforced by helping the older person to initiate actions. These actions can range from restitution to atonement, from finding replacements to finding redemption. Old age is framed by the reality of death. Loss and grief are frequent companions of old age. Time is both the ally and the antagonist of the therapist. It is the motor of rapid change: it is the limit of further fulfillment.

Freud—whom we would not remember, it may be pointed out, had he died before forty —was despairing about old age. Abraham (1953) was the first of the classic psychoanalysts to observe improvements in analytic work with what, in the 1920s, Abraham regarded as older patients (they were in their fifties). Jelliffe (1925), in the United States, noted that the age of the neurosis was more important than the age of the patient. While Freud emphasized youth and sexuality, Jung was more oriented to the life cycle as a whole (1933). Of Jung's patients, two-thirds are said to have been middle-aged and older, which may in part account for some of his theoretical differences with Freud. Jung emphasized "individuation"—that is, the development of the individual personality—and other psychological processes more commonly observed in the postmeridian period of life.

Only since 1950 have there been psychiatrists who have devoted

substantial amounts of time to work with older people. Grotjahn (1940), Gitelson (1948), Goldfarb (1953), Meerloo (1955), Weinberg (1957), Linden (1954), Greenleigh (1955), Busse (1967), Thompson, and Berezin (1963), among others, have written about psychotherapy with older people. Martin (1944), Lawton (1952), and Oberleder (1970) are among the psychologists who have worked with older patients. In family agencies as well as in community and multipurpose senior centers, social workers (Burnside, 1970; Kubie, 1953; Pincus, 1970; Rossman, 1971; Turner, 1953; Wasser, 1966) have provided both individual counseling and group work. In fact, more older persons probably have been aided through forms of group psychotherapy rather than through individual treatment.

Rechtschaffen (1959) wrote the last comprehensive review of psychotherapy with older patients in 1959. What he observed then still applies: there have been no systematically controlled studies of the effectiveness of various psychotherapeutic procedures with older people. (This is the case with other age groups as well.)

If there is any validity at all to a "geriatric psychotherapy" it may be a transitory one, lasting only until a body of knowledge is acquired that will then be available for all therapists who will be in contact with the elderly.

Obstacles to Treatment

In Western civilization, and in the United States in particular, there has been a broad, pervasive and negative view toward older people. This has been the institutionalized expression of the culture's defense against aging and disability. In an effort to dramatize the impact of the cultural devaluation of older people, the author has used the word "ageism" (Butler, 1969). Ageism is the systematized stereotyping of and discrimination against people because they are old, just as racism and sexism stereotype skin color and gender. Old people are categorized as senile, rigid in thought and manner, and old-fashioned in morality and skills. They are described pejoratively as "old fogies" and as "over the hill." Ageism allows us to see old people as "different" from those of us who are younger. We cease to identify with them as humans, and when we do this we can feel more comfortable about their poor social, personal, and economic plight.

The personal risk in ageism is different from that in racism and sexism. Racists and sexists need never fear becoming black or female, but all people potentially have the possibility of ending up old—and thereby becoming the object of their own prejudice. The traditional buffers of religious beliefs have been in the process of challenge and change. No general ethical or philosophical system has evolved as yet to deal with the whole of human life, including aging and death (Gorer, 1965). Since the mid 1950s, increasing attention has been paid to helping the dying patient confront death and its psychological impact (Eissler, 1955; Kübler-Ross, 1969). But aging, often the

prelude to death, has yet to be given equivalent consideration.

Psychotherapists reflect their culture (Butler, 1960). We have already seen how research, training, and service facilities have been neglectful of older patients. Underlying institutional negativism towards old age is the primitive fear and distaste of one's own aging, the reality of one's own eventual death. Despite therapists' awareness of this effect of countertransference, relatively little attention has been paid to its obstructiveness in work with older people. One ingredient, of course, is one's relations with one's own parents. The degree to which conflict, anger, and disappointment exists or existed with parents and grandparents may be decisive. Again, if distaste with working with older people is based on a dislike of ugliness, then visual esthetics—a fine sensibility in itself—becomes inhumane. It should be superseded by a moral esthetic derived from a vision of the human condition that inevitably must incorporate the fact of decline and reckon with mental and physical destruction.

Another element in countertransference is that the patient may die while in treatment, challenging the therapist's sense of importance. (Death, paradoxically, can also bring relief to the therapist when the treatment is not going well.) And another element, noted by Greenleigh, is the anger and resentment younger people feel toward their parents for taming them, for domesticating their impulses and instincts. Similarly, older people are also

held responsible for contemporary problems— "the mess we are all in"— such as pollution, war, and the like.

Therapists in American culture have been brought up to feel that they need to have instant gratification from a demonstration of their effectiveness. Their need for such cures must be counterbalanced by the realities of life and by the fact that one of the goals of therapy is amelioration and comfort as well as definitive change. Moreover, old people are part of a laboratory of lives-as-lived that provides knowledge for the therapist that is transferable to work with other age groups. One of the unfortunate consequences of infrequent contact with older persons in research and treatment is the denial of this important source of data about the nature of man.

The extent to which therapists work with the "young, attractive, verbal, intelligent, and successful" led Schofield to write of the "YAVIS" syndrome (1964). Often therapists believe they are wasting their skills on those who are so near death. (Yet on what other occasion could a person need more humane and compassionate attention?) Therapists who do work with older people are sometimes met with the contempt of their colleagues who think of them as having a morbid preoccupation in the elderly.

The elderly themselves may resist psychotherapy for a variety of reasons. They may fear the unknown. They may be very distrustful of the

possibility of losing their independence and fear that the therapist may "put them away." They may previously have had bad experiences with therapists and counselors who gave them short shrift. Because of institutional ageism old people may, in effect, be prejudiced against themselves, just as we see self-hate in a variety of disadvantaged groups. In studies at the National Institute of Mental Health, Margaret Singer Thaler" found that the Rorschach case records of some older people who accepted the negative attitudes of the culture against old age were similar to those of collaborating prisoners of war in the 1950-53 Korean conflict. (On the other hand, some older people's tests were like those of POWs who did not collaborate with their captors.)

Older people may actively collaborate with the cultural stereotype, even vehemently exploit it as a defense (Butler, 1960). They may call attention to their impairments and invoke their age to curry favor and assistance. The degree to which they may exploit their age may be excessive, leading to over nursing, the loss of autonomy, rapid deterioration, lowered morale, dissatisfaction, and earlier death. It is difficult for the older person and his family and therapist to walk the tightrope between the maintenance of basic dignity and independence on the one hand and the appropriate meeting of needs on the other.

One must also note the extent to which "aging graciously," "civilized behavior," "dignity," and "respect" may be used against older people—for

example, by their children or by doctors—forcing them to cover up their feelings of grief, pain, discomfiture, and anger over their lot. Nor can "tranquility" or "serenity" be accepted by the therapist as a defense of the older person against examination of the painful possibilities of old age.

Cultural attitudes and personal or countertransference reactions are not the only obstacles to treatment. Lack of knowledge as a result of inadequate research and training poses serious impediments. Poverty, so common and extreme in old age, is a major financial block. For example, Medicare has discriminatory provisions with respect to mental health care compared to physical health care: in general, an older person can afford perhaps eight psychotherapeutic visits a year under Medicare's annual outpatient limit of $250 a year. Also, older people are most numerous in inner city and rural areas where health services and psychotherapy are least available. Transportation may make care inaccessible. Moreover, fear of violent street crime in cities may lock old people in.

General Treatment Considerations

Older people are major survivalists. They have lived a long time and have survived many crises. Therefore the extent to which they are patronized or infantilized is quite inappropriate. Older people in crisis—whether enduring grief over the death of loved ones, fearing spiraling inflation, or

dreading an impending operation—may be anxious, dismayed, and confused, but they must not be written off as being in their "second childhood." They are reacting precisely as one would expect: with trauma-cum-anxiety, grief, and/or depression. Because the patients are old and have survived, it is important that partnership be the cornerstone of the psychotherapeutic collaboration. There should be a coming together in a joint venture to help work through the episode that has brought the patient to the therapist. The word "patient" literally means "to suffer;" the word "client" comes from a word meaning "to depend." Thus equality is more in order. The therapist and the older person must share responsibility in the resolution of the issue at hand. They must join in decision making. The older person must not be denied choices. It is a powerful beneficence when the older person feels he can teach a therapist some things —which, indeed, he can; therapists can, if they will, learn a great deal about life from older people.

It is difficult to estimate treatability. When in doubt, treat (Butler, 1973). It is very easy to decide that an older person is "a poor candidate" for psychotherapy. Some clear-cut functional depressive reactions may prove extraordinarily refractory to psychotherapeutic efforts. Some older persons with definitive organic brain disease may nonetheless profit enormously from psychotherapeutic work, including the gaining of insights into their historic and contemporary conflicts.

It is very painful for a person to be written off as hopeless. One must at times undertake therapy not only for its positive value but to avoid the negative impact of nihilism. Goethe said, "If you treat an individual as he is, he will stay as he is, but if you treat him as though he were what he ought to be and could be, he will become what he ought to be and could be." Therapists cannot permit themselves excessive private preferences but must work instead with various patients they may not prefer to work with, as part of a fundamental professional responsibility to consumers rather than to their special needs as providers.

The therapist's emotional commitment to work with older people must be explored. One may want to work with dependent, damaged older people because it is comfortable to be master in a situation that can offer the counterpart, in psychiatry, to the surgeon "burying his mistakes." It has been the author's impression, however, that therapists who work most effectively with older people are those who like to work with a variety of patients of various age groups and diagnostic categories. In general, therapists (hopefully) are open, flexible personalities interested in a range of life styles and with a sense of personal and cultural history. Nonverbal signs often give away the depth of this commitment to work with persons of different ages, including the older person. Facial expressions of revulsion and discomfort, movements of the body and manners of touch count among such evidences.

The use of "listening" as a form of therapy is crucial. Older people are often regarded as garrulous and their reminiscences as valueless. But loquacity and the expression of memories are due to loneliness and a tenacious reaching out for human contact, and to the occurrence of a basic process that the author has called the "life review"(Butler, 1963). The author conceived the life review as a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences and, particularly, the resurgence of unresolved conflicts. Simultaneously, and normally, these revived experiences and conflicts can be surveyed and reintegrated. One may put these concepts to work as life review therapy.

One may encourage the older person to use a tape recorder to record his life. One may ask him to bring in photograph albums, motion pictures that may be available, mementos, family records, and old letters to help conduct the review. Self-confrontation through the use of the mirror may also help the older person in formulating and resolving his life course. Pilgrimages to the homes of one's childhood and searching for knowledge of one's family and forebears are important avenues to establishing meaning and continuity. The fact of listening *per se* can be therapeutic, particularly to the isolated, lonely older person who is trying to give some sense and meaning to his life as he faces the prospect of death. Aiding the older person to develop a relationship with a companion—an intimate (Lowenthal, 1965)—is of great value to the patient and may make termination of professional psychotherapy possible.

However, termination need not be a goal in psychotherapy with an older person. This may be true for a variety of reasons. A fatal illness may be at hand; one may work with the older person until death. Even when a fatal illness may not be immediately present, changes are frequent, multiple, and rapidly occurring in old age. Restitution, growth and development, and resolution of issues are continuing tasks. Active reconciliation with siblings and friends with whom the person may have lost contact or been alienated is one direction in treatment. The moment that one part of the work may have been accomplished, such as making restitution for one loss, another may confront the patient. The therapist may simply need to be continuously available to the patient to aid him on the occasion of crises, or to have regularly scheduled and periodic sessions, or both. Moreover, as Jung wrote, "Serious problems in life are never fully solved. If ever they should appear to be so, it is a sure sign that something has been lost. The meaning and purpose of a problem seems to lie not in its solution but in our working at it incessantly" (Jung, 1933).

Whether the traditional separation between supportive and insight therapy is always appropriate among the elderly (or any age group), and whether the dichotomy is as sharp as the terminology would imply, is questionable. The social status of the patient, the presence or absence of brain damage, and other circumstances such as poverty and the quality of housing all contribute to the person's present mental status, outward behavior, inner

experience, and level of adaptation. Moreover, these factors are constantly changing, so that giving the patient insight may be appropriate at one moment, giving him support at another, and both may be appropriate on still another occasion. Most writers argue that full -scale classic psychoanalysis is rarely applicable to the older person. This has never been adequately tested. Major reconstruction of character may be neither desirable nor desired, but the patient should share in that decision. It should not arbitrarily and covertly be made for him.

Goldfarb (1955; 1956; 1953) takes the view that the older person needs a parent surrogate, requiring someone over whom he can develop an illusion of mastery, whom he can control for his own good. Goldfarb's "brief therapy" (1953) was originally developed in the institutional setting and probably reflects some of the qualities of total institutions in which passivity is expected if not demanded. From the study of Perlin (1958), persons with life-long passive personalities adjusted more effectively than the independent personality in the old age home. The independent person becomes the "problem patient"; he needs a powerful ally such as the doctor to provide him brief but effective contact. The passive person needs to control and, by nature, does so. Goldfarb's elaboration of his theory depends upon his definition of the older person as someone who is frail and dependent rather than upon a definition by chronological age. Other writers use chronological age as the initial basis for evaluation and recognize that discrepancies exist between

physiological, social, psychological, medical, and chronological aging.

Goldstein (1941) observed the occurrence of a catastrophic reaction among World War I soldiers, a massive behavioral response of irritability and anxiety when the person was confronted with a task he could not handle. This reaction, as might be expected, is seen from time to time among the elderly. A skilled therapist must monitor his work with the brain-damaged older person. He must neither overstimulate nor understimulate, he must not permit withdrawal and yet must not be excessively intrusive. He must use the range of nonverbal as well as verbal communications, including holding and touching, to maintain psychotherapeutic progress.

Effects of Various Settings

The older person's inability to come to the office regularly or at all cannot be hastily interpreted as "resistance." It may be a function of physical limitations, transportation problems and expenses, illness, and the like. Therapists should choose to respond to the needs of the older person rather than their own convenience. They may see the older person at home and must therefore take into account the meaning of seeing the older person on his home ground. Therapists may see older patients who are residents of a home for the aged, or convalescent or permanent patients in a nursing home. Therapists may conduct psychotherapy in mental hospitals, particularly

private mental hospitals—but rarely, and unfortunately, state institutions.

The therapist may see older people under favorable circumstances in their homes. But one may also sometimes encounter "battlefield" conditions (Butler, 1973). One may see the person in roach- and rat-infested homes in dangerous neighborhoods. There may be the smell of urine and feces. There may be the visual image of sickness and squalor in nursing homes, old age homes, and hospitals. It becomes essential to work through one's distaste and discomfiture. It is important, too, to try to establish a decent private setting within the most crowded surroundings, so that the older person can speak in confidence about himself.

Sometimes one will interview persons who are chronically chairfast or bedfast. It is important to remember that for these people the structure of their lives revolves wholly around the confines of their chair or bed, and that psychotherapy must be viewed in this context.

Communication Problems

A skilled therapist must learn nonverbal communication. Lip reading is necessary when working with the deaf, with those who are too weak to talk, and with those who are unable to talk. One develops one's intuition, making hypotheses concerning what the person might be thinking and feeling. Signals may be established so that the therapist speaks "for" the patient and the

patient nods in assent or disagreement. The use of touch and physical affection, so valuable to the old, must be mentioned again. In working with the deaf, clarify whether there is one "good" ear. In relating with a stroke victim, it is useful to maintain eye contact.

When called upon to work with older persons who do not speak English, one should either find therapists who speak the language or interpreters who can translate. One may even need help with ethnic dialects and slang. If one cannot find a therapist with the same cultural and linguistic background, one should at least have consultative advice from a representative of that culture and language.

Some six million older people do not have a telephone. Those that do find it very reassuring to have phone contact. Old people may understandably be quite anxious and fearful when isolated from the larger world, so the use of the telephone for therapeutic sessions is appropriate with the older person.

Respect for the more formal communication styles of the elderly is important, such as Mr., Mrs., and Miss, rather than what the therapist might prefer, such as first names. The presumptuous use of first names or nicknames implies careless, thoughtless, and even contemptuous attitudes toward the feelings of older people who grew up at a time when this was demeaning and disrespectful. Epithets used behind the backs of older people

are also expressive of disdainful attitudes. For example, "old granny," "gramps," "old biddy," "old fogey," "crock," and other such terms all indicate negativity. The style of the language of older people must be noted as well. A woman might refer to a "delicate condition" rather than pregnancy, for instance. One must be most respectful of the life styles of different people.

Psychoanalytic Theory

Psychoanalytic theory is a valuable means of viewing old age. Ego, id, superego, and ego ideal are useful constructs. In the presence of brain damage, impulses may overrun inhibitions. That is, executive functions having been damaged, the id may overpower the superego and the ego. Awareness of incomplete fulfillment of ego ideal occupies an important part of the content of the life review in both brain damaged and unaffected patients. With the latter, considerations pertinent to ego psychology indicate the continuing capacity of the elderly ego to grow and the superego to become more flexible. The notion of the weakening of the id or libido with age is unestablished. A full range of transference possibilities can be seen in the elderly as in any other age group. Thus one may see the older person taking the role of parent to the therapist, in which case dominating or patronizing behavior may supervene. Older people may also manifest helplessness, trying to imbue the therapist with magical powers. The notion of regression in relationship to age has been much misunderstood. Second childhood and

regression—fundamentally a Darwinian concept by way of Herbert Spencer and a neurological concept by way of Hughlings Jackson— occurs in relationship to loss and trauma, not in relationship to chronological aging per se (Modell, 1960).

The author (1973) has used the term "average expectable life cycle" as a counterpart to Heinz Hartman's concept of "average expectable environment" (1958) to bring focus to the notion that there are average normative experiences against which to measure individual patterns. In clinical work the author (1973) has also referred to the development of an individual inner sense of the life cycle. This is not the same as the average expectable life cycle or as the personal sense of identity, though it is certainly related to both. It is a subjective feeling about the life cycle as a whole, its rhythm and variability, and the relation of this to the individual's sense of himself.

Much has been made in the psychoanalytic literature of the relationship of the fear of death to the fear of castration and to the fear of impotence in old age. While each fear certainly reinforces the other, the fear of death per se is a legitimate, authentic concern, independent of the fear of castration.

Forms of Psychotherapy

The decision as to the form that psychotherapy should take with the old is similar to that with any other age group, once it has been decided that

psychotherapy itself would be desirable and desired. It is first essential to conduct comprehensive medical, psychiatric, and social testing in this age group (Butler, 1973; Rossman, 1971). Thus comprehensive psychological testing may be of some value in determining the presence of organic brain disease; in its presence, psychotherapy may be useful and indeed the more necessary.

With respect to group therapy, groups may be set up that are age-segregated, that deal with specific themes such as grieving widowhood, or that are age-integrated (Goldfarb, 1971). The latter may be balanced for age, sex, and personality dynamics. The membership of such a group might display a range of near-normal to pathological reactions to adolescence and might include representatives of married and single life, divorce, parenthood, employment and retirement, widowhood, illness, and impending death. Most groups tend to meet weekly. Sometimes there are co-therapists and, if so, usually one is male and one female.

In age-integrated group therapy-it has been noted that older people and younger people may be mascoted by the middle-aged who pre-empt leadership. Eventually, however, the unique contributions of the elderly come out. These include models for growing older, solutions for loss and grief, creative uses of reminiscence, and an historic empathy and a sense of life. From the point of view of the elderly, membership in a group helps

counterbalance the prejudices and segregation that they may feel in American culture.

Group therapy utilizes principles and techniques from individual psychotherapy as well as those related specifically to the group process itself. Group therapy has been widely used in work with the elderly, in and out of institutions (Goldfarb, 1955; Klein, 1965; Kubie, 1953; Linden, 1954; Linden, 1955). (In the past it was often used because it was economical.) Volunteers have been trained to conduct group therapy. So too have been administrators, aides, nurses, social workers, psychologists, and psychiatrists. Sociability and emotional catharsis have been objectives. In institutional settings, "management" of behavior is emphasized. Where group therapy endeavors to understand and not simply control, it can be most valuable in and out of institutions. Irwin D. Yalom has noted a range of possible contributions and certainly does not regard group therapy as of secondary value to individual therapy. Indeed, it may complement individual therapy. Combined individual and group therapy can be very useful. The corrective recapitulation of the primary family group, one of the features that Yalom emphasized, is particularly helpful in work with the older person. Altruism—a sense of giving to others—is another of the ten factors listed by Yalom (1970) that is pertinent to the older person. Yalom's list includes: (1) Imparting of information; (2) installation of hope; (3) universality; (4) altruism; (5) corrective recapitulation of the primary family group; (6) development of

socializing techniques; (7) imitative behavior; (8) inner personal behavior; (9) group cohesiveness; and (10) catharsis [1970, p. 5].

As in group therapy in general, the role of the therapist may be active or passive. It may involve various activities, embracing the passive one of listening and the active ones of questioning, explaining, teaching, protecting, reassuring, and confronting. In some cases therapists lose older patients because the therapist has inadequately prepared them and failed to intervene appropriately in group sessions.

A case illustration of this failure follows:

> Mr. John M. was pressured to enter group psychotherapy because of the therapist's concern for his profound sense of meaninglessness, alienation between himself and his son, and his depression, which appeared likely to become potentially severe. At his second meeting with an open group (one that had existed for some time) he in effect committed social suicide. He demanded that the group tell him exactly what they thought of him. He interdigitated this demand with severely critical, self-righteous remarks about members of the group, name-dropping, and statements about his past accomplishments. The therapists were unable to intervene successfully in protecting him against his all too effective masochistic demand for personal attack. Neither he nor the group had been well prepared for his participation. He was unable to deal with the anxiety generated by the group experience and dropped out.

Group therapy can be very useful to families of older persons and should be used more frequently for that purpose. For example, families need help in working through the admission of the older person into nursing and

old age homes. Indeed, families should frequently be involved in work with older people, although it must always be clear as to who constitutes the "patient." Sometimes the older person is "brought in" by a son or daughter, and it is quickly apparent that it is the adult child that needs help. Issues in family therapy include the need for decisions about the older person, feelings of guilt and abandonment, and old family conflicts. It may be necessary to see the entire family together. Older couples may also need aid in the working out of marital and sexual conflicts, the handling of serious illnesses and approaching death, and worries about children and grandchildren.

Sometimes one interview, one consultation, with an older patient or a spouse or an extended family may set the tone for months of reasonably effective living for both patient and family. An older person, stricken by guilt, may need one explosive session to reveal, confess, and resolve.

It is essential that the therapist deal with the environment of the patient and be conscious of the realities—social, economic, and otherwise—that constitute the day-to-day experience of older people. First of all, the patient must survive, requiring adequate food and nutrition—which, indeed, may also affect mental and emotional health. In some measure the therapist may need to become an advocate on behalf of his patient, persuading him to gain public housing to which he might be entitled, or to assist him in securing any legal assistance that he might need.

Drugs should be used judiciously and wisely in the course of treatment (Rossman, 1971), particularly when anxiety may be disruptive or depression overwhelming. Indeed, drugs should never be used alone but should be a component of a broad therapeutic program that includes psychotherapy or counseling (ranging from support to insight psychotherapy) and, possibly, the use of environmental resources. Drugs must be weighed as to their ultimate impact: no drug brings penitence, replaces memory, or resolves grief. It may be essential that the older person work through his grief; if the antidepressant or the tranquilizer suppresses the opportunity to ventilate that grief, it may create further problems later. Heavy tranquilization may feed into the older person's fears about his waning abilities. Many of the tranquilizers, for instance, create impotence. Similarly, care must be taken with sleeping medications. A simple bedtime regimen may be much more effective and safer than strong hypnotics. There is less of a morning-after hangover that can interfere with an active life, so contributory to mental well-being.

Common Themes in Psychotherapy

Psychotherapy in old age must certainly deal with grief, the losses of loved ones, and the dysfunctioning of one's own body and its parts. Efforts at restitution are required; one cannot deal in a negative context only, discussing what one has lost, but not what can be done to make up.

One great theme in psychotherapy with older people is related to guilt and atonement. "We have left undone those things which we ought to have done; and we have done those things which we ought not to have done," says the Anglican Book of Prayer. (There is also a guilt of survival [Chodoff, 1963] as well as a pride in survival.) The therapist, of course, has no power to grant mercy or to bring full alleviation to distress. But he can truly listen and bear witness. It is crucial that he not regard expressions of guilt as irrational but take them seriously as Martin Buber has stressed (Buber, 1957). And Camus has said, "We cannot assert the innocence of anyone, whereas we can state with certainty the guilt of all." The confrontation of genuine guilt makes it possible for the person truly to become free of it and move on. For the truth is that older people are capable of guilt-producing acts in the *here and now* as well as in the past.

Acknowledgement, then, is the first step in dealing with guilt. Denial by the older person, or a person of any age, obviously cannot be dealt with. But talk alone may not be adequate to expunge guilt. Acts of atonement, expiatory behavior, may be necessary.

A case illustration follows:

> A seventy-three-year-old woman spoke in a childish voice in a high pitch. She spoke constantly and was filled with excessive and compulsive symptoms to which she continually returned. Her main complaints were pain within her mouth and an itchy skin. She was clearly agitated and

> depressed and yet there was a disarticulation between the degree of seriousness which she presumed her symptoms entailed and the quality of her concern about them, suggesting the *la belle indifference* of the hysterical patient. She was self-degrading and spoke of her hatred of herself in looking in her mirror at herself. She thought of aging as a punishment. She distrusted people, including the therapist and all her doctors, from dermatologists to internists. In the course of the psychotherapeutic work her dependency and self-centeredness became increasingly clear to her. After ten or fifteen minutes of high-pressure, explosive speech she would begin to calm down and could deal at first with possible concrete solutions to her living situation (whether to live in her apartment or to move in with a daughter). The therapist took a comprehensive approach including coordination with the dermatologist for treatment of her dry skin and its consequent pruritus. The therapeutic work itself dealt most largely with guilt and atonement. She had been cold and withholding in her marriage, for which she was experiencing great regret and pain, which had slowly evolved over the ten years since her husband's death. It was necessary for her to actively contribute to others as well as talk out her feelings.

Another great theme is that of independence or autonomy, which at times gets admixed in some minds with identity. In old age most healthy people find themselves essentially the same as they have always been (Erikson, 1959; Perlin, 1971). With emerging medical problems (for example, changes in the body scheme or image) and emotional problems (for example, depression), the sense of the self may go through continuing re-evaluation. The problem is not simply self-sameness over time; the issue is often autonomy. "Can I survive independently without being a burden?" It is true, of course, that if one's identity is closely bound to autonomy, the two merge together, as it were. For instance, the patient whose identity has been that of a

dependent person may find it easier to accept illness and institutionalization than would an independent person (Perlin, 1958). Also, many older people deeply wish to escape their identities (Butler, 1973). (But Erikson [1959; 1963] has proposed a rather fatalistic acceptance "of one's own and only life cycle" in the last of his program of man's life stages. In his view, resolving "ego integrity versus despair," is the central task. Others have not found his conception universal.)

Another theme relates to the illusions or myths that have been built up or maintained over a lifetime. Obviously one cannot handle these with a frontal attack. The same principle applies in working with persons of all ages. One must work compassionately and carefully to understand and encourage a realistic lowering of defenses, rather than assaulting them overtly. *Primum non nocere,* first do no harm. Philosophic views and religious beliefs such as "suffering makes sense," and "I'm going to heaven," and idiosyncratic notions such as "I'm not that old" (the Peter Pan attitude) are quite common and must not be directly and negatively confronted.

Still another element concerns time. One may see older people who develop "time panics," who are fearful and frightened at the speed with which time moves. Others complain of the dullness and monotony of the rituals and patterns of their lives: "The salt has lost its savor." The therapist should help the older person to develop a sense of the immediacy of the here and now, of

presentness, which may make simple enjoyment possible and bring the tranquility and serenity of which ancient writers spoke. The author has referred to "elementality" in the context of this effort, indicating the importance of shapes and sizes, of geometry and color, of plants and growth, and of the stripping away of the conventions and encrustations of a lifetime (Butler, 1968).

Another theme not uncommon in psychotherapy with older patients relates to attitudes toward the young. Older people may feel hope and excitement over the possibilities of the future with respect to their children and grandchildren, or they may feel despair and anger over the behavior of the younger generation. The Anglo-Saxon etymology of the word "envy" gives away its ambivalence: it means both "admiration" and "hate." When the therapist is younger than the older person, as he is statistically apt to be, the issue of the relations between old and young must be dealt with. This is partly true because the older person may use the age difference as a defense. He may say to the younger therapist, "You are too young, you've had too little experience, you cannot possibly understand." In some measure this should be acknowledged. There is much that one cannot understand without the older person's active collaboration and teaching. In some measure this must be overcome through developing a sense of the history of the times in which the older person has lived, in order to enhance one's empathic relationship to older people. However, the defense of age difference must not be fully

accepted. One must avoid falling into a trap. It is not only the old who do this; patients of all ages and diagnostic categories often assert that someone outside of themselves "cannot possibly understand."

Of course almost everything can be grist for the defensive mill. The older person may say he cannot properly speak about a dead relative or marriage partner, that it would not be appropriate to admit anger. This protectiveness of the dead elicits unease in the therapist, who may be made to feel that it is immoral and reprehensible to question relationships that presumably one can no longer do anything about. However, it is not simply events (about which, indeed, one can do little) that are at issue in psychotherapy. Also at issue are the interpretation, reconstruction, and consequences of these events that are continuing to have a psychological impact that must be dealt with. This must be qualified, of course, by the humane and compassionate understanding of the defensive illusions already referred to.

Among the fears of old age are loneliness and poverty. About the latter much could be done through progressive social policy. That is also true of loneliness, in some measure. However, it is the way that life has been led that contributes most to the issue of loneliness. A person who has developed a balanced portfolio—different skills, activities, and roles; and not simply idle hobbies, but highly grossing activities—is better protected from loneliness.

He is also better able to deal with the sense of uselessness expressed in such statements as "I am finished" and "It's all over."

A sense of uselessness also results from defective social policy. There is no constitutional basis for arbitrary, mandatory retirement, and court cases on behalf of older people may lead to increasing implementation of their right to work as a function of their desire and competence. Until the millennium of an ideal social policy, however, any sense of uselessness and loneliness can be alleviated, in part, through psychotherapeutic work. There is no shortage, really, of things that need to be done on behalf of oneself and on behalf of society, and these can often be brought into natural alliance. The feeling of being able to be constructive and resourceful is of great therapeutic influence. To teach and to be heard are very important. The sheer fact of surviving per se is emotionally significant to the sense of uselessness. The day-by-day struggles to maintain one's house, create order, keep one's books, manicure one's lawn, and get to the store despite painfully arthritic knees are all important elements of one's mental well-being. It is paradoxical that the struggle for survival itself is important to mental health. (One must not be carried away with this notion, however, for boundary conditions are obviously important. There comes a point beyond which one cannot survive against overwhelming odds.) There are also the wealthy and powerful who have no need to struggle for brute survival but who nonetheless carry on internal intellectual and emotional struggles that may make them creditable,

confident, and satisfied human beings. Thomas Mann, for example, writing of the genesis of his novel, *Dr. Faustus,* described his own capacity to survive serious chest surgery.[2]

Related to the theme of uselessness is the more general abstraction that life itself is meaningless: "It is miserable to be old;" or, "There is nothing to look back on." Usually when older people are asked if they would live their lives over they tend to say "no." But they do not say "no" for the same reasons. One basis for saying no relates to existential despair. Existential psychotherapists might have been expected to have made contributions to working with older people hut have not done so directly (Frankl, 1963). Considering existentialism as one philosophy in the general humanistic tradition, it may be argued that a humanistically-oriented psychotherapy would be appropriate for all age groups, including—and perhaps especially—old age. For old age is surely the period in which one must wrestle hardest with the fundaments of life: its meanings; the fact of death; inner resources and solitude; grief and restitution; guilt and atonement; autonomy and identity; power and powerlessness; intimacy and distance; compassion and indifference; and, following Camus, suicide— which he regarded as the great philosophical problem.[3]

Another theme that often emerges pertains to pain. We know that pain thresholds vary with culture, social grouping, and ethnic background, as well

as with individual differences. How one lives with the pain of angina pectoris or osteoarthritis or lingering malignancy is a legitimate task for psychotherapy. The conquest or alleviation of pain should not be left to analgesics alone. Psychotherapy and hypnosis can aid in the reduction of pain. Its impact on spouse and family must also be treated.

Older people frequently express a sense of being a burden to others and indicate their desire not to be one. This may in part be legitimate. Calculated suicides are sometimes undertaken, particularly by men, to avoid leaving a family bereft of finances. Subtle, non-flamboyant forms of suicide may also be observed, including a failure to obtain medical care, not eating, and wandering in the streets. But the statement, "I am a burden," may also be a cry for help in which the older person is saying, "I need to be a burden and to be dependent, and there is no one on whom I can depend." It may also be an expression of hostility, reflecting family conflict and anger and a desire to embarrass the family. These various possible bases for the sense of burden form part of the controversy over euthanasia (which means "good death"). Passive euthanasia is increasingly accepted; Pope Pius XII and leaders of other Judeo-Christian religious faiths have declared that there is no need to use heroic means to perpetuate life. It is possible to sign a "living will" months and years prior to possibly being in the helpless position of a "living death." The problem of active euthanasia, however, goes beyond the purview of this chapter—and, in the author's view, of medicine in general. Active euthanasia

is a problem of social policy to which medicine and psychiatry may make a contribution, but decisions on active euthanasia should not be left—certainly not exclusively—to medical or therapeutic disciplines.

The sense of life is an important psychological description of the preparation for old age. Many people are unprepared for it and even psychologically deny its reality. Some pretend that they remain young, thus deceiving themselves but not others. This futile effort may be seen in many forms: frenetic efforts to maintain a youthful appearance, dying one's hair, seeking cosmetological surgery. It may be observed in counterphobia (Perlin, 1971), in which the older person endeavors to prove his prowess to himself and others despite aging, disability, and the prospect of death. One may see Peter Pans who petulantly refuse to grow up *and* old, who ignore birthdays and anniversaries, and who are literally shocked one day to find that they have attained old age. However, the sense of process, of being part of interlocking generations (which appears to be a common aspect of Eastern culture), can be effectively developed in a psychotherapeutic context. Developing a sense of life is, in fact, an integrative therapeutic goal, which relates all of the themes or issues discussed up to this point. Of course it almost goes without saying that a therapist cannot deal in vacuo with any of the themes that have been mentioned. Although the therapist and patient may jointly take up various issues one by one, they must ultimately be integrated.

Old people give the impression that they know certain secrets that young people don't know. One of the most morbid and despairing thoughts would be that the secret is that life is essentially not worth living, or that all is futile and vain when one conceives the larger cosmos. Camus, on the other hand, refers to the "benign indifference of the universe." The universe and life, in its ebb and flow, is not per se a malignant or malevolently-engineered process but a neutral one. There is no punishment for being either young or old; there is no superiority concerning what life is about, real or imagined, in the wisdom of older people or the innocence of the young.

One basis for the notion of older persons that they have great secrets is that this is a means of defending powerlessness. For in fact, old age is a socially acculturated weakness, an invalidity. That is one reason why equality in the therapist-patient relationship is highly desirable so long as it is not patently contrived. A partnership of this sort may then be generalized to a larger social field where the older person may regain a sense of control over his own destiny.

Special Treatment Problems

To begin with, one problem that frequently arises between the patient, the therapist, and the staff, particularly in institutional settings, concerns racial relations. In some geographic areas old people are taken care of by

minority-group personnel. Older black and other minority patients are the least likely to receive psychotherapy and decent psychiatric care, in many parts of the United States (Carter, 1972). On the other hand, older white persons' racial attitudes may boomerang against them, affecting their care.

Sexual Problems

In the United States there are over 11 million women among those 65 or older, compared to some eight million men, and some six million of them are widowed. Destitute, lonely older women form one of the most disadvantaged groups in American society. They also bear the heritage of unequal opportunities against women, having limited financial, intellectual, and other resources to face old age. The difference in life expectancy between men and women often means that the older woman has nursed her husband but has no one to nurse her. Unlike the older man, the older woman is denied sexual outlets. Because of the unavailability of men, women may become involved in difficult situations. One illustration may serve:

> Jenny Simmons, sixty-seven-years old, had continuing sexual needs and interests. She established what appeared to be a warm and sincere relationship with a forty-nine-year-old man who had recently been divorced. He confessed to her his confused feelings about her as an older woman and his interest in a young man. Unfortunately the older woman had always been vulnerable to men who had yet to resolve their relationships with mothers.

"From a psychosexual point of view, the male over age fifty has to contend with one of the great fallacies of our culture. Every man in this group is arbitrarily identified by both public and professional alike as sexually impaired." So state Masters and Johnson (Masters, 1970). For a variety of causes associated with chronological aging there are age-related sexual changes, but these are not necessarily a function of age per se. Sexual disability may be a function of drugs (especially tranquilizers), alcohol, and a variety of organic conditions. The older man ordinarily does take longer to obtain an erection, but as Masters and Johnson pointed out, "One of the advantages of the aging process in specific reference to sexual functioning is that, generally speaking, control of the ejaculatory demand in the 50-10-75 year age group is far better than in the 20-to-40 year age group." Most data show that older men are usually able to continue an active sexual life well into the 80s and even beyond.

Biologically, the older woman experiences little sexual impairment as she ages. If she is in reasonably good health she can expect to continue sexual activity until late in life, assuming she has maintained a frame of mind that encourages this and has a sexual partner with whom to enjoy it. The biological impact of the change of life has been questioned by recent studies, which show that the physiological changes are not of as great significance as psychological ingredients associated with the middle years (Neugarten, 1965). However, steroid insufficiency does cause a thinning of vaginal walls;

at times cracking, bleeding, and pain (dyspareunia) can result during sexual intercourse. Natural estrogen treatment can overcome this.

Sexual therapy has been undertaken successfully—for example, by Masters and Johnson. They have reported a 50 percent success rate in their older patients, even when the problem has existed for over twenty-five years. The psychotherapist may also be able to help provide sexual education of older persons, to help them face the guilt that may be associated with masturbatory and other variations in sexual activity that might be required because of physical illnesses. Psychological preparation is indicated prior to any surgery that may affect sexual capacity. This is particularly true when a man must have the perineal type of prostatectomy which may lead to sexual impotence.

Retirement

Another major problem of a special kind in late life is retirement (Streib, 1971). There is no question but that everyone "reacts" to retirement, but not everyone goes through a "retirement crisis." Retirement means different things to different people. Those who have been strongly identified with their jobs (sometimes called "workaholics") may find retirement extremely difficult. Others may see retirement as a relief from hard, bone-breaking work, or from boring assembly line employment. Attitudes and reactions to

retirement, of course, also depend upon other possibilities: alternatives for new careers and roles; the state of one's personal relationships; one's health; the variety of one's intellectual and skill resources; and so forth.

Pre-retirement preparation programs are still not frequent, and when they do occur—for example, within the federal government—they often neglect the ingredient of mental health in favor of considerations relating to finances, housing, and the like. Moreover, a retired person may not be in a position to know the real problems of retirement—of his specific individual retirement—until he is in it. What is it like for a husband and wife to be together for twenty-four hours a day? What does it mean not to have a time structure in one's life (Ferenczi, 1952)? How does a man's retirement compare to the situation for a woman who in effect has no retirement but continues to work at home? Psychotherapeutic work with respect to retirement therefore deals with a range of subjects that essentially includes the themes already described.

Alcoholism

Alcoholism is surprisingly common in late life (Gaitz, 1971). Today more people who have had long histories of alcoholism live longer than did so in the past. In addition, many older people develop alcoholism for the first time in late life, in response to grief, depression, loneliness, boredom, or pain.

Therapists have found working with alcoholism difficult at any age group and no more so with the old. One should call upon Alcoholics Anonymous and other forms of group therapy as well as individual psychotherapy. Because late-life alcoholism is more frequent than is recognized, and imbibing is a way of warding off feelings of loneliness and grief, the therapist must be careful about suggesting the use of alcohol. The world's oldest tranquilizer may bring relief and increase sociability, but it creates dangerous muscular incoordination and adds to the risk of falls. It may also lead to alcoholism and its devastating effects.

Brain Syndromes

Psychotherapy is one component in the overall management of a patient suffering with an organic brain syndrome. An individual may have counted heavily upon his memory: for example, a writer may have a massive depression associated with organically based brain disease. Through counseling, families may be helped in maintaining at home the older family relative with an organic brain syndrome. There is no doubt but that patients with definitive organic brain disease have been maintained in the community through an overall treatment program of which psychotherapy may be one part, even though the condition itself will not be reversed. Goldfarb's brief therapy (1953) may be of special value in this group, whose members need a sense of mastery.

Depression

It is dismaying at times, how refractory the depressions of later life can be (Butler, 1960; Kaufman, 1937). The milder depressions associated with a sense of insignificance (Busse, 1967) may be helped by therapists assisting the older person in finding an authentic interest, role, and place in society. With the more serious depressions related to the death of loved ones, serious illness, and other losses, the psychotherapeutic approach may not always be oriented toward insight, because insight may be unbearable. Instead, the relief of anger, grief, and guilt can be particularly valuable even if the overall therapeutic treatment and management context includes drugs—and, if they fail, electroconvulsive therapy.

A case illustration follows:

> The sixty-six-year-old patient had been in reasonably good health until five years before entering psychotherapy when he developed emphysema. Because of progressive disability he became depressed and socially withdrawn. His depression became severely immobilizing, and he sought and received early retirement. He regarded that retirement as forced and quickly became almost totally dependent on his wife; his demands became most burdensome. After intensive diagnostic interviews the patient was referred to residential treatment including psychotherapy. Upon hospitalization he was quite obviously depressed and very uninterested in his surroundings. His appetite was poor and he was an insomniac. He was demanding. He was seen in a program that included individual psychotherapy, group activities, and one of the tricyclic antidepressants. After three months he was visibly less depressed, his appetite picked up and his ability to tolerate physical exertion improved. He developed other interests and became much more understanding of his burdensome

impact upon his wife. He was discharged and was continuing to make good progress according to the one-year follow-up.

Anger

Anger is usually considered to be a crucial element in depression, but it has not been designated as a diagnostic entity in Western culture. It is so regarded in some societies, however, and perhaps it should be so regarded in our own. There are many manifestations of anger: violence; cold hostility; sarcasm; defiance; tantalizing and teasing; sneering; passive obstructiveness (either dependent or aggressive); gossip; withdrawal; and, of course, self-destructive behavior to the point of suicide. Anger must be confronted and expressed but its expression is not enough, contrary to popular belief. Anger may be a cover for deeper problems—for instance, relating to the need for intimacy. It is shocking to sense the extent to which lifetime grudges and events of decades past may psychologically be very much alive. Hate may outlive love.

Anger can be a useful force when it is put to work in the favor of personally and socially constructive ends. Sometimes, however, one sees an older person or older people in torrents of rage. It is as though the aging flesh fell away and angry children came out fighting.

Resistance against reconciliation, as between divorced spouses or

between parents and children, may be intense. Thus anger, resentment, and related feelings are a common problem in work with older people. Anger may relate to paranoid reactions, with the projection of one's anger on others. Anger and paranoid feelings may complicate depressions, involving, as they may, issues relating to dying and to mourning for others as well as for oneself and for the loss of one's own body parts and functions.

Death-Related Problems

Elizabeth Kübler-Ross's work (1969) has delineated five stages in the psychology of dying, and she has developed a therapeutic approach. The elements include: denial; then anger; then negotiation, as with God; then depression; and finally, acceptance. There are many small deaths along the course of life; these are intimations of mortality. When they occur, essentially the same stages are seen as are described by Kubler-Ross, and the same efforts must be made to deal effectively in counseling and psychotherapy with each evidence of mortality.

Work with older people, with disability, and with dying can be extremely difficult. The therapist needs ongoing consultation to help his patient and himself. It is important to reaffirm that the fundamental issues of life and consequently of psychotherapy—love, guilt and atonement, separation, and integration—can be dealt with to the very end of life. It must

not be thought, as is often said, that nothing can be done because there is no future for the older person, and that he only has an existence in the present. After all, we all live only in the present. And the great fundaments of life are always subject to change.

Memorial societies can offer a valid form of psychotherapy for survivors, where the center of concern in the service is the personality of the individual. Memorial societies also provide low-cost funerals, which are less destructive to the financial situation of low-income survivors.

The Uniform Anatomical Gift Act or its equivalent now exists in every state and in most Canadian provinces. It provides Uniform Donor Cards, which may be filled out and signed by the donor and two witnesses; these then constitute a legal document. The person has final say of the disposition of his body and its parts. This makes possible the bequeathal of one's body or body parts to medical schools, to the eye banks, or other facilities. This is a material expression of the natural sense of legacy that is found as part of the psychology of late life (Butler, 1968). It is pertinent to the process of psychotherapy itself to aid the older person in providing appropriately for others.

It is also essential to be wary of those older people who, out of their fear of desolation, illness and poverty, hoard excessive money and property. It is

important to explore the extent to which the older person may use his income and property as a weapon of control against his heirs. Fear of loss of money may also relate to a fear of death itself. The older person may in effect be saying, "I want to outlive my resources and live forever." From one angle the therapist may help the older person to focus on leaving a zero estate—that is, to utilize his resources in the here and now for his own edification and pleasure, rather than feeling obligated to provide for those who follow. But when he does provide for those who follow, he should be helped to do so in a way that is authentically constructive for his heirs and for society at large. Spendthrift and skip-generation trusts may superficially seem attractive to the older person, but they may really reflect their deep sense of failure as a parent. The therapist may do much to help relieve the older person of any sense of parental failure and, in effect, also really help the heir by throwing him on his own, requiring an independence that a large inheritance would not permit.

The emotional help needed by a widow differs from the needs of a widower. The latter, if he has been a typical husband, may be totally unprepared to cook for himself, sew on buttons, and the like. He may need concrete assistance in learning how to do these things for himself. The therapist must help him do this rather than simply finding someone else upon whom to become dependent. For widows, the grief associated with their state is a process that often requires a year's emotional journey as one moves

through fresh and painful memories, various anniversaries and holidays. This may be complicated by an anger which the therapist can help the survivor to express. The Widow to Widow Program established in Boston and staffed by widows as an experimental mental health program of preventive intervention could well be extended nationally. Like Alcoholics Anonymous, it would be a useful adjunct to the therapist in his work.

Paranoia

It is an absolute that one must be scrupulously honest with paranoid patients. (One should be so with all patients. A paranoid patient, however, cannot accept even the most usual and unintentional lapses.) The therapist must be attentive, make reasonable suggestions, and be firm, combining warmth with detachment. The therapist must *not* be "nice," giving out reassurances or accepting everything that is said. Nothing can anger paranoid patients more than to think that they are being "buttered up" or exploited. At various points, of course, there must be frank disagreements; for if there were none, that would also spell trouble. The therapist has to take issue with a patient or else the latter ceases to believe in him. The therapist must have self-confidence and know what he is talking about. The fact is it is most difficult to establish and sustain a therapeutic relationship of trust with paranoid patients. Rapport may be slow in building, and the work may be long-term. On the other hand, the paranoid person has been profoundly

deprived emotionally, yearns for closeness, and will not easily spurn it, although superficially he may show hostility and withdrawal. Irony and humor—referring to the universalities of the human condition—are valuable. Any work with the family must be done only with the full knowledge of the paranoid patient and usually only in his presence.

One case illustration will serve:

> Miss Anne Warner is an unmarried eighty-two-year-old woman living alone on a small governmental pension. She is both hostile and suspicious toward anyone who enters her life. She called the office of a therapist in the community mental health center to ask for help with symptoms of "dizziness and forgetfulness." However after several home visits were made she became more and more suspicious, finally cutting off contact after she intimated the therapist was trying to "cheat" her.
>
> Six months later she called and asked if the therapist would come again to see her. When the therapist arrived she was greeted warmly by Miss Warner who then spent a full hour telling her things she had stored up because, as she said, "I don't talk to another living soul. When I thought of who I could talk to I always think of you." She first admitted to paranoid thoughts concerning the therapist after seeing a similar name in the newspaper. After satisfying herself that the therapist was not that person she went on to discuss a frightening dream she had had which reminded her of her own death—she wondered if such dreams were natural or pertinent to imminent demise. She concluded by deciding she should be more realistic about her age and do those things she had always wanted to do. She had been thinking about buying a bus ticket for an extended trip around the United States, stating cheerfully there was no longer need to save for the future. "I will indulge the gypsy in myself." Miss Warner asked the therapist if she could count on her to help dispose of her belongings "in case I don't come back."

Narcissism

Narcissism—self-centeredness—is one of the problems seen in old age, but it is not new per se in old age; it is the outcome of a life. Camus put the following into the mouth of his character in *The Fall,* "It is not true, after all, that I never loved. I conceived at least one great love in my life, of which I was always the object."

Ingmar Bergman's motion picture *Wild Strawberries* centers on the life of a seventy-six-year-old physician. His "punishment" for his life of indifference, intellectualism, emotional withholding, and egotism is describable in part as "loneliness" and/or "deadliness." The protagonist says, "The last few months I have had the most peculiar dreams. . . . It's as if I'm trying to say something to myself which I don't want to hear when I'm awake, that I am dead, although I live." His daughter-in-law tells him, "You are an egoist, father. You are completely inconsiderate. You have never listened to anyone but yourself. All this is well hidden behind your mask of old fashioned charm and your friendliness, but you are as hard as nails even though everyone depicts you as the great humanitarian." As the film unfolds, even in his closeness to death, the protagonist undergoes major positive psychological changes.

Insomnia

Insomnia can be a most serious, regrettable symptom in late life. Early morning awakening is more common among the inactive who retire early and take catnaps throughout the day. This may be a step toward serious daytime sleep reversal, which should be avoided. Despite mythology, old people often need more and not less sleep, because of illnesses and degenerative diseases that create fatigue, headache, aches, and pains. People with insomnia may fear sleep itself, for with sleep their defenses are down; the defenses may be against anxiety, anger, and other emotions. Psychotherapy can help the individual to understand his particular brand of insomnia. It is important to establish simple rituals— warm tubs, well-made beds, bed boards for support, back massages, and white wine or warm sake (Japanese rice beer) before trying hypnotic drugs. Barbiturates may prove excitatory to older patients. When sleeping medications are used, non barbiturates or chloral hydrate may be the more desirable.

Nutrition

Another special problem to the psychotherapist may be nutrition. Older people, particularly those living alone, may eat little and poorly, and develop organic symptoms as a result. Referral to the internist and nutritionist is necessary.

Cooperating with Other Professions

Old age is a period characterized by multiple changes involving multiple symptoms. They may occur rapidly, or they may be sustained in a long plateau. Clearly a comprehensive approach is required. Philosophically the older person is dealing with the essence of existence during the closing chapter of life, but at the same time he is affected by a myriad of physiological, psychological, and social changes. It is therefore imperative that the therapist be willing to function within the team approach, and to reduce problems of hierarchy and status in order to work effectively with others, including medical specialists, nurses, social workers, and paraprofessionals. Sometimes psychotherapists may get clues to medical problems and environmental problems, necessitating proper referral to others. It may also be hoped that medical specialists and others will increasingly recognize the rewards that come from effective psychotherapy and will refer older people to therapists to bring relief to loneliness, pain, and despair—conditions all too common in later life.

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Notes

1 Old age is arbitrarily defined in contemporary society through custom, social security benefits, and other entitlements and retirement rules. The most commonly used dividing age is 65. Biologically, of course, aging begins with conception.

2 Mann, T. *The Story of a Novel* (New York: Knopf, 1961).

3 Camus, A. *The Myth of Sisyphus* (New York: Vintage Books, 1959; originally published in 1942).