THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH THE AGED

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Psychotherapy with the Aged

Probably no other group has been denied an opportunity for psychotherapeutic assistance as much as have the aged. The reason for this probably relates in large measure to the feeling on the part of most psychotherapists that the patient's life is almost over and professional efforts might be wasted. There are also concerns about senility and other brain dysfunctions and a general rigidity of personality which leads many therapists to expect an extremely poor prognosis. Much of the pessimism related to working with the elderly can be attributed to the influence of Freud, who saw geriatric rigidity as precluding successful analysis of the elderly. It was his opinion that "near or above the fifties, the elasticity of the mental processes, on which the treatment depends, is as a rule lacking . . . the old people are no longer educable." He also felt that "the mass of material to be dealt with would prolong the duration of the treatment indefinitely."

However, I believe probably the most important reason for pessimism relates to the personal countertransference feelings of the therapist which will be discussed in some greater detail in a later section of this chapter. At this time it suffices to say that I feel that the prevalent pessimism that exists in working therapeutically with elderly persons is basically unwarranted, for on the whole, I have found working with this group extremely rewarding. It is also my impression that psychotherapy may be less wasteful than other

approaches to the problems of aging because of its broadly beneficial effects on the mental and physical health of the patient as well as the emotional and economic relief derived by family, friends and community. This chapter will present the basic symptoms, psychodynamics and therapeutic problems that the psychotherapist is likely to confront in working with elderly persons, as well as suggestions in regard to various approaches which can be helpful in working psychotherapeutically with these persons.

SYMPTOMS OF AGED REFERRED FOR PSYCHOLOGICAL HELP

Typically, the symptoms that lead the person in advanced years to be referred for psychotherapy are not too unlike those found in most neurotic conditions. They include depression; anxiety; extreme obsessiveness or compulsive behavior; restlessness; quarrelsomeness; complaining; negativistic, agitated, clinging, dependent and childish behavior; threats of suicide; somatic complaints of all kinds; and sexual behavior unacceptable to the community ranging from exhibitionism to what is felt to be unreasonable desires in regard to remarriage.

Essentially, elderly persons are referred because they are considered a nuisance and an embarrassment to the family or community. These patients are frequently quite resistive to therapy because they see the therapist as an extension of the rejecting community and as someone who does not

understand them and who wants coercively to make them change their attitudes and behavior. They resent the referral to the therapist because of its implication that they are "crazy."

In some instances, the family may be convinced that their aged relative is psychotic because of behavior associated with cerebral arteriosclerosis, but typically they are most concerned with what they feel is paranoid type behavior. Due to a heightened state of fearfulness and feelings of vulnerability, many elderly persons feel extremely insecure and easily threatened; also, because they feel so much outside of the mainstream of family life, they may develop attitudes which sound quite paranoid. They constantly verbalize that no one likes them or they feel certain that everyone dislikes them. They may insist that the family is just waiting for them to die so that they can collect the patient's financial savings. The patient may generalize even further and assume that because the family "wants" him to die that perhaps they are deliberately depriving him of the care and assistance he requires to survive.

It is not unusual to hear elderly patients voice feelings that a conspiracy exists to get them hospitalized or into some kind of institution for the aged. They feel certain that they are being "railroaded." Many times their intense reactions are not only related to feelings of extreme vulnerability but may also be the result of guilt feelings. They may verbalize to the therapist that

they see themselves as a terrible bother, embarrassment and expense to the family, which leads them to believe that the family is justified in wanting them dead or out of the way. Most times these attitudes disappear with the security that comes with the development of the therapeutic relationship.

Depression

Depression is probably the most frequent psychological difficulty encountered in the aged. Depression is most often associated with some kind of loss, and the aged have to face and deal with a wide variety of losses. There are the losses through death of close relatives and old friends and the losses that come with separation when children are grown and not only leave home but frequently also leave the community in this highly mobile age in which we live. There are also losses associated with physical potency and also the loss of sexual potency and interest. The loss of sexual potency and interest means much more to the aged than just the loss of sexual gratification. Sexual libido is frequently unconsciously associated with the life force and its loss is quite often interpreted to confirm and remind the patient that he is close to death. There are also the losses in mental and physical ability and these may also serve as harbingers of their feared impending fate which also contributes greatly to their dysphoric state.

Declines in the effectiveness of sensory functioning such as impaired

vision and hearing along with the added contamination at times of other central nervous system difficulties which may affect speech and other organs of communication contributes greatly to feelings of alienation and isolation in the elderly person. This impaired sensory functioning also serves to decrease the steady stream of incoming stimuli which deprives the elderly person of the pleasurable action and opportunities to affirm the sense of self which usually result from such stimuli and thereby also contributes to feelings of depression. Depression in the aged associated with a diminution in physical and sensory adequacy, can sometimes be relieved with close medical attention. The therapist who works with an elderly patient also needs to work very closely with the family physician because the psychological well-being of his elderly patient is very closely related to their physical well-being.

There are also losses in the older person's sense of self-esteem related to not feeling wanted or needed which can contribute to depression. The grown-up children are no longer in need of the aging parent, the spouse no longer needs him in terms of sexual gratification, and in many ways, he is considered a nuisance around the house. There are very few takers in regard to the wisdom he feels that he has accumulated over the years, and he also feels less needed in terms of his vocational skills now that he has been forced to retire. These are just typical of the many losses, along with losses in financial and emotional independence, which contribute toward a diminution of self-esteem and therefore contribute toward depression.

The loss of work opportunity and income also leads to deprivations and frustrations due to the necessity of having to readjust to a new standard of living which calls for the loss of various comforts and pleasures. Many times it may even necessitate a relocation, which can be quite traumatic for the elderly person due to the loss of the familiar and the secure. The loss of work opportunity also makes them lose the opportunity to sublimate which leads to greater regression and increased hostility or depression.

The aged feel terribly helpless and vulnerable because they feel that they are progressively losing control over themselves and the world in which they live and this makes them regress in search of someone to fill their needs for protective dependency. They may use depression as a means of getting their narcissistic and dependency needs met.

Many elderly people feel angry at the fates for robbing them of their strength and abilities, but because they have nothing tangible upon which to express their hostility, they suppress it. This suppressed hostility is another cause of depression in these people. Depression may also be the result of self-hatred and guilt related to the fact that they may blame themselves for not fulfilling their lifelong goals and ambitions and now they feel that it is too late. Rather than accept the conclusion that perhaps they never had exceptional ability, they tend instead to berate themselves for opportunities lost due to insufficient motivation or insight. This preserves the illusion that had they

really tried, they probably could have succeeded, so that berating themselves for lack of motivation becomes a necessity even though it results in a depression.

Probably the most serious problem associated with depression in the aged is the tendency for suicide to seem an attractive solution to their state of unhappiness. The element of despair and hopelessness is what makes suicide a serious consideration. They feel that there is no longer any hope for them ever to achieve their goals and ambitions, the lost recognition or the lost physical and mental abilities which they once treasured so highly. The fact that they are convinced that nothing can change in their life, along with their fear of living with the loss of security, independence and gratifications, makes suicide a distinct possibility. When along with this there is the element of wanting to gain revenge on family members, because of real or fantasied hurts, through the humiliation that their suicide will bring to the family, then the possibility becomes a distinct likelihood.

Anxiety

Anxiety is another very prevalent symptom in those elderly persons who are referred for psychotherapy. All the basic anxieties known to man are found in their most intensified forms in the aged. Due to the fact that the elderly person tends to regress in an attempt to achieve a sense of protection

and security, many of the fears which were so prevalent in infancy and childhood such as abandonment and separation anxiety, castration anxiety and death anxiety return now in an exaggerated form and add to his already highly insecure state.

Abandonment anxiety is aroused due to the death of many close relatives and friends and the loss of others due to emotional and physical separation. This intensifies his fears of unprotectedness, vulnerability and isolation. His enormous sense of insecurity many times will lead to the development of various kinds of phobias which is the regressed and weakened ego's attempt to deal with the diffuse and threatening anxiety.

Castration anxiety is roused due to the elderly person's recognition of his progressive loss of physical, mental and sexual potency, which are unconsciously interpreted as a castration. This may either lead to over-reactive compensatory behavior in terms of increased attempts at demonstrating prowess in these various areas of deficiency or it may lead to over-exaggerated fears of authority figures, with the result that the elderly patient feels that it is necessary to resist and compete with the therapist, for if he did not, such nonresistance would be seen as a submission and therefore a castration.

Death anxiety becomes more intense, of course, because of the

recognition that more and more people of his age are dying and also because he is aware of his progressive physical and mental deterioration, which serve as a constant reminder of his imminent fate. This anxiety tends to make the elderly person more compulsive and controlling because he is trying to regain a feeling of omnipotence in an attempt to allay his anxiety around death. The control provides the illusion of omnipotence which permits the pretense that through his omnipotent control he might be able to forestall his own death. This often accounts for his extreme compulsiveness, rigidity and controllingness which become so offensive to the members of his family and community. There is usually also an intensification of obsessiveness of some thought which, through its ability to totally absorb the mind, serves as a defense against thinking about an even more disturbing subject which is really disturbing him the most—the fear of his own death.

Dependency Problems

Dependency and regressive behavior are other very prevalent manifestations in the aged. Financial and physical dependency tends to heighten their psychological dependency. The fact that they are compelled to rely on others for various kinds of assistance intensifies their feeling of helplessness and vulnerability, which tends to make them more psychologically dependent in order to force others in the environment to provide them with a source of protection and security. As a result they may

become very childish and clinging in their behavior.

Some elderly persons deliberately intensify their regressive behavior because they believe that time is growing short for them to gratify the basic infantile and childish needs which have for so long gone unmet. They can become extremely demanding of narcissistic supplies which usually engenders rejection from others and, as a result, intensifies their insecurity. There is thus a strong relationship between their state of dependency and their level of anxiety. The more dependent they are, the more crucial is it for them to feel a sense of protection and gratification and when they are rejected because of the excessiveness of their demands, it leaves them feeling like a helpless, vulnerable and abandoned child. This intensifies their demandingness even more, which leads to even greater rejection and a deteriorative vicious circle is established.

Sexual Problems

Many family members will refer their elderly relative for psychotherapeutic assistance because they have become very disturbed and frightened in regard to unacceptable sexual behavior, either within or outside the family. In addition to the prevalent problem of impotence and lack of sexual interest, one also sees a relatively large number of cases of exhibitionism and child molestation in the aged. Both of these problems

usually relate to the attempt to overcompensate for the intensification of castration anxiety discussed earlier as the result of deterioration in sexual and physical potency. Aging itself is unconsciously seen by some elderly males as a castration for they feel that they are losing their potency in all areas which is a great threat to their sense of masculinity. This is especially likely to be true if this has always been an unresolved problem in their background.

For the male, the phallic exhibitionism is an attempt to shock the perceiver. This reaction of shock is confirmation to the aging male of the fact that the castration he fears is not a reality. It affirms that he is still being perceived as a sexual being. Similar factors are involved in his molesting of little girls in that young children have a greater tendency to be shocked by the phallic exhibition, plus the fact that his penis takes on an appearance of being very large when compared to the genitals of a child, which unconsciously also tends to allay castration concerns.

Another problem that one often confronts is the family's concern about what they feel is an unrealistic desire on the part of their elderly relative to marry a much younger woman. Many older men do not find older women sexually stimulating enough, and fearing impotence as a confirmation of their castration, they tend to become involved with younger women. It also helps them deny their age and feel younger just being around younger women.

Many elderly women may also manifest a problem in the sexual area because they interpret the diminution in their attractiveness and desirability as a blow to their sense of worth and value. Many women have become overly identified with their physical and sexual attractiveness, and when they feel that they have lost these, it may result in over-compensatory seductive or promiscuous behavior which may get them into difficulty with their family or community. It becomes a challenge then for the therapist to help the elderly person substitute a new definition of beauty for the one they have always held. In order to restore their feeling of worth and esteem they need to understand beauty as something which emanates from inner qualities rather than just a physical sense of beauty. The importance in therapy of setting up new models and criteria for self-assessment by the aged will be discussed in more detail in a later section of this chapter.

PROBLEMS FOR THE THERAPIST IN WORKING WITH THE AGED

Of all the difficult psychological problems that the elderly patient may manifest, the therapist himself tends to be the single greatest problem in working successfully with the aged. Working with the aged is likely to produce a wider variety and more intense countertransference reactions on the part of the therapist than with any other group of patients with whom he is likely to work.

It is a rare therapist who has completely resolved all of his anxieties around death and he is not likely to be very pleased to have reminders and provocateurs of this problem, which is what the elderly patient represents. He tends to, consciously or unconsciously, reject the elderly person or deny him therapeutic services in an attempt to reject and deny the aging process in himself and the fact that he too will someday have to die. The therapist may rationalize his rejection of the elderly patient by insisting that this kind of patient is too rigid to change and that "you can't teach old dogs new tricks."

It is difficult to work with any elderly person without, in some way, triggering in the therapist all the unresolved problems that the therapist may have had with his own parents. Many therapists typically find themselves unconsciously punishing their elderly patient because of past, resentful feelings toward their own parents which were never resolved. This may occur because many therapists, as children, always resented their own helpless and dependent position in regard to their parents. When in therapy, the roles are reversed and this elderly patient, as parent symbol, is helplessly dependent on them, these therapists may try to get even for past hurts by parents by attempting to hurt the elderly patient through subtle or direct punishment and rejection.

There is also a great tendency for the older patient to view the therapist as his son which is a kind of "reversed transference." This plays havoc with

attempts to bring the Oedipal struggle to resolution. A therapist may also become very angry when his elderly patient treats him like a little child and does not give him all the respect which he feels he deserves for being an adult and an authority. There is frequently a very subtle but intense competition that goes on between the elderly patient and the particular kind of therapist who deliberately becomes a therapist because he essentially needs to be in the position and role of the controlling parent. This kind of therapist unconsciously delights in treating all of his patients as though they were helpless children. Some elderly patients, who also are unwilling to relinquish their parental attitudes toward all younger persons, will run into real conflict with this kind of therapist.

Some therapists cannot tolerate the elderly patient's regression and the reversal of the parent-child relationship for other reasons. They may still need to respect older persons as parent figures, or else they may have their own ungratified dependency needs which may come out into the open because of their craving for such gratification from the elderly patient. These therapists tend to very much resent the older person's helpless regression and they may attempt rather forcefully to coerce the patient into more mature and autonomous attitudes and behavior.

Some therapists tend to overreact to their own sense of guilt related to their feeling of superiority over the elderly patient. They are inwardly very

glad that it is the patient and not themselves who is old, deteriorating and close to death. Consequently, they may tend to overreact to this feeling of guilt with condescending pity or else tolerate too much inappropriate anger and demandingness on the part of the patient as being justified. It is as though the therapist were inwardly saying to himself, "If I were in that old man's shoes, I would also hate people who were healthy, happy and not so close to death." Other therapists become so revolted and disturbed by the elderly person's problems or their own guilt feelings that they may overreact negatively and hostilely to the elderly patient.

Some therapists have difficulty in dealing with the sexual seductiveness which may come from the elderly patient of the opposite sex. Some of these patients have recently lost their own spouse and they are likely to see the therapist as a man whom they have to impress in order to confirm for themselves that they are still physically attractive and desirable. For some therapists, especially the younger ones, the patient's sexual seductiveness may be an even more intense problem because of the unconscious Oedipal elements that are involved. If the therapist has not resolved his own Oedipal strivings, then this kind of patient will trigger all sorts of uncomfortable feelings in the therapist and threaten him very badly.

Therapists also tend to be highly disturbed by the extreme rigidity and demandingness on the part of the elderly patient. It may readily become clear

to the therapist that the elderly patient is not coming to therapy to work out his problems but only to get his dependency and narcissistic needs met and also to use the therapist for the necessary companionship to offset his intense feelings of loneliness and isolation. Some therapists feel very sensitive to being used and manipulated, and they tend to respond with great resentment and hostility. It usually reflects their own past, unresolved problems in terms of inability to trust persons, especially parent figures.

Other therapists, who have some doubts about their own worth and adequacy, need to see fast results in their patients and the aged's rigidity tends to greatly frustrate and disturb them. Many therapists are also disturbed by the fact that some elderly patients tend to use their "senility" as an excuse for their failures or lack of achievements and the therapist may become quite annoyed at the patient's unwillingness or inability to be more realistic. The therapist may also find himself annoyed at the elderly patient's use of his "senility" in order to achieve the secondary gains which accrue in terms of the gratification of nurturance and dependency needs.

What some therapists find most disturbing in working with the aged is that their own lack of meaning or philosophy in regard to death may become exposed, and this can be extremely traumatic for the therapist. Until he has to deal therapeutically with an elderly person, it is quite likely that the therapist has never been in a position where he has had to examine his own convictions

in regard to the problem of death. Now that he has to deal with this problem as an imminent reality to his elderly patient, the therapist may find himself lost for words or helpful suggestions which could constructively help to reduce the patient's level of anxiety. Probably philosophical issues and psychological realities become more confused in working with the aged than with any other group. All too frequently I have observed the therapist become relatively traumatized as he comes to recognize that he, himself, is not prepared to deal with the fear of death, the meaning of life and other related issues which heretofore he considered only philosophical and not especially relevant to psychotherapeutic practice.

THERAPEUTIC APPROACHES WITH THE AGED

Abraham, in contrast to Freud, sounded a note of optimism regarding the analysis of the aged when he concluded from his own studies that "the prognosis in cases even at an advanced age is favorable if the neurosis has set in in its full severity only after a long period has elapsed since puberty. ... In other words the age of the neurosis is more important than the age of the patient." Meerloo was another author who displayed a persistent optimism on the subject. He spoke (in contrast to the rigidity issue espoused by Freud) of the elderly patient as being almost too open to self-examination. "My impression is that because of the weakening defenses, there is a better and more direct contact with the unconscious. Older patients react more easily to

interpretations and feel more easily relieved by relating the actual conflicts with those of the past." Jungians, such as Cutner, insist that patients in the second half of life are more concerned with individuation than are younger patients because the introversion of libido is in the service of discovering and integrating the heretofore unconscious parts of the psyche. She goes on to say, "It is because the intrinsic tasks of the second half of life are so different from those of the first, that analytical psychology believes in the value of analysis and the possibility of a new start even after the chances of fulfillment on the biological plane have gone." Goldfarb, Wolff, Wolk *et al.* and Oberleder are just a few of the more current workers who have found that elderly persons are capable of change, redirection and rehabilitation through psychotherapy.

Unfortunately, treatment for the aged is not usually considered until an emergency state of mental and personality breakdown has developed. While symptoms of depression, anxiety, loneliness, irritability, sleeplessness and loss of self-esteem may justify psychotherapy for the younger patient, they are considered "par for the course" in the elderly person and are therefore not likely to attract attention. Usually the elderly person must qualify on the basis of loss of memory, disorientation or incontinence before he is considered for the same treatment, at which time, paradoxically, its feasibility may indeed be questioned.

The need for flexibility in the approach to the treatment of the aged needs to be emphasized. Appointments may be infrequent and sessions brief, but these arrangements may need to change with the advent of new crises. Environmental manipulation and the role of ancillary personnel in the treatment of the aged may even be more important than the sessions with the therapist. The psychotherapist must be a member of the treatment team, each of whom is on the alert for signs of which the others should be informed.

Thus, for example, misguided, overprotective treatment or undue neglect augments the fear and anger of the elderly person who tends to feel helpless and vulnerable to begin with. Such attitudes tend to worsen the elderly patient's psychological difficulties, increase the patient's inefficiencies and further disorganize his overt behavior. This fact makes it imperative that the family or those who act in nursing and attendant capacity be properly oriented to the patient's needs and that they have a working concept which can sustain them by providing them with a belief in their own capacity to master the problem. The family members must be helped to understand that the patient's aberrant behavior is really a call for help to which they need to respond constructively. One cannot overemphasize the importance of a cooperative social environment, when psychotherapy is attempted with the elderly patient. There needs to be frequent and open communication between the family members and the therapist. The family members need to feel comfortable in and recognize the importance of bringing all their reservations

or negative feelings toward the patient out into the open with the therapist. Only then can there be erected the consistent supportive atmosphere which is so necessary for the rehabilitation of the elderly patient. Poor communication can lead to the family and therapist working at cross purposes with each other which only serves to intensify the patient's insecurity and defeat the therapeutic endeavor.

THE USE OF THE TRANSFERENCE

Due to their regression, the aged typically tend to regard the therapist as a parent figure from whom they expect will come a feeling of protection as well as suggestions and guidance. They expect a great deal of direction and if the therapist does not initially meet some of these expectations or tends to be too nondirective, it will usually cause them to drop out of treatment because it undermines their sense of security and protectedness.

What the patient needs to believe is that there is hope and help. The therapist ought not to go out of his way to disillusion the patient as to the therapist's realistic capacity to help, even though he may recognize that their perceptions of his capacities are fraught with elements of the positive transference. The patient's belief in the helping capacity of the therapist gives the patient hope and provides him with the feeling of security which is necessary for him to adjust to his confusing world.

Early in therapy elderly patients tend to interpret all the therapist's suggestions to them for greater autonomy and active mastery, as a rejection of their needs for protection and narcissistic gratification. Initially they do not come to treatment in order to grow and mature emotionally. Such maturity represents to them greater autonomy, isolation, vulnerability and insecurity.

Most of all they are searching for a parent figure. They want protection, first and foremost. They feel analogously that they are "drowning" and first need to be thrown a life raft and later they can be taught how to swim. The therapist's insistence that the elderly patient perform autonomously and maturely too early in therapy is interpreted many times by the patient as though the therapist were shouting swimming lessons to a drowning man. Once they have achieved a sense of security through the therapy relationship, they can then consider a more mature means of dealing with their world.

The elderly patient's need to find a convincingly helpful figure is a trend which is usually hidden from himself as well as from others. It is not consciously embarked upon and carried out. The manner in which the campaign is conducted and carried out can deceive the therapist. The patient is likely to put the therapist through so many devious tests that the therapist is likely to conclude that he is not at all valued by the patient. For the elderly patient to view a person as being potentially helpful, he must somehow first try to dominate, manipulate and maneuver him in a variety of ways and the

therapist is likely to fail to appreciate that the patient may, by so doing, be displaying a genuine interest in and involvement with the therapist. He is basically only trying to test the therapist's emotional strength and security in order to be able to trust him and feel protected by him.

The receipt of specific advice, within acceptable ranges, is often taken as a symbol of having gained the therapist as an ally, friend or protector and simultaneously as proof of having triumphed over or controlled the therapist. In this way they come to feel that they have won the therapist's omnipotence and now own it themselves.

THE SHAME OF BEING OLD

There is obviously a great deal of shame attributed to being old. It is well recognized that once a person reaches the age of thirty both men and women become very sensitive and even may fie about their age. In our society and in many others as well there is a definite stigma attached to being old. Youth and the ways of the young tend to be highly valued and imitated. It appears that youth, vigor and life have all become equated. It is difficult for many people to feel fully alive without also feeling vigorous and young.

The shame of old age seems to be unconscious and deeply ingrained and apparently relates basically to the aged's diminution in sexual potency and ability to compete in the vocational arena. For a male to feel like a man it is

apparently necessary that he still regard himself and be regarded by others as a sexual being. Sexual vigor and a sense of personal value seem to go together. Old people tend to be seen as sexually impotent or asexual which makes it difficult for the elderly male to be perceived as and feel like a man. There is shame in feeling like a eunuch.

For most females, to be a woman is to be able to bear children. When a female becomes old and is beyond her child-bearing years it is often quite difficult for her to feel like a woman, for most women tend to identify themselves as a woman with their ability to bear children. She feels embarrassed, at least at an unconscious level, to have to admit that this loss of function is a reality even though at the more" conscious level she may seem to be relieved at the thought that she can no longer be pregnant. Women also tend to identify themselves and their worth with their physical attractiveness and sexual desirability. They always want to be perceived as being younger than their true age. This enhances their feeling of worth and helps them believe that they will always be able to compete with women of their own age for attention and recognition. Even if a woman cannot be competitive in regard to her beauty she can always feel competitively more desirable by being more youthful looking than others her own age.

In this society, one's sense of personal value is very much related to one's ability to compete. This is especially true for men. Striving and

achievement tend to be equated with aggressiveness and masculinity. Elderly men are ashamed to admit that they have not achieved as much as they should have for someone of such advanced years. There is a sense of shame in the loss of ability to compete because we are all in the competitive arena and those who are unable to compete feel like they are the vanquished in the contest called life. In that feeling of defeat and failure is shame experienced.

Every age group, except the elderly, has particular characteristics which it accepts and values as being distinctly its own. Youth has aspects which it values as distinctly its own as does middle age but the elderly do not value and tend to reject what is distinctly their own and attempt instead to emulate the younger groups. To accept that one is old is tantamount to accepting that one has been defeated by life and is out of the mainstream of life. One can accept the fact of retirement from the competitive arena only if one has felt victorious in the game of life and has some visible signs to demonstrate that supremacy; otherwise one cannot retire without also feeling some sense of defeat and shame.

If we applaud the old at all, it is almost never for doing what is typically characteristic for their age but rather for things that younger people do. Thus, for example, we may applaud the old man who can still play three sets of tennis, run a marathon race or father a child; or the old lady for looking as young as her daughter. However they are rarely applauded for that which

should be a distinctive achievement for old age such as a sense of wisdom and a non-striving peacefulness. For this reason older persons are under even more stress than younger persons to demonstrate their competitive adequacy. Younger persons who are not too successful are not yet failures because they still have the advantage of saying that they are still young and that in the future they will be successful, whereas this excuse is not possible for the elderly. They are under great pressure to demonstrate to all that they are still in the competitive arena and still able to do battle; otherwise they will have to admit that the game of life is all over for them and thereby have to accept their worthlessness.

Old people also feel a sense of shame because they are the constant reminders to the young of the deterioration that will one day also beset them. This produces an attitude of an almost reflexive rejection of old people. The elderly also serve as reminders to the young of their eventual fate of death. There seems to exist an unwritten, unconscious agreement that we must all help each other be distracted from the reality of death. In this respect, old people feel very culpable in the breach of this unwritten contract. The French have a saying, *le temps passe, la mort approche.* Every day one moves closer and closer to death. The feeling of abhorrence toward death tends to be projected onto the elderly which makes him feel a certain disgust about himself. This also contributes toward his feeling ashamed of himself and makes him tend to deny the reality of his age, at least to others.

All these various factors contribute to the elderly person feeling ashamed of being old, which leads him to reject his own age group and accounts for why he continues to use the middle-age model as the criterion for success and adequacy.

ELIMINATION OF THE MIDDLE-AGE MODEL

Too often there has been a social, medical and psychological attitude which rigidly insists that people must learn to accept their limitations, must resign themselves to their disabilities and must stop their struggling against these realities. With some patients this kind of attitude is helpful for it facilitates reality testing. But for the elderly patient it is not always appropriate. This attitude and the treatment based upon it often encourages feelings of failure, depression, despair or apathy in the elderly patient. To encourage acceptance of limitations and disabilities is usually to foster self-recrimination and loss of self-respect. It encourages the regarding of oneself as crippled and weak. This is not to imply that the therapist needs to encourage the distortion of the realities of the patient's limitations but rather suggests that the patient needs to come to see himself as *different* than, instead of *lesser* than, other, younger persons. He needs to come to compare himself to a new model of success and adequacy in place of the one he has been using.

The middle-age model, as the criterion for success and adequacy, has to be eliminated and replaced by a more appropriate model. He is a new person living in a new phase of life and he ought not to be judged or judge himself against the accomplishments and functioning of a forty or fifty year old any more than we can judge a child's accomplishments in comparison with those of an adolescent. These are qualitatively different people and we need new models and criteria of success for these different kinds of people.

Unfortunately the aged are still being compared and are comparing themselves with middle-aged persons in terms of adequacy and success, with resulting feelings of inadequacy and impotence. The therapist has to help the elderly person recognize that similar to other ages, old age has its advantages and disadvantages. The elderly patient needs to understand that he ought to be beyond the model of striving, achieving and competition. He needs to recognize that he has graduated into a new stage of life that others that are younger than he often wish they could move into. It is now permissible for him to rest and enjoy life. He can live creatively, instead of routinely, and follow his own whims. There is no longer any pressure to be adequate or to impress others. He needs to understand how fortunate he is to be out of this race for superiority.

He needs to come to see his new state as an advantage and as an age of liberation rather than loss. He is now liberated from the many hungers,

passions and strivings which kept the organism in constant turmoil. There is time now to be sensitive to and enjoy the things that one never quite had enough time to enjoy—the sunset, the grandchildren, the flowers, the birds in flight. How good it is to be free of the many past burdensome responsibilities. One is free to go places and do things that previously one could not give time to. One has the time to sit and talk with friends and really get to know people intimately rather than superficially as we have been so prone to do in the past.

A NEED TO FEEL USEFUL

The aged have collected a great deal of wisdom and experience over the years, and they need an opportunity to use it. A sense of feeling useful and unselfish is essential to developing an intrinsic sense of worth, so that one's sense of worth is no longer dependent upon competitive achievements. Aged persons need to be needed, not only because of a need to maintain a sense of personal worth and esteem but also as the means of dissolving their profound sense of loneliness. Many of these aged persons have been obliged to retire professionally, some find themselves alienated from their families and others have given up their homes to live in groups and shared loneliness, and for these reasons they need human contact and involvement desperately as the means of transcending their deep sense of isolation and loneliness. Even more than being loved and nurtured they need to love and give of themselves to

others for only by establishing communion outside of the boundaries of one's own ego is the sense of isolation and loneliness really dissolved. There are probably many more disabled, older persons whom the patient can help by reading to them or serving as a companion in their loneliness. There may be homeless children in institutions who desperately need the love, affection and physical and emotional contact that he can give. He can work on his avocational interests and hobbies and perhaps give the fruit of his labors to others who might be in greater need. He has a great need to be involved, but he needs to learn that he can be involved but in different ways than he has been in the past. Helping to make life meaningful helps to make life worth living and the best way to feel life is meaningful is to feel useful and needed by someone and to give of oneself unselfishly.

Activity is therapeutic for the aged. One of the therapist's primary responsibilities is to prevent the deterioration which results from withdrawal and disuse. The need for continuing human contacts, social participation and meaningful work in order to maintain function cannot be minimized. Psychotherapy must often be reinforced with a concrete activity program and the therapist must be prepared to assume the role of social planner, family consultant, recreational or vocational advisor, or just plain good friend.

Sometimes working with the surviving family to eliminate frictions and competitions can go a long way to reducing the elderly person's tensions and

anxiety. They need to be encouraged to help the elderly one feel needed. The therapist needs to help the family recognize that their elderly relative is not trying to compete or feel superior when he attempts to show them how to do something properly. Most often he is just trying to demonstrate to the family that he still has some use to them. He wants the family members to turn to him more and use him for his wisdom and experience and for what he can contribute. He is really saying, "Don't relegate me to the rubbish heap."

Much of psychotherapy with the aged involves providing them with opportunities for ventilation rather than insight. Sometimes it is therapeutic simply to siphon off immobilizing tensions by allowing expression of petty complaints. Another usually important aspect of therapy with the aged is helping them deal with any guilt feelings related to the death of past loved ones. Some tend, irrationally and omnipotently, to blame themselves or feel guilty that they never treated the lost loved one better than they did.

Part of the unique work with the aged is helping them to deal with their anxiety around death if this is a problem for them, as it usually is. They need to be able to look at and, if necessary, revise their attitudes and philosophy around death in order to be able to live without the constant preoccupation and fear of it. To help the elderly patient, who has concerns in this area, accomplish this, it is essential that the therapist first review for himself his own tenets and confront his own fears in regard to death. He must first derive

for himself a personal and direct understanding of the meaning of death if he is to ever work comfortably with the aged. Such meaning and understanding can never be given from one to another. It does not lie in theory, dogma, belief or philosophy and it is not something that can be handed down by some authority. Such personal meaning can come only through self-confrontation and self-discovery of the essence of the nature of one's fear of death. It is only then that the therapist will be in a position to encourage the patient to do the same.

Although no specific philosophy of death can be offered, the reader might find it helpful, in his exploration of his own fear of death, to reflect on the statement that "the meaning of death cannot be considered as an issue apart from the meaning of life." Finding meaning in life does not imply living according to a particular philosophy of life but rather has to do with one's ability to five fully and creatively. Life is very real; it is not an abstraction and therefore it is foolish to search for a philosophical or other abstract or conceptual meaning of life. If the reader now reflects deeply on the question of "How is one to live fully and creatively?" and clearly and personally sees the truth of the statement that "for one to live fully, creatively, and without the fear of death, one must live in a state of constant renewal, which means that one must know what it means to die to continuity, to die to the old, to the past, every moment," then he will be approaching not only a personal understanding of the meaning of life and the meaning of death, but the

essence of joy and beauty as well.

The following case is presented in order to help illustrate many of the characteristics of the aged presented in this chapter.

Mr. M, a 68-year-old man, was referred to me by a neighbor of his who was quite concerned about him because of a persistent depression. Mr. M had been a musician, a piano player in a small band, nearly all of his working life. Of late he had been fired from several bands because his playing had become badly affected due to a severe arthritic condition in his fingers and also because of progressively deteriorating eyesight. His inability to play well was not only affecting his ability to earn a living but he felt that it was depriving him of that which had always given him joy and meaning in life. In addition his wife had recently died and he felt terribly abandoned because he had come to depend upon her very heavily. He had almost no friends and had used his wife as the sole source of interpersonal gratification. Basically he was always very frightened of people and his wife had sheltered him like a protective mother. His feeling of loneliness and isolation was intensified by the fact that he had been unable to have any children and his life seemed to be totally empty.

Another contributing factor to his depression was the fact that he had always been very competitive with his brother who had surpassed the patient

in competence in almost every area. His younger brother had learned to play the piano much more easily than the patient and was currently still enjoying good health and a successful musical career. Mr. M felt terribly defeated by his brother and by life in general and inflicted a great deal of hate upon himself.

He talked about never having fulfilled any of his ambitions in life and he felt that it was now too late. In particular he had an ambition to write a song and get it published This was something his brother had never done. However he had never been able to find the time to devote to writing a good song and now his failing eyesight made it impossible for him to read and write musical notes clearly.

As we explored the problem together it soon became clear that what troubled him the most was that his impending death seemed to him to be such a final thing. He indicated that if he had had children to carry on his name and remember him or if he had written a famous song that this would help in some way to perpetuate his memory. He felt that he had in no way left his mark upon the earth and it was as though he had never existed at all. His sense of desperation brought him great agony. He wanted some place in immortality. He was desperately afraid of losing all hold on a sense of continuity and permanence. His death seemed too final, too absolute a termination to him.

The more he confronted and talked about his yearning for a place in eternity, the more he came to realize that he was overly preoccupied with death and in a sense had already "buried" himself. Spontaneously he began to feel that there might still be a lot of life in him yet and that maybe he had given up too soon. At this point we were able to talk about other vocational possibilities, and it occurred to me that there was a particular section of town that had no music teacher and that many of the mothers had expressed a wish to have a music teacher for their children. The idea of working with young children seemed to excite him very much. It seemed to offer him an opportunity to fill many of his unmet needs. He was even able to joke about the fact that the children would be less likely to be critical of his playing ability. The opportunity to bring the love of music into the lives of young people seemed to give his life new meaning. After some five or six sessions his depression lifted and he felt that he could now carry on with courage and purpose.

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