Psychotherapy with the Elderly

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What is special about psychotherapeutic work with older people? When we try to answer this question we may err in two opposite ways: by equating aging with extreme, *debilitated* or senile old age, thus accentuating the differences from earlier years, but taking a narrow, pessimistic view of the nature and value of therapy; or by overemphasizing the psychological similarities between older and younger adults and, in effect, *denying* and failing to take into account the impact of aging. These common errors have a history.

Until recently, interest in the mental and emotional problems of later life centered almost exclusively upon the most disabled segment of older people, the confused, demented, psychotic, institutionalized, physically ill or dying. Excluded was the larger, more vigorous segment of aging persons. Contributions to geriatric psychotherapy tended to be limited to approaches to the special problems of the disabled minority of elders, and they were often put forth as if they applied generally to the entire population of older people. On the other hand, dynamic psychotherapy, growing out of psychoanalysis, found its application and sources of knowledge first among young adults and then among children and adolescents. As interest extended to encompass the later years it was logical to stress continuities in psychological development over the entire life span. Early psychoanalytic discoveries pointed to the lasting importance of formative experiences in infancy and childhood. The excitement of these findings led to overvaluation of the idea that personality is established in all its essentials during childhood, so that later development merely repeats and reworks these foundations. It followed that the inner life of older people was only the continuation of post-adolescent existence without essential differences in normal personality or psychopathology except for organic brain diseases. The unique

qualities of older persons and the special experiences and problems of later life were neglected.

Difficulties in Applying Psychotherapy with Other People

Although today psychoanalytic psychotherapy is an established method for younger adults and even children and adolescents, when we try to apply it to aging or elderly patients we encounter special difficulties in defining when a person is "old," in approaching the topic objectively, in gauging whether patients are flexible enough to benefit from treatment, and in making useful generalizations.

While psychological aging, like physical aging, is correlated with adaptability, it defies simple definition. Although related to chronological age, senescence of body and brain, and accumulation of experience, aging cannot be equated with any of these. An 80-year-old, despite physical infirmities, may be more responsive, adaptive and forward-looking than a healthy 50-year-old. The only clearly established age-related change in the functioning of the central nervous system in the healthy older person is a slowing down of perceptual processes, with prolongation of the time spent in recovery between mental or physical actions that call for accurate perception and adjustment to changing stimuli; this decline is not uniform or specifically predictable. Some people are wise and experienced when quite young, while others remain relatively naive and simple through their late years. The complexity and ambiguity in defining "old" facilitate the errors of denying aging or equating it with senility. This may impede diagnosis of manifestations of illness which vary with age, or lead to misunderstanding of the motives, values and adaptive tasks of the older patient or to setting of too ambitious or too limited therapeutic goals.

A vigorous woman of 79, still able to run her own business, was observed to distinguish herself from her contemporaries and even somewhat younger friends who showed diminished energy, dwelled upon their physical illnesses and

complaints, or displayed an accentuation of characterological stinginess, as if *they* were the *old* people. Thus, she agreed implicitly with those who define old age as physical infirmity and she had a pejorative attitude toward old age.

Disparagement and denial of aging are prevalent in our youth-oriented culture where youthful appearance, activity and achievement are overvalued. When aging is recognized, it may be pictured as unduly bleak, or it may be caricatured or treated with patronizing praise. Psychotherapists may unconsciously reflect gerontophobia and prejudice against older people through stereotyped attitudes in which the aging are regarded a priori as burdensome, demented, psychologically rigid or untreatable (1). A number of common circumstances, especially with the debilitated older group, play a part in evoking and rationalizing these attitudes and in inducing countertransferences. Older patients frequently show increased needs for encouragement, appreciation, and even admiration. They express depressive helplessness, or demand advice, assistance and magical help, thus placing particular strain upon their therapists. Unpleasant regressive character manifestations may appear or intensify in later life. Often, attention must be paid to the needs and sometimes interfering behavior of family members. There may be difficulties in communication, as with patients who show the early indications of organic brain disease. Younger therapists may have insufficient empathy with the perspective, physical limitations and traumatic experiences of older persons. They must draw upon whatever analogous personal events are available to them, such as periods of intensified physical and mental change and development, illnesses, family crises, raising their own children and, especially, dealing with their own aging parents.

Regarding psychoanalysis, the most intensive form of psychological treatment, analysts, following Freud (2, 3, 4), have been reluctant to treat persons over 45 by classical psychoanalysis. Even though his own later discoveries regarding narcissism and the structural point of view (id, ego and superego) increased the scope and the effectiveness of analysis, and despite the cautiously optimistic findings of other pioneering analysts, Freud apparently

never revised his early opinion that by age 50 the mental processes are too rigid for favorable treatment results. As we know, Freud himself made major revisions and additions to his theories when he was near 70 and continued his scientific contributions into his 80's. His view may have impeded study of the psychodynamics of aging and application of dynamic psychotherapy in older people. Today many psychotherapists would agree with Berezin (5) that rigidity and flexibility are not functions of age but rather of personality structure throughout life. The impact of Freud's pessimism was mitigated by the initial successes of other analysts, such as Abraham (6) and Jelliffe (7). It was their point of view that chronological age did not of necessity involve deterioration of those intellectual and emotional capacities required for analysis, and hence *some* older persons could successfully undergo orthodox treatment. Kaufman (8) applied psychoanalytic principles in the treatment of two hospitalized patients with psychotic depressions, aged 56 and 60, achieving significant improvement. More recently, Hanna Segal (9) reported the 18-month treatment of a man in his late 70's with a chronic psychotic state of depression, paranoia and hypochondriasis, unresponsive to electroconvulsive therapy; and Anne-Marie Sandler (10) described the analysis of a man with narcissistic oversensitivity, treated between the ages of 58 and 65. These latter cases attest further to the possibilities for analysis, but also to the difficulties and limitations.

In a useful review of the literature on psychotherapy with geriatric patients, Rechtschallen (11) evaluated psychoanalytic studies as well as some other contributions ranging from idiosyncratic efforts of talented therapists through Jungian, Meyerian, general psychiatric and social casework approaches. He noted that psychotherapy with the aged had a slow, pessimistic beginning followed by a wave of optimism and then a more considered attitude. Although almost 20 years have passed, the papers reviewed have much to offer that is useful today.

Starting in the 1940s, Grotjahn, Alexander, G. Lawton, J. Weinberg, G. J. Wayne, M. H. Hollender, and Meerloo used modified analytic approaches which stressed support and the active participation of the therapist. For example,

Wayne (12, 13) suggested that the treatment begin with the elicitation of enough historical material to permit a psychodynamic formulation and an understanding of transference; that limited goals be set; and that a focus be kept upon a current problem that the patient consciously recognizes. He also made the following points: The patient should be given a readily perceivable part in solving his own problems; without deliberately avoiding material, no attempt should be made to rekindle old conflicts; the therapist should be active in providing guidance, reassurance and environmental manipulation; some educational techniques may be used, such as discussions of the cultural attitudes toward the elderly; scheduling should be flexible, with an effort to progressively decrease the number of weekly sessions; therapy need not be finally terminated; and tranquility, the goal of old age living, can be accepted and expressed tacitly in the therapeutic atmosphere. One may raise all sorts of questions, not easily resolved, about this advice: What is the nature of transferences in older people? Who or what limits the goals and how is this done? What is "activity" on the therapist's part? Is there a unitary "goal" of old age living? Yet, from a sufficiently broad and general standpoint, these and similar technical recommendations seem clear and sensible enough. But to which patient s and in which conditions do they apply?

It is difficult to make accurate generalizations about older persons as a group, since they present the greatest diversity and individuality in life experiences, personality styles and current circumstances. In order to help clarify the aims and technical approaches in psychotherapy of older people, and at risk of making another procrustean overgeneralization, the distinction will be made between those past middle life who ate *aging* and the smaller group of *debilitated aged.* There are, of course, many gradations and various combinations between these polarized extremes. Those in the group of the *aging* are experiencing: physical changes in appearance, attractiveness, strength, agility and reaction time; physical illnesses which are manageable rather than critical; some fluctuation and recession of instinctual drives; conflict over and reassessment of the balance between ideal aspirations and actual achievement, whether in

personal development, social relationships, community activities, work or creative efforts; the prospect of retirement from work; awareness of limitation of time and of the eventual reality of dying; the deaths of people who are significant to them; and changes in their relationships with spouses, children, friends and co-workers.

An *intermediate group* of people experience states of crisis stemming from severe physical and mental illnesses, losses by death, divorce or radical change in personal relationships, or failures in their work.

The *debilitated aged* show in varying combinations and degrees: the limiting and burdening effects of chronic, multiple or dangerous illnesses, with diminished functional reserves of organ systems; manifestations of brain damage; constriction of activities; inability to maintain themselves without considerable assistance from their families, community resources or institutional facilities; a dominance of pregenital drives; and the depletion of stimulation, affection and satisfaction, the recurrence of grief reactions, and the strengthening of defenses against painful affects resulting from repeated, cumulative losses of significant people.

If we distinguish these groups, we can see that much of the literature on psychotherapy with older people appears directed to the debilitated group. This is explicit in Alvin Goldfarb's (14) special application of psychoanalytic thinking in brief therapy for the very old, mainly braindamaged, residents of a home for the aged. His major point of departure was the overdependence of the aged, which he attributed to somatic changes, intellectual impairment, and socioeconomic and personal losses. Instead of responding as previous writers had with discouragement or promoting acceptance of dependency and providing dependent gratification, he attempted to utilize the patient's misperception of the therapist as a powerful parental authority. This illusion enables gratification of needs for affection, respect, protection and punishment. Patients were seen for five to 15 minutes weekly or less frequently. With those who have never been

able to accept a dependent position he attempted, e.g. by granting small concessions, to create the feeling of having triumphed and gained control over the "parent"/therapist.

The kind of behavior that Goldfarb refers to was seen in a married woman in her mid 70's with an agitated depression, hypochondriasis and a definite degree of loss of recent memory. She came to the psychiatrist's office accompanied by family members, usually by her husband and one or more children. Initially fearful of the interviews and urgently requesting relief, she cast her younger therapist in the role of a savior or at least a superior court judge. He demurred and cautioned her overvaluation but could not entirely escape this omnipotent role. In a later session, when she felt better, she clasped him in her arms, said that she loved him—teasing that he mustn't tell his wife—and at the end of the session gave him a kiss. He was, of course, pleased with her improvement and he accepted her positive expression as he might from any affectionate older relative.

The Aims and Techniques of Individual Psychotherapy

The purpose of any treatment is, of course, to relieve suffering, to allow normal functioning and, if possible, to "cure" and prevent difficulties. With these goals in mind, in psychotherapy we may place emphasis upon one of three intermediate treatment aims or strategies. We may try to bring about structural change, a further development and integration of drive derivatives, ego and superego functions, the self and other components of the personality. Alternatively, we seek to reinstate the best level of functioning that the patient has ever attained. Or we direct our attention primarily to assisting the patient's responsive and caretaking environment, usually the family. As shown by Grete and Edward Bibring (15, 16), our techniques for accomplishing these aims include the promoting of insight, adaptive intervention (manipulation), and basic supportive methods. Insight occurs at two levels. The form employed most often is clarification, the giving of understanding of what is preconscious, that is, "fit to

be conscious" but outside of immediate attention and comprehension. The other form of insight involves bringing to consciousness well-defended unconscious mental contents. The possibility of achieving insight depends upon the patient's tolerating an optimum intensity of conscious exposure to distressing conflicts that were preconscious or unconscious.

Gradual increase in self awareness was observed in a woman treated in her late 50's and early 60's for depression precipitated by grief at the death of her aged mother (17). Mrs. A's depression was marked by sadness, psychomotor retardation, and excessive concern with the distress that her condition produced in her family members. When most depressed, she repeatedly asked for reassurance and wanted change to occur without her understanding anything. When depression lifted, persistent clarification of her covered-over feelings sometimes led to appropriate weeping and the recall of events and emotions, particularly during the period of her mother's terminal illness. Her mother had died of a slow-growing gastrointestinal tumor after a two-and-one-half-year terminal illness in which she had little pain, but weakened, lost weight, and went through several crises. She lived by herself in a city 400 miles away, and although a married son lived in the same town, it was the patient, her only daughter, who assumed the burden of looking after her. Mrs. A, who had not been away from her husband for more than a day in over 30 years, spent long periods with her mother and observed her deterioration. When she returned home she constantly expected a telephone call announcing a further crisis. When the question of palliative surgery came up, she felt that the decision was placed in her lap even though another brother, living 2000 miles away from her, was a physician.

It became apparent that her mother had been phobic, overdependent and self-sacrificing. Moreover, the patient herself had struggled since childhood against similar fears, dependent feelings and masochistic tendencies. She spoke of having been somewhat depressed for many years. She dated this to the time when one of her children developed a school phobia, reactivating conflictual, repressed memories of her own struggle with her phobic mother who had tried

to keep her at home. Psychotherapy, assisted by antidepressant medication, was usually scheduled at weekly intervals and was intermittent. The patient came when distressed and at times, later on, when she wanted to work on her problems. Movement in therapy proceeded as follows.

She recalled more of the events preceding her mother's death, particularly the deaths of two other close relatives, one by suicide. Also, two of the patient's grown children had experienced significant emotional crises then. Her awareness of the precipitating causes of recurrent depressive episodes increased. These causes included experiences which reminded her of her mother, anniversaries, the prospect of vacations and other separations, the deaths of relatives and acquaintances, and, increasingly, her children's problems and her husband's approaching retirement. Clearly, she had difficulty in achieving objectivity based on sufficient psychological differentiation from her children. She recognized that she was oversensitive, particularly to boastful and overbearing attitudes of others. This became focused upon important family members. Eventually she experienced strong resentment of the humble and sacrificing role assumed by her husband and, she felt, forced upon her as well in relation to his family. As she expressed these feelings, over a period of time, she gained courage and became purposefully and appropriately more assertive in these family relationships. She received added support from one of her children who coincidentally had also started therapy. Her husband made an effort to be more understanding and she became more perceptive of his depressive symptoms. Her intermittent depressions were painful, but her affective expressions were freer. When well, she felt better than she had in years, her imaginative community activities blossomed, and she renewed old friendships. Her transference was generally positive and her husband was the one who expressed displeasure, at times quite strongly, with the long, slow course of treatment.

In this case a childhood neurosis, phobic and depressive, was covered over by reaction formations, though at the price of overdependence and masochistic attitudes. Her defenses broke down under the impact of problems of aging, i.e.,

her mother's death, the independence of her children, and her husband's retirement. A new equilibrium had to be found based upon better resolution of her early conflicts. Prevention of the recurrence of depression was one of the treatment goals.

Where insight plays a major role in achieving structural improvement, therapeutic manipulation or adaptive intervention (15, 16) is the technical principle most useful in reinstatement of optimum functioning within the existing personality structure. Particularly suitable for brief therapy of psychological emergencies and crises and for medical psychotherapy, it utilizes the patient's defenses and adaptive methods, enabling him to find and follow ways in which he can function more satisfactorily and gain increasing security without having to go through a major psychological reorganization. Goldfarb's approach, noted above, can be characterized as a form of adaptive intervention.

In the case of Mr. B, a 60-year-old, single man seen in a surgical ward consultation, we can see how both his character type and his age characteristics were taken into account in a therapeutic intervention (18). He was referred for psychiatric evaluation because he repeatedly postponed necessary surgical treatment. Almost seven months before, on a private surgical service, he had been operated for gallstones which obstructed his bile duct. The complication of acute pancreatitis necessitated drainage of an abdominal abscess. Because of his financial situation in the face of his long illness, the patient was transferred to the ward service. Subsequently, a third operation for revision of the sinus was performed. Although it appeared that a fourth procedure to assist drainage would shorten his hospital stay, he had become anxious and talked of signing out of the hospital. The patient had discussed this important decision with his sister who lived in another city. Greatly concerned, she had contacted his private surgeon and also the chief of surgery. This added to the house doctors' determination to treat him very successfully; the difficulties which they encountered then led to feelings of frustration and to definite tension between them and their patient.

When interviewed, Mr. B was friendly and polite, had a very neat appearance, and showed great consideration of others on the ward. He knew that he was upset and thought that the psychiatrist might help him to feel better. As he spoke of his grave fears about the proposed operation and then described his life and work, a picture of him emerged as a steady, reliable, responsible, planful, conscientious person, who approached decisions gradually. He had run his own business for many years with great resiliency in the face of setbacks, and had then taken over direction of a section of a larger enterprise, strongly identifying himself with the management. His positive appreciation of his former private surgeon contrasted with his feeling that the younger ward physicians were inconsiderate and "walked away'' from him at rounds. The psychiatric discussion and formulation centered upon the patient's compulsive personality structure and his seniority.

It was emphasized to the surgical staff that Mr. B felt disappointed and anxious because of the stress of his prolonged illness and reacted to pressure with indecisiveness and obstinacy, characteristic for the compulsive personality under stress. Accordingly, it was important to approach him in such a way as to permit him to use his careful, planful method of proceeding in order to deal with his anxieties adequately. He should not be pushed but rather be allowed further time to make up his mind about the operation. His questions were to be answered carefully, thoroughly, as often as necessary, and as unhurriedly as possible. With regard to his seniority and self-esteem, it was apparent that his transfer to the ward service had deprived him of the direct care of his private surgeon and he had found it difficult to establish a close relationship with the ward "management" in his accustomed manner. To correct this, it was to be suggested to the patient that if he felt anyone avoided answering his questions he did not have to accept this as final. In such circumstances he could make an appointment with the doctor to see him at a convenient time, e.g., after the rounds were completed. The doctors would try to establish clearly that the patient took an appropriate amount of responsibility in accepting or rejecting

surgical recommendations.

As it turned out, following discussion along these lines between the consultant, the surgeons, the patient and his sister, Mr. B decided to permit the operation. Afterwards, he expressed appreciation of the talks with the psychiatrist and the surgeons because they had shown him how he could be strong. He was now functioning as an active, self-disciplined, effective compulsive type of personality, utilizing his rational and systematic abilities. The only clear elements of clarification and support (directed to his self-esteem) were expressed in acknowledging to him that his present anxiety at the prospect of a relatively minor surgical procedure could be understood in light of the strain and discomfort of the long illness (which he had actually borne in a good spirit).

The method of basic support is sometimes denigrated as being limited to a kind of unskilled, mindless handholding, demeaning to both holder and holdee—as if it required little therapeutic judgment, and as if one could not have a legitimate need to have one's hand held. In the hope of countering this prejudice, my illustration of this technique concerns a highly intelligent and insightful university professor with a national reputation in his field. He had been married for many years and was pleased with the way his children had turned out.

At 65, Professor C was facing the pressure of imposed partial retirement, with loss of the security of tenure, the recent appearance of symptoms suspected to be heart disease, and his wife's anxiety in response to these developments. He questioned whether her current anxieties and some related tensions between them were at least partly his fault. Both he and his wife had benefitted from psychotherapy directed toward structural change in the past, before middle age. Interestingly, he had recently discontinued psychotherapy after a brief trial, because he felt his former therapist had been too talkative and too supportive, that is, too directive. He was concerned that his cardiologist tended to see the diagnostic possibilities and treatment indications in an all or nothing fashion. His impressions were accurate but also reflected his personal needs and sensitivities.

He understood that these feelings were related to his experience with his parents. His father had set an example of effective, professional, hard work, had encouraged his talent, had given him reams of advice and pressured him to be outstanding, was very stern, and had episodes of rage. The patient had identified strongly with his father's ways and values but reacted to his pressure at times by becoming stubbornly overcautious. His relationship with his mother had been very close and loving, and he took care of her in her late years until her death. This attitude of responsibility was continued with his young and admiring wife.

Although he did not specify how he thought psychotherapy could help, it was clear that advice was the last thing he needed. He utilized the sessions to air his concerns and get his bearings. One of the leading issues was the challenge to his self-esteem posed by the threats of illness (he had been quite athletic) and financial insecurity. He had strong feelings about the administrative opposition he encountered at the university where he believed that his contribution, which represented a special tradition of teaching in his discipline, was not well recognized. Here his insight and mature strength of personality proved useful. He said that he had recognized long ago that he was not the most celebrated living individual in his field. He was aware that when the urge to become famous was compelling he tended to overwork and to criticize himself. This awareness helped him to ease up and to regain his objectivity. In relatively few sessions he outlined his problems, expressed many feelings, remastered his revived conflicts, and then dealt with the realistic pressure that he faced. The therapist responded by indicating his understanding and trying to understand more, and by acknowledging the patient's expressions of feelings, attempted solutions, and frustrations and gains. These were supportive elements, gaining their effectiveness largely from a maternal transference. The therapist responded explicitly to Professor C's competence and experience, evident not only in his professional activities but in many of the ways in which he managed his life. This was an adaptive intervention. The therapist clarified issues which seemed most important, such as those bearing on the patient's self-esteem. Finally, the

therapist accepted certain limitations of their therapeutic effort, for example, when his tension with his wife required joint sessions which were undertaken with his wife's therapist. It is significant that, despite persisting conflicts, the patient saw himself appropriately within his age group with regard to issues of achievement and prestige. He told a charming anecdote in which one distinguished man reminds another that, unlike younger people, the latter no longer has to struggle to establish his position in the world.

A Comparison of Aging and Debilitated Patients

Among 16 patients treated in my practice, 11 women and five men ranging in age from late middle life to mid 70's, half were in the aging group, three intermediate, and five in the debilitated aged category. None was permanently institutionalized in hospitals, nursing homes or special residences. Almost all suffered some form of depression. In the aging group depression ranged from reactive (neurotic) to psychotic and paranoid. The intermediate group included one psychotic, paranoid depression and one of moderate severity, between neurosis and psychosis. All five of the debilitated patients had depressions, in two cases associated with senile brain disease. Three of these were anaclitic depressions associated with depletion of functions and satisfactions, while one was an agitated depression and another a deepening of chronic depression. With regard to diagnoses other than depression, two patients in the aging group had states of tension, another proved to have normal grief and a fourth was phobic. One of the patients in the intermediate category presented the surgical management problem cited above.

The precipitating causes of these problems were mainly personal losses and physical disorders. The aging patients were reacting to losses of mother, husband or brother, to physical or mental illness of a close relative, or to retirement from work. In the intermediate group two had physical illnesses and one was widowed. Brain damage and physical aging were the leading precipitants among the debilitated, followed by illness of a close relative, death of

a spouse or retirement from work. A range of personality types was found in all groups, but in this small series the only hysterical types were among the aging, while the debilitated showed more oral behavior.

In keeping with the findings of others, structural change as the principal therapeutic aim was found only in the aging group. The aim of reinstatement of optimum functioning was important in all three groups and was the only aim in the intermediate or crisis sample. Offering basic support was a major aim in the treatment of the debilitated, but it was also employed significantly with the aging. Assistance to and through the family was a treatment aim in most of the debilitated patients. Prevention of future suffering, maladaptation or breakdown was a principal consideration in the aging and intermediate groups in relation to widowhood, preparation for retirement, the regression promoting threat of physical illness, and changes in a marital relationship. Regarding duration of treatment, there was no clear pattern among the three categories, whether brief (under three months), average (up to three years) or long-term (over three years). I was surprised to find that half of my aging patients were in the brief category and that most of the patients in the debilitated group were seen for an average length of time. In the aging group, one of my long-term patients had subsequent unterminated maintenance therapy at monthly intervals, while one of the intermediate category patients was treated for an average duration and then seen in follow-up twice a year until her death 15 years later.

To recapitulate and highlight these observations according to each group, psychotherapy of the *aging* was aimed at structural change, restitution of personality functioning or basic support. These patients had neurotic or psychotic depressions, other neuroses or adjustment reactions, often precipitated by personal losses or retirement. They represented a full range of personality types. Prevention of future disturbance was an important consideration. In the *intermediate* group, the aim of treatment was restitution of optimum functioning. Illnesses were of crisis proportions in reaction to physical diseases or personal losses, and prevention was a common goal. The *debilitated*

aged responded to measures of basic support for treatment of anaclitic depressions set off by brain damage, physical aging or multiple personal losses. They often showed oral personality traits. Their families had a significant role in their treatment.

The Management of Crises

Zinberg (19) observed how frequently a psychiatric referral of an older patient involved an emergency. Psychiatric emergencies at any age may require considerable involvement with members of the patient's family, time spent in telephoning, and pressures for immediate help, with insight taking second place to dealing with problems of the moment. The number of emergencies one sees in practice is, naturally, a function of where and how one practices. However, it is my impression that these circumstances often prevail with older people and especially with the debilitated aged.

The fundamental therapeutic injunctions to safeguard life and functioning, and to do no harm, as they are followed in geriatric psychiatry, have certain implications which are highlighted in crisis situations. On the one hand, emergencies, whether of confusion, anxious agitation, incipient or acute psychosis, or suicidal despair, call for rapid, concentrated intervention. At the same time, the limited adaptability, poor tolerance of painful affects, and potential for ego regression shown by elderly, and especially by debilitated patients, dictate that we intervene in ways that are the least disruptive of the individual's familiar life-style. The threat of suicide requires, of course, stringent protective measures—we are reminded of the high incidence of completed suicide in older men. States of confusion call for thorough medical investigation, often in the hospital. Acute psychoses may only be manageable in an institution. Otherwise, if possible, we try to keep the patient at home and treat him or her in the office. We help mobilize the support of close relatives whom the patient trusts, and we communicate and present ourselves in ways that are familiar and understandable to the patient.

A 75-year-old woman who became confused after an operation for cataracts was managed entirely by restructuring her environment. It was her first hospitalization, and separation from her home and family played a major role in her postoperative reaction. The surgeon had gained her cooperation by a preparatory discussion of the procedure, and he prevented more serious delirium by avoiding any blindfolding. When she became frightened and noisy she was moved to a private room away from gravely ill patients. A small night light and side rails on her bed were provided. Restraints were not used. Her daughters took turns staying with her during the day and sleeping overnight, while other visitors were restricted. The patient had been a mildly anxious, slightly overdevoted mother and now her children, in turn, found it easy to be protective, even a little overprotective, toward her. Under this regime she calmed down, believing that she was in her eldest daughter's home. She was discharged with a clearing sensorium after the minimum of hospitalization.

The principle of keeping interventions to a necessary minimum has its parallel at the physiological level where medications for anxiety and mood disorders are prescribed cautiously, in small initial doses, while we monitor carefully for any side effects to which these older patients may be sensitive. Psychotherapy, resting upon the patient's consent and collaboration, is the least interfering form of treatment. The use of psychotherapy is almost indispensable, even when the principal treatment is medication or electroconvulsive therapy. At a minimum, it constitutes the basic support necessary to have patients accept and continue with other methods. When communication with the patient is severely limited due to brain disorder or psychosis, then psychologically correct measures of environmental support are necessary, as we saw in the preceding example.

The combination of drug treatment and psychotherapy is often employed in the management of emergencies. A 65-year-old woman with an intense, worsening depression had the kind of symptoms that often respond to medication. She suffered from insomnia, tenseness and lack of enjoyment, was

slowed down in speech and action, and felt ashamed of her condition. These complaints had begun a year before and had become more severe. Despite all this she was well-groomed and attractive in appearance. She lacked insight into any predisposing or precipitating causes of her depression. For example, she did not connect it with the death of her mother three years before. Mother, she said, was a nice person, who died in her old age after an illness of a few days, and "I got over my grief." Referral came through a former therapist of her oldest son, and this son accompanied her on the first two visits. Her husband, in his late 70's and retired from work, came in with her each time. She had had a thorough medical workup and had taken on prescription a number of standard antidepressants and tranquilizers. Despite the apparently correct indications for these medications, they had not brought relief. The patient was seen six times in all, twice in the first week, then at two-week and finally one month intervals, with a telephone follow-up.

In the interviews she quickly expressed an intense preoccupation with an elderly woman relative. They had had a misunderstanding dating back several years over a wedding gift given by the patient to this relative's grandson. The patient had meant to send a check but had accidentally mailed an empty envelope, and had then corrected this error. The relative's response, as the patient saw it, was to avoid attending the funeral of the patient's mother. Also, she had not sent gifts when the patient's grandchildren were born. The patient felt terribly guilty that she had, in turn, reacted by avoiding a baby shower for this relative's great grandson. Subsequent efforts by the patient at reconciliation had been rebuffed. Moreover, this woman's daughter, in her 40's and recently widowed, had also refused to see her. The patient could not answer why this troubled relationship was having such a drastic, lasting impact upon her.

She had grown up in a strictly regulated home as part of a small, stable ethnic community. She believed that, of all her siblings, she had been closest to her mother. Her marriage at 17 was arranged by a matchmaker. For the next 15 years her mother-in-law had lived out her life with her. The patient's existence

had centered around raising her sons, visits with nearby relatives, attending a women's group of her church, and enjoying some handicrafts. Her mother, in the same city, was very demanding of attention by her children. The patient remarked that she has tried not to be this way with her children. However, it is lonely without a daughter. Her oldest son's wife is rather independent and the patient has to telephone before she goes over.

At 15, when her mother became ill and unable to work outside the home, the patient left school to take a job in a factory where she contracted a severe case of skin disorder, an eczema that involved her hands and was believed due to contact with an industrial chemical. After her last son was born, she had two miscarriages and then, following her doctor's recommendation, had tubal ligations. This had saddened her; she wondered if one of the miscarriages had been a daughter. Completing the relevant medical history, at 38 she had had a previous depression but snapped out of it after two shock treatments. It was not clear whether this was related to the loss of pregnancies and the sterilization.

At the end of the first hour the therapist prescribed antidepressant and sleep medication, employing drugs that had been given her before. Five days later she reported feeling calmer and sleeping well except for one night. She continued to speak about her elderly relative, and it was learned that this woman carried grudges and had avoided other funerals of family members. The patient's son provided additional information tending to confirm the therapist's hunch that this elderly woman relative was seriously ill physically and probably had a severe personality disorder; both she and her daughter wanted the patient to stay away. The therapist recommended strongly to the patient that she stop pursuing a reconciliation, suggesting that she had done all the proper things and that this was a kind of misunderstanding which could not be resolved in a reasonable fashion at this time. In the absence of side effects, the dosage of medication was increased.

A week later she was more alert and cheerful. She read some notes that she

had made regarding her attempts to make up with her relative. The therapist reinforced his recommendation that she put aside this effort. On her fourth visit, two weeks later, she reported herself as back to normal. She complained that her husband doesn't go out of the house very much, implying that this limited her own mobility. The therapist suggested that she may need more outside activities and contact with friends, particularly women. He spoke with her about the death of her mother, putting forward the suggestion that she had reacted as most people do with feelings of loss, need, disappointment and even anger, and with an attempt at symbolic replacement of her mother. He said that he thought this was behind the pressure of her efforts to reconcile with the older woman relative. She listened but did not confirm or deny this.

A month later she had maintained her gains, and she described having had an enjoyable Christmas celebration. During the previous hour she had inquired about the therapist's name and its origins. Now, in a friendly way, she asked whether he had enjoyed the Jewish celebration of Hanukkah. The pressure to see her relative had abated. It was agreed to meet again in a month and then, if she had maintained her improvement, to terminate therapy and discontinue the medication.

At the final meeting she was looking and feeling well. The therapist complimented her on her appearance. She reported memories of her mother which had come back, accompanied by tears, during the Christmas and New Year holidays. Then she told more about the stresses which she had experienced in the preceding years. Two of her sons had divorced nine or ten years before. She had had good relations with these daughters-in-law and still kept in touch with one and with a grandson. However, she had lost touch completely with the other daughter-in-law and with a granddaughter.

In her late 40's she had taken a factory job and had held it until three or four years ago, when she gave it up with the plan of enjoying traveling with her husband. Then mother died and her husband became "too old" and sedentary for

this recreation. Now he is “her job” but she feels lonely. She was encouraged again to resume outside activities. The dosage of her medication was reduced and a date set to discontinue it. A week later she telephoned and said that she would like to stop all medication. It was agreed that she should. She was most appreciative of the help that she had received.

In this case, rapid intervention using psychotherapy and medication relieved an incipient crisis of worsening depression. It was essential to understand that the dynamic basis of her reaction was an unresolved grief reaction with attempted restitution of her loss through a current relationship. The relationship with her elderly relative was burdened with displaced ambivalent feelings, and was doubly unsuitable because of the relative’s own personality disorder. The support for undertaking therapy given by the patient’s son and the information that he supplied were essential. Suggestion, guidance, manipulation, and some clarification were utilized in the psychotherapy. The patient’s son reinforced her belief in the expert power of the therapist, a basis of suggestion. Intervention to help her calm down and distance the relationship with her relative may be considered a form of guidance. The therapist approached her severe superego reaction manipulatively by giving her credit for her good intentions toward her relative. The patient’s experience of grief during therapy tended to confirm the dynamic formulation and indicated some response to clarification. Previously medication alone had not been sufficient, but together with this psychotherapeutic approach it became effective.

Various Dimensions of Psychotherapy with the Aging and Elderly

In recent years a number of reviews and detailed reports of psychotherapy with older persons have enriched our understanding of the process and its applications.

M. P. Lawton (20) notes some frequent characteristics of older patients that may signal the desirability of particular approaches to therapy. Older people tend

to be relatively low in educational attainment as compared with younger ones, unfamiliar with psychological concepts, resistant to the idea of psychological assistance, and rejecting of moral liberalism. This suggests that the therapist must be careful in his choice of words, cautious in inviting older patients to explore tabooed feelings, and not too ready to assume that psychological explanations will be comprehensible. It may be better not to generalize too abstractly or to rely upon analogies and metaphors. Poorly structured interviews and the use of ambiguity may elicit anxiety and overcautiousness. Support may be necessary to maximize the older patient's ability to pursue problem solutions in his own way. The pace of therapy will often be slower than with younger persons. The therapist must tread between acknowledgment of the patient's limitations and succumbing to overgeneralized, ageistic devaluation of his patient. It appears that Lawton's observations are especially applicable to the debilitated aged.

Berezin and Fern (21) described a 70-year-old woman with a hysterical character disorder who was admitted to a mental hospital because of increasing alcoholism. She was seen initially because she had become a management problem. Psychotherapy twice weekly for 15 months enabled her to partially work through some early, persistent conflicts, so that she could function in less regressive ways and eventually make a satisfactory adjustment in a nursing home. During psychotherapy the availability of conflictual material, in the form of early memories and fantasies with their corresponding affects, was striking. As the discussants of this paper note, therapy enabled her to accept her age, i.e., that she was no longer adolescent. There is an interesting discussion of the use of transference in psychotherapy of older persons.

A beautifully written depiction of an eight-month treatment of a 66-year-old woman with a hysterical neurosis by Gitelson (22) highlights her transference reactions and the therapist's responses.

Hauser (23) details the treatment of a 78-year-old woman, utilizing

psychotherapy and ECT. She had her first paranoid depression at age 59. Among important issues in her life and therapy were her fear of being abandoned and left helpless, her overdependence and the need to be in control of personal relationships, her suppressed anger, a strongly sexualized transference, and her enormous effort to deny aging.

Zarsky and Blau (24) describe the response to two brief periods of therapy of a woman with a lifelong narcissistic character neurosis, reacting to the death of her favorite son. During periods of regression she showed clinging dependence, insatiable overentitlement, and endless rage and blamefulness. When functioning better, she was dominating, bright, charming and entertaining, with a capacity for making and losing friends. Treatment was at ages 60 and 70 with a five-year follow-up. The paper and discussions consider the psychotherapeutic measures that helped reverse the process of regression. Differential diagnosis and therapeutic aspects are taken up.

Ronch and Maizler (25) agree that insight-oriented, dynamically based individual psychotherapy is an effective treatment modality with the institutionalized elderly. A crucial area in such psychotherapy is the heightened resurgence of dependency conflicts because of the institutionalization itself. One must deal with increased manifestations of ambivalence and anger toward the staff, and the correlated fear of abandonment. The treatment of a paranoid, suicidal depression in a man with Alzheimer's disease is cited. After about a year the patient moved from a protected psychiatric facility up to the second highest level of self-care of eleven levels of progressive care in the institution. The technique of reality orientation was also used to solidify his gains in judgment, memory, intellect and orientation. Another example is of a 69-year-old woman with overdemanding behavior, depression, pain and anxiety following a spinal operation. She perceived therapy as a magical rescue. Environmental measures, adaptive intervention and clarification met with considerable success.

Hasenbush (26) reported the successful brief therapy of a retired elderly

man with intractable pain, depression, and drug and alcohol dependence. I think of this case as belonging to a category of patients who seem impossible to treat, but turn out, unexpectedly, to have some capacity for improvement. In some instances their psychopathology appears longstanding and deeply fixed. I have seen such patients whose chronic anaclitic depressions have worsened, increasing their suffering and distressing their families or others in their environment. Supportive psychotherapy and medication gave enough relief to make their condition tolerable. In other cases, life circumstances are the principal burdening and limiting factors. A woman in this group, with a reactive depression stemming from taking care of her husband who had Alzheimer's disease, was able to find some relief by ventilating her feelings of frustration. A man attached to his wife, despite her refusal of sexual intercourse, was able to manage by returning to a previous extramarital relationship. Dr. Hasenbush's patient seemed to belong to the first group with serious psychopathology. This 72-year-old man with lifelong character problems had retired from work seven years previously. Since then, he had suffered severe burning pain in a foot for six years, had not improved with two peripheral nerve operations, spinal blocks and 30 electric shock treatments, and had withdrawn to a bed and chair existence, depending upon increasing amounts of codeine, tranquilizers and alcohol. Despite all of this, there were some hopeful indications. The interdependence of needs and the matching of personality styles between the patient and his wife could be approached in concurrent therapy of both. Treatment in later life was facilitated by the psychoanalysis of each partner approximately 30 years before, even though the results of analysis had been limited.

Hypochondriasis is one of the typical disturbing symptoms of older people, and in its most common form reflects neurosis or borderline disorder rather than psychosis. It is often resistant to treatment. Busse and Pfeiffer (27) outline an approach to the treatment of this symptom by the family doctor or internist. They point out the limitations and drawbacks of giving the patient a full medical explanation or an organic diagnosis, of offering a psychiatric formulation of his

condition, or of doing surgical procedures. Effective techniques include listening, respecting defenses, and conveying recognition that the patient is indeed sick and the assurance that he will be cared for. The use of medication, handling of relatives, and the conduct and spacing of interviews are discussed.

Da Silva (28) describes the treatment of a man with manic-depressive illness, seen in a state hospital between the ages of 81 and 84. The paper, which should be read together with the discussions that follow it, gives a moving and impressive picture of the patient's deep, longstanding loneliness, the correlation of his life history with his personality and psychopathology in old age, the ways in which he related himself to his therapist, and the strong feelings he evoked in his therapist. His images and concepts of death are of particular interest. Treatment moved from a phase in which he denied his oncoming death to one in which he gave up the denial, reviewed and examined his life, and in effect prepared for dying. Psychotherapy appears as a means of prolonging and enriching life.

Myerson (29) discusses two cases of psychotherapeutic management of terminal illness, one involving an 85-year-old woman (30). He concentrates upon the personal hazards for the therapist of intense involvement with a dying person. He observes that we have come to believe that, in general, the dying patient is better off if he has the opportunity to talk about his impending death, and can be supported by the caring presence of people who respect his dignity. In dynamic psychotherapy, the patient's desire for explicit reciprocation of transference love felt for the therapist cannot be gratified. The borderline patient has poor tolerance for this frustration. Intense therapeutic relationships with dying patients run the risk of creating a borderline situation. It is often not possible to analyze and work out the patient's transference feelings under these circumstances. The therapist senses that the patient wants more from him than he can provide. This is the level of distress that is peculiar to professionals. We are forced to frustrate people who have needs that cannot be met, and we feel guilty—in part because we recognize that we have implicitly promised that we

would give what is desired of us.

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