INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the original text directly from the copy submitted. Thus, some dissertation copies are in typewriter face, while others may be from a computer printer.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyrighted material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each oversize page is available as one exposure on a standard 35 mm slide or as a 17" × 23" black and white photographic print for an additional charge.

Photographs included in the original manuscript have been reproduced xerographically in this copy. 35 mm slides or 6" × 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Accessing the World's Information since 1938

300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA

Order Number 8820912

Psychoanalysis of over-sixty patients: Its coming of age

Wilk, Sondra Ellen, Ph.D.

City University of New York, 1988

Copyright ©1988 by Wilk, Sondra Ellen. All rights reserved.

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

PLEASE NOTE:

In all cases this material has been filmed in the best possible way from the available copy. Problems encountered with this document have been identified here with a check mark __√__.

1. Glossy photographs or pages _____
2. Colored illustrations, paper or print _____
3. Photographs with dark background _____
4. Illustrations are poor copy _____
5. Pages with black marks, not original copy _____
6. Print shows through as there is text on both sides of page _____
7. Indistinct, broken or small print on several pages __✓__
8. Print exceeds margin requirements _____
9. Tightly bound copy with print lost in spine _____
10. Computer printout pages with indistinct print _____
11. Page(s) _____ lacking when material received, and not available from school or author.
12. Page(s) _____ seem to be missing in numbering only as text follows.
13. Two pages numbered _____. Text follows.
14. Curling and wrinkled pages _____
15. Dissertation contains pages with print at a slant, filmed as received __✓__
16. Other _____

PSYCHOANALYSIS OF OVER-SIXTY PATIENTS: ITS COMING OF AGE

by

Sondra E. Wilk

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1988

© 1988

SONDRA WILK

All rights reserved

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

12/29/87
Date

Laurence J. Gould
Chair of Examining Committee

January 27, 1988
Date

Herbert D. Saltzstein
Executive Officer

Louis Gerstman, Ph.D.

Marylou Lionells, Ph.D.

Hazel Weinberg, M.D.

Supervisory Committee

The City University of New York

Abstract

PSYCHOANALYSIS OF OVER-SIXTY PATIENTS:
ITS COMING OF AGE

by

SONDRA E. WILK

Advisor: Laurence J. Gould, Ph.D.

The aging of the population has focused attention on Western culture's negative attitudes toward the elderly. Psychoanalysts too have begun to examine their beliefs about this age group and psychoanalytic treatment.

This study examined the beliefs of six psychoanalysts each of whom had been treating patients over the age of sixty for several years. The purpose of the study was to learn as much as possible about the analysts' perceptions of psychoanalytic work with their over-sixty patients as compared with their over-thirty patients. A semi-structured in-depth interview was used to encourage the analysts to think about their work freely. To avoid the ongoing controversy over the definitive interpretation of "psychoanalysis" the subjects were permitted to define psychoanalysis or psychoanalytic psychotherapy of the elderly relative to their understanding of and use of this modality with their other patients.

The major finding was that these six subjects do productive psychoanalytic work with their over-sixty

patients with little or no modification of their usual methods of treatment. They treat the older patient "psychoanalytically" in very much the same manner that they treat younger patients. Widespread negative societal prejudice toward the elderly did not affect the decision to treat nor did it impede the treatment itself.

ACKNOWLEDGMENTS

Like all dissertations this study reflects the assistance and support of many people. Each person in his or her own fashion made essential contributions to the completion of this work.

My deepest gratitude goes to the "Institute" and to its Director (both unidentified for reasons of confidentiality) whose unfailing emotional, psychological and financial support made this entire enterprise possible. My debt to the organization, and most especially to its insightful and generous Director, can never be repaid.

I am also deeply appreciative of the singular contributions of:

"Dr. Adams"
Dr. "Brenda"
Dr. "Carrie"
Allan Cassorla, Ph.D.
Dr. "Delia"
Ms. Mary Encarnacion
Dr. "Ernest"
Dr. "Fireman"
Louis Gerstman, Ph.D.
Laurence J. Gould, Ph.D.
Mr. Edson Hoel
Joan Levine, Ph.D.
Marylou Lionells, Ph.D.
Over-Sixty Patients
Mr. Jose Naranjo
Mrs. Florence Schneider
Hazel Weinberg, M.D.
Daniel Levinson Wilk
David Levinson Wilk

For his incomparable wit, his unrelenting patience and his stubborn commitment to my goal, and for her intelligent and devoted attention to my needs, this dissertation is dedicated to my dear friend Larry Fucscher, Ph.D. and to my peerless sister Betty Levinson, J.D.

PREFACE

Like the late age patient, this dissertation has a longer history than most. It actually began some six years ago following an initial attempt to begin a psychoanalytic - psychotherapy service for people over sixty, at a known northeastern psychoanalytic training center. Commenting on the prevalence of age bias in American society (and wondering if it would affect the development of the program) I shared my concerns with a then thirty-five-year-old graduate psychoanalyst of that Institute. Not only was he totally disinterested in the service, but he was genuinely perplexed at my subsequent notion that I study the prevalence and sources of age bias in mental health professionals. "There's no study in that", he said, "what psychoanalyst would want to treat the elderly." When I asked why not, he turned his face upwards and asked some unseen presence if I were kidding. When no one answered, he shrugged and departed. I was left to wonder just how typical or atypical his spontaneous reaction had been. Another psychologist, a thirty-nine-year-old friend who has enjoyed working with the one sixty-four-year-old patient in her practice, and thinks of herself as having little prejudice in this area, asked me with obvious sincerity if I thought analysts might be reluctant to work with the elderly not because they are old, but in fact because they are ugly. "So you think old people are ugly," I said. There was a long pause as she struggled

with her awareness that this might be a value judgement. "I know what you're trying to say," she said, "but most old people are ugly." I stared at the bust of the old and venerated Albert Einstein set midway between us on my desk. She followed my gaze and added quickly, "Well, not Einstein!" The problem of age bias among psychoanalysts was becoming more intriguing for me.

In the inchoate psychoanalytic-psychotherapy service mentioned above, 32 psychoanalysts and psychoanalytic candidates (out of a possible 300+) had agreed to donate one to two hours minimum per week to the treatment of the elderly. Though their reasons for doing so were complex and multidetermined, many of the volunteers had a decided interest in, and real wish to work with this age group. Why some and why not others? I thought I had my dissertation. The tentative title was, "Psychoanalysts' Countertransferential Attitudes in Relation to Aging and to Their Willingness to Work with Elderly Patients." The study proposed to explore countertransferential and attitudinal considerations among psychoanalysts in relation to the aging process, the sources of such attitudes, and the relation of such attitudes to the analyst's willingness to work with elderly patients. The section concerning willingness to work with elderly patients nagged at me. The data was to be collected in questionnaire form. I found myself continually re-working

the section of the questionnaire dealing with the analyst's willingness to work with the elderly and, moreover, moving toward irrelevant (if not ridiculous) areas to gather my information. So, for example, I formulated the following question:

> You are offered an opportunity to consult or do research at a known facility for a satisfactory fee. You may choose to work in one of 5 specialty programs.
>
> Please rank in order of preference:
>
> a. Depression Research and Treatment
> b. Adolescent Outpatient Services
> c. Adult Outpatient Services
> d. Geriatric Outpatient Program
> e. Alcoholism Treatment

I recognized that I was asking psychoanalysts to make a choice about an extremely remote hypothetical situation, only because I believed that it would be useless to solicit such choices in terms of a private practice model. The analysts I knew were simply not refusing private referrals on the basis of age alone. In other words, I became convinced that prejudice and theoretical bias not withstanding, much useful psychoanalytically informed work with the elderly was actually being done. And, given the fact that such work was being done, my interest shifted to the question of whether it in any way differed from the psychoanalytic work done with younger patients. I was certain that this type of inquiry would be more useful to psychoanalysts and to their present and future elderly patients than would an investigation into the range and sources of age bias among analysts. I decided that I

would interview psychoanalysts from the above mentioned institute who were working psychoanalytically with any patients over the age of sixty.

My interests came to focus on the following questions:

1) How did the psychoanalyst come to be treating elderly patients? What effect, if any, did societal or professional prejudice have on the psychoanalyst's initial decision to treat elderly patients psychoanalytically?

2) Did psychoanalysts have any preconceived notions about their elderly patients prior to beginning work with them?

3) Did analytic work with the elderly differ in significant ways from analytic work with younger (let us say, over-thirty) patients? For example, excluding individual differences, was the content different in essential ways from that presented by younger patients? Were the transference reactions of older patients markedly different from those of younger patients? Were consistent modifications in technique in any way mandated by considerations of age?

4) What effect did societal or professional prejudice have on the psychoanalyst's attitude towards his patients during treatment. In other words, were there particular countertransferential difficulties. Were there particular countertransferential responses elicited by transference reactions characteristic of older patients?

In addition it seemed useful to obtain a case history from each of the analysts I proposed to interview so that the difficulties of a number of "over-sixty" patients could be examined within the context of the patients' life histories. If, for example, an analyst were to report that each of his over-sixty patients had presented with

problems of impotence the information might be understood differently if the analyst were to add that all of these patients had been sexually dysfunctional at the age of thirty.

This example incidentally, while fictitious, was not chosen arbitrarily. There exists in this culture an entire mythology of aging a small part of which concerns itself with impotence in the elderly (who are often viewed as impotent in more ways than one.) I soon came to understand that the specific questions of efficacy and technique in the psychoanalysis of the elderly are embedded within the social context of broader issues of ageism and societal prejudice toward the elderly. And, moreover, that the perennial question, "What is psychoanalysis?" took on a particular significance with respect to the elderly patient. It therefore became apparent, that the specific questions that I was interested in exploring could not be answered without adequate appreciation of the magnitude of social prejudice.

And if we return for a moment to that perennial question (i.e. what is psychoanalysis?) we find that there is no unmistakable answer. When it comes to defining psychoanalysis there is, as Levenson (1985) has written, great "dissarray in the ranks." A brief anecdote will illustrate. In August of 1985 a reporter, doing a short piece on the psychoanalytic institute at which the

subjects of this study trained, interviewed three senior analysts about their conceptions of psychoanalysis. The reporter thought he had found a common definition of psychoanalysis, as currently practiced, among the three senior analysts he had just interviewed. Proceeding to the fourth analyst interviewee, the reporter happily shared his conceptual "discovery", and waited for confirmation. The response of the fourth analyst was sobering. "That may indeed be what all of them do," she said referring to the first three, "but you can't call it psychoanalysis". I decided therefore, that for my purposes, the psychoanalysts I interviewed could define psychoanalysis or psychoanalytic psychotherapy of the elderly, relative to their understanding of and use of this modality with their other patients.

TABLE OF CONTENTS

Chapter

1 INTRODUCTION and METHODOLOGY.................... 1

Psychoanalysis, Aging and their Contexts......... 1
The Older Adult is Underserved by the Mental Health System.......................... 7
Evidence that the Elderly Can be Helped by Various Forms of Psychotherapy Including Psychoanalysis 11
Summary.................................... 13
Methodology 14
Subjects................................... 16
Procedure.................................. 18
Data Analysis.............................. 21

2 A REVIEW OF THE LITERATURE....................... 23

The Elderly and Society.......................... 24
Who is Old?................................ 24
Summary................................... 29
Old Age: Stigma and Stereotypy............... 30
The Developmental Tasks of Late Adulthood..... 34
Summary................................... 39

Research Attitudes Toward the Aged............... 39
Attitudes of the General Population Toward the Elderly........................ 40
Attitudes of Professionals Toward the Elderly.............................. 42
Summary of Findings.......................... 47

Psychoanalysis and the Elderly.................. 48
The Early Historical Perspective............. 49
Summary................................... 58
The Influence of Changes Occuring in Psychoanalysis and Psychotherapy on Dynamic Work with the Elderly............. 59
Some Later Writers - 1950's through 1970's.... 63
Summary................................... 77
The 1980's................................. 79
Countertransference........................ 96

3 BEGINNINGS; WHAT THE ANALYST BRINGS TO THE TREATMENT; WHAT THE PATIENT BRINGS TO THE TREATMENT..................................113

A Brief Introduction to the Subjects and to the Data....................................113
Analysts' Motivation for Working with the Elderly: Influencing Factors..................114
Selection of the Elderly Patient--Do Analysts Look for "Special" Attributes in their Elderly Patients?............................130
Presenting Problems of Older Patients: Do they Differ from Those of Younger Patients?...133
Illness and Death.............................134
Loss and Depression...........................136
Taking Stock: The Meaning of Life and the Urgency of Unfulfilled Desires.............138
Combatting Social Prejudice...................140
The Elderly Patient: Six Case Histories--A Study in Diversity............................142
Summary...147

4 THE PSYCHOANALYTIC PROCESS--THEORY: HOW PSYCHOANALYSTS THINK ABOUT THEIR OLDER PATIENTS.....148

Do Analysts Consider their Work with Older Patients to be Psychoanalytic?..........148
Initial Differences.............................149
Treatment Goals: Do they Differ from those for Younger Patients?..................152
The Patient's Narrative: The Constellation of Emerging Patterns in the Elderly as Compared with Younger Patients.........................161
The Relative Importance of Early versus Later Experiences on the Personality or Pathology of the Patient.. 164
Aspects of the Personality in Relation to the Aging Process.................................169
Character and Defenses 169
Narcissism 171
Dependency Needs.............................174
Envy..174
Guilt...177
Concerns of the Older Patient: God, Sex, Sickness and Money?....................................178
Summary...182

5 THE PSYCHOANALYTIC PROCESS--PRACTICE: WHAT PSYCHOANALYSTS DO WITH THEIR OLDER PATIENTS...184

Analytic Technique: Differences or Modifications Based on Differences in the Patient's Age.....184
Working with Dreams.............................193
Characterizing Movement in the Older Patient's Treatment......................................195
Transference Issues.............................199
Countertransference Issues......................203

The Impact of Working with Over-Sixty Patients on the Lives of these Analysts................209
The Influence of Theory on the Work of these Six Analysts with their Older Patients........213
The Components of Successful Aging: What does Practice with Older Patients Teach Us?........219

6 SUMMARY AND CONCLUSIONS............................225

The Impact of Social Prejudice on the Decision to Treat..228
Selection of the Elderly Patient.................232
Presenting Problems..............................233
Psychoanalyzing the Over-Sixty Patient: the Work Itself....................................237
Initial Differences 238
Setting Goals.....................................240
The Patient's Narrative..........................242
The Relative Importance of Early versus Late Experience...............................243
Early Experience and Affect....................246
Aspects of the Personality and Defensive Styles in Relation to the Aging Process.......247
Character and Defenses 247
Narcissism.......................................248
Dependency Needs, Envy and Guilt 249
Sex..250
Analytic Technique: Differences or Modifications Based on Differences in the Patient's Age.....251
Characterizing Movement in the Older Person's Treatment.....................................255
Transference Issues..............................256
Countertransference Issues.......................259
The Influence of Theory On the Analyts's Work...264
Final Comments...................................266

Appendix

A SIX CASE HISTORIES..............................270 a

B DEMOGRAPHIC DATA ON THE OVER-SIXTY PATIENTS SEEN BY THE SIX SUBJECTS OF THE STUDY..............333 a

C THE SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE......339 a

Bibliography.......................................343

CHAPTER 1

Introduction and Methodology

As I have stated, the general subject of this dissertation is psychoanalysis and the aging patient. The literature in this area has been scant and much of it has been discouraging regarding the efficacy of psychoanalytic treatment for those over sixty. Only recently has there been anything more than the isolated published report about successful psychoanalytic approaches toward treating the elderly. In fact, much is surmised though little is actually known (or at least divulged) about the nature of this work. This dissertation will illustrate the particular issues encountered by graduate psychoanalysts who are treating their elderly patients with psychoanalytic treatment and who believe that this is a useful way to work with older patients. It should be noted that both psychoanalysis and aging are problematic concepts though each is frequently referred to as if it were clear and indisputable. This assumption of obvious meaning has clouded both the literature and the attitudes of professionals with respect to psychoanalysis and the aging. People assume that they share a common notion of the concept of psychoanalysis or the concept of aging. This is inaccurate.

Psychoanalysis, Aging and their Contexts

This is not merely a study of the views of today's psychoanalysts toward their "older" patients. It is also

an inquiry into the evolution of such attitudes in the history of psychoanalysis and of the influence of the larger social context of which the psychoanalytic movement was a part. It is in the history of psychoanalysis that we first encounter the notion that older people cannot be psychoanalyzed. Part of this attitude was based on a mythology of aging which encouraged a distorted view of the elderly.

For example, I was able to observe the comings and goings of an associate's patients because of the location of my office. One male patient, a tall handsome, tanned, lean, Chief Executive Officer (who often strutted in for his sessions tennis racquet in tow) frequently stopped to chat with me. He proved to be articulate, informed, witty, sharp, rich, married and seventy. I never particularly thought of him as elderly and I don't know if his analyst did. On occasion that patient mentioned a recurrent physical symptom--he had tennis elbow. What's the point? The point is that when people in this society talk about the elderly patient, rarely do they visualize this patient. They tend to base their views on misconceptions that have prevailed for many years. But who is the elderly patient?

Following convention I have defined the "older" patient as "over sixty." Old age may be defined by chronology but this is hardly conclusive. People age

differently. Moreover sixty is not simply thirty years older than thirty. Just as black skin, in this culture, is not simply darker than white. In each case the uses (and misuses) of the past have bearing on the present.

"Old" is not a self-evident category. It is perceived and defined variously, often by cultural pejoratives. Some think that old is sick, or that old is senile, unproductive, rigid forgetful, etc. The elderly, of course, do not conform to such stereotypes, (as Rodin and Langer observed in their 1980 article.) Beliefs and writings about the elderly (and about treatment of the older patient) have often reflected these negative cultural values. Explication of such values is therefore central to this study.

Psychoanalysis is a cultural enterprise--it does not take place in a vacuum. Cultural values are held by the therapist, cultural values are held by the patient and they are also implicit in the theory (Person, 1986). Values may change but their influence cannot be overlooked.

Just as "elderly is not a self-evident category, neither is psychoanalysis. There are many schools of psychoanalysis and their ideologies differ. Even within schools, professionals often disagree strongly about both theory and technique. Therefore, authors discussing the efficacy of psychoanalytic treatment of the elderly haven't always agreed on the meaning of psychoanalysis,

just as they haven't always agreed on the picture of elderly. Their divergences on the subject of psychoanalysis of the elderly were sometimes based on their different understandings of what is meant to be old and of what it meant to do psychoanalysis. These underlying conceptual differences are not always obvious.

If Dr. X stated that elderly people could not be psychoanalyzed he may have had in mind the kind of treatment which insisted upon five times per week, on the couch encounters, the development of a transference neurosis, the absolutely 'neutral' stance of the analyst, and similar parameters which have come to be associated with a "classical" psychoanalysis. Perhaps, in addition, he visualized the elderly patient as a debilitated or cognitively impaired fragile individual with severe and immediate life crises. It would hardly be surprising if he felt that the treatment might not be suitable for the patient. But this is not now, nor has it been, the singular definition of psychoanalysis. Furthermore, this is hardly a description of the typical older patient, although many may have thought so.

In arguing today for the successful extension of psychoanalytic therapy to the elderly it would be arrogant to assume that a giant leap has been taken. Many changes have occurred in the last eighty years. One can cite changes in treatment, in theory, in patients, in beliefs,

in stereotypes, in demographics, in economics, and perhaps in the aged themselves. All are relevant to this study.

Moreover, the ranks of the elderly are swelling. It is projected that by the year 2020 one out of every five Americans will be over the age of sixty-five (Santos & VandenBlos, 1982, preface). The field of aging itself shows parallel growth with a proliferation of literature in the last sixty years that has risen from less than ten publications in 1920 to 653 publications in 1979 (Poon, 1980, p. xiii). The 1980's have been witness to increasing efforts to examine the second half of life. These efforts have raised basic questions regarding concepts and methods used in the study of both the older adult personality and the process of personal adjustment. The "graying" of society has led to increased demand for mental health services for elders but in fundamental respects the mental health profession has not kept pace with the needs of older adults and the development of trained personnel to address the needs of this population has become a major issue.

Aging, unless death prevents it, is a common and inevitable human experience. We shall all ultimately become members of this minority group. Yet in this culture, which places an exaggerated premium on youth, "getting old" is something of a shared national phobia. Billions of dollars are spent in the purchase of talismans to ward off evidence of impending "decrepitism." Wrinkles

are lotioned, creamed, covered with wax strips or lamb placenta, cut by plastic surgeons, sandpapered by dermatologists, or injected with silicone. Body parts which have responded to decades of gravitational pull are hoisted, tucked, reshaped, amplified, reduced. Hair is colored, pasted, woven, transplanted. Potions are swallowed, infused, bathed-in. We complain that the aged are poor workers, unproductive citizens, crotchety mean neighbors, and we tend to think that aging inevitably leads to mental and physical deterioration.

Studies examining such diverse cultural influences as children's and adolescent's literature, contemporary fiction and poetry, and popular jokes, all show evidence of negative stereotypes of the elderly (Rodin, 1980). There are three interrelated aspects to the problem of ageism according to Butler (1980). These are prejudicial attitudes toward the aged and the aging process; actual discriminatory practices against the elderly; and institutional policies which perpetuate stereotypic beliefs.

Of the many myths about aging the view of old age as a disease is perhaps the most insidious. Old age is inevitably associated with physical decrepitude, infirmity, mental failing (senility) and sexual impotence. In fact, it is reported that fewer than five percent of those over sixty-five need to be hospitalized or

institutionalized. The remainder are capable of living productive, self-fulfilling lives (Galton, 1975). Myths about old people abound and lead to the mistaken view that old people are qualitatively different from young people. While many older people do acquire one or more chronic disabling problems, most of these difficulties can be prevented or treated, with restoration of, or stabilization of function. Many problems attributed to aging are often diseases that effect all age groups. Post mortem studies of Korean War casualties produced evidence of coronary heart disease at an average age of twenty-two. High blood pressure affects at least ten percent of the population, old and young (Galton, 1975). Physical changes do accompany aging: diminution of hearing and visual acuity, gradual decline of muscle strength, bone loss, etc. But even here there is evidence that an important percentage of so-called diminished functions of aging can be altered by exercise, diet, or preventive techniques (Galton, 1975).

The Older Adult is Underserved by the Mental Health System

Older adults run a greater risk of mental illness than any other age group (Brink, 1979). The President's Commission on Mental Health in 1978 estimated that one person in four over the age of sixty-five experiences serious psychological difficulty. As recently as 1975, specialized services for the mentally ill elderly were

mandated as a response to the underutilization of community mental health centers by older adults (Gatz, Smyer, & Lawton, 1980). In 1969, four percent of the patient care episodes in community health centers were with adults sixty-five years of age or older. However, older adults at that time comprised over ten percent of the general population. This proportion has remained stable through 1977. Even within the community mental health centers, the older adult was likely to receive a biased sample of the range of services available, for example, group rather than individual therapy, paraprofessional rather than professional therapists.

Several explanations are offered for the underutilization of mental health services by older adults. These include: a) the biases and stereotypes of therapists and other mental health professionals; b) the reluctance of the current cohort of older adults to consider their problems in psychological terms; c) the insufficiency, inappropriateness and expense of mental health services. With respect to the latter, some people have recommended increased budgets and numbers of professionals, while others have questioned the appropriateness of traditional psychological-intervention approaches to what they consider to be the special needs and characteristics of older adults (Gatz et al, 1980).

In contemplating solutions Gatz (Gatz, Smyer & Lawton, 1980) cites a number of authors who feel that the social

system, rather than the individual should be the focus of the intervention. She even suggests that therapists support therapeutic interventions only because:

> As Sarason (1977) has noted, (well meaning professionals) soon found severe limitations on the type and range of activities they could pursue under the banner of professional services. In addition, it should be no surprise that, having learned to do psychotherapy, clinical assessments, and case management, these professionals find older adults in need of just those kind of mental health services (p. 9).

One might see in a solution which seeks to deprive an older individual of the benefit of treatment until such time as society corrects its ills and injustices--some measure of exactly the same kind of bias that the proponents of this solution are attempting to correct.

The prevalence and persistence of society's negative stereotyping of the elderly has had some deleterious effect on the health care professionals who operate within its context. Many health care professionals (and their elderly patients) share the cultural cliches about the aging population. One author notes that even gerontologists see aging as a kind of illness, and suggests that their professional choice many be a counterphobic reaction to the fear of aging that they share with other members of their culture. "Often enough, gerontologists suffer from the delusion that they can avoid their fate by studying it" (Gutmann, 1980, p. 98). Gutmann believes that this "catastrophic view" of aging,

results in an avoidance of real encounters with the subjective experience of aging. He suggests that even in their research approaches, gerontologists employ their institutionalized practices of not looking at the aged.

By and large, studies investigating the attitudes of a broad range of health care professionals reflect the existence of basically negative attitudes towards the elderly. Physicians have been charged with practicing what Galton (1975) refers to as "condescension medicine" on their elderly patients, and anecdotal illustrations attesting to this claim are standard lore in almost any family. In fact Cyrus-Lutz (1972), quoting a study by Spence and Feigenbaum done in 1968, notes that prejudice against the aged among medical students was noted to be stronger even than their color prejudice.

In a recent article, Robert Butler made the following indictment:

> Teaching about aging in general and mental health in particular is still largely absent in medical schools; in fact, there is negative teaching about older persons. Terms like crock and gork are common references to older patients. We still do not teach clinical pharmacology, so the profound complicating affects of polypharmacy remain, putting older people at risk and often leading to their confusional state.
>
> We still confront the disinterest of psychiatry and the struggle to obtain recognition of geriatric psychiatry as an important subdiscipline by the American boards of psychiatry and neurology. We continue to practice Peter Pan medicine addressed to younger people, not to the realities of complications in the older population. The nation has no effective health promotion and disease prevention policy, which means and includes mental health (1986, p.4).

An additional manifestation of professional bias is the pessimistic picture of the psychotherapeutic treatment of the elderly. In reviewing the literature Silberschatz (1982) notes that greater emphasis is placed on the institutionalized, demented or on the otherwise seriously physically or psychologically impaired adult than on psychotherapy with the more representative faction of the age group--that is to say the self-sufficient, independently functioning adults. As further evidence of prejudice, Silberschatz cites the many authors who advocate medications as the treatment of choice for the elderly, sometimes in conjunction with supportive adjunct psychotherapy. He sees evidence of biased treatment goals in the use of medications, in modifications of technique and in limited expectations of the treatment.

Negative attitudes on the part of health care professionals have been shown to affect services to the aged, though their implications for psychoanalytic treatment are now open to question. Few would disagree that prejudice exists, that impediments to improved service exist, and that there has been a strong connection between the two.

Evidence that the Elderly can be Helped by Various Forms of Psychotherapy--Including Psychoanalysis

The preceding examples notwithstanding, there is some clinical literature which attests to the efficacy of psychotherapy and psychoanalysis for the older adult. In

recent years, professionals have begun to examine their beliefs about older people and have become more concerned with therapeutic intervention in later life. Brink argues strongly for the effectiveness of geriatric psychotherapy stating that "....the most ubiquitous myth in geriatric mental health is that elders cannot be treated effectively with psychotherapy" (1979 p. 146). Even Brink, however, takes pains to make a disclaimer about psychoanalysis, calling it inappropriate for geriatrics (p. 11). But this may be changing.

Recently, Wayne Myers (1984) a classically trained psychoanalyst stated that "....psychoanalysis of older patients ...is both feasible and useful." Myers' book, Dynamic Therapy of the Older Patient is a testimony to the usefulness of the individual therapy model in the treatment of the older adult. Nemiroff and Colarusso, in a book written in 1985 (devoted entirely to psychotherapy and psychoanalysis in the second half of life) conclude on the basis of current and past research that "psychodynamically oriented psychotherapy and psychoanalyses are valid clinical techniques for selected patients in the second half of life, regardless of age" (Introduction). The authors, whose developmental point of view differs somewhat from the more classically analytic perspective of Wayne Myers, present case histories of successful psychotherapies with patients between the ages of forty and eighty. And most recently Jerome Grunes,

like many of the other authors who have contributed to Sadavoy's recent book (Sadavoy & Lesczc, 1987), notes that "The analyzability and amenability to psychotherapy of aged persons approximates that of people in other age groupings" (p. 43).

The addition of psychoanalysis to the list of useful therapeutic techniques in the treatment of the elderly is, for the most part, a recent event. Not only have psychoanalysts been subject to the cultural biases reviewed above, but they have been influenced by specific psychoanalytically derived prejudices which can be traced back to Freud's great reluctance to treat patients over the age of fifty (Freud, 1898, 1904). There were, even in the early days of psychoanalysis, analysts who supported the use of the psychoanalytic method with older patients (Abraham, 1919/1977; Jeliffe, 1925, Jung, 1954; Kaufman, 1940; Grotjahn 1940). And up until the 1980's other analysts were to write of their experiences treating the elderly (Wayne, 1953; Meerloo, 1955; Segal, 1958; Zinberg and Kaufman, 1963; Berezin, 1963, 1978; Cath, 1965; Sandler 1977; Kahana, 1978; Myerson, 1978). But these were relatively few in number and their impact on the analytic community with respect to the analytic treatment of the elderly seems to have been limited.

Summary

We have been thrust into an examination of the older

adult personality by the sharp increase of elderly persons among us. The aging of the population has also affected psychoanalysts who have begun to examine their beliefs about this age group and psychoanalytic treatment. Psychoanalysts, however, do this within a cultural framework that denigrates and stereotypes the elderly. No study of psychoanalysis and the older or aging patient can be undertaken without an understanding of the concepts of aging and psychoanalysis. Though these seem to be self-evident categories they are not, and therefore need to be defined. The definitions, like the concepts, are neither exact nor unitary. They are fluid and complicated. Like a juggler in a circus, these ideas and concepts must be kept in full view at all times in order for the work to proceed.

Methodology

This study examined the beliefs of six psychoanalysts each of whom has been treating patients over the age of sixty for several years. The subjects were asked about their psychoanalytic work with over-sixty patients in comparison with their psychoanalytic work with a younger group of patients characterized here as over-thirty patients. My own excitement about this question (the evolution of which is described in the Preface) was recently echoed by a number of psychoanalysts.

Simburg (1986), in preparing for a presentation to members of the American Psychoanalytic Association, on the

psychoanalysis of the older patient, asked his colleagues what they wished to have discussed. Their questions focused on the following themes: 1) Does the patient work in psychoanalysis, and is the analysis such that it would be considered a real analysis. In other words, would the patient show the changes with which analysts are familiar in any ongoing analysis; 2) What are the differences in analyzing someone over sixty as compared with someone just over thirty; 3) How far is the patient from the thoughts and _feelings_ of childhood experiences (not simply from the memories of childhood); 4) Does the ego remain flexible; 5) Are their contraindications for the analysis of anyone over sixty. Simburg was surprised that there seemed to be no curiosity about the analyst's motivation for working with an older patient.

Since I have already documented my own curiosity in this sphere, each of these themes was included in the questionnaire which was used as a guide in the semi-structured interview (See Appendix C). To reiterate: the purpose of this study was to learn as much as possible about graduate psychoanalysts' perceptions of psychoanalytic work with their over-sixty patients as compared with psychoanalytic work with their over-thirty patients. In this sense, the dissertation can be understood as an exploration of the particular countertransferential attitudes encountered in

psychoanalytic work with the elderly. <u>In other words, these six analysts were asked to render personal judgments about their work with the elderly. What they thought were the real issues, what they thought was myth, what moved or distressed them about their patients, what narrowed or expanded the work, and so on. Whatever it is we may learn about their older patients through this study, it is the analysts' own perspectives that are the true focus; and what each one believes about his older patients and about his work with them is the major contribution of this work..</u> The semi-structured in depth interview was chosen as the method of investigation as it was designed to encourage the six analysts/subjects to think about their work freely, without the constraints of a more structured approach.

<u>Subjects</u>

Six psychoanalysts were studied pertaining to their work with patients sixty years of age and over. The psychoanalysts were all graduates of the same psychoanalytic institute. This similarity of analytic training was desirable so as to minimize sharp theoretical conflict. In order to understand and illustrate an expanse of views within the Institute a range of analysts was chosen. Three were men and three, women. Three, psychiatrists; and three, psychologists. Three were from a European background and three were American born. Ages ranged from the late thirties to the seventies. (Two of

the analysts were categorized as 35 to 49 years of age; two as 50 to 59 years of age; and two as 60 to 70. The exact ages were not given so as to assure confidentiality.) These variations were included to provide additional interest and to address certain attendant issues. Since this is an exploratory study no claims were made that these analysts are in any way a representative sample of the analytic community. In fact, they were chosen precisely because of their experience in working psychoanalytically with the elderly. My aim was to illustrate these experiences and their complexity.

A sample size of six subjects was chosen for a number of reasons. Each psychoanalyst/subject, it should be noted, was himself a data bank in that each subject was in essence asked to review a large portion of his caseload. Six subjects seemed large enough to investigate some interesting hypotheses, yet small enough for the data to be manageable. Because each subject was required to present one full case history of work with an over-sixty patient, care was taken to limit the total number to an amount that could be reviewed and retained without being overwhelming. Six, was also sufficient to cover the variables discussed above. There was also a diversity of religious affiliation.

Subjects were chosen according to the primary criterion of experience working psychoanalytically (or

with psychoanalytically informed psychotherapy) with patients aged sixty and above. In this regard, their work with elderly patients reflected their psychoanalytic training and was similar, in significant ways, to the work that they did with their younger (i.e. over-thirty age group) patients. Each subject had several years experience of doing such work with patients over the age of sixty. In fact, one potential subject, an expert in the field of geriatric psychiatry was not be considered for this study because he had an unique (non-analytic) approach to work with the debilitated elderly which differed from his work with his younger patients. This failed to meet the criterion which demanded that the psychoanalytic treatment offered to the elderly by any given analyst be essentially the same in theory as that being offered to his younger patients.

Procedure

Volunteer subjects were recruited through personal contact with the investigator based on her word-of-mouth knowledge of their psychoanalytic work with the elderly. Subjects were psychoanalysts who had completed psychoanalytic training at a highly regarded psychoanalytic institute located in the northeast section of the United States. Graduate psychoanalysts of other analytic institutes were not interviewed so as not to complicate the study with internecine theoretical debate on the nature of psychoanalysis.

The analysts were informed at the beginning of each interview that there was no hidden agenda. The purpose in conducting the study was made clear to each subject and each was informed that structure could be modified should they recall pertinent information not specifically asked. Subjects were also free to proceed with the interview in a manner that conformed to their respective individual styles. Tape recordings of the interviews were transcribed in order to serve as a back up to the notes taken by the interviewer. Subjects were assured that the recordings would be heard by the investigator only. Subjects were further assured of anonymity and of the maintenance of confidentiality with respect to all of the case material presented.

A series of two to four interviews was conducted with each subject and the total time spent with each varied from four to six hours. Interviews were held at intervals of one to two weeks to allow both subject and interviewer to process the information of each interview. Subjects were asked to make themselves available for follow-up contacts if necessary. Interviews were arranged in a location most convenient for the interviewee, usually his own office.

A modified focused clinical interview was chosen as the format that would best enable the investigation to proceed in as open and as unbiased a manner as was

possible. Questionnaires and rating scales were ruled out as they would inevitably focus the subjects on certain aspects of their work with patients and might inadvertently ignore pertinent data not anticipated at the outset of the study. The semi-structured interview is well known as an interview technique.

The interview format began with the subject's first encounter with over-sixty patients and with the subject's fantasies about this age group even before work with them had first begun. The questions were worded so as to leave the interviewee free to select the data pertinent to his or her situation. For example, the first question ("How did you come to be working with over-sixty patients?") led some subjects to associate immediately to their own personal histories while others had no such thoughts in mind. Nor was there any specific question about societal bias and if subjects had been unaware of it or had felt untouched by it, it would not have arisen explicitly as an issue. Questions tended not to be limiting. For example, a question was worded, "What types of problems tended to be brought in by individuals in their sixties, seventies, and eighties?" Questions were deliberately worded in such a manner so that subjects would have an opportunity to respond freely to the question. If, after the response, certain areas heavily reported in the literature were not mentioned by subjects, they were asked directly about their impressions. To illustrate: the literature deals

specifically with the impact of certain kinds of losses on the elderly patient. If a subject had volunteered nothing on this matter in response to the above question, the subject would have been asked if the issue of loss had arisen with patients and then if the issue differed with respect to older and younger patients.

Data Analysis

Following collection and preliminary organization of the data, the questions raised by the literature review were addressed. As was noted, (and as will be documented in the literature review which follows) for many years it was thought that the elderly could not really benefit from a real psychoanalytic inquiry. Therefore, among psychoanalysts who bothered to consider the issue at all, the basic question with respect to the elderly was, were they able (or unable) to benefit from psychoanalytic treatment. In the mid 1980's, however, a spate of literature appeared which began to contradict these early views. And if, in fact, there was consensus that the elderly were indeed treatable then the issue of treatability per se would fade from primacy as other concerns replaced it. One would instead want to know if psychoanalysis with the elderly were actually different. If the answer were "yes," one would want to know the ways in which it differed, the reasons for the difference. One would want to know if the old themselves were essentially

different from the young and if thematic age specific concerns were discernible above and beyond the individual differences among people of all ages. One would want to know the ingredients of normal or successful aging and the ways in which this differs from problematic or pathological aging. One would wonder about the analyst's feelings about treating the old, more often than not an age group with which he has had less experience and about which he certainly has had less specific training.

Data were therefore analyzed along three general dimensions: 1) the nature of the older psychoanalytic patient, 2) the content and the process of treatment, and 3) the analyst's countertransference (direct and indirect). Having originally suggested that the elderly were actually heterogeneous group I nonetheless looked for any common traits which these analysts thought might characterize older patients as a group and might differentiate them from younger (over-thirty) patients. I never discounted the possibility, however, that perhaps (to paraphrase Harry Stack Sullivan) the elderly would turn out to be are more simply like younger adults than otherwise; and that psychoanalytic treatment of the aged might reflect this.

Chapter 2

A Review of the Literature

This study looks at the experience reported by psychoanalysts doing psychoanalysis or psychoanalytic psychotherapy with persons in their sixties and seventies and above; a population of patients considered by many analysts to be unsuitable for psychoanalytic treatment. This reluctance to treat the elderly analytically, to some extent has roots in Freud's skepticism regarding psychoanalysis for anyone over the age of fifty. But it is also a function of myths and stereotypes stemming from widespread societal discrimination towards the elderly and the prevalence of ageism among mental health professionals which cannot help but influence the context in which this work is undertaken.

Brink (1979) writes that ageism:

> is like racism or sexism in that it is a pervasive set of stereotypes and prejudices that underlines generalized differences between the majority of Americans (in this case, the young) and a specific minority group which is in somewhat of a disadvantaged position. Agism emphasizes the negative images of growing old....Unlike the negative images involved in racism and sexism, those of aging are learned when the person is young; they do not affect him directly, but become transformed into negative self-images as the person himself ages. The real negative effect of agism on mental health is that many individuals are slowly conditioned to accept lower levels of activity, achievement, importance and interaction as inevitable. This is true, not only of the elders themselves, but of their caretakers as well (pp. 30-31).

The literature review moves from general societal views of the elderly, to the views found in the field of mental

health (social work, psychiatry, psychology) and finally to a much more focused examination of the views described in the psychoanalytic literature.

The Elderly and Society

> "...The sixth age shifts
> Into the lean and slipper'd pantaloon
> With spectacles on nose and pouch on side,
> His youthful hose, well sav'd, a world too wide
> For his shrunk shank; and his big manly voice,
> Turning again toward childish treble, pipes
> And whisteles in his sound. Last scene of all
> That ends this strange eventful history,
> Is second childishness, and mere oblivion,
> Sans teeth, sans eyes, sans taste, sans everything"
> (Shakespeare, As You Like It, Scene VII
> lines 157-166)

Who is Old?

Depending upon definition and upon individual variation, the beginning of old age is arbitrary. Chronological age, taken alone, seems to be an unsatisfactory measure of aging, though it is one most frequently employed.

My mother (a women in her seventies) is thinking of switching from her fifty-year-old physician to another physician who may be less apt to refer to her as "a little old lady." Her physician insists that his characterization of her is based on fact. He has said to her flatly, "But you are old." My mother snaps back, "Not to me!", and adds, "and furthermore, I'll bet you don't go around calling Cary Grant a little old man--and he's over eighty."

Old age is frequently in the eye of the observer,

determined by his criteria and by his purposes. Mathews (1978) writes, "(The) definitions of 'old' are not made on a societal level by general consensus, but depend on the purpose of the definer" (p. 59). Some writers note that part of the difficulty in defining old stems from the increasing heterogeneity of the aged. People tend to age differently. Because of this they become more dissimilar than alike as they grow older (Goldfarb, 1971; Lidz, 1980). Yet society tends to lump the aged together in a false, misconceived, stereotypical image of aging (Steury, 1977). Nonetheless, "old" in this society and in others is defined as a category. This being the case, how does one decide eligibility and what assumptions does one make in using the term "old"?

Many writers see aging as a time of loss and they characterize the elderly accordingly. Mathews (1978) and Lidz (1980) focus on old age as a socially constructed category such as "too old to work" or a visit to the Social Security office at the age of sixty-five. An emphasis on losses of these kinds links aging with isolation and dependency.

Berezin (1972, 1978) too speaks of the aging in terms of the extra organismic conditions he believes the elderly face. He cites such external conditions as losses of friends and family, loss of occupation, loss of power and prestige, and also somatic changes and alterations of self

image. (Berezin points out, however, that each person will respond to these conditions by modes of management which are part of his habitual lifelong manner of functioning.) The question becomes then, to what degree do we attribute the limitations and impairments of the functionally aged to the aging population as a whole, and how do these limitations color our views regarding the general population of the aged? Others have observed that the label of old age is generally applied to persons who have suffered some kind of functional loss--either in the physical, mental or social sphere. Such definitions have definite repercussions in terms of a pervasive stereotypical view of the old, as we shall discuss later on.

Goldfarb (1977) speaks of functional aging. He characterizes this as the loss of physical and mental capacities such as a decline in mental agility, ability to remain oriented, memory, ability to use information and to make accurate calculations. The nature and degree of impairment will vary among individuals. Kahana (1974) and Steury (1977) believe that our views of the elderly are very much affected by our emphasis on functional aging. They note the tendency for society to expect that all elderly people will undergo severe physical and mental deterioration long before their deaths, so that interest in the elderly focuses almost exclusively on the debilitated. Kahana maintains that "approaches to the

special problems of the disabled minority of elders were often put forth as if they applied generally to the entire population of older people (p. 72). Such views of the aged as functionally limited are generalizations applied to an entire group from observations of a small minority. These authors state that the vigorous, productive, well-functioning majority of elderly suffer because they are included in this minority definition of aging, and that the special unique qualities both of older persons and of later life become largely ignored. The majority come to be viewed as the exception rather than as the rule.

Others have attempted to define the elderly by dividing them into subgroups. Kahana (1974) divides older persons into three groups: those past middle life who are aging, older people in crisis, and the debilitated aged. According to Kahana, the "aging" are characterized by changes in appearance and strength; physical illnesses which are manageable rather than crippling; reassessment of conflicts concerning achievements and aspirations; awareness of time limitations and the eventuality of death; changes in relationships with and loss of significant others. The "debilitated" aged may have combinations of chronic, multiple or severe illness; organic damage; constriction of activities; inability to maintain themselves; a dominance of pregenital drives; and severe depletion of interpersonal satisfactions

including recurrent grief from repeated interpersonal losses. An intermediate group experiences traumatic states of crises which stem from a severe illness, losses by death and divorce, or work failures. Much of the literature on psychotherapy with older people is directed towards the debilitated group leading to unfortunate erroneous generalizations. Although Kahana distinguishes characteristics of the aging and the debilitated aged in order to clarify techniques of geriatric psychotherapy, these distinctions are also useful in separating myth from reality.

Reisman (1954) and Grotjahn (1950) characterize the elderly in terms of their responses to the aging process. Reisman conceptualizes three typical responses to aging: "autonomous", "adjusted" and "anomic". The "autonomous" bear within themselves sources of self renewal like Bertrand Russell or Toscanini, they continue to enjoy life vigorously and they are fairly immune to cultural strictures and stereotyping. The "adjusted" (who constitute the majority) are without the personal resources of the "autonomous" but have adjusted well to the culture and are beneficiaries of a cultural preservative. Though they are not renewed by an inner transformation they are sustained by what they have gleaned from the culture (work roles, power, prestige, etc.), but only so long as cultural conditions remain stable and protective. When the culture cannot protect

the individual, and when he has few inner resources, he simply decays. This is the "anomic solution" to aging. Grotjahn also cites three potential reactions to aging. The normal solution, as he views it, is the acceptance of the life as lived. Another is increased rigidity of the ego in an effort to maintain characterological defenses. The third is a neurotic or psychotic regression.

Kahana (1974), Reisman (1954), and Grotjahn (1950), have attempted to classify reactions to aging as essentially good (or very good), bad (or very bad) and the in-between. It is the in-between who will no doubt give us the greatest pause for thought.

Summary

The elderly are a vastly heterogeneous group. This frequently goes unrecognized because narrow perspectives on aging have been generalized to the entire group with deleterious consequences. Depending upon their purposes, different people utilize different models or definitions of aging. Some professionals view aging as a time of loss. They may define such losses as external (or socially constructed) or as functional (i.e. physical and mental losses). Some choose to characterize the elderly in terms of the aged person's reaction to the aging process itself. As with other eras of the life cycle, reactions to this stage of life are generally characterized into terms which translate loosely into

good, bad, or average. There is however no universally accepted definition or understanding of the concept of "old".

Old Age: Stigma and Stereotypy

If the literature varies in its definition and description of the elderly, it speaks with one voice of the cultural depreciation of the old man and the old woman. They are disposed of, if possible, in a businesslike manner by means of old age insurance, domiciliary institutions, and public assistance without regard to their individual emotional needs (Wayne 1953, Mathews 1979, Steury 1977).

There was a time, Rudd (1958) reminds us, when life was regarded as a complete event "its constituent stages being of equal value in the sight of God." Each stage was seen as significant in the life of the individual and in the life of the community. This is no longer the case. One grave obstacle to the final stage of development is the unattractive picture society has painted of old age.

We characterize (or should be say 'caricaturize') the elderly as:

> Feeble, frail, fatigued, forgetful, senile, sick, silly, infantile, incontinent, constipated, dependent, depleted, decrepit, depressed, regressed, unproductive, uncreative, unattractive, undesirable, unresourceful, rigid, alone, afraid.

The accuracy of the stereotypes has, in the main, been challenged in the literature, but (for the present) the stigma remains. Old is a demeaning status. "Old people

are the possessors of a stigma that is in the middle ground between discrediting and discreditable" (Mathews, 1978, p. 61). Degradation may be blatant or subtle, but either way it is pervasive. The language is replete with descriptive epithets--"old bag, "old maid", doddering old fool", "dirty old man", "old fogey" and so on. (1) We often see the elderly portrayed as such in television situation comedies.

It is incumbent upon therapists and their patients to examine the myths and stereotypes that have been accepted as givens and to alter those generalizations which do not conform to the facts.

Among these are the notions that the old are:

Unproductive.

The notion obtains that at the age of 65 or 70, people become unproductive and disengaged from life. In reality, old people tend to remain actively concerned about their personal and community relationships and they continue to achieve and to produce. Some become unusually creative om their later lives. (See King, 1974; Steury, 1977; Butler, 1979.)

Senile.

Many gerontologists dislike the use of the term 'senile' which they consider to be a useless and prejudicial wastebasket diagnosis. Brink (1979) notes

---

1) The 89 year old uncle of a colleague moved from his New York suburban heterogeneous environment to a Florida town, populated largely by retirees, many of whom are widows. As he had been a productive and active businessman up north, he was asked what he thought of his new community, with some expectation that the move was a disappointment. "It's pretty good," he said. "Up north I was just a dirty old man. But in Florida - I'm a sex symbol."

that senile behavior may be caused by the presence of an organic brain syndrome which has its origins in an acute or chronic condition. This is disease and not aging. And while the symptoms may occur after age 65 they are most likely to become clinically significant before that age. Although there is a tendency to think that all old people have damage to the brain, the aging processes per se probably play a very small role, if any, in the production of psychopathology. Older people may display symptoms (such as confusion or disorientation) which may be temporary, reversible and caused by external factors. (See Rudd, 1958; Brink, 1979; Butler, 1979.)

<u>Sick</u>

For some, the very word "old" is synonymous with ill health. Rudd (1958) points out that ill health is an abnormal state often due to faulty patterns of living and stress conditions. Disability and ill health can be decreased markedly by health living in early life and middle age.

<u>Unresponsive to Therapy</u>

The literature is replete with evidence that elderly persons are receptive to psychotherapy, including psychoanalysis (Blank, 1974; Lewis & Butler, 1974; King, 1974, 1980; Shainess, 1979; Myers, 1984; Nemiroff & Colarusso, 1985; Cath, 1986). Lewis and Butler (1974) point out that we often fail to remember that older people are survivors. They have the capacity to reconcile their lives, to confront guilt and to discover meaning. According to Blank, Pfeiffer concludes that elderly patients are highly responsive to therapy. "In terms of the therapist's investment of time, results are frequently more dramatic with elderly patients than with almost any other age group" (p. 64).

<u>Regressed</u>

Berezin (1978) calls regression the sine qua non of aging and he attributes it to the diminution of genital primacy. 1

However, Steury (1978) states that the depletion of sexual drive is not clinically supported. He cites

---

1) Even Wayne is a victim of this stereotype (1953) remarking "The aged neurotic often senses a great relief in the physiologic quiescence of sexual urges which at one time were experienced as oppressive and tyrannical" (p. 103).

Kinsey, Newman and Nichols, Pfeiffer, Masters and Johnson, and Schuster, all of whom report that chronological age is no barrier to the continued sexual life of the old. Steury (1978) says that, in an extensive multi-disciplinary N.I.M.H. study of human aging (1963) of men 65-91 years of age, the "subjects were found to be alert, constructive, optimistic and resourceful, contradicting stereotyped notions of regression to a second childhood among the aged." When regression is observed in the old it cannot be attributed to depletion of drive energy. It may be an adaptive response to the pain of loss and suffering. "Regression is not a fact of aging per se and is not a specific component of this developmental phase of the life cycle" (p. 7).

Rigid

Rigidity is not a unitary concept. People may be rigid in one form and not in another (Brink, 1979). Several authors have found that the old, more than any other group, are willing to admit to errors or imperfections in their personalities showing that they are not defensively rigid (Grotjahn, 1955; Wheelwright, 1959; Kahana, 1978; Berezin, 1972; Brink, 1979). A number of suggestions have been offered for any higher rigidity levels found in elders.

Meerloo (1955) and Brink (1979) suggest that old age "stubbornness" may represent a mental stability and continuity that actually corrects some inner vacillation of man, or that rigidity and cautiousness are aids to survival and reactions to a hostile environment. Perhaps only those with experience have the inner freedom to stick with their own ideas. The old pursue college studies and new endeavors with success (Steury, 1977). And the conservatism of the elderly tends to be exaggerated, with much of it deriving from socioeconomic pressures and not from "aging" (Butler, 1977). Extreme rigidity and a tendency to stick with familiar strategies even when they repeatedly fail can be seen as a sign of poor adjustment -- but this would be true at any age.

I.Q. Decline

Longitudinal tests of intelligence show relative stability into the later years. Total knowledge (crystalized intelligence) is most resistant to decline and, for most individuals, continues to rise, although the ability to learn new things is more subject to some decline. However, the difference in longitudinal measure of fluid intelligence in no way approximates that observed in close sectional studies (Brink, 1979).

Fear of Death

Steury (1977) believes that the old regard death differently than they did while young. During middle age, the perception of time is altered from time past to time remaining. The old in contact with death and the acceptance of the inevitability of death becomes part of the thinking of most persons. Meerloo (1955) believes, conversely, that the aging cannot accept the reality of being mortal. Becker (1973) treats this as an existential issue which raises questions beyond the scope of this paper. Briefly, Becker's thesis is that humans cannot accept the fact of their mortality and that their lives are permeated by denials of death. For Becker "castration anxiety" actually represents their fear of death and not the other way around. Consciousness of death, and not sexuality, is the primary repression. Man's body is his constant reminder of his mortality as it is subject to deterioration and cannot be mastered. For Becker, life's crucial task (and the test of true maturity) is the acceptance of the process of aging and the mourning of one's own eventual death.

The Developmental Tasks of Late Adulthood

If, as has been stated, the elderly are not merely their chronological ages, if they are not their stereotypes, if they are not a homogeneous group--then what do they, as cohorts, share in common? Some have suggested that it is in the unique tasks specific to this phase of late adulthood-- tasks which every old person must confront -- that we find our common denominator.

Colarusso and Nemiroff (1981, 1985) in an examination of adult development cite the contributions of Erik Erikson to the understanding of the entire life cycle as a continual process of development. (I shall confine myself here, primarily to the years beyond the age of sixty.)

Erik Erikson offered the first integrated psychosocial view of individual development from birth until death. He

posited eight stages of human development each of which is organized around a crucial issue for the individual in relation to the world. For Erikson, development proceeds by the resolution of successive states of disequilibrium or conflicts in which the solutions of subsequent stages are partly dependent upon what transpired during previous stages. Erikson places persons in their sixties and beyond in the eighth or final stage of the life cycle. The central conflict of this stage is integrity vs. despair. A life lived with much satisfaction and few regrets leads to a sense of integrity--a feeling that life has been meaningful. Integrity of the self allows for the acceptance of what is to come without fear. A life regarded as a series of missed opportunities results in despair, bitterness and a fear of death which symbolizes emptiness.

Daniel Levinson's (1978) psychosocial theory allows for specific but overlapping developmental eras of about 20 years each. Each era encompasses sequential alternations of stable periods and transitional periods during which time certain tasks must be encountered and mastered. Levinson labels the years from sixty to eighty "late adulthood", and labels those from eighty on, "late, late adulthood."

Although the main focus of Levinson's work was male cycles from late teens to the late forties, he did make some provisional statements about these later years. For

Levinson late adulthood--ushered in by numerous biological, psychological and social changes--begins in the early sixties and ends in the middle eighties. This era, like the others Levinson describes, is not demarcated by a single universal event, but in the fifties and sixties mental and physical changes intensify a person's experience of his own aging and mortality. Although men at age sixty differ widely, each must deal with some decline in or loss of his middle adult powers. According to Levinson during the Late Adult Transition (sixty to sixty-five years of age) a man fears that the youth within him is dying and that only the old man within him will survive. His task is to sustain his youthfulness in a new form appropriate to late adulthood, and to find a new balance of involvement with society and with the self in which the self (the voice within) has greater primacy. Levinson believes that this can be a season as rich and full as the others, so that late adulthood is both an era of decline and an opportunity for development. As does Erikson, Levinson sees this time as one of appraisal, of integrity versus despair. This will require an accommodation to the flaws and corruptions that are inevitably a part of any human life.

A new era, says Levinson, begins at eighty. At this time the process of aging is much more evident than the process of growth. Under favorable conditions there is

psychosocial development as well as senescence. Although at the end of all previous eras man prepares for the beginning of a new one, a man in his eighties knows the death is his next era. To be able to involve himself with living, his task is to make peace with his dying. He must come to final terms with the self and to be ready to give it up.

Nemiroff and Colarusso (1985) postulated seven hypotheses to serve as a theoretical foundation for adult development. Among these are the notions that 1) development proceeds during the adult years as an ongoing, dynamic process and that 2) all adults in their later years will have to deal with the normal crisis precipitated by a recognition that time is finite and that death is inevitable. Some of the tasks these authors list as appropriate to the phase they term late adulthood (age sixty and above) are the following:

1. Maintaining physical health
2. Adapting to physical infirmities or permanent impairment.
3. Using remaining time in gratifying ways (integrity versus despair)
4. Adapting to loss of partner, friends
5. Remaining oriented to present and future, not unduly preoccupied with the past
6. Forming new emotional ties, seeking and maintaining social contacts
7. Reversing roles with children, grandchildren
8. Attending to sexual needs and expression
9. Continuing meaningful work and play
10. Using financial resources wisely, for self and others

The developmental perspective is one way of looking at adults who are moving on to late age. While attesting

to its usefulness, there are some who believe that this viewpoint could have negative impact on the elderly individual and on the effectiveness of therapy. The fear is that emotional disturbance will be viewed as normal aging, and that the older person will be told that his emotional difficulties are part of the normal aging process (Colett, Griffith & Zil, 1984). The authors contend that such a view would lead therapists to expect less from their older patients and to subtly encourage diminished expectations from the patient. These writers prefer to see the patient as one who is momentarily vulnerable; but potentially productive, effective and worth the therapist's therapeutic effort. Actually, one must always distinguish normative development from impairment. The authors' warnings, then, might be applicable to any developmental era; adolescence, for example, when emotional difficulties have been dismissed as "merely a stage." But because of the pervasive stereotyping of the elderly, particular care but be taken not to dismiss their complaints as normal. A brief anecdote will illustrate. A popular story is told of a centigenarian who made several consecutive visits to his doctor because of pain and stiffness in his left leg. The physician could do little to relieve the patient's discomfort and said to the patient, rather characteristically, "You know, Mr. B you're expecting a

great deal from that leg. Don't forget it's 100 years old." The patient replied, "Well, doc, my right leg is 100 years old too, and it doesn't give me a bit of trouble."

Summary

Although people may become increasingly heterogeneous as they age, they may nevertheless be facing common developmental tasks. Change and decline, though they may vary greatly among people, are concomitants of aging which must be faced. During this time of appraisal one must find satisfaction in one's life, despite its inevitable flaws, in order to gain satisfaction and to avoid despair. After the age of eighty, man knows that death is his next 'era' and he must come to terms with it.

The developmental perspective can provide useful guidelines about the aging process but widespread ageism makes it incumbent upon professionals to seriously examine emotional difficulties and to refrain from dismissing them as 'normal aging.'

Research Studies on Attitudes Toward the Aged

We have observed that neither psychoanalysts nor their patients are immune to pejorative societal views of aging, and we have described some of these views. Evidence of these negative cultural attitudes is not limited to anecdotal record. There have been attempts to move beyond description to more formal research studies designed to examine the nature and effects of attitudes

toward the elderly. I will briefly review some of the findings first as they apply to the general population and then in relation to health professionals.

<u>Attitudes of the General Population Toward the Elderly</u>

Attitudes toward the elderly are most positive in primitive societies and decrease, with modernization, toward generally negative views in Western industrialized societies (McTavish, 1971).

In the United States, the literature credits Tuckman and Lorge (1953a) with initiating an extensive series of empirical studies on attitudes toward old people. In this early study on graduate students (mean age thirty) the authors found a substantial acceptance of the misconceptions and stereotypes about old people. Old age was viewed as a period of economic insecurity, loneliness, resistance to change and declining physical and mental powers. In a subsequent study (Tuckman, Lorge, & Spooner, 1953) the authors confirmed that the home environment contributes to the similarity in attitudes between parents and between parents and children. Further evidence of stereotypic thinking was found by McTavish (1971) in a comprehensive survey of the literature. A review of many studies revealed numerous commonly held stereotypes in addition to those enumerated above. Added to the list above were characterizations of the elderly as: ill, tired, disinterested in sex, forgetful, less able to learn

new things, self-pitying, withdrawn, grouchy, unproductive, defensive, and stuck in the least happy period of life. Such labels are often internalized by the elderly themselves (Rodin & Langer, 1980).

The more interesting findings, to my mind, have to do with the softening of these stereotypes under certain conditions. Three researchers noted that stereotypic thinking fades as subjects receive more information about people and contexts. Weinberger and Millham (1975) found that college students expressed significantly more negative attitudes toward a representative seventy-year-old than toward a representative twenty-five-year-old. But when given personalized descriptions of individuals in each age group, the students judged the seventy-year-old more favorably.

Kogan (1979) also discovered that when he presented subjects with a single stimulus (one person who had a number of visible attributes including being old) age seemed not to be a particularly salient characteristic in the subjects' judgements of the stimulus (person). However, if subjects were asked to make comparative judgements of a young and an old stimulus person, a large number of aging stereotypes were elicited. Kogan suggests that when individuals react to a general category of persons they must rely on cultural stereotypes that do not acknowledge the special characteristics of persons within the category. When an individual stimulus person is

presented, their individual characteristics (as opposed to general stereotypes) become more salient. In a subsequent review of the literature Green (1981) like Kogan, notes that age and a host of other individuating factors combine to produce an impression of an individual. Summarizing additional studies, Green also points out that the context in which research participants view the elderly is an important determinant of reactions. In the absence of context, stereotypes flourish. For example, people who simply use chronological age as a criterion of aging subscribe to more stereotypes about old people than those who do not (Tuckman and Lorge, 1953b). People who do not rely on stereotypes but give the issue serious thought are likely to evaluate many relevant factors.

These findings are especially germane to psychoanalytic work with the elderly. Although cultural attitudes impinge on analyst and patient, the psychoanalytic process is directed toward the _specific_ patient and toward the relationship of the two people in the analytic dyad. In psychoanalysis, individuality and context play a major role.

Attitudes of Professionals Toward the Elderly

A number of studies have been done on the attitudes of various professionals toward the aged which show that professionals have shared with the general population many of the same negative biases toward the old.

Physicians come to equate aging with disease, death, disability, hopelessness and helplessness (Roche Report, September 15, 1978). Hopelessness and helplessness have also led social workers to conclude that work with the aged was almost useless (Robb, 1977), and psychiatrists to assume that the older person is a poor investment for psychotherapy because he is boring, garrulous and resistant to change or just plain senile. (Butler, 1975) In one study, only 25 percent of the psychiatrists surveyed reported treating younger and older patients equally, and 39 percent reported that they tried harder with patients under the age of fifty. Not one tried harder with patients over the age of seventy-five (Miller, Lowenstein & Winston, 1976).

Social work, law, medical, religious, and nursing students were found to be strikingly ignorant of the most basic facts about the elderly and disinclined to work with them (Robb, 1977; Geiger, 1978; Monk & Kaye, 1982). In fact the attitude of medical students actually deteriorated over the course of their four years in medical school (Butler, 1977). Medical school may reinforce the students' negative image of the elderly by limiting the students' encounters with old people to the acutely and chronically ill (Roche Report, September 15, 1978). Solomon and Vickers (1979) studied the attitudes of medical students and staff members (including those on a psychogeriatric team) of an American Medical School, and

concluded that stereotypical attitudes toward the aged had undergone little change in the past twenty-five years. The impact of such bias, according to Holtzman, Beck and Coggan (1978) has been the unwillingness or inability of many professionals to serve the older members of the community. Registered nurses have expressed unwillingness or reluctance to work with geriatric clients (Robb, 1977). And fully 53 percent of 800 physicians who indicated an interest in geriatrics shunned their responsibilities to nursing home patients (Zimring, 1977). Further, of 220 professionals surveyed by Wolk and Wolk (1971) only 44 chose to work with the aged rather than with other age groups. Perhaps the most damning observation was that made by Sparacino (1979) who in speaking about the impact of negative attitudes upon mental health professionals noted rather pointedly that in a survey of English psychiatrists in training, many reported that they would rather emigrate than practice psychogeriatrics.

A slightly more subtle form of bias was reflected in the referral patterns of physicians in a general medical hospital. Older patients were less likely than younger patients to be referred for appropriate psychological consultation although their responses, (like those of the younger patients) to the MMPI were such as to be categorized as abnormal. The authors protest that there is no reason why a sixty-five-year-old man's depression

and somatic concerns should have to be tolerated by the patient, while a nineteen-year-old-girl complaining of stomach pain with no organic findings is immediately referred for psychological consultation. It was suggested that the physicians were less sensitive to the complaints of the elderly and moreover that "even in those physicians who were sensitive to these complaints, an opinion existed that older people were less likely to profit from psychological intervention" (Ginsburg & Goldstein, 1974, p. 414).

Not every study reported showed a preponderance of negative bias. More than half of the physicians surveyed by Ford in 1968 revealed no differences in preferences based on age (Robb, 1977). And Garfinkel (1975) found that psychotherapists working in the outpatient psychiatric clinic of a municipal hospital did not subscribe to the common stereotypes of aging. Garfinkel attributed this to the educational level and psychological sophistication of her sample.

A number of researchers considered the ages of therapists as well as the ages of their patients in examining the effects of bias in treatment situations. One study found that the therapist's age, relative to that of the patient, is a significant factor in the initial evaluation and early phase of therapy of neurotically depressed out-patients (Karasu, Stein, & Charles, 1979). Patients older than their therapists were seen by

therapists as being most impaired, with least motivation, least capacity for insight and worst prognosis. Patients younger than their therapists were viewed as being the least impaired, and as having the greatest motivation for therapy, most capacity for insight and best prognosis. Therapists expressed a decided preference for treating younger patients and 67 percent of the therapists (whose average age was twenty-nine) were not even interested in treating patients in the forty to sixty-five year old category.

The above were similar to the findings of Garetz (1975) who reported that younger psychiatrists (mean age 43 years) diagnosed organic brain syndrome significantly more often than older psychiatrists (mean age 64.5 years) who more often diagnosed anxiety--a more treatable condition. Younger psychiatrists significantly more often thought evaluation and somatic treatments were indicated in aged patients whereas older psychiatrists advocated more comprehensive treatment such as psychotherapy. Additionally, psychiatrists who found older patients more interesting and more gratifying were significantly older on the average than those who found these patients less interesting and gratifying. (Similar results were reported by Wolk and Wolk, 1971.) As a group, general psychiatrists saw a significantly higher proportion of older patients (13.78 percent) than did either community

psychiatrists (8.45 percent) or psychoanalytic psychotherapists (5.68 percent), and they also reported a greater degree of interest in these patients.

Ford and Sbordone (1980) found that at a highly significant level, psychiatrists regarded older patients as being less ideal and as having poorer prognoses than younger patients. Their treatment plans for older patients were less likely to emphasize psychotherapy. Contrary to the findings cited above, these authors found that the influence of the age of the psychiatrist did not follow a readily understood pattern. However, they did find that irrespective of the patient's age, patients with certain diagnoses were considered to be more desirable than patients with other diagnoses.

Summary of Findings

These studies are useful because they confirm the prevailing notion that western culture discriminates against the aged. Mental health professionals also succumb to the stereotyping of the aged and their prejudices create barriers to effective service. Private practitioner psychiatrists treat far fewer elderly patients than other psychiatrists and have expressed less interest in this age group. Younger professionals appear to be more embedded in biased attitudes than older professionals although stereotypes have been shown to lose their impact when the elderly person is viewed in his totality. As psychoanalysis is a method of treatment that

focuses on the total patient it is expected that the extreme stereotypic labels often found in the literature will not prevail. However it remains to be seen if the effects of cultural bias will occur in the treatment in more subtle ways, and if in fact there are any across-the-board modifications that psychoanalysis requires in the treatment of the older patient.

Psychoanalysis and the Elderly

"There is little convincing evidence in the research or clinical literature to support the view that older adults can be effectively treated by psychodynamic psychotherapy. Rather, a review of the literature on psychotherapy with older adults presents a confusing and often pessimistic picture of the treatment of this age group" (Silberschatz, 1982, p. 2). This has in fact been the conventional view until very recently. Wayne Myers, in 1984, wrote what was termed a "ground-breaking" book on the usefulness of the psychoanalytic method with patients over fifty, a population that he considered to have been neglected and undiscovered both psychiatrically and in psychoanalytic literature. The following year Nemiroff and Colarusso (1985) contributed to the literature by offering case histories of successful psychotherapy and psychoanalysis with patients between the ages of forty and eighty in conjunction with new conceptualizations of the authors' adult developmental theory. Lawrence Lazarus

(1986) has recently edited a monograph entitled, Clinical Approaches to Psychotherapy with the Elderly. And finally, Joel Sadavoy and Molyn Leszsz (1987) are responsible for editing a book entitled, Treating the Elderly With Psychotherapy. Clearly, the aging of the population has begun to have some effect on a number of members of the psychoanalytic profession who have felt called upon to examine psychoanalysts beliefs about older people. Natalie Shainess (1979) a psychoanalyst, as recently as seven years ago expressed utter astonishment at the probability of successfully treating the elderly with analysis. She remarked with candor, "In recent years, a growing sense of surprise has thrust itself into my awareness --at the analyzability and the capacity for change in older people" (p. 385). A review of the history of psychoanalysis and the elderly obviates the need to speculate on the reasons for Shainess' surprise.

The Early Historical Perspective

Psychoanalysis has been little interested in the subject of old age, or for that matter, in adulthood itself, from the developmental perspective. Freud (1898, 1904) was reluctant to treat persons over fifty years by classical technique suggesting that the personality was too well established, too characterologically rigid and therefore less amenable to change. He felt that older people had so much life history behind them that the wealth of material to be dealt with would prolong the

duration of the treatment indefinitely. This latter objection is particularly interesting in light of Freud's belief that the crucial events of personality formation transpire before the age of six. But implicit in Freud's objection was his further assumption that a successful analysis would include a complete reconstruction of the life history and a resolution of all major conflicts experienced during a lifetime. And Freud's notion that an improvement in mental health in the elderly would come too late to be of any real value, implied that the investment of time and effort was worthwhile only in the young (Rechtschaffen, 1959/1977; Nemiroff & Colarusso, 1985).

There have been speculations about the reasons for Freud's dislike of aging (King, 1974, Nemiroff & Colarusso, 1985; Cath, 1986; Miller, 1986) as there have been about the reasons for its impact on the psychoanalytic community (Kahana, 1979; Myers, 1984). But whatever the truth of such speculations Freud's pessimism seems eventually to have had a long-standing effect on therapists' beliefs (Rechtschaffen, 1959/1977; Sparacino, 1978). This did not often take the form of explicit doctrines against treating the elderly with psychoanalysis. The bias was more one of omission than one of commission in that the elderly were not being treated psychoanalytically, since psychoanalysis was not considered to be an effective treatment for this age

group.

In those earlier years three other analysts also wrote about their feelings that psychoanalysis was not an optimal treatment for patients of a more advanced age. Like Freud, Fenichel (1945), and Alexander and French (1946) believed that the plasticity of and the possibility for change in older persons was very limited. These authors stated that prognosis was better for the young who had a greater opportunity for change and who would respond more readily to treatment. Fenichel thought that forty represented the upper limit of the ideal age for undertaking an analysis, though he stated that analysis was not impossible later. Here, he felt that the situation of the patient was decisive so that a patient with real possibilities for gratification was a more hopeful candidate than one whose only learning would be an awareness of irreversible past failures.

There were however several analysts who, during those historic years of psychoanalysis, believed that it was possible to successfully treat older patients. I refer specifically to Abraham, Jeliffe, Jung, Erikson, M.R. Kaufman, and Grotjahn; each of whom will be discussed individually, if only briefly. Given what we now know to have transpired in the field in the intervening years we can infer that their influence in this particular area was rather minimal. On the other hand this was not a major issue of that time.

Karl Abraham (1919/1977) was the first of the few who took issue with Freud's position that therapy could not be useful after fifty. Abraham was persuaded by patients themselves to take them on in treatment and found that "a considerable number of them reacted very favourably to treatment. I might add," he wrote, "that I found some of these cures as among my most successful results" (p. 313). Abraham felt that the prognosis in the psychoanalytic treatment of older patients could be favorable if the patient had had several years of appropriate sexual and social functioning following puberty. Those who had not done so were apt to respond poorly to treatment irrespective of age. "We may say," commented Abraham, "that the age of the neurosis is more important than the age of the patient" (p. 316). Contrary to Freud's belief, Abraham's experience indicated that memories "of the earliest period of childhood" could be recovered with a thoroughness equal to that of younger patients.

Jeliffe (writing in 1925) is also known to have supported the use of the psychoanalytic method with older patients. He was essentially concerned with the suitability of patients for orthodox psychoanalysis and was less likely than other analysts to consider modifications of his method. Jeliffe considered psychoanalysis to be a rigorous treatment which required "real guts" and honesty on the part of his patients, and

he told them as much (Rechtschaffen, 1959/1977). Jellife did believe that in some cases of real deprivation of resources the patient's illness (neurosis or psychosis) seemed to be a better solution to life's difficulties than any that reality could offer. Some 20 years later Fenichel, as noted above, expressed his opposition to psychoanalysis of the elderly for precisely these reasons (Kaufman, 1940; Rechtschaffen, 1959/1977; Blum & Tross, 1980).

Jung (1954) was the first psychoanalyst to write extensively about the second half of life. He had a stronger feeling for the importance of adulthood and gave it a more significant role in his theorizing. He noted that Freud's views were applicable to the young but observed that the psyche undergoes a marked change during the course of life and that the tasks of aging have a merit of their own. Jung felt that middle adulthood was a period of significant psychological growth and transition during which time a person could begin to get in touch with formerly repressed aspects of the personality. He stated that men in their forties become more aware of their feminine aspects, as women are more comfortable with their masculine aspects.

Though Jung believed that adulthood was of sufficient importance to deal with it conceptually, as Mann notes, his emphasis was on normative development rather than on clinical issues (Colarusso & Nemiroff, 1981; Mann, 1976;

King, 1974; Nemiroff & Colarusso, 1985).

Erikson (discussed earlier) was among the few psychoanalytic theorists who dealt with adulthood as a significant developmental phase of the life cycle. But as Gould (1972) and Mann (1976) noted, Erikson's major interest was in childhood and adolescence, and the psychoanalytic community has continued to focus on his conceptualizations in these areas whereas his writings on adulthood have been largely ignored.

M.R. Kaufman (1940) discussed his successful work with two patients "well advanced in years" (i.e. over 55 years old). As a result of his work with these patients, Kaufman concluded that psychoanalytic technique with relatively little modification was applicable to the elderly (p. 75). Rechtschaffen (1959/1977) observed that Kaufman's patients did not meet the criteria of analyzability suggested by Freud and Fenichel because Kaufman's patients were too old and psychotically depressed when treatment began. Nonetheless, Kaufman observed rapid change in relatively short periods of time leading him to dispute the contentions that change in older patients is predicated on long periods of treatment. Kaufman questioned Freud's early views concerning the rigid ego of the aged. He saw rigidity as one more variant in the range of defense mechanisms (rather than as an irreversible physiological impairment) for which

psychoanalytic interpretation was the treatment of choice (Rechtschaffen, 1959/1977; Myers, 1984).

Myers (1984) fusses a bit about neither treatment being truly "psychoanalytic" because the rule of free association was not followed. But he emphasizes that 1) both patients did improve after several months' treatment; 2) improvements were maintained over the long term and 3) patients were able to form potent relationships with Kaufman.

In 1940 Martin Grotjahn wrote the first of three articles on the treatment of the elderly, entitled "Psychoanalytic Investigation of a Seventy-one-year-old Man with Senile Dementia," a treatment which was undertaken as a research problem. Grotjahn hoped that the understanding of the psychodynamics in the case of a psychosis would help in the understanding of the everyday problems of growing old. Grotjahn felt that the patient's biological and social dependence made the analyst more of a real object (as opposed to simply a transference object) in the analytic situation and as such was similar to child analysis. Though he cautions against generalizing from so unusual a case, the author felt that growing old was a particular trauma for the narcissistic person "who in his imagination possesses eternal youthfulness" (p. 97). In Grotjahn's model, this narcissistic blow repeats the castration threat so that the neuroses of old age are defenses against castration anxiety. Grotjahn felt that

his patient's strong transference to the therapist, afforded protection against fears and allowed for a partial readjustment to reality.

Both Rechtschaffen (1959/1977) and Blum & Tross (1980), viewed Grotjahn's discussion of this case as one of the first in which an analyst was to strongly emphasize the real needs he was required to fill in the life of the geriatric patient. Blum & Tross saw Grotjahn's treatment as an admixture of social contact and support with analytic interpretation of unconscious symbolic meaning. They likened this to the eventual shift in psychoanalysis toward ego psychology and a concept of adaptation. Rechtschaffen suggested that Grotjahn seemed to have anticipated the development of modified analytic techniques in the treatment of the aged. None of the authors pointed out that Grotjahn's patient with organic senile dementia was more sick than he was old. One could undoubtedly find a more appropriate case from which to generalize universal theories about treatment of the aged, unless of course one specifically intends these theories for the sick, debilitated, psychotic aged. But this in no way detracts from Grotjahn's useful observations.

In "Some Analytic Observations about the Process of Growing Old," written in 1951, Grotjahn notes that the essential task of the aging person is the integration of his past life experience. Commenting further on his 1940

case, Grotjahn noted that an accident in the patient's 65th year had shattered his lifetime illusion of narcissistic invulnerability. However, the patient's excessive narcissism prevented him from using this last chance to make a realistic adjustment. Instead he adopted psychotic defenses to deny the threats of reality. Grotjahn believed that psychiatric treatment would be more useful to those patients who did not suffer from psychosis or extreme narcissism. He said that in some cases the experiences of aging could be a therapeutic asset and actually facilitate therapy. For example, resistance to unpleasant truth is often lessened in old age and reality demands which may be narcissistic threats to the young may have become acceptable to the old. Occasionally, too, aging people will have less trouble integrating interpretation than younger patients in analytic therapy. "Lifelong struggle", stated Grotjahn, "is sometimes a good preparation for psychotherapy: it loosens the ground and shatters character defenses" (p. 309). And finally, Grotjahn spoke of integration of one's life as it has been lived, and acceptance of death as the tasks of old age. (A concept similar to Erikson's 7th stage of the life cycle.)

In his third article on the subject written in 1955, Grotjahn addressed himself to transference and countertransferential issues in working with this age group.

Summary

Despite Freud's pessimism and the prevailing analytic mood there were a few psychoanalysts who, during the earlier years of psychoanalysis, observed that their older patients did in fact respond well to psychoanalytic treatment. Some psychoanalysts addressed the clinical issues encountered in their work while others wrote more generally of the significance of the second half of life to the entire life cycle. These authors noted that contrary to popular belief their patients 1) did not suffer from rigidity of the ego, 2) could make and sustain significant improvements in treatment, and 3) were sometimes less resistant to treatment than were younger patients. The theory and techniques of classical psychoanalysis served as the point of departure for psychoanalysts writing during this period and so there was some concern among them about any deviations from the classical model (i.e. modifications in treatment) necessitated by age. For example, the possibility that the analyst might have to be more of a "real person" to the elderly patient was suggested. For the most part the actual deviations cited were due more to diagnosis than to age.

Nonetheless the importance of a "classical" frame of reference and its impact on the assessment of "analyzability" cannot be dismissed. Before continuing

with a review of the literature of subsequent years I shall briefly consider the evolution of psychoanalytic concepts and its effect on dynamic work with the elderly.

<u>The Influence of Changes Occurring in Psychoanalysis and Psychotherapy on Dynamic Work with the Elderly</u>

The literature on the early historical perspective of psychoanalysis with the elderly (as presented above) stems from the principles of orthodox or classical psychoanalytic theory. That is to say, Freudian thinking about theory and method was the accepted point of departure from which all deviations were measured. In examining the subsequent literature on psychoanalysis (and psychotherapy) and the elderly one must keep in mind that it occurred within a larger context of the evolution of psychoanalysis itself. Modifications that were thought to be peculiar to work with the elderly were to some extent barometers of changing thought in the field itself. There grew to be considerable variation in what might properly be called psychoanalysis or psychoanalytic psychotherapy and the criteria for determining which patients were appropriate candidates for insight-oriented therapy were broadened.

At its inception the application of Freud's theory of therapy was limited to a few types of cases. As knowledge of psychoanalysis grew, people with all kinds of emotional difficulties began to seek treatment in increasing numbers. Alternative perspectives were

advanced by Rank, Ferenczi, Reich, Horney, Fromm and many who followed (Thompson, 1950). Modifications in theory and in practice became part of the field and part of the literature. While some analysts held fast to the belief that only hysteria, obsessions and phobias were suitable cases for psychoanalysis, many did not. Certainly there was a push to find effective therapeutic techniques for many kinds of emotional difficulties. Nonetheless there was internecine quarreling as to what might appropriately be called psychoanalysis and these disagreements have never been resolved.

Classical analysts believed that analysis differed from other forms of therapy in three essential ways: maintenance of neutrality by the analyst, development and resolution of a transference neurosis, and the use of interpretation as the primary therapeutic intervention.

Clara Thompson (1950) believed that the mid-1920s witnessed the beginning of great changes in therapeutic technique and goals. With respect to technique she cited a tendency to greater activity on the part of the therapist, a structuring of the patient's discourse towards pertinent topics (and away from "interminable, unfruitful" free associating), a decrease in the number of hours per week required for treatment, and an acceptance of the patient's sitting up if this was deemed to be more useful. As regards goals, Thompson spoke of a move away from the uncovering of childhood repressions and toward an

expansion of awareness of the ways in which the patient himself contributes to his difficulties in living.

There are many who would strongly disagree with Thompson's 1950 description of psychoanalysis, and might instead call it therapy, or psychoanalytic psychotherapy. Paolino (1981) states that the American Psychoanalytic Association organized an official committee on the evaluation of psychoanalytic therapy. After five years of work the committee remained unable to agree on criteria by which to distinguish psychoanalysis from psychoanalytic therapy (also called psychoanalytically oriented psychotherapy). Paolino writes "It is not at all uncommon to find one author referring to psychoanalysis, while another author discusses identical concepts but associates them with psychoanalytic psychotherapy" (p. 105). The controversy has raged for 50 years and continues to do so. To address it further is beyond the scope of this study, although Paolino provides a most satisfactory reference list (p. 114).

A number of factors are relevant here. First, one must keep in mind that treatment hardly ever exists in pure form. The clinical situation is almost always far more complicated than any theoretical dogma.

Second, the writers cited above and those discussed below made their observations about the elderly amidst fluctuating notions both as to what constitutes "analysis"

or "psychoanalytic psychotherapy" and as to who is an appropriate candidate for such therapy. Judgments with respect to the latter varied from the beginning. Harry Stack Sullivan of the United States and Bion or Segal in Britain treated more seriously ill patients with psychoanalysis than did Freud. In general, adherents of any given school had little or no communication with adherents of another school. Furthermore evolutions of psychoanalytic thought occurred within particular schools and some Freudians today advocate psychoanalytic treatment for borderline and narcissistic character disorders despite the fact that, at one time, they believed this to be ill-advised. The elderly, then, are just one group whose relationship to psychoanalysis has been part of evolving thought.

The third consideration has to do with the elderly themselves. Aging is changing. Our interests in aging are changing, our attitudes toward aging are changing and the aging themselves are changing. And to underscore one theme of this dissertation, the aged are not so much old, as they are many of the other attributes which characterize them as individuals. Our purpose here is not to articulate the effects on each of these factors on the theorizing of the authors cited below. It is rather, to emphasize that every time an author comments on psychoanalysis with the elderly all of these factors come into play. In essence, each author conveys, not only his

sense of therapy with the elderly, but though not always explicit, his theory of therapy and his theory of aging. And, among authors, these are not alike.

Some Later Writers - 1950's through the 1970's

One enters the 1950's with the knowledge that the face of psychoanalysis was changing. A number of differing techniques laid claim to the label of "psychoanalysis" and there was increasing awareness that no treatment method was applicable to all problems. To this day, psychoanalysts continue to debate which treatment for which disorder. It is against such a backdrop that we shall review the writings of the following authors: Wayne, Meerloo, Segal, Klein; selected members of the Boston Psychoanalytic Society (Berezin, Cath, Zinberg & Kaufman, Kahana); Sandler, King and Shainess. Clearly, what an author proposes as the proper treatment for the elderly will be influenced by his understanding of what it means to be old, at times based on his experience with idiosyncratic problems of aging. Nevertheless certain themes do emerge and these will be summarized at the end of this section.

George Wayne (1953) advised that in general therapists not continue to seek the ideal patient for a rigid psychoanalytic technique. He suggested that they adapt techniques to the needs and capacities of the patient. He felt that treatment of neurosis in the aged was similar to

treatment of younger patients, but suggested that treatment of the aged might require greater flexibility from the therapist. What possibly distinguishes the aged from younger patents, according to Wayne, is their depreciated status in society, perceptible evidence of organic decline and a tendency to somatize. Wayne, like Grotjahn, explained feelings of rejection and isolation triggered by such factors as the rekindling of childhood castration fears and long term core conflicts. Despite such a generalization, Wayne does stress the need for assessment of the _individual_ patient stating:

> Every therapist has patients who at fifty work better and show more satisfactory results than others at twenty- five...These patients who work and respond well in therapy are characterized by the lesser need for secondary gain from the illness, as well as by greater ego strength. The patient's suitability for therapy and the extent of goal limitation, must rest then upon the therapist's unprejudiced evaluation of these factors, as well as upon the real demands of the patient's environment (p. 115).

Based upon his sense of the psychodynamic implications of the cultural bias toward the elderly, Wayne offers what for him represents a modified psychoanalytic method of therapy. It is problem-oriented and does not necessarily probe unresolved conflicts. Wayne suggests:

1) Enough historical material is obtained to permit a genetic psychodynamic formulation and to understand transference behavior. The therapist seeks to understand the patient's characteristic way of dealing with life situations.

2) Goals are decided as soon as possible. Structural character changes are not necessarily the objective.

3) A crucial current problem may be the central focus. It will keep the patient from feeling the therapy is tangential and will maintain his interest and his hopes. Old conflicts need not be rekindled.

4) The therapist's role is relatively active in directing the course of therapy. He offers interpretation of transference reactions and also "manages" the patient by way of supportive reassuring discussions, guidance and environmental manipulations.

5) The patient faces the analyst in order to decrease anxiety, increase the feeling of being understood, lessen dependence on the analyst, and minimize regressive material. A reverse transference may ensue.

6) The patient should be given a part in solving his own problems and not be allowed to fall into a dependent passive attitude.

7) Some time should be devoted to realistic discussions of the cultural attitude toward the elderly as reflected in society and in the patient's particular situation. The patient should be helped to accept himself as an elderly person.

8) Duration and frequency of therapy must be judged individually. Visits will usually vary from 1-3 times per week. Therapy will usually last from six weeks to a year. Therapy need not be finally terminated and the patient must feel he can return if necessary.

Meerloo (1955) treated patients as old as seventy-two, seventy-three, and eighty-two years of age with regular analytically oriented psychotherapy. While known to have been persistently optimistic on the subject of treatment of the elderly (Rechtschaffen 1959/1977), some of Meerloo's assumptions about the aged went unnoticed. For example, Meerloo chose to define aging as the onset of involution and decline. This being the case it is not

surprising that he expressed his beliefs that older people have no future, that they suffer a weakening of ego and ego defenses and that psychopathologically old age is "a traumatic neurosis with continuing trauma" (p. 74). Nonetheless Meerloo is a true advocate of the aged and of treatment for the aged. He presents a scathing indictment of American society whom he blames for the shock value attached to every suggestion of elderly decline.

According to Meerloo (1955) a changed psychotherapeutic procedure is required for the elderly. The analysis of resistance is not needed because defenses break down spontaneously and so older patients may respond more readily to interpretations. Like Grotjahn (1955), Meerloo attributes decreased resistance to the patients' urgent needs to review their lives and to assess their achievements in the light of their goals. This is in contrast to Freud who viewed geriatric rigidity as an obstacle to treatment and in contrast to Kaufman who viewed rigidity as a defense to be dealt with therapeutically. Rechtschaffen (1959/1977) believes that Grotjahn and Meerloo stand in fundamental disagreement with the majority of therapists who have noted the aged patient's need to cling to a self-concept developed over a life-time.

Again, like Grotjahn (1955), Meerloo (1955) believes that in working with the elderly the therapist is more often called upon to fill a need for interpersonal

relationships which are missing in the patient's life. This may make resolution of the transference more difficult (Rechtschaffen, 1959/1977; Myers, 1984). Meerloo notes that older patients, who often feel themselves to be in a hostile world may form an intense transference to a caring therapist which may result in a dramatic turnabout in symptoms. Meerloo also comments on reverse-transference, that is the likelihood of the usually younger therapist representing a child rather than a parent to the patient. In connection with this Rechtschaffen (1959/1977) comments on another view of this phenomenon. He cites Hollender's position that the aged patient might indeed feel toward the younger therapist as he does to an adult child, but ventures that such a child would actually be like a parent to the patient. Although he believes that in many cases the same rules of psychotherapy can be used with older as are used with younger patients, Meerloo, like Wayne, stresses the greater need for education, for environmental modification, and for indeterminate termination, in working with the elderly (Rechtschaffen, 1959/1977).

Hanna Segal's 1958 article on the analysis of an old man was reviewed by Myers (1984). Myers credits Segal with being the first to cite clinical material from the analysis of an aging patient though he notes that the analysis lasted for only 18 months because the patient

relocated. The patient, a man in his mid-70's, saw his imminent death as the cause of sorrow and mourning. The analysis enabled him to come to terms with his own life and he ended the treatment feeling that his life had been worth living. Treatment also helped the patient to see his children and grandchildren as separate people rather than as projections of himself. And he could now love them without envy of the longer time they had yet to live.

Myers (1984) notes that Melanie Klein, in her book, Our Adult World (Basic Books, 1963), concentrates on the attenuation of excessive feelings of envy as a criterion for normal adaptation to old age. Klein stated that people who could identify with the pleasures of significant others in childhood without excessive envy were more likely to be able to do so in old age. Myers comments on the Eriksonian theme of acceptance of the past without too much envy - as a prerequisite for successful aging. But he fails to mention the centrality of the theme of envy in Klein's late writings. In Klein's view excessive envy in a person can lead to the sabotaging of life throughout the life cycle (Klein, 1957/1980). That she should feel this to be true in the last stage of life is not surprising.

The Boston Society for Gerontological Psychiatry has, over the years, sponsored symposia on the psychoanalytic psychology of aging which have since been published as three books. The first of these, Normal Psychology of the

Aging Process (Zinberg & Kaufman, 1963; revised 1978), boasts an impressive list of contributors (many of whom are also members of the classically oriented Boston Psychoanalytic Society and Institute.) Some salient points of a number of authors who contributed to the 1963 (revised edition) volume will be quoted here.

Zinberg and Kaufman (1963) feel that all of the defense mechanisms and ego functions that were available to an individual in his youth are potentially available in old age. They state that defenses are specific to the individual rather to the aging process per se. Therefore changes in defenses occurring during aging would be only relative shifts in enduring patterns. The authors state that it is not possible to define one single type of older person. But they do think that the need for narcissistic supplies (love, succor, respect, and gratification that comes from people) occurs more in the aged because fewer responses from other people are available. Where new approaches to treatment are employed--because of psychosis, hospitalization, or for other reasons--psychoanalysts should remember that many analytic principles and techniques remain relevant.

Berezin (1963/1978) notes that conditions of loss may impinge on any aging person, but the essential information will be knowledge about the individual who suffers the losses. Berezin was, at the time of this writing,

concerned with the centrality of regression in the life of the aged. He saw as evidence of regression a preoccupation with food and with bowel conditions related to the refusal of old people to relinquish genital primacy at a time of life when the sexual drive is not physiologically active. This view of older age sexuality seems to have been modified in Berezin's subsequent writings. In a review of the literature on "Sex and Old Age", completed in 1969, Berezin debunks the notion that old age either is or should be a sexless era and refers to the many elderly who have strong sex desires (Berezin, 1978). Even later Berezin states,

> Older people of any age want the same things they have always wanted -- the same, in fact, as those sought by younger people: affection, intimacy, love, tenderness, and all sorts of nurturing experiences, including sexual ones... The chronological age of the patient is essentially irrelevant to the issues of psychotherapy: illness is relevant, but not age. The same can be said for the sex life of the elderly -- sexual activity in men and women never ceases because of age alone. Sexual activity may diminish in frequency, perhaps in intensity and it may be affected by health factors, but it is otherwise unaffected by age in both men and women.... The older person who was sexually active in youth will be active in old age.... The sex drive may be seen as a model for viewing the elderly in other aspects of life as well" (Berezin, 1982, p. 2).

The notable points of an article written by Stanley Cath for the 1965 volume of the Boston Society were outlined by Myers (1984). Cath focused on the increasing dependency needs and use of transitional objects (money, photographs) observed among older patients as a response to the loss of significant people ("object losses") in

their lives. Cath believes that the depletion of resources in late life triggers restorative measures to rebuild self-esteem. An example would be the idealization of children seen after some loss of sense of self. In a more recent article, Cath (1986) reports on therapeutic work with a woman in her late fifties who was greatly helped by her treatment. Cath reiterates his construct of "omniconvergence", a peaceful coming together of the personality that he believes to be characteristic of the older personality. He pays particular attention to the impact of the real changes that take place within the patient's home, family and social setting, but he does this no matter what the age of the patient. Cath believes that analytic growth in his patient occurred under difficult circumstances because of a last-chance imperative: last chance for self-improvement and self-actualization.

In April 1977, Anne-Marie Sandler of the British Psycho- Analytic Society presented a case at a Scientific Meeting of the Boston Society on "Psychoanalysis in Later Life." The case is said to be the most detailed case history of the analysis of an older patient and as such deserves some elaborated attention here (Kahana, 1978; Myers, 1984; Nemiroff and Colarusso, 1985).

Sandler (1978) describes the analysis of a fifty-eight year old man seen five times per week until the age of

sixty-six, and characterized by Sandler in her paper's subtitle as "an aging narcissistic patient". Mr. X came for treatment because of a panic attack related to his fear of inability to function effectively at work. He was described as an awkward, self-effacing man, sexually impotent with a beautiful wife whom he idealized, intensely proud and easily humiliated, desirous of love and admiration. In the course of his treatment he left his job, returned to school where he earned an advanced degree magna cum laude, left his wife, remarried, became sexually active, designed and built a house in the country, and took a part-time teaching job -- in his new field. The case was discussed by Kahana (1978) and Myerson (1978) and later reviewed in the literature (Myers, 1984; Nemiroff and Colarusso, 1985). Sandler's focus and the subsequent discussions are of enormous interest here.

In reading Sandler's (1978) presentation, one is struck by the fact that the case unfolds as if age were of relative insignificance. There are no reported special difficulties in analyzing the patient that stemmed from his age. Sandler states,

> ...one might start by taking it for granted that adaptation to inner and outer reality must continue through life...It seems to follow that psychoanalysis, insofar as it is an intervention in the ongoing process of adaptation, can be of use with older patients just as with younger ones....(The patient) presented with a neurotic personality disorder with marked preoedipal conflicts and severe problems in the area of self-

> esteem regulation. He had long-standing difficulties in work, sexuality, and social relations. He could, I think, have benefitted from analysis at any time in his life...(p. 6)

Myerson (1978) begins his discussion of the case as follows:

> I shall discuss the patient Mrs. Sandler so beautifully describes as if his age were irrelevant to the basic therapeutic issues....I shall take the point of view that the course of his analysis would have been essentially the same no matter at what age he had undertaken it....(p. 57)

Myerson goes on to say that Sandler provided the best possible treatment to her patient and that whatever limitations existed were due to the patient's childhood experiences and not to his age. Myerson's remaining discussion concerned itself with the issue of the development of a transference neurosis ("a best way to be analyzed") and the limitations of narcissistic patients in this regard. No further mention was made of the patient's age.

Myers (1984) in his review of the case makes only two references to age. One, that Sandler notes the patient is concerned with aging and two, that the patient's mourning for his father helped him to prepare for his own old age. Myers' greater interest is in Sandler's use of self-psychology formulations as opposed to classically analytic interpretations. (i.e. feelings of humiliation rather than feelings of castration anxiety). Nemiroff and Colarusso (1985) similarly point out that "Sandler's case illustrates brilliantly how a standard psychoanalysis can

be useful to a man in late middle age who is approaching old age and suffering from neurotic symptoms embedded in a narcissistic matrix" (p. 31). The point is--that for each of the discussants the age of the patient did not really alter the psychoanalysis. In fact Kahana (1978) in his discussion of the case finds that its value to the study of aging is its focus on narcissism. In other words, the dynamics of the case were not obscured by a focus on the patient's age. Kahana finds that, "The patient's therapeutic movement is the most telling argument against unyielding 'rigidity' of mental processes." Movement included awakening of feelings, loosening of defenses, mobilization of conflicts at phallic and prephallic developmental levels, representation in dreams of unconscious wishes and fears, response to skillful interpretations, recovery of memories, increasing insight, better resolution of conflicts and reorientation of his life (pp. 44-45).

Both King (1974, 1980) and Shainess (1979) have written papers based on their analyses of patients in mid-life. These patients are slightly younger than the age group addressed in this study but both authors make comments which extend our knowledge of psychoanalysis of the elderly. King (1974) describes her analytic work with a number of middle aged patients whom she classified as narcissistic personalities. She speculates that these

patients, all successful professionals, first sought treatment at mid-life because they felt that the prospect of aging threatened them with disintegration. These were patients who, according to King, had used their professional roles, achievements, and family members' successes to support interpersonal egos. These were false-self identifications which could not hold up against the physical, psychological and social effects of aging. King suggests that the following five factors are sources of anxiety and concern which lead patients to seek therapy during the second half of life:

> 1. The fear of the diminution or loss of sexual potency and the impact this would have on relationships.
>
> 2. The threat of redundancy, or displacement in work roles by younger people, and awareness of the possible failure of the effectiveness of their professional skills, linked with the fear that they would not be able to cope with retirement, and would lose their sense of identity and worth when they lost their professional or work role.
>
> 3. Anxieties arising in marital relationships after children have left home and parents can no longer use their children to mask problems arising in their relationship with each other.
>
> 4. The awareness of their own aging, possible illness, and consequent dependence on others, and the anxiety this arouses in them.
>
> 5. The inevitability of their own death and the realization that they may not now be able to achieve the goals they set for themselves, and what they can achieve and enjoy in life may be limited, with consequent feelings of depression or deprivation (p. 154).

One can see that the common denominator among these factors is loss. King states that the awareness of such

changes brings a sense of urgency into the analysis which may facilitate a therapeutic alliance stronger than that established with younger patients. She feels that an understanding of patient's life cycle pressures becomes available to the analyst through the vehicle of transference which highlights past conflicts and makes them accessible to analysis. King finds that the analyst can be experienced in the transference as any significant figure from a past which may span five generations. And further--for any one of these transference figures the roles may be reversed (i.e. the patient treats the analyst as he felt he was being treated). The author believes that the successful treatment of older patients is dependent upon their re-experiencing and working through in the transference, the traumas and psychopathology of adolescence. During both of these phases of the life cycle the individual must face sexual, biological, socio-economic and role changes, as well as conflicts about dependence and independence. King suggests that these shifts precipitate identity crises which necessitate changes in self-image and may injure self-esteem.

King addresses certain reality problems that the analyst may encounter in treating older patients. These include time limitations imposed by age, possible financial constraints, and negative therapeutic reactions

linked to older patients' fantasies that by avoiding therapeutic improvement they stop the clock and therefore avoid aging and death.

Shainess' (1979) analytic work with middle aged patients led to the analyst's surprise at her patients' capacity for change and caused her to reconsider her own bias against working with older people. Although Shainess' presentation of her work is very different from that of Sandler, as in the case of Sandler, treatment proceeded without any unusual concessions to the age of the patient. The changes in these patients would have been noteworthy at any age since Shainess selected for presentation "four patients who would hardly have been regarded as promising prospects for analysis, even if they had been young" (p. 399).

Shainess asks herself what enabled her patients to change or rather what makes for change in psychoanalytic treatment. She extrapolated a few factors in her patients, and especially those in herself in attempting to account for change. In extending this to the older person she suggests that change may be related to the analyst's intuitive feeling of hope.

<u>Summary</u>

The authors of the 50's, 60's and 70's, focused more than did their predecessors on the lowly status of the elderly in Western culture. This is not to say that the analysts themselves were immune to the effects of that

bias, but they were cognizant that the elderly had come to be regarded as a class and that their class was subject to cultural prejudice. In addition, psychoanalysis was itself evolving and some analysts (moving beyond the realm of a rigid classical psychoanalytic technique) were becoming more comfortable with greater flexibility for different patients and perhaps even for different classes of patients. In some instances, when analysts presented case histories of individual older patients the age of the patient was treated as just one attribute which was not of overriding significance. When aging patients were conceptualized as being part of a class (i.e."the elderly") there was an attempt to distill the alterations, modifications and manifestations of psychoanalytic treatment that applied to the elderly as a group. (In fact this very manner about thinking of older patients as suggested by some of the research presented here on pages pp. 43-47.) When viewing "the elderly" as such, psychoanalysts continued to see loss as a major issue, suggesting that decreased resources led older patients to have increased needs for narcissistic supplies, more intense transferences, or greater needs for the analyst to be more of a "real" person (all variations on one theme). There was also a sense that the losses triggered measures among the elderly to rebuild self-esteem, and that old age served as an incentive to work harder in treatment because

of a sense of urgency (termed "the last chance imperative" by Cath, 1986) which also resulted in decreased resistance. Additional attention was paid to certain reality problems (such as the limitations imposed by a fixed and diminished income) that analysts may confront. Despite the search for common themes, psychoanalysis always returns to the individual. Berezin (1963) cautioned that one must keep one's eye not on the losses themselves but on the person who experienced the losses.

The 1980's

The separation of the writings of the 1980's from those of the previous decades was not arbitrary. The 1980's have been witness to an explosion of interest in older people and this seems to have sparked the psychoanalytic community as well. This is not to say that the authors reviewed here are new to the field; indeed they are not. But one senses that they write for a more accepting audience than did their predecessors. Shainess' (1978) shock that older people can change is not so much in evidence. Work with the elderly is becoming more fashionable. There is less debate about whether psychoanalysis with the elderly is feasible and greater interest in the individual old person and in what treatment with that old person can teach us--about psychoanalysis, about personality, about aging, about change, about life.

Kernberg (1980) in his examination of narcissism,

states that all humans must eventually come to terms with their own limitations. This is usually faced during middle life. Such acceptance implies a resolution of oedipal rivalries and preoedipal envy and leads to experiences of enjoyment and gratitude rather than jealousy, shame and envy. Self-acceptance despite limitations is a sign of emotional maturity. This is in contrast to the denial, rationalization, cynicism and self-blame of the narcissistic personality. In Kernberg's view narcissistic individuals spoil success because they are endlessly greedy and never satisfied. Though ungrateful for their pasts they nevertheless envy what they no longer have. Regret over the passage of time and guilt over what was missed makes aging especially difficult for these people.

Kernberg (1980) sees narcissistic personalities as prone to depression in middle age. At this time they may see psychoanalytic treatment as holding out hope for self-awareness and growth. Both motivation and prognosis may be better than if they had sought treatment earlier in their lives. Like Shainess, (1979) Kernberg feels that the analyst's conviction that the middle-aged patient has the time, opportunity and potential for changing his life will enable the analyst to help his patient come to terms with the past and with the present. The analyst's attitude toward his own aging may determine how far he

dares to go with his patient.

Cohen (1982), like Kernberg, remarks on the tendency of narcissistic patients to seek psychoanalysis at middle age or later, and after earlier attempts at self-cure have failed. And, like Kernberg, he observes that the declines and losses of aging triggers underlying envy and destructiveness for which older narcissistic patients seek relief. In presenting a patient in his mid-fifties whose main complaint was that he suffered from loneliness, Cohen underscores how the patient's fear of dependence increased his narcissistic defenses which in turn increased his loneliness. Aging may require one to seek environmental help and in so doing to acknowledge dependency. Psychoanalysis can mitigate excessive envy and rivalry and thereby diminish the loneliness which often accompanies aging.

In his discussion of Cohen's paper, Loch (1982) questions whether psychoanalytic treatment in a mid-life crisis differs from standard treatment. He concludes that no "technical parameters have to be taken into consideration" (p. 270). Pollock (1982) discussing the same paper suggests that the patient's pathology could have emerged at any time and is not specific for middle or later age. He emphasizes that middle aged and older patients are not all alike and he lists eight categories of disorders applicable to patients of any age. To these he adds changes, specific to aging (e.g. retirement),

which may call for the newer defensive and coping strategies. Some people adjust to stress without dysfunction, in others pathology, not previously evident, may emerge. Pollock states that psychopathology need not be linked inevitably with childhood. Rather later life experiences affect later life reactions. In his work with middle aged and older adults, Pollock has found that they retain a capacity for insight, for therapeutically induced transference, for dream analysis, for motivated change, for present and retrospective self-observation, for mobilization of libidinal and constructive aggressive energies, for mourning the past in a way that allows for investment in the future.

And finally, four recent articles have been published on the psychoanalysis of the older patient (Simburg, 1986; Miller, 1986; Cath, 1986; Muslin, 1986). Simburg reports on the analysis of a sixty-four year old woman whose age, he found, did "not complicate the work of analysis" (p. 131) but who in some respects had assets which facilitated the work. He reasoned that development continues throughout the life course, that structural changes (ego and superego functioning) continue to be possible, that criteria for analyzability remain constant and that the chronological age of the patient is not an indicator of eligibility for psychoanalysis. Simburg's patient was able to recall childhood experiences and the feelings

associated with them and to see their relevance to the present. Preoedipal and oedipal material were available to the analysis. Simburg further observed (as King had noted in 1980) that at any moment in her analytic hour this patient could be dealing with material involving any one of five generations. This flow of identifications through the generations, repeats Miller (1986), is a more complex time spectrum than one usually deals with in the analysis of younger patients. Certain distinctive qualities were found in the older patients who had been referred to Simburg; each quality of positive value in facilitating the work. These were: the patient's sense of reconciliation to his achievement level, a relatively low level of defensiveness, acquired wisdom, a sense of personal values, and a quality of mood for which Simburg used the term _mellow_. (Italics are Simburg's.) Cath, both in the course of chairing the December 1982 meeting of the American Psychoanalytic Association (his remarks reported by Nancy Miller, 1986), and in an article published in 1986 ("A Psychoanalytic Hour: A Late-Life Awakening", discussed above on pages 70 and 71) reaffirmed his dedication to correcting the misperceptions of psychoanalytic ageism. Individuals in later life, no more or less than earlier, wish to protect themselves from loss and express a continuing need for repair and restitution. The need for protection may motivate a deeper attachment to the analyst and a wish to find invulnerability

(something Myers, 1984, has also suggested), and possibly anticipatory grief which would show itself by a distancing from spouses or children.

And last, in describing the applicability of Kohutian self-psychology to the treatment of the elderly, Muslin (1986) too, found that his seventy-year-old patient's psychopathology of the self, manifested by presenting symptoms of depression, hypochondriasis, lack of vigor and anhedonia, was not age specific. And additionally, that advanced age did not interfere with the psychoanalytic process. In working with elderly patients with deficits of the self, the analyst must accurately appreciate the self-needs of the patient and appreciate the fact that they do possess the ordinary capacities for the work.

Perhaps Muslin's (1986) article, more than any other, heralds the inclusion of the elderly patient into the realm of psychoanalytic inquiry. When "schools" of psychoanalysis begin to lay claim for the efficacy of their particular treatment approaches to certain groups of patients, one may surmise that the acceptance of members of that group as viable candidates for psychoanalysis has begun to take place.

Three Recent Books on Psychodynamic Treatment of the Elderly

As was noted both in the Introduction to this study and at the beginning of this section on "Psychoanalysis and the Elderly," three books have recently been published

which strongly advocate psychoanalysis and psychoanalytic psychotherapy for the elderly. Each book offers evidence of clinical success in this area.

Myers (1984), the author of the first published of these books, and an analyst trained in the classical tradition states firmly that, "In essence, Freud's dicta against analyzing people over the age of 50, because of their presumed ineducability and their inelasticity, was unwarranted, unwise, and inaccurate" (p. 237). Myers presents six cases, four of which were psychoanalytic treatments of patients between the ages of fifty-four and sixty-two, and two of which were of patients aged sixty and seventy-one, who were treated by psychoanalytic psychotherapy. He goes on to state his conclusion, based on his work with older patients, that their analyses do not materially differ from those of his younger patients. Analyzability is determined for his older patients using the same criteria that obtain for younger patients. Namely, psychological-mindedness and introspective capacities, the capacity for reality testing, the acceptance of one's life and the significant people in one's life without rage or envy toward them, the capacity to invest new objects (and hence to form a transference relationship with the analyst), and the ability to accept one's own imperfections. Like others before him, Myers feels that certain issues have special relevance in the

treatment of the aged. These include the capacities to come to terms with one's own limitations, to enjoy life and others without envy, and to perceive time as finite rather than as infinite. With respect to the perception of time, Myers cites King (1980) in suggesting that motivation may be increased in the elderly by virtue of their recognition that the treatment may represent the last opportunity to change their lives. The theme of loss, already prominent in this literature review, is also discussed by Myers (1984) who notes that the impact of loss on an older person, whether the losses be those of physical capacities or of significant persons or roles, is inevitably related to the sense of self and to regulation of self-esteem. To some extent then successful analytic treatment in this age group must lead to a degree of acceptance of limitations. An additional core issue for Myers (1984) is the extent to which the transference wishes of older patients seem to ignore age differences between patient and therapist. Intense sexual transferences are not unusual. Myers finds, however, that an older patient may attempt to "suck up the youth" of the younger analyst to avoid recognition of the aging processes and the imminence of death. He refers to this as the "Dracula syndrome" (p. 243). Myers is especially open about his personal reactions in his work with his patients and these reactions are covered in some detail in the section on Countertransference which follows.

A word about the cases is in order because they provide a feel for the actual work with older patients. Myers' (1984) cases illustrate the efficacy of psychoanalysis and psychoanalytic psychotherapy for the over-sixty patient. By his own admission, not all of the cases were "unmitigated success stories" but few analyses are. What they do illustrate is the heterogeneity of life histories and what can be accomplished in treatment at any age. Myers first presents a fifty-nine-year-old man with a lifelong potency problem whose earlier psychotherapy had not been successful. The patient's father had died at the age of sixty and the patient wanted not only to live beyond that age but to find some happiness in life. The analysis lasted six years during which time the patient remarried, resolved his potency problem, and formed more meaningful interpersonal relationships. Myers notes rather emphatically that it is unlikely that the patient developed a remarkably greater capacity for object-relationships during his analysis. Rather, the obstacles to the patient's original ability to relate to others intimately were removed by the trust developed in the transference relationship. The patient was resilient, had access to unconscious material and to childhood memories, worked well with free association, dream and fantasy material. Myers (who was forty at the time treatment began) felt that the patient wished to "borrow" the

analyst's youth in order to develop his own sense of manliness.

The second case is that of a fifty-four year old depressed, lonely, alcoholic woman whose son had died in Vietnam and whose husband subsequently died of a heart attack. This analysis also lasted six years and differed very little from standard analyses demonstrating "...the ability of the older patient to deal with difficult psychodynamic, genetic and transference material with the ease of a younger patient" (pp. 66-67). The patient gave up drinking and embarked on a productive life. The third case describes a fifty-five year old virginal masochistic woman. Myers (1984) uses this case as an occasion to point out that most older individuals suffer some degree of survivor guilt since they have outlived certain significant people in their lives. Because of this, according to Myers, it is sometimes easier for older patients to work with younger analysts who are likely to survive them and thus not be injured by their anger. In other respects, Myers discusses this case as he would any other without any special alterations due to age. He focuses on the dynamics, in this case the patient's masochism, on the elements of transference, and indeed on the opportunity to reaffirm his own support of the principle of deprivation in analysis based on the fact, he reports, that one can never really make up to the patient for childhood deprivations. (That this should necessarily

serve as justification for "deprivation in analysis" is highly debatable and is apt to produce exactly the kind of controversy among analysts that was alluded to earlier in the literature review.) The patient ultimately established a meaningful relationship with another woman which included a gratifying sexual interaction. And, Myers reasons, if the patient's considerable achievements were in any way less than complete, this was a function of early scarring and not a function of the age at which she began the treatment.

The treatment of a depressed war veteran of sixty-two whose business had gone bankrupt some years prior to beginning his analysis was Myers' fourth case. In addition the patient had suffered a mild heart attack and his wife had left him. Like the patients described above, this man made considerable growth in treatment. He modified lifelong problems with warmth and guilt, gained ample understanding of early longings, lessened both his fears of castration and of loss of individuality, and was far happier at the end of his treatment. He remarried, returned to work, and embraced life.

The remaining two cases were that of a seventy-one-year-old Jewish woman who had an erotic transference to her analyst and of a sixty-year-old narcissistic university professor who had problems of impotence of ten years duration. The seventy-one-year-old woman, who

illustrates that intense sexual transferences are not uncommon in older patients, resolved a delusion of fifty years duration that a black man had fathered her son. The narcissistic male patient fared less well and Myers considers the treatment to have been a failure. He states that this patient had little capacity for introspection, was not psychologically-minded, and would have been a poor treatment risk at any age.

In The Race Against Time, the second published of the three books under discussion, Nemiroff and Colarusso (1985), both training analysts at the San Diego Psychoanalytic Institute, apply their concepts of adult development to the practice of psychoanalysis and psychotherapy with older patients. The authors promote the notion that ongoing developmental processes (including treatment processes, such as transference and countertransference) are influenced by later adult events and not simply by early childhood experiences. They suggest that an assessment of psychopathology be based on dynamic and developmental considerations rather than on chronological age. Nemiroff and Colarusso note that in older as with younger patients sudden interference with one or more lines of development (for example, love, intimacy, sex, relationships, etc.) may cause symptoms or regression. Events may occur in adulthood which result in fixations or developmental arrests, just as such events occur in childhood. The therapy therefore should address

those obvious factors which impede ongoing development. In the case of the physical illness of a patient, for example, one would focus on recovery and on the maintenance of good health. In commenting on the cases contributed to their book by colleagues, Nemiroff and Colarusso state that the key to the successful treatments was to the ability of the therapists to take <u>both</u> childhood and adult experience into account and to "focus on the current, phase-specific adult developmental tasks as well as the residue from earlier experiences and conflicts" (p. 304). A further illustration of the significance of the adult past are the multigenerational transference reactions formed by older patients. Nemiroff and Colarusso observe that the therapist who works with older patients is the object of powerful transference feelings from <u>all</u> stages of the life cycle (p. 319). This focus on the recent adult past is probably far less unusual at the Institute from which the subjects of this study have graduated, than at the San Diego Psychoanalytic. For this reason, I shall not focus at great length on what others (classical analysts in particular) might perceive to be a revolutionary or inventive point of view although I do believe that view to be resourceful and useful. The authors' essential point is that psychoanalysts can be helpful to their older patients if the analysts can locate their patients on the

life cycle and if they are aware of the kind of developmental tasks these patients face. Such tasks will include reactions to the aging body, to illness, loneliness, time limitations, and the prospect of death.

Ten detailed case histories of patients between the ages of forty and eighty are provided. These, like Myers' (1984) material, attest to the effectiveness of intensive psychodynamic treatment for this age group and suggest that "the race against time can serve as a stimulus for therapeutic motivation and action" (p. 170). (And, like Myers, the surprise that such therapies should work for the elderly verifies the insidious nature of the bias about the dynamic potential of older patients.)

Thirty-one year old Jill Crusey relates her five month intensive dynamic treatment of a sixty-two-year-old man a treatment triggered (as in the case of Myer's sixty-two year old war veteran) by the patient's heart attack and by his wife's stroke. Crusey asks how it is that the patient led a relatively adapted life and then suffered psychological difficulties. She concludes that his former coping mechanisms could not handle the type of change he was experiencing and that a neurotic equilibrium was shattered. Throughout the course of treatment the patient was able to accept the limitations of his entire life cycle and to acknowledge disappointments, something, Crusey acknowledges, an individual must do at any stage of development. In so doing, the time left to him became

important and like Myers' patient he resolved to make it a productive and lively period.

Of particular interest were Gary Levinson's case history of a woman whom he treated from the time the patient was sixty-two until she reached the age of seventy-two, and Gene Cohen's treatment of an eighty-year-old-childless widow. Levinson's patient suffered mightily from some of the concerns that this culture has come to associate with "aging" individuals, in that she worried about her looks, her failures and the passage of every year. Yet this woman, despite physical infirmities, used her great capacity for introspection to turn her life around. She felt more positive on the occasion of her seventieth birthday, than she had felt at sixty-five, because she had reestablished her role as a mother and a grandmother and because she had found a purpose in life. The therapist's flexibility enabled him to work closely with the other physicians involved in the patient's care as well as to involve himself in the reconstitution of her family and the caretaking of her dying brother. Cohen's eighty-year-old patient was an eminently resourceful woman who sought treatment for the first time because of the death of a close male friend and loneliness. Her history showed a capacity for change and for adaptation to loss that did not desert her in her later years reinforcing the idea that older patients can and do utilize these

capabilities not only in their remaining years but in their therapeutic encounters as well. This patient stopped treatment after a year and a half and following a new relationship with an "older" man of ninety-seven and the resumption of an active, independent life. Cohen reports a moving addendum to the treatment. The patient suffered a massive stroke and not only lost touch with her own history but was unable to communicate this history to her caretakers at a nursing home. As a severely dysfunctional woman without a history she was treated as the ward pest and avoided. Cohen acted as an advocate for his former patient gathering personal items of memorabilia to show to the nursing staff. The "pest" became a person and clinical management improved.

Nemiroff and Colarusso (1985) devote an entire section of their book to histories that deal with the impact of loss on later life development. Poignancy, if not tragedy itself, weaves itself through some of these stories and pain, grief, and mourning are in evidence. But in reading these stories I was nowhere left with the sense of hopelessness or frustration so often feared as one expectable countertransferential reaction to the patient who will soon die. These particular stories, and the courage of patients and analysts described, strengthened my impression that psychoanalytic interventions can be useful up to and in the face of death. Grotjahn whose essay, "Being Sick and Facing

Eighty," is a chapter in this book writes, "I always thought old age is an achievement in itself. I now know better: To get sick and to live on, _that_ is an achievement (p. 296).

Treating the Elderly With Psychotherapy, (Sadavoy & Leszcz, 1987) the last of the three published books to be discussed here, contains papers by a number of experienced clinicians. I will limit my comments here to areas previously covered in this literature review although additional concepts may be germane to remaining chapters. The attempts of individual authors, such as Grunes, to debunk stereotypic myths and to display evidence of the capacities of older patients will not be included since these have already been covered in great detail. The premise of George Pollock's chapter ("The Mourning-Liberation Process") is that a crucial element for successful aging entails mourning for prior states of the self. When one can accept aging and its changes and mourn for the past the result can be a liberation for current living. The case histories presented above seem to document this thesis indicating that the psychoanalytic dyad is of great value in aiding the person to accomplish this task. Pollock states, "All people, including and especially old people, want to talk about themselves, and this is part of the therapy that promotes the mourning-liberation process (p. 23). Pollock also makes the very

interesting observation that the meaning of significant kinship relationships may change as life progresses. Thus an eighty-year-old mother may not mean the same to her sixty-year-old daughter as she did twenty or thirty years ago. The meaning of children to parents may change, as may that of spouse to spouse. This is helpful to keep in mind although one would hope that any psychoanalyst would explore, with patients of any age, the individual meanings to the patient of the patient's relationships to significant others. The existence of role reversal in the elderly is a possibility advanced by Berezin (in his chapter, "Reflections on Psychotherapy with the Elderly"). The children of the aged patient may contact the therapist (as parents do with child patients) necessitating some modifications in technique in the earliest stages of treatment.

Countertransference

Because this study views treatment of the elderly through the eyes of their analysts, countertransference issues (psychoanalytic terminology for the emotional reactions of analysts toward their patients) merit particular attention.

Countertransference is a term that engenders a good deal of controversy and analysts vary in their definitions and uses of this term. A fair number of these definitions will be discussed here although my purpose is neither to give the reader an exhaustive review of the nomenclature,

nor to imply that we will arrive at some definitive use or uses of the concept as it applies to work with the elderly. It is rather to convey the complexity of both the concept and of the process; and to suggest that the countertransference themes that are said to apply to the psychoanalytic treatment of the older patient are heuristic approximations and not scientific truths.

Freud, who made only two published references to countertransference, viewed it primarily as a hindrance which interfered with the analyst's ability to listen to his patient objectively; although Freud did note too, that countertransference was the analyst's use of his own unconscious to understand the patient (Epstein & Feiner, 1979).

The meaning of countertransference and its role in the analytic process has continued to stir debate in the analytic community. From the classical standpoint, countertransference remained an interference with effective analysis. But Epstein and Feiner (1979) cite the contributions of many who countered the prevailing stance and focused on the therapeutic usefulness of countertransferential material. And recent assessments of the status of countertransference (Epstein & Feiner, 1979; Gorkin, 1987) indicate that psychoanalysts remain in disagreement about the term. These authors cite the three major conceptions currently in use:

1) The totalistic approach views all of the analyst's feelings and attitudes towards the patient as countertransference. This includes both conscious and unconscious responses.
2) The classical approach defines countertransference as the unconscious and resistive reaction of the analyst to the patient's transference (or as the analyst's transference to the patient.)
3) The counterpart approach is one in which countertransference is considered to be the predictable and expectable response to the patient's transference or to the patient's way of interacting. (Winnicott used the term "objective transference" in differentiating what he thought to be the analyst's reaction to the actual personality of the patient from the analyst's own conflict-laden responses (Gorkin, 1987).

The first definition, the totalistic response, is the broadest definition of countertransference. While the second, the classical, is the narrowest. Fortunately, we need not enter the debate. What is essential to this study is an understanding of the great variety of ways in which the analyst's feeling and emotions can effect the treatment. Marshall (in Epstein & Feiner, 1979) describes four types of countertransference reactions which derive from the axes of two variables: the source of the countertransference and the extent of the analyst's

awareness of the countertransference. His model looks like this:

	Unconscious	Conscious
Therapist Induced	Type 1	Type 2
Patient Induced	Type 3	Type 4

That is to say, one group's main characteristic depends on whether the countertransference stems from the patient or the therapist. The other dimension is the degree of the analyst's awareness. It has been noted, however, that no countertransference reaction is really either one type or the other, since therapists are susceptible to their own vulnerabilities as these may be triggered by any individual patient. Therefore these two general classes of countertransference can only be differentiated by degrees (Beitman, 1983).

Other analysts have made other distinctions and refinements. Heinrich Racker (Epstein & Feiner, 1979) for example, distinguishes between direct and indirect countertransference. He sees direct countertransference as the analyst's response to the patient, and indirect countertransference as a response to an emotionally significant other, *outside the therapeutic setting* (italics mine). This particular distinction is emphasized for reasons that will shortly become clear.

Racker also spoke of resistances of the analyst which

coincided with resistances in the patient concerning the same issue. He defined this as the analyst's counterresistance (Robertiello & Schoenewolf, 1987). Robertiello and Schoenewolf, took this a step further in describing situations in which the counterresistance stems primarily from the therapist, involving behavior by the therapist designed to resist any change in the relationship. These authors then expand this definition to include influences that fall outside the realm of countertransference for which they posit the term "cultural counterresistances."

> For example, a liberal-minded therapist who is resistant to hearing a conservative patient's opinions about social issues and hence falls silent, changes the subject, or in other ways expresses a judgment about those views is, we believe, acting out a counterresistance that is not an aspect of the countertransference per se but, rather, an expression of values rooted in the cultural milieu in which the therapist was brought up. Thus...we put great emphasis on internalized societal values, fixed belief systems, biases, and the like. The therapist not only has to help the patient overcome his or her biases, belief systems, and values insofar as they serve as resistances, but also must overcome his or her own cultural counterresistances (p. 13).

Even before proceeding to additional refinements it is clear that the definitions given thus far present us with a fair number of thorny problems. The analysts interviewed in this study are being asked to make differentiations about analytic work with their patients based on the variable of the patient's age, an attribute highly charged with values rooted in the cultural milieu.

In some ways then, age can be seen as a possible source of indirect countertransference. Having dwelled at length upon the extent and intensity of ageism in this society we may speculate that age itself might constitute an emotionally significant other which induces a (countertransferential) response in the analyst. This may be taking liberties with Racker's definition of indirect countertransference but it bears consideration. Certainly the idea of counterresistances, that is to say, the therapist's societal biases (as an extension of countertransferential reactions) is one that has merit. To amplify, what if the analyst has strong emotional responses to aging and to the aged themselves, above and beyond the character and behavior of any given patient. What are the ramifications?

Let's design a sample simplified scenario. A patient is garrulous, whinny and rigid. The analyst is sleepy, bored or irritated. Is this patient induced countertransference? The patient is eighty-years-old. The therapist thinks to himself, "Damn these old codgers, they all run off at the mouth, they never stop complaining and you can't get them to change." Is <u>this</u> patient induced countertransference? Further, what if the analyst has many unresolved conflicts about his elderly parents or his own aging? And may we not also ask what happens in the same analyst when his younger patients are garrulous,

whinny and rigid?

Beitman (1983) discusses the influence of stages of psychotherapy on countertransference. He notes that during the initial or engagement stage therapists may react to the surface presentations of their patients. Age may be just such a surface trigger and could elicit a self-statement on the part of the therapist of the following nature: "Older people cannot be helped psychotherapeutically; I won't try" (p. 87). Beitman notes that these kinds of statements represent biases present in the culture and that therapists, as part of the culture, are influenced by its biases.

When the scope of psychoanalysis widened and more severely disturbed patients entered psychoanalysis there was some consensus that they generated more chronic and chaotic transference reactions in their analysts than did neurotics. In fact Heimann suggested that different kinds of patients might be expected to evoke different types of expectable transferences (Gorkin, 1987)--a notion now subsumed under the counterpart definition of countertransference. Has it not been suggested (and is it misguided) that this is true of some elderly patients?

Part of the difficulty in an examination of couuntertransference and the elderly is that we are forced to search for common themes or generalities in an area that places great emphasis on the person's individuality. Fordham (in Epstein & Feiner, 1987) comments that Jung

believed that each analysis differs in basic ways from every other analysis. He quotes Jung's statement that "Psychotherapy and analysis are as varied as are human individuals. I treat every patient as individually as possible, because the solution to the problem is always an individual one....A solution which would be out of the question for me may be just the right one for somebody else" (p. 194). Given this caveat we must endeavor to answer our questions about the differences between countertransferential reactions to the over-sixty patient, as compared with the over-thirty patient, as best we can, ever mindful of the limitations imposed by the question itself. The literature on psychotherapy with the elderly focuses on a number of areas which ostensibly provide material for heightened countertransferential issues:

The therapist's own anxieties about aging are apt to be activated and may lead to countertransferential blindness.

Increased anxiety may derive from a number of sources. Therapists may identify with the loneliness, grief, or relative poverty of patients and may see their future selves in their patients. This tends to be independent of the professional's social or economic status. In working with the elderly, psychoanalysts are forced to confront their own inevitable aging and to appraise and to evaluate their own lives. In working with young people an analyst is at least assured that he has

survived the problems of the earlier age group. No such assurance accompanies the work with the elderly. Because it is difficult to face in others what causes great pain in oneself, the therapist must deal with a potential source of therapeutic blindness that could lead to underanalysis of the conflict of aging in patients. Furthermore, overidentification with the accumulated misfortunes of an elderly patient would interfere with a realistic assessment of the patient's possibilities.

The mentally impaired elderly may present particular problems resulting in what Goldfarb (1977) terms psychiatric errors. For example, physicians may encourage an aged person to accept his limitations implying that limitations are an inevitable result of aging. Or physicians may distance themselves from an aged patient for fear of encouraging dependency. Or the doctor may actually become angry or frightened by the emotionally determined dependency needs of the mentally impaired patients. Helping the aged may symbolize the relinquishment of dependency claims by the therapist himself and he may wonder who will care for him if he must care for parental surrogates. There is a primitive fear that to feed another is to deplete oneself. There may also be a fear of death which is unrealistic and represents the individual clinician's failure to transcend the culture's superficial relationship with this aspect of

life. Any of the above may result in neglect of possible remedies. Stern, Smith and Frank (1952) suggest that the symbols of old age, such as helplessness or feebleness, are deeply rooted and associated with castration fear (Stern, Smith & Frank, 1952; Kastenbaum, 1963; King 1974; Goldfarb, 1977; Rechtschaffen, 1977; Rubin 1977; Sobel 1980; Miller, 1981; Lewis & Johnson, 1982; Nemiroff & Colarusso, 1985).

Conflict over relationship with aging parents or grandparents.

The therapist's own child-parent relationships may come into play. Unresolved or unanalyzed feelings toward parents and grandparents will complicate the therapeutic situation. Oedipal strivings and guilts may result in unconscious feelings of hostility and revenge towards older patients, displayed as impatience or harshness. The patient's age may bring unconscious death wishes toward parental figures too close to the surface. One must be careful not to view work with the elderly as an opportunity to triumph over childhood wounds and submission (Stern, Smith & Frank, 1952; Wayne, 1953; Grotjahn, 1955; Meerloo, 1977; King, 1980; Sobel, 1980; Miller, 1981; Myers, 1984; Nemiroff & Colarusso, 1985).

Older patients are perceived as low status patients.

To grow old in this society is to enter into what is perceived as a low status relationship. Association with a low-status patient might be felt as a contamination and

might lower the therapist's status in his own eyes. Some therapists believe that their interest in work with the elderly is viewed with suspicion or contempt by colleagues and that the societal prejudice against the elderly is extended to those who treat them. The aged were not viewed with favor as candidates for psychotherapeutic techniques. It was thought that the defenses of such patients were so rigid and their need for gratification so reduced, that they did not really have sufficient motivation for change. They were seen as fixed, rigid, hopeless crocks, not articulate, not stimulating, and failing in many areas including their responsiveness to therapy. Therefore the therapist who treats them may seem to be out of step with modern thought (Kastenbaum, 1963; King, 1974; Steury, 1977; Goldfarb, 1977; Miller, 1981; Nemiroff & Colarusso, 1985).

Treatment for older patients is viewed as low status treatment.

Since the elderly were seen as unsuitable patients for traditional forms of psychoanalysis or psychoanalytic psychotherapy, it was believed that therapy with this group would have to take the form of support. This was regarded by therapists as a second rate procedure (Kastenbaum, 1963). Emilie Sobel (1980) discusses countertransference difficulties which derive from the modifications in technique of the brief, supportive, and transference indulgent psychotherapies. She has observed

that the therapists who use these techniques consider them to be denigrated techniques. Sobel notes that advanced age per se does not call for the application of supportive techniques and she states quite clearly that there are persons who retain analyzability throughout life (p. 213). But in speaking of the regressed later life patient Sobel suggests that transference needs might usefully be indulged instead of interpreted during periods of developmental crises. She believes that this can be useful in reestablishing ego functions and in forestalling further regression. But, she notes, the average psychoanalytic therapist has difficulty serving this function, regarding the therapy in every way as second class treatment. Introduction of extra-analytic procedures is devalued in the literature as well. She found that professionals regarded less-than-analytic treatment to be too limited in scope, process, and result, to be gratifying to the therapist. Therapists believed that the treatment did not utilize their full technical competence and therefore fell short of their expectations. Sobel believes that an understanding of what this kind of treatment can accomplish will show that this type of therapy engages a full spectrum of analytic talent. She reports that there are many gratifications in doing this work including mastery of the fear of the trauma of aging and a chance to actively remedy some of the devastation of

this phase of life. "Finally, there is that gratification which comes from activating the therapist's ego ideal as a member of a service profession, in more tangible form than is usually possible" (p. 221).

Frustration due to perceived limited success.

When patients get older some of the events in their lives become more irreversible. Professionals may therefore believe that the success of their work is limited and this may serve as a narcissistic blow. Or they may avoid elderly patients because of a fear that the patients may become debilitated or die. With needy patients, in particular, psychotherapists may feel unable to control or to understand their work leading to feelings of helplessness and frustration (Stern, Smith & Frank, 1952; Goldfarb, 1977; Meerloo, 1977; Nemiroff & Colarusso, 1985).

In addition there may be a sense that the aged patient will not live long enough to pay back the therapist's investment. This reflects a market place tradition in which qualities of human experience are replaced by conventionalized external units. "To deny therapy to the aged because they do not have a 'long-enough future' would be self-deceit. Either a person is worth helping now or he is not worth helping" (Kastenbaum, 1963, p. 300).

Unresolved Sexual Feelings

Both Grotjahn (1955) and Meerloo (1977) speak of the

anxiety that is aroused in dealing with sexual problems of the aged. Grotjahn says that unresolved sexual conflicts in the therapist may set off the unrealistic wish that older patients will live beyond sin and sex, like little angels. "Such a therapist may not be tolerant and realistic enough to understand his elderly patients in one of their most important sources of conflict, guilt and depression" (p 422). Meerloo states that the denial that Freud had to battle concerning infantile sexuality is now being applied to older people. Even medical transference denies sexual gratification to the old. Meerloo cites the case of a sixty-eight year old woman who spoke to her doctor of a vaginal complaint which she thought to be a consequence of sexual abstinence. The physician told her that sex should stop at the age of fifty.

Myers (1984) feels that analysts and therapists continue to give short shrift to the sexual needs and desires of older individuals. He notes that in his own work with older individuals, intense erotic transferences were frequent, as were prominent countertransference responses related to Myers' feelings toward his own parents and toward his former analyst. Myers does not neglect the importance of sexual functioning to the regulation of self esteem. He states, "The continuing capacity to conceptualize oneself as a sexually functional being serves as a source of positive feedback for the self

esteem in an individual of any age" (p. 518). And the therapist who is not prepared to accept the undiminished intrapsychic sexuality of the older patient and its appearance in the transference, will be limited in his work with this age group (Nemiroff & Colarusso, 1985).

The Reality Problems

There are certain reality problems which may influence the analyst's emotional responses to the older patient. The analyst may be aware that there are time limits within which he and his patient will have to work. This may strain the work. Patients may behave as if time were unlimited leaving the analyst to carry the urgency of their situation. There may be financial considerations if a patient is unable to continue after retirement, or difficulty in obtaining payment from an impoverished patient. Therapists may be overwhelmed by the diversity of problems the older patient may present; and by the difficulties entailed if it is necessary to coordinate multiple treatment modalities. There may be reactions to an older patient's difficulties in physically getting to the therapist as well as fears of overinvolvement and time demanded by anxious relatives. Finally, it may be more difficult to terminate the analyses of older patients. They may develop a negative therapeutic reaction which is linked to the fantasy that by avoiding change they will be avoiding death. In this way they may manage to convey the impression that the

analysis is keeping them alive. This can make termination very difficult (King 1980; Miller, 1981).

The Countertransference Reactions of One Psychoanalyst.

In his book on Dynamic Therapy with the Older Patient (1984) Wayne Myers presents some details of his countertransference responses to certain of the six patients he describes. He relates how his own dreams enabled him to recognize and to understand some of his countertransferential reactions, and how this understanding helped him to deal with some of his own unfinished business. Myers speaks of the following:

1) A prominent wish to rescue two patients - in one case exacerbated by the patient's age, by his problems, by similarities in the family constellations of patient and analyst, and by the fact that Myers' father was dying when he began work with the patient. In the second case the patient's World War II record resembled that of Myers' dead brother.

2) A wish to lend the patient his masculine strength so that the patient might become a more adequate man. This was related to the analyst's desire for the patient to be an idealized father figure. Myers also felt separation anxiety when this patient went away.

3) Positive and negative feelings toward a patient that were triggered by the patient's superficial resemblance to Myers' former analyst. Myers became aware

of these feelings when dreaming about the patient early in the course of treatment. The dream enabled him to put to rest some residual irritation he had felt toward his former analyst upon termination of his own treatment and to better understand his own attitudes toward his patient.

4) Anger toward a difficult patient whose therapeutic failures thwarted Myers' wish for success which stemmed in part from Myers' desire to resurrect his lost father.

Myers concludes:

> What this case once more illustrates is the vital importance of monitoring one's own countertransference responses towards one's patients. This seems to me to be of especial importance in dealing with older patients, who may evoke responses that are displacements of prominent feelings toward, or fantasies about, one's parents or one's own analyst. These countertransferences are hardly insurmountable (p. 235).

CHAPTER 3

Beginnings: What the Analyst Brings to the Treatment; What the Patient Brings to the Treatment

A Brief Introduction to the Subjects and to the Data

The subjects, Drs. A through F, have been provided with pseudonyms which will enable the reader to identify them by gender. Drs. Adams, Ernest, and Fireman are male; Drs. Brenda, Carrie and Delia are female. The ages of the subjects are within the following ranges:

Drs. Adams and Brenda (between 60 and 70 years old)
Drs. Carrie and Delia (between 50 and 59 years old)
Drs. Ernest and Fireman (between 35 and 49 years old)

The specific ages and degrees (half are M.D.s and half are Ph.Ds) have not been listed in order to preserve confidentiality. Nonetheless the subjects are hardly anonymous in the sense that the reader will get some feeling for them as people. This is partly due to the manner in which they presented their data.

Most of the subjects were quite free in revealing either their personal histories or their feelings about their work and their patients. Because I wanted to preserve the richness and complexity of these analysts' perceptions about their patients, I have quoted them often and at great length. These first-person narrations provide a "feel" for the subjects and their struggles with the issues which I consider to be an essential aspect of this study.

The chapters which follow are organized in the

following way. Chapter 3, focuses on "Beginnings" what the over-sixty patients and their analysts bring with them to the treatment situation. Chapters 4 and 5 concentrate on the treatment process itself, the treatment of the over-sixty patient and the ways in which it is similar to or different from the treatment process as it pertains to the over-thirty patient. Chapter 6 contains the summary and conclusions.

Analysts' Motivation for Working with the Elderly: Influencing Factors

For these six psychoanalysts working with the elderly was mostly happenstance. No one actually thought, "When I grow up I want to be a gerontological psychoanalyst," and there were certainly no early (that is, pre-professional training) enthusiastic daydreams among any of them about eventually working with the aged. But when the opportunity presented itself to take on some over-sixty patients no one expressed indifference. In fact, four of the six expressed active interest and displayed some initiative in taking on this age group. The other two "hardly noticed" that they had been working with over-sixty patients. It was only after the fact (i.e. in response to my question, "Do you have a fair number of over-sixty patients in your analytic caseload?") that they realized that they did indeed have these patients in treatment. Certainly none of the six was *disinterested* in working with the elderly; none thought that this would

present obstacles or hardships; none turned them away nor found them unsuitable for intensive treatment, at least not based on age alone.

Those who "hardly noticed" that they were already working with over-sixty patients were the two analysts who themselves were over-sixty. Dr. Adams observed that his patients got older as he himself got older. He stated that the referral sources in his case are people who try to match patients by age and who prefer to send older people to older therapists. In any case, it has been his policy to take people as they come. "If I have the time I see them and I do what I can with them. I don't even think in terms of age....As a matter of fact, I had my first over-sixty patient when I was in my thirties. I have always felt that I knew what I was doing, I have always taken careful histories, and have worked with the patient's experience of things, and so I have never felt that age matters that much."

Dr. Adams grew up in a family where the comings and goings of multiple generations (four or five generations), was a common event. He deduced that the chronological age of a person never tells one how old that person is. "In a number of instances I saw that the older people were "younger" than the young people. And I did not equate chronological age with "old." And if anything, my experience in treating people analytically confirms that."

Dr. Brenda (the second "over-sixty" analyst), similarly found that analyst's aging itself brought older patients. She felt that many older patients do not want to see someone very much younger than themselves because older patients, in advance of the treatment, fear that they will not be understood by a younger analyst. While Dr. Brenda had no particular interest in seeking work with the aged, she had a fervent interest in the aging process and a strong and positive identification with older family members which long preceded her work with the elderly.

Of the four remaining analysts, each had expressed an interest in taking on over-sixty patients. Dr. Carrie had an active interest in the life-span and admitted to a sparseness of knowledge about the upper end of the age scale ("I realized that I did not know much about work with the older patient and this was a situation that I wanted to correct.") Dr. Delia had an ardent interest in older people based upon personal family history and experience. Drs. Ernest and Fireman had had "fortuitous " referrals of older patients when each analyst was approximately thirty years of age. Drs. Ernest and Fireman both continued to work in this area and one of them even took some special courses in the field of gerontology.

Of the six, three psychoanalysts (Drs. Brenda, Delia and Ernest) had extremely strong positive family

attachments to older persons. Dr. Adams also had positive attachments although his expressions of feeling about these attachments were not nearly as forceful as those expressed by Drs. Brenda, Delia, and Ernest. (It is hard to know whether the multigenerational family affinities were less persuasive or whether his reporting style simply differed markedly from those of the others.) Dr. Carrie felt that her early experience had minimal influence on her professional development and Dr. Fireman reported early experiences which might have reinforced some negative stereotyping of the elderly. But this was overcome with little difficulty.

There is a decided "old-world" feeling in the stories that Drs. Brenda, Delia, and Ernest relate of their relationships to elderly grandparents. The benevolence, wisdom, comfort, and unconditional love of the old, experienced by the young, shone through in the memories of Drs. Brenda and Delia. Dr. Ernest saw another face of his grandmother, but it did not cloud his relationship with her.

Dr. Brenda:

> I was brought up by a very beloved grandmother. My parents for various reasons were not able to give me what I needed emotionally because they were heavily invested in intellectual and business pursuits. When I was born I was handed over to a nanny which was not unusual at the time. But my grandmother was fantastic. She was warm, and principled and intelligent and lovely and much revered in the town in which she lived for the way in which she would indiscriminately help people. My

grandmother was practicing psychoanalysis without a license, that I can tell you. Everyone came to speak with her. I absolutely adored her and it was mutual. So that I have this in my background.

In grandma's home, there was a hearth in a brick wall. And the wall was warm and she would lean up against it and sleep. And I would get everything I could find and dress her as she slept. And she would awaken and say, "What is this?" And I would reply, "Oh you look so beautiful grandma, I have made you a queen." I was thousands of miles away from her when she died. But I dreamed of her death the moment that she died. To the minute, I had a dream to the minute.

Dr. Delia:

I really like older people, I feel comfortable with them and that has to do with my life experience because my best relationships were with my grandparents. That is where I felt most accepted, most comfortable. The relationships with my grandparents were my least conflictual relationships, I could be myself without having to be a certain way.

My maternal grandparents were consistent figures for me throughout my childhood and into my young adulthood. I spent a great deal of time with my maternal grandmother, a basically healthy woman who died when she was ninety. My paternal grandfather was also quite important to me and even now when I think about it, I consider them to have been very unusual people. They were accepting, giving, insightful people and very much liked by those around them. They helped people and they had a great many friends. My paternal grandfather was a distinguished scientist and was publicly recognized for his work. But he was also a very human man. He was unpretentious and would talk to everybody. There was never an air of superiority about him. My grandmother too, was very tolerant of people. They both had that quality, not simply with me but with all people.

When I involved myself in working with the over-sixty patient I did not consciously analyze the connection to my grandparents or why I had always felt so especially fond of old people. I knew that I found it very satisfying to work with old people--it was interesting to me. I was interested in hearing about their history, I felt that they had a lot to say, and that I had a lot to learn. That is why I got so involved in working with this age group. I

seem to get less irritated with the elderly than I might with a younger patient. Although, I basically am very tolerant even with younger patients who are difficult. Actually, I do not remember having had any negative reactions to elderly patients.

There are, of course, patients who are difficult to engage in treatment. But there were never any negative feelings that I brought with me to the treatment situation as regards the patient's age. None!

Dr. Ernest:

My maternal grandparents were in my life way into my adult years. They lived very close by and at times in the same building. Even my grandfather's mother, who died at the age of 92, was alive for many years during my lifetime. She was an old Italian lady nicknamed Nonna, and the family would make pilgrimages to gather in her presence. My maternal grandmother was another presence in the house and a very strong woman. She could be very castrating in her own way but she really liked me and she was probably the most benevolent person in my life. I was the first grandchild and a real favorite of hers. She had two children, my mother and my aunt whom she really dominated. But to me, she could do no wrong. I never really experienced her destructiveness but I saw her strength. She came to the United States from Europe and worked first as a governess and then as a cleaning lady in a prestigious high school which by coincidence I later attended. She worked very hard and had no qualms about using her money to better her children. She bought my aunt a piano which cost her $900--a great deal of money in those days. And she sent my mother to college. The day that I got married, she arose early in order to wash the car. She would do gardening and would move these tremendous cinder blocks. She just had a tremendous amount of strength and determination. Towards the end of her life she broke her hip and then had chronic difficulties. Then her memory started to go and she became senile. My grandfather continued to care for her until she died at the age of 82. After my grandmother died, I became closer to my grandfather and got to know him better than I had during her lifetime. Prior to her death he had been quiet and in the background. My grandfather died at the age of 87.

Right now probably 10 to 14 percent of my practice are people who are over sixty. Ever since I

> have been in private practice, there have been older patients. What I would find with the elderly people, and maybe it has to do with my own experience or childhood, was that I was much more comfortable with older people.

Dr. Carrie's parents were old enough to be her grandparents but they had little effect on her attitudes toward the elderly because they died when she was quite young. A close relative of hers, however, began analytic treatment while in her late sixties and Dr. Carrie was privy to some of the details of that treatment and certainly to any evidence of the effects of the treatment. This provided some confirmation that it could be done.

Among the six subjects, Dr. Fireman alone admitted to having a fair number of stereotypical notions about the elderly prior to beginning work with them at the age thirty. He expected them to be rigid; thought that they would "kvetch" a lot about physical pains and symptoms; would focus greatly on loneliness, death and dying; would have a fairly narrow view of their own experiences; and would exhibit depressive and dependent attitudes. He surmised that his ideas derived from some early experiences of people in their fifties whom he had considered "old" while he himself was a child of nine or ten. "Aunt Anne, a very distant aunt, used to come over to visit and she was very repetitious. And my mother, who was very much interested in helping shut-ins, would take us carolling at Christmas time and we would make the rounds of these houses all of which were inhabited by

people who were invalided in some way. In addition, I grew up with a friend who was Oriental. When we visited his family, his grandmother, who spoke no English, and who said nothing at all in any language, would sit in the corner and smoke her pipe. She really was kind of disengaged but her behavior was considered to be quite appropriate. So my associations to old people were that they were sick, immobile, and very needy of contact especially from younger people."

Dr. Fireman reported that his first patient, a sixty-nine-year-old woman, fulfilled his fantasies of the stereotypic elderly patient. She had been diagnosed as depressed before seeing Dr. Fireman and she had come to see him for more definitive evaluation and consultation. She had retired three years earlier, her husband had died, and she felt that she had no purpose in life. She had two children and spent most of her time complaining that they did not visit her or take care of her. Adding to the patient's burden was the initial diagnosis of depression. She felt that with all the problems she had, she did not need to be told that she was depressed. A subsequent diagnosis of anxiety by yet another consultant relieved her considerably and she was much better after that. Undaunted by what he then viewed as stereotypical traits, or perhaps encouraged by the quick cure, Dr. Fireman began to treat other elderly patients almost at

once. By the time he began to treat his second elderly patient he was heavily invested in the treatment and had the feeling that his older patients could actually teach him something about life. And as it turned out soon after, Dr. Fireman had a number of very satisfying and valuable interactions with older people in his immediate environment, one of whom was his own analyst.

Among this group then, Dr. Fireman is unusual in the negative fantasies which he had about the elderly prior to beginning work with them. While the others had no such impressions of the elderly, they were not totally without anxieties about the aging process itself.

Of the over-sixty analysts, Dr. Adams never really considered age an issue. Insofar as his own aging was concerned, Dr. Adams said that he always had a number of anxieties about the vicissitudes of the life cycle, although these were not necessarily specific to aging itself. He was afraid of becoming infirm in any way and particularly of losing his mental capacities; he was apprehensive about becoming financially dependent upon children (a fear which had diminished over the years); and he was fearful of losing sexual potency if it were a psychological rather than a physical matter ("I would not have stood for that, I would have done something about it.") Always an active man, Dr. Adams became even more so in his fifties, increasing his regular participation in sports and adhering to a rather strenuous exercise regime.

("I did these things to remain active, not to remain young.")

Dr. Brenda, who had positive feelings toward the elderly, nevertheless feared the aging process in herself. She notes, "In spite of the wonderful experience I had with my grandmother, and despite my many elderly friends, I was for years very afraid of my own aging. On the one hand I had this very positive identification, on the other hand I had the feeling that things were very different in today's world. I had fears of sickness; fears of losing my attractiveness; and I had fears of losing power and strength, physical, social and emotional." Dr. Brenda's qualms began when she reached the age of forty-five, in response to which she began a new sport in which she eventually acquired a high degree of excellence and acclaim. She feels that her own fitness and extreme good health have been partially responsible for the resolution of her fear of loss. As far as Dr. Brenda is now concerned, "age is only important if you are a cheese."

Only one of the two over-fifty psychoanalysts expressed any concerns about her own aging and these were minimal. Dr. Carrie admitted that she does think about it and wonders if there might be a time when she can no longer do what she wishes to do. She ajudged (as did Dr. Brenda) that as a therapist she was perhaps less affected by some of the potentially negative consequences of the

aging process than, for example, an artist who might be unable to work effectively because of the latter's dependence upon manual dexterity and visual acuity. Interestingly, Dr. Carrie's one apprehension was in an area that has direct bearing on her capacity to function as an analyst, and that is her memory. She felt that her memory was changing in two basic ways. The first was that she no longer paid as much attention to things that did not seem important. And the second (and less agreeable way) was that her memory for names was no longer as sharp, so that she might forget the name of a patient's husband or child and have to find some way of compensating in the analytic dialogue.

Dr. Delia expressed no such fears. She directed her concerns to the need to counter society's prejudicial attitudes toward the elderly. "My maternal grandmother," she reminded me, "lived in a society where the age and the elderly were venerated. She was respected, she helped with her grandchildren, she always had a very good feeling about her age. In fact, old age eventually freed her from a difficult marriage and she felt freer as she got older. To her and to me, aging was just another part of living. It remains so today. She was active, productive; she did things she liked to do; she had friends and a boyfriend, she had her own life.

And my paternal grandfather worked until the very last day of his life and he also felt very good about

himself. I do not worry about my own aging. I worry that my child with little access to grandparents does not have the same richness that I had."

The personal concerns of Drs. Ernest and Fireman (the over thirty-five analysts) with respect to aging were negligible. But Dr. Ernest gave an exquisitely sensitive accounting of his utilization of mundane events to identify with the elderly and to enter their world.

Dr. Ernest:

> As I get older, if I break ribs or if my back goes out I begin to understand how much of the physical abilities of our lives we take for granted while things are working properly. The other day I went over to my mother's house after a snowstorm. I said, "I'll go shopping for you." She said, "No, I will go with you." She wanted to maximize her functioning. She took the shopping cart. I said, "I'll carry it." She said, "No. Open up the cart." I said, "Why should we open up the cart before the groceries are in it." But we open up the cart and she pushes it, and I see that it has become a clandestine walker. And then I started looking around at the elderly in the neighborhood and they were all doing that. Well you don't realize what a chore it is to simply go shopping until you have to move at their pace. You have to go slow, you have to wait at the corner, you have to make certain that no vehicles are anywhere in sight before you venture to cross the street. It's a big deal crossing the street in baby steps. Go across Broadway and those cars are killers. And everyone is telling them, "Hurry up, hurry up." All of these things are things that we do automatically. It only strikes us how difficult daily functioning can get when we get injured.
>
> My vision has changed radically over the past three years and I have had to get a pair of reading glasses that are stronger than my previous prescription. And it's amazing. I love sitting down and reading. But if I look up and away, everything is a blur. The glasses are so strong that I have to remove them in order to once again see things at a distance. Old people go through that sort of thing.

> Of course the elderly go through these experiences in increments which makes the adjustment a bit easier. But you get a sense that if old people complain they are not being crotchety. They are simply being what we ourselves are going to become.

Several factors other than the early family setting had an impact on analysts' attitudes toward the elderly. Dr. Fireman (the only one of the six who felt that he had had negative stereotypical fantasies about the elderly) chose an analyst who was considerably older than he was, and he believes that the analysis challenged his stereotypic attitudes toward the elderly. Dr. Fireman was curious about his analyst and wondered how older analysts were getting along in their lives. There were times, according to Dr. Fireman, when he considered his analyst to be senile, the victim of a memory deficit, and akin to Ronald Reagan in competence. But he added, with a touch of humor, that these seemed to be occasions where his hostility simply nourished any ageism in him. "When neurotic defenses interfered with my memory of recent events," said Dr. Fireman, "my analyst had no trouble at all in remembering them in detail." He also admired his analyst's very active participation in the professional world, an involvement undiminished by age. On one occasion, Dr. Fireman took the opportunity to spend some time with a much older analyst, not his own, at a weekend professional conference. During the cocktail hour the older analyst approached Dr. Fireman and offered to share with him some martinis which the older analyst had brought

with him in a glass jar. "At first" said Dr. Fireman, "I thought--wow what a cheapskate. And then I realized that this is the kind of stuff my grandfather used to do. It was part of growing up in the Depression era and it also had a kind of midwestern quality which I associated with my grandfather."

Dr. Delia also chose an analyst considerably older than she was, motivated in part she thought, by her extraordinary relationships with her grandparents.

Dr. Ernest, whose analyst was not remarkably older than he was, commented on the impact of having two supervisors who were very much older than he. Unlike his younger supervisors, these people wanted to get something done and did not want to "futz around." This was not clearly a function of age because these were decidedly "no-futz-around-supervisors" even when they were younger. Dr. Ernest stated too that many of the teachers in his pre-psychoanalytic professional training were in the "elderly range" and he had a great appreciation for what they knew as clinicians.

Other influences are noteworthy. Dr. Brenda worked for seventeen years as a consultant in a State Hospital where she was constantly dealing with old men who had all kinds of problems with severe pathology. Although during some of these seventeen years Dr. Brenda was dealing with her own fears of aging, the contact with these patients

increased her empathic feelings towards them. She was lucky enough, says Dr. Brenda, to have been worked with a wonderful doctor who was approaching the age of seventy. This doctor had tremendous empathy towards these old men and Dr. Brenda witnessed wonderful treatment procedures. "He reminded me of my grandmother," said Dr. Brenda, "so which way could I go but in the same direction? What I felt for these old men was an enormous empathy for their distressed emotional states and I tried to do whatever I could to help them. I made it a point to keep up with all of the relevant reading and I gave them my best. It never increased my fears in any way. I think that it gave me more experience and more understanding and this certainly included psychoanalytic understanding. So I learned from my supervisor and I learned from these patients."

Dr. Fireman's first elderly patient was a woman whom he felt typified some of his stereotypical ideas about the elderly. But he nevertheless remained interested in treating this age group. Dr. Ernest's first patient was a seventy-year-old woman, who today would be diagnosed as an Alzheimer's patient. Dr. Ernest found her "fascinating." She had earlier been in treatment with a number of very famous analysts none of whom could she remember due to her severe memory loss. Dr. Ernest worked with her in individual treatment for about five years. In relating the story, it occurred to Dr. Ernest that he had begun work with this woman shortly after the deaths of his

grandmother and grandfather and that this patient, in many ways, suffered from the same kind of memory deficit his grandmother had experienced. Whether this influenced the treatment remains unclear. However, Dr. Ernest states that the experience of working with this woman stimulated his interest in working with older people.

Dr. Ernest mentioned one additional factor with respect to his early pleasure in working with the elderly which was not specified by any of the other subjects, namely a sense of freedom that he felt in working with these patients. Early on, said Dr. Ernest, the analyst feels very constrained by his supervisors (whether real, imagined or internalized) and by metapsychology which prescribes what one can and cannot do. Some analysts define a certain metapsychology to which they adhere and then, of course, they develop all kinds of reasons for breaking with it. They call the reasons "parameters" (as in parameters which have to be introduced to take care of this or that "special case," rather than examining whether the theory is useful in the first place.) Since it was not clear at the time if these constraints applied to the elderly, Dr. Ernest felt as if he had a great deal more freedom. He could act without feeling guilty that he was acting out. This allowed for a certain playfulness, an experimentation, a freedom that he didn't feel he necessarily had elsewhere, and so the work with the

elderly became valued for this reason as well.

<u>Selection of the Elderly Patient--Do Analysts Look for "Special" Attributes in their Elderly Patients?</u>

There existed at one time a mythology that the prime candidate for a psychoanalysis was a YAVIS, a patient who was Young, Attractive, Verbal, Intelligent and Sexy. None of the subjects had a corresponding acronym for their older patients. In fact, there is no evidence at all that such a mythology obtains for older patients. Nor is there any evidence insofar as these subjects are concerned that the myth applies to their younger patients. If the patient has a problem that he wishes to work on in treatment, these six analysts will take the patient just as far as he can or desires to go in the work. In this respect, they treat their over-sixty and over-thirty patients in quite the same manner.

For Drs. Adams, Brenda, Delia and Ernest, what interested them in an older patient was exactly the same as what interested them in a younger patient. The very concept of an "interesting" patient was totally extrinsic to Dr. Adams' manner of thinking about his patients. Dr. Adams takes all patients as they come and considers it part of his job, for which he is adequately paid (or as he said, "almost adequately.") "Sure," he adds, "there are some people who are more interesting than others, but that is not why I see patients. I see patients if I feel we can work together and formulate an issue that we can

attack. In that sense, seeing an older patient is no different from seeing a younger patient. And that is how I spend my time."

Dr. Delia, too, looks for a patient who is interested in exploring the issues irrespective of age. She asks the questions, is the patient psychologically minded, can the patient talk about feelings? Unless there are specific contraindications, Dr. Delia treats the patient. "I feel that one should give it a try, regardless of age. In time you see if they can get involved and how they work. You give it a chance. It has nothing at all to do with age."

Dr. Brenda feels similarly, stating that the issues with patients of any age are those of increasing the patient's creativity and potential for life. If patients are interested in examining the issues and getting on with living, then Dr. Brenda will work with them. This again, is true of younger patients as well, except for the fact that society sometimes encourages the older patient to expect less of himself. Dr. Brenda expects less from no one, young or old. Her feeling that life is to be lived as fully and as creatively as possible is conveyed to her patients.

Dr. Ernest does not differentiate between his older and younger patients although he is sensitive to the consequences of prior treatment. He believes that someone who has been in treatment before presents different issues in terms of how they approach the present treatment. To

whatever extent the older patient is more likely to have been in treatment before, this will be an issue of concern.

Drs. Carrie and Fireman both look for something in their older patients which they perceive is slightly different from what they look for in their younger patients. Dr. Carrie is particularly challenged by older patients who feel that while they still have things they wish to accomplish, success might not be possible because of their ages. "This, says Dr. Carrie "is the kind of existential dilemma that I find fascinating. This is very different from treating the younger person, unless the younger person talks about a handicap that is interfering with something he wants to do." Dr. Carrie's position is very similar to Dr. Brenda's position but with a subtle difference. Dr. Brenda says in effect let's work on what you can get out of life, age is an irrelevancy. Dr. Carrie says let's work on what you can get out of life, recognizing that age has imposed some limitations. Dr. Carrie believes that there are many more realistic situations--social, cultural, physical, and developmental realities--which can limit the older patient's possibilities.

Dr. Fireman's approach was somewhat different from that of the other five analysts. As the only subject who began this work with some negative assessments of the

elderly, Dr. Fireman has become very curious about the lives the elderly have lived. He is "impressed with a certain wisdom that one finds in the older person that one does not get from working with a person who is swallowing goldfish at a fraternity party, or worrying about getting a date." Dr. Fireman is interested in the stories that the elderly have to tell, of what it was like growing up during the Depression, or fighting in the Second World War. He feels that the elderly have ordered their priorities and shed attachments that are of little value, like the need for material wealth or position, and this touches something in him. Dr. Fireman is not unaware of the impact of his own needs upon his perspective. "What sparks my interest," says Dr. Fireman, "is my neurotic interest in or wish for a wise old man figure. There is a need on my part to be speaking to the wise old man or the wise old person. And then there are times when _I_ become the wise old man in some form. With one older patient I was the father who she really wanted and never had."

Presenting Problems of Older Patients: Do they Differ from Those of Younger Patients?

Almost every patient comes into treatment with the idea of addressing some kind of difficulty in living. In this respect, all the analysts agree, the elderly and the young are the same. Indeed, many of the problems brought in by both groupings are generically similar: marital difficulties; disturbed family relationships; work

problems; sexual problems, and so on. The forms that these difficulties take may be age specific or they may be quite similar to those of the younger patients. For example, none of the analysts presented the case of a college drop-out among their older patients. (See Appendix A.) However, one analyst did present the case of a patient who discontinued advanced education (i.e."dropped out") and another analyst presented the case of a mature man who returned to and successfully completed college. Marital difficulties among the elderly may be essentially unchanged from the difficulties of earlier years but may be exacerbated by the retirement of one or both partners. According to these analysts, there are five areas which do seem to be of greater concern to the elderly: illness and death; loss and depression; taking stock of one's life; combatting social prejudice; and the need to care for elderly parents.

Illness and Death

Drs. Adams, Brenda and Fireman noted that both the fear of illness and death and the incidence of complaints surrounding illness and death occur in greater frequency in their elderly patients. And Dr. Ernest claims that a person is lucky if he reaches a certain age and does not have at least one physical ailment that presses for attention. Both Drs. Adams and Brenda give great weight to the influence of fear in the exacerbation of physical complaints. According to Dr. Brenda many older people act

as if a physical disaster is inevitable and they live in expectation of the blow. Dr. Brenda mentions the more positive attitude of an eighty-seven year old woman of her acquaintance who lives as if she is neither sick nor old, although she has been ill and she is not young. She is productive, active, energetic, vital and thriving. Nothing in her life has been seriously modified because of age or because of illness. On the other hand, Dr. Ernest points out that many people (including their physicians), tend to dismiss the physical complaints of the elderly. Physicians may view complaining as a kind of futile exercise which goes nowhere, whereas the complaining often serves a function in and of itself. Dr. Ernest regularly receives referrals from internists who hope to translate the physical complaints of their patients into actions the internists can take in order to reduce their feelings of helplessness.

Dr. Adams feels that women are much more unaccepting of aches and pains and will focus on them as major difficulties, whereas men tend to ignore them. He sees this as a real difference between the sexes and hence in their presenting problems. Women pay more attention to such difficulties and come in for treatment because of them. (This does not appear to have been the experience of the other subjects.) Dr. Delia reported physical symptoms only as a concomitant to depression and noted

that in her case load, the patients' attention to physical symptoms invariably disappeared as depression lifted.

Loss and Depression

Drs. Brenda, Delia, Ernest, and Fireman, felt that issues of loss and depression are more characteristic of the elderly patient. Dr. Ernest considers the issue of irrevocable loss to be the fundamental difference between the over-sixty and the over-thirty patient. He acknowledges that while younger patients go through setbacks which damage their self-esteem, the notion that there will be other chances remains alive in a way that it does not for somebody who is older. The support systems for older patients, as a rule, have not been as flexible as those for younger patients. As the things or the people upon whom older patients have depended disappear, nothing replaces them. The over-sixty patient finds himself going to a great many more funerals than he did when he was thirty. He wonders by how many years his newly purchased appliances will outlive him.

In younger people, the anxiety or depression triggered by the loss of support generally leads to the wish to make some constructive moves. Then they may become afraid to take the next step. But the issue can be different with older patients--they may in fact be realistically lacking the capacity or resources to undertake the effort. Drs. Brenda and Delia stated that more of their older patients presented with depression as

a reaction to a feeling of hopelessness or to losses which are felt more profoundly than in people who are younger. Losses are very often a reality for this age group because their friends and relatives actually do disappear.

All four analysts observed a heightened awareness of a decrease in physical functioning in the elderly and all suggested that some elderly people cannot tolerate the physical decrements that may occur as part of the aging process. Dr. Delia said that the withdrawal secondary to the depression left patients feeling isolated and set into motion a further reinforcement for the depression. The circularity of this operation is clear. What makes the process a bit more difficult to work with in the elderly is their tendency be more isolated than younger patients due to the deaths or relocation of family and friends. Even when they are not depressed, older people have to work harder to maintain a social network. Dr. Delia related the case of one patient who lost a large social network when she left her job. This is not uncommon. The patient had to create a new social network for herself which she eventually negotiated successfully.

There may also be a loss of options, for example, the opportunity to work. While it is true that young people become depressed if they are fired and not valued, they usually acknowledge that they can go somewhere else and get another job. And they usually can. No old person

feels that way about getting another job, because it is realistically very difficult to do. Even in her own case, points out Dr. Brenda, she would be unable to move her practice and begin again. On the other hand, it is clear that such eventualities do not always trigger depression. Some patients are enterprising and will assess their skills, compile their C.V.s and work in an area which pleases them.

Taking Stock: The Meaning of Life and The Urgency of Unfulfilled Desires

Drs. Brenda, Delia, Ernest, and Fireman each spoke of a kind of "taking stock," an assessment of the meaning of one's life, or an examination of one's successes and failures, and a reconciliation to the lived life, as a precipitant to treatment in older patients. Drs. Brenda and Delia accept older patients who enter treatment in order to help them to finish their life work--whatever that may be. While younger patients have many unfulfilled desires, they often feel that they have a longer span of time in which to finish an important task. Older people no longer have time for procrastination and there is a far greater sense of urgency. Dr. Delia's patient said to her, "If I don't work it out now, then this is it. I do not have any more time." Dr. Delia also felt that her patients were motivated by a need to find meaning in their lives and to give something to others, to leave something behind them. Dr. Ernest stated that the very process of

taking stock can arouse anxiety and propel the patient into treatment. He notes as well that the sense of urgency is not limited to the patient. The analyst is also aware of time and of wanting to get something done quickly. He says, "I want the patient to really get something out of every session. We should want that all of the time with all of our patients but I think that we lose sight of it when we juxtapose the length of an hour over a period of four or five years. I think that when one works with the elderly one becomes more sensitive to the importance of time with all of one's patients. And possibly one gets more work done if psychoanalysis is not seen as such an interminably open-ended experience. The idea of trying to be more goal oriented in your head might be constructive. You may not reach it; you can't just pigeon-hole people. But if the patient really gets a sense that the analyst wants to get something done and will move along they are more likely to avail themselves of your services. I was astounded once when I realized that John Gedo has analyzed only fourteen cases in his whole career. I mean fourteen human beings! It's just that metapsychology is based on such very little data and that is what brings it under criticism."

Once aroused, the sense of urgency is usually a strong motivating force. Dr. Fireman points out that taking stock is not so much a function of time lived as it is of time left. He has seen the same dynamic in younger

patients who have been faced with the possibility of dying.

Combatting Social Prejudice

Drs. Brenda, Delia, and Ernest speak about the insidious effects of social prejudice. Dr. Ernest comments that the most powerful force which identifies the elderly as a group is that which identifies any disparaged minority. The patient must always struggle against it and some do this more successfully than others.

Dr. Delia finds that to the extent to which patients are identified with and accept social prejudice, they are to the same extent damaged by it. They feel that society is against them in some way and they accept this as a given.

The critical issue to keep in mind when working with this age group is that social prejudice does exist and that in given situations one should accept such realities and move on to the analytic work. Sometimes patients use societal prejudice defensively so that they appear to be far more oppressed than the situation warrants. This kind of functioning must also be identified for the patient. In many respects the analytic task of assessing reality is functionally the same in the younger and older patients. The difference resides in the need to recognize that a certain degree of prejudice does exist.

Dr. Delia notes that psychoanalysts are not immune to

the effects of prejudice and that if the therapist is prejudiced he will be unable to do the work. Said Dr. Delia, "I had a patient who was a professional who went to someone for treatment when she was in her sixties. This is an unusually youthful and attractive woman. The first thing that the therapist said to her was that she must have been very attractive when 'she was younger.' Then he told her to go out and do some 'busy work' to get rid of her depression. This patient had the ego strength to say this is not for me and to get out, but not before he left her with feelings of hopelessness because of what he recommended. Older people are made to feel that there is no hope and that there is nothing to which to look forward, and that they are not important. When the therapist colludes with society's prejudices, then it takes a great deal of strength for the patient to overcome this."

Dr. Brenda also related a story of professional prejudice involving a patient and his physician. An elderly patient had an intestinal problem of several years' duration and was unable to get any doctor to relieve the problem. A physician in another location subsequently operated, totally relieving his symptoms. He wrote to Dr. Brenda asking her if his prior physicians had been entitled to tell him to disregard the symptoms since he had so few years left to live. Dr. Brenda told him that no one had a right to tell him low long to live. He wrote

back and said, "Thank you, that was my feeling too."

<u>The Need to Care for Elderly Parents</u>

Drs. Adams, Brenda and Carrie noted that the need to care for elderly and sometimes infirm parents is no longer limited to middle-aged patients but is often an obligation of the elderly as well. These responsibilities may be a triggering factor in treatment. Dr. Carrie states that while not all mature patients have had children, all have had parents. Often the parents live at a distance, sometimes in nursing homes. The concerns of these patients with respect to relating to their parents are similar to those of younger patients, including the issue of making themselves available, sorting out the limits of their responsibilities, responding to demands, etc.

Both Drs. Brenda and Carrie felt that a forty-year-old-patient experiences an elderly parent as more of an interference with his or her own life than does the older patient. Older patients are more aware that their-ninety-year-old parents may soon die. Many feel that their remaining time with the parent is important to them so that the caretaking duties are carried out with less resentment.

<u>The Elderly Patient: Six Case Histories--A Study in Diversity</u>

Tucked away in the appendix are six case histories; one from each of the six psychoanalysts interviewed for this study. (See Appendix A.) The choice of which patient

to present was left totally to the discretion of the analyst with the caveat that the treatment be "analytic" and, of course, that the patient be over sixty. The case histories were requested so that the over-sixty patient and his problems might be observed within the context of the patient's life.

I should like to very briefly acquaint the reader with the six patients:

> Mrs. Z. ("The woman who would not change") is a professional woman who began treatment with her present analyst at the age of sixty-five in the hope that her husband and children would alter their relationships with her. She had retired from her organization and had returned to school for advanced education in her area of expertise but had "dropped out" in what her analyst viewed as a period of acting out. She was seen three or four times per week for about three years and made some gains in a treatment that the analyst characterized as "not a total success story," adding that the lack of success had nothing whatsoever to do with age but with the patient's narcissistic character structure.
>
> Mr. Y ("A journey from hypochondriasis to full creativity") is a seventy-year-old-successful male executive who had three periods of treatment. The second period began when he was sixty-three and lasted for about five years at two sessions per week. The third period began when he was seventy and is continuing. He has increased his productivity, his creativity, his accomplishments, his physical activities (including a resumption of sexual activity after many years of abstinence), his wealth, his philanthropy, and his ability to derive satisfaction from all of the above. He has never felt so vital.
>
> Mr. X ("Analysis interminable?") is a seventy-one-year-old man who was in a classically oriented therapy (twice then once per week) from the age of thirty-five to fifty-five, when his analyst died. He began treatment with his present analyst ten years ago, at two sessions per week, because of anxiety attacks and some depression. During the recent period of treatment, Mr. X liquidated his business

(his choice), cut remaining ties with his divorced wife (the divorce had been her choice), remarried, resumed an active sex life which is important to him, and increased his participation in athletics. He fears that his current wife will leave him, is concerned that his earning power has diminished, and continues to suffer from panic attacks. He is "wedded to the idea of psychoanalytic inquiry", works with dreams and early memories, believes he is being helped and plans to stop treatment at some point--but not today.

Mrs. W ("Singing her song at sixty-three") is a sixty-three-year-old wealthy married woman, mother of four, who aborted a singing career in her late twenties after giving a performance which received only fair reviews and resulted in performance anxiety. She has been in treatment for five years, at the rate of three sessions per week. The issues for her were the possibilities for herself in terms of her music and the realization of her earlier dreams for herself; and character issues of submissiveness, low self-esteem, lack of entitlement, and certain passive-aggressive qualities. She has worked through many of these character issues and is now concentrating on the attainment of her singing ambitions.

Mr. V ("Emerging from shame, guilt and self-hatred") is a sixty-four-year-old professional, divorced, Black man who has been seen once a week for two years. He entered treatment to explore his problematic relationships with women and difficulties with his eighteen-year-old daughter. His belief that his birth had caused serious damage to his mother, that he had precipitated his wife's psychosis, his homosexual activity, and the consequences of discrimination led him to feel that he was unacceptable. Guilt and self-hate became prevailing themes of the analysis. Treatment (and a resumed participation in sports) has increased his self worth and he emerging from the burdens of the past.

Mrs. U ("A second wind at sixty-five") is a sixty-five-year-old musician, divorced, mother of three, who has been in treatment (twice per week individually, and once per week in group) for two years. She entered treatment following a series of losses (her lover, money, and some treasured possessions), which left her feeling betrayed and alone. Treatment enabled her to appreciate how much of herself she had renounced to please her husband (during the period of her twenty-six year marriage),

> in much the same way as she had done as a child in relation to her parents. She has relinquished her deferential posture, taken new risks, resumed her musical career, is preparing for a major recital, and has developed a strong caring relationship with a new man.

In the previous section the subjects theorize about similarities in the presenting problems of their elderly patients. The case histories that they chose to present not only display the diverse aspects of the over-sixty patient, but offer many areas in which these problems are more similar to than they are different from the problems of younger patients.

Mrs. Z had long-standing marital difficulties for which she had earlier sought other kinds of treatment. Mr. Y, a high achiever, suffered from persistent discontent and from a propensity for somatization, both of which decreased with treatment as his capacity for creativity and satisfaction increased. Mr. X was a chronic patient who sought relief in analysis, from a lifetime of high anxiety, and problems with women. Both Mrs. W and Mrs. U were performing artists who entered treatment subsequent to raising their families, with wishes to renew careers which had been previously arrested. (There are a number of similarities between these two women which have far more to do with their sex and the character of the times in which they were raised than to their current ages.) Finally, Mr. X looked to treatment for help in dealing with his teenage daughter

and inveterate problems with women, opening up in the process an awareness of a lifetime of guilt and self-hatred. None of the five areas of difficulty outlined in the previous section (and underlined below) emerge as being especially problematic to the over sixty patients discussed above. Illness and death related to aging play no special role. Although it is true that Mrs. Z's husband died of a chronic illness this event did not trigger her decision to obtain treatment nor was it the source of her problems. Depression resulting from irrevocable loss was likewise not an issue for any of these patients. Mrs. U, who suffered a number of severe losses which propelled her into treatment, surrendered to none of them and overcame them all. Her losses, moreover, were not necessarily the losses attributed to the over-sixty patient. Ten years after she divorced her sadistic dominating husband, Mrs. U's lover left her for another woman. A friend negligently lost some of Mrs. U's choice possessions, and she herself lost a portion of her savings in a speculative venture. Combatting social prejudice against the elderly was not an identified problem for five of these patients, although Mrs. U was exposed to a combination of sexual and age bias on the part of a physician whom she had seen. Mrs. W correspondingly encountered some sexual prejudice on the part of a previous therapist who had "traditional views" about the "place" of women in the home. Mr. V was subjected to

racial prejudice. The need to care for elderly parents was similarly not a concern for any of these patients.

The one area which is probably germane is taking stock of one's life and the urgency of unfulfilled desires. This was a factor for both Mrs. U and Mrs. W in terms of their respective desires to return to the careers of early adulthood and of their awareness that this was very likely the last chance to make such a decision. Mr. Y was also "taking stock" and, parenthetically, his acceptance of a marriage without sex as being both good and viable for many other reasons coincided with some risk-taking in the area of sexual performance and in the resumption of sexual activity.

Summary

In summary, it appears that analysts come to treat the elderly as part of a fortuitous process, with a variety of attitudes regarding the meaning of aging and the elderly. While they appear to be in agreement that there are particular kinds of concerns which the elderly patient brings into treatment, their complete case studies reveal little need for work on the issues which they see as possibly representative of the elderly patient. The case studies are characterized far more by the diversity of issues and concerns raised by the patients than by any problem areas generally thought to typify the aging patient.

CHAPTER 4

The Psychoanalytic Process--Theory: How Psychoanalysts Think about their Older Patients.

Do Analysts Consider their Work with Older Patients to be "Psychoanalytic?"

"Yes!" said Dr. Adams, who elaborated throughout the interviews about his working style and philosophy. "Yes!" from each of the six psychoanalysts whose work is covered in this study. Although the subjects differed in their ways of thinking about their patients and their styles were vastly dissimilar, they shared basic assumptions about psychoanalysis regardless of the age of their patients. All saw an increase in self-knowledge and personal growth as essential and appropriate tasks of treatment. All assumed that unconscious factors or elements out of awareness contributed to the development of obstacles which interfered with the patient's understanding of himself. All assumed that an understanding of the events and relationships of early childhood was germane to the understanding of the events and relationships of adult life. All presumed that change was possible. All regarded psychoanalysis as something of a hermeneutic journey. All posited certain conditions (a frame or climate) as fundamental to the analytic situation.

It was agreed that the establishment of trust or a working alliance between patient and analyst was one such necessary condition. All hypothesized that the manner in

which the patient responds to the analyst supplies information about the analytic relationship as well as about the patient's characteristic ways of responding to others, including significant others from his childhood. All worked with symbolic representations, including dreams.

All six subjects held these beliefs in common, and all considered their work with the elderly to be "psychoanalytic." Nonetheless there were subtle differences in the way in which some of these analysts work with their "over-sixty" as compared with their over-thirty patients.

Initial Differences

Two of the analysts, both psychiatrists, are much more careful about evaluating the medical histories of their over sixty-patients than those of their over-thirty patients unless there is special need to do so in a younger patient. Each analyst makes the assumption that the older patient is more likely to have a significant medical history and that physical symptoms must therefore be carefully addressed. One describes the following event:

> Just a few weeks ago I saw an elderly patient who had fallen the week before and hurt her elbow. Well, just a year prior to that she had fallen and hurt her leg and back. I'm not certain that the doctors ever arrived at a definitive diagnosis and the patient still complains of weakness in her leg. So I did a very careful inquiry about the fall in which she hurt her elbow. We went into how it happened in great

> detail, because I am not at all clear about what precipitated two orthopedic incidents in the course of one year. I probably would not have done this with a younger person.

Both analysts are also more alert to medications the elderly are taking. One analyst, over the years, has returned patients to referring internists convinced that the medications patients were taking had caused their symptoms. In two such cases, symptoms of depression were directly related to the dosages of beta blockers which the patients were taking for hypertension.

Both analysts, aware that the elderly may be on a variety of medications prescribed by their doctors, feel that the analyst must note the impact of the medications on his patients. This includes noting whether patients are taking the medications as directed, and watching for the possible side effects of such drugs such as forgetfulness, mistakes, and the like.

The third psychiatrist also felt that scrupulous attention to medications is a necessity when dealing with the very elderly patient. She wondered if her psychopharmalcological skills were good enough to deal with this age group.

Occasional reluctance to analytically treat an ailing older person may take another form when the psychoanalyst is also a skilled physician. One reports as follows:

> I don't know how I would feel about treating someone who had a strong family history of strokes or high blood pressure. I don't know if I would want them to have a real cathartic experience with a great deal of

> rage. I actually encountered such a situation with a patient who left my office after a very emotional session and who ended up in the hospital after having suffered a stroke. You cannot say that it happened because of the session but you cannot say that it did not happen because of the session. So such kinds of physical difficulties can present problems in terms of the analyst's willingness to forge ahead with certain kinds of interactions. Now one would not have these reservations with the younger patient even though it is conceivable that a younger person might have an aneurysm.

While the Ph.D's were not unmindful of physical symptoms in their older patients they apparently felt less burdened than the M.D.s by the responsibility of monitoring the medications.

One of the M.D. analysts, meticulous about taking a medical history of his older patients, does not go as quickly to a detailed inquiry of the older patients's past history. He feels there is so much of the latter to cover, that he concentrates initially on getting a better sense of the present. "I want to get a sense of what was happening in the past five or six years, before I get into what the parents were like or what the experience of growing up was like. You may come away feeling that you have a fuller history with a young person after an initial consultation, but that is because the young have less history to relate."

Only two of the six analysts (one M.D. and one Ph.D,) mentioned other slight differences that one may notice in older patients. Older patients don't come out in all kinds of weather; they may take longer to enter and leave

the office; one may have to speak more loudly and more distinctly to them; there may be more telephone calls than one is ordinarily used to; and the patients with circulatory problems may be noticeably more alert at certain times of day. Three of the analysts felt that the older patient had fantasies of what psychoanalysis was supposed to be (five times a week, use of the couch, a "neutral" analyst, etc.), and that they did not want such treatment. One analyst felt that fewer older patients will come more than two times per week. Although it was agreed that these sentiments were expressed by the younger patients as well, two analysts felt that the younger patient was more apt to accept the analyst's judgment on such matters whereas the older patient was more of an independent consumer.

Treatment Goals: Do they Differ from Those for Younger Patients?

Increased self-knowledge may be the preeminent goal of treatment but few patients or analysts work explicitly toward such an abstract objective. Most patients enter treatment in order to address what Harry Stack Sullivan termed, "difficulties in living" and thus have a sense of goals when they begin treatment.

While three of the subjects, Drs. Carrie, Delia, and Fireman found no difference in the setting of goals between older and younger patients, the remaining three analysts found a number of distinctions all of which were

mostly a matter of emphasis in the treatment.

For example, if one aspect of an analytic treatment is the alteration of maladaptive functioning by means of some internal reorganization, then the duration of the preexisting maladaptive patterns and the duration of the internal organization may affect the treatment. The latter three analysts appreciate that a life lived counts for something. They do not always view a thirty-year-old patient's understanding of life and the tasks to be accomplished in the same way they would the corresponding perceptions of older patients. These analysts believe that older people have spent more time becoming who they are, have had more practice being who they are, and have less time in which to change who they have become. If who they are has been satisfactory for most of their lives, they may be more hesitant to change than the thirty year old. While these distinctions can create different emphases in the treatment they do not detract from the psychoanalytic nature of the work with the older patient.

Drs. Adams, Brenda, and Ernest believe that the analyst has greater impact on younger patients who lack the buffering effect of the older patient's accumulated life experiences. Drs. Adams and Brenda are comfortable with the strength of this impact, but Dr. Ernest believes that the analyst must proceed with greater caution in analyzing younger patients because of their greater vulnerability.

Both Dr. Adams and Dr. Brenda indicate clearly that the patient sets the analytic goals. Dr. Adams states that this is so with all of his patients regardless of age. While in essential agreement, these subjects report events which suggest subtle differences between their treatment of older and younger patients. Dr. Adams is more apt to question the goals set by certain younger patients than he is to question the goals set by certain older patients. Dr. Adams concedes that he might feel differently about a twenty-five-year-old patient who lives life less completely than he might and who wants to stop treatment, than he would feel about an older patient who wants to stop treatment. For example, Dr. Adams feels that a younger patient who was continually spaced-out out smoking pot, could not afford to discontinue treatment. "I feel this way," says Dr. Adams,

> because the patient has a long life ahead of him and he has got to live with himself and the consequences of his actions for a long long time. I might ask an older person if he feels he might be able to do something more productive or more creative if he clarifies this or that, but I would <u>not</u> say to him that he <u>cannot afford not to do it!</u> But I would view the actions of the twenty-five-year-old as exploiting and abusing both society and himself and therefore I feel that I would have more justification for intervening with the younger patient. Whereas the older patient has smelled the salt air. My feeling is that sure I would like the older patient to do more, but I don't feel that I am as certain that I know what is right for the older patient. Whereas I do know that if this twenty-five-year-old does not get a hold of himself that he is going down the tubes. The older person knows more about the consequences of his actions and it is therefore more a question of his choice. The twenty-five-year-old

> may need somebody to tell him what the older person has learned by living.

Dr. Brenda states unequivocally that unless a sixty-year-old patient has selectively failed to attend to a major portion of the self, he already has a very good idea of who he is, what his limitations are, what he considers to be positive and negative about himself, and about his patterns and habits. For good or for ill, says Dr. Brenda, the older patient has established a certain equilibrium in his life with which he is not anxious to interfere. If circumstances have disrupted his sense of balance, the patient wants to retrieve it without additionally fracturing it in the treatment. As a result, Dr. Brenda believes that the analyst should allow the patient sufficient autonomy in the setting of goals. Normally, adds Dr. Brenda, the older patient initially comes to treatment to solve an interpersonal problem. "Therefore," she states:

> I pay very careful attention to what they want and I go with that very much. If someone says to me, as one patient did, 'I want six months of treatment to sort out my frustrations about having my husband around all the time,' I will respect that highly. So the goal will be determined by what the patient feels. Now the six-month lady might not be finished in six months at which point we would examine together whether or not she wished to continue. Then she might decide to go on for another six months, or she may have expanded her goals.

Like Dr. Adams, Dr. Brenda would be more inclined to work with the thirty-year-old to see what he might wish to explore or change about himself. Her comments reflect

sentiments similar to those of Dr. Adams:

> Of course it always depends on the patient, but the thirty-year-old has got a lot of living to do. It may pay him to do the hard work now. You cannot really say that to a sixty-year-old in the same way because that person had already achieved a number of goals and he is more likely to know what they want to do with the next twenty-five years even if he has not done it. If the older patient does not know or if he is limiting himself then of course I will treat the situation in the same way that I do with the younger patient. But in general it has been my experience that there are specific things that the older person wants help with. A thirty-year-old is unexplored territory to himself. He really does not know who he might yet become.

Dr. Brenda is quick to point out that there are always exceptions among her older patients, such as late bloomers, and people who want to take advantage of unexpectedly changed circumstances. But she feels that frequently the older patient will begin treatment in order to address specific problems.

Like Drs. Adams and Brenda, Dr. Ernest places great significance on the life experience of the older patient. As he states, "if you are dealing with somebody who has lived through seventy years of his life, he really does have on board a whole life system that has worked for him over a long period of time." While Drs. Adams and Brenda are more reluctant to interfere with this system, Dr. Ernest believes that he can move ahead more aggressively because the embedded nature of the older patient's system will protect him from the power of the analyst's impact. The younger patient does not have the same protection and the analyst may accordingly need to be more cautious in

terms of the intervention.

The nature of the treatment of older patients will often be determined by the patient's viewpoints about analytic treatment and the role of the analyst. If older patients are not interested in making explorations past the point of their presenting difficulties their analytic work may be of shorter duration. Nevertheless, says Dr. Adams, truly remarkable changes have occurred among some of his older patients. According to Drs. Brenda and Adams, patients can become engaged in psychoanalytic therapy once exploration has begun. The initial goals of older patients, however, are not as diffuse as those of younger patients and older patients do not often come in with the hoped-for changes in self that may characterize some of their younger counterparts. While Dr. Brenda sees psychoanalysis as a "second chance" for the patient, she feels that the elderly do not always view the process in terms of its full potential. If the patients focus on practical matters, Dr. Brenda begins where they are, often continuing with a further expansion of goals.

Dr. Adams concurs that older patients expect less from the analyst, less from the treatment, less from themselves, and many do not even expect that anyone will listen to them. Older patients often find that their physicians do not listen to them and that their families do not listen to them. As a result, they develop the

belief that no one wants to listen to them.

Dr. Delia also agrees that older patients expect less from analysis than younger people but she does not view this as short-circuiting the treatment in any way. In her rendering of the patient's attitude, she says, "... the older patients ask less of you. Much less. I don't know where people get the idea that older patients are demanding." This perception has intensified Dr. Delia's wish to expand her patients' vistas and to enlighten patients as to just how much is truly possible for them.

Drs. Carrie, Delia, and Fireman, conversely, found no difference establishing goals with older patients. All three work in a very open-ended fashion with both older and younger patients. Dr. Carrie said this might be a reflection of her patient population, but Dr. Delia asserted that she always approaches treatment in an open way. With all patients she looks toward the future and sees what can be done. Dr. Delia helped a dying patient to find satisfaction and meaning in his life. But this was the task that the patient had set for himself.

Whereas Dr. Delia tended to focus exclusively on the past only with her dying patient, Dr. Ernest is generally more interested in the past lives his older patients and correspondingly less interested in their future goals. Dr. Ernest admits,

> To some extent that is a kind of expression of ageism, and it is a discriminatory bias. Because if they are allowed to and if they feel entitled to have

> creative goals, elderly people can really develop new interests and do different things. But there is that sense when you sit down with somebody who is eighty-six-years-old, that you want to find out as much as possible about what his life has been like. So you essentially ask the patient to tell you a story about what his life has been like, instead of concentrating on his plans for the future. I just started seeing somebody who is eighty-six-years old. He had two long marriages and his second wife and a sibling had just died within a week of each other. This is a very bright and lively man and when you talk to him you get the impression that he is able and could still run a business. He is now extremely lonely and fearful because he has always had a woman to take care of him. In working with him there is a tendency to go into his history and get a kind of anemnesis of what his life has been like. Now I do think that this has to be resisted to a certain degree and that the analyst does have to focus on the patient's goals for himself and on his interests. Because statistically he has a better chance of living to be one hundred than I do.

Dr. Ernest believes that the elderly are the victims of age bias and may feel less hopeful than younger patients about the setting of new goals. He observes that many older patients come into treatment because their functioning has decreased. For example, if an elderly patient who has lived a penurious life, experiences severe financial distress and is compelled to diminish his savings, he discovers that his characterological ways of operating don't fit the new situation and he deteriorates. In such cases, the first order of business, according to Dr. Ernest, is to restore the previous level of functioning. This is no different from how he would deal with a young person who comes in with a severe depression. "You want to find out how to get them back to not being depressed." But with the younger person Dr. Ernest feels

that there may be greater possibility for some internal reorganization. One therefore moves beyond restoration to previous levels of functioning (since the previous level was a prelude to the depression), and focuses on how the patient can do things differently. Dr. Ernest will attempt to proceed this way with his older patients as well, but if he is working with a patient in his seventies or eighties who has deteriorated, Dr. Ernest believes that he is doing the patient a service if he can restore the patient to the level of previous functioning. He therefore focuses his attention on those defenses which the patient has used to advantage and he tries to see how these can be actively engaged. With a younger patient, Dr. Ernest might be more inclined to explore the entire defense structure, or to shift defenses to something more permanently constructive. But with the older patient who has shown some decline, goals may more frequently be to restore rather than to explore. This does not mean, cautions Dr. Ernest, that he is without hope for change in the elderly, it means only that his emphasis may be just a shade different.

Dr. Fireman states that generally treatment goals are determined less by age than by whether the person is neurotic or psychotic. He is much more aggressive in defining goals for the psychotic patient than he is with a patient who has no problems with reality testing. For Dr.

Fireman, pathology not age is the determining factor in setting analytic goals.

The Patient's Narrative: The Constellation of Emerging Patterns in Older as Compared with Younger Patients

Among the six subjects, Drs. Brenda and Carrie, notice variations in the emergence of patterns which do seem related to the age of the patient. Dr. Brenda finds that such patterns emerge more quickly in her older patients and that she gets a sense of the life style of the older patient much sooner than she does that of the younger patient.

These patterns of life, says Dr. Brenda, give one a sense of who one is. Sullivan calls these perduring patterns which characterize the self. The elderly exhibit such patterns.

Dr. Carrie thinks that the analyst gets a more thoughtful selection of key incidents from older patients, which have probably been reworked and reworked in the patient's mind. "The patient may be wrong in what he pins his difficulties on," says Dr. Carrie, "but older patients are clearer (than the young) about what they want you to know about them. The older patient's assessment of the past is much more succinct. This can have disadvantages because it may also mean that the assessments of key issues are more fixed and that it will be harder for the old to see things in another context."

Dr. Carrie distinguishes between the older patients' concise examination of central issues and their styles of delivery. She finds that older patients tend to be more talkative and attributes this to their feelings that they have already burdened their families with details about their lives that their families would rather not hear. She also feels that a sense of urgency contributes to their pressured delivery.

Dr. Brenda thinks that the thirty-year-old patient is less knowledgeable about himself and cannot narrate the essentials of his life story in the same concise manner that an older person can. Her older patients have developed more of what she refers to as "common sense" and an ability to "put two and two together more easily" than her younger patients. This facility, states Dr. Brenda, is simply a function of longer experience in life. People do manage to learn by their experience. She also feels that a sense of urgency in many of the older patients keeps them on target.

Dr. Ernest also believes that the analyst gets a clearer picture of the characterological style of the older patient sooner than he does of the younger patient but he attributes this to the information-gathering techniques of the analyst. Since one is more likely, initially, to focus on the older patient's present problems (as opposed for example to early family history), one is more likely to get the kind of information that

diagrams the patient's character style. With respect to narrative style per se, Dr. Ernest's experience is slightly different from that of Drs. Brenda and Carrie. Dr. Ernest feels that his younger patients give a clearer answer of what their experience has been while the older patients present a great deal of detail. He cautions that obsessional patients of either age group will present a great deal of minutiae and, like Dr. Adams, states that the obsessional young patient is the obsessional old patient. But Dr. Ernest's response to the older patient's detailed presentation differs from his response to that of his younger patients. He is less apt to break in to the older patient's narrative out of a concern that many older people are dealt with impatiently. He also suspects that older people may surround topics with a great deal of detail so as to compensate for any real or imagined memory deficits. They will come at a topic from many different directions in order to make a point clear. On the chance that such as explanation may have some validity, Dr. Ernest will not interrupt the older patient's detailed narrative so as not to increase the older person's anxiety about memory loss.

Drs. Adams and Fireman state that the nature of the difficulty and the patient's character organization are the determining factors in how the story of the patient's life emerges in treatment. This has nothing to do with

age. Dr. Fireman observes that if the patient is psychologically minded and can identify the patterns of behavior in himself, he can more easily describe them to the analyst and to use them in the treatment. Dr. Adams describes naive people who are difficult to treat because they never seem to understand what the analyst is asking. While very depressed people often have few associations to the analyst's questions and give limited responses or they "put you off." These patients are more likely than not to have certain character styles which prevail throughout the life span, affecting the emergence of patterns in the narrative. Dr. Adams states, "An old dipsey doodle was very likely a young dipsey doodle." Dr. Adams, also sees a tendency in his older patients to use more stereotypical thinking in relating their stories because one tends to stereotype as one becomes further removed in time from the memory of an event. According to Dr. Adams, "the further away we get from an actual experience the more we tend to alter or embellish it. That is what analysts mean by narrative truth as against historical truth. But I must say this is a minor point, because I don't think we ever really get to historical truth whether somebody is six or sixty. The truth is always the truth as the patient tells it to you."

The Relative Importance of Early versus Later Experiences on the Personality or Pathology of the Patient.

Despite the acceptance among these analysts of the

very important role that later-life experiences play for older adult patients, there was a strong feeling that early experience was crucial.

"Obviously," states Dr. Adams, "very early experiences tend to be more fixed and embedded." The first five years are especially important if they have been traumatic, in the opinions of Drs. Brenda, Carrie, Delia, and Fireman. These analysts are not convinced that early experiences are quite as embedded if development has been fairly normal. For Dr. Fireman, working with older patients had reemphasized the importance of early childhood experiences. He noted that:

> despite the various experiences that have occurred to people in their 5th, 6th, and 7th decades, the strengths of the early experiences leave indelible traces. Patients remember humiliations, shame, being excluded, and being labeled. And these experiences and the feelings associated with them continue to color the lives of the patients....I guess there are certain corrective experiences, such as chum relationships, that Sullivan talked about which undo some of the early trauma. And I have actually seen this work with latency age kids. But in the patients that I am thinking of, it seems that those preadolescent and adolescent periods did not provide them with any kind of corrective solutions to their problems.

Dr. Brenda feels that pain leaves a much stronger imprint than pleasure and that traumas of early childhood may make an impact on memory in a way that pleasure does not. So it is both the nature of the experience <u>and</u> the time frame within which it occurred that influence the developing personality. "I can tell you this," she says,

"from my own experience and from my experience with patients: if there has been an early trauma, you carry a scar. You never get rid of it. There are certain vulnerabilities that I carry with me that I have learned to respect in myself. These are vulnerabilities which cause me difficulty, areas to which I am always alerted. And I see this happening often with my patients."

Dr. Ernest agrees that early experience is critical but adds, "I have an adaptational model of therapy so that the early experiences are seen as part of a continuum of experiences of constantly shifting adaptations. They are important, but they are not the <u>only</u> thing."

Dr. Carrie, perhaps slightly more than the other five analysts, tends to focus less on the early childhood experience with her older patients. "I think," she says, "that there is less feeling on my part that I need as complete a picture of where the older person is coming from." The older her patients get, says Dr. Carrie, the more aware she becomes of the influence of later experience. Though of course, she adds, the later experience is inevitably filtered through earlier experiences.

Drs. Adams, Brenda, Delia, Ernest and Fireman feel that their older patients are at least as interested in talking about early childhood experiences (in fact sometimes more so) as their younger patients and that many of the older patients truly delight in seeing their lives

in perspective and in reexamining the events. If the patient is analytically minded, believes Dr. Delia, he not only recovers memories but is very close in affect to those memories. Dr. Ernest, too, states that in the treatment of the elderly the very early memories can come up in a highly intense way and that his patients are able to use them well. Dr. Brenda senses that her patients wish also to separate the painful events from the "good stuff" and to haul out from earlier times whatever one can which was good, They desire to have catharsis about the bad and to remember the good. According to Dr. Fireman, his older patients may or may not wish to discuss early experience depending, not upon their ages but, on their defensive structures or on why they have entered treatment and what is uppermost in their minds. A person who has a clear situational depression, tends to be more task-oriented than a patient with character difficulties of longstanding which he is likely to trace back for decades. But even this is not fixed.

Drs. Brenda, Delia, and Fireman state that the proportion of affect that accompanies early memories depends upon the patient and not upon the age of the patient. "Certainly," says Dr. Brenda, "the elderly are as able as younger patients to express affect. Needless to say," she adds, "things are falsified sometimes and you have to be careful in listening. But this is true of all

age groups. This is an intrinsic part of doing analytic work." Dr. Fireman, too, observes that the older patient's ability to recapture a memory is equal to that of a younger patient. He says that these memories are vivid, intense, and dramatic.

Drs. Adams, Carrie, and Ernest suspect that older patients may stereotype more as they abstract the experience of the earlier years. Early experiences have been worked over so much, states Dr. Carrie, that some of the affect gets lost (unless one is talking about extraordinary trauma.) Affect is more evident in connection with the headlines that people have about their lives. Dr. Carrie gives the following example of a "headline" event.

> I have a patient with vivid memories of daily practice sessions at the piano. His mother remained in the background and yelled whenever he hit a wrong note. This was a repeated scenario. The patient never could be comfortable playing the piano, which he loved. He had to practice, practice, practice. To this particular patient, the piano playing was a highly charged event. He played as if there were always somebody listening with a highly critical ear. He was super critical of his own playing; he took on his mother's voice. He once said that he had the image of a monster lurking in the background every time he sat down to play.
>
> In the course of therapy the memory and the accompanying affect have been modified. The mother is remembered as difficult but not mean. The monster has become far more benevolent.
>
> Clearly, younger patients also revise feelings and also become more aware of what may have affected a particular parent at a particular time. The minute there is understanding the memory becomes rounded out. A patient may not give up the anger but may say, `I am angry, but other things were happening at

> the time that make the event more understandable.' These revisions of memory are no different for the young than they are for the old.

Dr. Ernest also talks about the kinds of distillation of early experiences that Dr. Carrie has labeled "headlines." These he calls "short hand accountings" of an event or a series of events which occurred early in the patient's life and which have taken on symbolic meaning. Such accountings may be used defensively to remain removed from more current issues.

Aspects of the Personality in Relation to the Aging Process.

Some have wondered about the influence of the aging process on various aspects of the personality and on the defensive styles of the older person.

Character and Defenses

With the exception of "wisdom" accumulated over the years, the subjects in this study see nothing in the way of character or defenses that can be ascribed to the process of aging. Dr. Ernest believes that "once you move away from certain statistical physiological indices, such as the change in the kidney filtration rate, the group differences just don't appear. There is a high degree of variability." Drs. Adams, Brenda, Carrie, and Delia feel that for the most part people continue to act in their characteristic ways and that defenses are a function of these character styles or of a particular clinical syndrome. That is to say, defenses are not

related to the age of the patient. On examination of their histories one can easily determine that the reactors remain reactors and that the initiators remain initiators, says Dr. Adams, and he suggests that a diminution of passions (and perhaps also of vigorous physical activity) may be the one trait that distinguishes older from younger patients. He views his older patients as more even handed about experience and he, and Dr. Carrie, like to think of this as "wisdom."

Dr. Fireman correspondingly believes that life events reorder the priorities of the individual in such a manner as to make older people more appreciative of what is really important and what is trivial. (The attribution of "wisdom" to older patients is common to each of these analysts. See pp. 222-223.)

Dr. Brenda speculates that if defenses have worked over a lifetime of use they may be more ingrained (i.e."the character armor may be more definite") but they are not resistant to change. More work may be required of both patient and analyst and this takes time, but once the patient recognizes the development and meaning of the defense, resolution is possible assuming that the patient wishes it.

Dr. Brenda provides the example of a male patient in his sixties who removed himself from a business position and successfully entered a new profession. Dr. Brenda reports that the patient had never had an enduring

relationship with a woman and that he had essentially spent a portion of his life throwing away the essence of what he needed and wanted. A childhood memory, of his literally having discarded a longed-for lemon popsicle following an enraged encounter with his mother, became the metaphor of Dr. Brenda's work with this patient. Both patient and analyst understood the patient's lifelong stance as a defense against basic mistrust. Every time he developed a relationship with a woman, he threw it away. He is now enjoying a substantive relationship with a woman; his blatant hostility is gone and he is beginning to live more fully.

Narcissicism

In the experience of each of these analysts, narcissistic concerns are not exacerbated by the aging process although they may assuredly be clear problems throughout the life cycle. Dr. Ernest states that the loquaciousness sometimes attributed to older people might actually be a kind of "narcissistic" ruminative thinking about the self which may serve as a healthy defense against a painful daily awareness of certain kinds of losses. Regarded in this way, one would understand it as a constructive psychological adaptation. In such cases, the analyst might be well advised to let the patient continue on without being pushy about getting to the point. This kind of rumination and indulgence directs

attention to the patient; and sometimes the attention itself is precisely the point.

Dr. Adams believes that the impact of aging is a very individual matter. Although he thinks that women are more offended by the aches and pains which may occur with age, he sees no gender difference with respect to the acceptance of change of appearance as one grows older. The older narcissist was the younger narcissist irrespective of gender. Dr. Adams cites the case of a patient who lost all of her hair as a result of a medical treatment when she was over sixty. This was difficult for the patient to deal with and represented a wound, but it would have been so, says Dr. Adams, when the patient was forty. If the aging process itself is understood by the patient as the source of narcissistic injury then the patient very likely has regarded other life experiences as the source of earlier narcissistic wounds. "Sure," says Dr. Adams, "people with these kinds of character styles have a rougher time when they get older, but they had a rougher time when they were younger. Life wasn't such a bed of roses for them then....If the patient says he wishes he were younger, then I am apt to reply, 'So that what!?' And after awhile they begin to see that it wasn't so great when they were younger and it is not so terrible now. So their skin is a little bit more flabby--what the hell. They seem to accept it if you challenge them about it." Dr. Fireman also believes that narcissism connected

with physical beauty is an issue for the older patient if it has was an issue when the patient was younger.

According to Dr. Fireman, the development of such a value system often starts very early in life. One of his patients began training her granddaughters never to sit under a full light, lest it show wrinkles and imperfections. She was very preoccupied by her appearance and was teaching her granddaughters to share her values. Dr. Fireman suspects that this is slightly more problematic for women who have been heavily invested in their beauty throughout their lives and continue to be so into the aging process. Their emphasis on physical appearance is not new but it may be harder for them to use their looks to produce the feedback--which is triggered exclusively by beauty--which they have come to expect from the environment. "On the other hand," says Dr. Fireman, "I have seen older women in treatment who had thought of themselves as being ugly or deformed as young people, and who, while in treatment with me, have come to see themselves as looking and feeling good."

Dr. Brenda tends to view narcissism as a societal affliction stating that relationships based on narcissistic investments are symptomatic of a refusal to relate in interpersonal terms and exemplify a move away from personal integrity. What may happen as one gets older, according to Dr. Brenda, is that patients can no

longer mistake the narcissistic exchanges of their earlier years for meaningful relatedness and they wind up feeling empty and alienated.

Dependency Needs

Dependency needs, state all of the subjects, present no particular difficulties among the aging. Dr. Adams does not use the term dependency needs in the sense that one talks about unconscious yearnings for certain kinds of nurturance. He uses the term to describe people who need people and attributes this to character styles which are not at all age related. Dr. Brenda likewise feels that unresolved dependency needs may be a problem at any age.

Envy

None of the six analysts felt that envy presented special difficulties for the older patient. According to Drs. Adams and Brenda, people who are envious and cannot resolve their envy have a problem at any age. Dr. Brenda believes (as she did when speaking of narcissism) that western society encourages the development of envy so that it becomes more difficult for both patient and analyst to distinguish societal ills from individual pathology.

Drs. Ernest and Fireman correspondingly state that envy is characterological and, in their patients, the trait most embedded, intractable and resistant to change. It is therefore not surprising to find that it persists into the later years. Dr. Ernest depicted a patient, now seventy-three, who had been in a battle with her daughter-

in-law for a period of twenty years over allegiances of daughter-in-law and grandchildren to the daughter-in-law's family of origin. The patient felt neglected but refused to compromise her position in any way. Dr. Ernest felt that the inner workings of the envy had not shifted, and were unlikely to shift, despite the fact that his patient has become more intellectually aware of the cost of her envy (the pleasures she had given up) throughout her life. One may begin with a patient when the patient is over-sixty and see evidence of the envy. But because analysts see patients at specific points in time, it is difficult to understand how they have really been throughout their lives, and to appreciate that some attributes have existed for many, many, years. Dr. Ernest's patient admitted to the existence of her "sensitivities" since adolescence.

Dr. Fireman pointed to the case of a Jewish woman who was told as a girl of seven that only boys counted for something. Her envy of her brother was still a problem when Dr. Fireman saw her at age seventy-years-old. The patient was not as well-off financially as her brother and her envy of him was the entire theme of the treatment. It is sometimes hard to determine, added Dr. Fireman, to what extent envy exhibited by an older person is characterological. Consider, he said, the following remarks made by older patients in the course of treatment.

> I suppose when you buy a car you think of your family and kids and all of the people you have to live for. I have already done that part so that when I get a car I know that this will be my last car.

And,

> Why are you asking me about sex. I am not like a young person going out. I am sure that you go to all sorts of dance halls and things like that. That is part of your life but I am sort of beyond that.

And,

> Why don't you spend some of the money that I gave you and take a good vacation. I don't really go away except to visit my kids on Long Island.

Younger patients certainly make similar kinds of envious remarks and the thought that the analyst is vacationing on the patient`s money is not reserved for older patients. A younger patient may say, "I am living in a small apartment, and I don't have enough money to spend, and what is the point of my taking a vacation anyway." It is thus hard to determine whether envy expressed by the old of the young is anything more than a characterological style which simply utilizes a current situation for its expression. The bitterness may extend throughout the life cycle. Dr. Fireman continues:

> If you feel good about yourself and what you are doing then it does not matter whether you are twenty or forty or sixty. And if you have a character structure in which your are constantly living out the role of a victim, or expressing some kind of paranoid ideation, these personality constellations are likely to continue into old age if they are not corrected earlier. One sees envy operating in people in their thirties, forties, fifties, and upwards. One sees envy operating in adolescents. An adolescent does not get into the college of his choice and he feels that his life is over and is suicidal. At nineteen or twenty he maintains that his life would have been totally different if he had gotten into that

> particular college. Well maybe it would have, but that does not necessarily mean that it would have been a better life. In a certain sense it is the same dynamic as the envy of the elderly. It's not the age of the person that creates the envy.

Guilt

Dr. Delia alone brings up the issue of the guilt which older patients feel toward their children. Younger patients if they have any guilt, she observes, have it toward their parents. But older patients have guilt not only toward their parents but toward their children as well. They feel guilt for things that they did not know and could not have known. And, says Dr. Delia, the more insight they develop the more guilty they become because they feel they could have done it differently. Younger and older patients may feel that they have wasted some or many of their own years, but only older patients agonize over the thoughts that they have injured their adult children in some fundamental ways. Dr. Delia feels that one must strike a delicate balance in the work in this area. The analyst does nothing to prevent some necessary and realistic mourning. On the other hand one can take issue with a severe punishing superego by pointing out that the children were influenced by many factors and by many other caring people and friends. One can also remind patients that relationships between children and parents are interactive. Most important is the patients' understanding and acceptance of the fact that they could not have done it differently given who they were at the

time. This theme appears in any mourning of lost opportunities or regretted actions, but only among older patients does it hang so heavily with respect to their now grown children.

Concerns of the older patient: God, Sex, Sickness and Money?

God

Only Drs. Brenda and Delia recount an upsurge of interest in issues of religion and faith among their over-sixty patients. They point out that the interest is not necessarily in ritualized religion although there are people who become more ritualized primarily because they need the support of a group. As they see it, their older patients become more spiritual and they equate this with the search for meaning and integrity which both feel is a central focus of the older individual.

Sex

Drs. Adams and Brenda feel that sex plays a different role in the lives of older people. Whereas in the young, the sexual drive may have been paramount, overriding all other considerations, in older people it is more likely to be attached to the need for love and for tenderness. "I think" says Dr. Adams, "that older people can't have sex just for sex." Or in the words of Dr. Brenda, "the over-sixties don't have the horniness of the over-thirties."

Dr. Carrie notes that her older female patients complain that as regards sex, the men are more passive

than they were when they were younger, more passive than the women, and far more passive than the women would like them to be. (Along these lines, Dr. Fireman presents a lively vignette of an older man--in his seventies--whose wife had died; he wished to remarry and found a satisfactory partner. In Dr. Fireman's words, "The new woman, in her mid-sixties, said that she would not marry him because he had been impotent for years and she said that he would have `to get retrained by a hooker.' It was before the AIDs stuff and all. Anyway he went to this woman who helped him with his impotence problem. And he got all his stuff working and then they got married.)

Dr. Delia feels that any diminution of sexual drive in a formerly (sexually) active patient is usually related to depression and that the sexual drive will return to normal functioning once the depression lifts. She finds that her older patients are sexually alive and cites the case of a woman patient in her late sixties who found a seventy-eight year old boyfriend. "They go dancing," says Dr. Delia, "and they make out often. Even I was surprised. This is the best relationship that this patient has ever had in terms of being equal, and they really do enjoy themselves."

Often, patients forget their past histories and they present their problems as age-related. But a careful inquiry will show this to be an incorrect determination.

Drs. Adams and Delia find that the incidence of sexual dysfunction is usually due to psychological origins and is unrelated to age. Dr. Delia says that when she finds sexual dysfunction in an older patient there is preexisting pathology. In Dr. Adam's experience if a man is sexually active when young he tends to be sexually active when old, unless a major physical impediment or a major emotional trauma intervenes. In his practice, these have been the exceptional cases. For the most part, the young men who have trouble with their wives about sex come in as old men complaining of the same problem.

It was once the belief that women became more sexually active after menopause but Dr. Adams discovers that since contraception is so readily available the women are sexually active in their childbearing years as well.

Hypochondriacal Concerns

None of the analysts see hypochondriacal preoccupations as a particular concern of the elderly although all agree that one is more likely to see age related physical symptoms in older patients. All have had patients of all ages who have used bodily concerns defensively. Dr. Brenda sees hyponchondriacal obsessions in older persons as a manifestation of the fear that something physical will disrupt life as it may have done in some of their peers. She feels that this is specific to the culture and that it is not especially limited to

one's patients. Dr. Fireman says that if hyponchondriacal preoccupations come up with his older patients he challenges them in the same way that he might with a younger patient. "I'll say, `Just think, you cannot pass Key Food without thinking that asparagus is on sale and that it is going to help your digestive system. Well this will save you from thinking about other things.' And Dr. Fireman will then focus on some current concerns which are being discussed in the treatment. "Or," he continues, "hypochondriacal concerns can be used as a way of organizing a `victim role' which is true of younger patients too." Dr. Fireman does find that if his older patients have a number of legitimate physical complaints, they rarely have had the opportunity to discuss these at length with their doctors. Sometimes the complaints are chronic so that they are never really completely cured; sometimes the medications which the patients must take to control their illnesses may present additional difficulties. In such cases, the therapist is the "doctor" who will listen better than the other doctor, and the airing of the complaints may present a very significant resistance to the treatment for a period of time. After a while, one has to dislodge that.

<u>Money</u>

Older people get scared more easily about money, report Drs. Adams and Ernest, and they are always afraid

that they will not have enough money to take care of themselves. Dr. Ernest sees this as an actual fear of becoming dependent upon others whereas Dr. Adams views this as a concealed wish for immortality as if the older patient yearns for enough funds to keep him going forever. "I have a patient," says Dr. Adams, "who is an investment advisor. And he tells me that the older his clients are, the more they want long term investments. Whereas the younger clients are interested in quick gains. I think that is a manifestation of the same thing."

Summary

All six subjects consider their work with older patients to be psychoanalytic. If asked to distinguish between older and younger patients the subjects speak of subtleties rather than substance.

Most of the subjects are more cautious about physical symptoms in their older patients and less likely to assume that these are of psychological origin. The establishment of goals in treatment is unaltered in essential ways, although three subjects do give greater credence to the older patient's expression of what he wants from the treatment process. What the older patient wants may initially be more focused and more urgent than the expressed goals of younger patients.

Nor does his narrative distinguish the older from the younger patient, although three subjects do find that their older patients can more easily relate the key

incidents of their lives.

Subjects state additionally that traumatic early life experiences remain crucial for older patients who can recapture early memories with little or no loss of affect. Finally, subjects see nothing age-related about character and defenses with the exception of the maturity or "wisdom" that older patients glean from many years of living.

CHAPTER 5

The Psychoanalytic Process--Practice: What Psychoanalysts do with their Older Patients.

Analytic Technique: Differences or Modifications Based on Differences in the Patient's Age.

None of the six analysts makes any notable modifications in analytic technique with older patients. There is a sense among most of the subjects, however, that interacting with an older patient is sometimes slightly different than interacting with a younger patient. These analysts have variously described the interaction with older patients as more equal, more direct, more real, and freer. It is not clear to what extent these observations are attributable to the patient or to the analysts' own fantasies about "older" persons.

Drs. Adams and Brenda believe that differences in analytic technique (aside from differences which exist among analysts), are connected to the character and pathology, and sometimes to the situation of the patient, but not to the age of the patient. For example, Dr. Adams mentions that he always keeps a certain distance with paranoid patients that he is unlikely to keep with other patients. But he offers no analogous technical mandate about "older" patients. With the exception of more careful attention to the physical complaints of the older patient--is a pain in the chest anxiety or a heart attack-- Drs. Adams and Brenda make no modifications in analytic technique based on age alone.

"The things that don't work with older patients don't work with younger patients and vice versa," states Dr. Adams. Dr. Brenda notes that "anything that you can do with the younger patient you can do just as well with the older patient." Dr. Delia likewise feels that her method of treating the elderly is no different from the manner in which she treats younger patients. "I work analytically, according to the patient's capacity for insight, to engage with me in a working alliance, to work in the transference, to explore the past and see connections to the present, to cooperate in the treatment, to keep the contract, to work with dreams....I work this way without any concession to the age of the patient because none is necessary." Nonetheless, Dr. Delia feels that she is freer and more direct in her work with older patients.

Dr. Brenda finds that the older patient is more sensitive than the younger patient to the actual mood states of the analyst and will pick up on things that the younger patient does not. If, for example, you are ill, states Dr. Brenda, your older patient is more apt to notice and comment about it because the older patient has probably been responsible for the welfare of other people for a good portion of his adult life. Unless the older patient's particular dynamics warrant it, Dr. Brenda will not "analyze" an older patient's comment about the

analyst's illness. Dr. Brenda might instead reply, "I don't feel well today, but I _can_ listen to you without difficulty." Dr. Brenda feels that the analyst must be very "alive" with older patients so that they never get a sense of deadness in the room. This is not imperative with younger people who tend to be more self-absorbed. Three of the subjects, Drs. Carrie, Ernest and Fireman, note that they are generally more active with their older patients but usually as a function of many other factors which happen to be associated with the person's age. For example, each of Dr. Carrie's older patients has been in treatment before. As a result she does not know if her ability to make interpretations more quickly is a consequence of the patients' age or of their having worked this way previously.

Dr. Ernest was more active with older patients, which allowed him to be more active with younger patients as well, so that he in no way views himself as an analyst who maintains, or prefers to maintain, a strict climate of abstinence. However, says Dr. Ernest, "if one were to establish a frame of relative non-activity in which one took on abstinent interpretive stance, and if one inculcated that frame with the patient, one would get the same kind of data and working through of the issues in an elderly person that one gets with younger patients." An abstinent stance, according to Dr. Brenda, "would be an utter disaster." She feels older patients in certain

situations, particularly those who use the analyst as a role model, may have a useful need to know a bit more about you. They may ask questions which deserve a direct answer especially in those cases where there is no one else to ask. Some older patients have had life experiences which they correctly ascertain the analyst has also experienced, such as raising children, having grandchildren, buying a car, etc. Older patients may comment on such an event in an effort to learn something which will be helpful to them in their own lives. According to Dr. Brenda, the analyst's "What do you mean by that?" response is a form of "cruel and sadistic punishment. She believes:

> It simply does not work. If someone is having problems with adult children, and sees my adult kids in the vicinity of my home office, and asks me a question about raising kids, I think it is mean to say, 'What do you mean by that?' I feel that the cushion of my experience is something that the patient can rest on. I will not answer questions about my feelings, but interestingly these patients do not ask. They seem to know what is appropriate. But this is different from what I might do with a thirty year old patient if the patient was defining himself and really needed to have me to keep the distance. To some extent then, it is really the circumstance and not the age that influences the analytic stance. I think that there is often a need to be more real with older patients who tend to be isolated. And this is not a function of their age, it is a function of the isolation and their diminished resources.

Dr. Fireman tells the story of his second over-sixty patient who felt that she had been swindled, not merely out of a great deal of money but of some important family

relationships as well. She had consulted an internationally known lawyer before entering treatment with Dr. Fireman and complained that she had not been helped by the attorney. She asked Dr. Fireman if he could get her a lawyer. "Now generally, says Dr. Fireman, "I don't get involved with that." He continued:

> With this particular patient who presented herself as wanting suggestions, I acceded to the request. I hadn't thought until this moment of the parallel between this woman's dilemma and a similar experience of mine, but in any case I gave her the name of a lawyer whom I had known to be very ethical and who I thought might be interested in the case. I did this knowing that this could repeat a pattern of hers from the past. A pattern in which her previous therapists had suggested that she seek legal counsel and in one way or another had left her feeling betrayed. I pointed out to her that this was a pattern that she and I could be falling into, one where she would once again feel that people did nothing but disappoint her --myself included. And that statement really opened up an entire area, a recollection of years of her maintaining herself in the role of victim. But I really think that it was important for her to have someone that would actively seek a lawyer for her and also to have a person participate in her failure. I think it unburdened her to know at least that she had tried her best. This was a necessary ritual of standing up and speaking out for herself....But I'm still not certain of what made me want to be more active with this woman. I think it was the fact that she seemed to have no other resources and no other means of support. In thinking about it I do feel that the need to rescue her and to fail had to do with her situation and her pathology and not with her age.
>
> I must say that I do this with patients who have no resources. For example, with very disturbed patients who can't negotiate the system. Take a schizophrenic patient who can't get five dollars from a welfare check and listen to the crap that the social service people put them through and you get some idea of what they have to put up with. Now if I say to them quite honestly, `I don't see how you put up with this, it

> would drive me crazy! With what you are going through it is remarkable that you did as well as you did.', and if I have gone through the experience with them then I can genuinely feel a respect for what they have been through and they can see that it was just as difficult for me. That is valuable.
>
> The other side to this kind of activity is the fostering of an unnecessary dependency. If I actually serve a certain need for the elderly person this may be no different from becoming a substitute male for a young woman who is trying to develop some heterosexual relationships. There are different ways of getting trapped within the treatment that are common to any age group. So one has to be aware of this, and of the different representation that these things take in different age groups and at different stages....Now with a younger patient in the same circumstances, those of needing a lawyer, my tendency would have been to be less active. I would have spent more time with what resources they had tried, and I would have been more inclined to say that I am not an expert in that area, that I think the patient should certainly consider seeking legal advice and that the question is why is the patient coming to see me.

Dr. Fireman finds in retrospect that he was quite a bit more active with the patient than he believes he would have been with a younger patient with the same problem.

Drs. Ernest and Fireman echoed Dr. Brenda's sentiments regarding the propriety of being more real with some elderly patients. Dr. Ernest remembers a fifty-eight-year-old patient who arrived for a session and found a note from him announcing that he had gone to the hospital because his child was being born. Thereafter on the anniversary of the birth, the patient would present Dr. Ernest with a token gift for the child which he felt strengthened the bond between them.

In later years there were occasions where patients

sent Christmas or Chanukah cards to Dr. Ernest. "When this happens with younger patients, states Dr. Ernest, you might ask the patient what he was feeling, or what he was thinking about, how did you happen to think about it - and you try to link it up with what is going on in the treatment as data to be analyzed. With the older patient you are more accepting of that kind of behavior, still remembering that limits must be drawn. If someone should come in with an expensive gift then you have to deal with that."

Dr. Fireman at times wonders if his role with some elderly patients is that of replacing a lost and needed family member in circumstances where the patient feels isolated and alone. He observes, with some amusement, that his older patients will bring him things, such as a free restaurant guide, and tell him about places to get bargains. He understands this behavior to be the older isolated patients' need to have an impact on another person, a need which is intensified in older patients simply because there may be fewer people in their lives. Given this understanding, Dr. Fireman reacts differently to such behavior in an older patient:

> If it were a younger person whom I were seeing in analysis, I would treat it a bit differently.... In some ways, I think that you make a choice. I worked with a woman who was dying and who wanted to know that somebody would be there when she died. She did not have anybody else and I fulfilled that role for her. I guess if it were my choice, I would not have chosen that kind of job. But her therapist had gone away for the summer and I was around that summer and

> she knew that she was going to die that summer. I mean I didn't even know the woman well and she thanked me very much. It was very sad. She wanted somebody to hold her hand when she died. And why not? She didn't have anybody else but me. There you become a real person; but that is very different.

Drs. Carrie and Delia feel that they are more "with" older patients and that the dyadic relationship is more "equal." This is partially based on their perception that older patients have acquired wisdom through life experience. Dr. Carrie asserts that older patients use their life experiences in a way not yet available to the young. "Life really teaches people something. I learn from these older patients. I learn from all of my patients but this seems to be a more profound learning. I think I am more humble with older people; I give them credit for what they have learned. I always work analytically but at times one feels more of a need to educate the younger person. Here I feel it less. I rely more on an equal dialogue."

Other circumstances may also influence the analytic frame. Dr. Ernest notes,

> You make allowances for weather shifts, and often for illnesses, that you might not ordinarily make. On the other hand it really makes you think about why you are not making allowances for someone younger who feels well enough to come to the session but whose head is congested and whose attention is not good....I set a little more time aside at the beginning and at the end of a session so that I am not impatient about an older person leaving, because there is another patient in the waiting room. I don't want to be sitting there thinking that there is a patient outside waiting and then find that I am angry. Because the elderly can be slower about getting out of the office. With a thirty-year-old

> you might wonder if they are trying to schnoor a little more time and you would take it up with them. But to insist on the "establishment" frame with the elderly would be insensitive, although people often do. At times I would think about ending the session a bit earlier to allow for the extra time that it takes an old patient to go. But then I thought, 'They are paying for their time, and they should get their time.' And this is something that the analyst needs to accept.

"Now again," continues Dr. Ernest,

> These are generalities. There are people who were doing the same thing at twenty that they are now doing at the age of sixty-five. And the issue may have more to do with character than with the circumstances of a patient's aging. If this is the case, you might then set very clear boundaries and tell the patient that the session is up and that 'we will talk about this next time.' You have to get a sense of what the issues really are and never jump to conclusions about any of these kinds of events.

"I must say," Dr. Ernest goes on,

> that I am more likely to have a cup of coffee with an elderly patient. I'm not sure why, but I think it has to do with the fact that I was more comfortable having a cup of coffee with my grandmother. Well of course in any setting if you are going to have a cup of coffee then you had better offer one to your patient. And I recall that it started with this patient that I was seeing for double sessions. Having a cup of coffee changed the whole tenor of the relationship. The patient had had an analysis with somebody who had put the patient on the couch and who had kept a very strict kind of neutrality. The patient would raise a lot of anger about that in the sessions with me and he was also feeling somewhat immobilized. One time he became extremely upset about a betrayal by his wife. He came into the office and there was a cup of coffee brewing, and I said, 'Do you want a cup of coffee and we will work this out?' And he did, and from that time on it became a part of the treatment and things started to get better.
>
> So, as in other cases where you have a couple of positive experiences, you are willing to try the thing again. Now I don't offer patients coffee as a regular thing, but every now and then I'll introduce the coffee.

Both Drs. Carrie and Ernest are interested in the older patient's current experience. Although Dr. Ernest finds that his older patients' narrative style is generally to relate more detail, Dr. Carrie is less insistent on getting highly detailed descriptions of early life experiences from her older patients. She finds that the early experiences have already been rehashed so many times that there is usually very little mileage in going over the details again. She also observes that the patient wants to get to the immediate problem and that they have a sense of urgency about getting to their future tasks.

Working with Dreams

There is nothing exceptional about the way in which the subjects work with dreams with their older patients; they all state explicitly that they work with dreams in the in the very same manner with both age groups. Dr. Brenda states, "I work...with the metaphor and at getting at the feelings. Possibly, older patients are more reluctant to share what they feel, not necessarily because they do not know what they feel but because they believe it is private." Dr. Brenda suspects that most older people grew up in a world less accepting of a public expression of feelings, so that they have a harder time acknowledging the feelings in the dyad. Dr. Brenda admits, however, that her suggestion is confounded by the dynamic issues and would be difficult to ascertain. She

notes that she often appears as herself in the dreams of older patients while she tends to be disguised in the dreams of younger patients. This may be a function of the more "equal" relationship that seems to exist with her older patients.

Dr. Ernest also approaches dreams in his usual fashion, in "a kind of formalistic way," inquiring about the details of the dream, the residuals, the feelings, and trying to place it all in a context while working with the patient. Dr. Ernest finds that the actual content of the dreams of older patients may contain suggestions of failing capacities or anxieties about death. Sometimes, as with the younger patient, dreams are no more than fragments. But older patients are disturbed about fragments because they attribute them to failing memory.

The older patient, says Dr. Ernest, may have been indoctrinated into the lexicon of psychoanalysis and feel that he has failed to live up to expectations if he cannot get "deeper" into something. "One of my patients," reports Dr. Ernest,

> is wedded to the idea of "psychoanalysis" and feels that it holds the key to his salvation. He had been in treatment before seeing me and he is a kind of chronic analysand. In fact he does a bit better when he gains some mastery over his world and he gets worse when he lapses into some kind of "analytic" position of excavating some deep dark secret. So I try to limit that a bit without in any way disparaging his previous analysis. Well this patient comes in with pieces of paper and his dreams written down. And he is the student and he is bringing his work to the professor and he will uncover some secret and be at peace with himself. Part of his problem is

> that he cannot accept as normal the usual dysphoric moods that we all get into without becoming scared. So I use my analytic understanding of the situation but I do try to shift things in a pragmatic way. Here we see that a previous analysis may have an effect on the manner in which an older patient thinks about his dreams. While the patient and I might have done it differently, in this case I am always aware of a reluctance to stir things up too much because of the patient's investment in the previous analysis and in the way in which things were done. This is really unrelated to age, but rather to the effect of a previous analysis.
>
> ...to add a comment about dreams, I think that one has to remember that if the analyst appears to adopt a neutral and abstinent position the patient is much more likely to play by bringing in dreams. Edward Tauber wrote about it. It is not really that the analyst is being neutral, it is rather that the analyst has chosen the arena in which he will be more active--and that arena is dreams. So if that is the place where the analyst really becomes a person, then that is where the patient will play. All of this means that whether or not a patient brings in dreams, and how one works with them, is a very complicated issue.

Dr. Adams had the impression that his older patients brought in fewer dreams, but he was uncertain about the accuracy of the impression. He may well be correct in that a number of studies have shown that older people have less REM sleep. (Personal communication, Dr. Paul Gitlin, Mount Sinai Hospital)

<u>Characterizing Movement in the Older Person's Treatment</u>

Movement is change--change outside of the treatment and within the treatment. While the particular factors which represent significant change may vary from subject to subject, and most definitely among patients, there are no distinctions which specifically differentiate movement

in older as opposed to younger patients.

Dr. Adams describes patients who have no awareness of their impact on people and who go through life with little realization of what they do and how it influences others. In such cases, says Dr. Adams, movement would be characterized by the patient's increased awareness of his behavior and its ramifications.

Dr. Brenda defines movement in relation to goals defined by the patient. In the abstract, says Dr. Brenda, both old and young may seek joy in life. But joy or satisfaction is connected to the attainment of specific goals which the patient has laid out for himself. Insofar as the precise content of the goals is concerned, there are undoubtedly variations depending upon the developmental stage of the patient. For example, reports Dr. Brenda,

> a young person comes to you and says I want to find the right person and settle down and have children, or I want to separate from the attachment to my parents. In midlife there is the empty nest stuff and the need for a transition to other areas of productivity and fulfillment. And later still, one has to acknowledge and let go of losses and to create the newly recognized integrity that gives meaning to ones life. And I think that we measure progress in terms of how well the person is negotiating all of these transitions.
>
> Over sixty, the quiet enjoyment and simplification of life becomes more and more of an issue. Generative tasks still abound. It remains important to create, to generate, to produce. But these efforts may take different forms in different people. I may want to write a novel, or paint. Other people may want to better relationships with their children or grandchildren. Most older people want to leave something behind, and this becomes a theme of the

treatment against which movement is measured.

Dr. Carrie does not conceptualize movement in any conventional sense, and does not gauge movement in terms of her own expectations of the patient. She has no expectations of the patient. Dr. Carrie views treatment as a process in which time the patient becomes increasingly free to reveal what he is experiencing in the presence of the analyst. This interactional process _is_ itself the movement which, in theory, bears absolutely no relation to the ages of the participants.

If movement is different in older patients, Dr. Carrie suggests that it may be a result of a patient's previous treatment with an analyst who subscribed to a different model of therapy. Another reason might be their tentativeness about openness, which is counter-cultural for their age group, and which therefore requires a bit more effort on the part of older patients.

When Dr. Carrie must undo some of the notions of the previous treatment, she proceeds with caution so as not to undermine a therapy that may have been good and useful to the patient.

Dr. Dalia's views on movement are akin to those of Dr. Carrie:

> We always look toward the future to see what the patient can do. I think that is precisely what helps them, the underlying assumption that of course they will be moving in therapy. I approach the treatment in a completely open way, and I have been able to engage my older patients and to do some very exciting analytic work with them. I never had any sense that

> they would not move in psychoanalysis based on age alone.
>
> If the patient used the age as an excuse, in terms of 'what's the sense' or 'what's the use,' I would try to point out the use of age as a resistance and to reiterate that they had originally come into treatment because they wanted to change things in their lives and because they believed that it could be done. If the patient wants to live differently it is viable no matter what the age.
>
> This only becomes a problem if the therapist colludes with the patient in such a notion. The therapist may do so consciously or unconsciously but the latter is the greater problem. It may be blatant or subtle; the analyst may become too passive; the analyst may fail to have expectations that the patient can go forward; in other words there are various forms of giving up on the patient. This can happen with younger people too, but in those cases the therapist does not blame it on the age.

Signs of change in the patient are indications of movement for Dr. Ernest as well. These signs may be exhibited in the patient's outside activities or in the treatment itself. Dr. Ernest explains:

> The patient could be describing a situation where he is being criticized at work but is not developing the kinds of somatic symptoms, or going into the kinds of major depressions that were characteristic of his previous responses to the situation. I would consider that a possible indication of some internal change that is viewed from the perspective of the outside functioning. This is one criterion; and I think to me it is the most important criterion.
>
> Now within the treatment itself there are certain indications. These include: bringing up dreams, being able to deal with things in an affective way, and a kind of shift in the manner in which the patient participates in the therapy. But there are some people who can come up with all kinds of things within the treatment and then they still go on about their lives in the same old way, and they still complain about their lives in the same old way. I become skeptical about that.
>
> Or consider the people who seem to change on the

> outside but their situation within the treatment seems rather the same. I think this kind of thing is more related to the frequency of the treatment sessions. The more frequently the patient comes, the more likely you are to see shifts within the process itself. New material comes up in different ways, and this seems to be related to the frequency and not to the age of the patient. I am thinking of a patient who had various kinds of dreams about various kinds of things about which he had forgotten. Things he had never spoken of before even though he had been in treatment on other occasions in his life. Perhaps these had emerged, but possibly not in the same way with somebody he was only seeing one time per week as they eventually did with me.

Dr. Fireman sees movement as the elimination or reduction of obstacles which interfere with the patient's capacity to be open to new experience. Dr. Fireman works to discover his patients' repetitions enacted both with him and outside the treatment proper, in order to highlight the conflict the patient is repeating so as to allow the development of a different solution to the problem.

Transference Issues

Drs. Carrie and Delia find virtually no differences in the transference reactions of older patients. Irrespective of the age of her patients, Dr. Delia finds that the main traction of any treatment is the transference. She states,

> I work in the transference, and transference is my major focus. I don't work exclusively in the transference. If a patient is having a problem that is troublesome, I don't neglect it, I don't put it aside. I deal with it and then I try to connect it to the transference.
>
> In one case involving an older patient we got to very important connections with respect to the patient's relationships both to her mother and to her

> daughters. The mother was overbearing and controlling and she went to the other extreme of permissiveness with her daughters. And she herself continued to be the good and dutiful child with me. It was through the analysis of our relationship that she began to examine her personal style and was eventually able to become much more realistic in her relationships with others.

Drs. Adams and Brenda also believe that transferences are individualized, and that there is a range of transference reactions among older and younger patients. However, when pressed, Drs. Adams and Brenda offer impressions of the impact of the patient's age on the transference. Dr. Adams feels that older patients are perhaps somewhat less apt to become as involved in the transference because they are trying to solve certain kinds of immediate problems. Eroticized transference is less frequent although eroticized feelings do occur. Older women patients usually become embarrassed by these feelings which they cover by talking in a silly way. "On the other hand," adds Dr. Adams,

> there is less eroticized transference from younger patients as well, so maybe I am no longer a sex symbol. Now of course that implies that transference is not so much fantasy. And the longer I practice, the more convinced I become that transference is in some way based on the actual connection between the therapist and the patient....It is based on the impact of a certain aspect of the analyst's personality on the patient. In other words, take the oedipal situation. I don't think that it is any great news that people get involved with their parents, sexually or otherwise. The point is, what makes the adult continue to react to that kind of person in the same way that he did when he was a child? If a patient got angry with an analyst for not paying attention, the Freudian formulation would be who in the patient's past did he feel failed to

> pay attention to him. Whereas I would ask the patient, 'What is the significance to you? Suppose I don't pay attention, suppose I don't remember, what does that mean to you?' I would not challenge the patient's perception because I would believe that his perception is in some ways accurate. It is what he does with the perception that I would be interested in."

Dr. Brenda also senses a diminution of erotic transference among her older patients and proposes that erotic transferences take a different pathway and are masked. She described a highly successful male patient in his mid-sixties who expressed feelings of conquest towards her. These feelings contained no overt sexual expression as they might have in a thirty-year-old patient. Conversely, Dr.Fireman has observed that erotic transferences both in their homosexual and heterosexual aspects, are equally as strong in his older as in his younger patients.

With the exception of the diminution of erotic transference, Dr. Adams sees no differences in the transference reactions of older and younger patients. He views aspects of the transference as a function of the pathology of the patient and the frequency of the sessions, and not of the age of the patient. More intense transferences, he argues, occur when patients are seen more frequently. It would be hard, he adds, to see someone three or four times a week and _not_ to have an intense relationship, "although unfortunately many people succeed in doing this." Whereas both Drs. Adams and

Fireman stipulate that the intensity of the transference is connected to the frequency of the sessions, Dr. Fireman has observed that an older patient who is isolated may seem more needy to the analyst thereby lending a feeling of greater intensity to the transference.

Dr. Ernest comments about multigenerational transferences which he views as exclusive to older patients, noting that they have often related to him as if he were their adult child and the bearer of their grandchildren. Like Dr. Adams, Dr. Ernest includes observations about how his understanding of and use of transference is different from the early classical position. The Institute in which he trained "tended to use transference to get a line on the current issues rather than as a vehicle for pointing out to the patient the manner in which he distorts the world, presumably so he can keep from distorting." Dr. Ernest finds that this approach fits much better with older patients because if such a patient gives him a Christmas card, he will not insist on a classical abstinence requirement. He states further:

> I guess the Freudians would say that you would be acting in the transference with your patient. Which I think you are. But I think it is a necessary operation....Needless to say, one sets limits with older patients as well. If a patient comments on your plants that is one thing. But if it gets to the point where she wants to cut down your plant and repot it for you--then some of her problems become clearer. Then there is an issue of her neediness and her inability to understand where the boundaries are. Now that kind of situation would probably not come up

> with an analyst who adhered strictly to the classical tradition. Of course, there are older patients for whom this never happens. They will talk about their issues, their fantasies, and their dreams in the same way that younger patients do.

<u>Countertransference Issues</u>

Drs. Adams, Brenda, Ernest, and Fireman contend that countertransferential feelings are always far much more a function of the individual differences than of the age of the patient. Dr. Adams, in fact, deals more broadly with the complexity of countertransference as a concept than do the other five subjects. He adds to the widely acknowledged sources of countertransferential responses (See pp. 96-112) the fact that the analyst comes into the session with ideas, feelings and attitudes of his own which have certain ramifications not merely for the relationship but for the treatment process itself. Speaking of the analyst's work with his patient, Dr. Adams asks,

> How does the analyst know what to question the the patient about or what to ask him? On what basis does one note the importance of something to oneself or to the patient. Surely some of this is based on the analyst's life, on his attitudes, on who he is. If, for example, you think it is a bad thing when somebody ignores somebody else then you are going to find out what makes them ignore the other person. In a sense you are going to make the patient uncomfortable about it, even if he is comfortable with it. On the other hand if you accept it, you are not going to bother him about it, it is going to be ego syntonic for both of you. So countertransference issues tend to be particularized in ways which we do not always address.

"For me," says Dr. Fireman, "the age is not so much a factor in the countertransference as is the nature of the

crisis or the level of psychopathology." Dr. Brenda also notes that the pathology of a patient often triggers countertransferential feelings in her so that, for instance, she might find herself drained by a patient's pathology, "but never by a patient's age." Dr. Brenda admits to certain anxieties about aging and death, but feels that she is so aware of these anxieties that they cause no countertransferential interferences in her work with her patients.

Dr. Carrie acknowledges that her emotional responses to three of her older patients may contain some elements of stereotypical thinking about aging. The first patient had a dependent transference, as any younger patient might also have, but Dr. Carrie began to fear that the patient would never leave treatment. A second patient focused continually on her reaction to toenail surgery and Dr. Carrie found it difficult to get her to focus on anything else. Although she concedes that she probably would have felt similarly with a younger patient, Dr. Carrie continues to think that a younger patient would have gotten off the subject earlier and easier. A third patient exhibits a single-minded stubbornness which can be annoying, although Dr. Carrie speculates that she would feel equally annoyed if younger exhibited the same traits. Nonetheless, she believes that younger patients are less inclined to become stuck on an issue in the same manner.

Additionally, Dr. Carrie expects that her older patients will be more flexible rather than less so, because she would like to think that life experience teaches people the value of greater flexibility. This is often not the case.

Dr. Fireman sheds some light on the analyst's feelings of irritation when an older patient is repetitive:

> There are people who are very repetitious--younger and older ones. There is one patient in particular who is really very disconnected to me. And I can start commenting and trying to reflect on something that she is saying and she just goes off on her own tangent. So it becomes very irritating after a while, and I become angry and hostile. I ask her, "Did you have any thoughts about that?" And she will say, "I don't even remember what you said." Sometimes I wonder what my function is as she goes on talking nonstop. And I think that with the older patients it is not a function of age so much as it is a function of the age of the relationship. This older person is telling me a story that happened fifty-five years ago and they have told that story over and over and over again. It has a different quality because you feel if the thing has been going on for fifty-five years, how much change is going to take place. Or, if you interrupt it after all of these years, will there be more constructive resolutions to the problem. This is not to say that these kinds of repetitions are characteristic of older people. Not at all. But when they happen in older people, they feel different from similar kinds of repetitions encountered in the young. And that has to do with the analyst's thoughts about them.

Dr. Delia's countertransferential reactions, she says, stem from her own neurotic problems. "The feeling of never doing enough," she says, is present to some extent with patients of other ages but is exacerbated with elderly patients through no fault of theirs. These

feelings are not always evident in the treatment, but when they are and when the patients notice it, they tend to reassure her that they are in fact being helped. Paradoxically, Dr. Delia feels that she herself derives more satisfaction from her work with older patients. "I feel more free," she muses, "so the whole thing becomes more rewarding. I must say that I have younger patients with whom it is a great pleasure, but older patients are special. Some analysts," she continues, "seem to feel that the elderly are more fragile. But that is not true. And if one tries to protect the patient from issues with which they must deal in order to go on to the next stage of growth, then one is doing the patient a great disservice. This is not, to the best of my knowledge, a countertransferential pitfall to which I have succumbed."

Dr. Ernest also suspects that he "does more" for his elderly patients because at some level he is not doing what he thinks that he should be doing for his parents. To that extent he acknowledges that there are certain needs being met through his patients that should be met elsewhere. Both Drs. Ernest and Fireman hold that termination is less clear with older patients (not, they hasten to add, that is clear with younger patients). This being the case these analysts are confronted with the idea that their older patients may die, which creates a strain. Says Dr. Fireman:

> These are patients who I care about, and then they end up being very ill and dying. When this happens I find it helpful to talk to a friend. It probably has to do with my own feelings of abandonment. Another strange reaction is that I am fearful that I am going to get what they got. I guess there is a little paranoia there. And I try to take good care of myself, to eat right and to jog and to exercise and doing things like that because I would like to give my body the best chance in life. I go to the hospital and I see what these people have done to their bodies. So I think that illness and death is something that you have to take into consideration when you work with very old people.

Both Drs. Ernest and Carrie have noticed that some older patients have inherited a cultural tendency to idealize "doctors" which may not only affect their abilities to deal with negative transference but may also fuel the analyst's sense of omnipotence. Dr. Ernest feels that the analyst may become anxious about the view that is being projected on to him. "It can become very easy then, from that position, to respond with all kinds of suggestions--this is what you should do, this is where you should go....and this may convince the analyst of the patient's helplessness and of the analysts' helpfulness and will ultimately fail to address the areas in which the patients can really be helpful to themselves."

One of the younger subjects, Dr. Ernest alludes to a subtle difference in the management of his own anxiety when dealing with the material presented by an older patient. He states:

> There is also the sense when I am dealing with an eighteen-year-old-patient--as I am-- who is struggling with the issue of dropping out of college,

> that I have a certain reference to my own "eighteen - year-oldness." This does not mean that it gives me a clear insight into the patient but it gives me something to refer to and I am using my anxiety in a different way than I am using it with a patient who is seventy. I don't know what seventy is going to be like for me.
>
> We all have some notions in our heads about how life should be lived. We may pay lip service to the idea that we don't have such notions--but we have them. But we really have the experience up until the age we have actually lived. We have fantasies about the future years but that is a different story. You operate in a different way, when on the one hand you have the experience and on the other hand you have the fantasy. To me it is an abstraction as to how a person should live his life at seventy whereas it is not an abstraction about how a person my age should be living his life. It may not be what the patient is going to do, or what the patient should do--but you get a different sense in addressing the material. It gives you a reference point that binds anxiety in a different way for the therapist.

Three of the younger subjects, Drs. Carrie, Ernest, and Fireman expressed some mild initial embarrassment in dealing with the erotic material of their older patients. Drs. Carrie and Ernest felt this both in response to the discomfort felt by the older patient and because of the societal taboos with respect to one's own parents. Dr. Ernest comments:

> I have older patients who have erotic dreams and thoughts. The patient may become embarrassed about the appropriateness of the feelings. And there are elderly patients toward whom I have had erotic responses which gave me a touch of the same sense of embarrassment. That's not supposed to be, but if you've got it--you've got it. Of course I have had it with younger patients as well. With younger patients there is a certain protection in the knowledge that this is a fantasy, and this is their drive, and they can do something else with it. But with an elderly woman who I treat, all she has is the dream or the fantasy. So in a sense you have to give that play and not interpret it from the position of,

"Now redirect your instinct!" This is where you have to be able to accept that, and your own countertransferential feelings and also to sit with your own anxieties that you are participating in prurient episodes and not get too alarmed about it. You may wish that the patient could go to JASA and find a boyfriend but that is not always possible. So the analyst has to make some kind of allowance for that and not become too anxious about its appearance in the treatment.

The Impact of Working with Over-Sixty Patients on the Lives of these Analysts.

Effective psychoanalysis is always a learning experience for both participants. Psychoanalysis involves the analyst's careful attention to his own feelings and personality as well as to the patient's and good analysts seldom fail to increase their awareness about aspects of their own functioning as a result of their interactions with patients irrespective of the age of the patient.

Three of the six subjects interviewed commented spontaneously on the impact of their work with over-sixty patients on their own lives. Dr. Adams, for example, believes that older people "get more interested in themselves as they get older" an interest which he attributes to a healthy concern for their own welfare. From time to time work with older patients leads to self-reflection. Dr. Adams noted that he has always taken good care of himself and continues to do so. He feels that his propensity to "accept (without bitterness or self-pity) the things that happen to one in life, whether as a result of aging or other situations" has made life and aging more agreeable. Dr. Adams takes the position that because

the vicissitudes of life do not often fall into well-ordered meaningful patterns--one learns to cope.

Dr. Brenda feels that her work with older patients, as well as her friendships with older colleagues, has caused her to be more reflective about the meaning and philosophy of her own personal life. Like Dr. Adams, she speaks in terms of the capacity to cope and also of the choices people have about what kinds of meaning they eventually impart to events that occur in their lives. "Patients will recreate the story and the mythology of their lives. How they recreate it after sixty is most important. Whether they recreate it as a series of losses, with more losses to come; or whether they recreate it as a series of learning experiences which were in some measure gainful, is essential. Because if they are going to focus on the losses (and we all have losses), there will be nothing but regret and despair." Dr. Brenda applies this philosophy to her own life as well.

Both Drs. Adams and Brenda addressed the issue of who should treat the older patient. Dr. Brenda, drawing on her own personal experience, feels that this is best done by analysts who are past their mid-forties. She states,

> There has been a lot of literature on how the young doctor who is working in a nursing home is perceived transferentially as a son figure. Well that may sometimes be the case. But in a nursing home you are working with very limited people. I don't think that that necessarily happens in private practice. I think that what happens in private practice is that the person who is over sixty does not go to the

> younger person. So we should be training psychoanalysts to work with the over sixty patient and we should select people in their late forties or fifties who are full of vim and vigor, and who are going through transitional periods, who can identify with their patients and who will want to learn from them....I have used everything that I have learned from my own aging and I have been able to give it to my patients.
>
> I think some of the younger people may come in with a theory of something and then want to apply it to the aging. You have to look at aging and all of its meanings, all of its possibilities. Then in time we may have something theoretical to say about it.

Dr. Adams, conversely, believes that the significance of relative age of patient and therapist depends entirely on how professional the therapist is. "The less professional the persona that the analyst has, the more important the relative comparative age. The more professional the persona, the less important the comparative age." He continues, "It seems to me that when the analyst is a serious professional the comparative ages of patient and analyst become less significant."

Dr. Ernest's work with older patients raised other kinds of issues for him. As one of the younger of psychoanalysts interviewed, Dr. Ernest became more acutely aware of his own limited time frame while treating older patients:

> I am sure that this is something that everybody talks about. You become aware of their limited time frame and then you become aware of your own limited time frame. A patient of mine who is an insurance broker told me that at best he had eleven years on his actuarial tables, and he is in very poor shape to begin with. So he is worried about why doesn't he just go out and do something. It impelled me, out of my anxieties, to ask, "Well how much does a man my

age have on the actuarial tables?" Of course he came back the next day and told me almost twenty-nine years. That was very upsetting. I should have resisted asking that question which may more properly illustrate a break in the frame and the anxieties that get to me. Whereas if he were not an insurance salesman, I would not have had access to that information. Or I would not have phrased it that way, or perhaps I would have thought about it more privately. But working with older patients raises these kinds of issues.

And in addition, my own parents are going through the kinds of changes that I see in some of my older patients. And working with these patients allows you to hear your parents in a different way. My mother has always been concerned about the key to the safe deposit box. She says, "When I die, I want you to empty the safe deposit box, that's the first thing you do." She does not want to be burdened with an explanation of legal requirements, she simply wants my reassurance that everything will be taken care of. Most of the time I failed to reassure her. It was only when I heard a patient tell me about her frustration with her son--to whom she wants to talk about this issue--that I was able to hear my own mother in a different way. The son kept reacting very anxiously and he did not want to hear what my patient had to say. Now she was not trying to make him feel guilty and she was not trying to be a pain in the ass; she simply needed reassurance that this little part would be taken care of. Reassurance would be to address the issue, and he had been unwilling to do this. Sometimes I find myself inexplicably calling my mother having to do with some session that caught me in parallel.

Another aspect of Dr. Ernest's work with his older patients has been his own reflection on the sense of freedom this brought to his analytic work in general. (See pp. 129-130.) The fact that it took work with older patients to "loosen" his analytic style is something that Dr. Ernest thinks about because he believes that it tells something about the characterological issues that he brought to his analytic work.

<u>The Influence of Theory (Developmental or Other) on the Work of these Six Analysts with their Older Patients</u>

No one really practices without some kind of a theoretical model, yet none of the six analysts interviewed was explicit or definite about subscribing to a particular theory. All were quite knowledgeable about theories but they were cautious about the reductionism they attributed to some theories and they felt that patients and treatment could suffer if theory were misused as dogma. Therefore, while the subjects were not unmindful of theory, in their clinical practices they tended to focus strictly on the patient: on the experience of the patient, on their interactions with the patient, and on the patient's past and present interactions with significant others. Theory is seen as an heuristic tool. This does not change when they work with on over-sixty patient.

"I never think about a theory," says Dr. Adams; "I'm no respecter of theories," claims Dr. Brenda; I don't really think about the theory," remarks Dr. Ernest. And Dr. Fireman asserts, "I don't have a developmental theory. I suppose if I live to be seventy I will have one. But as far as my patients are concerned, I listen to what they tell me and I don't work differently based on the age of the patient."

Dr. Adams never thinks about the developmental tasks of certain age groups. While he thinks that Daniel

Levinson's stages may have heuristic value for some, they are not terribly helpful to him. The stages as presented by Levinson do not correlate with his personal experience or with the experience of his patients or people he knows. Dr. Adams firmly believes that the tasks that Levinson sets forth occur at different ages for different people. In people of Dr. Adams' acquaintance, the stages occur, on the average, ten years later than Levinson states. There is such variability in older people of the same age, says Dr. Adams, that stage theories are just impossible to utilize. "As a matter of fact, not only do I think that the theory is not helpful, I think it is an impediment." Dr. Adams thinks about older patients in the same way that he thinks about younger patients. He doesn't label this as theory, but calls it strict attention to the manner in which they "usually cope with life." He gives the following vignette as an example:

> This is a sixty-eight-year-old patient who has a history of having had a silent coronary, a coronary without pain. But he had been diagnosed and had gone about getting himself into shape. Now just this morning, when the temperature is 30 degrees, he leaves his office where he had been working since seven in the morning. Now he is walking along at a very brisk pace, feeling very good, when suddenly he begins to feel very weak and unable to move. Lost energy, no pain, realizes he is having the same warning symptoms from over-exertion that he had had prior to his coronary. So he stopped for a while and rested, and he walked slowly, and he was able to come for his session and in fact arrived early enough so that he could rest in the waiting room before his session.
>
> Now, what is the difference between this man and a

younger patient? The difference is that he does in fact have something wrong with his heart, and the probability of a younger person having real coronary difficulties like that is much smaller. And so the analyst would wonder about how to get at the experience in a different way. In other words, here we are accepting the history and the medical findings that the patient has some kind of heart failure and that the heart failure can produce these symptoms. And that probably there is stress involved and perhaps some other variables as well.

But the fact is, if he had started out walking slowly, would not have happened to him. What he was doing, was trying to deny his infirmity. And he realized that to start out at such a fast pace, in the cold weather, with his physical condition was inappropriate. What he cannot accept is his helplessness, because he translates this into an experience of inadequacy on his part. They are not the same.

Surely, a younger person also has to know and to accept his limitations. When one is realistically helpless, the realistic feeling is one of helplessness. It is not inadequacy. So the problem here is not that this man has a physical condition, or that he is more likely to have this particular kind of physical condition when he gets older. The problem is that his need to control things is still influencing his ideas. And I am sure that it was influencing his ideas when he was forty, and when he was twenty, and maybe when he was ten.

So I don't see anything uniquely age specific about it. It just has to do with this particular impairment at this particular time. I'm sure that if he had had a fractured leg or something else when he was younger, he would have had the same problem. It is his way of coping with the facts of life.

I am not very impressed when people say that the facts of life change when you are older. Of course they do, but that is hardly something that we need a whole theory about. And to make it age specific may be useful at times, but it is hardly "the truth."

Dr. Brenda admits that she has read developmental theory but states that she is "not a respecter of theories." While she agrees that there are certain tasks

that one generally tries to accomplish during certain periods of life, she prefers to think of this as common sense or "human life." "My theory," she says, "if you want to call it that, is to confine myself to observation. And," she goes on,

> an observation about something is very different from a postulation about libido theory, or object relations, or a theory of desire such as Lacan has. That is not something that I want to buy just like that and stick on to people. If it happens to fit somebody, and it is useful, I might use a concept or two as a metaphor. If you have a preconceived notion that an over-sixties patient needs to sublimate his libido, than you are predetermining for that patient that he is old and worn out.

Dr. Carrie says that she has been influenced by adult developmental theory and indicates that her comfort in forgoing a detailed inquiry of childhood, her appreciation of the wisdom of life experience, and her belief in the weight of adult experiences, are affirmations of this influence. But like Dr. Adams, she rejects Levinson's notion of stages as being too narrowly defined. "We can't really talk about stages anymore," she states,

> not with the appearance of second marriages in the culture, and things happening much later in life then they did before. I don't like the lock-step theory and I don't like the idea of tasks. Cultural norms change. I take each treatment and each patient on an individual basis. Take the idea of loss. Everyone deals with loss at any time in life. What is perhaps a concern of the older patient is that there are things one cannot do anymore. That can be a narcissistic injury for some people, and for some people it is just another fact of life. I think that the one developmental given is the view of one's parents getting older. People may speak about the empty nest syndrome without realizing that this is not universal since not everyone has children. But everyone has parents. And to watch the older

> generation dying is a developmental task. This I think may be central.

Dr. Ernest stated that he doesn't think of his patients in terms of the developmental literature, but if pressed to consider developmental issues, he would imagine that the relinquishment of certain goals (which he emphasized takes place throughout the life cycle) becomes more acute in the elderly population. There seems to be a shift, he says, in the view of oneself as increasing one's skills or one's acquisitions; towards a view of oneself as consolidating or holding on, and as developing a greater tolerance for things going wrong.

Like Drs. Brenda, Delia, and Fireman, Dr. Ernest sees in his elderly patients, an increased concern with "being able to pass something on; whether it is their own wealth or their own story, whether it is to their children or to their grandchildren, so there is a great deal of emphasis on getting these people off to a good start. They must also," adds Dr. Ernest, "come to terms with their grown children, and to a lesser extent with their grandchildren, as people who have lives of their own. And their demands for contact with children or grandchildren have to be brought into line with what these people are all about."

When asked to think developmentally about his older patients, Dr. Fireman suggests, as did Dr. Adams, that the themes of earlier years appear but often in a different context. For example, a person, who in his mid-forties

considered himself to have been trapped by a job, may in his mid-seventies consider himself to be trapped by a physical difficulty--a victim throughout the life cycle. Dr. Fireman does pay particular attention to developmental transitions whenever these appear in the life cycle. Such transition may occur for older patients when they are required to separate from their adult children. Dr. Fireman says that in treatment,

> we will address the fact that while probably scary it also affords them freedom from certain responsibilities. And this can open up an entire new set of opportunities that they never had before. Now they can retreat from it, or they can invite it and make some use of it.
>
> There are some constricting realities. Younger people tend to think that they will live forever. But death is closer for the older patient and usually leads to self-assessment. Mourning the loss of a spouse may be made all the more difficult by the knowledge that there are fewer opportunities around to meet new people. And the loss itself may have a different quality. When one lives thirty or forty years with a person, with the idea that one will spend the remainder of one's life with that person and then they suddenly leave you - well that may be different from having an earlier loss.
>
> On the other hand the manner in which I have worked with that clinically, is actually to work back to earlier issues of separation and loss and one often finds that there is much more to the loss than its connection to the spouse. Sometimes it is simply easier to think that the loss of the spouse is the entire issue. Patients are apt to idealize the lost spouse and I never challenge that. Challenging is not productive. But if one amplifies it and speculates on what an idyllic life it must have been, the patient becomes quite eager to point out all the shortcomings. Patients who have resolved these issues have found things to be valued or gained in their new independence. In this way it is very similar to working with younger patients. One goes on to the next step.

> I always point out to patients the ways in which they can sort of end up dying, without having any sense of fulfillment, or they can be productive. And we think about the various reasons for why they might be choosing one role versus the other.

The Components of Successful Aging: What Does Practice with Older Patients Teach Us?

Four of these analysts state explicitly that successful aging and successful living are one and the same. Drs. Adams, Brenda, Delia and Fireman believe that aging, like life itself, is a process of continuing growth including the growth of personal integrity and an interest in the welfare others. Dr. Adams states that if people are affirmative and have an active interest in the world around them, they remain lively and engaged, whereas negative rather than affirmative reactions to life will surely age one before his time. Dr. Fireman uses the words, "productivity," "curiosity," and "risk-taking. I think," he says, "that you have to be open to new experiences and not to operate out of an unnecessary sense of fear that might keep you from taking risks. You have to be available to new experiences and expose yourself to new things." Dr. Delia remarks on her own therapeutic contributions to this process:

> In working with patients, all patients, I never feel hopeless. If the patient wants to change I try to find what was valuable in their lives. It does not have to be in big accomplishments, just the capacity to have loved someone or to have done something. Then you can build on it. One older patient had had a particularly hard life. Then I found out that she had always had friends. Friendship is something that she is really good at; she listens, she is sensitive, she really cares about people. She is beginning to

> recognize her capacity for friendship and this is important. So the issue is--does the person want to change something? Then you find out what they already have. And they always do have something.

Dr. Ernest speculated on the ingredients of a successful life and tried to relate these to the process of aging. "I think," he said,

> that one has to look at the models that a person has had as well as innate endowments. People who have a certain flexibility in dealing with situations probably do better at living in general--and this includes the aging process--because life is a process of change that must be dealt with constantly. There are some people who get thrown by minimal changes and others who can adapt under extraordinary conditions.
>
> And luck is a factor in conjunction with these other characteristics which can help or hinder a person in terms of taking advantage of fortuitous things that occur or in dealing with bad luck. Take the lady who got trapped under the crane. You find a person like that whose luck can be horrendous but whose resources are extraordinary. But for most of us, good fortune or bad fortune plays a major role in what happens to us. People have different circumstances and the kinds of situations that are presented to a person have to be taken into account along with their coping mechanisms.
>
> Having friends is probably a major factor in successful living. This includes friends your own age. We used to vacation at an artist's colony on the eastern coast and we would stay at guest houses, most of which were run by these elderly widows. I remember sitting in the parlor with these octogenarians and watching the 1972 Republican Convention and I could not keep up with the political dialogue that was going on among them. They were physically robust, they had a very lively interaction with each other, and they seemed to be very successful.
>
> An elderly woman, whom I saw for thirteen years, had a close friend who was ten years older than she was. (The patient died at the age of seventy-four and the friend survived her.) Well, when the patient was seventy and the friend was eighty they two of them took a bus trip across the country. They had the usual assortment of medical problems--you know blood

pressure problems, arthritis, nothing lethal--so as I think about it they had a certain physical health. And they had a darn good time. I guess, then, that I would have to say that physical health plays a major factor partly because it allows for more contact and more mobility. If you become immobilized you enter into a whole arena where you are dealing at best with a tolerant caretaking environment, and at worst with a hostile environment that does not want to take care of you. I think every older person fears that things would get really bad if they could not get about and get their needs met.

It's hard to draw a line on what is successful development or successful aging from a clinical sample because we probably don't see a lot of people in life who have really adapted quite well. We tend to draw conclusions from maladaptive patients and then make statements about what is normal. Social scientists may be in a better position to study this using a sample that has not come in for treatment.

Dr. Brenda posits four steps to successful aging: "First, she says, you must have an absence of fear." She continues:

> If you want to call that courage, that is fine.
>
> And second, you must take care of your body. You cannot separate mind and body, and if you want to take care of your emotional health, then you must pay attention to the body. Your aging body may not be what it used to be but you fix what you can fix and you look at yourself and you see what is good.
>
> Third is coming to terms with the meaning of your life. While some options will be closed to you, there are many many doors that remain open. You will find a door if you look for one. You may have another twenty or thirty years to live. What do you want to do with your life? If you cannot take this next step, then you have to take stock and see what is stopping you.
>
> And finally, you have to let go of your youth. This does not mean letting go of your mind. Unless you have some physical impairment, your mind gets better until the day you die and that is what I mean about all the doors being open.

Dr. Carrie sees successful aging as a recognition of

the limitations of the present. There are specific things, she says, that an eighty-year-old cannot do that a forty or twenty-year-old can. One has to accept what one cannot do, and still see that there are things that one can do. Dr. Carrie said,

> I like to use the image of downhill skiing as opposed to cross country skiing. Downhill has the experience of racing and of speed, but you miss out on the fine details of the landscape. While in cross country skiing you can take your time and see different things. I think that Winnicott wrote about that--the more contemplative joy of nature.

Dr. Carrie also sees the ability to ask for what one wants as a requirement of successful aging. One may not get it, but one is less apt to be left with the feeling of missed opportunities. It is really important to communicate one's needs.

All subjects commented on the "wisdom" of the older patient as a special strength in the analytic process. And all struggled with the word wisdom, not certain that it conveyed precisely what it was they felt about their older patients. Dr. Brenda toyed with the words, "common sense," while others considered: "experienced," " attuned", "good judgment," and "sensible."

Dr. Fireman thought that his older patients had a more highly developed sense of values and priorities than did his younger patients. And Dr. Adams added Simburg's (1986) term, "mellow." Dr. Adams also quoted Erich Fromm who said that people cannot really be analysts before the

age of forty because they lack sufficient life experience. Dr. Brenda offered forty as the age before which wisdom is unlikely to have developed. Drs. Adams and Brenda agree that some people gain wisdom through life experience which, when it occurs, is a strength. Dr. Carrie also regards the wisdom of the elderly as a strength although she feels one must frequently work through the patient's anxiety in order to unveil it. Once you do, you find a "certain kind of maturity that you simply do not find in a younger person." Dr. Ernest defines this maturity as the older patient's many opportunities to have encountered a great many situations. If the therapy is a new situation, the patient will be helped by his previous experiences in dealing with new situations.

One ought not to conclude that the subjects thought all old people "wise." (If such were the case, the likelihood of countertransferential idealization of the elderly would seem to be operative.) These subjects did not consider all their older patients to be wise. In contemplating the strengths of their older patients these analysts generally affirmed that long years lived usually count for something, that people learn from life, and that one can readily observe such processes in one's patients.

Drs. Carrie and Ernest also find that the older patient's sense of urgency and his wish to "get on with it" can be a decided asset, as can be a real sense of

wanting to feel better and the tenacity to become so. Dr. Ernest finds that his older patients are more forceful in their claims that if something "does not happen" they are not going to remain in treatment. The analyst, says Dr. Ernest, then feels less protected by the position, "let's see how things develop" and is pressed to really try to formulate things in a quicker way and not to regard one's seven o'clock hour as filled for the next five years. "Of course," he adds, "this does not happen with all analysts, but it happens often enough. Remember Woody Allen in 'Sleeper' as he awakens after 200 years of sleep and comments, 'Two hundred years? I would have almost been finished with my analysis.'"

CHAPTER 6

Summary and Conclusions

There is a story told of an Eastern European rabbi who was approached by five men who wanted his help in settling a dispute among them. The rabbi listened carefully to the first man's account of the story and when the man finished the rabbi said to him, "You know, you're right." The second man then proceeded with his version only to have the rabbi remark, "You know, you're right." As the others in turn then told their sides of the story, the rabbi would reply, "You know, you're right." A witness to the encounter who had listened with increasing frustration looked at the rabbi and said, "Excuse me rabbi, but they can't <u>all</u> be right." The rabbi stroked his beard and replied thoughtfully, "And you are also right."

Beard aside, I feel a bit like that rabbi. Almost everything that has been said about "the elderly" is correct in that it assuredly applies to some old person or to some old patient. It simply does not apply, however, to "the elderly," who are a vastly dissimilar conglomerate of persons. Given such diversity, is there anything useful that can be said learned from psychoanalytic treatment of the over-sixty patient? Certainly, but with the caveat that generalizations be regarded with appropriate caution in an area where individual differences among patients are far more extensive than those purported to exist between

groups of patients.

The major finding of this study is that six subjects do productive psychoanalytic work with their over-sixty patients with little or no modification of treatment. The second finding (discussed at length in the literature review), is that both psychoanalysis and aging have so greatly changed during the last fifty years that the fact that the elderly can be analyzed is not so very surprising. A third finding is that widespread negative societal prejudice toward the elderly did not affect the decisions of these six subjects to treat the elderly nor did it apparently impede the treatment itself.

Also of interest is the fact that a detailed inquiry such as this, of the long-term work of several analysts affords a perspective not available to one analyst who reviews several of his own cases (e.g. Myers, 1984), or to analysts (such as Nemiroff & Colarusso, 1985), who examined the individual cases of several analysts. In viewing each subject in relation to his analytic work over many years, one can see that each analyst's customary way of looking at life, at experience and at his patients, influences his perceptions and his understanding of those perceptions. In other words the character or style of the analyst affects the data in ways that are not always addressed. (See, for example, Dr. Adams' comments p. 203.)

It is clear that all six subjects have characteristic ways of expressing themselves and of perceiving their patients. Dr. Adams tends to speak of self awareness and the acceptance of one's own or life's imperfections; Dr. Fireman portrays the patient's sense of himself as "victim" and is concerned with the capacity for new experience and risk taking; Dr. Brenda sees obstacles as a call to action, if one door is closed a new one is there to be opened; and so on. These analysts do not use such terms and concepts merely to describe individual cases, they use them to organize their experience. One must therefore be careful not to attribute to an individual patient, traits which may be more properly related to the analyst's habitual mode of construing his world or his work. It is this aspect of an analyst's attitude towards his practice and his patients which is more readily visible when one has listened to the same analyst discuss a large number of his cases.

Having concluded that valuable psychoanalytic treatment of the elderly can be practiced without concession to age, and unsullied by cultural, professional or personal ageist bias, this dissertation became an exposition of nuances, and of relationships among various factors: the character and values of the analyst; his philosophy of treatment; the impact of the patient's pathology on the treatment process, and so on. Like a web

of ever-increasing complexity, an examination of such nuances inevitably raises more questions than it pretends to answer. With this in mind, the following comments constitute a recapitulation of the more subtle findings of how older patients differ from the young. These distinctions are always in counterpoint to two of the major assertions of this study--that older patients are not alike, and that in the psychoanalytic treatment of the older patient other factors are far more consequential than age.

The Impact of Social Prejudice on the Decision to Treat

This summary begins with an issue presented in the preface, the impact of societal prejudice on the analyst's decision to work with the elderly.

The negative impact of societal or professional prejudice on the decisions of these six analysts to work with elderly patients was nowhere in evidence. This is not a great shock given the fact that I chose as my subjects psychoanalysts who had evinced some interest in working with the elderly and psychoanalysts whom I knew to be actually working with the elderly. These subjects did not include the thirty-five-year-old analyst mentioned in the preface whose sensibilities were offended by my suggestion that analysts might actually enjoy working with older patients. Six years have passed since I first spoke with him and perhaps he's changed his mind--but perhaps he has

not. Clearly then, there are groups of people for whom this study cannot account. Nevertheless, even for these six psychoanalysts, there were factors suggested by the literature which could have but did not discourage them from treating the elderly.

First, a quick glance at the positive influences. Drs. Brenda, Delia, and Ernest had deep emotional ties to grandparents who were not only loving but who were also creative, productive people. Dr. Adams also grew up in a five-generation family where elders made vital contributions. These subjects believe that their family histories gave them respect, if not reverence, for the elderly. On the other hand, both Drs. Brenda and Ernest encountered events which might have affected them negatively, but had only positive impact. Dr. Ernest's grandmother became senile before she died. Rather than deterring him from working with the elderly (Roche Report, September 15, 1978), it increased his interest in his first older patient who probably also had Alzheimer's disease. (Dr. Ernest's only disappointment was with his patient's inability to recall the details of her previous analyses with "giants" in the field, in whose techniques the young therapist had more than just a passing interest.)

Dr. Brenda too faced subsequent influences which might have, but did not, alter her willingness to treat

the older patient. First of all she became fearful of her own aging. Gutmann (1980) speaks of the counterphobic aspect of gerontologists' motivation to work with the elderly, but counterphobia did not appear to be Dr. Brenda's motivation with respect to her patients. She neither pursued nor embraced treatment of the older patient; she simply did not refuse to treat them when they were referred to her. She took a series of measures to deal personally with her fears of aging. Furthermore, Dr. Brenda worked in a State hospital for seventeen years dealing with severely and chronically ill old men. The research (Butler, 1975, 1977; Robb, 1977; Zimring, 1977; Miller et al, 1976; Roche Report, September 15, 1978; Holtzman et al, 1978; Solomon & Vickers, 1979; Sparacino, 1979) points to the possibly calamitous results of such experiences. But Dr. Brenda's work only increased her interest in and understanding of both her elderly patients and of their severe pathology, due in no small measure to the influence of her seventy-year-old-physician mentor whose professionalism and humanity on the ward inspired her.

Dr. Fireman was the only one of the six subjects to concede having some really unpleasant views of the elderly before working with them. His first over-sixty patient was a woman who reinforced all of his fantasies about the typical elderly patient. Neither his prior attitudes nor this first sterotypical over-sixty patient deterred Dr.

Fireman from continuing his work with the elderly population, which he took on with interest and satisfaction.

What do these analysts' experiences say about the effects of societal prejudice on their willingness to work with older patients? They suggest that Weinberger and Milham (1975), Kogan (1979), and Green (1981) were probably correct that sterotypical thinking fades in the presence of context. It appears to me, however, that "context" has more variables than we know. It is quite possible that other subjects whose positive and negative experiences with the elderly appear similar to those of these analysts, could feel differently about treating older patients. For some psychoanalysts, societal and professional prejudices become countertransferential, while for others they are just more grist for the mill.

In the main, these analysts began treatment with elderly patients with feelings of enthusiasm or at least of benign interest. Dr. Ernest's sense of freedom in his work with this age group, made the work all the more valued. The constraints of a classical metapsychology, or of supervisors intent on the methodical application of rules, did not, in Dr. Ernest's thinking, necessarily apply to the elderly. He could therefore act with greater autonomy and with a sense of playfulness, that eventually allowed him to work more freely with younger patients as

well. In fact, Dr. Ernest approached his work with the elderly with an attitude that might ideally be applied to work with patients of any age. "In thinking about work with the elderly," he said,

> I am reminded of a book that I read by Walker Percy, The Message in the Bottle, in which he wrote a chapter entitled, "The Loss of the Creature." Percy describes the experience of coming upon something totally new and unjaded. His example is the Grand Canyon--from the point of view of an American who sees it for the very first time. Not as a tourist who has seen a picture of it or who keeps saying, wait till I tell the folks at home about this. And the person thinks, I never saw this before, I don't know what it is, but I have to make sense of it in someway. I have to poke it, I have to see if it moves, I kind of have to sniff the air, I have to talk to it and see what comes back. In many ways that is the experience of dealing with the elderly patient--if you are not restricted by preconceived notions.

Selection of the Elderly Patient

In assessing the analytic potential of older patients, these six subjects use essentially the same criteria they use for evaluating younger patients. The subjects are in no ways surprised at finding these attributes--psychological mindedness and ability to form new relationships, etc.--in the over-sixty population. The affirmation that such attributes exist in older patients, conforms to the findings of Pollock (1982), Myers (1984), and Simburg (1986).

The subjects do not consider these qualities to be any more "special" when found in older patients, nor do they feel that older patients need to have any "special"

traits to make them more attractive as patients.

One subject, Dr. Carrie, feels challenged by older patients who regard age as an obstacle to the realization of certain goals. She holds that this "existential dilemma" differs from the predicaments of younger people because aging often imposes certain realistic limitations. Dr. Carrie finds that her patients' growth, despite any such limitations, is exhilarating. For some analysts, approaching the end of life can provide an opportunity and an intensification of the need for resolution which adds particular interest to work with the elderly patient. Whatever the age of the patient, the ultimate objective, for all subjects, is to increase the patient's potential for creativity and for life.

Presenting Problems

Pearl King (1974, 1980) indicates five sources of anxiety which lead patients to seek therapy in the later years. (See p. 75). The subjects of this study similarly point to five areas of difficulty, four of which overlap with King's sources of anxiety.

Three of the analysts observe, as did King, that fear of illness and death, or complaints related to these issues, occur more frequently in their older patients. It is the _fear_ of illness, rather than the event itself, which Drs. Adams and Brenda consider the more usual impediment to active living. Such fears may be heightened by Western culture's view of illness and physical

disability as anomalies which must be expunged with all possible speed rather than events of life with which one copes.

A fourth subject (Dr. Delia) found that physical symptoms accompanied depression and generally ceased as the depression lifted.

The second sphere of difficulty specified by these subjects, that concerning issues of loss and depression, is consistent with the findings of King (1974, 1980) and with those of a number of other authors (Berezin, 1973; Kahana, 1974; Goldfarb, 1977; Steury 1977; Lidz, 1978; Mathews, 1978; Nemiroff & Colarusso, 1985).

Dr. Ernest believes that the issue of _irrevocable_ loss is the fundamental difference between older and younger patients because younger patients have greater faith in the likelihood of additional opportunities than do older patients.

The nature of the losses mentioned by these subjects, such as decrease in physical functioning, reduction of job opportunity, loss of significant persons, is in keeping with that noted in the literature. Significantly, none of these subjects mentioned loss of sexual functioning (one of King's points) as a difficulty of aging, because they see sexual dysfunction as unrelated to age.

These subjects assert, as did Berezin (1963/1977; 1978), that loss itself is not the real issue. Patients

respond to losses in ways that reflect their habitual modes of functioning, and they differ in their reactions to loss. The psychoanalytic task is to examine the patient's habitual modes of reacting, and to provide an opportunity for constructive change.

The third area mentioned is the need or desire of older persons to "take stock" and evaluate the meaning of their lives. This process may be accompanied by a sense of urgency about unfulfilled life dreams and an acceptance that some dreams will remain unfulfilled. Pearl King (1974, 1980) and several of the developmentalists (Levinson, 1978; Colarusso & Nemiroff, 1981, 1985) refer to this process in terms of Erikson's notion of "integrity vs. despair," which all see as the central conflict of the final stage of the life cycle. The need for older patients to ascribe meaning to their lives and moreover to leave something behind appears to be an important task of late adulthood. One of the subjects (Dr. Fireman), having observed precisely the same dynamic in younger patients who are dying, discerns that the task is not so much a function of time lived as it is of time left.

The fourth area of difficulty offered by the subjects is the older patients' frequent confrontation with the prejudices of society. The demeaning effect of social prejudice is named by three of the subjects as an adversity imposed upon the aging. Like Wayne (1953) and Mathews (1978), Dr. Ernest, believes the identity of the

elderly as a disparaged minority is unfortunately what distinguishes them as a group. As the subjects report, however, older people respond variously, many refusing to be held hostage by the injustices of their environment.

The fifth and final issue addressed by these subjects was the responsibility of over-sixty patients to care for their elderly parents, an area which has not been covered in the literature on aging. The subjects point out that as the population ages, older persons are required to participate in the care of their even older parents. Two of the subjects believe that the over-sixty patient finds such duties more acceptable than he might have in his younger years. The older patient knows his parents will die and wishes to spend more time with them. Younger patients may be more conflicted because of responsibilities to their nuclear families.

Some agreement exists both among subjects, and between subjects and authors quoted in the literature, that particular types of distress may bring the over-sixty patient into treatment. Except for the desire to reach a previously established goal (i.e fulfill a dream), however, none of the patients entered treatment specifically to address these kind of concerns. (The analysts' full case histories are presented in Appendix A.) This should not be surprising because we have

established that the "[stereo] typical older patient" is far from typical. When it comes right down to cases the generalities do not necessarily apply.

Consider the references made to Sandler's (1978) case history of an "aging narcissistic patient" whom she analyzed between the ages of fifty-eight and sixty-six. Sandler herself remarked on the patient's "long-standing difficulties in work, sexuality, and social relations," noting that he could have "benefitted from analysis at any time in his life..." (p. 6). In discussing the case, Myerson (1978) states explicitly that the patient's age was irrelevant to the therapeutic issues and that the problems he brought to treatment stemmed from his childhood experiences. In some situations the age of the patient is just one more trait that is not of cardinal significance. This was true of Sandler's patient, of Meyers' (1984) patients, and of the patients presented in this study. Sometimes the infrequent but sterotypical concomitants of particular pathways to aging are very much the issue, as in the cases presented by Nemiroff and Colarusso, (1985), or as in the case fragments touched upon by some of the subjects in this study.

Psychoanalyzing the Over-Sixty Patient: the Work Itself

Simburg (1986) polled his colleagues about the nature of their interests in psychoanalysis and the older patient. Their answers provided a template for the

organization of this study. Two of their major concerns bear repeating:

1) Does the older patient work in psychoanalysis and is the analysis such that it would be considered real analysis?

2) What are the differences in analyzing someone over sixty as compared with someone just over thirty?

All six subjects in this study agree that the age of the patient is no barrier to work in "real" psychoanalysis. Although the subjects differ in style they share certain assumptions about the nature of psychoanalytic work. (See p. 148.) These assumptions correspond to Simburg's (1986) experience that the older patient can work in "psychoanalysis" and that the chronological age of the patient is not an indicator of eligibility for psychoanalysis. It is also in keeping with the experience of others (Meyers, 1984; Nemiroff & Colarusso, 1985; Miller, 1986; Cath, 1986; Muslin, 1986).

Having established that all six subjects believe they are doing psychoanalytic work with their elderly patients, the following comments will summarize the ways in which the age of the patient, including the analysts' feelings about the age of the patient, may influence the analytic work. The discussion begins at the beginning of the treatment "works through" this process.

Initial Differences

Two of the three physician analysts make a more detailed inquiry of older patients' physical complaints.

All three physician analysts are alert to any medications the older person may be taking and to the possible impact of such medications. (While psychologists are also respectful of physical symptoms they seem to feel less responsible for monitoring medications. Two subjects are also more alert to subtle differences in the mobility of those older patients who have been affected by visual, auditory, or physical impairments. King (1974, 1980), also addresses certain "reality problems" that the analyst may face in the treatment of older patients.

Subjects view the existence of previous treatment as one of the most important features of the over-sixty patient, because prior treatment invariably affects the present treatment. In fact, all of the patients presented by these subjects in their case histories (Appendix A) had previous treatment. Mrs. Z had managed to sabotage all of her previous therapies. In the early years of her marriage, Mrs. W had been exposed to some therapy which her current analyst considers to have been problematic. (Mrs. W's earlier therapist had scolded her and left her with the impression that whatever the difficulties in her life she was at fault and had to bend.) Mr. V had received brief family therapy and counseling which had been somewhat helpful in dealing with a few crises situations. Mr. Y had received some good therapy at the age of thirty-eight, for marital problems. Mr. X's twenty

years of classically oriented therapy had terminated upon the death of his therapist who had "been like a father" to him. And finally, Mrs. U had been in two previous therapies, one which had been helpful to her during her divorce, and a subsequent short-lived encounter with a male therapist whom she believed had been totally disdainful of her. In each case, the present therapist was required to deal with the residue of the prior therapy.

Setting Goals

Silberschatz (1982) saw evidence of bias in professionals' limited expectations of the treatment. I myself wondered if the patient's age in any way influenced the establishment of treatment goals. Three of the subjects found that the patient's age did not affect the establishing of goals. The remaining three subjects found subtle distinctions.

The analyst who perceives the older patient to be more mature than the younger patient, gives greater authority to the older patient's judgment about treatment goals. Drs. Adams, Brenda, and Ernest believe that the younger patient may need someone to tell him things which an older patient may have learned through life experience. Because Drs. Adams and Brenda are the two oldest subjects (sixty to seventy-year-old range), one may speculate that their own respective acceptances of their 'lives as lived' led to their increased acceptance of the older patient's

goals. But this is conjecture. Two factors mitigate against such a conclusion. The first is that one of these subjects is closer in age to one of the subjects in the fifty to sixty year age range then they are to each other. The second is that Dr. Ernest, who concurs with Drs. Adams and Brenda, is in the youngest age range; that of thirty-five to forty-nine.

It might also be asked if the relatively greater acceptance, among these three subjects, of the older patient's goals limits the patient and is therefore a form of ageism. These subjects' case presentations, discussions of other patients, descriptions of their work, and their own accountings of their feelings with respect to older persons and older patients, make this a doubtful hypothesis. Dr. Ernest, nonetheless, wondered if his tendency to concentrate on an older patient's past and present, as opposed to a more immediate and heavily expressed concern for the patient's future goals, is a discriminatory bias. In view of Dr. Ernest's response to his own question with the assertion of his belief in the older patient's large potential for future development, an "ageist" label seems inappropriate.

With respect to setting goals, Dr. Ernest believes that if patients come into treatment because of decreased functioning his first task is restoration of functioning. One then moves beyond restoration to some internal

reorganization. Analysts cannot always move "beyond restoration," and this is true in their work with older and younger patients. On the other hand analytic work will usually move beyond restoration for both age groups. (See for example the case histories of Appendix A.) Drs. Carrie, Delia and Fireman found no difference at all in the setting of goals based on the age of the patient. Dr. Fireman stating that goals are determined not so much by the age as by the degree of pathology.

<u>The Patient's Narrative</u>

Does the patient's age influence the narrative? Two subjects (Drs. Adams and Fireman) feel that it is not the age of the patient but rather the nature of the problem and the patient's character organization which affect the manner in which the patterns of a patient's life emerge in the treatment. Dr. Adams believes that because people tend to stereotype as they become further removed in time from an actual experience, older people tell portions of their stories in a more stereotypical fashion. (If true, it is of little consequence to Dr. Adams who believes that the analyst never really hears the historical "truth" in any case.)

Three subjects (Drs. Brenda, Carrie and Delia), find that the patterns of the older patient's life do seem to emerge more quickly and that the analyst gets a more concise selection of key incidents in the patient's life. Dr. Brenda feels that the older patient is kept on target

both by his increased self-knowledge and by his sense of urgency, whereas Dr. Carrie believes that these stories have been reworked in the older patient's mind. Dr. Ernest also holds that the analyst is more apt to get a sense of the older patient's characterological style sooner than he does with the younger patient. Dr. Ernest suggests that this happens not merely because of the patient, but because the analyst tends to more closely concentrate on the older patient's present problems and therefore gets the kind of information that depicts the patient's character style.

It would seem that "all things being equal," the older patient may tell his story with less diffusion than the younger patient, probably as a result of having replayed it many more times. But it is also true that pathology and character organization are the overriding considerations in the patient's narrative.

The Relative Importance of Early vs. Late Experience

Dr. Ernest's implication that the analyst's focus on the present problems of the elderly breaks with analytic precedent provides a useful transition to one of the more interesting issues in psychoanalysis--that of the relative importance of early versus later life experiences on the personality or pathology of the patient. The importance of very early childhood experiences has reigned supreme in the annals of psychoanalysis.

The importance of later life experience has more recently found its way into the literature. George Pollock (1982) remarks that psychopathology need not be linked inevitably with childhood and that later life experiences affect later life reactions. Nemiroff and Colarusso (1985), supporting Erikson's conceptualization of adulthood as a consequential developmental phase of the life cycle, promote the view that the later adult events are also influential and may cause "fixations or developmental arrests" just as they are caused by early childhood experiences. In other words they believe that early childhood and adult experiences have influenced the older person. The psychoanalytic institute from which the six subjects of this study graduated is reputed to be sympathetic to the idea that later life experiences do play a role in shaping adult patients.

All six subjects, nevertheless, deem early experience to be crucial, particularly if the experience has been traumatic. They believe that both the nature of the experience and the time frame within which it occurred form the developing personality. All subjects gave examples of the longtime effect of grievous early experiences on the lives of their adult patients. Dr. Brenda was so committed to this notion of event plus time frame, however, that she spoke of her own early trauma and the manner in which it has affected her throughout life. Although the rawness of the event has subsided, Dr. Brenda

has been left with certain vulnerabilities to which she is always on the alert.

Certainly such early events and patterns were evident in the case histories presented by these patients. Mrs. Z's analyst spoke of Mrs. Z and of her husband as still having the encumbrances of the ages of three and five. Mrs. W at sixty-three was finally beginning to work out the childhood relationship with her mother and to understand its impact upon her adult life and indeed upon her relationships with her own daughters. Mr. V at sixty-four was first getting in touch with the burden of guilt he carried at his family's insistence that his birth had been responsible for his mother's illness. Mr. Y, seventy, had spent a good part of his adult life acting out his mother's hypochondriacal anxieties and dealing with his father's contempt for him, which lasted well into his adult life. Mr. X, seventy-one, had a lifetime history of trouble with women, dating back to his mother's refusal to allow him any kind of satisfactory relationship with his father. Mrs. U, at the age of sixty-five, was first uncovering memories of cruel treatment at the hands of austere and puritanical parents.

I must ask myself in retrospect whether the phrasing of the question (i.e. the relative importance of early vs. later experiences) set up a false dichotomy. This was not intended as a question of the lady or the tiger. In

reviewing these case histories I did not intend to imply that any of these patients were untouched by their early adult or later adult experiences. Quite the opposite. With the possible exception of Mrs. Z, these patients were very much affected by late experiences, and most especially by their treatments. Nor do Nemiroff and Colarusso (1985) suggest that early experiences cease to have an impact in late adulthood. In fact they state that the key to successful treatment is the ability to address both childhood and adult experience. It does seem the case though, according to these subjects, that when pathology exists in late adulthood, childhood experience is not that far behind.

Early Experience and Affect

I stated above that Simburg's (1986) psychoanalyst colleagues were interested in the answers to specific questions about psychoanalysis and the older patient. Among them, "How far is the patient from the thoughts and feelings of childhood experiences (not simply from the memories of childhood?)" Like Abraham (1919/1977) who took issue with Freud on the subject as far back as 1919, these subjects found their older patients to be as interested, if not more so, in talking about early childhood experience. Early memories can come up in an intense way and the patients do make good use of them. The elderly are as able as younger patients to express affect and the proportion of affect that accompanies

memories is a function of who the patient is and not of his age. Three of the subjects observe that if the older patient abstracts the experience of earlier years in some stereotypic fashion he may lose some affect unless he has suffered some exceptional trauma.

Aspects of the Personality and Defensive Styles in Relation to the Aging Process

The literature review (see pp. 23-112) examines and refutes many of the long-held stereotypical beliefs about character traits and defensive styles attributed to the aging. Nevertheless the influence of the aging process on various aspects of the personality or on the defensive styles of older persons remains an area of interest.

Character and Defenses

Apart from their definite inclination to depict older persons as mature, "wise" and as having learned through living, the subjects of this study saw nothing basic in the way of character or defenses that can be attributed to the aging process. In this view, they are very much in agreement with Zinberg and Kaufman (1963). Four of the subjects insist that people, as they age, continue to act in their characteristic ways and that defenses are a function of these character styles. Dr. Brenda points out that defenses are not resistant to change and describes the case of a patient in his sixties who altered a lifelong defensive posture in order to create a more satisfactory life. Both Drs. Adams and Brenda (the two

oldest subjects), intimate that passions may attenuate in the older patient and they describe delicate shifts in the intensity and priority of lust that takes place between the ages of thirty and sixty.

Unlike Wayne (1953) who saw a tendency to somatize in older patients, these subjects state that the defensive use of somatization is not age-related. All agree, however, that there is probably an increase of somatic complaints among the elderly because they are apt to have more physical symptoms. None sees hypochondriacal preoccupations as a particular concern of the elderly.

Narcissicm

Grotjahn (1940), Kernberg (1980), and Cohen (1982) see aging as a special problem for narcissistic individuals. (See pp. 55, 80-81.)

However, the subjects in this study take the position that narcissistic concerns are difficult problems throughout the life cycle and that aging is no more a trigger for distress than are all of the other situations which impinge upon the narcissist during his lifetime. That is to say, if the aging process itself is understood as a source of narcissistic injury, then the patient probably regarded other life experiences as the source of other narcissistic wounds in earlier years. Or, to again quote Dr. Adams, "People with these kinds of problems have a rougher time when they get older, but they had a rougher

time when they were younger."

Dr. Brenda adds that certain segments or classes of society encourage narcissistic forms of un-relatedness which fail to provide authentic interpersonal relationships. The substitution of such forms of experience for true intimacy, may leave a patient feeling empty and alienated in his later years.

Dependency Needs, Envy and Guilt

Although Cath (as reported by Myers, 1984) focused on the increasing dependency needs observed among older patients in response to the loss of significant people in their lives, the subjects of this study felt that dependency needs presented no special problems for the older patient. If people had been dependent in early life, the losses of aging would be dealt with in characteristic fashion. There are universal human needs--for intimacy, for relatedness, for companionship,--which if not met, create distress for all people. But this is not the same as stating that the "dependency needs" of older people increase. The subjects simply did not find this to be the case.

Nor did the subjects feel that envy presented special difficulties. Myers (1984), was concerned that excessive envy might damage the aging process. This is undoubtedly true. But once again the subjects of this study point to the characterological nature of envy and point out that people who are envious and who cannot resolve their envy,

have problems with this at any age.

Myers' (1984) concern, however, is not to be totally dismissed. Drs. Ernest and Fireman find that with their patients, envy is the trait most embedded, intractable, and resistant to change. It is therefore not surprising to see evidence of it in the later years. If one sees a patient for the first time when the patient is older, it may be more difficult to understand how certain attributes have persisted over the patient's lifetime. Age may therefore be incorrectly blamed for longstanding characterological traits.

One subject, Dr. Delia, has been impressed with the guilt that older patients feel towards their children. While younger patients may feel guilt toward parents, only older patients can feel guilt towards adult children. They may feel that they have damaged the lives of their children by behaviors which they have only come to recognize and regret late in their own lives.

Sex

The time has arrived (or very nearly) where the appellation "dirty old man" refers to a male who has not washed. Berezin's writings (1963/1977, 1978, 1982) are an example of the evolution of thought on age and sex. In 1963 Berezin viewed older people as having entered a time of life when the sexual drive is not physiologically active. By 1978 he referred to the many old people who

have strong sexual desires; and by 1982 he observed that the person who was sexually active in his youth would be active in old age and that the sex drive might be used as a model for viewing the elderly in other aspects of life as well.

The subjects in this study expect and find that their older patients will be interested in sex, and sexually active if the situation permits. Most find that sexual dysfunction is unrelated to age and is usually of longstanding origin or the result of a major physical impediment or major emotional trauma. Dr. Delia finds that like other physical complaints, diminution of sexual drive in a patient who has been active sexually is usually related to depression and will return to full functioning when the depression is alleviated. Dr. Adams points out that sometimes the patient will forget his past history and present his sexual problem as if it were age related; but this is often an incorrect determination. Most of the subjects feel that it is regrettable that the opportunity for sexual expression may diminish as people, especially women, get older and lose their partners. The subjects consider the continuation of sexuality a normal and essential aspect of aging.

Analytic Technique: Differences or Modifications Based on Differences in the Patient's Age.

George Wayne (1953) felt that treatment of the aged might require what for him represented a "modified"

psychoanalytic method of therapy. (See pp. 64-65.) Some of his suggestions, such as "the patient faces the analyst", are no longer considered to be "modifications" in many analytic circles. Some other suggestions, such as "the therapist <u>manages</u> the patient by way of supporting reassuring discussions, guidance, and environmental manipulations" are likely to be considered modifications by almost all analysts.

As more analysts began to treat more older patients, they began to find that "no technical parameters have to be taken into consideration" (Loch, 1982, p.270; See also, Simburg, 1986, p.131; Muslin, 1986).

Although the subjects of this study may differ slightly with Wayne (1953) with respect to his understanding of "psychoanalysis"--these subjects would not, for example, insist on the use of the couch, demand abstinence and neutrality, or mandate the development of a transference neurosis--they do state that none among them makes any notable modifications in analytic technique with older patients based on the age of the patient alone.

Drs. Adams, Brenda, and Delia believe that differences in analytic technique, not attributable to differences among analysts, are associated with the character, pathology, or situation of the patient and not with the age of the patient.

Three of the subjects, Drs. Carrie, Ernest, and Fireman, are generally more active with older patients

which they attribute to certain factors which may be correlated with the patient's age. For example, Dr. Carrie traces her ability to make interpretations more quickly to the fact that her older patients have had prior treatment and can work with greater ease in the analytic mode. Dr. Ernest attributes his relatively active stance to the fact that he felt less compelled to follow the "rules" of classical analysis with older patients because the rules were not originally intended for older patients. This permitted him to work more actively with older patients and eventually with his younger patients as well. Dr. Brenda, who is not in agreement with the classical position on abstinence, spoke adamantly against its use with older patients in particular. She feels that it disregards the older patients' years of accumulated knowledge, their more equal relationship with the therapist and, sometimes, their greater isolation. Dr. Fireman recounted a case where his greater activity with an older patient was based on her situation and on her pathology. In general, he tends to be more active with patients who have no resources.

I would like to return to Dr. Brenda's comment about being more "real" with older patients. Martin Grotjahn (1940) was the first analyst to comment upon the real needs the analyst might be required to fulfill in the lives of older patients who are socially or biologically

deprived. (See also Meerloo 1955.) To some extent this is reflected in the practices of some of the subjects of this study with some of their older patients. Dr. Fireman notes that if the older patient is isolated, one of the things he has lost is his ability to have an impact on another person and to feel effective. Dr. Fireman thus may permit some interactions which he would more frequently "analyze" with a patient who was not so isolated.

But this is not the entire story. There are at least three other factors promoting the more "real" or more "equal" relationship that these subjects perceive takes place with their older patients. One is that older patients have learned a complicated system of social amenities through which to express themselves--cards for special occasions, attention to another person's needs or state of health, a shared exchange about a newly discovered "gem" of a restaurant--and if these are routinely analyzed one may humiliate or embarrass the patient with very little gain to show for it.

A second, and perhaps less obvious, factor is that analysts have also learned a complex system of subtle social behaviors, not necessarily negative, which intrude upon their interactions with the elderly.

I was amazed to discover recently that when talking to the younger of my nephews, the pitch of my voice was considerably higher than when speaking to the elder, whom

I perceive as just entering adulthood. If introduced to the mother of a friend, I do not respond as I would to someone my own age. We rise when an older person enters a room, we relinquish our seats on buses, we introduce younger people to older people, and we further alter our behaviors in untold ways. This has an impact, often unstated, on the analytic relationship as well.

The third factor is the subjects' belief that older patients use their life experiences in ways that younger patients cannot yet do and that they can learn more from their older patients. The question of being real then, is not merely a function of the analyst's perceptions of the older patients' deficiencies. It is more often a function of the analysts' view of the patients' maturity, the patients' strengths, and inculcated social mores.

<u>Characterizing Movement in the Older Person's Treatment</u>

Kahana (1978) stated that the therapeutic movement of a particular older patient was a telling argument against the stereotype of mental rigidity. (See p. 74.)

Like Kahana, (1978) the subjects of this study find that there are no distinctions which specifically differentiate therapeutic movement based on the age of the patient. The subjects defined movement in more general terms than did Kahana and it is not clear if these patients in whom they see therapeutic movement always progress in each of the spheres which Kahana outlined.

All of the subjects speak of change in the patient in particular ways. Dr. Adams defined movement in terms of the specific difficulty of the patient. Patients oblivious to their impact on people would show movement in increased awareness of their behavior and its ramifications. Dr. Brenda is more apt to assess movement in terms of the patient's goals. Dr. Carrie thinks in terms of the patient's increased freedom to feel his experience in the presence of the analyst. Dr. Delia's views are similar. Signs of change in the patient, as noted in the treatment process or in the patient's outside life are indications of movement for Dr. Ernest. Dr. Fireman, however, characterized movement as the elimination of obstacles which interfere with the patient's capacity to be open to new experience. In any case, it is clear that the subjects make no concession to the age of the patient in their definitions of analytic movement.

Transference Issues

King's (1974) statement that the understanding of the patient is filtered through the vehicle of transference expresses one of the basic tenets of psychoanalysis. King and Nemiroff and Colarruso (1985) note that the analyst can be experienced in the transference as a significant figure from all stages of the life cycle. Myers (1984) has the singular point of view that the older patient, in what he calls the "Dracula Syndrome", may attempt to

"suck" up the youth of the younger analyst to avoid recognition of the aging process. If true, this would cast doubt upon Myers' notion (made with reference to the erotic transferences of older patients) that older patients disregard age differences. They certainly would have had to noticed his "youth" in their wish to borrow it. Perhaps he meant that older patients disregard certain kinds of taboos, those which prohibit older patients (i.e. parents?) from having sexual fantasies about their younger analysts (i.e. children?). The reverse taboo, children's sexual fantasies about their parents (as well as their patients' discomfort), may contribute to the initial mild disquietude noted by Drs. Carrie, Ernest, and Fireman, in dealing with the erotic material of their older patients. Dr. Ernest points out that in his erotic responses to younger patients he feels a certain protection in the knowledge that the younger person can act on the erotic fantasy in real life. With the older patient the opportunity to do so is not always present.

Unlike Myers (1984), Drs. Adams and Brenda (the oldest subjects), find a diminution of eroticized transferences among their older patients. While Dr. Brenda sees eroticism as "masked," Dr. Adams feels that his younger patients also have less erotic fantasies about or feelings toward him. Conversely, Dr. Fireman, one of

the younger analysts, has observed that erotic transferences are equally as strong in his older as in his younger patients. Perhaps, think Drs. Adams and Brenda, they are no longer "sex symbols." The longer he practices, explains Dr. Adams, the more convinced he becomes that patients' transference reactions are triggered by the impact of certain aspects of the analyst's actual personality upon the patient.

This returns us to Myers' (1984) contention that the age of the analyst is disregarded in the transference, and touches upon one of the knottier debates in the field of psychoanalysis, the extent to which transference is a function of who the analyst really is. It had been my impression that this dispute was being waged largely between the classical analysts -"who the analyst really is has no part in the transference" -and the interpersonalists -"who the analyst really is makes a difference," until I heard Wayne Myers give a talk, sponsored by the Columbia Psychoanalytic Institute on his work with the elderly. When the discussion period began, I was fascinated by the controversy among the classically oriented analysts as to whether the patient would willy-nilly have the same transference to an analyst irrespective of whom the patient chose to see in analysis. My own view is that this rarely happens unless the patient is severely narcissistic. Like King (1974), Drs. Carrie and Delia find that the main impetus of the treatment is

the transference and they find no difference in the transference reactions of older patients. Like Drs. Adams and Brenda, they believe that transference reactions are individualized and that the wide range in the nature of transference among younger and older patients is based on many factors. According to these subjects, both younger and older patients may treat the analyst as if the analyst were any significant figure from the patient's past. The older patient has a longer past and may therefore have been influenced by a wider range of significant persons.

These subjects feel that aspects of the transference are usually based on the pathology of the patient and the frequency of the sessions. More intense transferences usually occur when patients are seen more frequently.

Of the six subjects, Dr. Ernest alone commented specifically upon the multigenerational transferences, observed by King (1974) and Nemiroff and Colarusso (1985), which Dr. Ernest agrees are exclusive to older patients. Dr. Ernest said that patients have often related to him as if he were their child, and therefore, the bearer of their grandchildren.

Countertransference Issues

In its earliest form, this dissertation focused on the countertransferential attitudes of analysts toward their elderly patients in a culture rife with prejudice toward its older citizens. We have seen, however, that

this negative societal bias had little effect on the decisions of these analysts treat elderly patients. In summarizing the findings of this study, it seems particularly significant that the countertransferential snares enumerated at length in the literature (See Chapter 2 pp. 103-112.) are virtually absent among these six subjects.

None of the supposed countertransferential difficulties identified in the literature appears to have interfered with these subjects' desires or abilities to treat their older patients psychoanalytically. Needless to say, countertransferential blindness would be hard for the subjects to report unless they had seen evidence of it after the fact. But none reported any difficulties in respect to the patient's age, and therefore they did not conform to the countertransferential stereotypes outlined in the literature. For example, relationships with grandparents (as well as with previous older analysts) appear to have led toward the development of positive feelings toward patients. This seems to have been of therapeutic benefit to the patient and, one hopes, not unanalytic.

Insofar as analysts' parents were concerned, there seemed to be no displacement of negative feelings on to older patients. On the contrary, relationships with living parents were improved by virtue of the understanding gained from work with older patients. There was no hint that subjects had any thoughts that the

treatment or the patients were low status. Frustrations due to limited success always involved the pathology of the patient and never the patient's age. Indeed, several analysts treated dying patients with dedication and compassion despite their own occasional anxieties about the patients' terminal illnesses. There was no theoretical denial of sexual gratification toward the old and the stories of old patients who were "swingers" were relayed with support and delight, as in the case of the gentleman who was sent to be "retrained by a hooker." Therapists were not overwhelmed by the "real problems" but showed a certain flexibility (hospital sessions, reduced fees), when such problems arose.

Four of the subjects (Drs. Adams, Brenda, Ernest and Fireman) claim that countertransferential feelings are always more of a function of the individual differences among patients than of the age of the patient. Analysts respond to the patient, and they respond to the patients' transference. Drs. Brenda and Fireman cite the patient's pathology as an important source of countertransferential reactions. The patient's age is largely irrelevant. Obviously, countertransferential reactions also stem from the personality, character, and unresolved issues of the analyst.

Dr. Delia's countertransferential problems, she says, stem from her own neurotic fear that she is never doing

enough for her patients. This may be exaggerated with the older patient given Dr. Delia's reverence for this age group, but occurs with patients of all ages.

Of the six subjects, Dr. Carrie (and to a lesser extent Dr. Fireman), admits that some of her responses to traits of three older patients contain elements of stereotypical thinking about the elderly. The patients' behaviors which irritated her were a reluctance to leave treatment, an almost exclusive focus on toenail surgery and general stubbornness. Yet these behaviors would have been equally annoying had they been manifest by younger patients. But Dr. Carrie feels, however, that younger patients would not have persisted in them for such a long period of time. Moreover, Dr. Carrie would attribute such behaviors in younger people to the patients themselves, whereas with older patients she would attribute them to the age of the patient.

Dr. Fireman, discussing one of his own "repetitive" patients states rather succinctly, "This is not to say that these kinds of repetitions are characteristic of older people. But when they happen in older people, they <u>feel</u> different from similar kinds of repetitions encountered in the young. And that has to do with the <u>analyst's</u> thoughts about them."

Dr. Carrie's responses are perhaps the only example of negative stereotyping among the analysts interviewed in this study. In retrospect, I wish I had asked Dr. Carrie

to speculate in detail on its possible impact upon the treatment. I did not do so at the time because her descriptions of the treatment of these patients led me to understand that her feelings were on the surface, totally in awareness, and in no way detrimental to the treatment. But in theory, once the analyst attributes something in the patient to a class or category of people, there is always the danger that individual differences will become masked.

Both Drs. Carrie and Ernest caution that some older patients maintain a greater than average tendency to idealize doctors. This may feed the analyst's sense of omnipotence or increase the analyst's anxiety so that he responds by becoming more directive, less analytic, and ultimately less helpful to the patient.

Drs. Ernest and Fireman (like Meerloo, 1955) hold that termination may be indeterminate with older patients. While this is sometimes true of younger patients, only with the older patient is there a more realistic possibility that the patient will die. These considerations create a strain which the two analysts relieve in appropriate ways unrelated to the interaction with the patient.

Only Drs. Adams and Brenda brought up the issue of who should properly treat older patients. Dr. Adams feels that the relative age of patient and therapist depends

entirely on how professional the therapist is. If the therapist is totally professional and knows his work, the comparative age is insignificant. Dr. Brenda believes that treatment of the over-sixty patient is best done by analysts who are past their mid-forties. She feels that her own aging has made her more sensitive to issues of aging in her patients. Drs. Adams, Ernest, and Fireman were all about thirty years of age when they began to work with older patients and none states that his relative youth in any way interfered with his interest in or ability to work with older patients. (In contrast to the research literature of the 1970's; Wolk & Wolk, 1971; Garetz, 1975; Karasu, Stein & Charles, 1979.)

The Influence of Theory on the Work of these Analysts with their Older Patients

"My theory," says Dr. Brenda, "if you want to call it that, is to confine myself to observation." And that is pretty much the thinking of her five colleagues. It appears in general, that these subjects are hesitant to identify themselves as adherents of any given "theory". They pause because they are wary of the reification of theory, fearing that theory becomes mistaken for fact, because such commitment to a theory leads to parochialism, and because they are not convinced that any one theory is helpful in clinical work with a broad range of patients.

What the analyst must do, says Dr. Adams, and despite the difficulty of the task, is to keep these theories in

the back of one's mind while one is treating the patient, without letting the theory interfere with the focus on the patient. All of these subjects remain very close to the clinical material. And they seem to be in agreement that whatever the age of the patient, and whatever the issues, one sticks closely to the data; one analyzes the data and hopefully the patient grows.

With respect to developmental theory and its application to the older patient, these subjects are not sympathetic to the views of the stage theorists (Levinson et al, 1978, for example) who conclude that adults progress through predictable stages, completing certain developmental tasks before moving on to subsequent stages. In the experience of these subjects, chronological age is an unreliable predictor of what any individual will be confronting at any given age. People divorce at sixty, remarry at sixty, begin new careers at sixty, and the old timetables no longer apply. It appears that there is simply far more variation among older people than among younger people. Drs. Adams and Carrie find that Levinson's stages are not accurate. Dr. Adams sees Levinson's theory as in an impediment to the understanding of the adult and feels that people deal with events and transitions which occur throughout the life cycle in their characteristic ways. Or, as Dr. Fireman states, the themes of earlier years may appear in a different context.

One developmental task that all subjects agree about

is the older patient's need to pass something on.

Final Comments

A friend is fond of repeating the phrase, "The future ain't what is used to be." I think he borrowed it; but no matter, he is right. Among the things the future used to be but no longer is--is brief. Turning sixty in 1987 is vastly different from what it was in the early 1900's. Older people are healthier, more vital, more active, better educated, and more financially secure than they used to be. These older people whose numbers have increased (and will continue to increase) disproportionately in our society, are doing much to dispel the stereotypic myths which have literally plagued the elderly for centuries.

The subjects in this study have also done much to dispel long-held myths about the psychoanalytic treatment of the elderly. They treat the older patient "psychoanalytically" in very much the same manner that they practice psychoanalysis with their younger patients. Where there are differences, these differences are largely due to circumstances. If the patient has had prior treatment, this will have an effect on the present treatment. If the patient is isolated and has no resources, this will have an effect. If the patient is ill, if the patient is taking medication, if the patient is physically impaired, these things may influence the

treatment. But, as the subjects emphasize, each one of these contingencies might affect the treatment with their younger patients as well.

The subjects agree that older patients undeniably differ from younger patients in two areas--older patients have had longer experience in living than younger patients and they are, as a result, more diverse. This diversity is to some extent a result of the differing biological effects of the aging process and to some extent a consequence of the greater variety of formative experiences to which the older person has inevitably been exposed. But it is only now that people are living longer and more productive lives that the range of these diversities has come to be appreciated.

These facts open up entire new vistas for scientific investigation not merely with respect to the older person but with respect to the younger person as well. Longer lives have the potential for altering the entire life cycle. The teenage son of a co-worker was obsessing about what path to follow after his high school graduation. His indecision was frustrating to his mother, Mrs. Daniels, who expressed her irritation to me. Jumping to the young man's defense I commented, "Well it's a big decision, David is deciding what to do with the rest of his life." Mrs. Daniels corrected me at once. "That's not true, she said. "People no longer have to decide what to do for the rest of their lives at nineteen years of age. There's

plenty of time to go down another road. David is only taking the first step."

Furthermore, once we put to rest the stereotypical notions about older people, and begin to examine the enormity of their diversity it is, as they say in the vernacular, "a whole new ballgame." We have a great deal to learn about the many options a long productive life has to offer and this is the issue that will merit attention.

This dissertation has underlined the viability of psychoanalytic work with the elderly and has established that the work does not differ markedly from that with the younger patient. A next step might be to synthesize the data of individual analytic treatments into a more sophisticated theoretical understanding of the many meanings of late adulthood. Another interesting area for exploration would be an examination, in light of the extended life span, of the natural histories of character pathology. (This suggestion was offered by Dr. Laurence J. Gould in a personal communication.)

It is apparent that the psychoanalysts who participated in this study consider successful aging and successful living to be one and the same: a process of continuing growth. I was amused by a true story that Dr. Adams shared with me. Shopping on Manhattan's Upper West Side he noticed two older men greeting each other in the street. One said to the other, "So how was your

vacation?" And his friend replied, "Thank God, not so bad." For people who are affirmative, engaged, open to new experiences, able to maintain friendships, and willing to take risks, life after sixty can be "Thank God, not so bad." In fact, the case histories indicate that it can be good.

No subject suggested that old age is a bed of roses. That it is not. Even the patients presented in this study who were basically healthy and active had their fair share of obstacles and grief. (See Appendix A). But they kept going. Most of them used treatment well. What the subjects do allege is that life itself is not a bed of roses. One unavoidably deals with problems throughout the life cycle. This too is evident in the case histories.

A final story. I recently attended the confirmation of the son of a friend. Reverend Joseph Alexander was remarking about difficult times. Life, he said, does not make sense. Pollution of the planet, he said, makes no sense at all. And, he continued, how are we ever to understand genocide? Who can begin to explain the rationale of escalating nuclear armament? Why do very bad things happen to very good people? The world, he exclaimed, seems to be in chaos. But it is in such confusion, he asserted, that we find the real strength of the human race. People look at life and they see that it does not make sense. But they keep on believing in it anyway and they go on living, trying to improve themselves

and the confusion around them. And that, says Dr. Brenda, is the secret of a good old age.

Appendix A

SIX CASE HISTORIES

THE CASE OF MRS. Z: The woman who would not change

Mrs. Z first came to see me when she was 65 years old. A professional woman, who had been retired from the organization with which she was affiliated, she had embarked on an additional course of training in her profession which she felt would afford her greater freedom in the use of her professional expertise, as well as add to her professional development. She was already highly regarded in her field, and a woman of some reputation in her area of interest.

Mrs. Z who had a long history of intermittent prior treatment, began a three times (and occasionally four times) per week psychoanalysis at this time because of the continuation of disturbed family relationships exacerbated by the stresses of her new professional challenge, her husband's chronic and degenerative illness, and his recent retirement.

When Mrs. Z arrived for her first session I saw a beautifully dressed, very pretty, petite woman, who spoke well and carried herself with presence. With meticulous enunciation she attempted to run the entire show, talking with infrequent pauses and showing early signs of the suspicious and competitive traits that were to mark her treatment. Actually I had gleaned some sense of what might lie ahead when, in her first telephone call to me, she carefully spelled out her street address tagging each letter to make certain that I understood her correctly.

Two of the tags remain in memory. "D" as in don't, and "o" as in oppositional.

We had all kinds of problems immediately. An experienced patient, she was not the least hesitant to "supervise" my work labeling my comments as trite, obvious, irrelevant, and the like. She would misinterpret questions and statements and complained that neither she nor members of her family had been helped very much by their previous treatments.

Mrs. Z's major dissatisfaction was the blatant ingratitude of her family. She saw herself as generous, giving, concerned and involved. She viewed her husband of 40 years, as extremely schizoid and withholding and she considered this to be harmful both to herself and to her children. She could not see this as an intractable character problem but viewed it as anger and hostility directed specifically towards her. Mr. and Mrs. Z argued frequently and a major fight every eight to ten days was endemic to the relationship . (Although the two had an ongoing sexual relationship which continued until Mr. Z's death.) It was not uncommon for Mrs. Z to become abusive during these fights giving vent to her fury by throwing kitchen utensils clothing and food at her husband. On one occasion she complained of a severe headache and took to her bed. She asked her husband to bring some ice from the kitchen and to prepare an ice pack for her head. He took

more time to accomplish this task than she thought appropriate and precipitated one of their characteristic arguments in which she accused him of deliberately ignoring her while she was pained and distressed despite the fact that she nursed him devotedly when his neurological disease required attention.

She felt that he should anticipate her needs, as she did his, and that he mostly failed to do so. If it was a cold day and he did not leave the house a few minutes before she did in order to warm up the car before she got into it--he was in trouble.

Mrs. Z felt that the fights between herself and her husband had increased following his retirement from an excellent and responsible professional position. Although he continued to do some consulting to his prestigious firm, he did indeed have more time on his hands. When both husband and wife had been working full time the difficulties, though they existed throughout the 40 years of marriage, had seemed more manageable. Or so it appeared retrospectively.

Mrs. Z was troubled by the constant bickering with her husband. She was truly concerned about his neurological condition and ever fearful that its degenerative course would result in his imminent death. She felt guilty about adding to the strain of his life by her carping and worried that she was making him worse. While she in part regretted the difficulty she felt she

was causing, she nonetheless experienced a certain sadistic pleasure in her activities.

Mrs. Z's discontent with relationships was not limited to the faults of her husband. She experienced her children as equally ungrateful in the face of enormous generosity on her part as a devoted and selfless mother. She stated that she had given all for her son and for her daughter, that she has anticipated their needs and their desires during their growing years and that she had continued to give and to give and to give. Her reward for this beneficence was to be victimized. Her husband, who was far less involved, was regarded as the good daddy by the children while she was viewed as the disciplinarian. Though she raised the children and invested herself in them, she believed that it was her husband who symbolized love and kindness to them while she remained unappreciated. She felt that her husband had secretly colluded with the children, now 39 and 36 years of age, to put her down and to assure that none of her nobleness was returned to her. She stood alone, with nobody on her side. She attempted to manipulate her family with guilt but this did not work to her satisfaction.

Both Mrs. Z's son and her daughter have problems. Marvin, the older of the two, is described as adversarial and difficult. He is single and thought to be bi-sexual although this is not absolutely clear to Mrs. Z. She

worries that he will never marry and that she and her husband will never have grandchildren. (This did turn out to be the case for the husband who died during the course of Mrs. Z's treatment.) Anna, the daughter, is married to a wealthy professional man and is herself totally involved with her career as a lawyer. Mrs. Z's son-in-law is thinking of changing to another profession and Mrs. Z sees him as a malcontent who is generally dissatisfied with whatever endeavor he is involved in. Like her son, Mrs. Z's daughter seems unlikely to have children and the prospect of grandchildlessness haunts her.

Mrs. Z entered psychoanalysis with the expressed hope that her family relationships would change. She wanted to see if she could get more from her husband and more from her children because she felt that she was terribly deprived. This was the feeling of a lifetime.

Mrs. Z was the fourth daughter of parents of considerable standing in the community. The family had been in the United States for five generations and prided themselves on their history and on their many contributions to the country and to the arts. Mrs. Z's father was considerably older than her mother, and he was already close to 60 years old when Mrs. Z was born. The three older daughters were well into their teens and in various boarding schools, and Mrs. Z was raised virtually as an only child. Mrs. Z's mother was 40 when she was born and mother died of a stroke at the age of 57 when

Mrs. Z was 17 years old. This was an especially painful event for a great number of reasons. First, Mrs. Z in the throes of teenage rebellion had been arguing with her mother just prior to the mother's death. The very sudden death, with no opportunity for reconciliation left the teenage daughter with intense feelings of guilt and destructiveness. In addition, Mrs. Z felt that her mother was basically a quite nice woman who had yearned for affection and tenderness and who had received too little from her husband, Mrs. Z's father. The father, on the other hand, was a paranoid and extremely critical man whose alternate mode of behavior was often a somewhat embittered silence.

Nevertheless Mrs. Z was special to both parents who were attentive to her sometimes to the point of being over-protective. She attended schools close to her home and, in the early years, was often accompanied to school by either parent at an age when other children were navigating on their own. She recalls trying to please her parents and wanting very much to please them. She remembers herself as being a good girl and as "different" from the way she is now, although she admits to bouts of tyrannical behavior even in her early years. Following her mother's death, Mrs. Z continued to live with her father and to care for him. While in her twenties, Mrs. Z married her childhood sweetheart who entered the armed

services in his professional capacity during the early years of the marriage. Marvin was born while his father was away from home, and Mrs. Z was caring for her infant son and for her elderly father. A self-absorbed and narcissistic mother-in-law complicated her life and gave her little of the attention and the affection she had remembered as being part of her early relationship with her mother. She felt that her mother-in-law was demanding and self-serving and that she could depend on her for very little in the way of help, support or understanding. She came to view her mother-in-law as a woman who loved to be serviced and her husband as a man who loved to service his mother. Her husband then, was the good little boy to his mother, but not so good, according to Mrs. Z, to his wife and children. In the retelling, Mrs. Z feels that those early years were trying and she now resents some of the burdens under which she feels that she labored, but she has no memory of feelings of resentment at that time.

A major trauma which occurred some years following her husband's return is very well remembered. Her father, always a difficult man, was becoming increasingly difficult and tyrannical. He was resentful of Marvin and Anna and accused Mrs. Z of too much devotion to her children and of paying too little attention to him. He suffered from diabetes and a variety of other disorders and was on several medications about which he often became confused. Mrs. Z's interventions were regarded variously

as intrusive, ineffective, and inappropriate and he railed against her constantly. She felt that both she and her husband were knocking themselves out by looking after her father and that both were subjected to vitriolic diatribes, including the often repeated threat that when he died she would have only herself to blame. He died when Marvin was about ten years old and Mrs. Z has never been certain that she had not been a "bad" daughter. Though the death was thought to be of natural causes there was some thought that he may have mixed up his medications and whether this was true or not (and whether it was inadvertent or not) has never been clearly established in Mrs. Z's mind. She continues to feel guilty about the deaths of both her mother and her father.

When Mr. Z returned from the service, he moved rapidly ahead in his profession and Mrs. Z began to prepare for her own profession. The couple created a wide circle of friends, most of whom Mrs. Z continues to see until this day. Mrs. Z had her second child, Anna, and these years of the couple's successful professional development and the growing years of the children are remembered as being "not so bad".

The serious problems began to arise when the children became teenagers and needed to separate from their mother. The truth was that Mrs. Z simply could not separate from her children without splitting. And the issue was the

death of the mother and the internalized identification with the tyrannical father. Neither parent was very dead for her.

The impact of the parental identifications was a continuous thread in the therapy. Mrs. Z envisioned her father as a mean gorilla with hulking shoulders and clumsy insensitive fingers and her mother as a delicate flowering plant, beautiful and sweetly scented but confined to a small clay pot. A reported late childhood dream was a variation on this theme of a tyrannical beast carting around a potted flower which was lovely but confined and helpless. Something akin to Fay Wray at the mercy of King Kong. Mrs. Z could not decide if she herself were beast or bud. Though neither struck her as a very satisfactory condition she had difficulty envisioning other alternatives. One was either a sweet smelling victim or a mean beast.

During the early months of treatment I felt an ample amount of ambivalence towards this patient who likewise found me very trying. She disagreed with my payment policy which we had discussed in great detail, feeling that any interruption in the flow of her life (and there were several, some of them genuinely serious and distressing) was sufficient cause for special consideration on my part and for instantaneous dissolution of the rules upon which we had jointly agreed. When I did, in advance of a potentially disruptive turn of

events, agree on modification of the rules these modifications always turned out to be insufficient after the fact, as far as she was concerned. Although I was charging her a low fee, she accused me of being interested only in the money and of having inadequate concern for her suffering. She said that she had little respect for psychoanalysts and that she did not understand them. And so we battled about all manner of things but still and all she settled down and began to trust me and we began to work on some of the unresolved issues regarding her parents.

Mrs. Z's relationship with her husband did in fact take a turn for the better and they shared stretches of intimacy uninterrupted by the usual squabbles. From time to time, at her behest, I would see the two of them as a couple and we would work on major stresses that threatened the new equilibrium. After some time however, it occurred to me, that whenever Mrs. Z would begin to work on some of the feelings concerning her father that were not easily available to her, she would drag in her husband as a diversion. We discussed this but she found it almost impossible to remain with this subject matter. We began to talk about those areas in which Mrs. Z seemed to act very much like her father but there was no way in which she really could stick with it. She was not going to separate from that identification. On two occasions she

became quiet and sad, stating that she had come to understand that she was often just as much as a dastardly beast as her father had been. "Oh my God, she cried, isn't that too bad." I agreed that it was unfortunate but added that it was not necessarily inescapable. She was relieved, but only momentarily. Following these moments of insight some interpersonal difficulties with teachers and fellow students, became greatly magnified. I recognized her resistance to these insights and understood her behavior as acting-out. Her troubles at school were drawn along the very same battle lines that had been established in the analysis. She expected to be excused from classes or assignments when her home situation required greater participation from her and she expected to be compensated for her suffering. The rules were not to apply to her. She was curt with others, including friends, would make snide remarks in their presence and then when they would distance themselves, she would protest about how much she had sacrificed for them and about how little they paid back.

Mrs. Z was not oblivious to her behaviors. She would recall the vague memory of the "nicer" self; the little girl who tried to please her parents, the young model mother who sacrificed for her children. She attributed the emergent nastiness to the physical residue of a partial hysterectomy she had undergone some ten years earlier. But her surgeon and gynecologist had monitored

her condition carefully and had prescribed the necessary replacement hormones and neither felt that there was any physical reason for any behavior change, and particularly one of ten years duration. The other major stressor as far as she was concerned was her husband's uncertain health. And this was assuredly a factor to contend with.

Unfortunately Mr. Z's condition began to deteriorate rapidly. Mrs. Z decided to devote herself entirely to his care and took an indeterminate leave of absence from school. I again agreed to see them, on rare occasion, as a couple. Mr. Z was indeed schizoid. I thought of him as alexithymic. He frequently did not have the words, or he did not have the connections between the words and the feelings. It would generally take an extremely long time before he got a feeling connection that others would more often get in seconds. In many ways, he seemed a good man. Despite his pain he continued to consult to his former firm at a very low fee, taking pride and pleasure in helping younger professionals up the ladder which he had previously ascended. In addition, he was clearly totally and absolutely devoted to his wife. He minded her abuse and he wished for it to change. She, on the other hand wanted him to change, to become more feelingful. She was quite clear about herself - there was no way that she was going to change and I felt that I had reached the end of the line with her.

I told Mrs. Z and Mr. Z. that I felt that neither party wished to change or perhaps that neither could change any more than had been done already. We agreed to stop with the understanding that I would be available to either of them if they so desired it. Mrs. Z nursed her husband until his death and then came in for a series of sessions following his death. She is now interested in changing her children and we are working on the issue of whether or not this goal is doomed to the same fate as her wish to change her husband. My current stance is that I cannot help her unless she wishes to change.

Clearly the treatment of this patient is not a total success story. But this has nothing whatsoever to do with age, it has to do with her character structure. Her narcicissim and negativism made me uncomfortable. But this is exactly the kind of patient who creates discomfort in the analyst and the analyst has to be able to tolerate it. A borderline patient who is oppositional and 18 years old could create this. While it is true that there are certain alleged older age issues which brought this woman into psychoanalysis at the age of 65 (her so-called physical ailment, her husband's neurological illness, her husband's retirement) it is also true that she had been in treatment at other times in her life. Furthermore, the illness was illness and not old age. Certainly some of the tasks of middle and late life had not yet been achieved but the essential difficulty for each of these

people is that they still had the encumbrances from the ages of five and three respectively. They had never resolved them and they were resistant to resolving them and that is a shame.

<u>THE CASE OF MR. Y: A journey from hypochondriasis to full creativity.</u>

Mr. Y is a 70 year old successful male executive who returned to treatment with me complaining of depression. He was depressed, he said, because of the onset of gastro-intestinal distress which was a repetition of discomfort he had had several years prior when only minimal physical findings had been made.

A trim, muscular man of average height his erect posture made him appear taller than he was and his full head of hair had greyed only at the temples. He had an imposing presence which seemed undiminished by his depression.

Mr. Y first began analysis (with a different analyst) at the age of 38 at the urging of a close friend. At the time he was having marital difficulties with the his first wife and problems with his twin daughters. He worked with his first analyst for about eight years and transferred to me when the first analyst died. We worked together until he was 50 and then he returned again at 63 when his father died, and now again at 70.

Mr. Y was the second of four children of financially comfortable second generation American parents. A brother, the youngest and favorite of the four died when Mr. Y was six, and he grew up with one older and one younger sister. Mr. Y's mother was terribly concerned about her health and obsessed about Mr. Y's health as well. She paid

particular attention to the passage of food through his alimentary canal and didn't hesitate to use laxatives and other means of assuring regularity. Not surprisingly, Mr. Y is a man with a history of hypochondriasis and has had many somatic complaints over the years. Surgery for a complicated hernia problem when the patient was in his twenties had necessitated the removal of one of his testicles following which he reported difficulties with orgasm. He accepted this as an inevitable result of the surgery which I questioned.

In later years sex therapists and urologists disclaimed the attribution of physical causality. They felt that it was psychological. But Mr. Y had made a truce with the symptom; a truce which puzzled me. He claimed that sex was not that enjoyable anyway so why bother, and indeed his lack of real sexual pleasure with his first wife was not a treatment issue for him.

This patient lived in the shadow of a wealthy, penurious, authoritarian father who was the iron-fisted chairman of a huge business. Father remained the active head of the business until his death at the age of 100. Until that time, father and son worked side by side entangled in a thorny relationship in which the father utilized every conceivable opportunity to indicate his contempt for his son's business ability. Actually, Mr. Y was a shrewd business man and the business grew even larger following the death of the father. However, there

were difficulties.

At the time of the father's death, the patient was already 63 years old. Save for his Army service during the Second World War he had never really been on his own. He returned to treatment at the age of 63 following the death of his father. He was concerned with the operation of his business and had wonderful plans for expanding and modernizing it. He did not, however, want the expansion to interfere with his very full and active life. He had excellent plans for growth and development, but did not wish to have to take care of all of the details himself. After many interviews with many people he hired a team of managers whom he felt had a proven record. He felt confident that he could trust the new team though I was less sanguine about his choice. He had also been married to his second wife for about ten years and alluded to marital difficulties which once again he would not discuss. And again, he saw the issues in treatment as centering on the problems of his two daughters and his second wife's three sons.

The family issues were the focus of the treatment as was Mr. Y's growth in other areas. His business had grown enormously under his direction, and he was making ten times as much money annually as his father had accumulated over a lifetime. Unlike his father, and thanks to his ability to work this out in treatment, he was also

spending hundreds of thousands of dollars, though not without some emotional expenditure. Much of his spending was philanthropic and he gave generously to support his areas of interest. He was interested in the arts and became an active Trustee of a major cultural institution. His personal contributions and his superb fundraising abilities were immediately recognized and he became a major force in the organization. While this gave him a great deal of pleasure, pleasure for Mr. Y was rarely unqualified. It was almost always accompanied by some dissatisfactions--he had not done enough, did not have enough, was not good enough. When he left the second period of treatment, things were going well--sort of. He could certainly say that life was not so bad, but he couldn't really bring himself to feel that life was good.

Now to the issues of this current period of treatment. When he returned for his third period of treatment at the age of 70 it was this time at the urging of his second wife who was getting tired of his recent depression. A depression, or so he maintained, which was caused by the recurrence of some specific physical distress. Quite matter of factly, and only in passing, did he mention that the team of managers whom he had hired to run his business (and moreover who had become close and "trusted" acquaintances) had stolen over one million dollars from his business. Actually the sense of betrayal and the questioning of his own judgment was very much more

painful than the loss of the actual money. And we explored these issues and their relationship to his depression.

Almost as casually as he had brought up the theft, Mr. Y mentioned that he and his second wife had not had sexual intercourse for several years. I asked him what his feelings were about that and he said that I was familiar with his sexual history and that sex had never been all that terrific. He said that he had tried to speak with his second wife about the fact that they were not having sexual relations but that she had simply agreed that they hadn't been doing it; following which the issue had been dropped. He had evinced some interest in discussing it and certainly in knowing her feelings about it but he did not press her when she closed the issue. The issue nonetheless did not die. Always an athlete, Mr. Y had gotten himself into superb physical shape. He played racquet ball almost daily, and swam and played golf several times a week. Furthermore, no physical aches or pains, could deter him from these activities. He now feels that he is in perfect physical condition. His heart is good, his lungs are good, and if he did not have the gastro-intestinal distress his health would be perfect. And since he feels so very good he wants to know why the hell he and his wife are not having sex. So after a lifetime of relative disinterest in sex, this 70 year old

patient has become interested in sex. He feels that he has gotten it together and he is telling his wife that she had better damn well talk to her analyst about why they are not having sex.

Another issue is Mr. Y's involvement with the cultural institution in which he had now become a major force. This institution is in the middle of a multimillion dollar fundraising campaign for which he had the primary responsibility. At this point his dedication is not merely to the institution itself and to the arts, but to the very people who keep it going and to the many performing artists that he had come to know over the years. This is no longer a commitment to an idea, it is a commitment to people and to people whom he has come to love. These attachments are very meaningful to him and he suffers grave disappointments if his fundraising efforts falter. Often large contributors who promise to help fail to come through with their pledges and these defaults worry and depress him. This man has received many accolades for his work in this area and a great deal of public and private recognition. Yet these have seemed to be insufficient or at least they fade from view when he encounters an obstacle.

The overriding problem in Mr. Y's life and in his treatment has been his chronic discontent no matter how good things get. This is a guy who is never satisfied with his performance in anything. And this is a man who

is running his own massive business, managing a significant and important cultural establishment and sits on the boards of a number of influential institutions. Even though he is working harder now than he has ever worked in his life (he is doing more and he is accomplishing more) he still has the attitude that he is a a rich man's son who never really worked hard at anything. His version of his college days is that he never did the work, crammed before exams, played around and had fun, and got things done. Now here he is doing all of this work and he is still not satisfied. He is still not pleased. This is a function of how he chooses to think about things. Because who can feel satisfied raising money? If you go to a man with one hundred million dollars and the man tells you that he has other more important social issues to give money to, then suddenly you are missing one hundred million dollars. And if you are giving a lecture on operas, there is no end to what you can learn about the operas, the music, the performers, and so on. And he has not been satisfied with his wife, nor with his children, nor with her children. And he is not satisfied with the treatment.

Let's turn to the transference. Mr. Y gets angry with me when I am not like his mother. If I don't take the same microscopic view of his physical complaints that his mother did then he thinks that I don't care. But I

don't say to him you feel this way because you want me to be your mother. It is not that simple. What we get into is his belief that you show your concern for somebody by being curious as to what is the matter with them physically rather than by expressing your interest in their productivity or in their general welfare. Aside from this, it is generally hard to work when somebody has a somatic complaint. He may not have any distress for five or six days and then at the end of a week he complains of distress. Then I try to carefully go over with him what has happened on the seventh day. As one might conjecture from the preponderance of physical complaints, this is a man who is not terribly psychologically minded. Despite all this psychoanalytic treatment, and all of his gains this is a man who is really struggles to think psychologically. Because of this there is one aspect to the chronic dissatisfaction that I have not broached. What not being satisfied also means is that he does not have to be close to me. He does not have to be intimate. Chronic dissatisfaction is a way of keeping people at a distance. Who wants to be around somebody who is always complaining about not being satisfied? He achieves incredible accomplishments and then he cries about not being satisfied. It can feel like a slap in the face. So this is a distancing operation and I feel more distance with this patient than with patients who do not do this sort of thing. But I certainly have

said to him, "You are never going to be satisfied." And he has replied, "That is the truest thing you have ever said, why did you not tell me that before?" Well I have said it to him at least 5000 times before. So we continue to work on this issue while we wait to see who is going to drive whom crazy first.

Now this issue is finally beginning to change. I'm not sure that I understand why. Mr. Y has begun to actually come to terms with what he has in life. He realized that the sexual aspects of his marriage were not so wonderful but he reasoned that he had never had such great sex anyway. Recently he had sexual intercourse with his wife for the first time in a great many years. He continues to push to discuss this issue with her, but talking about it remains difficult for her for the present time. On the other hand other aspects of his relationship with his wife are very good and some which need improvement, he has set about trying to improve. Although his wife is successful in her own area of the arts, she is nevertheless quite dependent upon him for the kinds of things that "men do better." This will include mechanical things, and financial endeavors. He has now changed his partnership with her with respect to some of these old patterns which were not constructive to the relationship. She is learning to do some of these things for herself or to call in her own experts in particular areas, a luxury

which they can well afford. This seems to be working out well and his need to control and to feel that the woman does not know anything about mechanics or about money has lessened.

I think that in all treatment, and irrespective of age who the person lives with or is most involved with determines the outcome of the treatment as much as the patient.

In addition to the above changes, Mr. Y has become increasingly productive and creative in the arts and his talents are being appreciated and lauded. He has now permitted this to be a real source of unmitigated pleasure.

This is a man who has made real gains in his life. He did not come in because of age-related problems and if anything he is younger now than he was when he came. He is in better shape physically, he is productive, creative, successful, and happy. He has finally understood that life need not be perfect to be good.

THE CASE OF MR. X: Analysis interminable?

This is the case of a man of 70 or 71 (he does not know the exact date of his birth.) He was born in eastern Europe the youngest of nine children of whom five were boys and four were girls. As in the case of many eastern European families the father left eastern Europe for America during the patient's infancy working in the States for over ten years before he could finally send for his family. So Mr. X did not really meet his father until he was ten years old, and even then his mother created difficulties in the relationships between her children and their father. Mr. X was left in the care of his mother though he was basically raised by his older sisters, only two of whom remain alive. The few memories of his early childhood which endure are fraught with anxiety: scenes of pogroms and of bullies rushing in and beating up the frightened townspeople. Though the patient's background is Jewish he remembers little in the way of any religious instruction as part of his upbringing and he never had a Bar Mitzvah.

I first saw Mr. X about ten years ago when he was 60. He came in because of recurrent anxiety attacks, some depressive feelings and some horrific temptations. For example, if he were standing on a subway platform he would be terribly afraid that he would jump in front of a train and kill himself. He had been in treatment from the time he was 35 until he was 55 years of age, and had stopped

when his therapist had died. The therapist had been like a father to him and he felt the loss keenly.

When Mr. X began treatment with me he had been divorced from his second wife for three years although he and his wife had been separated for several years prior to the divorce. The marriage had lasted for 20 years and had produced two children. According to the patient one day his wife simply asked him to leave, stating only that she wanted a divorce. After a number of demands, he finally said O.K. to her, never believing that it would actually happen. Then the pair became embroiled in a very acrimonious separation with a host of issues about money and support that persist even to this day. Mr. X had first married in his teens and his young wife had also left him after of period of one month.

For his entire life, Mr. X had worked in the leather industry as a manufacturer of handbags. He was moderately successful as the head of his own company and employed about twelve people. Nonetheless he did not enjoy his business although he felt tied to it. He had the typical problems of the small business man. There were always loans to be paid off, shipping and billing problems, employee complaints and similar kinds of repetitive issues.

The patient reports that he had always had severe anxiety symptoms. Sometimes he would have somatic

symptoms such as facial tics or hyperventilation. Or he would become depressed and withdrawn for extended periods of time. He felt, however, that he had been helped greatly in his treatment with his former therapist.

Mr. X was raised in the Canarsie section of Brooklyn in a very poor family. Economic conditions required that he drop out of high school to go to work and he had regretted the necessity of interrupting his education. During his previous treatment he managed to earn his High School Diploma. He then continued with his education, taking college courses in the evening. This was a tremendous triumph for him since his family had offered him no encouragement and he had always felt that he was not smart enough and that learning was difficult for him. But his previous therapist, whom he saw once or twice a week, had been very encouraging to him in this area. He had actually looked forward to college as a way of putting his business on the back burner while he attended to his studies, but he really was unable to leave the business.

I first began to see Mr. X two times a week and this continued for many years. Recently I have been seeing him one time per week. During his early years of treatment with me, Mr. X struggled with the idea of giving up the business and getting out of the handbag field. He finally did this but not until he was under tremendous financial pressure. Part of the focus of the treatment at that time was to deal with the anxiety about liquidating the

business and clarifying his wishes and his decision making processes. He overcame his anxiety and filed for bankruptcy and was greatly relieved. Liquidation of the business also enabled him to really separate himself from his divorced wife. She had retained a percentage of the business and her continued involvement in the business had required consistent interactions with her which made things very difficult for him. He considered himself to be retired from the business though he continued to see old associates and to arrange small business deals for them from time to time, which they found helpful and which supplied some small supplementary income for him.

About seven years ago, Mr. X began to date one of the handbag designers who worked for his company. Although he had known her for many years, they had not had any sort of relationship until the death of her husband. At that point they started to socialize. They dated for many years while he was also dating many other women. This patient had a lot of trouble with women whom he invariably experienced as demanding. His manhood was easily threatened, and if women were critical of him, he became enraged. This was a long standing anger dating back to his early childhood.

Mr. X's experience of his mother was that she was furious with his father, would entice the children into taking her side in arguments with his father, and would

undercut his father. But she would never permit the children to criticize the father directly. So she would kind of support the father in some ways, while covertly undercutting him. This left my patient feeling that women were vulnerable, weak creatures who had to be rescued by men. Certainly his mother required constant rescue from her husband by her children, and particularly by her male children.

Many years later Mr. X became aware of his anger with his mother for not allowing him to have some kind of relationship with his father to whom he was really a stranger. He recognized that he had spent a good deal of his life vilifying this father/stranger in his own mind. His counterreaction was to see in any woman that he felt was making a claim on him, a repetition of his mother's unacceptable behavior. That is, a demand to be taken care of by a woman who was really quite capable of taking care of herself. And an exploitation of Mr. X by that woman for her own advantage, ultimately depriving him of what he would need.

When he originally started dating the handbag designer whom he had known for so many years, he was really in the position of the authority. She had seemed, in the early stages, like a woman without a self. She would somehow mould to whatever it was he did, so that he would experience her as perfect and himself as a kind of pygmalian figure. He felt a great deal of power and

competence as he introduced her to other worlds. Sometimes he would criticize her because she did not have his broad range of interests and then she would try to broaden herself. He had an enormous interest in the theater and so he would spend a great deal of time taking her to shows and tutoring her in the things she should look for and she seemed to respond well to that.

Eventually Mr. X married this vital woman who is about ten years younger than he. They have now been married for two years and he seems to have some mixed feelings about it. For one thing, she is intensely involved with her own children who are constantly plagued by a host of problems. She seems always to be running around trying to pick up the pieces and he is very jealous of that for two reasons. The first is that she does not attend to him to the same degree. The second is that his two children have really grown apart from him and do not keep in touch whereas her kids are always calling her. It may be because they need something, but they do call. And she always responds. So he is feels implicitly criticized as a parent as well. In addition to the above, he is resentful of the fact that she has continued to work as a designer and brings in the main portion of their combined income. He consults to small businesses every now and then and he participates as a volunteer in some theater groups but this does not meet his needs to feel that he is the

breadwinner, a role he has held since his high school days. He wants a paying job, and this has been a very difficult stress for him.

Mr. X is a very physical person. This is a man who has had a very healthy sex life. There was something of a hiatus during the years of his second marriage because he felt intimidated by his wife whose appetite he felt that he could not satisfy. She made him feel inferior and inadequate. He feels that his present wife is very responsive, but again, he is in the role of being the tutor and that is a role that gives him great pleasure. In terms of his physical accomplishments, he was a sprinter during his teenage years and he often jokes about his need to outrun all the street gangs of his youth and its impact on his physical abilities. He is still very active, playing tennis and handball, and is apparently quite competent even with adversaries ten to fifteen years younger than he is. This affords him a certain self-esteem and when he becomes injured it is devastating for him because a primary source of self worth is not available to him. Several intense depressions occurred when injury prevented him from playing at is usual level of expertise.

Now for some of his symptomatology. Always an anxious man, he began to suffer from panic attacks about four years ago and these have gotten worse since he has been married to his third wife. They are worse in the

sense that they frighten him more because they are not always distinguishable from heart attacks. He will have difficulty in catching his breath, sometimes he will have chest pain, and the symptoms can exactly mimic a myocardial infarction. And since one cannot rule out an MI, these are symptoms that are worrisome both to my patient and to me. So one is always in the position of checking out these symptoms and in a way one is constantly dealing with a sort of post traumatic stress disorder. Every time the patient has one of these things, he becomes worried that he will get it again--and what if this time it really is a heart attack! He responds to these episodes by calling me on the phone and we talk about it for a couple of minutes. He has my home number for emergencies but he rarely uses it. But knowing that I am available to him by phone has the effect of reducing his anxiety.

These panic attacks are a resurgence of symptoms that Mr. X had when he was younger. Usually they are do to a new situation and they are not responsive to pharmacological treatment. I have tried a number of the standard kinds of medications and find that he develops side reactions that are more worrisome to him than any relief that they may provide. Furthermore, this is a man whose self esteem is tied to his ability to cope on his own, and so the very idea of medication becomes

destabilizing. He is also a man who believes strongly in the efficacy of a real psychoanalytic inquiry. His first therapy was one in which he spoke about his feelings and analyzed his dreams and he continues to feel that this is useful to him. He brings in various dreams which he carefully records and feels that they may hold the key to his panic attacks. He believes in the search for the neurotic root of his anxiety; that is to say, find the answer and the anxiety will disappear. Part of this is a defensive operation. In other words, his connection to an analytic inquiry is partly a defense against certain kinds of adjustments most people are required to make when they age. He cannot always play handball as if he had the body of an eighteen-year-old. A man of his age will indeed find it much harder to find a paying job than a man who is thirty years younger. So there are factors of aging that require certain kinds of adjustments which are based on reality factors and not necessarily on a neurotic core.

What actually terrifies Mr. X is that his wife will leave him for a younger man. He sees her as active and vital while he no longer has his moderately successful business. He surmises that his second wife stayed with him early in the marriage because he had his business and because she had too much invested in it to leave him. Not until their children were grown did she leave him to do other things. He fears that he has little to offer other than his ability to make money and to provide for a family

and his new wife has now become much more competent in this area. Now in point of fact he never really was a rich man. He may have had one million dollars in assets, but he had one and one-half million dollars in debts.

While he seems unrealistically concerned about money this is a troublesome issue to raise in the treatment. Here is the countertransferential kernel: it feels very difficult when you are making more money than the patient to raise the idea that he is dealing with a real distortion. Because one does have the sense that maybe life is easier for the analyst, and perhaps there is also the feeling of not wanting to engage the patient's envy of you. But in the case of this patient, the fact is that he does have a certain nest egg. He owns his own home which is maintained at a fairly low expense; his wife is working; he can take a vacation to Europe every other year; and his needs are being met. What concerns him the most (and what is likely provoking my countertransferential response) is that his earning power is on the wane. It is not the amount that counts so much as the fact that one has less than one had before. (This tends to be a common concern among older people. I have one woman whose husband makes one million dollars a year, and who will shortly be retiring on a yearly income of five hundred thousand dollars and she is in a major depression about this.)

Mr. X also happens to be my lowest paying patient. I have charged him this rather low fee for many years and I feel inhibited about increasing his fee. Although a five dollar per session increase would not affect him financially it would affect him psychologically--it would add to his depression. It is not a worth doing. I feel absolutely no resentment at continuing with this low fee. If he cannot afford it psychologically, and I choose to work with him at this fee, then I feel no resentment. I must admit to a kind of social embarrassment at saying that I continue to see a patient at such a low fee. This is my problem and not the patient's.

Mr. X is very interested in the work and I do consider it to be psychoanalytic treatment. There is a constant flow from past to present and present to past and we will use the material to see how his anxieties are connected to past experience. And that does seem to help him. Part of the help is in being able to put a label on something, in being able to categorize it. Why it works, I am not sure anybody knows but putting things into a linguistic framework binds anxiety. It is the same as Freud talking about the dah experience. The child names the toy and masters the separation. That seems to be what happens with Mr. X. I don't have the sense that we discover something that is very different from what we have known before but he brings up new material and new memories in support of issues with which we are constantly

dealing.

The patient does see himself as wanting to terminate treatment at sóme point but he is now too frightened to do that. When he does stop, I will not view it as a final separation. When one stops with a person of this age, it is always with an option to return. If something should arise after termination and he should want to come back for a short period to deal with it - that will be fine.

THE CASE OF MRS. W: Singing her song at sixty-three

Mrs. W, a sixty-three year old woman, was raised, in a wealthy New England community, as the only child of an upper class religiously non-affilliated family of Jewish origin. A twin sister had suffered oxygen deprivation during delivery and had been left seriously retarded and disabled. She had been institutionalized following the birth and had died in late adolescence.

Mrs. W's parents were totally immersed in cultural pursuits; her mother was an artist, her father owned several galleries, and both parents were musically talented as well. An aunt, uncle, and grandmother lived in another wing of the house. The family frequently played chamber music and sang together for their own amusement and Mrs. W's beautiful voice and musical talent were discovered while she was quite young. She was given piano lessons but it was her voice that was really nurtured. While music was an avocation for the family, whose primary interest was art, it was made much more of a serious business for the little girl whose practicing habits were carefully monitored. She was not permitted to play until she had both practiced the piano and vocalized for the established number of hours.

Mrs. W was sent to a private school run by a Protestant denomination in order to get a "good" education. Learning to be a lady was considered to be part of this education and her demeanor was carefully

watched both in school and most especially at home. She was not to be exuberant, she was always to be restrained, polite, and well mannered. Nonetheless she was an active youngster who did well in her studies and who was given, and took advantage of, the opportunity to study voice with the finest teachers. Some she liked, others she did not. She completed her education in an excellent college and trained with the goal of becoming a recital artist, or perhaps of singing opera.

Even today, at the age of 63, Mrs. W is a striking looking woman. She is a bit taller than average, with the build and bone structure of a Vogue model and she dresses with impeccable style and taste.

Mrs. W. met her husband and married when she was 22 years of age. She and her husband, an enormously wealthy investment banker, had four children - two boys and a set of twin girls.

Given the fact that there were many in the way of household help, Mrs. W was not required to abandon her musical career in order to raise her family. She performed quite a bit and was establishing a reputation for herself as an artist. However, in her late 20's, after winning a major role in an opera performed by a well-known company, Mrs. W received mediocre notices on opening night. The reviews were not all that bad, attributing some of the difficulty to opening night

anxiety and certainly pointing out her inherent strengths and capabilities, but Mrs. W was totally devastated. She was, in fact, so discouraged that she decided not to continue in her career as a performer. She declared that her primary responsibility was to her children and she determined to remain at home and to raise them herself. Her high standards and her perfectionism prevented her from viewing the opera performance as a learning experience. She saw her performance as a monumental failure and she gave up that aspect of her career.

She did not give up music entirely. She continued to study and to play the piano, and she continued with her vocal coaching. She also taught theory and did some coaching at a local conservatory. But except for her family, with whom she continued in her own early tradition of singing for pleasure, she did not perform.

Mrs. W began treatment with me some five years ago and I have been seeing her three times per week. Prior to this she had had some treatment during the earlier years of her marriage, when her children were still small, partly because of marital difficulties. Her therapist had very quickly determined that she had more problems than did her husband (a conclusion incidentally with which I am not at all comfortable) and the patient herself had quite willingly gone along with the theory that something was wrong with her. After all this was not a new feeling for her. She has been and remains forever concerned that she

is too loud (coming from a family where restraint was in order) that she talks to much (a lady is reserved) that she is not intelligent and so on and so forth. Now this is a very bright, very lively, very attractive woman who really enjoys people. But she is very insecure. The first treatment experience really did not do much for that. And in fact she became increasingly phobic about her music and about her ability as a performer.

Mrs. W came into treatment with me following a friend's successful treatment experience with another analyst. Mrs. W was slightly envious of her friend's good feelings about her therapy and she asked the friend to get her a referral. When she came to me she was doing very little with her singing, as was mentioned above, and she was fearful of attempting to do more. The issue for her now is what is really possible in terms of her music and her earlier dreams for herself. The voice does change with age, although this differs among people and among voices. On the other hand she has developed her piano skills over the years and is an excellent pianist. When she came into treatment her dilemma was, should she give up all public expressions of her music - including her teaching - and reserve music for her own private pleasure, or should she attempt to complete her earlier dreams to the best of her ability?

The conflict is exacerbated by additional concerns.

Mrs. W is aware that the choice to make singing or piano her primary focus, is a choice that many women cannot even entertain. Her wealth makes this possible. Because she is being supported by her husband she has time and money for these personal pursuits. She wonders if she is entitled to make such choices or whether (and this is where Erikson's notion of integrity is applicable) she ought not to be doing something more meaningful for the good of others. She is of course a constant "volunteer" but she does not devote the major portion of her time to volunteer activities.

During the early part of the treatment she was explicitly appreciative of the fact that I was not "scolding" her. Her previous therapist--whom she has come to view as an old-fashioned person--had instructed her not to be so concerned with her career and had advised her to be available to her family. He had also suggested that she submit to her husband's unusual sexual preferences. The treatment experience was such that she was left with the impression that she was at fault and that whatever the family difficulties it was her obligation to bend.

When Mrs. W experienced me as a more supportive figure she became tremendously relieved and began to believe that she might not be such a bad person after all --and maybe--just maybe, her wishes for herself were legitimate.

Despite her apparent acquiescence to these many

outside influences, Mrs. W had her own ways of being controlling. When she began treatment with me she talked incessantly, almost compulsively, and it was hard to get a word in edgewise. She was also quite controlling with her children. She needed to be able to let go somewhat and to allow them to make their own mistakes and to lead their own lives. And she needed to keep from rescuing them every time they did make a mistake. She has made remarkable strides in these areas. She has been able to let go with respect to the children, and she definitely listens more when I have something to say. I do not always have to interrupt her torrent of words.

Mrs. W brings in long, complicated dreams. She works well with dreams and these have been extremely useful in getting at early childhood material. In fact, far more useful that direct inquiry. They would bring back early memories particularly those of her mother, and we were able to work very effectively in this area. We spent a good portion of the early treatment on issues involving her relationship with her mother, as they affected her then and as they impinge on the current aspects of her life. Her mother did emerge as a prominent figure in her life and she has been quite responsive to work in this area. A bit later in her treatment we shifted to her relationship with her children and particularly with her twin daughters. Interspersed among these two major foci,

were her feelings about her sexuality and her discomfort with her own desires and needs. She had worked openly and competently in each of these areas. The one thing that has been very hard for her to get to--and that she had been defending against--is her anger with her husband. In part, she remains terribly grateful to him for the luxurious life he has provided for her and for her children. And so, as is typical of her, she does not feel entitled to be angry with him. But we are continuing to work in this area. She is beginning to show some anger with me and this has been a time in coming.

For a long time there was an idealized transference in part because of the marked difference from her earlier analyst, but this is beginning to crack. Her husband, while a rather detached man, is also very supportive. And so my being supportive, in the sense that I do not injure her self-esteem, was close to what she experienced her husband as doing with her. She is now able to leave a session with me feeling disappointed with me. This was something she could not do before. If she felt disappointed, it was because there some something wrong with her, something about her which had prevented her from getting more from the session. Now she can feel that I was not quite with it.

In the transference, she never experienced me as the mother, nor as a child. I was more the idealized mother. My overriding experience with her is that she regards me

as an equal, although like some of my other older patients, she has difficulty addressing me by my first name. I see this patient in the office attached to my home so she is more likely to observe more about my life than patients who come to my other office. Also, because she tends to be a very formal person, I am perhaps a bit more open with her and a bit less formal than I may be with other patients. I felt that perhaps she was a bit too formal and I thought that perhaps a little modeling would not hurt. I have however been very careful not to tell her too much about myself because she had experienced her previous analyst as too open and I was not eager to repeat that experience. I have noticed that something that is going on between us has permitted her to feel more relaxed and more open in her sessions.

Having worked through many of these issues we are now addressing the issues of fulfillment with respect to her music. We spend a good deal of time discussing in great detail exactly what happens to her when she tries to perform; the differences in doing so in the house among family members as compared with close friends, acquaintances and strangers, needing to be perfect and her tendency to disparage herself despite feedback that constantly belies her fears. She is regarded as an excellent pianist and her teaching and coaching are very much sought and praised. And this in surroundings where

the competition is keen. At this point she is beginning to sing in public and to talk about the possibility of singing and playing in larger public arenas.

THE CASE OF MR. V: Emerging from shame, guilt and self-hatred.

Mr. V is a sixty-four year old Black man whom I have been seeing once a week for a period of two years. He has been divorced for eleven years and has three children; a twenty-two year old son, and two daughters ages twenty and eighteen. He is a big man, muscular, tough, and without a trace of a wrinkle. I sometimes look at him with a bit of envy probably nurturing some hope that I will look that good when I reach his age.

Prior to beginning treatment with me, Mr. V had some family therapy and some individual counselling during the time of the impending divorce from his wife. But he had never touched upon the issue of his homosexuality and the guilt surrounding it with his previous therapist. This was a longstanding issue which he very much needed to talk about. When he came to see me it was to discuss this issue, to talk about his problematic relationships with women, and also to explore the difficulties he was having with his youngest daughter who was a perpetual school dropout. He was frustrated by and furious with her and he did not know how to manage the situation.

Mr. V grew up in Chicago, the youngest of eleven children. Because there is a gap of twelve years between the patient and his next oldest sibling (a brother) his contemporaries were his nieces and his nephews. Following his birth, which was unexpected, his mother developed what

appeared to be serious medical complications. His older siblings told him repeatedly that his birth was responsible for the marked change in his mother and a portion of his treatment with me has been spent in exploring the circumstances of his mother's illness which was very much in evidence years before his birth. This has been a significant investigation. But the myth obtained that had he not been born his mother would have led a healthier and a longer life, and he has lived his own life with the sense that he had damaged her.

Mr. V grew up in a household where teasing by his cousins was a frequent occurrence. There was a fair range of skin colors among the members of the family and he was just about in the middle. He was psychologically abused by his female cousins and one in particular, whose skin was darker than his, teased him by telling him that he looked like a chimp with long arms and big black lips.

With the exception of the familial teasing, the issue of race was not a concern for Mr. V. during his early years. At the age of ten he moved from a racially mixed neighborhood to a white neighborhood and was one of the very few Black kids in the school. Once he returned to school after the school day to play ball in the gym with the kids. The door to the school was locked and he felt that he had been locked out because he was Black. This was his first sense of societal discrimination. A shocking sense of the consequences of discrimination

struck him in the aftermath of the Second World War. When he returned from overseas after the war he visited a movie house in Times Square. He saw a movie or a documentary about the holocaust. As he left the theater he remembers thinking that people were being treated like garbage. There were pictures of trucks dumping humans as if they were nothing more than garbage, and he said to himself that this could happen to black people - that he could be treated like that. And so he had a sense of himself as being unacceptable; a sense of himself as being like garbage and easily disposed of. It was something that he carried with him.

Mr. V returned to school following his stint in the military. He also became part of the hippie movement moving into a bohemian environment, smoking pot, hanging around with artists and satisfying his love for blues music. And then he got involved in homosexual activity. He had had some homosexual encounters in the military, but he engaged in a long term homosexual relationship after his discharge when he was in his early twenties. He cared deeply for his lover but he felt guilty about the sexual activity and ended the relationship after four years. As a teenager he had gone to see a prostitute with a group of his friends, but he had been unable to have an erection and had been humiliated by the experience.

Shortly after ending his homosexual affair, Mr. V

met his future wife, who was working toward a professional degree. He became serious about school, completed college and earned a Master's Degree in education while his wife was also completing her education. He felt that they would both be professionals and would lead a more reserved middle-class life. They married, found an apartment in a largely white neighborhood, and some years later had their first child. At this point, Mrs. V showed the first signs of emotional disturbance which increased dramatically. By the time all of the children had been born she was quite ill and had attempted to seriously injury both her husband and her children. With the support of her family, with whom he maintained contact, he removed himself and his children from her presence. His wife eventually immersed herself in prostitution, drugs and alcohol, and when I first began seeing him he was enormously distressed at the thought that this seriously disturbed woman, the mother of his children, was out walking the streets.

The daughter with whom Mr. V is having the most difficulty looks very much like his former wife. This reawakens a lot of bad memories for him and confounds his already troubled relationship with this daughter. He is anxious about handling her, about the setting of limits, and he wonders is she is going to go crazy like his former wife. His son and his older daughter, both of whom resemble him, seem to have made the separation very well. The possible impact of the physical appearances of the

children have triggered the memories of his early days with his cousins, and of their focus on skin color. This led to an inquiry into his feelings of his superiority over his darker skinned cousins and inferiority with respect to the lighter skinned cousins.

In the course of his treatment, Mr. V's relationship to his wife was subjected to the same careful exploration that had taken place with relationship to his mother. He felt terribly guilty about having separated from her and he believed that in some ways he had precipitated her psychosis. After a detailed inquiry the time frame regarding the development of her illness became clearer to him. She had become psychotic, had threatened to kill him and his daughter--and in fact had tried to do it--and this had preceded his decision to divorce her. She became crazy before the divorce and not after the divorce. But there remained in him a sense of residual guilt, a guilt that he held on to.

In addition, he was having sexual difficulties with the women that he was dating and in discussing these difficulties he became flooded with guilt about his early sexual relationships. So guilt and self-hate became predominant themes in the analysis.

This was a man who in his early years thought he had make his mother ill, and then thought he had triggered his wife's psychosis. Now we must deal with his self-

recrimination and self-hate. What has emerged recently is the difficulty he has had in setting limits for his children, and particularly his daughters. He becomes masochistic because he expects to be exterminated as punishment for having killed his mother. And he gets himself involved in humiliating sexual experiences in order to deal with his guilt. The other side of this is his rage at women for having humiliated him.

Because he had felt helpless as a child and at the mercies of his female cousins, the idea of having sex with women was scary for him. In his earlier homosexual relationships he found it necessary to penetrate his partners first, as a way of devaluing them. We have begun to focus on those areas in which he has felt effective with female friends and with female colleagues. He has also begun to assume more of a male authoritative role in his work and with his daughter.

Mr. V structured his experience by maintaining that he should not set limits for his daughter because it was his fate to be abused. He has begun to recognize this dynamic is now changing his patterns of dealing with his youngest daughter. He told her that she could not simply "hang out" around the house. If she did not wish to return to school she could either get a job or leave home. She started to work and she has begun to feel much more productive.

Mr. V is feeling better about having dealt with these

feelings of shame, guilt and self-hatred. He is really beginning to like himself more and is considering completing an advanced degree. He has received a good promotion and is doing work that is rewarding to him. And I think that he is really feeling some compassion for himself and has forgiven himself for some of the things that contributed to his feelings of guilt.

The matter of race, and of Mr. V's submerged resentment of white people has also come to the fore. Mr. V had an encounter with a white colleague in which Mr. V wound up feeling terribly betrayed. It was clear to me that Mr. V was dealing with my "whiteness" as well and we discussed this in a street idiom that I thought would have an immediate impact on him and with which I was very comfortable because of my own background. He told me that he had actually never thought of me as being white, and we got into the whole issue of racial stereotypes and the differences in the experience of being Black as compared with being white.

Mr. V has recently begun to take up a number of sports that he enjoyed as a youngster. This has been an incredible experience for him in that it has provided him with a sense of freedom that he had not felt before. He felt some power over his life and over his choices and he began to think about the fact that one could feel heavy and pulled down by one's choices, or one could feel free.

The physical activity has increased his sense of self-worth and the feeling of freedom about making choices. But freedom itself and the responsibility for one's choices holds certain terrors which he had heretofore avoided by placing himself in the role of the victim. He is aware of this, and aware of his vulnerabilities in this area. He has gone back through his life and sorted out the choices that he made at various points, i.e. divorcing his wife, raising his kids, and similar issues. His understanding what lay behind these choices has been freeing for him.

I really enjoy working with this man. I have a fondness for him that stems in part from the nostalgic memories he reawakens in me. He often speaks of family get-togethers in a southern state in which I have lived at times in my life, and I can picture the tempo and the flavor of the south. And I remember my own childhood, in a biracial neighborhood, where my two closest friends were Black. Blacks and whites lived in the same community but there was a line distinguishing where the whites lived from where the Blacks lived. His stories bring me back to my own experiences and I reevaluate them in the light of his perspective. I remember with pain, one occasion where I observed a racist interaction and I did not stand up for what I believed. I did not participate except for my silence. But the cost of speaking out was too great and I made a choice and chose the weakness in my character

instead of the strength. I regretted it then and I regret it now.

Although this man comes only one time a week I believe that his treatment is analytic. He is a very active, available man and is psychologically-minded. He is very good at bringing up past memories and sticking with them for as long as it takes to shed some light on his current functioning. He is very analytically oriented and has certainly derived some benefits from his treatment. I have gotten a sense of accomplishment from having worked with this patient because he has really emerged from a depression into a man who feels good about himself and hopeful about his life. That is not to say that we are home free, or that there is not still work to be done. There is a certain repetition compulsion about lifelong patterns that continues even after we have well understood the dynamics. So while he no longer seeks homosexual relationships to add to his feelings of shame and guilt, he recently did something quite deceptive at work that again triggered feelings of self-abnegation. And so we dealt with this terrible thing that he had done, and figured out what was motivating him. In the course of this particular journey we discussed the size of his penis and his feeling that it was small, and the relationship of this perception to the feeling that his integrity as a person was too small. He kind of emerged from this and

became more accepting of himself and did not use it as an opportunity to plunge himself into a cycle of self denigration and depression. He will bounce back and forth but he knows what it is to feel self-love.

I never think of this man as an "over-sixty" patient. In many ways he is dealing with the developmental issues of a forty-year old man. In any case his issues are quite unrelated to the aging process both in his mind and in mine.

THE CASE OF MRS. U: A second wind at sixty-five

Mrs. U first consulted me two years ago at the age of sixty-three. I have been seeing her individually twice a week and, for the past year and one half, she has also been attending a group one time per week. She had been divorced for ten years after a marriage which had lasted for twenty-six years.

Mrs. U was an extremely accomplished wind instrument musician with a record of public success. An attractive, modestly dressed, youthful looking woman, she complained mainly about depression and anxiety states. She suffered from sleeping disturbance, lack of energy and panic states. She said that she felt as if she were plodding through life and losing the fight, stating that she wanted to gain a better sense of her own strength and ability.

As we explored the precipitating factors for Mrs. U's depression and anxiety, it became clear that she had suffered a number of severe losses during the past two years. A man with whom she had been living subsequent to her divorce, had left her for a much younger woman. In this she felt terribly betrayed. Following this separation she lost a collection of musical scores and instruments which had been on loan to a former acquaintance and which had been lost through his negligence. This was tantamount to a second betrayal. And if that were not enough she had lost much of her savings in a joint speculative venture with yet another friend.

The loss of her boyfriend was a cutting blow. Mrs. U found it a shattering experience to be without a man virtually for the first time in her life. She doubted her desirability and worried that she would never again find a man. The loss of her musical scores and instruments troubled her and she felt that she might not be able to duplicate her special collection. All in all she felt forgotten, undesirable, unwanted, and lost.

Before we began to work together, Mrs. U had consulted two therapists, both of them male. The first therapist had been helpful to her during her divorce, but she felt that the second therapist had been totally disdainful. It seemed to her that he had not been interested in her problems, had not explored the reasons for her creative block (she was dissatisfied with her musical proficiency and unable to write music) and had insulted her by recommending that she get involved in some sort of volunteer work. She left and she did not return.

I found Mrs. U to be likeable, perceptive, very intelligent, and sensitive; a woman who responded with great interest and curiosity to analytic inquiry. We began to explore her current situation and her history.

Mrs. U had been married for twenty-six years to a fellow musician who was less well known than she. In retrospect she came to understand that she had deliberately attempted to keep a relatively low profile

because he was so obviously jealous of her success. She had raised two sons and two daughters, with much devotion and care, in a suburban community where her reputation was one of a good wife and mother. Her artistic accomplishment remained hidden from her neighbors despite the fact that she taught music in a local college. In her treatment she began to understand how much she had held back in her career so as not to compete with her husband.

Mrs. U was always trying to please her husband and never felt secure with him. He was a rejecting, demanding, seductive and cruel man who was given to violent rages and outbursts. Mrs. U was afraid of him and was forever trying to pacify him and to gain his love. Her marriage lacked intimacy, though she felt closeness and love from her children. Mrs. U. left her husband after his abusive violence and threats toward her and she was blamed both by her husband, as well as by her own parents, for breaking up the marriage. She had in fact resolved to leave when her husband ordered her to abandon music because of his own wish to surpass her in this field. She felt threatened to the core and totally committed to her identity as an artist. This she would not, could not, give up. She elected to give up the marriage.

In treatment, Mrs. U realized how much of herself she had renounced during the course of her marriage, and how protective she was towards a husband who was insensitive

to her needs. We began to investigate the roots of her submission, her helplessness and guilt. She started to understand that she had submerged her own wishes to please her husband, much the way she had done as a child in relation to her parents whose approval was always temporary and always dependent upon how "good" a child she was.

Mrs. U grew up in the midwest as a part of a white Anglo-Saxon Protestant family in which she was the older of two daughters. Her father was a distinguished astronomer and a professor at a prestigious university. He was austere and puritanical; strict, aloof, cold, and preoccupied with his career. He had relentlessly high expectations of his children. Mrs. U's mother was a beautiful and vain woman, bright, self-centered and cold. She herself had given up a promising career in physics in order to marry and to raise a family but she actually paid scant attention to her two daughters. She preferred her involvement in social activities while the children were raised by a strict and very punitive British nanny.

A picture of Mrs. U's childhood emerged as not merely lacking in affection but full of fear, punishment and cruelty on the part of her parents and the British nanny. She was afraid of her father who often punished her more severely than he punished her sister. It was her impression that as she grew older, her father became more

respectful of her; and when she grew to adulthood he expressed regret for having been too hard on her during those earlier years. Mrs. U was touched by this and felt that she had forgiven her father for the pain that he had caused her. Later, in treatment, she was to recognize just how much anger she had suppressed, and how much she had suffered from her father's criticisms during her adolescent years. He had been cruel. He had often, during dinner, teased her unmercifully about her table manners while at the same time forbidding her to leave the table. He would insist that she remain seated which she did feeling both humiliated and trapped. After much resistance, as childhood memories were gradually uncovered, Mrs. U finally cried for her times of agony.

Mrs. U's sister was said to have beauty, while she was said to be able and intelligent. Her parents supported the development of her talent and she was permitted to study with the maestros of her choosing. She was in fact given an excellent musical education.

Although the memories of her father were ambivalent and painful, it was the relationship with her mother that was the more difficult to explore and to uncover. This had been the more traumatic relationship. Mrs. U knew that she had never loved her mother although she had been dependent upon her and remained so even as an adult. It was sometime later in the treatment when Mrs. U, moved by my understanding of her feelings as a child, began to cry

stating that she had never had anyone on her side, and that she had never really had a mother. Mrs. U felt that I was the "good mother" that she had never had; the good mother that she sought throughout her life in a series of substitute figures.

A dramatic breakthrough occurred when Mrs. U described a very early screen memory which had repeated itself in nightmares throughout her life and which had been the source of many of her symptoms and panic states. While still a toddler she had been tied up for periods of time presumably as a punishment for masturbation. On one occasion, completely terrified, she started to choke. Someone came and released her. In later years a second cousin verified that when Mrs. U was a child her mother tied her up, behavior which the aunt characterized as deplorable. The choking and terror remained with her for years and she suffered from panic states and asthma. The asthma did not abate until after she left her husband.

I was visibly shaken when I listened to the story for the first time and I was quite literally moved to tears. Mrs. U at first related the experience with dispassion and only later, as she repeatedly retold of the occurrence, was she able to cry for herself again and again. It became clear that being a victim was a "leit-motif" in Mrs. U's life. She had been victimized as a child, she had been victimized in her marriage, and she was victimized

subsequent to its dissolution. But she also had many strengths. She had her talent; in her music she felt most free and alive. She had close friends of many years duration whom she loved. She had children and other relatives who were loving and supportive. She had been an excellent student and had distinguished herself as a musician at a very early age.

In our work together we focused on a core problem which was her inability to ask for what she needed. She did not feel entitled to live for herself and she had little experience in having done so. This issue became central to our work together and one which she addressed as well in her group work.

Mrs. U's tendency to defer to others and to take care of their needs became an important issue in the group where others gently confronted her with her inability to say no or to express anger. Slowly, she became more outspoken. The group experienced proved to be an important adjunct to our work together. It was an unusual group, composed of women in their fifties and sixties, and seventies, who gave each other a good deal of support. Members identified closely with each other finding that they had much in common, not merely in terms of life experience, but interestingly in terms of unconscious dynamics. Each was alone in this period of her life, each had suffered many losses, all were intelligent, intuitive, and shared interests in the arts. Several had had abusive

parents and most had felt deprived of affection and support. They were able to share their experiences with empathy and enormous understanding and this proved to be very helpful to Mrs. U who was much liked and admired.

Treatment enabled Mrs. U to understand that part of her childhood experience had caused her to live in fear of losing people's love. Trapped in her childhood terror and guilt she continued to seek love by constantly trying to please others. She gradually became more assertive, though always in her very gentle way, slowly but surely gaining in strength. She became more straight-forward with people, took greater risks in exposing herself and began to question some of her deeply ingrained constricted WASP heritage. She began to express anger with me and to express anger in the group as well. It seemed that the group held and nurtured her and showed her how one could fight for oneself without untoward consequences.

Mrs. U continues in treatment. Her creative talents have blossomed and expanded and she has once again begun to write music. She is also preparing for a very special recital. She has become far more active socially, and has found a man with whom she is developing a strong and caring relationship. While life is not without its setbacks, Mrs. U feels stronger, more confident and less victimized. I admire her courage, her endurance and I am very much impressed by her growth.

Appendix B

DEMOGRAPHIC DATA ON THE OVER-SIXTY PATIENTS SEEN BY THE SIX SUBJECTS OF THE STUDY

DEMOGRAPHIC DATA

As part of the semi-structured interview, each subject was asked to supply demographic data on patients he had seen who were sixty years of age or older. Subjects were permitted to rely on memory and were not required to consult their appointment books. The purpose of this inquiry was merely to get a "feel" for the kinds of problems that older patients define as bringing them into treatment, as well as to get some sense of how many over-sixty patients these six subjects had seen in treatment.

They data are far from exact. Some subjects remembered their patients more accurately than others. Some subjects included patients who were being seen in hospital clinics, and other subjects included patients whom they had seen for a consultation. Because the data are useful for the intended but very limited purpose of the inquiry, (i.e. what may bring the older patient into treatment?) they are included in this Appendix.

The patients are identified by number. The letter "c" next to the number indicates that the patient was seen in a hospital clinic. The letter "T" next to length of treatment indicates that treatment has terminated. The letter "g" next to # sessions per week indicates that the patient was seen in a group. Patients' ages are generally the current ages of the patients. However, if treatment was of short duration, (two years or less) subjects occasionally gave the age at which the patient began treatment.

FEMALE PATIENTS

pt	age	occupation	length of rx to date	#/wk
1	60	professional	2 yrs T	2

Presenting Problem: chronically anxious and dissatisfied with her considerable achievements.

pt	age	occupation	length of rx to date	#/wk
2	60	professional	1 yr T	2/1

Presenting Problem: divorced woman involved in many affairs and uncertain of the intentions of one of her lovers. Became depressed and phobic during treatment

pt	age	occupation	length of rx to date	#/wk
3	60	business	6 yrs inter.	2

Presenting Problem: severe depression

pt	age	occupation	length of rx to date	#/wk
4	60	artist	1 yr	2

Presenting Problem: depression and addiction following inappropriate medication.

5 60 housewife 3 yrs 1
Presenting Problem: depression associated with metastatic cancer.

6 60 perf.artist 6 mos 3/2
Presenting Problem: recurrent anxiety and writer's block.

7 60 professional 6 mos T 2/1
Presenting Problem: alcoholism and depression; adjustment disorder

8 60 business 3 yrs 2/1
Presenting Problem: reactive depression to difficulties with son.

9 61 housewife 6 mos 1
Presenting Problem: marital complaint

10 61 business 2 yrs 2
Presenting Problem: depression

11 62 housewife 3 mos T 3
Presenting Problem: isolated, and depressed owing to impending death from serious illness.

12 62 business 1 yr T 2
Presenting Problem: depressed, overweight and concerned about the difficulties of a child.

13 62 housewife 1 1/2 yrs 1
Presenting Problem: panic disorder; multiple family problems.

14 62 business 2 yrs 1ind 1g
Presenting Problem: depression following death of husband.

15 63 housewife 1 yr T 1/2
Presenting Problem: depressed when professional children left the home.

16 63 professional 12 sessions 1
Presenting Problem: depressed due to problematic relationship with daughter.

17 63 singer 4 yrs 3
Presenting Problem: anxiety and depression connected to indecision about resumption of singing career

given up during early adulthood.

18 63 musician 1 1/2 yrs 2ind 1g
Presenting Problem: depression and anxiety states following a series of severe losses.

19 63 avocations 1 1/2 yrs 1
10 yrs 2
Presenting Problem: depression related to death of husband.

20 65 business 6 mos 1
Presenting Problem: marital difficulties which exacerbated after husband and patient retired.

21 65 profession 2 yrsT 3/4
Presenting Problem: marital and family problems of longstanding.

22 65 business 4 yrs T 2
Presenting Problem: marital difficulties and contemplating divorce; difficulty in relationships with children.

23 66 business 2 session consultation
Presenting Problem: recurrent depression triggered by death of older male friend and feeling of disloyalty to husband.

24 66 professional 3 mos T 1/2
Presenting Problem: need to assert herself on behalf of a parent whose wishes conflicted with doctors'.

25 66 business 3 mos T 2/1
Presenting Problem: endogenous depression; treated on medication as well by consulting physician.

26 67 professional 2 yrs 1
Presenting Problem: depression at death of boyfriend and loss of job.

27 67 teacher 5 yrs 2/1
Presenting Problem: betrayed by family of origin; wanted legal and psychological recourse.

28 68 writer 2 yrs T 2
Presenting Problem: writer's block and family difficulties.

29 68 housewife 3 mos T 1
Presenting Problem: problematic relationship with daughter.

30 68 writer 6 yrs 1
Presenting Problem: anxiety

31 68 housewife 3 yrs 1ind 1g
Presenting Problem: Family difficulties

32 70 housewife 3 mos T 1
Presenting Problem: physical illness, and physical illness of husband with little in way of financial resources.

33 70 business 2 session consultation
Presenting Problem: phobic about travelling to work; felt family did not value her contributions.

34 70 housewife 6 mos 1
Presenting Problem: depression associated with anger at children

35 70 business Rtd 1 mo 2/3
Presenting Problem: manic

36 71 artist 5 yrs crisis
Presenting Problem: patient comes in times of family difficulty for help with interpersonal problems with married children.

37 72 housewife 10 sessions T 1
Presenting Problem: agoraphobic

38 72 housewife 1 1/2 yrs 1
Presenting Problem: depression triggered by children leaving home area and neurological disease.

39 73 housewife 2 session consultation
Presenting Problem: feared that husband's heart attack would change her life style. Uprepared for possibility of illness in self or husband.

40 73 business 9 mos T 1
Presenting Problem: acute depression following minor surgery which did not have desired result.

41 73 business 14 yrs T 2/3
Presenting Problem: manic depression later
patient also on medication 1 month

42 74 philanthrop 4 yrs T 2
Presenting Problem: beginnings of senile dementia

43 74 housewife 1 yr 1
business
Presenting Problem: depression

44 74 housewife 2 yrs 1
business
Presenting Problem: depression

45 74 business Rtd. 2 yrs T 1
Presenting Problem: accident which led to depression

46 74 charity 3 yrs T 1 dbl
Presenting Problem: felt her adult children were not sufficiently successful and envied accomplishments of others.

47 77 philanthr. 12 yrs varied
Presenting Problem: problematic relationships with family, particularly daughters-in-law.

MALE PATIENTS

1 60 business 1 yr 1
Presenting Problem: marital difficulties

2 60 professional 3 yrs 2
Presenting Problem: problems with intimacy

3 60 professional 5 mos 2
Presenting Problem: marital problems

4 60 professional 2 yrsT 2
Presenting Problem: low self-esteem

5c 61 retired 1 1/2 yrs 1
Presenting Problem: depressed due to inability to fill time satisfactorily following retirement.

6 62 business 1 yr T 1
Presenting Problem: difficulty in asserting himself with parents. (came for treatment with wife)

7 64 teacher 2 yrs 2/1
Presenting Problem: relationships with teenage children; inability to establish a heterosexual relationship.

8 65 business 4 mos T 1
Presenting Problem: marital difficulties; resolved

9c 65 retired 2 yrs . 1/month
Presenting Problem: does not take medication and fights with spouse.

10 66 professional 1 1/2 yrs 1
Presenting Problem: depression following heart attack

11 67 civl svce 1 1/2 yrsT 1
Presenting Problem: suicidal

12 70 artist 1 yr 1ind 1g
Presenting Problem: depressed as a result of forced retirment due to personality problems.

13 70 business 2 yrs 2
Presenting Problem: depression 10 yrs variable
(recent treatment period) 5 yrs 2

14 70 business Rtd 10 yrs 2
Presenting Problem: difficulty with children

15 70 business 5 yrs 4
Presenting Problem; family and potency

16 80 artist 3 yrs 2/1
Presenting Problem: somatic complaints in an obsessive personality disorder

17 86 business Rtd 1 yr 1
Presenting Problem: panic attack following death of wife

Appendix C

THE SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE

The following is the questionnaire that was used for the semi-structured interview. (It was intended that certain areas be covered by the subjects in their responses although this was by no means rigidly followed. This areas are included in the description below, and have been placed in parentheses.)

SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE

Code #_____ M_____ F____ Ph.D.___ M.D.___ Age____

In the broadest sense I shall be trying to answer the following question regarding psychoanalysis or psychoanalytic psychotherapy with the over-sixty patient.

What, in your experience, are the differences (if any) in treating by psychoanalysis or by psychoanalytically informed psychotherapy, someone who is over sixty, as compared with someone who is over thirty. (Note also if the work has made any contributions to the subjects own notion of an interpersonal theory of aging.)

THE INTERVIEW PROPER

1. How did you come to be working with over-sixty patients (was this the usual referral network, an active interest and pursuit, etc.)

2. Prior to working with this age group did you have any particular thoughts about the elderly ?

3. What piques your interest about an older patient? (Does this differ from that of the younger patient; is it a sense of past accomplishments, future potential, empathy with pain or the nature of the symptom; the person who made the referral, etc.)

4. What types of problems tended to be brought in by over-sixty patients? (Are there differences among older patients of different decades, as for example individuals in their 60's, 70's, 80's and 90's; reactions to loss; physical disabilities, phase specific developmental problems; work difficulties; etc.)

5. Do patterns emerge more quickly when you hear the life story of the older patient?

6. How do you characterize movement in the psychoanalytic treatment of the older patient. (Does this differ in any way from how this is conceptualized in work with the younger patient?)

7. How do you set goals? (Does this differ in any way from how goals are set with the younger patient?)

8. Does the patient work in such a way that you or any of your colleagues would consider the work to be psychoanalysis or psychoanalytic psychotherapy? (what about interpretation;
use of transference; nature of the working alliance; analysis of defenses, etc.)

A) Are there characteristic defenses used by the elderly?

B) Are you more or less active with older patients (or is there no change at all based primarily upon age.)

C) Are there special modifications that you make or special techniques that you use in working with this age group?

E) Are there any aspects of psychoanalysis that cannot be transferred to work with elderly patients.

9. Do you work with dreams? (If yes, what are the differences or similarities in your work with patient's dreams or even in the content of your own dreams.)

10. A) What is your feeling, if any, of the relative importance of very early versus later experiences on the personality or the pathology of the patient?

B) Are the elderly as interested in talking about their feelings as are younger patients. What about the expression of feelings in general and in relation to childhood experiences.

11. Is there anything that distinguishes older from younger patients in terms of structure or if you prefer to think of it in other terms, in relation to essential aspects of the personality? (Also, are there any differences with respect to issues of religion and faith; hypochondriacal concerns; sexual needs or concerns; other?)

12. Some people have commented upon the impact of narcissism, dependency needs, and envy on the personalities and problems of the older population, or as specific issues in the treatment. Have you found these to

be influential in either respect in ways that differ from their impact on the lives and treatment of younger patients ?

13. Transference: Some people have remarked on particular differences or attributes of the transference in working with this age group. Do you find any validity in that? If so, how?

(The literature has focused on multigenerational, reversed oedipal, intense or eroticized transferences; as well as upon the experiences of adulthood as sources of transferences. There has also been a concentration on the older patient's need for the therapist as a real person.)

14. Countertransference: Some people have remarked on particular differences or attributes of the countertransference in working with this age group. Do you find any validity in that? If so, how?

(The literature has focused on many aspects of countertransference: fear of dependency needs; own anxieties about aging and death; unresolved feelings about own parents or former analysts; fear of therapeutic impotency; fears that patient will die; difficulties when therapist becomes a "real object"; need to be a rescuer; fear of negative response from colleagues; etc.)

15. Does adult developmental theory influence the way in which you look at patients? If so, how? If not, what is the context in which you work with these patients?

16. Do you have a theory of successful aging? (What contributes to or detracts from successful aging.)

17. Is there anything special about the older patient that might add to the patient's suitability for or competence to do analysis? Are there any particular strengths that the older patient brings to treatment?

DEMOGRAPHIC DATA

I would like to have some general information about the over-sixty patients that you have had in treatment. You need not go back to your appointment books since what you have in memory will be sufficient. Please tell me the age and sex of each patient; the number of times per week you saw each patient, the length of the treatment, and the presenting complaint.

BIBLIOGRAPHY

Aaronson, B. S., (1966). Personality stereotypes of aging. Journal of Gerontology, 21, 458-462

Abraham, K. (1977). The applicability of psychoanalytic treatment to patients at an advanced age. In Selected papers on psychoanalysis (pp.312-317). New York: Basic Books, Inc. (Original work published 1919)

Alexander, F. G. & French, T. M. (1946). Psychoanalytic therapy: Principles and applications. New York: Ronald Press.

Arnhoff, F. N., Freeman, L. C., & Parlagreco, M. L. (1960). Projected symptoms of old age and present person assessment. Journal General Psychology, 62, 37-41.

Baltes, P. B., & Skinner, E. A. (1983). A life-span study continued. Science, 220, pp. 62-63.

Barrett, C. J. (1978). Effectiveness of widow's groups in facilitating change. Journal of Consulting and Clinical Psychology, 48, 20-31.

Becker, E. (1973). The denial of death. New York: The Free Press, Macmillan Publishing Co.

Beitman, B. D. (1983). Categories of Countertransference. Journal of Operational Psychiatry, 14(2), 82-90.

Berezin, M. A. (1972). Psychodynamic considerations of aging and the aged: An overview. American Journal of Psychiatry, 128:12, 33-41.(Original work published 1963)

Berezin, M. A. (1978). Some intrapsychic aspects of aging. In N. E. Zinberg and I. Kaufman (Eds.), Normal psychology of the aging process (pp. 75-98). New York: International University Press.

Berezin, M. A. (1983). Psychotherapy of the elderly. Aspects of aging (Report No. 4) Smith Kline & French Laboratories.

Berezin, M. A. (1987). Reflections on psychotherapy with the elderly. In J. Sadavoy, & M. Leszcz, (Eds.), Treating the elderly with psychotherapy (pp. 45-63). Madison: International Universities Press, Inc.

Berland, D. I. (1979). Expressive group psychotherapy

with the aging. International Journal of Group Psychotherapy, 29(1), 87-108.

Bibring, E. (1954). Psychoanalysis and the dynamic psychotherapies. Journal American Psychoanalytic Association, 2, 745-770.

Birren, J. E. (1965). Reactions to loss and the process of aging: Interrelations of environmental changes, psychological capacities, and physiological status. In M.A. Berezin, & S. H. Cath, (Eds.), Geriatric psychiatry: Grief, loss and emotional disorders in the aging process (pp.96-108). New York: International University Press.

Blank, M. (1977). Raising the age barrier to psychotherapy. Geriatrics. In S. Steury and M. Blank (Eds.). Readings in psychotherapy with older people (pp 62-67). Rockville, Md. National Institute of Mental Health (original work published 1974)

Blaser-Andreas B. (1980). Role of stereotypes in selecting patients for psychotherapy. Psychotherapy & Psychosomatics, 33(1-2), 59-68.

Blum, J. E. & Tross, S. (1980). Psychodynamic treatment of the elderly: A review of issues in theory and practice. Annual Review of Geriatrics and Gerontology, 1(10), 204-237.

Braceland, F. J. (1977). The mental hygiene of aging: Present-Day views. In S. Steury, & M. Blank (Eds.). Readings in psychotherapy with older people (pp. 73-78). Rockville, Md. National Institute of Mental Health (original work published 1972)

Braceland, F. J. (1979). Aging: From the inside and outside. The Eighteenth Carrier Foundation Symposium. New Jersey: Roche Laboratories, Division of Hoffman-LaRoche Inc.

Brink, T. L. (1979). Geriatric psychotherapy. New York: Human Sciences Press.

Brower, H. T. (1985). Do nurses stereotype the aged? Journal of Gerontological Nursing, 11(1), 17-28.

Butler, R. N. (1963). The life review: An interpretation of reminiscence in the aged. Psychiatry, 26, 65-75.

Butler, R. N. (1967). Aspects of survival in human aging. American Journal Psychiatry, 123, 1233-1243.

Butler, R. N. (1975). Psychiatry and the elderly: An overview. American Journal Psychiatry, 132, 893-900.

Butler, R. N. (1975). Psychotherapy in old age. In D. Freedman & J. Dyrud (Eds.), American Handbook of Psychiatry (Vol. 5, 2nd ed., pp. 805-828). New York: Basic Books

Butler, R. N. (1977). Myths and realities of clinical geriatrics. In S. Steury and M. Blank (Eds.). Readings in psychotherapy with older people (pp 79-85) Rockville, Md. National Institute of Mental Health (Original work published 1970)

Butler, R. N. (1979). Care of the elderly, special needs for special people. Resident and Staff Physician, September, 43-47.

Butler, R. N. (1980). Ageism A forward. Journal of Social Issues, 36(2), 8-11.

Butler, R. N. (1983). An overview of research on aging and the status of gerontology today. Milbank Memorial Fund Quarterly/Health and Society, 61(3), 251-61.

Butler, R.N. (1986, May/June). How to create effective care spectrum? Money is there for needed health system reforms. Perspective on Aging, 4-6.

Cath, S. (1986). A psychoanalytic hour: A late-life awakening. In L. Lazarus (Ed.). Clinical approaches to psychotherapy. Clinical Insights, (pp. 2-13). The Monograph Series of the American Psychiatric Press, Inc. Washington, D.C.

Chacko, R. C., Knox, D. & Blattstein, A. (1983). A developmental minority: The elderly and mental health care. The American Journal of Social Psychiatry 111, 2, 36-41.

Coe, R. (1967). Professional perspectives on the aged. Gerontologist, 7, 114-119.

Cohen, G. D. (1976). Mental health services and the elderly: Needs and options. American Journal of Psychiatry, 133:1, 65-68.

Cohen, G. D. (1977). Approach to the geriatric patient. Medical Clinics of North America, 61(4), 855-866.

Colarusso, C., & Nemiroff, R. (1981). Adult development, a new dimension in psychodynamic theory and practice. New York: Plenum Press.

Colett, I., & Griffith, S., & Z. I., J. (1984). Some problems with the concept of normal aging. Journal of Operational Psychiatry, 15, 51-54.

Comfort, A. (1980). On going to the forest: Geriatrics and pastoral thanatology. Journal of Operational Psychiatry, 11(1), 33-40.

Corin, E. (1982). Elderly people's social strategies for survival:A dynamic use of social networks analysis. Canada's Mental Health, September, 7-12.

Cyrus-Lutz, C., & Gaitz, C. M., (1972). Psychiatrists' attitudes toward the aged and aging. The Gerontologist, 12, 163-166.

Editorial (1980). Shadow of death over aging. Science, 207:4438, 1

Eisdorfer, C. (1978). Societal response to aging: Some possible consequences. In L. Jarvik (Ed.) Aging into the 21st century (pp. 123-135). New York, Gardner Press.

Eisdorfer, C. (1980). Stress, coping style and aging (Report 11). Smith, Kline & French Laboratories, Socialcultural Factors.

Eisdorfer, C. (1983). Conceptual models of aging - the challenge of a new frontier. American Psychologist, 38(2), 197-202.

Epstein, L., & Feiner, H. (Eds.). (1979). Countertransference. New York: Jason Aronson, Inc.

Erikson, E. H. (1980). Identity and the life cycle. New York: W. W. Norton.

Estes, C. L. (1980). Constructions of reality. Journal of Social Issues, 36(2), 117-132.

Fenichel, O. (1945). Psychoanalytic theory of neurosis. New York: Norton

Ford, C. V., & Sbordone, R. J., (1980). Attitudes of psychiatrists toward elderly patients. American Journal of Psychiatry, 137, 571-575.

France, M. H. (1982). Seniors helping seniors: A model of peer counselling for the aged. Canada's Mental Health, September, 13-14.

Gaitz, C. M. (1974). Barriers to the delivery of psychiatric services to the elderly. The Gerontologist, 14, 210-214.

Gallagher, D., Thompson, L. W. & Levy, S. M. (1980). Clinical psychological assessment of older adults. In L. Poon (Ed.) Aging in the 1980's (pp. 19-40). Washington, D.C.: American Psychological Association.

Galton, G. (1975). Don't give up on an aging parent. New York: Crown Publishers, Inc.

Garetz, F. (1975). The psychiatrist's involvement with aged patients. American Journal of Psychiatry, 132:1, 63-65.

Garfinkel, R. (1975). The reluctant therapist 1975. Gerontologist, 15, 136-137.

Garner, J. D., & Mercer, S. O. (1982). Meeting the needs of the elderly: Home health care of institutionalization? Health and Social Work, 183-191.

Gatz, M., Smyer, M.A., & Lawton, M.P. (1980). The mental health system and the older adult. In L. W. Poon (Ed.), Aging in the 80's: Psychological issues (pp. 5-18). Washington, DC: American Psychological Association.

Geiger, D.L. (1978). How future professionals view the elderly: A comparative analysis of social work, law and medical student's perceptions. Gerontologist, 18, 591-594.

Getzel, G. S. (1981). Helping elderly couples in crisis. Unpublished manuscript.

Ginsburg, A., & Goldstein, S. (1974). Age bias in referral for psychological consultation. Journal of Gerontology, 29(4), 410-415.

Gitelson, M. (1948). The emotional problems of elderly people. Geriatrics, 3, 135-50.

Glass, C., & Knott, E.S. (1982). Effectiveness of a workshop on aging in changing middle aged adults' attitudes toward the aged. Educational Gerontology, 8, 359-372.

Goldfarb, A.I. (1955). Psychotherapy of aged persons: One aspect of the psychodynamics of the therapeutic situation with aged patients. Psychoanalytic Review, 42, 180-187.

Goldfarb, A.I. (1977). Psychiatry in geriatrics. In S. Steury, & M. Blank (Eds.), Readings in psychotherapy with older people (pp. 173-181). Rockville, Md.: National Institute of Mental Health (original work published 1967)

Goldfarb, A. I. (1978). A psychosocial and sociophysiological approach to aging. In N. E. Zinberg and I. Kaufman (Eds.). Normal psychology of the aging process. New York: International University Press.

Goldfarb, A.I., & Sheps, J. (1977). Psychotherapy of the aged. In S. Steury, & M. Blank (Eds.), Readings in psychotherapy with older people (pp. 182-192). Rockville, Md: National Institute of Mental Health. (original work published 1954)

Gorkin, M. (1987). The uses of countertransference. New Jersey: Jason Aronson, Inc.

Gould, R. (1972). The phases of adult life: A study in developmental psychology. American Journal Psychiatry, 129, 521-531.

Green, S. K. (1981). Attitudes and perceptions about the elderly: Current and future perspectives. International Journal of Aging and Human Development, 13(2), 99-119.

Grotjahn, M. (1940). Psychoanalytic investigation of a seventy-one-year-old man with senile dementia. Psychoanalytic Quarterly, 9, 80-97.

Grotjahn, M. (1951). Some analytic observations about the process of growing old. Psychoanalysis and the Social Sciences, 3, 301-312.

Grotjahn, M. (1955). Analytic psychotherapy with the elderly. Psychoanalytic Review, 42, 419-427.

Grunes, J. M. (1987). The aged in psychotherapy: Psychodynamic contributions to the treatment process. In J. Sadavoy, & M. Leszcz, (Eds.), Treating the elderly with psychotherapy (pp. 31-44). Madison: International Universities Press, Inc.

Gutmann, D. L. (1982). Training in the clinical psychology of aging: Observations and recommendations. In J. F. Santos & G. R. Vandenbos (Eds.), Psychology and the older adult: Challenges for training in the 1980s (pp. 97-107). Washington, D.C: American Psychological Association.

Gutmann, D. L., Grunes, J., & Griffin, B. (1980). The clinical psychology of later life: Developmental paradigms. In N. Datan & & N. Lohmann (Eds.), Transitions of aging (pp. 119-131), New York: Academic Press, Inc.

Henig, R. M. (1978, December 3). Exposing the myth of senility. The New York Times Magazine, pp. 158-167.

Hicks, D. A., Rogers, J. C. & Shemberg, K. (1976). Attitudes toward the elderly: A comparison of measures. Experimental Aging Research, 2, 119-124.

Holtzman, J. M., Beck, J. D., & Coggan, P.G., (1978). Geriatrics program for medical students. 11. Impact of two educational experiences on student attitudes. Journal of the American Geriatrics Society, 26(8), 355-359.

Horowitz, M. J., & Wilner, N. (1980). Life events, stress, and coping. In L. W. Poon (Ed.), Aging in the 1980's: Psychological issues (pp. 363-374), Washington, DC: American Psychological Association.

Hunter, A. J. G. (1980). Brief psychotherapy for unresolved grief in an 82-year-old-man. Journal of Geriatric Psychiatry, 14(2), 247-262.

Jacques, E. (1965). Death and the mid-life crisis. International Journal of Psychoanalysis, 46, 502-514.

Jarvik, L. F., (1978). Aging into the 21st Century - Middle-agers today. New York: Gardner Press, Inc.

Jung, C. G. (1954). The aims of psychotherapy. In Sir H. Read, M. Fordham, & G. Adler (Eds.). Collected works of C.G. Jung, Vol. 16 (pp. 36-52). New York, Pantheon Books.

Kahana, R. J. (1978). Psychoanalysis in later life. Journal Geriatric Psychiatry, 11(37), 37-49.

Kahana, R. J. (1979). Strategies of dynamic psychotherapy with the wide range of older individuals. Journal of Geriatric Psychiatry, 12 (1): 71-100.

Kahana, R. J. (1987). Geriatric psychotherapy: Beyond crisis management. In J. Sadavoy, & M. Leszcz, (Eds.). Treating the elderly with psychotherapy (pp. 233-263). Madison: International Universities Press, Inc.

Karasu, T. B., Stein, S. P. & Charles, E. S. (1979). Age factors in patient-therapist relationship. The Journal of Nervous & Mental Disease, 167(2), 100-104.

Karpf, R. J. (1980). Modalities of psychotherapy with the elderly. Journal of the American Geriatrics Society, 28 (8): 367-371.

Kaufman, R. (1940). Old age and aging: The psychoanalytic point of view. American Journal Orthopsychiatry, 10, 73-79.

Kaufman, I. (1978). Psychodynamic considerations in normal aging. In N. E. Zinberg and I. Kaufman (Eds.) Normal psychology of the aging process (pp. 99-106). New York: International University Press.

Kastenbaum, R. (1963). The reluctant therapist. Geriatrics, 18, 296-301.

Kernberg, O. F. (1980). Pathological narcissism in middle age. In O.Kernberg, Internal world and external reality, object relations theory applied (pp. 135-153). New York: Jason Aronson.

King, P. (1974). Notes on the psychoanalysis of older patients. Journal of Analytic Psychology, 19, 23-27.

King, P. (1980). The life cycle as indicated by the nature of the transference in the psychoanalysis of the middle-aged and elderly. International Journal Psycho-Analysis, 61, 153.

Kleemeier, R. W. (1958). Somatopsychologic effects of illness in the aged person. Geriatrics, 13, 441-449.

Klein, M. (1980). Envy and Gratitude. In Melanie Klein (Ed.), Envy and gratitude and other works (pp. 176-235). London: The Hogarth Press and the Institute of Psychoanalysis. (Original work published 1957)

Kogan, N. (1979). Beliefs, attitudes, and stereotypes about old people. Research on Aging, 1(1), 11-36.

Kogan, N., & Shelton, F. C. (1962). Beliefs about "old people": A comparative study of older and younger samples. The Journal of Genetic Psychology, 100, 93-111.

Kogan, N., & Shelton, F. C. (1962). Images of "old people" and "people in general" in an older sample. Journal of Genetic Psychology, 100, 3-21.

Lawton, G. (1952). Psychotherapy with older persons. Psychoanalysis, 1(2), 27-41.

Lawton, P. M. (1976). Geropsychological knowledge as a background for psychotherapy with older people. Journal of Geriatric Psychiatry, 9(2), 221-233.

Levenson, B. A. (1985). The interpersonal model. In A. Rothstein (Ed.), Models of the mind (pp.49-67). New York: International Universities Press, Inc.

Levin, S., & Kahana, R. J. (Eds.). (1967). Psychodynamic studies on aging: Creativity, reminiscing, and dying. New York: International Universities Press, Inc.

Levine, D. M. (1975). Staffing patterns and professional profiles of the health care manpower. Gerontologist, 15(4), 314-317.

Levinson, D. (1978). Eras: The anatomy of the life cycle. Psychiatric Opinion, 10-11, 39-47.

Levinson, D., Darrow, C.N., Klein, E.B., Levinson, M.H., McKee, B. (1978). The seasons of a man's life. New York: Alfred A. Knopf.

Levy, S. M., Derogatis, L. R., Gallagher, D., & Gatz, M. (1980). Intervention with older adults and the evaluation of outcome. In L. W. Poon (Ed.), Aging in the 1980s (pp. 41-61). Washington, D.C: American Psychological Association.

Lewis, J. M., & Johansen, Keith, H. (1982). Resistances to psychotherapy with the elderly. American Journal of Psychotherapy, 36(4), (497-504).

Lewis, M. and Butler, R. (1974). Life review therapy: Putting memories to work in individual and group psychotherapy. Geriatrics, 29, 165-173.

Lidz, T. (1980). Phases of adult life: An overview. In W. Norman and T. Scaranella (Eds.). Mid-Life Developmental and Clinical Issues (pp. 20-37), New York: Brunner/Mazel.

Lindemann, E. (1944). Symptomotology and management of acute grief. American Journal of Psychiatry, 101, 141-149.

Linden, M. E. (1956). The older person in the family. Social Casework, 37, 75-81.

Linden, M. E. (1957). Effects of social attitudes on the

mental health of the aging. Geriatrics, 12, 109-114.

Linden, M. E. (1958). Some sociopsychological implications in aging. Changing concepts in the care of the aged. American Journal Orthopsychiatry, 28, 322-328.

Linden, M. & Courtney, P. (1953). The human life cycle and it's interruptions: A psychologic hypothesis. Studies in gerontologic human relations. American Journal Psychiatry, 109, 906-915.

Lionells, M., & Mann, C. H. (1974). Patterns of mid-life in transition. Unpublished manuscript.

Loch, W. (1982). Comments on Dr. Norman A. Cohen's Paper: "On loneliness and the aging process". International Journal of Psychoanalysis, 63, 267-273.

Luborsky, L., & Chandler, M., & Auerbach, A., & Cohen, J. & Bachrach, H. M. (1971). Factors influencing the outcome of psychotherapy A review of quantitative research. Psychological Bulletin, 75(3), 145-185.

Mann, C. (1985). Adult development: Individuation, separation and the role of reality. Contemporary Psychoanalysis, 21(2), 284-296.

Mann, C. & Lionells, M. (1976). A proposal to study depressive elements in mid-life. Unpublished manuscript.

McTavish, D. (1971). Perceptions of old people: A review of research methodologies and findings. Gerontologist, 11(4), 90-101.

Meerloo, J. A. (1955). Transference and resistance in geriatric psychotherapy. Psychoanalytic Review, 42, 72-82.

Miller, D. B., & Lowenstein, R., & Winston, R. (1976). Physician's attitudes toward the ill aged and nursing homes. Journal of the American Geriatrics Society, 24, 498-505.

Miller, N. E. (1981). The narcissistic personality in later life. Abstract of paper sponsored by the Division on Psychoanalysis presented at the 89th annual meeting of the American Psychological Association, Los Angeles, California

Miller, N.E. (1986). The psychoanalysis of the older patient. Journal of the American Psychoanalytic

Association, 34(1), 163-177.

Monk, A., & Kaye, L. W. (1982). Gerontological knowledge and attitudes of students of religion. Educational Gerontology, 8(5), 435-445.

Mueller, J. (1977). A bibliography of doctoral dissertations of aging from American institutions of higher learning 1974-76. Journal of Gerontology, 32(4), 480-490.

Muslin, H. (1986). Psychoanalysis in the elderly: A self-psychological approach. In L. Lazarus, (Ed.) Clinical approaches to psychotherapy with the elderly. (pp. 56-71). (Clinical Insights, The Monograph Series of the American Psychiatric Press, Inc., Washington, D.C.

Myers, W. A. (1984). Dynamic therapy of the older patient. New York: Jason Aronson, Inc.

Myers, W. A. (1985). Sexuality in the older individual. The Journal of the Academy of Psychoanalysis, 13(4), 511-520.

Myers, W. A. (1986, January). Transference and countertransference Issues in treatments involving older patients and younger therapists. Paper presented at the meeting of the Association for Psychoanalytic Medicine, New York, N.Y.

Myerson, P. G. (1978). Psychoanalysis in later life. Journal Geriatric Psychiatry, 1(37), 57-66.

Naus, P. J. (1973). Some correlates of attitudes towards old people. International Journal of Aging and Human Development, 4, 229-243.

Neugarten, B. (1978). The future and the young-old. In L. Jarvik (Ed.), Aging into the 21st century - Middle agers today (pp. 137-152). New York: Gardner Press

Neugarten, B. (1979). Time, age and the life cycle. The American Journal of Psychiatry, 136(7), 887-894.

Neussel, F. J., Jr. (1982). The language of ageism. The Gerontologist, 22(3), 273-76.

Oberleder, M. (1967). Adapting current psychological techniques for use in testing the aging. The Gerontologist, 7(3), 188-191.

Otto, H. A. (1964). Research on human potentialities:

Application to geriatric programs. Journal of the American Geriatrics Society, 12(7), 677-688.

Paolino, T. (1981). Some similarities and differences between psychoanalysis and psychoanalytic psychotherapy: An unsettled controversy. Journal of Operational Psychiatry, 12, 106-114.

Pardes, H. (1981). The aging: Mental health problems. New York State Journal of Medicine, April, 798-801.

Pfeiffer, E. M.D. (1979). Psychotherapy of the elderly. Proceedings of the Eighteenth Carrier Foundation Symposium (pp. 33-37). Nutley, New Jersey: Roche Laboratories.

Person, E. S. (1986). Women in therapy: Therapist gender as a variable. In H. Meyers (Ed.). Analyst & patient: Dimensions in countertransference and transference (pp. 193-212). New Jersey: The Analytic Press.

Pollock, G. (1981). Reminiscences and insight. In Solnit, A. J., & Eissler, R., & Freud, A., & Kris, M., & Neubauer, P.B. (Eds.), The psychoanalytic study of the child (pp. 279-297). New Haven: Yale University Press.

Pollock, G. (1982). On aging and psychopathology. International Journal of Psychoanalysis, 63, 275-281.

Pollock, G. (1987). The mourning-liberation process: Ideas on the inner life of the older adult. In J. Sadavoy, & M. Leszcz, (Eds.). Treating the elderly with psychotherapy (pp. 3-29). Madison: International Universities Press, Inc.

Poon, L. W., & Welford, A. T. (1980). Prologue: A historical perspective. In L. W. Poon (Ed.), Aging in the 80's: Psychological issues (pp. ix-xii). Washington, DC: American Psychological Association.

Rabins, P. V., & Motts, L. Z. (1981). Changing staff attitudes encountered in establishing a psychogeriatric unit. Hospital and Community Psychiatry, 32, 729-730.

Ratna, L. (1982). Crisis intervention in psychogeriatrics: A two-year follow-up study. British Journal of Psychiatry, 141, 296-301.

Rechtschaffen, A. (1977). Psychotherapy with geriatric patients: A review of the literature. In Steury, S., M. D., & Blank, M. L. (Eds.), Readings in psychotherapy with older people (pp. 45-61). Rockville

Md.: National Institute of Mental Health. (Original work published 1959)

Reisman, D. (1954). Some clinical and cultural aspects of aging. American Journal of Sociology, 59, 379-383.

Robb, S. (1978). Beliefs and behavioral intentions of student nurses toward the elderly. Unpublished doctoral dissertation, University of Pittsburgh, Pennsylvania.

Robiner, W. (1987). An experimental inquiry into transference roles and age. Psychology and Aging, 3, 306-311.

Robiner, W., & Storenet, M. (1983). Client perceptions of the therapeutic relationship as a function of client and counselor. Journal of Consulting Psychology 30(1), 96-99.

Roche Report: (1978) Modifying physicians' negative attitudes toward the elderly. Frontiers of Psychiatry, (Roche Laboratories). Nutley, N.J.

Roche Report: (1982) Geropsychiatry: is it ready to meet the growing demand? Frontiers of Psychiatry, (Roche Laboratories). Nutley, N.J. 12:1, 12-13

Rodin, J., & Langer, E. (1980). Aging labels: The decline of control and the fall of self-esteem. Journal of Social Issues, 36(2), 12-29.

Rosencranz, H. A., & McNevin, T. E. (1969). A factor analysis of attitudes towards the aged. Gerontologist, 9, 55-59.

Rosenthal, M. (1983). Geriatrics: A selected up-to-date bibliography. Journal of the American Geriatrics Society, 3(2), 83-98.

Rowe, J. W., & Kahn, R.L. (1987) Human aging: Usual and successful. Science, 237, 143-149.

Rubin, R. (1977). Learning to overcome reluctance for psychotherapy. Journal Geriatric Psychiatry, 10(2), 215-227.

Rudd, T.N. (1958). Old age: The completion of a life cycle. Journal American Geriatric Society, 6, 1-9.

Rustin, S. L., & Wolk, R. L. (1963). The use of specialized group psychotherapy techniques in a home for the aged. Group Psychotherapy, 16(1-2), (25-29).

Sachs, B. C. (1983). Aging well. Psychosomatics, 24(3), 225-230.

Sadavoy, J. (1987). Character disorders in the elderly: An overview. In J. Sadavoy, & M. Leszcz, (Eds.). Treating the elderly with psychotherapy (pp. 175-229). Madison: International Universities Press, Inc.

Sadavoy, J., & Leszcz, M. (1987). Treating the elderly with psychotherapy. Madison: International Universities Press, Inc.

Salter, C., & Salter, C. (1976). Attitudes toward aging and behavior toward the elderly among young people as a function of death anxiety. The Gerontologist, 16, 232-236.

Sandler, A. (1978). Psychoanalysis in later life. Problems in the psychoanalysis of an aging narcissistic patient. Journal Geriatric Psychiatry, 11(37), 5-36.

Santos, J., & Vandenbos, G. (Eds.). (1982). Psychology and the older adult: Challenges for training in the 1980s. Washington, D.C: American Psychological Association.

Schilder, P. (1940). Psychiatric aspects of old age and aging. American Journal of Orthopsychiatry, 10, 62-72.

Schoenewolf, G. (1987). Countertransference and counterresistance. In R. C. Robertiello, & G. Schoenewolf (Eds.) 101 Common therapeutic blunders, (pp. 3-14). New Jersey: Jason Aronson, Inc.

Secourd, P. F., & Jourard, S. M. (1953). The appraisal of body-cathexis: Body-cathexis and the self. Journal of Consulting Psychology, 17, 343-347.

Shainess, N. (1979). Analyzability and capacity for change in middle life. Journal of the American Academy of Psychoanalysis, 7(3), 385-403.

Shapiro, D. (1985). Psychotherapy and subjective experience. Psychiatry, 48, 311-317.

Silberschatz, G., & Curtis, J. (1982). Research on the psychodynamic process in the treatment of older persons. Paper presented at the conference on psychodynamic research perspectives on development, psychopathology, and treatment in later life. Sponsored by the National Institute of Mental Health, Bethesda, Maryland.

Simburg, E.J. (1986). Psychoanalysis of the older patient. Journal of the American Psychoanalytic Association, 34, 117-132.

Sobel, E. (1980). Countertransference issues with the later life patient. Contemporary Psychoanalysis, 16(2), 211-222.

Solomon, K., & Vickers, R. (1979). Attitudes of health workers toward old people. Journal of the American Geriatrics Society, 27, 186-191.

Sparacino, J. (1978). Individual psychotherapy with the aged: A selective review. International Journal Aging Human Development, 9(3), 197-220.

Spence, D. L., Feigenbaum, E. M., Fitzgerald, F., & Roth, J. (1968). Medical student attitudes toward the geriatric patient. Journal of the American Geriatrics Society, 16(9), 976-983.

Stead, E. A., Jr., & Stead, N. W. (1980). Problems and challenges in the treatment of the aging patient. Disease of the Month, 26(1), 5-41.

Steer, R. A., & Boger, W. P. (1975). Milieu therapy with psychiatric-medically infirm patients. The Gerontologist, April, 138-141.

Stern, K., & Smith, J. M. & Frank, M. (1953). Mechanisms of transference and countertransference in psychotherapeutic and social work with the aged. American Journal of Gerontology, 8, 328-332.

Stern, K., & Williams, G. M., & Prados, M. (1951). Grief reactions in later life. American Journal Psychiatry, 108, 289-294.

Steury, S. (1977). The later years: A psychological perspective. In S. Steury & M. L. Blank (Eds.), Readings in psychotherapy with older people (pp. 45-61). Rockville, Md.: National Institute of Mental Health. (Original work published 1976)

Steury, S., & Blank, M. (Eds.). (1977). Readings in psychotherapy with older people. Rockville, Md.: National Institute of Mental Health.

Thompson, C. (1950). Psychoanalysis: Evolution and development. New York: Hermitage House.

Thorson, J. A., & Whatley, L., & Hancock, K. (1974). Attitudes toward the aged as a function of age and

education. Gerontologist, 14, 316-318.

Tuckman, J., & Lorge, I. (1953). Attitudes toward old people. The Journal of Social Psychology, 37, 249-260.

Tuckman, J., & Lorge, I. (1953). When aging begins and stereotypes about aging. Journal of Gerontology, 8, 489-492.

Tuckman, J., & Lorge, I. (1956). Perceptual stereotypes about life adjustment. Journal of Social Psychology, 43, 239-245.

Tuckman, J., & Lorge, I. (1958). Attitude toward aging of individuals with experiences with the aged. The Journal of Genetic Psychology, 92, 199-204.

Tuckman, J., & Lorge, I. (1958). The projection of personal symptom into stereotype about aging. Journal of Gerontology, 13, 70-73.

Tuckman, J., Lorge, I., & Spooner, G. A. (1953). The effect of family environment on attitudes toward old people and the older worker. The Journal of Social Psychology, 38, 207-218.

Vaillant, G. (1977). Adaptation to life. Boston: Little, Brown.

Waslenki, D. (1982). The psychogeriatric problem. Canada's Mental Health, September, 16-19.

Wass, H., & Meyers, J. E. (1982). Psychosocial aspects of death among the elderly: A review of the literature. Personnel and Guidance Journal, 61(3), 131-137.

Wayne, G.J. (1953). Modified psychoanalytic therapy in senescence. Psychoanalytic Review, 40, 99-116.

Weinberger, L.E., & Millham, J. (1975). A multi-dimensional, multiple method analysis of attitudes toward the elderly. Journal of Gerontology, 30, 342-345.

Wenkart, A. (1967). Death in life. Journal of Existentialism, 8(29), 75-90.

Wheelwright, J. B. (1959). Some comments on the aging process. Psychiatry, 22, 407-411.

Wilensky, H., & Barmack, J.E. (1966). Interests of doctoral students in clinical psychology in work with older adults. Journal of Gerontology, 21(3), 410-414.

Wilensky, H., & Weiner, M. B. (1977). Facing reality in psychotherapy with the aging. Psychotherapy: Theory, Research and Practice, 14(4), 373-378.

Williams, G. O., & Gjerde, C. L., & Johnson, R. E. (1982). Self-ratings of skills in geriatric medicine by family physicians. Journal of Family Practice, 15(5), 1000-1007.

Williams, T.F. (1982). Aging: Perceptions, myths, and the future. Medical Review, Spring, 2-6.

Wilner, M. (1978). Individual psychotherapy with the depressed elderly outpatient: An overview. Journal American Geriatric Society, 26(5), 231-235.

Wilner, M. & Maizler, J. (1978). A Horneyan perspective on psychotherapy for the aged. Psychiatric Annals 8:11, 607-613.

Wilson, R. W., & Glamsu, F.D. (1982). The impact of gerontological intervention of osteopathic medical students. Educational Gerontology, 8(4), 373-380.

Wolff, K. (1971) Individual psychotherapy with geriatric patients. Psychosomatics, 12, 89-93.

Wolk, R., & Wolk, R. (1971). Professional workers' attitudes toward the aged. Journal of the American Geriatrics Society, 19, 624-639.

Wylie, H. W., Jr. & Wylie, M. L. (1987). The older analysand: Countertransference issues in psychoanalysis. International Journal of Psychoanalysis, 68, 343-352.

Yalom, I. D. (1987). Foreword. In J. Sadavoy, & M. Leszcz, (Eds.). Treating the elderly with psychotherapy (pp. ix-xiii). Madison: International Universities Press, Inc.

Zimring, J. G. (1977). Physician and geriatric patient. New York State Journal of Medicine, 77, 968-970.

Zinberg, N. E. (1978). The relation of regressive phenomena to the aging process. In N. E. Zinberg and I. Kaufman (Eds.), Normal psychology of the aging process (pp. 123-138). New York: International University Press.

Zinberg, N. E. (1978). Social learning and self-image in aging. In N. E. Zinberg and I. Kaufman (Eds.), Normal

psychology of the aging process (pp. 159-176). New York: International University Press.

Zinberg, N., & Kaufman, I. (1978). *Normal psychology of the aging process.* New York: International University Press.