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Psychotherapeutic/Psychoanalytic Treatment of the Elderly

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Abstract

Elderly patients who may have been able to deal satisfactorily with earlier periods of stress may find that in latter life they are impacted by an array of devastating losses and crises subverting their abilities to adapt satisfactorily. Psychotherapeutic/psychoanalytic treatment has been demonstrated to be helpful to many elderly patients, especially if the psychotherapist/psychoanalyst chooses to relax a traditional analytic stance and actively engage the patient with the exploration of new relationships and activities which may relieve any residual loneliness.

We also propose that an alternative concept of termination be considered which includes the possibility of post-termination follow-up contacts between patient and analyst. We detail the advantages of this

conception both for patient and analyst, which may be particularly useful for elderly patients.

Introduction

We know of no consensus definition of “elderly”; it varies with epoch and society. While defined as ages 55 and older in Freud’s day, post-industrial retirement and government programs have moved the marker to 65. The American Psychoanalytic Association, for example, proscribes a training analyst from beginning a training analysis with a new candidate after the training analyst is 70-and-a-half years old, presumably to protect the candidate from loss. One concept of old age places it at those ages nearing or surpassing the average span of human beings. Wikipedia reports that white Americans born in 2010 are expected to live until age 75.9 African Americans to live to 75.1 years and Hispanic Americans to 81.2 years. We arbitrarily suggest (for this paper) that the elderly be considered 75 years or older

Psychotherapists/psychoanalysts treat individuals, and the concept of statistical averages has limited meaning. Many individuals today live far beyond age 75, and this group is the focus of our paper.

Psychotherapeutic/psychoanalytic treatment of the elderly revealed problematic attitudes at its start since Freud (1905) (facing 50) believed that psychoanalysis was not appropriate for his age group and beyond; “On the one hand near or above fifty the elasticity of the mental processes, on which the treatment depends, is, as a rule, lacking” (p. 264). Freud may also have been influenced by his assumption that libidinal activity was sharply diminished in this age group, and, therefore access to, and the interpretation of those libidinal conflicts he considered central to analytic treatment, might

not be feasible. Abraham (1919), however, fourteen years later, wrote about the value of psychoanalysis with patients “of advanced years”. Recently Settlage (1996) felt that the matter had been settled by the subsequent reported treatment experiences of analysts; “The myth of the unsuitability of middle-aged and elderly individuals for psychoanalytic treatment has been dispelled” (p. 548); (Cath, 1990; Cath & Miller, 1986; Coltart, 1991; Crusey, 1985; Dunn, 1997; Griffin and Grunes, 1987; Kahana, 1993; Limentani, 1995; Lipson, 2002; Nemiroff and Colarusso, 1985;1990; Panel Report 1986; Sandler, 1984; Segal, 1958; Simburg, 1985; Wagner, 2005). Erikson (1959; Erikson et al., 1986) included old age in his articulation of lifecycle stages and Settlage added that “The concept of adult development, including in old age, has received increasing exposition and acceptance (Crusey, 1985; Gould, 1990; Griffin & Grunes, 1990; Levinson, 1985; Nemiroff & Colarusso, 1981, 1985, 1990; Settlage, 1996; Simberg, 1985)”.

Settlage (1996) graphically described two periods of psychotherapeutic/psychoanalytic treatment of a woman poet at ages 94 and 99 years. In his discussion he considered whether the described treatment was psychoanalysis:

“I believe that psychoanalysis as a method of treatment is most cogently defined by its therapeutic action—by structural change resulting from the engagement and progression of psychoanalytic therapeutic process.

The patient clearly had the capacities needed for optimal participation in psychoanalytic work: the ability to form a therapeutic relationship, psychological mindedness, abstraction, introspection, reflection, appreciation of symbolic representation and tolerance of surfacing memories, fantasies and feelings. Although the analytic couch and the usual frequency of four or five sessions a week were not employed, the treatment had the hallmarks of psychoanalytic work: free association, the use of dreams, transference, transference interpretation, resistance to the exposure of repressed mental content, insight, the resolution and working through of intra-psychic conflict and change in psychic structure. By these criteria, the work with this patient was psychoanalysis.” (p. 558).

(We believe that the relationship between psychotherapy and psychoanalysis is quantitative rather than qualitative.)

Granting such, the treatment supports the observation that chronological age by itself is not an index of suitability or unsuitability for psychotherapy/psychoanalysis (Simburg, 1985, p.132.) There is no evidence that the psychotherapeutic/psychoanalytic process is age-related; the psychotherapeutic/psychoanalytic process may take place throughout life. Simburg characterizes psychotherapy/psychoanalysis as dealing with repressed infantile issues and later life-course issues. 'Human object need and its derivative, transference, remain constant, insistent, and enduring throughout life' (Cath, in Panel Report, 1986, p. 164). Whereas physical strength diminishes with age, the intensity of the unconscious mind remains 'timelessly intact' (Crusey, 1985, p. 158, p. 165)."

Despite this growing acceptance of the value of treatment of the elderly, evidence suggests that psychotherapeutic/psychoanalytic treatment of the elderly remains limited. For example, a review of PEP yields only 24 papers about the elderly in contrast with 248 about adolescents and 1244 about children. In addition, it is noteworthy that while many American Psychoanalytic Association institutes and others provide courses about the treatment of children, adolescents and adults, few institutes provide a course in the treatment of the elderly. Our survey of institutes indicate that one institute provided a study group and another offered an elective course; 14 institutes provided neither a course nor a study group. In sum, none of the 16 responding institutes provided a required course in psychoanalytic treatment of the elderly.

The Elderly are Subjected to a Devastating Array of Losses

Settlage (1996) notes that the losses of old age have been documented and underscored (Berezin & Cath, 1965; Cath, 1962; Crusey, 1985; Goin,

1990; Hildebrand, 1985; King, 1980; Pollock, 1977; Sandler, 1984). The range of disturbing losses, taken together, may be relatively unique to this phase of development, except in wartime, natural disasters or epidemics; loss of loved ones and/or of friends, loss of parenting gratification, loss of health including physical prowess, vision, hearing and memory, loss of professional identity, loss of social status and income, and loss of self-esteem. In vulnerable individuals such losses may produce depression at any age, often accompanied by the risk of suicide. The Centers for Disease Control and Prevention note that more people die of suicides yearly than in car accidents with suicide predominantly weighted towards both ends of the life arc; teenagers and the elderly. Of 100,000 people ages 65 and over, 14.9 died by suicide in 2007 compared to the 11.3 for our national average (Home Health and Education Publications). Elderly white men have the highest rate, 29 per 100,000.

The Nature of Loneliness

When I woke they did not care

Nobody, nobody was there

Come back early or never come

When my silent terror cried,

Nobody, nobody replied

Louis Macniece (Orr, 2013)

Loneliness is often a cardinal concern in the treatment of the elderly, and warrants some reflections on the concept. Fromm-Reichman's (1990) paper about loneliness, although it focused on its psychotic dimension, brought the concept of loneliness to analysts' attention as a facet of distress. Albert Murray in an interview described it graphically: "But nothing hurts quite like the loss of old friends. There are ways to cope at the time they die. But weeks and months later you realize you can't phone them and talk: Duke Ellington, Romare Bearden, Ralph Ellison, Alfred Kazin, Robert Penn Warren, Joseph Mitchell. It's hard to believe they're all gone" (Watkins, New York Times Obituary, 2013, p. A15). Sullivan (1953) clearly articulated how hard it may be to define loneliness: "I, in common apparently with all the denizens of the English-speaking world, feel inadequate to communicate a really clear impression of the experience of loneliness in its quintessential force" (pp.260-261).

Given marked variations both in biological endowment and in child rearing customs, we can assume a characterological variation in the need for relationships and intimacy, and pleasure or tolerance of being alone.

Sullivan (1953) described loneliness as “the exceedingly unpleasant and driving experience connected with inadequate discharge of the need for human intimacy” (p.290). Loneliness is caused thus not by being alone but by being without some internally defined needed relationship. Weiss (1973) reports, similarly, that loneliness syndromes give rise to yearning for the relationship – an intimacy, a friendship, a relationship with a kin – that would provide whatever is at the moment insufficient. This form of loneliness, based on the absence of a close emotional attachment, to another human, can only be remedied by the integration of another emotional attachment or the reintegration of the one that had been lost. Some people may find comfort with pets or nature and not need psychotherapeutic/psychoanalytic treatment. However, we are often confronted with those who may experience the loneliness of emotional isolation, of utter aloneness, whether or not the companionship of others is, in fact, accessible to them, and it is they who seek and are suitable for intensive analytic work throughout the age range. In contrast, the specific form of loneliness associated with the absence of an engaging social network – the “loneliness of social isolation” - can be remedied only by access to such a network. Since both elderly men and women are especially vulnerable to the loss of critically important social ties and to physical isolation, they are, therefore, at increased risk for loneliness. Weiss concludes that “It is easy to see the lonely as out of step, as unwilling to make necessary overtures to others, as lacking in qualities necessary to satisfactory human relations. In this way we blame even as we purport to explain” (pp. 74-75).

Dealing with the Disturbing Losses of the Elderly

As we grow, multiple non-family members play increasing supportive roles in our lives, beginning in infancy, with nannies, grandparents, baby sitters and child-care workers, followed by teachers, friends, neighbors, coaches and mentors, and then often spouse(s), new family members and colleagues. The influence of family of origin members usually declines throughout life; the influence and importance of friends waxes in adolescence and increases again in the elderly period when, in a mobile society, friends and not family may well be the primary sources of love, care and support (Cath, 1997).

Both Fleming (1972) and Bowlby (1973) asserted that we all need to feel confident that there are one or more trusted persons that will come to our aid should difficulties arise. Buechler (1997) adds that in both attachment theory and the Sullivanian understanding of the human condition “we are struggling to maintain the security we need as a base from which to venture into the unknown” (pp. 160-161).

Psychoanalytic Treatment of the Elderly

A subset of elderly patients who had developed reasonably satisfactory adaptations to the vicissitudes of earlier periods of development, with or without therapeutic interventions, may find the host of challenges and stresses of that stage exceeding their adaptive capacities. Numerous reports document that psychotherapeutic/psychoanalytic treatment can be extremely helpful and beneficial to the elderly (references cited earlier by Settlage, 1996). A.M. Sandler (1984), importantly, points out that some psychotherapists/analysts treating elderly patients may be too eager to discard the impact of external events and view the presenting symptoms entirely as a result of the breakdown of the mental agencies of the individual” (p.473). We conceive that the elderly person may previously

have achieved a reasonably adequate adaptation, but defenses may no longer be adequate for the new developmental tasks and losses of being elderly. In addition, awareness of the shortness of time ahead may provide impetus for seeking help. Sandler concluded that “Mrs. A’s illness should not be understood as due to the emergence of a neurosis ... To me it seems evident that Mrs. A became depressed because she found herself unable to cope with the internal stresses and conflicts aroused in her by the process of aging” (pp. 488-489). Nemiroff & Colarusso (1985) similarly view the treatment of older patients as specific to this discrete phase of development. Valenstein (2000) is even more focused and in agreement with our views when he describes “the transference serves two purposes: for reality-based attachment needs, where it is pivotally restitutorial for the object-deprived older patient who has fewer opportunities for new attachments; and also, as far as feasible, for the facultative recapitulations of the past and their understanding as they experientially unfold.” (p. 1583). He adds that in working with the older patient “we are more accepting and inclined to be more responsive to the older patient’s needs for attachment and support, even though that may depart in some measure from the priority traditionally given the analysis of the transference in its recapitulations of past conflicts and relationships” (p.1584-1585).

Changing the Role of the Analyst and the Frame of Treatment

We propose that after the apparent completion of extensive and intensive psychotherapeutic/analytic work to repair endogenous, narcissistic, neurotic roots of loneliness, with or without supplementary pharmaceutical help, if the patient remains troubled by persistent feelings of reality-based loneliness, the psychotherapist/analyst may utilize a modified stance that actively suggests the remedial development of new friends and activities to

remedy this loneliness, while exploring any resistances to that suggestion. Although we have not collected data about the effect of such suggestion on treatment outcome, we do not anticipate significant negative impact while a positive outcome is plausible. We hope psychotherapists/analysts will consider applying this suggestion in stalemated treatments in which an isolated patient remains troubled by persistent feelings of loneliness. If tried, we hope that the results of such efforts will be reported.

Weinberg (1989) proposed this transition for the analyst to become the “ambassador” of friendship, a role possibly doubly difficult for an analyst unaccustomed to taking such an active role in treatment, and, perhaps due to age, background and personality thus unfamiliar with both the complexities of friendship in later life and local resources. The need for, and even the concept of generating friendships may be a challenge for both analyst and patient, possibly more so for some male analysts and male patient dyads, since usually at every life stage women focus more on, and have more friendships, than men.

Weiss (1973) prescribes, “I can offer no method for ending loneliness other than the formation of new relationships that might repair the deficit responsible for the loneliness. And I think this solution ordinarily is not easy”(p.231). A campaign of search for a single attachment figure is a risky enterprise simply in terms of the likelihood of success. Patients who enter treatment hoping to find a replacement for a lost attachment figure constitute therapeutic problems because of the limited probability of success. Rather, the focus should be revised to developing relationships with several others, engagement with various activities, and memberships in networks *on bases valid in themselves*. Cacioppo & Patrick (2008) similarly advise, “Don’t focus on trying to find the love of your life or to reinvent yourself all at

once. Just slip a toe into the water. Play with the idea of trying to get small doses of the positive sensations that come from positive social interactions” (p. 237).

Just as some psychotherapists/analysts have acknowledged the limits of their pharmaceutical knowledge and have become comfortable in seeking consultation for pharmaceutical treatment, they may now need to acknowledge limited knowledge in social networking. Referring the patient to an experienced social worker or to a reputable service center may provide the necessary auxiliary support.

While we think that psychotherapists/analysts should always be prepared to seek outside help for problems beyond their expertise, this need may arise more frequently in the treatment of the elderly with their multiplicity of losses, illnesses and stresses. The transference significance of the analyst turning to outside help may provide a bridge for the patient’s own outreach and recognition of limits. The psychotherapist/psychoanalyst may be supported by a functioning, trustful therapeutic alliance with the patient, which may help the patient deal with the ensuing concerns, negative reactions and failures in response to the analyst’s suggestion.

Termination of Psychotherapeutic/Psychoanalytic Treatment of the Elderly

Traditional psychoanalytic theory prescribes total patient-analyst separation after termination to support mourning the loss of the analyst. There is no evidence that total separation influences mourning, or that occasional post-termination patient-analyst contact inhibits mourning (Craigie, 2002). Kantrowitz (2014), based upon an empirical clinical interview study, agrees and notes that post-analytic experiences of grief and extended periods of mourning were not less intense for analysands who were

part of the analytic community than for those who were not. She also notes that for some patients completing treatment was a very hard won achievement, and when it occurred joy, not grief, predominated in their feelings about ending; mourning was not the predominant emotion. She adds that older people may be more reluctant to end their analyses and feel more grief at ending it since the experience is likely compounded by the actual or expectable loss of others who are emotionally important to them. In general, in her cohort, the way individuals remembered their analysis was affected by their post-treatment contact with their former analyst. Some analysands clearly felt that later contact with the former analyst was sustaining, though this was less likely to be true for analyst/patients. Further, she concluded that each analysis and each ending is shaped by the nature of the particular issues of the analysand and the particular analytic dyad.

Schachter and Kächele (2013) have presented an alternative concept of termination in which during the termination phase, if the patient has not considered the possibility of post-termination contact with the analyst, at an appropriate time the analyst should question why this has not been discussed. After an analytic exploration, the analyst may propose to the patient the possibility of occasional post-termination patient-analyst contacts and the benefits of such meetings. Kantrowitz believes that unless the former analysands chose to re-contact their former analysts, they would be left on their own to assimilate post-analytic experiences that might be unexpected, painful or confusing. The decision about whether to plan such follow-up contacts should be a mutually-agreed one. We believe that such contacts may provide the patient with the following benefits: 1. Enables the patient to re-experience the analyst's caring (especially relevant for elderly patients previously vulnerable to loneliness; (such contacts may occur informally,

spontaneously with elderly patients); 2. May reinvigorate helpful introjections of the analyst; and 3. Provide additional opportunity to deal with unresolved idealization of the analyst if appropriate. Such follow-up contacts may also provide the analyst with information about the inevitable post-termination changes in the patient's life, positive and negative, which may help the analyst revise and improve his/her conceptions of the course of the analytic treatment. Since the follow-up contacts may be of use and of interest to the analyst as well as to the patient, we suggest that the analyst not charge for these follow-up contacts. The frame of the follow-up contacts has been modified from that of the treatment itself, becoming perhaps more person-to-person, with the patient's needs and welfare remaining paramount. Follow-up meetings may have to take place in other settings, hospital rooms or other venues, while maintaining the professional roles.

There are no data available to compare the therapeutic effects of traditional concepts of termination to those of Schachter and Kächele's concepts of termination. One study has reported that psychotherapist/analyst-initiated follow-up contacts were beneficial to the patients (Schachter et al., 1997), "In the first case the meetings facilitated the patient's re-entering treatment, leading to significant further growth. In the second and third cases, the meetings re-ignited mourning for the analyst and furthered analytic gains. The authors' overall impression was that the post-termination contacts were helpful for all three patients." (p.1193).

Next, a clinical example of patient-initiated post-termination contact with an older patient is summarized (JSS). This treatment of a previously analyzed childless mental health professional suffering through a second failing marriage was assumed on a face to face basis at the patient's request. The previous analyst had been a well known older male; JSS was a woman,

new to the analytic community, with a child analytic background and a focus, in this psychoanalytic therapy, on attachment and caretaking by the patient's mother who had early lost both parents and felt impelled to explicitly prepare her only son to become an orphan. Subsequently his father became more outlined as an active intelligent man whose first wife had died and who had abandoned their son to relatives. The patient himself had been sent to live for some time to an aunt who ran a depression-era boarding house while his parents were both ill.

The patient as a boy rose to the challenge of raising himself, abandoning his parents before they might leave him. He found a way to support himself successfully at a boarding school, college and graduate school. He remained relatively isolated though superficially adept both socially and professionally throughout a career in the armed services and thereafter. After several years of therapy he chose to return to an analytic schedule on the couch during which he dealt with his narcissistic injuries, his hypochondriasis and isolation, and fearing of angering attachment object solicited specifically when his analyst drank iced tea during a session. His father became a more understandable and significant figure and he subsequently accepted responsibility for his aging mother, and brought her closer to his locale and installed her in a nursing home. Meanwhile he divorced, suffered the rage and narcissistic injury at the hands of his adopted grown step-sons who rejected him, and found and remarried a warm successful woman with adult children and grandchildren. Midpoint in this analytic phase, when he was well past 75, I asked him if I could present the analytic work in a European discussion group and he agreed. Both of us were disappointed when the discussion focused almost entirely on the ethics of analyzing an elderly patient.

Termination took place after a two year discussion when the psychotherapist/analyst retired and relocated. He requested post-termination contacts and they were arranged by email and took place at approximately six month intervals at his choice of restaurants in her city except on rare occasions when the analyst returned to their old city to visit friends. On those occasions we also met at restaurants; he always paid for the meals and no fee was charged. We both enjoyed food and were comfortable together. When he became aware of mortal illness, the analyst increased the frequency of visits in both cities; the last two sessions took place in his home where, for the first time, the analyst met his wife and helped support her utilization of home hospice care. The last meeting between us was clearly a farewell. He summoned his strength and walked me to the car while pulling his IV line.

Kantrowiz (2014) in a general statement, concludes that nowadays psychotherapists/analysts believe post-treatment returns may be helpful, and certainly are not viewed as harmful to patients' therapeutic gains.

Conclusion

Old age is the last developmental stage. Some elderly may be subjected to a devastating array of losses and crises that exceed in scope and nature those of those former, earlier stages of development which the patient managed satisfactorily. Widespread losses may generate intensely distressing feelings of loneliness and depression and call upon the universal need to feel confident that there is one or more trusted persons who will come to our aid when difficulties arise. This feeling of support may be often lost in the actuality of reality or psychologically lost during feelings of loneliness; the psychotherapist/analyst, realistically, may provide one such anchor.

If intensive psychotherapeutic/psychoanalytic work with an elderly patient has proven helpful but left the patient isolated in reality with remaining, painful feelings of loneliness, the psychotherapist/analyst has the option of enlarging the treatment by actively suggesting that the patient consider developing new relationships, interests and activities. Furthermore, proposed periodic post-termination patient-analyst follow-up contacts, in addition to providing the advantages delineated, can provide a form of maintenance therapy and caring which may assist the patient in continuing endeavors to avoid persistence of loneliness by supporting new relationships and activities.

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