Schachter J, Kächele H & Schachter J (2013) Psychoanalytic treatment of the elderly. *Psychodynamic Psychiatry 42 (1): 51-63*

Psychotherapeutic/Psychoanalytic Treatment of the Elderly

Joseph Schachter, M.D., PhD

Horst Kächele, M.D., PhD

Judith S. Schachter, M.D.

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.

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; 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 for psychotherapy/psychoanalysis **(Simburg, 1985, p.132).** It also demonstrates that the psychotherapeutic/psychoanalytic process is not age-related. The process is the same in the elderly as in the younger patient. 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 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 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)

Many elderly people struggle with painful feelings of loneliness. Fromm-Reichman's (1990) paper about loneliness, although it focused on its psychotic dimension, brought the concept of loneliness to analysts' attention as a dimension 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".

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, can only be remedied by the integration of another emotional attachment or the reintegration of the one that had been lost. We are familiar clinically with patients 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 we may treat with intensive analytic work. 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, subject to 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).

The emotional isolation of those without a committed intimate relationship points to the vulnerability of those who have never married. However, for some, the impact of divorce and widowhood with predominant feelings of failure, rage and guilt and of evoked desertion, more than the loss of an emotional attachment, can become the stimulus for treatment. While marital status is one of the better predictors of intimate connectedness and the married tend to be less lonely than single people, it is not a panacea – not everyone finds marriage to be self-affirming. Those released from unsatisfying marriages may seek treatment to help develop more fulfilling relationships. Those people who have led full lives with careers, many friends and interests, may feel lonely if this life collapses around them in old age leaving them at a loss.

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 psychotherapyists/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 restitutional 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 offer 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. 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 service center such as the Mt. Sinai Martha Stewart Center in New York may provide the necessary auxiliary perspective. At the Center for Elderly Suicide Prevention of the Mt. Sinai Martha Stewart Center the descriptive brochure reports that staff and volunteers handle 3000 calls a month to the "friendship line" (a name deemed more acceptable to seniors than "suicide hotline").

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, supported by a functioning, trustful therapeutic alliance with the patient*, is in a better position to have suggestions accepted than a psychotherapist whose work with the patient has been solely limited to pharmaceuticals*. Importantly, the psychotherapist/analyst is also prepared for, and may be in a better position to help the patient deal with the ensuing concerns, negative reactions and failures in response to the analyst's suggestion.

Termination of 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 (Craige, 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 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 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, 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). Details of one of the three post-termination contacts are presented of a young person because no such case study is available of an elderly patient.

Charlie Presenting Problems

Charlie, a 27-year-old single musician, came to me (G.C.M.) seeking help in 1982 because of 'problems maximizing what I consider to be my potential'. He had many casual friends, but had never dated a woman for more than a few weeks. 'People consider me a warm, outgoing clown … I'm a perennial 21-year-old.' He had embarked on numerous projects, including college, without carrying any through to a successful completion. With considerable guilt and anxiety, he said that he was afraid of his own potential for aggression, especially towards women. Charlie recalled many loud arguments with his mother over his refusal to eat a large variety of foods. He became aware in his teens that she had a drinking problem. He felt responsible for his mother's drinking and her death from cancer when he was 21, his 'perennial age'.

Summary of the Psychotherapy/Psychoanalysis

Charlie began treatment at a reduced fee with his customary energy and enthusiasm. He developed an initial (defence) transference of making himself a gentle, entertaining submissive clown. I gradually helped him to see how frightened he was of me, and that his fear of me was actually a fear of my discovering his own hostility towards me. As this fear of his own hostility became better understood, the transference deepened through his wish to compete with me, yet he was harshly self-critical for having the wish.

Over the next few years clarification of his aggressively

charged sexual and competitive wishes and harsh self-punitive reactions to them enabled him to experience more freedom to develop his considerable musical talents. By following his associative pathways from his punitive expectations of me, we came to consider the possibility that early sexual over-stimulation by his mother had occurred. Early rage reactions and frightening omnipotence were frequently re-lived during these sessions. We understood these to be consequences of his early, over-stimulating relationship with his mother. These and other sources of guilt were worked through with many dramatic and convincing transference enactments. Defensive submission alternated with rage in rapid succession, finally giving way to interpretation. We also made sense of his guilt on the oedipal level, as reflecting a frightening fantasy of competition with father, influenced by an unmodified early sense of omnipotence. By 1987 he had developed confidence in himself at work and with women, had completed college, begun a career as a professional musician, and fallen in love with an attractive, capable woman. After several years, they decided to marry.

Termination phase

When the resulting emotional growth had become evident to him, he brought up the possibility of terminating. I too came to a sense that he was ready to terminate. While I did not suggest that we *would* have contact after termination, I could imagine circumstances in which it might be useful. So I said nothing to rule out the possibility, or to suggest that if we should meet again it would be a sign that analysis had somehow failed.

Once we set a date for the last session, many of his prior symptoms surfaced again. I interpreted these as resistance to the feeling of losing me. It was only five weeks before the last session that Charlie realized that he would miss me, through an incident that crystallized his grief. One of his students had finished a series of lessons, but missed the last one. My patient was puzzled and upset about this. The student had, Charlie told me, been devoted to

him and had made enormous progress over years of hard work. Charlie wondered if the student hadn't liked him so much after all. I said: 'You have a blind spot here. You can't see that *your* student was upset about leaving *you* because you're trying *not* to be upset about leaving *me*'. Now he allowed himself to cry during each of the next three sessions, and I too felt tearful. He referred to 'the blind spot' every day for a week. He told me he loved me. Muffled noises on the street outside my office sounded to him like a small child crying. After this poignant episode, we were able to finish on our agreed date without further difficulty.

Post-termination Contact

Five years later, while I was making plans to visit the city in which I had lived during his analysis, I contacted Charlie. I did this only after considerable soul-searching. I was well aware of my wish to see him. I decided that meeting again was unlikely to hurt my patient and would probably help him to re-examine his feelings for me. I felt it was important that I remain in an analytic role; this visit would be a part of the analysis. In thinking this way I was defending myself against the imagined accusation that I was 'acting out' with my former patient.

I contacted the original referring psychiatrist to ask him to let Charlie know I would be returning to town for a visit and to enquire whether he would be interested in meeting with me. I wanted to give him the chance to decline without awkwardness. Charlie replied through the psychiatrist that he was delighted to hear from me, and he would be eager to see me again. Since I conceived of this session at the time as an extension of the analysis, despite my having taken the initiative, I charged my previous fee. My views have evolved since then, and today I would not charge for such a meeting.

We met in the referring psychiatrist's office for one fifty-minute session. When our eyes first met, he suddenly broke into tears. I felt tearful, too, and excited. Then he quickly suppressed his tears and began by telling me a funny story, the entertaining

clown defense. Within moments we fell into the easy, mutual familiarity we had enjoyed before termination. I continued to feel excitement, and I realized how much I had missed him. I asked about his life and, in particular, his current handling of the issues that had been so troublesome before and during the analysis: work, relationships with women, and tolerance of his own aggression. He told me of his considerable professional success, with only a trace of the previous guilt. Sadly, he described his father's recent death and mourning for him.

He went on to describe his marital difficulties and the likely failure of his marriage in the near future. I asked him if he wanted me to let him know if I would return again. He said, 'Yes, absolutely'. The mutual pleasure at being together was evident. During this hour he recalled many details of the analysis and referred to them repeatedly. I was astonished at how much the meeting brought back to me also the experience of working with him years ago. The meeting was deeply satisfying, not unlike periodic visits with my own adult children.

Two years later, in 1994, I telephoned Charlie to ask permission to publish our experience of the above visit. He was again delighted to hear from me and readily agreed to my request. He told me that he had realized precisely at the time of our meeting that his marriage had failed, and he had since ended it, 'the hardest thing I ever did'. Three months later he met a new woman. They were now living together quite happily and planned to marry. He added, 'This is the first time I have been in a relationship where I felt this kind of commitment, where it really works'.

He recalled having dreams of being in my old office both before and after we met two years ago. 'There was a real warmth between us in those dreams. I took them as confirming that I was on the right track. After meeting with you I realized once again that I can make decisions and live my life as an adult man. It took me a long time to realize [during the analysis] that you didn't have all the answers.'

I asked if there had been anything unhelpful about our meeting again. He replied that he didn't think so. 'It would have been artificial if you had come to town and I had *not* seen you. It was a reminder of the genuine search for truth which we had done together.' I also asked if he still thought much about his mother. 'That's the relationship I have the most figured out. If not, I couldn't have married A, and that led to B [with whom he is happy]. I don't think about Mom much any more. That was twenty years ago [that she died]. I'm at peace with her. Now I'm mostly dealing with myself as my father's son. Seeing you again was important to me. It was like seeing my father as a human being.'

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, elicited specifically when his analyst drank iced tea. 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 of his adopted grown step-sons who rejected him 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 her old city to visit friends. On those occasions we also met at restaurants; he always paid for the meals and no fee was charged. 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 supported home hospice care. The last meeting between us was clearly a farewell.

A critical view of post-termination contacts was presented in one paper (Levine and Yanof, 2004) which described problematic adventitious post-termination contacts between training analysts

and their former patients. That paper was written by a COPE Study Group of the American Psychoanalytic Association composed of traditional analysts who believe the analyst should prioritize the possibility of further treatment over all other considerations, thus denigrating possible post-termination contacts. In a subsequent paper (Yanof and Levine, 2005), in response to a commentary by J.S. (Schachter, 2005) wrote that in the first paper they had been discussing post-termination contacts that were unplanned, mostly collegial and social, and not construed to be part of the clinical treatment situation, but they did not further explore these issues.

Kantrowitz (2014) concludes that nowadays psychotherapists/analysts believe post-treatment returns may be helpful, and certainly are not viewed as harmful to patients' threapeutic 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 illuminate 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 be 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 which may assist the patient in continuing endeavors to avoid persistence of loneliness by supporting new relationships and activities.

References

Abraham, K. (1919). The applicability of psycho-analytic treatment to patients at an advanced age. *Selected Papers. London*: Hogarth Press, 1927, pp.312-317.

Berezin, M.A. & Cath, S.H. (1965). *Geriatric Psychiatry: Grief, Loss and Emotional Disorders in the Aging Process.* New York: International Universities Press.

Bowlby, J. (1973). Attachment and Loss. Vol.2: *Separation, Anxiety and Anger*. New York: Basic Books.

Buechler, S. (1997). *Attachment Theory as a Secure Base for Psychoanalytic Explanation: A Review of Attachment Theory: Social, Developmental and Clinical Perspectives,* edited by Susan Goldberg, Roy Muir and John Kerr. Hillsdale, N.J.: The Analytic Press, 1995, 528 pp., *Contemporary Psychoanalysis,* 33:157-161.

Cacioppo, J.T. & Patrick, W. (2008). *Loneliness. Human Nature and the Need for Social Connection.* New York: W.W. Norton & Company.

Cath, S.H. (1962). Some dynamics of middle and later years: a study of depletion and restitution. In *Geriatric Psychiatry: Grief, Loss, and Emotional Disorders in the Aging Process,* ed.

M.A. Berezin & S.H. Cath. New York: International university Press, pp. 21-72.

Cath, S.H. (1990). *Treating the Elderly with Psychotherapy. The Scope for Change in Later Life: (*eds.) J. Sadvoy & L. Molyn, Madison CT: International Universities Press, 1987. *Psychoanalytic Quarterly,* 59:143-147.

Cath, S. H. (1997). Loss and restitution in later life. In *The Seasons of Life: Separation-Individuation Perspectives,* eds. S. Akhtar & S. Kramer, Northvale, N.Y.: Aronson, pp. 129-156.

Cath, S. & Miller, L.E. (1986). The psychoanalysis of the older patient. *Journal of the American Psychoanalytic Association,* 34:163-177.

Coltart, N.E. (1991). The analysis of an elderly patient. *International Journal of Psychoanalysis,*72: 209-219.

Craige, H. (2002). Mourning analysis: The post-termination phase. *Journal of the American Psychoanalytic Association* 50:507-550.

Crusey, J.E. (1985). Short-term dynamic psychotherapy with a sixty-two-year-old man. In *The Race Against Time: Psychotherapy and Psychoanalysis in the Second Half of Life.* (eds.) R.A, Nemiroff & C.A. Colarrusso. New York: Plenum Press, pp. 147-166.

Dunn, J. (1997). Psychotherapy with the elderly. *Dutch Annual of Psychoanalysis,* II, 1995-1996, A. van Dantzig: 220-226. *Psychoanalytic Quarterly,* 66: 368-369.

Erikson, E.H. (1959). *Identity and the Life Cycle. Selected Papers.* New Yrok: International University Press.

Erikson, E.H., Erikson, J.M. & Kivnick, H.Q. (1986). *Vital Involvement in Old Age.* New York: Norton.

Fleming, J. (1972). Early object deprivation and transference phenomena: The working alliance. *Psychoanalytic Quarterly,* 41:23-49.

Freud, S. (1905). On psychotherapy. SE vol. VII: pp. 255-268.

Fromm-Reichman, F. (1990). Loneliness. *Contemporary Psychoanalysis,* 26:305-329.

Goin, M.K. (1990). Emotional survival and the aging body. In *New Dimensions in Adult Development,* ed. R.A. Nemiroff & C.A. Colarusso. New York: Basic Books, pp. 518-529.

Gould, R.L. (1990).Clinical lessons from adult developmental theory. In *New Dimensionsin Adult Development*, ed. R.A. Nemiroff & C.A. Colarusso, New York: Basic Books, pp. 345-370.

Griffin, B.P. & Grunes, J. M. (1987). The aged in psychotherapy: Psychodynamic contributions to the treatment process. In *Treating the Elderly with Psychotherapy, (eds.) J. Sadavoy & M. Leszcz. Madison, CT. International Universities Press*, pp. 312-344.

Griffin,B.P. & Grunes, J.M. (1990). A developmental approach to psychoanalytic psychotherapy with the aged. In *New Dimensions in Adult Development,* ed. R.A.Nemiroff & C.A. Colarusso. New York: Basic Books,, pp. 267-287.

Kahana, R.J. (1993). The psychotherapy of the elderly self. *International Journal of Psychoanalysis,* 74: 1087-1088.

Kantrowitz, J.L. (2014). *Myths of Termination.* New York: Routledge.

King, P. (1980). The life cycle as indicated by the nature of the transference in the psychoanalysis of the middle-aged and the elderly. *International Journal of Psychoanalysis,* 61: 153-160.

Levine, H. & Yanof, J. (2004). Boundaries and postanalytic contacts in institutes. *Journal of the Amaerican Psychoanalytic Association, 52*:873-901.

Levinson, G.A. (1985). New beginnings at seventy: a decade of psychotherapy in late adulthood. In *The Race Against Time: Psychotherapy and Psychoanalysis in the Second Half of Life*, ed. R.A. Nemiroff & C.A. Colarussoo. New York: Plenum Press, pp. 171-188.

Limentani, A. (1995). Creativity and the third age. *International Journal of Psychoanalysis,* 76: 825-833.

Lipson, C. (2002). Psychoanalysis in later life. *Psychoanalytic Quarterly,* 71: 751-775.

Nemiroff, R.A. & Colarruso, C.A. (eds.) (1985). *The race Against Time: Psychotherapy and Psychoanalysis in the Second Half of Life.* New York: Plenum Press.

Nemiroff, R.A. & Colarusso, C.A. (1990). *New Dimensions in Adult Development* New York: Basic Books.

Orr, D. (2013). *Free Range* A poet whose work inhabited a variety of subjects and forms. The New York Times Book Review, September 1, p. 18.

Panel Report (1986). The psychoanalysis of the older patient. Reported by N.E. Miller, *Journal of the American Psychoanalytic Association,* 34:163-177.

Pollock, G. H. (1977). The mourning process and creative organizational change. *Journal of the American Psychoanalytic Association,* 25:3-34.

Sandler, A-M. (1984). Problems of development and adaptation in an elderly patient. *Psychoanalytic Study of the Child,* 39: 471-489.

Schachter, J. (2005). Postanalytic contacts in institutes. *Journal of the American Psychoanalytic Association,* 53:260-264.

Schachter, J., Martin, G.C., Gundle, M.J., & O'Neil, M.K. (1997). Clinical experience with psychoanalytic post-termination meetings. *International Journal of Psychoanalysis,* 78:1193-1198.

Schachter, J. & Kächele, H. (2013). An alternative Conception of termination and follow-up. *Psychoanalytic Review,* 100:423-452.

Segal, H. (1958). Fear of death: Notes on the analysis of an old man. International Journal of Psychoanalysis, 39:178-181.

Settlage, C.F. (1996). Transcending old age. *International Journal of Psychoanalysis* 77: 547-564.

Simberg, E.J. (1985). Psychoanalysis of the older patient. *Journal of the American Psychoanalytic Association,* 33: 117-132.

Sullivan, H.S. (1953). *The Interpersonal Theory of Psychiatry.* New York: W.W. Norton.

Valenstein, A.F. (2000). The older patient in psychoanalysis. *Journal of the American Psychoanalytic Association* 48: 1563-1589.

Wagner, J.W. (2005). Psychoanalytic bias against the elderly patient: Hiding our fears under developmental milestones. *Contemporary Psychoanalysis,* 41:77-92.

Watkins, M. (2013). Scholar Saw a Multicolored American Culture. Albert Murray, 1916-2013. The New York Times. Tuesday, August 20, p. A15.

Weinberg, H. (1989). Clinical aspects of friendliness and friendship. *Contemporary Psychoanalysis* 25: 357-370.

Weiss, R.S. (1973). *Loneliness. The Experience Emotional and Social Isolation.* Boston, MA: The Massachsetts Institute of Technology.

Yanof, J. A. & Levine, H. B. (2005). Judith A. Yanoff and Howard B. Levine respond. *Journal of the American Psychoanalytic Association,* 53:264-265.