Psychodynamic Psychotherapy With Older Adults

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Even though the percentage of the population older than 65 years is growing and will continue to do so (1), elderly persons are underrepresented in all forms of psychotherapy (2–4), although one well conceived and comprehensive review appeared in this journal in 1999 (5). In addition, the number of articles published on psychodynamic psychotherapy with elderly persons has dropped since the early 1990s. This paper addresses the variety of ways psychodynamic therapy can be useful for the older person (6–9).

Principles

Empathic listening, exploratory inquiry, and interpretation and clarification of unconscious determinants are essential parts of psychodynamic therapy. All of these techniques are used with both older and younger patients in psychodynamic therapy. The main distinction that therapists should make between older and younger groups is that as people age, they become more physically and psychologically diverse from one another. For example, one 75-year-old may be running a corporation, whereas another may need nursing home care.

Older persons may enter therapy for many reasons, ranging from lifelong neurotic symptoms to crisis events to debilitating processes (10). However, irrespective of the presence of physical problems, the need for therapy about psychological issues remains. For example, a legally blind man in his nineties focused his therapy on his feelings of rejection in a relationship with a new woman friend.

Psychotherapy fits well with the developmental process in late life. Butler's life review therapy (11) uses the normal reminiscing of aging to deepen the person's self-knowledge, often with exercises such as photo scrapbook review, memoir writing, and pilgrimages to childhood sites. However, unfocused reminiscing may not be suitable for persons who have trauma histories, such as Holocaust survivors, or for persons who have early dementia. For Erikson (12) late life is about putting one's life into perspective and negotiating between ego integrity and despair. The expectable events of aging, such as retirement or relationships with adult children and grandchildren, often serve as an impetus for self-reflection and psychotherapy.

Vaillant (13,14), Rowe and Kahn (15), and others have shown that age can make one more resilient to stressors. In late life, lifelong adaptive styles are central to a person's being able to negotiate the stresses of aging. Therapists can help older persons understand how their mode of managing difficulties earlier in life may be used appropriately for current late-life problems. For example, a 78-year-old woman, who had written in her youth, was able to deal with her husband's death by writing about her reactions to her loss.

Special aspects

Transference and countertransference

The low percentage of older patients in psychotherapy is partly due to their fear that visiting a therapist means they are "crazy." Additionally, some therapists may maintain unrealistically negative attitudes about aging and see older persons as incapable of change. The viewpoint of these providers needs to change in order to increase access to treatment for older patients (16–19).

It is true that transportation difficulties, problematic reimbursement patterns, and insufficient resources for specialized geropsychiatry decrease the access older persons have to psychotherapy. However, it is important to explore the extent to which a barrier to psychotherapy is transference based or rooted in the patient's psychology. For instance, an 80-year-old woman resisted therapy, saying "psychiatrists can't change old people." With time this resistance was understood as related to a long-standing oppositional pattern, as well as to the woman's difficulty of directly asserting herself. After exploring past interpersonal patterns, she became quite involved in treatment, eventually developing a more direct and effective style of assertion.

The frequent age difference between the patient and the therapist may lead the patient to relate to the therapist as a son or a daughter. Less obvious may be more subtle transference manifestations occurring around issues of dependency. For instance, a healthier elderly patient who sees the therapist as a parent or an educator may sell short his or her own abilities. Some frail elderly persons may see the

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therapist as a rescuer, whereas other frail elderly persons may feel as though the therapist represents an envied competitor with whom they can no longer compete, thereby leading them to view therapy as a demeaning circumstance. Romantic transferences, with their unrequited nature, can also be a source of humiliation for the patient. Awareness of these and other transference possibilities among older patients is important in order to allow therapy to progress.

The therapist's fears of aging and memories of parents or grandparents are a common area of interference in psychodynamic psychotherapy with older patients. For example, if a therapist bridles at parental control because he has unresolved negative feelings toward his parents, he may view the older patient in the same negative light, that is, as excessively controlling. Issues centered on aggression can also stir up countertransference feelings (17). For instance, the therapist may see a frail but demanding elder as helpless and, because of inappropriate rescue fantasies, fail to recognize the aggression contained in the relentlessness of the patient's demands. Endless rounds of attempts to help the patient may then result and exhaust the effectiveness of therapy. In this case, the countertransference interferes with the therapist's being able to see how the patient's aggression and self-absorption pushes away the very help the patient so desperately seeks.

A different countertransference dynamic centered on aggression could occur if the therapist is aware only of the patient's aggression and the therapist's consequent anger at the patient. In that case, the therapist may be unaware of how the patient's helplessness stimulates the therapist's feelings of helplessness. The patient's underlying vulnerability will not be understood, and the therapist may become excessively punitive and withdraw the help the patient needs.

Involvement with other persons

With older patients, psychotherapy may involve multigenerational issues, because families are often very involved in the older patient's everyday life in a way that is not true for younger patients. Retaining the confidential nature of the therapy without the family's feeling unnecessarily excluded is paramount. Even when the referral is made by a family member who accompanies the patient, the visit should usually begin with only the patient and the therapist. Before the meeting ends, family members can be included for additional input. These guidelines of confidentiality helped one 85-year-old woman whose daughter brought her for therapy. The privacy of the therapy permitted the 85-year-old to explore her feelings of guilt about a long-ago affair. Although she never discussed the affair with her daughter, the older woman's guilt diminished, and the relationship between the mother and daughter improved.

With cognitively impaired patients, the active involvement of family members is essential. The therapist can first meet separately with a family member to help predict how the patient's cognitive impairment will effect the development of the therapy relationship. Often psychotherapy with more debilitated patients becomes a combination of individual and family therapy, but the confidential nature of the individual meetings remains. A usually pleasant 85-year-old man with mild dementia directed angry outbursts toward his son but had no memory of the incidents. A low dose of a neuroleptic was helpful but did not completely alleviate the episodes. Father-son therapy sessions were held to review the incidents. With these sessions, the psychiatrist was able to model ways of confronting the disruptive nature of the incidents, despite the father's failing to remember them. They also discussed ways the father could calm himself, such as simply going to his room. Later, the father's issues with controlling his anger could become part of the father's therapy sessions, and the frequency and intensity of the outbursts diminished.

Special populations

Psychotherapy with elderly persons often includes special attention to age-related sensory deficits. For example, the therapist can minimize the problems of age-related hearing deficits by facing the patient, speaking clearly, using a lower-pitched voice, and emphasizing consonants.

Patients with impaired memory also require adjustments of therapeutic technique. Reviewing important provisos, with "homework" between sessions, can counteract memory problems. Helping the older person organize information, with mnemonics, memory cueing, or written lists, can buffer the effects of organizational problems. The therapist should explore the patient's feelings about his or her cognitive deficits and address them to the extent the patient is receptive. An 82-year-old man knew he was experiencing the early stages of Alzheimer's disease and was concerned about the progression of the disease. He told his psychiatrist, "I know it will get worse." The psychiatrist agreed and helped the man explore this issue in therapy. In therapy the patient said that his main concern was becoming lost on one of his walks. They talked about how scary getting lost was and also how a "safe return" identification bracelet from the local Alzheimer's Association could protect him. Repeating this interchange on successive visits helped the patient obtain the bracelet and become less fearful. Practical ways of preventing getting lost were also discussed, practiced, and reiterated.

The therapist can also adjust the focus of psychotherapy depending on the type of physical illness being treated. Psychotherapy for an elderly patient with an acute illness should focus on reestablishing the patient's preexisting equilibrium. For patients with a chronic illness, the goal is to help the patient adapt to the new status, including grieving for the lost functions. For patients with lost mobility, the therapist needs to work with the patient on how to adapt to such limitations while maximizing quality of life. The delivery of psychotherapy by way of home visiting services has partially addressed the problem of helping home-bound older persons in selected localities (20,21).

The patient's communication with the primary care provider can frequently become an important focus during psychotherapy. For instance,

the passively oppositional behaviors of an intensely independent person may need to be addressed to prevent the patient's avoiding essential medical care. With a more passive person, the goal may be to increase the patient's assertiveness with the physician to ensure that the patient receives the medical attention that he or she needs.

Although many elderly persons are closely involved with their family, others are quite isolated. There are twice as many women as men in the 65 to 85 age group (22). This fact can put women at higher risk of isolation, which can lead to a higher prevalence of depressive symptoms. Psychotherapy with such individuals should attempt to improve the woman's socialization by supporting her involvement in appropriate community activities and her search for compatible friendships.

When a patient has medical problems, it is especially important to retain a psychological focus while integrating the patient's physical difficulties into the psychotherapy. For example, an 81-year-old man with a ten-year history of coronary angioplasty entered therapy to address his angry manner with his family, a symptom that was related to his sensitivity to embarrassment and humiliation. During the course of therapy, he had a repeat angioplasty. On return to his psychiatrist, he acknowledged that his physical symptoms could be related to his psychological problems. However, because he wanted to focus on lessening the emotional storms with his family, the therapy remained directed toward his sensitivity to embarrassment and the situations he perceived as humiliating.

Conclusion

Psychodynamic psychotherapy with older people uses the same principles as that with younger people and fits well with the developmental process of late life, namely the attempt to put one's years of experience into perspective. Special aspects of working with older persons should be noted, namely the transferences and countertransferences commonly seen with older patients, as well as the particular issues raised by family involvement and physical disabilities seen with advancing age. While attending to those realities of aging, it is paramount to retain the focus on the patient's psychological concerns. ♦

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partment will likely adopt psychopharmacologic interventions with less emphasis on the psychological and social interventions that may also be beneficial to the patient.

Ultimately, implementing the ETHOS model depends on the current needs and future projections of the psychiatric emergency department in terms of patient's demographic characteristics, patient's use patterns, community expectations, and fiscal policies for these services. ♦

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