The Elderly Therapist Patient

I am 91 years old and have been in practice for over 66 years. During this span of time, I have been part of a changing culture and been exposed to many new clinical developments. Today, there is much more emphasis on the use of the therapist's emotional resources as a therapeutic response to a patient's communications. Involved in this development are important contributions from brain research, attachment theory and mindfulness-based interventions. Professionally and personally, this explosion of information and stimulation places a heavy burden on the elderly. There is a demand to keep up with the quick pace of life. At the same time, the vulnerability of aging, the reality of loss and the possible shame that arises out of these life changes, requires attention and communication. The intent of this paper is to open up a dialogue that connects all of us to the challenges that face the elderly therapist and patient.

The title of this paper requires clarification. The concept of developmental challenges implies that getting older produces unique emotional struggles that are connected with the experience of aging. Our bodies show signs of wear and tear. There are losses of friends and colleagues and we are aware of the specter of life ending.

The notion of old age has changed remarkably during my lifetime. Now, middle age extends into the sixties, and old age begins between 80 and 90. This extension of our lifespan bears little resemblance to the one that was part of our parent's time. Being in your sixties then was already considered old. Both my parents passed away at the age of 62.

The notion of old age requires reformulation. Subjectively, it becomes a period of loss, pain, as well as the potential to develop a capacity for reflection. The confrontation with our death puts everything in perspective. A reflection on what is truly important in life may take center stage. As we age, many of us are involved with a long-term life review.

The term expansion refers to a broadening of the subjective experience of consciousness. Many of us seek an elevation and expansion of consciousness that can best be described as spiritual. An emotional investment in a community may act as a bridge into a level of being that goes beyond our self-centeredness. In this state of consciousness, we become part of something larger than our individual selves which in turn creates a sense of unity and love with the universe. Although a spiritual investment can be found at any age, it is not a substitute for going through the other stages of interpersonal development. As we become older, however, a spiritual investment may be an important connection to our own mortality. For some, death is merely a transitional point in becoming part of something larger than one's individuality. By contrast, contraction refers to moving away from the outside and becoming more self-centered, preoccupied with illness, immobility, feelings of despair, aloneness and the dread of death. As we enter this final stage of life, I believe

there is a struggle with both ends of this polarity. Some maintain an investment in the wonder of the world and universe. Others move away from the challenge of expansion and prepare for death by becoming more self-centered, preoccupied, impotent and fearful. Many move somewhere in between these two polarities.

For the elderly therapist, this developmental struggle spills into clinical practice. Questions of the therapist's health, illness and possible impending death creates a vulnerability as to what is shared with patients. Other questions arise; when to refuse new referrals because you are getting too old and may not complete your work with a given patient? What do you tell your patients when you have been suddenly hospitalized? What do you share regarding a terminal illness? Our patients will sense something is wrong with our physical health even when we decide that this information is too intrusive to the therapeutic process. Although we do not intend to overwhelm our patients with too much personal information, we know we cannot hide behind our neutrality as our unconscious will communicate our reality even when we attempt to keep this information out of the treatment dialogue. In fact, I have been exposed to reports where patients are informed of their therapist's death by the doorman. Some of these patients may have learned for the first time that their therapist was struggling with a terminal illness. They may have known something was wrong, but their therapist offered nothing but denials to their questions.

Patients need time to process the illness or possible death of their therapist. Everyone has the right to stay or leave treatment when their therapist faces a debilitating illness. Due to the therapist's vulnerability, this is truly a difficult task. For example, when I returned to my practice from my recent illness, one supervisee stated he was leaving. He did not want to feel trapped by an assumed obligation to take care of me. Opening up a discussion was not easy for either party. However, it was also an opportunity to deal with separation and loss for both participants. When my supervisee informed me of his intention to leave, my own physical and emotional vulnerability required a good deal of processing both in and outside of the supervisory session. Ultimately, I recognized that there was a boundary regarding the investigation of this request. He had the right to leave regardless of the underlying emotional conflict, this was not therapy, but supervision. My physical vulnerability became an important factor in my acceptance of my limitations, and once again, I faced surrendering to forces I could not control. In this example, the physical reality of being older, illness, the limitations of role and lifespan, all became aspects of the challenge of working as an elderly supervisor.

I wish to elaborate with some further personal information. I do not accept long term patients, but even those who come for short term contact require processing regarding their choice to see an older therapist. Both parties need to explore the very real possibility that treatment could suddenly be limited or curtailed by unexpected illness. In the back of my mind looms the specter of patients taking care of therapists who have not been able to accept that they are no longer healthy enough to conduct treatment. The notion of patients taking care of me fills me with shame and abhorrence. I remember a senior therapist who was in the early a stage of cognitive deterioration. Some of her patients were already taking care of her. As colleagues, we were able to help her face the possibility that she was no longer equipped to do her work. She reluctantly agreed. My hope was that I too will encounter colleagues that would have the courage to inform me of my personal deterioration should this occur.

Neurological research has an important place in this discussion. We are all painfully aware of how short-term memory becomes impaired with aging. However, there is a saving aspect to this decline. As a consequence, there is more room for long term memory to ascend into consciousness. Parts of relationships that have been long forgotten suddenly erupt; old music, movies and literature reemerge with striking vividness.

I return to the personal to illustrate this process. I will cite my own history. I think of my sister and her relationship to her son. From my perspective, she has been both overprotective, infantilizing and yet harbors a deep disappointment in her son's inadequacy. In the past I viewed my sister as a very sophisticated version of my mother who also expressed deep disappointment in me as her son. As I have gotten older however, memories have emerged of my sister's helpfulness in my struggle to become a man. She intuitively knew what was needed. She became my ally as I struggled to wrench myself from my mother's grasp. She knew I needed the companionship of boys and recommended that I go to the local YMCA. I now remember her care and thoughtfulness and recall her listening to my growing interest in girls and with a non-judgmental and supportive ear.

This version of my sister as a good mother substitute in my early years now merges with a very different sister who was mother to her own son. Struggling with these multiple versions of my sister produced a richer, more complex relationship both to her and even my mother. The healing of this split has produced a greater acceptance regarding a very complex relationship. As with many relationships, we are a mixture of positive and negative forces. Our splits tend to oversimplify and distort relationships into good or bad, loving or rejecting. In mending these splits, there arises a loving openness that is less judgmental and more accepting of both others and ourselves. Healing splits creates a freedom and an emotional capacity to deeply accept and face life's possibilities. What has emerged with my relationship to my sister is a striking example of our increased ability to resolve complex and difficult formative connections as we age. We are all a mixture of positive and negative life relationships. When patients offer a simple version of something as all good or bad, this is a red flag to go deeper to understand the parts that have been left out. For myself, I am more at peace with my own internal splits.

Becoming an older therapist has created a number of changes in my clinical perspective as well as a deeper comfort with the therapeutic process. I am more patient with an individual's unique rhythm in processing therapeutic material. I now await closure rather than injecting a connection that only creates a surface integration. The Serenity Prayer often used in A.A. comes to mind. I hope that now I have gained the wisdom and courage not to try to make things happen that I cannot control. This thoughtfulness can be acquired at any age. I do believe, however, that facing and enduring the life cycle crises intrinsic to aging contributes to a broader perspective. As an older supervisor, I probably am less omnipotent and aggressive in my confrontations. I have also evolved in my interventions, becoming more mirroring and supportive. I offer more information and explore countertransference. I understand that growing as a therapist is a lifelong process.
At 91, I still have much to learn.

If you have the opportunity of working in a nursing home, you may encounter patients that are hungry to tell you their life story. I believe that the eagerness to share one's life story creates a reflectiveness between the past and present and the forces that seem to govern our lives. Because of this development, I believe that some older patients are natural candidates for psychoanalysis. For them, this quest for life integration becomes a transitional point from one level of consciousness to another.

I cannot deal with the issues of becoming older without addressing our relationship to death. Depression can become an important cornerstone of this period. We see instances of life long chronic depression, as well as intermittent periods of sadness and despair that revisit the older person. There are many aspects of therapeutic intervention related to the meaning of death all of which demand a good deal of thought and reflection. Many books have been written about the meaning of death. My intent here is merely to open up the door for a dialogue.

As therapists, we encounter elderly patients who are very bitter and depressed about the prospect of their death. If they are articulate, they may lament "is that all there is? I feel cheated". Some see death as a deprivation. Others fear death as a symbol of the destruction of the self with little to honor or respect. Others lament whether anyone will remember them once they are gone. Depression emerges with each loss of a relationship and injury to their physical capacity. Old age is not golden but is often full of pain, sadness and loss. In some instances, this depression has been part of a lifelong pattern. For these patients, old age simply means the end, nothing else.

Certainly, there are accounts of a near death experience that present a different perspective about death. These individuals report bright light, serenity and a sense of peace that is hard to describe. However, for the most part, the idea of death becomes a projection of an earlier traumatic experience that includes a very dysfunctional attachment relationship. These patients present a most challenging therapeutic experience. How not to merge and yet be open becomes a very difficult balancing act for any therapist. For myself, their depression invades my very existence. From the very beginning of contact I feel a dreadful heaviness as they enter my consulting room which invades the entire atmosphere. I struggle to regain my center and ground. Often, it is only after focusing on my breath in a deep and intentional way that I can be with the power of their unconscious. This takes an enormous amount of discipline and focus. In treatment both parties struggle to stay present. In these instances, my awareness is constantly thrown into a deep hole, and I struggle to regain my own rhythm and separateness. This process becomes the hub of treatment. When we encounter patients with prolonged depression, we face our own limitations as well as humility. Sometimes I recommend a visit to a psycho-pharmacologist.

Throughout the process of aging, I have struggled with shame in sharing my personal vulnerability. In this past year I have encountered a series of cardiac difficulties which required that I was away from my practice for 4 months. Patients and supervisees appreciated the information I shared with them. I told them how long I expected to be out, the nature of my illness, and that I was making progress in returning to work. Most of the people in my practice found this information helpful. However, a piece of me would have preferred to keep this information confined to my immediate family. Yet, when I did return, everyone appreciated the information. As a consequence, I felt much better for sharing it.

As I become older, I encounter many more physical limitations. In the past, I have enjoyed being physically active, but now walking has become a task that I do for my physical health. Sometimes, my body aches and I shamefully decide to spend money on myself to take a 3 block taxi ride to the bank. I remember my parents living through the depression and vividly recall how they saved money by shutting off the utilities from time to time. There simply was not enough money to go around. I am still impacted by this experience. Many individuals in my generation have constantly prepared themselves for financial disaster. I often smile at myself that sometimes, I still think I need to hoard my money for my old age. I am aware that adults of a different generation anticipate the world to be much rosier and supportive. Much to their chagrin, life sometimes becomes a more difficult struggle than they anticipated, which, in turn, plunges them into a state of frustration and bewilderment.

When I first started the Art Therapy program at Pratt, most mental health professionals never heard of the term art therapy. Applicants came to the program with a sense of excitement in exploring something new and different. However, when I retired from Pratt, applicant attitudes evolved into something very different. Questions of a very different order constantly came up in class discussions. The requirements to become a professional and meet all the standards was foremost in their mind. Art therapy had become an established profession with all its attendant regulation and red tape.

Another example of our changing times is the ubiquity of the computer. My grandchildren are adept with the use of the computer, having been exposed to this resource in kindergarten. For myself, acquiring computer competence often leaves me left in the dust. I do not type. Thankfully, I can employ people to do computer work because I know that there is much information that can only be communicated efficiently and effectively by computer and over the internet in today's society. If I did not have the money to employ someone, I would reluctantly learn to use the computer, although I suspect that I would feel frustrated and angry with yet another task that takes me away from what I really want to do.

I think smartphones are wonderful, but I still stay with my landline. The technological revolution has speeded up time and information gathering. This evolution boggles my mind. Many of my patients laugh when I say, "please don't send any messages by internet or text; leave messages on my answering machine". It looks like my equipment comes out of the dark ages.

Insurance companies have also had a major impact on the current practice of therapy. I don't accept patients who are covered by insurance for I am not accustomed to being supervised by a clerk in an insurance office. However, I will accept patients out of network, but it is their responsibility to deal with the red tape of reimbursement. In the near future, I will be open to working with Medicare patients as I am aware that my personal doctors fall under Medicare, and I would be reluctant to see anyone who is not covered by this insurance. I am told that one mistake on a Medicare application invalidates the entire request for remuneration. The red tape to apply as a provider under Medicare seems very formidable. If I do decide to become a Medicare provider, I will find a technician to take care of the technicalities of working with government regulations. Money spent to hire a technician becomes a good investment for many elderly therapists.

The changing culture has also introduced new terms that are not very comfortable for me to live with. I now have become acquainted with the many meanings of “queer” and the subtle distinction between that and being bisexual. I understand that the term African American is no longer “politically correct” for not all black people come from Africa. With the above changes emerges a growing awareness of the bipolar push and pull of our society. There is a tremendous force towards regulation and control. Working in a community agency becomes overwhelming due to the flood of forms that take up time available for seeing patients. Control and submission to authority becomes an important force that we must contend with. Today, there also exists a counter force that opposes control, phony regulation and stereotyping. As part of this complex culture, we encounter a growing sensitivity to gender characterizations that lead to pathologizing. Many of us still remember the experience of associating homosexuality with mental illness. Today, some of my colleagues are still not comfortable with homosexuality as an expression of freedom. Coping with these new developments stretches my tolerance for change.

In the last 10 years, my approach to patients has changed. I am more aware of non-verbal attachment theory and the interventions that arise out of this development. The body has become extraordinarily important in the transmission of sensory motor contact. Yet, a great amount of psychoanalytic training is both cognitive and theoretical. Even therapists that I have trained are still drawn to the interpretive and cognitive. I believe training in sensorimotor resonance can become an important cornerstone in learning the sheer breadth of therapeutic interventions. In being an older therapist, I find this development easy to understand. I have always been drawn to the non-verbal as an important part of treatment. However, there are few institutes that offer training in both non-verbal and more traditional ways of working.

The basics of psychoanalytic training still remain a very important framework for my therapeutic work. Yet, I do believe that space must be made for an expanding theory that synthesizes change rather than becoming mired in old therapeutic roles that are not as effective. A resistance to change may be part of the story of becoming an older therapist. There is also a good deal of evidence that an older therapist can become expansive and innovative while still respecting some of the basic fundamentals of treatment. As an older therapist, I struggle with being open and still maintaining my center and ground in my rigorous training as a psychoanalyst. At the core of our response to all these new developments, there can be a deep sense of shame regarding the vulnerability to life’s changes. Yet, in sharing all of these cross currents, we may find ourselves less alone and better able to expand, as we struggle with the dynamic conflicts of becoming older and perhaps a little wiser.

I cannot end this paper without reflecting on the social climate that surrounds us. I am so aware of a societal backdrop that is full of chaos and polarization. My older supervisory groups cannot contain themselves from sharing their thoughts about politics. Even some of my younger supervisees now talk about the current political situation. This is unusual when their thoughts would usually be in the realm of establishing themselves as practitioners and a professional identity.

As an older therapist, two points in history come to mind that are cogent to our current situation. Both the period of McCarthyism and the second world war are vivid lessons in our dealing with tyranny. In the former period, the tyrant, McCarthy, ultimately pushes the boundaries to create the seeds of his own self destruction. We simply gave this tyrant too much space to wield his destructive influence. Ultimately it was the army that stood up to him. The McCarthy period was bleak, but we survived it. In World War II, many people lost their lives before we faced the stark reality that there was no compromise with a tyrant except to kill or be killed. I still remember Chamberlain, the prewar prime minister of England, who compromised with Hitler by annexing Czechoslovakia. He labeled this compromise “Peace in our Time”. England and America later learned that we had no choice but to fight rather than bury ourselves in a state of disassociated passivity, denial, or worse still, identifying with the aggressor. In both instances, fear and terror became an instrument of an evil force that traumatized the world. As an older member of this society, these memories vividly come into consciousness. There are lessons to be learned from history. Do we need to learn all over again that our collective voice is an important part of our very survival? Obviously, there are no simple solutions to a very complex world. As a member of the older generation, I am keenly aware of how the personal and the societal overlap one another. A powerful dialogue may be an important step towards the synthesis of many diverse voices.