The Older Patient in Psychoanalysis

Arthur F. Valenstein

The demographic shift toward extended longevity has led to a commensurate increase in the length of the working and productive years, and with it an increase in the number of so-called “older” patients who come into psychoanalysis or psychoanalytic psychotherapy. This led the Psychoanalytic Research and Development Fund to support a four-year study by a small group of experienced psychoanalysts of “the older patient in psychoanalysis.” Aging and old age are considered to be the final developmental crisis of the successive epigenetic phases of the life cycle. Eleven case presentations and various briefer clinical vignettes informed us that older and even old individuals, who seek treatment themselves or who are appropriately referred, respond in a positive and effective fashion to psychoanalysis and psychoanalytic psychotherapy. As do younger patients in analysis, such older people, motivated by the wish to make the most of what time is left, become interested in understanding their pasts with respect to the present and the future. The life stories of two older men who undertook analysis, and the courses and outcomes of their analyses, illustrate our findings and impressions. In both cases conflicts and difficulties from earlier developmental phases, extending back even as far as the oedipal and preoedipal years, were revived during their older years. And although these conflicts might have been beyond definitive resolution, what is salient is the extent to which they were ameliorated: sufficiently that they did not impede a satisfactory adaptive solution of the final crisis of the normative sequences of the life cycle.

If magic were to play its part, as indeed it does for the very young and for the very old whose second childhood is proverbially upon them, I should invoke the spirit, if not the presence, of Mark Twain,

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who was but a young sixty-six in 1901, when in a letter refusing an invitation to attend 80th anniversary celebrations of the state of Missouri he wrote:

I am admonished in many ways that time is pushing me inexorably along. I am approaching the threshold of age; in 1977 I shall be 142. This is no time to be flitting about the earth. I must cease from the activities proper to youth and begin to take on the dignities and gravities and inertia proper to that season of honorable senility which is on its way.

This prologue may be a clue to how my interest turned towards psychological aspects of the process of aging. It followed quite naturally from where I am on the chronobiological slope of life, but it has a source from without as well: from patients at this phase of the life cycle who have consulted me or otherwise come to my attention. Some have been in analysis, even at quite an advanced age, and others have been in psychoanalytic psychotherapy. Fortuitously also, about eight years ago I was invited by the Psychoanalytic Research and Development Fund to chair a small group of experienced analysts in a systematic study of “the older patient in analysis.” It seemed timely to undertake such a study in view of the demographic shift toward an older population, the longevity of which has been substantially extended, as has the span of its working and productive years. Concomitantly, a change of view regarding the accessibility of older patients to psychoanalysis had taken hold. Psychoanalysts were and are seeing more so-called “older” patients in their widened practice of psychoanalysis.

In substantial measure I shall draw upon the data of this study group, and on some aspects of the discussions that took place at its meetings. I trust that I do so in a reasonably correct and representative fashion. Nonetheless, this paper essentially represents my own thoughts and elaborations.

1 The original members of the study group were Martin Bergmann, Joseph Coltrera, Alvin Frank, Sidney Furst, Alexander Grinstein, Philip Hershenfeld, Deanna Holtzman, Daniel Jacobs, Peter Neubauer, Henry Nunberg, Mortimer Ostow, Bernard Pacella, Arthur Valenstein, and Annemarie Weil. Several were lost to the group in the course of time, and in the closing phase of the study two participants who had presented clinical cases, Ruth Lax and Samuel Herschkowitz, joined the group.
Over the course of the study we were informed by eleven case presentations and various brief clinical vignettes.

Historical Antecedents and Literature

The literature about growing older until finally one is inescapably aged is vast. I can hardly do justice to it, and necessarily shall be narrowly selective. The philosophical musings and poetic references from ancient and biblical times, and on to the present time, speak to the continuity over the centuries of experientially directed attitudes toward aging.

Psychologists, psychiatrists, and sociologists have published much about the process of aging over the last fifty years, but most of them write at a manifest level. Comparatively recently, though, contributions referring directly to unconscious currents and motifs have increasingly come into the literature, largely in consequence of the broadening of the domain of psychoanalysis to include developmental and adaptive processes that are dynamically active throughout the lifetime (see, for example, Abraham 1919; Berezin and Cath 1965; Bibring 1966; Cath 1985, 1986, 1997; Cath and Miller 1986; C.D. Cohen 1985; N.A. Cohen 1982; Coltart 1991; Crusey 1985; King 1980; Grotjahn 1985; Hildebrand 1985, 1987; Hinze 1987; Kahana 1980; Levinson 1985; Nemiroff and Colarusso 1985; Notman 1985; Pollack 1987; Radebold 1994; Sandler 1984; Segal 1958; Settlage 1996; Simburg 1985; Wylie and Wylie 1987). Perhaps Freud's early (1898, 1905) statements about the inapplicability of analysis to "people who are very advanced in years" discouraged the application of psychoanalysis for the older person—which at that time meant those in their late forties and the years beyond. Paradoxical and outmoded though Freud's statement

3 “Psycho-analytic therapy is not at present applicable to all cases. It has, to my knowledge, the following limitations. It demands a certain degree of maturity and understanding in the patient and is therefore not suited for the young or for adults who are feeble-minded or uneducated. It also fails with people who are very advanced in years, because, owing to the accumulation of material in them, it would take up so much time that by the end of the treatment they would have reached a period of life in which value is no longer attached to nervous health” (Freud 1898, p. 282; emphasis added). The qualification at present is historically significant. At various times in his writings Freud made it explicitly clear that he did not have a closed mind pertaining to future advances and modifications of psychoanalysis. “We must be patient and await fresh methods and occasions of research. We must be ready, too, to abandon a path that we have followed for a time, if it seems to be leading to no good end” (Freud 1920, p. 64).

4 “Freud's comments on the educability of older people and the elasticity of their mental processes around age 50 are ironical; this is especially true because he wrote this when he was nearing his 50th birthday during a productive creative phase of his life and work in which he seemed most educable and elastic. There is the further irony in that Freud's view of the greatest masterpiece of all time was a work done by a playwright in his 8th decade. Sophocles was 71 when he wrote Oedipus Rex.” (Cohen 1985, p. 196).

seems today, his position becomes understandable in the context of evolving ideas in psychoanalysis. It should be recalled that analysis was a conflict psychology during the early days of its theory and practice, and it continued so in large measure throughout Freud's lifetime. But the view then—and it prevailed into the 1960s—was that analysis was best suited to younger people whose lives were much ahead of them. They could look forward to a life expectancy that would be substantially greater than that of their seniors. Perhaps, for them, certain major life decisions would not yet have been made or been irreversibly consolidated; and they had more of a future for change and readaptation. And since their character structure was likely to be more elastic, there was potential for a vital enhancement of their intrapsychic and interpersonal capacity “to love and to work.”

5 Obviously, though, insofar as it was exclusionary, such a view was detrimental to the psychoanalytic study and treatment of the older individual.

Since the concept of the infantile neurosis, i.e., the oedipus complex, was central to the theory of neurosogenesis at that time, it followed that for the older patient this paradigm complex would be deeply repressed and virtually inaccessible behind all that had transpired during the intervening years of living and aging. Furthermore, even if core conflicts could be lifted to consciousness, how much opportunity might there be in time or in life to make use of the insight and freedom that had been gained?

Retrospectively, though, it becomes clear that once analysis was supplemented by contributions from two directions, the prospect of analysis for older individuals changed (Hildebrand 1987). First, following on Hartmann's (1939) introduction of adaptation as an ego-psychological attribute, came the psychosocial
developmental frame of reference elaborated by Erik Erikson (1950, 1963) and its exegesis by David Rapaport (1956)—namely, a theory of epigenesis that is normatively operative throughout the lifetime, including the final developmental crisis of “old age.” Second came the developmental data from systematic infant observation and child analysis. Once integrated, these advances led to a clinically applicable developmental and object relations theory. And from this came the therapeutic relevance of relational features in the psychoanalytic process, which contribute to the transferential ambiance and to the effectiveness of the analysis of the older patient.

5 Attributed to Freud by Erikson (1969, p. 96).

### Aging and Biological Features

Aging is biologically inherent in a life process that is genetically encoded and phenotypically expressed from the beginning. Just as every organism is programmed for growth and the nodal phases of development, so is it uniquely programmed for longevity, for old age, and for its inevitable outcome, death, according to its genetic timetable, barring extrinsic or iatrogenic psychological and/or physical intrusions that may prematurely shorten or terminate its expectable life span. We may say that aging is driven by a biological clock, but that the clock ticks more slowly for some than for others. Its balance wheel is sprung by both genetic and environmentally induced biological and psychological factors.

Perhaps biological truisms such as these implicitly and explicitly influenced Freud to introduce his speculative and controversial suprordinate theory of the two classes of “life” and “death” instinctual forces. After all, Freud came from a richly creative preanalytic career in neuroscience and neurology, and he never really abandoned science and biology as a frame of reference for psychoanalysis. Looking back, he might have been on a firmer footing had he more closely held this theory to its biological underpinnings, rather than applying it to psychoanalytic metapsychology—as some who followed him have done more literally than metaphorically. Freud (1920) postulated that the death instinct, the inevitable trend toward Thanatos, exists in effect under the aegis of life: that it is a special case of the life instinctual drives in that one strives to live so as to ensure that one finally dies in one's own unique fashion, according to a biologically predetermined genetic destiny.

But are there any compensations that come with the biology of growing older? What accounts for the fact that older people are said to mellow and become wiser as they age? The term “aging” parenthetically implies the biological process of a general physical decline and metabolic involution. Although the mind/body distinction is a useful conceptual construct, it is not an actual biological dichotomy, and it follows that the endocrinological downturn will find its psychological reciprocal. Consequent to the catabolic involution of the hormonal level and equilibrium that comes with aging, there is a gradual diminution of the sexual and aggressive drives. But there are qualitative and quantitative variations among individuals, and this influences the timing and extent of these changes, which occur earlier and more extensively for some than for others. An exceptional few celebrated personages, such as Bertrand Russell and George Bernard Shaw, keep their alacrity and libidinal vitality, and their mental acuity and creativity, until virtually the end of a very advanced age (see, for example, Settlage 1996). Older people are less driven by the restlessness and impulsion to action that vitalyze youth. Aging is associated with a shift in the balance between thoughtfulness and affect-suffused impulsion to action. In the course of living over a long time, a person accumulates a considerable experience in the outer interpersonal world and concomitantly within the intrapsychic world. As the “fires” of passion and aggression die down and become less peremptory, relatively dispassionate reflectiveness in the setting of a broadened and deepened life experience is likely to lead to sage and considered judgment. In earlier times, and in simpler societies less under the pressure of modernity and competitive materialism, the older person was customarily celebrated for the sagacity he had presumably gained in the course of becoming older.

6 The average longevity of a mouse is three years; of a dog, twelve years; of a chimpanzee, twenty years; and at birth for humans in the United States, it was recently (in 1992) seventy-two years for men and seventy-nine years for women, an increase of approximately twenty percent over the last fifty years.
Being “older” but not yet old is one thing, but becoming really old in fact is usually deplored.8 The celebration of old age may be sincere and more or less gratifying—depending on the individual and his culture—but such honoring is compensatory, and adaptively it serves denial. Even so, it may ring hollow once capabilities and stamina are depleted, and age and illness begin to take their toll on body and mind. Becoming older relieves one of the heat and expectations of youth, but it also gradually depletes one's own resources (see, for example, Grotjahn 1985). Not only is there the departure from the era of one's epoch of youth and one's contemporaries of earlier years, but a reifying narcissistic self-sufficiency is endangered, not that this is exigent for

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7 “As age blunts one's enjoyment of physical pleasures, one's desire for things of the intelligence and one's delight in them increases accordingly.” (From Plato's The Republic).

8 Galen in the second century “looked upon old age as something lying between illness and health” (de Beauvoir 1972, p. 18). Dr. Johnson wrote in a 1784 letter to W.G. Hamilton, “My diseases are an asthma and a dropsy, and what is less curable, seventy-five years.” And John Mortimer (1988), born in 1923, said, “When you get to my age life seems little more than one long march to and from the lavatory.”

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everyone. When all is said and done, life’s arrow points in only one direction, and life is a once-run course.

I will now turn to the relativity of becoming “older,” and the use of that term, before turning to illustrative clinical material and several facets of our topic that it illustrates.

**The Relativity of Time and the Nostalgia of Memories: The Term “older” and its Several Meanings**

During older years time is sensed as passing more quickly than in the younger years, especially the years of childhood when time carries the subjective quality of being inordinately viscous. Some of you may recall how unbearably long the early grade-school year was—as if the summer vacation would never come. Gifford (1978), writing on “Some Developmental Aspects of Time Perception,” points to “the familiar phenomenon of time passing more quickly with advancing age, which is usually associated with a gradual reduction in the variety and intensity of sensory stimulation.” He interprets this as “a possible adaptation to the involutional phase of life” (p. 131). Still, more than involution may be involved, especially for that subset of highly productive individuals who seem to have been generously endowed with élan vital. They seem never to have had enough time for their interests and activities. Aging, once it sets in, seems to propel time so that it passes even more quickly than before. And the attendant gradual decline in mind and body becomes an omen, signifying the foreshortening of life. It is just such high-energy individuals who are prone to discouragement and depression once inroads are made on their vitality, and they may be the very ones who can be helped by psychoanalysis.

Throughout life a dynamic tension exists between living in memory within a nostalgia of the past, and living in the present towards the future. Characteristically this comes to fruition during the aging years. The extent to which older people live in reminiscences of the past, nostalgically romanticizing memories—or at least what they construe to be unadorned memories—is legendary. After all, since living forward is hindered by the loss of physical vigor and mental alacrity, as well as by the algorithmic curtailing of the life-span, living backwards amounts to paradoxically recapturing and reliving the past, impossible though this is in reality. The same old stories are told time and again, to the boredom or exasperation of younger family members. Such phrases as “It was better in the old days,” or “You have it easy; you have no idea how life was back in olden times, let me tell you,” are commonplace. A comment of Mark Twain is again succinctly to the point: “The older I get the more vividly I remember things that never happened.”

Pollack (1987, pp. 3-29) suggests that liberation from lost objects and aspects of the past does not occur unless these are adequately mourned. A concomitant aging process, should there be one, only adds to the feelings of deprivation and abandonment. Probably to a certain extent it is so that nostalgia—each person's “remembrance of things past” (Proust 1913-1927) is part of a normal mourning process. Pollack recommends that older patients can be psychotherapeutically helped to complete this mourning process, so as to free themselves of the depression that implicitly envelops the lost objects of the past. Thus liberated they are enabled to move on actively into the present. This may be true, more so for some than for others, but that is not all there is to the ruminations of those who grow
older. For it is also adaptive to live life where it is more to be found, through a lengthening out of the past in compensation for the foreshortened future. It follows that Proustian memoirs and creative autobiographies flourish during older years.

But the term older is ambiguous in itself. Literally, it is no more than a comparative measure of objects and their functions along a time scale. Only by the nature and consensual understanding of its application is it lent psychological and social specificity. When a first-born child is said to be older than her younger brother or sister, the term older refers to sibling order, with the implication of physical, psychological, and social differences among the children. It does not signify aging within the concept of old age as the final psychosocial stage in an epigenetic developmental schema of the life cycle. Even so, there too it is a relativistic measure when applied to the developmental phase of old age. Older does not distinguish between those who are older by having gone beyond the lifeline position that is biologically marked by the climacteric for women, and a corresponding normative mid-life developmental crisis for men. One age bracket might include those who are between fifty-five and sixty-eight, in distinction to those who are perhaps seventy-five and beyond. For the latter, it is true that they are older, but parenthetically, the term “older” is euphemistically preferred over having really become old, or even aged, to use a world that is to be avoided all the more because of its pejorative connotations. For much

older persons the time gradient is distinctly steeper, and their lifetime is limited. The goals and aims of analysis remain parallel to those of the younger patient—namely a relative reduction or resolution of intrapsychic conflict and interpersonal disharmony, and a better adaptation to where one is and to what lies ahead—but there are differences, which I shall discuss further along.

“Older” has further nuances as well (Kahana 1980, p. 318). I call those who are in their mid-fifties through upper sixties the younger older group. A patient who is older but paradoxically also younger still has time for an active life with opportunities for change. In consequence he may be strongly motivated to assimilate and work through the experiential and insightful yield of an analysis. Human nature being what it is, though, what usually comes first is denial in thought or deed that growing older might be in the wings. Magical thinking and the power of fantasy exert their force. Somewhere there must be an equivalent of the proverbial “fountain of youth” to ensure one’s future and immortality; if not in this life, at least in the hereafter.

Commonly enough, denial is lived out or acted out through a metaphoric restitutional grasping for the brass ring that would entitle an older adventurer to a “freebie,” a once-again ride on the carousel of youth. But in due course, as the reality principle becomes influential, denial becomes less tenable. Perhaps a latent realization that one is growing older comes to the manifest surface, motivating an intention to make better use of time before choice and active living are pre-empted by old age—older older. A woman of sixty-two on beginning psychoanalytic psychotherapy said, “I guess I should be working very hard so that I can use and accomplish with the time I might have left in order to live life at its best.” Such a woman is probably one of that subset of sturdy people who are outside of the usual time curve of aging: who are exceptional in maintaining their physical vigor and their active psychological and social capacities.

But what of those whose aging has gone beyond the cusp, who are in their eight or even their ninth decade, the so-called older older patients? Indeed, they are aging, but as earlier mentioned, the term older is preferred over old, since in our time and culture old is an approprium, implying that one has become a useless burden to be

shunted aside. For those who are now really aged, infirm, and penultimately vulnerable to final illness and ultimate termination, old age is truly an affliction. 10 I was once told by an academic whose “little gray cells” were fewer but who was doing well and was still productive, of having been dismissively referred to by a younger colleague as “that really old one.” Indeed, she was on the further shore of being older, but not yet exigently so. Notwithstanding, even if one is more enlightened and gracious about it, is there a place for the old and for the psychoanalytic or psychoanalytically informed treatment of the old? Simone de Beauvoir (1970) left us a salutary volume on the societal devaluation and neglect of the old, titled The Coming of Age.

The goals and aims of analysis or psychoanalytically informed psychotherapy for the really old are of a different order, because for them the future is incipiently a non-future. To put it structurally, there are limitations on

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9 Leo Berman (personal communication) stated: “Where does acting out end and living begin?”

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the intrapsychic reorganization of id, ego, superego, and reality. From an adaptive point of view, the surround and
the realm of the interpersonal are likely to be more circumscribed. And finally, going from living under the sway of
the “life instinctual drives,” as Freud metaphorically conceptualized it, to dying, returning to a disintegrated
inanimate state in keeping with the so-called “death instinctual drives,” is the inevitable endpoint of the
developmental crisis of aging. A sensitively informed psychoanalytic psychotherapy, as has been described by a few
analysts (Eissler 1955; Nemiroff and Colarusso 1985), may facilitate the traversing of this rite of passage. Within
an empathically responsive transference-countertransference matrix, the values and perspective of a mutually
understood or shared Weltanschauung may be salutary. Gene Fowler, a journalist of an earlier decade, said to a
friend as he lay dying in bed, “Please hold my hand. I was always afraid to go home alone in the dark.”

The following two cases illustrate the diversity of factors encountered in the analysis of the older patient; they
are quite different, though they share some aspects of the psychological impact of the aging process.

10 H.G. Wells titled his final work A Mind at the End of Its Tether (1945). As recently as seventy-five years ago the following
custom was part of a stone-age Eskimo culture that was highly adapted for survival. When the “old one” could no longer
contribute to the hunt and had become only a burden, it was time to go. The “old one” would ask to be left behind from the hunt
in a completely sealed-in igloo (see Freuchen 1961, pp. 199-204).

Illustrations

The First Patient

This story of a successful business man who returned to analysis when he was sixty-five is representative of the
younger older man who still has time for an active life and the possibility of significantly modifying its course. Henry A. had been unhappily married for about thirty years, but the marriage was breaking up coincident with his
having fallen in love with another woman, whose marriage also had been emotionally unfulfilling.

Ten years earlier he had been in analysis for a period of three years because of insomnia, nightmares, and fears. Also, although he was highly successful in his business, he functioned in it with such aggressiveness and intensity that it stressed him and his associates. This analysis was considered by him to have been successful because he had achieved what he came for—the alleviation of the presenting symptoms. His analyst felt that the real core of the
incipient panic that lay behind his effectiveness and success had not really been reached. More tranquil and less
driven, he had left that period of analysis still emotionally deprived and apparently not able to love deeply. Nonetheless he himself was satisfied with what had been achieved and he decided to interrupt the analysis.

Seven years later he returned to the same analyst because he was no longer satisfied to live life as he had been
doing. Some thirty years earlier he had married a very attractive but emotionally unavailable woman, thoroughly
unlike his mother in appearance and manner. Nor was she intrusive, demanding, or controlling as his mother had been. But she turned out to be distant and unavailable, and did not change through the many years of their marriage. Although they had three children, they, too, were disappointing, and did not fill the void for this increasingly sad and lonely man. Even though physically fit and vigorous, he had given up on sex, having resigned himself to a belief that he was just too old for it. Feeling that it had passed him by, though, contributed to a mood of defeatism and reactive depression. He returned for further analysis because for the first time he had become consciously aware of the
limitations of his life as he had been living it, and the uncertainty of his future. He had not yet met the woman with
whom he was now planning a new life, but he was preoccupied by the emptiness of his life, and that was his
emotional ambiance when he did meet her.

They met by chance, although we might see it as an existential moment—as chance from without encountered
by a prepared mind and a seeking heart from within, so to speak. Both he and this woman often walked along the
river of the small city in which they lived. From time to time they would pass each other, and after awhile they
began to greet one another. Next they started to walk together. A friendship grew around common interests and
the emptiness of both their marriages, for both had spouses who were emotionally unavailable. Over a period of four or five months their mutual attraction deepened, and they became intensely involved in a highly
passionate love affair. They resolved to divorce, to marry, and to be together. He who had never been able to
really love a woman felt transported, so fulfilled was he by Jane N., this new woman in his life. In marked
contrast to his wife, Jane was intellectually and emotionally responsive, and sexually passionate. Never before had he been so drawn to a woman; so much in love was he that sometimes he felt as if he were an adolescent, sexually renewed and experiencing a life he had never known when he was young. In this final developmental phase of aging, it appears that he was reliving unknown aspects of adolescence.

Yet he continued to be thoughtful and concerned for the well-being of his wife, who apparently had always been an emotionally isolated and fragile woman. He said: “I have to make a choice about my future. If I go back to her and give up what I have with this woman, I will be in prison. I will have no one and will be alone.” At the same time he felt guilty about abandoning his wife, and when it came to the divorce he did his best to ensure her financial security and to protect her.

About his background, briefly: he was the younger of two children of Jewish parents, second generation in this country. His father, a big, powerful man, was said by his mother to have been impossible: an excitable shouting man to whom she had had to subordinate herself. His own memory of his father was quite different. He recalled his father as having been close to him, sharing and protective of him, and providing of a sense of security. Once he came into analysis, this was decisive for the form of the transference, wherein his analyst became a protector much as his father had been when he was a child. In contrast, his mother was an anxious woman who believed that no one was to be trusted. She constantly warned him that life was dangerous and that one always had to be ready to fight. True, his father had had high expectations, but he shared that value with his father, and was an

achiever. Unfortunately, his father died when he was fourteen. For Henry, that meant losing the only person who had been on his side. He was left in an inconsistent position: he was dependent upon a mother who accentuated his fears, and he had to escape from her for that very reason. So he finished high school at fifteen, and went to a prestigious college, where he finished by the age of eighteen.

He went on to have a highly successful career, due in considerable measure to his identification with his strong and effective father, but also guided from within by his mother's attitude that in every encounter in life, in every negotiation, you had to be prepared to fight. These motifs had colored the transference during his first analysis, in which the analyst came to be a securing figure in replacement of the lost father. At the same time the substantive content of the analyst’s interventions and the tone of his voice additionally affirmed that he was the very antithesis of the patient's mother, who had invariably cautioned him to “watch out,” nullifying any sense of safety. Similar aspects sustained the second analysis, but were further worked through in the ambiance of his love affair with Jane. In that setting he recapitulated and completed previously arrested developmental features of his adolescence towards the realization of a capacity to trust and intimately care for a woman.

To turn back to his affair with Jane, at its height it was exceedingly passionate and romantic, with great expectations, but it was no simple “love story.” He divorced and she undertook to do so as well. But as they undertook the merging of their households the going was not easy. Devoted to the patient as she was, and determined to please him and make him happy, Jane, unlike his wife, was an active woman with a mind of her own, although she was neither competitive nor uncompromising. So that he might adapt to her essentially reasonable preferences and autonomy, the patient was engaged both in the analysis and outside of it in working through his transference predilections from his father, and his incipient distrust of, and fears of being controlled by, a woman. Still, once they actually began living together there were practical differences between them in their modes of daily living and adjusting to each other. He increasingly felt that he could not coordinate and orchestrate the arrangements and management of the household with her, whereas just as his wife and his children had formerly, she experienced him as demanding and unfairly expecting things. She said in effect, “I move into your house but I do not feel it is mine or that we share it together. You run it and I feel I am only a guest here.”

He agreed that he was a demanding person but felt that he had made progress and that he had become easier and more given to compromise and sharing, which was true. Nonetheless, she was not completing her own divorce, nor did she definitively sever all social ties to her husband, or give up her own home. He was deeply disappointed that she was failing him in what he most needed: her reliable presence in a shared family home, and love for the future. Finally he said to her, “We are just living together but I feel I cannot rely on you and I feel alone.” So, unhappy as both were at the prospect, for they really did love each other, at his suggestion she moved out with her children and the relationship ended.
Henry was left feeling rejected and depressed and deeply wounded, but he longed for her voice and for contact with her. A miserable sense of painful emptiness (Freud 1926, p. 169) in the middle of his chest was evocative of an abandoned baby crying out, before and beyond words. Fear of abandonment lay behind his dread of being alone and unloved in the future. In his analysis this led to a reconstruction of his life as a child, to his experience of his mother as an essentially paranoid woman who had told him that the world was inevitably untrust-worthy and hostile, and that you had to fight and protect yourself by being in control and always in power. Through this incredibly intense pain his longing for a nurturing maternal object was analytically revisited. And through the analysis of it he came to know and understand his longing for a strong but reliable woman whose maternal presence and caring would protect him against this paranoid mother and all that she had represented.

But hope springs eternal, and after a few weeks he met a very attractive, intelligent woman, Dorothy C., in appearance somewhat similar to those young women who had attracted him in his earlier years. She was a musician, much younger than he, non-Jewish, and totally unlike his mother. Driven by his passionate need for love and attachment the relationship quickly developed towards intimacy. Influenced by her doubts— their age difference, his wealth in contrast to her poverty, and her need to slow things down—he became less driven and pressured her less. After a while she moved in with him and allowed him to support her financially so that she could give up her job and compose. But history began to repeat itself as his need to control her, much as he had always controlled others, came forward. She reacted against it, sometimes angrily, and other difficulties arose related to their difference in age and expectations. So after about two years, she called an end to their sexual intimacy and moved out. However, their underlying affection and friendship was maintained, and he continued to care for her and to be helpful to her in any way that he could.

Although this “love affair” with Dorothy coincided in certain respects with his pattern as a young man of being ephemerally attracted to slim and pretty young women, in major respects it was quite different. For although he had apparently sought and found a sexually exciting young woman, he came to love her just as he had previously cared for Jane. And, more realistic now, his love and attachment to her became intense and abiding even though she was not a vulnerable and dependent woman whom he could control.

Despite an original facilitative narcissism, his potential for caring and attachment had gained ground and deepened through the intricacies of these intense experiences in loving and attachment. And it is doubtful that they could have taken place had he not been in analysis at the time. In due course his expectations further modulated, and his search for enduring companionship turned towards women closer to his age. In his business activities he became less controlling, sharing more with his younger associates. And he became more accessible and much closer to his children.

The women he had sought before marriage, and to whom he had felt drawn during the years after marriage, had always been very young and attractive, but emotionally vulnerable and economically dependent. He had chosen them in reaction to the overpowering and controlling mother of whom he had been afraid. As he understood this and became involved in the analytic working through of it, he was able to make emotionally intense commitments during his seventh decade, first to Jane, who was forty-five years of age, mature, and self-sufficient. When that relationship failed he could again allow himself to fall passionately in love with Dorothy, and to enjoy a sexual and interrelated life with her far beyond earlier expectations. It is doubtful that he could have had these experiences without the analysis, nor could he have realized an increasingly resilient potential for intrapsychic change and interpersonal readaptation.

The Second Patient

A different situation prevailed for a married man who at the age of seventy-seven started analysis with a thirty-nine-year-old married woman analyst after having been in psychoanalytic psychotherapy with her for three years. He had consulted her because of a broad range of anxiety symptoms, including social phobias and panic attacks from which he had suffered for most of his adult life. His wife's ailing health and his sense of time running out motivated him to seek treatment despite failures with seven or eight previous therapists over a period of fifty years. He had been seeing a psychiatrist whose office was on the ground floor, but when this psychiatrist moved to the eleventh floor he had to
discontinue because of incipient panic that would mount the higher he might go. This was the first time he had ever been in treatment with a woman, and it turned out to be fortuitous for the form of the transference as it unfolded, for the interactive nuances of the transference-countertransference, and finally, for the favorable outcome of the analysis.

He alienated others with his sarcasm and avoidance, and had few friends. His dreams were often vivid panoramas of violence and sadism. In the analytic situation much of his rage remained ego-syntonic and came into the open only at the beginning and ending of each session. At those moments he would rapid-fire comments of a hostile or sexual nature at his therapist, veiling them in his typical sarcastic style, while all the time watching her facial expressions.

His analyst, at that time a senior candidate in analytic training, questioned her motivation in choosing somebody who was too old really to finish analysis, and she consulted several senior analysts beforehand. She adjusted the fee structure so that he paid a low fee, which was all he could manage. In effect, this amounted to a gift within the transference-countertransference matrix.

Just before he started the analysis, a mishap occurred that proved to be significant for the development and nature of the transference. His wife, who had always been a trusted and affectionate partner, suffered a stroke. Next, to add to their difficulties, she fell out of bed and broke her hip. A few facts about the marriage are relevant to the transference. He and his wife had no children, and later on, in the course of the analysis, it was learned that their intimate life had come to an abrupt halt thirty-five years earlier, after she had had an ectopic pregnancy. She resigned herself to remaining childless, and they never had intercourse again.

11 Appreciation is expressed to Jolyn W. Wagner for generously sharing her material of this case, and to Max Warren for bringing it to our attention.

In contrast, his analyst became pregnant with her fourth child during the psychotherapy. Doubtless this contributed to the disclosure of his sexual interests early in the analysis, and the emergence of an erotized transference. Concomitantly, as he became more involved in the analysis and increasingly attached to his analyst, his fears of rejection surfaced.

At first he was quite uneasy on the couch, but his wish to sit up diminished the more he talked about his fears and his feelings. He was surprised to find that he was becoming more direct with other people, which he ascribed to his becoming freer and more direct with his analyst. Soon he became openly curious about her, wondering where she lived and yet reassuring her that he was not a “stalker.” She noted “how little seventy years have done to significantly alter his basic fears.” Presently he began to bring small gifts which she accepted, such as several tomatoes from his garden (which led to some bantering about “hot tomatoes”) and other small items. When he became more active with his erotized teasing, she accepted it and responded verbally, but not inappropriately, in a playful way. As this seventy-nine-year-old man, who had been so inhibited socially and so sexually shy and secretive throughout his life, increasingly played out erotic innuendoes and transparent symbolizations, his phobic symptoms receded. With the verbalization of his heretofore warded-off intrapsychic conflicts, and the gradual expansion of his experience of them in the setting of the transference-countertransference, his fear of heights lessened. And in due course he could go up in the elevator to the sixth floor of the hospital to visit his wife each day.

The analysis, as such, was terminated after four years, at which time the patient was eighty-one. The need that he not be “abandoned,” though, for that is how he would have felt it, led his analyst to continue to be available to him when he wished, and as his health and life situation declined she would see him on an intermittent basis. She was there for him when his wife was in the nursing home where she died, and again when he went through several severe illnesses. There is no doubt that his analysis and the subsequent supportive availability of his analyst enabled him to adapt and survive during this closing phase of his life.

Since a detailed presentation of the many aspects of this interesting and unusual analysis is impractical, I shall simply jump ahead to certain general formulations regarding the intrapsychic and intersubjective aspects of the analysis that were therapeutically fortunate and pragmatic for the treatment of a man of this age, whose neurotic problems had been lifelong. Toward the end of the second year of the analysis the analyst noted that in the beginning phase:
…the most persistent limitation of my ability to work effectively with the patient came not from impulses created by character armor that had been rigidified by decades of usage, but by my own counter-transference inhibitions ranging from my own strict childhood upbringing to respect your elders, to concerns and fears about frailty and mortality, and initial indecisiveness regarding his use of sexual innuendoes followed by characteristic disclaimers. “I am just too old, just an old man” [Crusey 1985, pp. 164-165, 170].

She wondered also about the usefulness of delving into the sexual fantasies of an old man who perhaps would have no use for their resolution, and about whether it might have been more productive to concentrate on the more accessible conflicts surrounding the inevitable losses and mourning that constitute old age. She wondered whether an analysand's age should factor into the timespan granted to an analytic endeavor, and pondered, “Is there a greater sense of urgency created by the recognition of the effects of aging, and of course, of mortality?” She concluded that it was necessary to grantsexuality a stature in all phases of life and of the life cycle.

It does seem that oedipal aspects, which had been active throughout and which had been intersubjectively played out to a considerable extent within the transference-countertransference matrix, might have been passed over or at least underestimated. Here she was, young enough to have been the daughter of this man whose wife had not been sexually available to him for years, and who, during his analysis, was old, infirm, and finally bed-ridden in hospital. Initially the analyst had been somewhat inhibited in response to his increasing erotic mischief-making in the transference. A major aspect of thetransference had included her being experienced as an essential maternal transference figure, and to a lesser extent a father figure. However, an oedipal improvisation and recapitulation had also taken place, and in the course of it he apparently recaptured an assertiveness and élan vital that had been inhibited for years and symptomatically embedded in his social inhibitions, anxiety, and phobias. Nor was this analytic experience one-sidedly beneficial; it also added to the analyst's theoretical range and clinical resiliency.

Notwithstanding that much analytic work had been taking place in the best sense of the concept (i.e., interpretative interventions and insight-seeking in both transference and extratransference material), the analysis of this more-than-older man, indeed this old man, took place in an analytic situation that was quite different from the traditional classical model. This analysis turned on an intersubjective transference-countertransference experience that proved to be therapeutic in helping the patient manage better in the present and in anticipation of the future, including the imminence of ultimate termination. It was felicitous for this man, considering his needs and current position in life. In treating an older patient genetic determinants are certainly germane and not to be shortsighted. However, rather than formally following a genetic approach that takes as its primary aim the resolution of past developmental mishaps and conflicts, as if by the book, the analyst must approximate analytic goals to the present position and motivation of the older patient. This analyst did so, perhaps more fortuitously than a more experienced and traditional analyst might have.

This highlights a question. To what extent is such an analysis analysis as such, and when does the psychoanalytic treatment of the older patient become more a psychoanalytically informed psychotherapy? To put it pragmatically, are we seeing the overlap of psychoanalysis and psychoanalytic psychotherapy? Perhaps this question is something of a “buyer's choice,” with the added caution: caveat emptor.

Another way to formulate the question might be to consider that special circumstances enter into the analysis of children and the analysis of older individuals. Adapting analysis to meet the specificities of the successive phases of the life cycle is more than technical parametry; it is analysis within the concept of its widened scope. Just as adult analysis must necessarily be modified to meet the developmental and realistic needs of a child in a child analysis, so the analysis of the older person, especially as he becomes an older older person, is framed differently by nature and circumstances. For a child inanalysis, the analyst is both a transference object and simultaneously a real figure in the life of the child as he progressively develops; and so it is for the older patient. For just as the child makes his way up the developmental ladder towards maturity, the older individual analogously but in reverse awkwardly makes his way regressively down the ladder toward “second childhood.”

A Few Technical Considerations

Throughout the life cycle, epigenetic sequences of development successively mobilize, each in turn, age-related issues for adaptation and progressive growth, and developmental mishaps and conflicts that have been regressively
reactivated from earlier phases. It follows that the final phase of the sequence, old age and its prospect of ultimate “termination,” has its effect on the analysis of the older patient and on the complex of therapeutic factors in the psychoanalytic situation. Mostly it is in the form, intensity, and content of the transference (and its reciprocal, the countertransference) that the analysis of the older patient is likely to vary from the analysis of a younger person. Indeed, the patients whom we studied, especially those in their eighth and ninth decades, came with needs and motivations for analysis attributable to having become irreversibly older with a foreshortened and uncertain future.

A comprehensive discussion of these differences and their effect on psychoanalytic technique would go beyond the scope of this paper. However, I will briefly consider some of the most compelling features that we encountered. A pervasive sense of loneliness and an intensified need for attachment is characteristic of the aging patient, particularly with those of the older older group who had lost a primary attachment partner, perhaps a wife or a husband, and who were left very much alone (Notman 1985; Cath and Cath 1985). Further, the downward drift of the psychological and physical effects of the anabolic process of aging is commonly experienced as an injury, a narcissistic loss of self-sufficiency. Not only are older people, especially those who are already older older, suffering the loss of important ties to others, but familiar moorings to their own mind and body as they had always known themselves are also apparently slipping away. An octogenarian once put it this way: “I am basically alone now. It didn't bother me much when I was younger, and sometimes I enjoyed it. Back then I could always count on being there for others and for myself as well. But now, although I have acquaintances and friends, I can no longer really count on anyone or on myself to be my own backup and safety net.”

The search for an understanding of intrapsychic conflicts and developmental derailments or mishaps is very much a part of the analysis of the older patient, just as in principle with all analyses, and it can be a surprisingly fresh and successful adventure in many instances, even for those at an advanced age. However, especially for the older patient, if the analysis is to proceed favorably towards enhanced self-understanding and self-acceptance, i.e. mutative insight, it pivots on the development of a mutual sense of sentient resonance and vital “connectedness” in the realm of the transference-counter-transference. In this regard the transference serves two purposes: for reality-based attachment needs, where it is pivotally restitutational for the object-deprived older patient who has fewer opportunities for new attachments; and also, so far as feasible, for the facultative recapitulations of the past and their understanding as they experientially unfold.

In contrast, in the analysis of a younger patient where loss and isolation are not usually exigent, interpretation and insight may be more the intention and substance of the analytic process, the aim and goal being to reach a reliable level of autonomy and interpersonal involvement that is consistent with “termination” in the traditional sense of resolution of the transference and its closure.

In all analyses, perhaps, the analyst to a greater or lesser extent serves as a transitional object towards the enhancement of ego integration and the restoration of self-integrity. But for the analyses of older patients the regaining of a reliable and consistent sense of being one's own familiar self has a certain urgency. The older patient in the final phase of the life cycle is internally and externally confronted with the existential problem of coming to terms with herself or himself as still the same, and yet paradoxically not the same, insofar as the self is a self who is aging.

Working this through analytically is a restitutive process (Cath 1965, 1997) in the course of which an older person's productivity may be restored or even enhanced, as Settlage (1996) described so well in his evocative report of the psychoanalytic treatment of a creative poet in her centenarian year. Also, in our study we were privileged to hear a presentation that is consonant with his report. We were told of a musician who had become depressed after having been retired from a teaching position as a matter of age. She felt that life had become empty and futile when she started analysis at the age of sixty-eight. Nine years later, having returned to university for graduate studies in her field, she submitted a creative composition as her doctoral thesis and at the age of seventy-nine was awarded a Ph.D.—an extraordinary achievement for a woman of that age. Through the analysis she had become deeply insightful and had come to understand herself and her difficult life course. She was able to look in the mirror and say, “I am an old woman, and will never find a man,” and “If I don't pass the examination, it won't be the end of the world, but I will try.” As the issue of termination began to appear in her associations she calmly but sadly spoke of the impending separation from her analyst who in transference and
in reality had become known to her as a reliable supportive father and good maternal object. He, in turn, sharing with us some aspects of his countertransference, spoke of having listened to her throughout in the empathically sympathisch way she had always longed for from her deprecating and rejecting father. As for the future, her analyst said that although it was not his usual policy with younger patients, he anticipated that she might call him or be in touch with him after the so-called termination, and that he would see her should that be needed.

The analysis of this woman, and the analyses of similar patients in their eighth and ninth decades, brings to mind a fundamental developmental paradigm that underpins transference predilections throughout the life cycle; the infant’s early developing sense of self and other within the decisive sentient bond between the mother and her infant child—the primary object experience (Stone 1965; Greenacre 1954, p. 674). Of course there are always exceptions—some of them notable as I pointed out earlier: people who maintain their poise and self-regard—but for the most part older older individuals tend to regress toward primary-object and anaclitic needs. In consequence the transference is likely to tilt toward a preodipal dyadic position in comparison with the form and level of transference-countertransference recapitulations during the analysis of younger neurotic patients.

In these respects the age and gender of the older patient vis-à-vis the age and gender of the analyst are significant for the qualitative form of the transference-countertransference and for the course of the analysis. It may be fortuitous for the set of the transference-countertransference if the analyst is also an older person, as this may facilitate an identification with the analyst’s perspective and the development of common sustaining values and a shared Weltanschauung. It is no coincidence that it has become acceptable, and is no longer uncommon, for applicants to be accepted for psychoanalytic training and to undertake it when they themselves are middle-aged or occasionally even in their sixth decade.

To generalize, there is a difference in the way we approach and work with the older patient. We are more accepting and inclined to be more responsive to the older patient’s need 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. A sense of humor towards aging, ironic though it may be, and a spirit of generosity may be the outcome of an analysis which for older patients is not quite “terminable” in the usual fashion, since reality-based transference aspects of the relationship are incipient sustaining aspects of analyses that may continue to remain facultatively open in a particular regard. An open or swinging door may necessarily have to remain as a matter of empathic attachment and responsibility if circumstances call for it. This actually took place with the second described patient, whose analysis continued into his eighty-second year, with occasional psychotherapeutic visits to his analyst continuing thereafter.

I am well aware that I have highlighted the decline of growing older, and the hazards of becoming really old in particular. Notwithstanding, I should like to strike a balance by emphasizing that all is not lost even as one becomes aged. As others have reported (King 1980; Sandler 1984; Settlage 1996) consistent with these two cases, there are older people who are not inclined to sit back passively and let time drag them down. Some of them maintain a sense of humor12 that helps them, and others around them, along the way and as they approach the “final exit.”13 Older and even old people respond in a positive and effective fashion to psychoanalysis and psychoanalytic psychotherapy (Nemiroff and Colarusso 1985). What is more, those older individuals who seek treatment themselves or who are appropriately referred participate effectively in the analytic process. As younger patients in analysis do, such older people become interested in understanding their past with respect to the present and the future, and they are further motivated by the wish to make the most of what time is left.

A project of this sort—for that is what the venture of analyzing an older person really is—may very well counter the regressive and depressive trend of the older years, and enhance both ego integration

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12 Freya Stark, the adventurous woman traveler and writer who died at 100, was asked at ninety-three about death. She replied, “I feel about it as about the first ball, or the first meet of the hounds, anxious as to whether one will get it right, and timid and inexperienced—all the feelings of youth.”

13 Ogden Nash, the humorist, was dying in Doctors’ Hospital, at that time the most expensive facility of its kind in New York. A few friends came to say goodbye, and to them he said, “The trouble is that I’m dying beyond my means.”
and capacities and the restitution of the self. This took place with several of the cases considered by our study group.

So, how are the pains and perils of aging to be mitigated? Turning back to Erik Erikson and to his lifelong partner and collaborator, Joan Erikson—since they were personally involved in traversing old age as the final stage of the life cycle, they carried out a systematic follow-up study of old people with the collaboration of a younger colleague, Helen Kivnick. The subjects were people known to them from a research project carried out in the 1930s, and many of them had survived, actively and spiritedly, into old age. In 1986 the Eriksons published a book called Vital Involvement in Old Age, the moral of which might be, “Use it or lose it!” And in further consideration of this implicit activity-passivity dimension (Rapaport 1953), we might take heed of George Bernard Shaw's suggestion: "One should die young, but delay it as long as possible.”

References


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