The Later Years From A Gestalt Systems/Field Perspective: Therapeutic Considerations

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Our previous paper on the elderly, “The Later Years from a Gestalt Systems/Field Perspective: Conceptual Background” (2002), deals with the developmental issues of this age group from a theoretical point of view. This paper will focus on some of the unique features that a Gestalt therapist needs to consider when her client is an elderly person, or is part of the caregiving system of the aged person. We believe that the Gestalt principles of awareness, dialogue, support, and wholeness are particularly important for the therapist when working with this age group. We also stress that the therapist view the therapeutic encounter itself as a system, and be particularly sensitive to generational differences between herself and her clients with respect to values, language, and goals, as well as the impact of the relationship on herself and her work.

HELPING THE ELDERLY DEAL WITH LOSSES

While the experience of losses by the elderly is universal, styles of dealing with them are individual and must be respected by the therapist. For some elders, the power of their introjections prohibits the expression of many emotions, deep as they may be. Crying may be forbidden because it implies self-pity, and anger is taboo because it is viewed as negative. A vivid example of each occurred when an elderly woman in her late seventies, unusually attractive and well-dressed, came into therapy because she was feeling overwhelmed by taking care of her beloved husband who was ill with lung cancer and close to death. After 60 years of an unusually happy marriage, Frances was feeling exhausted and devastated by what she had to face. She had been nursing her husband with loving devotion for several years without any help, or even the thought of asking for it. Now she was
baffled by unfamiliar feelings and bewildered by their intensity. Eruptions of anger alternated with profound, bottomless grief, and yet she could not let herself express either emotion. Anger was “not fair” and grief was self-pity, and both were unacceptable to her. In her work with the therapist, Frances slowly connected the power of her belief system, her introjects, with her sensations as she talked about her recent experiences. Gradually, the wet tears that she quickly dried with her white handkerchief were followed by heart-wrenching sobs. She learned to tell her husband when she needed to rest, and tell him he had to wait without feeling that she was being an unloving, bad wife. Because of her work with a Gestalt therapist, Frances was able to deal with her husband's death, to mourn him and the bountiful life they had lived together, without feelings of guilt or crippling despair. She continued to live a full life that included, after several years, a relationship with a man she had known in high school who had also lost his spouse.

In sharp contrast, another elderly woman, seeing the same therapist at that time, dealt with her losses and her aging differently. Doris, a woman of considerable means, was divorced twice and lived alone in a large house in an exclusive neighborhood. She had few friends and tended to alienate each of her children from time to time with her demands and criticisms. Her work in therapy for a long time consisted of simply venting her complaints and unhappiness; neither the world nor her family were treating her in a way that she felt was her due. As Doris seemed impervious to any attempt on the part of the therapist to widen her focus and broaden her awareness, the therapist resigned herself to simply being a witness to Doris' unhappiness. Given her isolation, her inability or unwillingness to make real contact, and her rigidity, the therapist's presence was all she seemed to want or be able to handle. Her unhappiness was chronic and impenetrable. She refused to take an anti-depressant, but was willing to undergo numerous minor surgeries for various ailments. The quality of life for each of these two women was vastly different, and seemed to depend on the degree of penetrability of their personal boundaries; that is, on their ability to take in new information and to form new gestalts, and, by doing so, change their behavior.

In elderly clients, depression, and other dysphoric feelings are often denied or displaced by acting out behaviors such as excessive drinking, having affairs, making abrupt changes in life such as divorce, moving to an unfamiliar location, or other risky behavior.

The Gestalt therapist will often need to work closely with the elderly client's physician to know the effect of any medication the client may be taking on her behavior. Medications usually affect the elderly differently than younger people (Matthews, 2002).
COMBATING DESPAIR THROUGH INTEGRATION

More than half a century ago, Erik Erikson (1950) suggested that the major final task in an individual's life cycle is trying to make sense of her total existence. For the elderly, putting together the various pieces of the past makes, in Gestalt terms, a complete conceptual whole, or at least a series of loosely linked wholes that are meaningful to the elder. Erikson believed that without the successful completion of this integration, the individual was left with a sense of despair—a sense that his or her life had been devoid of meaning. "The lack or loss of this accrued ego integration is signified by fear of death: the one and only life cycle is not accepted as the ultimate in life" (Erikson, 1950, p. 268-269).

Thus, in this final period of life, the individual struggles to look back and make some sort of overall meaning out of life. This work often takes the form of reviewing in detail important events—the high points of life—that changed one's life in a significant way.

When asked to share these important life moments, the elderly client often will first choose moments of triumph, moments about which she feels especially proud. It is only when considerable trust has been built up between client and therapist (and only then, with much encouragement and some prodding) that the client might be willing to talk about shameful moments of defeat and despair which have had an equal, or perhaps more profound impact upon changing the direction of her life.

However, it is not just the big moments of triumph or despair that form the totality of one's life. It is the small, everyday, perhaps mostly forgotten events that constitute the backdrop against which the drama of the big events are played out—in Gestalt terms, the all-important ground in which the more easily remembered, colorful figures are imbedded. But it is these ground events that give context, as well as depth of meaning or significance, to big moments. Robert Wendlinger's *The Memory Triggering Book* (Wendlinger, 1995) presents practical suggestions for stimulating "lost" memories useful to the therapist who is working with the elderly client.

The importance of "telling one's story" has been pointed out by others in different contexts. For example, Jennifer Andrews and her students in Southern California have been working with elders in retirement homes who have been isolated and "disremembered" from their communities. By helping these elders to retell their life stories in detail over a period of time to respectful listeners, they found that the elders regained some sense of meaning, integration, and purpose. In some instances, feelings of aloneness and isolation were reduced (Andrews, 2001).

Having one's history known and appreciated by others also forms one of the basic approaches of Alzheimer's care in Bell and Troxel's (1997) successful work as described in their book. Specifically, the authors stress that the caregiver obtain as much information as possible about the elderly person's
background, including traditions and values, with the obvious intention of offering "cues and reminders of his or her previous achievements ... [and] ... proud heritage."

The richness, excitement, challenge, and value to the therapist of the lives of their clients, whether they come to the office for help, or they are seen in residential facilities, is no better illustrated than in Erving Polster's (1987) splendid book, Every Person's Life Is Worth a Novel. This title certainly holds true in the lives of elderly patients, who have lived that much longer—if only to have experienced that much more of the world in which they have played out their own novel. If they were to view their own lives as a complex novel, how would they like to conclude it? What is unfinished? What can never be finished? What is satisfactorily finished? What can be looked back on with pride? What with some shame? What rewards can justifiably now be given to oneself?

In her Preface to the Extended Version of The Life Cycle Completed (Erikson, 1997), Joan Erikson points out that the root meaning of the word "integrity" is "tact," from which we derive "contact," "tactile," tangible" and "touch." She continues, "Without contact there is no growth; in fact, without contact life is not possible.... Integrity has the function of promoting contact with the world, with things, and above all, with people. It is a tactile and a tangible way to live, not an intangible, virtuous go to seek after and achieve" (p. 8). This view is similar to the Gestalt principle that growth occurs only through contact with the environment (Perls, Hefferline & Goodman, 1951).

How paradoxical then, as we have mentioned previously, that our culture tends to promote the isolation of the elderly; to segregate, and often to "warehouse" them when they become somewhat problematic to deal with! The larger field of our culture does little to encourage or assist the elderly to remain "in touch" with the social groups of their immediate and remote past; therefore, the elderly often react by seeming to prefer isolation. It is surely the responsibility of therapists to be aware of this isolating tendency in our culture and the alienating effect this has upon the elderly person.

In considering the issue of integrity during this period of the elder's life, the therapist needs to focus on supporting her client in making sense out of the whole of past experiences. The therapist can do this by helping the client look at the broader field and at the more immediate systems in which her past experiences have occurred, as Lee has implied (2002). At the same time, the therapist needs to sensitively encourage her client to become more aware of, and to broaden, her here-and-now, everyday experiences.

**DEALING WITH UNFINISHED BUSINESS**

Significant unfinished business can interfere with the process of integration that is critical to achieving a peaceful and satisfying old age. Regrets
about choices in life (e.g., choosing a career over children, singleness over marriage, the wrong profession; or a missed opportunity for advancement, or failing to express affection to loved ones) can lead to intense feelings of remorse, resentment and depression. Obsessive self-criticism for making what now seems like a wrong choice often leads to these distressing emotions.

Disturbances in family relationships can also block integration, and though families are notorious for having unresolved problems, they seldom know what to do about them. A long-standing, unsettled quarrel with a sibling, a child, or a close friend remains like an unplucked thorn in one's finger; it can be overlooked and even forgotten at times, but its soreness does not disappear. The therapist can help the client understand the self that made the decision that now feels wrong, the context in which it was made, and the level of awareness possible for the client at that time. She can help the client develop empathy for that self and express the current emotions about the choices. Finally, heightening the client's awareness of the benefits of the choice that was made at that time, as well as the resulting losses, can eventually lead to the acceptance and valuing of one's steps in life. Integration then becomes possible.

If closure is reached with respect to the unfinished business, new figures are free to emerge; the individual is able to focus on what is possible in the present. This can lead to satisfying future activity, often in an area of interest that had been set aside because of time and lack of energy. Some people who had never engaged in art before, take up painting in their later years and find intense satisfaction in it. We have a friend who, in her late 70's, began to take classes in painting for adults at the local university. She discovered not only a new passion, but also a bright talent that brought attention she had never before received. Another dramatic example of this is Grandma Moses whose illustrious career as a painter began in her old age. Resistances, such as stereotypical introjections and projections about acceptable behavior in the elderly frequently cause new and potentially satisfying activities to be preempted in the later stage of life. One woman who had always wanted to dance, and briefly entertained the idea of doing it once she had the time, stopped herself by thinking, "I can't do that! What would people say seeing an old woman like me prancing about?" By exploring these introjections and projections, the therapist can help the client make a more realistic and satisfying choice.

**RESETTLE PRIOIRITIES**

In addition to dealing with various losses (internal and external), issues of integration, and unfinished business, there remains for the elderly client the matter of setting priorities for the future, however brief it might be. As one client put it, "Yeah, doc, that's all very well, but what do I do now?"
This elder's poignant awareness of the importance of the here-and-now life yet to be lived is most appropriately termed "Gestalt."

It becomes the task of the therapist to help the elderly client set those remaining priorities: "What's important to you now?" This may well be something that the individual recently became interested in, but has not realized its importance in her life until now. A symphony musician forced to give up playing because of a physical condition, who was suffering from this great loss, has recently come to realize the importance in his present life of his study with his wife of the mystical aspects of Hebraic literature.

What turns out to be a high priority late in life may be a longed for, but never acted on, activity from the past. This is the type of unfinished business that the therapist can bring into sharper awareness; the client can then deal with any resistance to beginning now.

A more difficult challenge for the therapist is the elderly person who seems to be unaware of any strong present needs or activities of interest. Often the client makes the assumption (usually because of an outdated introject) that an area of interest has to be special and grand or it's not really worthwhile. For example, the client may say, "my small interest in collecting recipes for sweet chutney seems silly."

**WHEN IS A GROUP APPROPRIATE FOR THE ELDERLY CLIENT?**

Studies by Vaillant (2002) and Snowdon (2001) have emphasized the value of a strong, supportive social network in assisting the elderly to have a satisfying old age. Yet, a common occurrence is the isolation and loneliness among the elderly for a variety of reasons. Some older couples move to new communities, trading their big house for a smaller one once their children are grown. Others choose to move because they desire a better climate, but find it difficult to make new friends in the new location. Elderly people often witness the deaths of close friends and spouses, leaving them bereft and alone. Other elderly people, who move with pain and reduced agility, sharply reduce their movement and hoard their decreased energy, which lowers their energy level even more, and isolates them from social contact.

One task of the therapist is to evaluate whether a group would be beneficial to this type of client (as she would with any client) and make an appropriate recommendation. Obviously, there are cases where a strong supportive network exists, but other problems lead a person into therapy. The nature of the group is a critical factor as well. Although some elderly people find delight in associating with younger people, and are interested in their struggles, many older people may feel more isolated in a group with few, if any, people close to them in age. A challenging, confronting group that deals with a lot of interpersonal conflict would probably be difficult for many older people. At their advanced stage of life, the elderly are
rarely interested in greater awareness of themselves, or in changing themselves. They are primarily interested in others being interested in them, in hearing their stories or their opinions (Andrews, 2001). Hence, the best and safest kind of group is one that leans more toward being a support group than a therapy group, and is composed primarily of elderly members. They then have an audience with similar reference points for the context of their stories.

SUPPORTING THE SYSTEMS SURROUNDING THE ELDERLY CLIENT

Significant changes in the status of the aging family member can have a profound impact on the surrounding family system. For example, in the traditional family in which the husband has been the breadwinner and the wife has been the homemaker, the husband's retirement can change the balance in this long-term, two-person system—at times, not for the better. "I took you for better or worse, but not for lunch," as the wife in the old joke says. Another example of a system disruption might be a retired and widowed parent coming to live with her recently married, busy, working daughter and her equally busy husband, which creates turmoil in that family system.

System disruptions can motivate family members to seek out mental health professionals for help with their strongly ambivalent feelings about caring for elderly relatives. They want to take care of the older relative and also feel that it is an offspring's duty to do so; however, they are also reluctant to sacrifice too much of their own freedom. Learning to negotiate appropriate levels of care with one's parent at an adult-to-adult level may be a new and awkward experience, and one that requires considerable guidance and support from the aging parent's psychotherapist.

Help from professionals is also sought when deterioration in the elder's physical and/or mental health requires more care than their surrounding family system can provide appropriately. At this juncture, family members may begin to have feelings of guilt and shame for no longer being able to take care of their aging relative as they feel they should. A useful strategy for the therapist is to explore the various introjections and projections that lie behind the "shoulds" and "oughts" which generate these feelings of guilt and shame. Clearly, the danger of following blindly these "shoulds" and "oughts" is that they often lead to burnout, with all its negative effects on the caregiver, along with the possibility of elder abuse, as described previously.

The therapist can support the family in the difficult and often painful decision to place the aging relative in an institution. When this level of support is needed, the therapist can refer the family to professionals who can make appropriate placement determinations. (See the example described in Bayley, 2000.)
Once the deteriorating elderly family member has been placed in an institution, it is rare that the surrounding family system is completely satisfied with the care that she receives. Dissatisfactions may range from mild annoyance to major complaints. At this point, families often feel powerless to effect any change in the care that the system is affording their loved one. Depending upon the nature of the organization (public, private-charitable, or proprietary), its size and its complexity, the family may feel that they are dealing with an inflexible bureaucracy, and their sense of this being a "responsive, manageable system" dissipates. Under these circumstances, families often look for help to the therapist with whom they previously had contact (Woldt & Stein, 1997). The therapist can offer the family strategies for getting action by locating key people with whom they can consult when the usual hierarchical approach has not been fruitful. For example, if the organization is a public institution, the therapist can suggest that the family contact an appropriate person in government who has decision-making clout with that institution's budget. Or, if the institution has a religious affiliation, the approach may be to identify a significant person inside that system who would respond to the family's complaint. The mental health professional acts, in these cases, as a kind of organizational consultant to the family.

PERSONAL ISSUES FOR THERAPIST IN WORKING WITH THE ELDERLY

Nowhere does the therapist need to pay more heed to two of the basic principles of Gestalt, phenomenological and dialogic methods, than in working with the elderly (Hycner & Jacobs, 1995; Resnick, 1995). The characteristics of this kind of two-person system may have unique problems that interfere with good contact between the therapist and the client. For example, there may be a considerable age difference between the therapist and elderly clients, or the therapist simply may have little or no experience with older people—and a lack of familiarity with the culture in which the older person lives. As a consequence, generational differences in values may be misinterpreted. The young therapist may value the expression of emotions, and think it therapeutically beneficial, while the elderly client may value containing emotions. An older person may view the common practice among Gestalt therapists of using first names, for themselves and clients, as disrespectful. Lynne Jacobs' appropriate quote from Buber, "It is the responsibility of the therapist to meet the patient and not the patient to meet the therapist," is particularly important for therapists who work with older clients to keep in mind (Hycner & Jacobs, 1995).

Another area the therapist needs to be aware of is that the deteriorating effect of aging leads to some common characteristics that are irrelevant to individual personality or presenting problems, and may be misunderstood.
Studies have shown that the elderly take more time to process information (Light, 2002). They move and think more slowly and short-term memory problems are legion. Missing an appointment may not mean resistance, but simply a memory lapse. A slow response may not mean a reluctance to deal with an issue, but rather the actual time an older person needs to think. A younger therapist will need to adapt her pace to these characteristics.

A major block to good contact may be unaware projections on the part of the therapist toward the client. Woldt and Stein (1997) have written about the effects of our cultural bias toward the elderly, and its presence among therapists. They note that, regardless of the changing job market, there is still a reluctance among mental health workers to work with the elderly. Therapists tend to see them as "unlikable, dependent, helpless and unable to learn." Possibly adding to this cultural bias are potential counter-transference issues related to therapists' feelings about, and unfinished business with, their own parents. Unless the therapist is aware of any projections, she will be unable to accurately see or hear her client, thereby diminishing good contact.

It is easy to observe the elderly being judgmental about the younger generations. "This isn't the way we used to do it! Why do they have to do it that way?" The speed of change in our culture may often be difficult for the elderly to deal with, and they often react with complaints and judgments. However, the young also may be judgmental toward the elderly; and in the case of a therapist and client, where generational values may be different, it is incumbent upon the therapist to be acutely aware of her own tendency to make judgments.

The therapist who works with an elderly person also needs to be aware of the differences in life goals between the young and the old. While the young are usually more interested in achievement, in reaching specific goals such as a career position, or in establishing a family, the elderly often want to look back to find meaning in their lives and find peace in their remaining years.

Finally, the younger therapist must be aware that motivations for seeking therapy may differ widely among the elderly, and may not always be what the therapist expects. For example, in the case of Doris described above, the client seemed to be content to use the therapy hour to voice her complaints and unhappiness with others; no therapy was accomplished, nor did she seem to wished it over the course of the years it went on. By way of contrast, the obvious positive, social motivations of the elderly who look forward to regular, simple encounters with young undergraduate and graduate students, such as reported by Andrews (2001) and Woldt & Stein (1997), were clearly "therapeutic" in outcome, and offer useful examples to be kept in mind.

If the relationship between a younger therapist and an elderly client goes well, both people will find it hugely rewarding. Working with an older...
client can give the therapist a view of old age different from the usual stereotypes, one that is just as rich and satisfying as younger ages, which may reduce her own fear of aging. A close and trusting relationship with a younger person can expand the elderly client's view of herself through the therapist's understanding and appreciation of her life.

CONCLUSION

This paper has focussed on therapeutic considerations that might be applied using a Gestalt systems/field model when working with elderly clients, their surrounding immediate, significant systems, and the broader fields in which they exist. Attention is also paid to the therapist's issues in working within these systems.

Closure: In helping the elderly to deal with loss, issues of closure were appropriately invoked. Of particular importance were situations in which closure was not possible, but where the acceptance of that fact—perhaps with some deep mourning for the first time—could be experienced by the client as closure.

Integration and Wholeness: Helping the elderly to look back and make sense of their lives through "telling their stories" was stressed as an important aspect of their therapy. It is key to include not only past events of which they are particularly proud, but also those that form the equally important dark side of their lives—the part of their history that they tell only to those they trust. Here-and-now trust in these types of situations has the potential to lead to significant dialogical considerations between client and therapist.

Facing the Present—Actions: Those who work with the elderly soon become aware of their tendency to live much of their lives increasingly thinking about the past and being pessimistic, and often depressed, about the future. Helping the elderly client to focus on the difficult phenomenological task of answering, "What is exciting and important to me right now? What would I like to do? How can I take that first step to do it?" can be a challenge for the therapist.

Support! Support! In addition to the one-on-one more traditional therapy model, we have also discussed when it may be appropriate to make use of a group, and what type of group may be best. Further, we have discussed the impact of the deteriorating elder on her surrounding family system with its increasing caregiving duties, and appropriate support from professionals with a background in Gestalt theory. Finally, by way of offering support to therapists who are beginning to work more with the elderly (as we all shall because of our aging population), we discuss personal issues that the younger therapist would do well to heed. As we see it, these issues are closely related to the phenomenological and dialogical aspects of Gestalt therapy applications.
REFERENCES


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