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Grow Old Along With Me

Psychotherapists and the Aging Process

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ABSTRACT

This paper, first presented at the 2017 PPAA conference, examines the process of ageing upon psychoanalytic psychotherapists and the dilemmas that it brings to clinical practice, through the lens of psychoanalytic thinking. This includes the process of working out how one's practice is closed, and dealing with impairment in the therapy. These are issues both for the individual and for the professional association. The cognitive neuroscience of normal ageing will be discussed as well as possible illness and impairment. A case vignette will be discussed illustrating some of the issues discussed.

Death!

Well there, I have named it, and so it cannot exist in the shadows, unseen. However it can't completely dominate this paper, so we will go on to other matters and return later to face it more directly.

Human beings experience the process of ageing, and being older, in very different ways. As Isca Wittenberg describes, some people become bitter and controlling, but others "have continued to grow in emotional strength, wisdom and love right up to the moment of death" (2013, lcn 2721). Wittenberg wonders why transience and the bodily changes inherent in ageing can be managed so well by some, with the implication that others may really struggle.

This paper aims to examine more closely the factors that operate to determine how we deal with the concept of an ending to our work and our life, as well as the effects of ageing upon our work as psychotherapists. The comprehension of the emotional consequences of these issues imposes a toll upon the author and audience. It is not easy to write or to hear of endings.

Acceptance of ageing first of all requires experiential knowledge. Through a train of associations, our knowledge develops that an ending is inevitable, that our time is limited. Intellectually, we all know this of course, but when it comes to our work, often the awareness that our capacity to work is kept at bay. In the field of psychotherapy, bodily changes often don't limit the ability to work, at least not as much as in other fields. So ambitions to work as long as we desire can easily take hold. The work of mourning, what Junkers terms "Work on the ageing process" (Junkers, 2013, p. 504), can be transformative and be perhaps the most helpful one for people to be able to accept the changes of ageing. Varchevker (2010) talks of the difficulties brought about by the problems of integrating the changes of getting older. Early traumatic and neglectful experiences, together with a narcissistic predisposition and a stalling in moving toward the depressive position, all contribute to an impairment (Ogden, 2004). A too heavy narcissistic investment in the body, and for psychotherapists, our cognitive abilities, may lead to a crushing sense of loss when these deteriorate. If there is a failing to have loving enough relationships with our objects, so that we no longer want to live with the living, then there is a sense of a barren social world, with a limited supply of others to whom to turn to for comfort. Recourse to manic omnipotent defences, a denial of ageing and limitations, can be employed to stave off a depressed awareness of an ending if the capacity to mourn is severely impaired.

Since the unconscious knows nothing of time, in the internal psychic world we are not aware that we are ageing. What makes us aware is the impingement from the external world of the reality of changes. Chiefly, these are signs of deterioration in bodily functions. Aches and pains, tiredness and loss of stamina, poor balance and strength, plus the accretion of illnesses of different sorts all remind us that our bodies are not what they were. The harsh mirror of reality also takes form in the reactions of other people, particularly the young. The realisation that you are sexually invisible can be a hard shock. Sometimes there

can be institutional reminders in the form of retirement. Eligibility for Seniors cards and discounts, superannuation benefits and insurance company restrictions on the availability of insurance products all hit home. Children growing up and having their own children and the loss of colleagues, relatives and friends are a *momento mori* for most people. However painful these reminders can be, at least they assist us in mourning for our past health. One problem of working psychoanalytically is that we never age in our patient's transference, so that it's easy to phantasise that we don't get older.

There are however advantages in growing older, in particular the positive effects of experiencing wisdom (Quinodoz, 2013). A working lifetime of seeing patients enables a great store of clinical wisdom and skills to be developed. This is absolutely invaluable in terms of treating patients and cannot be replicated earlier in life. If we add that living a productive life, weathering its triumphs and disasters, a lived life being a great boon to therapeutic work, then maybe the effects of ageing can be outweighed or at least attenuated. A number of authors (Junkers, Quinodoz, Kottler and Carlson) all stress the possibility of aged therapists entering into a new sense of being, calmness, reflective capacity and sense of satisfaction, perhaps to a degree not before experienced in their lives. Signs of ageing are there to be endured and wryly laughed at, and professional life may not be as it once was, but a new door can be opened. Life may be experienced more in the present, rather than in the future or the past.

Obviously, generalisations can be somewhat unsafe, for each person is different. Maybe we can, however, not be weighed down by undue pessimism but, rather, exist in the present where both positive and negative factors operate within each individual. Awareness of this is perhaps the most important capacity that allows us to decide whether to continue practising.

Perhaps it is not so unusual that we dread awareness of ageing and loss of functional ability, for it leads us to a fear of losing our good internal objects, and an ending to our existence. At an internal level, awareness of an ending, of continuity of being, of our death, is unthinkable (Freud, 1915). Intellectually we all know it has to happen, but to experience it can feel unbearable. Over the centuries, humankind has attempted to evade a sense of an ending (Willock, 2007). Winnicott (1963) talks of the annihilation of being for the infant, which Junkers (2013) relates to an annihilation anxiety brought about with the thought of death. We can deny it, sublimate it, disassociate from it or even become psychotic as a response to it (Segal 1958). It is the reassuring presence of our good objects that assists us to face the anxiety triggered by loss of our powers, faculties and even life itself. If these are not sufficiently developed or are not secure enough, if we haven't had the experience of a "good enough" early environment in the shape

of parental care, nor a good enough analysis or therapy, then existential anxiety regarding death will become greater and problems may develop in recognising and acknowledging our limitations and in mourning the passing of our capacities. Religious beliefs such as a concept of an after-life or rebirth, or ideas that death is a sacrifice that creates something better, like martyrdom in the service of a cause, all may be seen to assist in facing death. It is noteworthy that both religion and nationalism have diminished in Western culture.

However, the idea that our generatively and creativity can bring about a good future for others can be transformative. Children and grandchildren, our life's efforts in building something better, can be of immense benefit in ageing.

For psychotherapists, the concept of developing our skills and allowing these to benefit our patients, as well as passing these skills on to new generations of therapists through supervision and teaching, is absolutely vital. This generativity enables us to experience a greater security in our good internal objects and know that our goodness has eventually triumphed over badness. Where a belief exists that one has not balanced this moral ledger, or not to a good enough degree, then there can develop a gnawing doubt in the capacity of our good objects to survive in the face of destructive attacks. Examples might include evading the pain of professional growth, destructive wishes or actions towards colleagues, or hurtfulness or evasions of responsibilities towards patients. It is vitally important that conscious awareness of these liabilities develop for any kind of psychological work to be done. Reparation is an important step in the ability to mourn, even if this is towards the internal representations of our damaged or neglected objects.

To become aware, once one feels it is too late, as in facing news of one's impending death, can be tormenting. This is perhaps one reason it can be so insurmountable an object for some when facing cognitive signs of ageing. It is an attack then, not just on a narcissistically invested quality, which can be seen as a sign of pathology, but on creativity and generativity, the essence of our goodness, and maybe a reassurance of our capacity to repair harm through helping others. Loss of our ability to make up for past actions or omissions requires even further work.

Junkers (2014) relates that the therapist can often feel lost and isolated in ageing. This is particularly true if there are clear cognitive signs of decline, and thoughts of ending practise begin to surface. She links these feelings of loss with a developing sense of exclusion from the professional group and the recrudescence of working through oedipal anxieties. How will we cope? Will we continue to be thought about by others, will all our contributions be forgotten in time, have we been good enough, are we still good enough and will all that fade into the future?

Ageing has been said to be more about a state of mind than about bodily changes. Cruickshank states that ageing is more defined by culture than biology (2016). By definition, how we think about an ageing self must be viewed through an internal lens produced by our mind, a lens constructed by different influences. What does it mean to say "I feel old", which is different from "I am getting older". Feeling old may have more to do with our psychological and physical states, but it's also affected by our context, our culture and society.

Culture has a powerful effect upon how we view older age. Traditionally, elders have been valued in cultures where their knowledge and experience are seen to be of benefit to the community. Whether this value was in the understanding of animal behaviour in hunter/gatherer societies, experience of dealing with famines in agricultural societies, or political strategies for dealing with enemies in nation—states, elders' wisdom was seen as an invaluable resource. However, the assumption was that patterns would be repeated for the future. Animals' behaviour wouldn't change very much over the generations and other humans encountered in conflicts wouldn't behave too differently. Predictability was operating.

When there developed a period of great changes, knowledge of patterns that could be counted on from past experience actually impeded the capacity of a culture to adapt. Examples come to mind of the native Americans' disastrous encounter with the European invasion (Lear's concept of radical hope, 2009) and the response of Jewish communities in Eastern Europe to the Nazi Holocaust. If the best way of confronting violent anti-Semitism over the centuries of pogroms was to collaborate and adopt non-violent responses, employing these previously successful strategies in facing the enemy of genocide made sense. It was only later, when its true nature was recognised, that alternative responses to their persecution, such as the Warsaw uprising, eventuated. In times of such change, values and innovation, energy and ability to run against the accepted ideas come to the fore, and the young become of greater importance than their elders. In such societies, the burden of having to look after the old, sick and frail outweighs the value of experience arising out of pattern recognition.

Today's world involves tectonic shifts arising from the impact of massive technological changes unheard of in human history. Social changes, e.g. the altered role of women arising from medical advances (i.e. the contraceptive pill), further compound a sense of shock in response to change. Mainstream western cultures are now essentially adolescent; they elevate omnipotent thinking and denigrate the value of authority and experience. Being old is not cool. Ageing individuals are imbued with negative characteristics, echoing Shakespeare " sans teeth, sans eyes, sans everything" (in As You Like It) and Freud himself in describing himself as crabbed and sterile (1972) .

Getting a new job after 50 years of age is difficult in the modern corporate culture. This creates an alteration in the balance between the single person versus the group. Individualism is valued more than cohesiveness of the group. So, the elders are now seen as more of a burden than an asset. Set against this negatively biased view of elders are the benefits of radical advances in health initiatives that enable people to continue working and functioning well into their eighth decade, and living into their 80's or even 90's. The sixties have begun to seen as the new middle age (Kottler, 2016) prompting a change in societal attitude toward the value of elders. Governments have even begun to re-evaluate a pension age. A complex patchwork of different work cultures is emerging, in which some fields, e.g. IT, completely denigrate the middle aged and older person, while in others they are still valued.

Psychotherapy has its own micro-culture, one where wisdom and experience are valued and where change has been slower—very different to that faced by those in fast changing fields or where ageism is prevalent. Psychoanalytically oriented associations often include people who become members only in their middle age and in which the elders are usually held in high esteem, even venerated. Quinodoz (2013) talks of the importance of having a "protective super-ego" location 777 in such organisations, as distinct from the persecutory one found in some aspects of society. It is of immense benefit to have a safe refuge where people who have made such great contributions to the life of the association can walk into meetings, meet with their colleagues and continue to feel valued. It can be a situation of mutual enrichment and a direct antidote to a sense of being thought useless and a burden, or just plain invisible (an absent super-ego).

Perhaps it is not just the factors intrinsic to ourselves, our body, mind and our culture that can help or hinder our ability to adjust to ageing. There are our personal choices, our idiosyncratic ways of dealing with life. Wittenberg (2010) eloquently describes the helpful protective actions of passing on our wisdom to the next generation, but also being able to freely acknowledge the gift of knowledge given by our forebears and teachers i.e. that we are links in a chain.

Fear of the future can be held under reasonable restraint, the past can be seen as a foreign country that has a reduced capacity to cast a shadow, but the present can be experienced with great intensity and "a source of wonder constantly renewed" (Quinodoz, 2013).

Cognitive Changes

Although the effects of ageing on the body do affect the therapist, they do not greatly reduce the capacity to function unless people are in the grip of an acute

illness or are in significant pain. Very different indeed to professional athletes who have already begun to deteriorate in their late 20's. Gymnasts are over the hill at 25 years and Usain Bolt, the sprinter, is retiring before 30. However, ability to function depends on our cognitive capacity, which for most people does not seem to alter much unless the curse of dementia appears. It is often said that unless you get sick or die you can work almost indefinitely. Let us look at this more closely as it is our cognitive capacity that most often attracts our narcissistic investment.

In normal ageing, cognition may be affected to some degree, but it's largely unchanged until people are in their mid-sixties. This acuity however can then, for some, deteriorate markedly so that by the time most people are seventy-five years old, some deficits are evident. What are these effects? Glisky (2007) describes the following:

1. **Attention**

   We see a general slowing of information-processing, so that thought takes a little longer. This is particularly exacerbated when there is divided attention: for instance when we are required to be concentrating on two or more different areas at the same time. In our field of psychoanalytic psychotherapy, one example is the need to attend carefully to the verbal material of the patient as well as being aware of our own countertransference and to reflect on what is being communicated in the transference by the patient. Non-verbal cues such as bodily movements and facial expressions need also to be observed. The greater the attentional demands imposed upon the therapist, the more likely it is that deficits will be revealed as people age.

2. **Working Memory**

   This is a neuropsychological concept that relates to the ability to function in the real world and involves a combination of memory and problem solving. Marked deficits in how we use memory and organise it to deal with external situations are shown, and result from slowed processing and age-related difficulties in filtering out irrelevant information.

   In our work, this shows itself in a decreased ability to make sense or hold in mind what the patient tells us in the course of a session, and so work out how to respond in a psychotherapeutic manner. It isn't just a problem in recall. When we are in pain, are not well or are stressed, are in noisy environments or take substances, working memory is further impaired.

3. **Long Term Memory**

   There is some good news here! Ageing doesn't affect most aspects of long term memory to any great degree. However, there are two areas that can be impaired. Episodic memory, the "I remember" experience, such as of patient material from previous sessions, can be affected. Problems

in reality-monitoring , "Did I give that interpretation or did I just think it?", are evident, together with difficulty remembering without cues (e.g. names of people). The context of when the patient brings the material, and the degree of emotional tone all help considerably. Prospective memory, remembering to do things in the future, can be reduced too. Events like remembering cancellations or breaks are examples. Cues like diaries and reminders are invaluable here.

4. **Emotion and Perception**

A reasonable degree of emotion in the patient is helpful to us as it stimulates us, but too much or too little emotion in the therapist worsens any memory problem. This is particularly true if we are facing stressful situations such illness or losses.

Perceptual difficulties which arise frequently in ageing further worsen cognitive problems. Hearing impairment that makes it harder to hear the patient properly stretches our capacities, and lack of visual cues if we have poor eyesight exacerbates the degree of divided attention. Seeing patients on the couch may also create difficulties. Therapists need their brains to be stimulated in order to think clearly.

5. **Higher Functions**

Some impairment can be noted, but generally it is the new situations that crop up in the psychotherapist's work that can pose the most problems. When one has had a lifetime of experience, commonly occurring problems in therapies with patients, that can be dealt with by delving into a bank of previous responses, may not pose such difficulty. However, if there is impairment, novel situations, or patient issues not previously encountered, could both be problematic.

So, does this evidence help us to decide if we can continue to work psychotherapeutically as we grow older?

Firstly, it must be noticed that there is a great amount of variability between individuals as to the degree of cognitive deterioration suffered with age. Some individuals seem to have minds as clear as a bell and others seem dramatically affected. It is not possible to predict a future path on an individual basis although our increasing age makes it more likely that cognitive changes will occur. By the age of 75 years nearly all people have a degree of deterioration (Peisah, 2016).

Secondly, on a more hopeful note, such cognitive effects of normal ageing are not necessarily predictive of continued cognitive deterioration as found in dementia. It is unsettling that such symptoms might be the first sign of a more sinister course, but if this is the case, then fairly rapid changes ensue.

Thirdly, our continued work over the years can be protective in itself. Continued exercise of our cognitive capacities, e.g. in listening to patient material and thinking of a good interpretation at the same time, may enable us to not be so affected by problems of divided attention. Similarly, with issues in working memory. Our therapeutic function forms part of a continuously repeated pattern over many years, rather than new learning. It might need a bit more effort and some mental cueing, but these highly specific cognitive activities might be reasonably preserved.

People can develop the syndrome of Mild Cognitive Impairment (MCI), in which there are clear-cut deficits in memory, language, attention and visuospatial skills. Although greater than half of such people, with a prevalence of up to 19% of the population (Gauthier, 2006) progress to full dementia within 5 years there still is a considerable proportion who remain stable or actually remit to some degree. The only way of telling if MCI is present is to test people repeatedly over time.

What becomes essential then is the capacity for insight into the presence and nature of one's cognitive difficulties. Many people might notice the odd symptom, a forgotten car in a parking lot or names of patient's friends and relatives. However, the tendency in us all to deny the possibility of impairment in our most valuable areas of functioning and therefore an awareness of an ending, can lead to a failure to join the dots and see the emergence of a general pattern. It is possible that we might not be aware of having difficulties, especially if there already exists a degree of cognitive decline (Power, 2016).

The association in our minds between effects of ageing and eventual death can paralyse our thinking and make us believe that nothing can help age-related decline in our capacity to function as therapists. It has been observed that such capacity to function is dependent more on the ability for compensatory mechanisms to exist, than on the level of cognitive changes, per se (Gauthier, 2006). This is both at a neural pathway and at a conscious behavioural level, (however this is not true for MCI and dementia, that is moderate to advanced deterioration).

For How Long Do I Practice?

The question that all ageing therapists must face is when to stop practising and the manner in which that is to be done. It is a question that we all wish to avoid, unless clinical practice is deeply unsatisfying or we are faced by sudden ill health and thus thrown into instant retirement.

In order to make such decisions, which are replete with complexity and emotion, the clinician has to be able to evaluate the situation in the light of brutal

reality. This is both hard and painful. One of the reasons for its difficulty arises out of human nature, which prefers predictability.

Taleb (2007), reminds us that humans use the past to predict the future and that we like to assume that we have all the information we need to do so. Although we are intellectually aware that ageing brings illness, we usually grossly under-estimate the likelihood of ill health striking us and the effects of such illnesses upon our capacity to function adequately (Taleb, 2007). Human beings don't like to acknowledge the contribution of chance to our fate.

The protection that we falsely believe omnipotence grants us is partly derived from our identification with psychanalytic knowledge (Junkers, ibid). If we are able to see what lies beneath conscious awareness, then perhaps we could know what lies in store for us. If we are spared the perils of major illness, especially life-threatening ones, then our defences can enable us to continue believing that it is not we who will fall prey to disease, it is the other.

Psychoanalysis can foster in its adherents a deterministic view of the world, so that through our efforts to keep ourselves healthy, we believe we can protect ourselves from our body's malfunctioning. The great advances that have occurred in medical science can lure us into a false sense of comfort, blurring the possibility of ill health being around the corner. We filter out the dangers and risks by finding individuals around us who have remained fit and well with sharp minds, who work effectively well into their 80's. Can we not all be like Betty Joseph who was spry and giving clinical seminars into her 90's, we say. However those who deteriorate can be forgotten … "You're as old as you feel" is a great mantra, although such selectivity may sometimes be used in the service of denial (Wittenberg, 2013).

Human beings cannot bear to live with too great a level of uncertainty. When the stakes are so high, namely, our lives and our health, then anxieties and fears generated by the likelihood of major illness must be lessened by our defences for us to continue daily functioning. The chance of illness or death occurring outside of our ability to control it or predict it accurately is too much for us to bear thinking about and unlike the roll of a dice or turn of a card, we don't even know the probability of such a fate with any reasonable accuracy.

However, even if they cannot be extrapolated to single individuals, we can have approximate probabilities for groups of people. There is some value in estimating how ageing can affect such probabilities, so let us examine these in more detail.

Death itself has been pushed back over the years, particularly in Western countries like Australia, with advances in health and nutrition, prevention of disease and better and earlier detection of symptoms. So now, two thirds of people live

past seventy-five years of age, and more for women. The median age for women dying is 84, and for men 78. However, the rate of death exponentially increases, once we turn fifty five. The decade between 65 and 74 sees a tripling of mortality rates, and the following decade between 75 and 84 has a further tripling again. We are nearly ten times likely to die in this last decade compared to the first decade of 55–64.

The presence of major illness creates impairment by itself, leaving aside the effects of treatment for the illness, and the compounding effect on cognitive functioning. Once people are over sixty-five years old, there's a one in three chance of developing some form of cancer. For strokes, the risk is one in ten over the following decade, and doubles each decade. Women have only half the risk but this evens out over time. There is a one in five chance for heart attacks at the same age. Although there is some co-morbidity, it is more likely than not that we will end up with some kind of chronic medical disorder serious in its effect on our functioning by the time we are in our seventies. So we have to consider the effect on our future even if we can still function. If there has been a heart attack, will there be a further vascular event down the track?

Progressive cognitive deterioration is another common problem. Mild cognitive impairment, which is now considered a separate entity, is quite frequently seen, with one in five being diagnosed after sixty-five years old. This is a serious problem, as half of sufferers go on to develop full dementia within five years. Dementia of various types becomes increasingly common with age with one in five being diagnosed by the age of eighty.

In considering when to stop practising, a major factor to consider is the impact of illness not only upon the therapist but also upon the patient. This can occur through the consequences of continuing to work in an impaired state, the effect of sudden terminations, or combination of both. A number of authors, including Denis (2013), Eissler (1975) and Abend (1982) have discussed the problems of continuing to practise with a severe chronic illness. Although there is disagreement as to whether this is advisable and whether the patient needs to be informed, all authors agree that making the patient endure a dying therapist is an act of sadism. What cannot be endured by the therapist may be passed on to the patient. This is akin to Bion's description of the reversal of maternal reverie where the mother pushes her own uncontrolled anxiety into the infant. Even if the therapist isn't actually dying, to be unable to adapt to impairment will in turn impair the patient's capacity to accommodate to reality, as Quinodoz (2008) points out.

We can argue for different practises, but central to the issue is the potential for minimisation of awareness of the patient's experience, and the difficulty of

taking into account the great uncertainty of the outcome of the illness. Perhaps what we cannot bear consciously must be projected into the patient for them to bear, including the gnawing fear that death may come at any moment, even in the session itself. This actually occurred to my grandfather, SH Foulkes, psychoanalyst and founder of Group Analysis. Seeming to be in reasonably good health, he continued to work in his much-loved profession into his late seventies. In the penultimate group session of an experiential group whose members consisted of the younger generation of group analysts, the future leaders of the profession, he suffered a fatal heart-attack, dying on the spot. One member saw him clutch his chest, and that night developed a detachment of his retina in the same quadrant as the view of my grandfather's last dying action. Being forced to bear witness to the ending of a trusted person's life, not to mention seeing their suffering and being powerless to help, is traumatic and potentially destructive. Although in this example it was a bodily function that was damaged, generative and creative capacity can also suffer as a result. The death of the founder of the new discipline in front of his acolytes cast a pall for many years over the Group Analytic Society in terms of its ability to evolve.

Even if less dramatic in its occurrence (Denis, 2014), sitting with an unwell therapist can be a deeply disturbing experience with far reaching consequences. A number of patients have written about their experiences of having to sit with a therapist who was clearly unwell, and who eventually died (Randles, 2014). Not infrequently the manifest illness was never able to be discussed openly, and was often denied or minimised if brought up by a fearful patient. One vignette may illustrate this situation.

Patient R, a man in his 40's, with a history of early environmental losses, came for treatment to an experienced and highly trained psychoanalytic therapist, a women, then aged in her late 60's. The patient attended three times a week, but in the last four years of a 12-year treatment, the therapist, W, developed cancer. She did not inform the patient of her diagnosis, but continued to work, aside from breaks for treatments. The reason for this apparent heroism was only understood with hindsight. W. was the sole breadwinner, having to provide financially for both partner and children. She confided in her colleagues that she believed she could not afford to cut down her work, let alone stop. She believed she could function adequately as a therapist, and felt that she didn't want to burden her patients by informing them of her condition. The patient R noticed that W, who was seated behind him on the couch, seemed increasing tired. There were unexplained sudden breaks and at times she seemed to fall asleep, breathing heavily. She seemed preoccupied and distracted at times. He was scared about what might be happening, but too afraid to confront her. Eventually he screwed up the

courage and asked her if anything was wrong, but his query was interpreted as his own issue and not answered. He did not ask again.

One day he was rung by the therapist's partner to say that W had gone to hospital and that sessions should resume in a week. In two weeks he received another phone call to inform him that she was too unwell to ever resume the therapy and he was to make other arrangements himself. A few weeks later he read in the newspaper of her death "from a long illness".

The death brought up for him the abandonment by his father who had left the family home abruptly, never to return. His anxiety greatly increased and he became more withdrawn, both from professional activities and intimate relationships.

Discussion

There is clearly an enormous variation in how people age, in terms of their capacities and their attitude to them, and in their ability to practice. The severity of cognitive impairment and medical illnesses are vital determinants of capacity, but another is the ability of the therapist to work through the changes and losses that time brings. The "calm awareness "of Quinodoz (2008) and the " being more fully alive to who [we] really are" of Davenhill (2007) perhaps can only exist when there has been such a process of mourning and acceptance. However, for this to occur, there needs to be an awareness of loss.

This is the conundrum. If we are too effective in denial of ageing and death, and so maintain our psychic equilibrium, then we cannot adjust to changes, and so cannot practice in reality. We lose the ability to see ourselves clearly. Group denial of the effects of ageing and the risks of illness, found commonly in psychoanalytic associations, with a norm of practising into old age, plays an important role in maintaining denial. Segal (2014) quotes Catherine Mayer (2011) in her description of 'amortals' who wish to repudiate old age and "continue to live exactly as they have always lived until they die" (p. 177). This is usually achieved by working very hard or distracting oneself through excessive activity or drugs. Illness usually leads to the wish to suicide.

Perhaps this is an extreme example, but lesser forms of this state may be seen in some colleagues. Practising into older age is not a problem per se, and could be seen as a preferred option. However to do so, **without taking into account age-related changes** can produce marked distortions of reality.

Although many therapists conduct themselves in an otherwise ethical manner, when confronted with major illness or terminal disease, the reactions of some seem to be a mixture of omnipotent denial and a passing on of the cruel unfairness experienced when these defences are shattered. Denis' (2013) description

of a vampiric relationship with patients and an identification with the Greek God Cronos who devours his children in order to stop them overthrowing him, is apt.

No firm conclusions can really be made about the question of when and how to say goodbye to our working life. A plethora of strategies may be employed. These include:

Setting a date for a complete cessation of practice when still well.

This allows for long term planning, but is a blunt instrument in that some of the therapies may be cut artificially short. The patient's needs have to fit in with the therapist.

Gradually cutting down one's practice by not taking on new patients.

This is the exact opposite, with the therapist fitting in with the patient. This is ethically sound, but of course it is the therapist who may be resentful then. What is done with all these holes in the daily schedule? The patient may also sense that there is an end approaching, and respond by prematurely terminating or clinging on with a tenacious continuation of symptoms.

Business as usual

If the therapist is subjectively feeling they are functioning well, then they can opt to continue practice until tiredness or medical events supervene. The view of "I know, but …" or a defiant "I'll work till I drop!" operates. Sometimes there is a recognition that taking on new patients too late in the piece may not be a sound policy, and taking on other forms of work that provide satisfaction and financial reward is a better option. Examples of the latter include supervision, teaching and medico-legal work.

Power (2016) surveyed 17 psychotherapists who had retired at different ages and in varying manners. There was marked variability in their experiences, but little correlation with age. Those who retired early to pursue other interests had much greater ambivalence, but coped better after a grieving process. However, one man who ended practice, due to poor health, in his eighties said "It [retirement] makes one an old man or woman straight away".

There's no correct or best way of ending our working lives. Working out an ethical balance between the therapist's needs and the needs of the patient is integral to the therapeutic task .

Perhaps the guiding principle should be that there is a continual need to consider both the therapist's physical and psychological reserve on the one hand

and the professional load on the other (Peisah, 2016). However, this requires the ability to truly estimate one's own capacity, a difficult feat in itself. The natural tendency to minimise the probability of a medical illness has to be taken into account. We don't like to think that we're going to get sick. This also means that there might be reasonably abrupt endings to therapies or at least reductions in frequency, if illness supervenes.

The effects of our early analysed experiences and the ending of our therapies are not thought of enough, nor is the effect of chance considered much in making a decision. Not making a decision is of course still making one—that illness or death will decide for you. The cruellest way of ending an illustrious career is having to face a forced ending by a complaint, when someone else decides for you.

Thaulow (2014) believes that it is extremely important to allow the patient the responsibility of deciding when to stop treatment. Patients too can estimate risks of illness and death and can guess your age although of course won't know your medical history e.g. history of heart disease or cancer. Revalidation of practising registration by medical colleagues or AHPRA is a topic for discussion as you consider this paper.

The question of the bluntness of the instruments used to determine capacity must be asked. Some countries set a fixed age for withdrawal of registration, e.g. 70 years old in Norway.

Guidelines

If we can't set hard and fast rules for this most difficult decision, perhaps only the most general guidelines can be offered. Therapists might reasonably decide to continue practising if they are well in mind and body, since the chance of supervening illness or death is faced by the young as well—"I will take my chances". But there must be limits.

The recognition of impairment is difficult if not impossible to achieve purely subjectively. Colleagues' and partner's concerns are vital in drawing attention to impairment. People need to speak out, and their words need to be taken seriously. Other psychoanalytically oriented organisations have established Assistance or Benevolent Committees, where concerns can be addressed without the immediate need for a formal ethics complaint.

If, however, a medical condition develops that impairs function, then the therapist might consider:

- Giving up practice in the case of Mild Cognitive Impairment, let alone full Dementia. This is because denial and lack of insight are profound and are an inherent aspect of the disorder.

- Being both in therapy and supervision if there is a significant chronic medical illness that isn't terminal.
- The necessity of therapy if the condition is terminal. Honesty is an important ingredient so that the patient may give informed consent to the continuation of the treatment. Termination of the therapy should occur but there needs to be some time for both therapist and patient to work this through. Another therapist could be found, with the patient possibly commencing this therapy concurrent with the first.
- Peer review is helpful if there is no medical illness but practice is continued in older years. Honest feedback can be invaluable for both continuing practice and for stopping. The need to pay attention to health is vital, particularly in terms of exercise, and risk factors such as hypertension. Honestly evaluating limits by taking into account tiredness, concentration and memory issues is necessary: No long days or taking on too many patients.

The Association

Another important factor in determining how therapists deal with their ageing, is the professional association, whose impact is often greatly underestimated.

In times of great losses, especially the cascade of losses that can face the aged, it is the group, the analogue of the original family, that can be of immense support. It is common in modern western society for families to drift apart, often leaving people with a bare minimum of support.

Sebastian Jurgen (2016) in his examination of returned servicemen with traumatic stress disorder, is a strong proponent of the value of a supportive community, akin to the tribe in hunter-gatherer societies. A cohesive association of the tight knit of social connections that enhance the sense of belonging can be an immense benefit to the aged professional, particularly if family ties are weak or absent. Having the role of an honoured elder whose contributions are valued can help guard against threats of loss of status and invisibility or even a feeling of being a burden to society. The group can also be the voice of reality in standing up to blind omnipotence and saying, "It is time"—A protective *memento mori*. Being able to remain a member of an association, attend professional development events, and sit on committees if desired and able, even when retired, allows for a sense of continuity that guards against annihilation anxieties. Just as Dartington (2007), in her moving account of her own dementia, acknowledges her need for her husband "to be an extension of my thinking", perhaps older therapists need the assistance and support of their colleagues as well as family.

The moral imperative to speak out when evidence that a colleague is obviously unwell and may be unfit to practice is oft forgotten, with turning a blind eye becoming a shared norm in the professional association. This is illustrated in the following vignette:

Sally was a senior psychoanalytic therapist, in her early seventies, but still with a large caseload of patients, a model of how people could work effectively as they aged. She was diagnosed with cancer, in an advanced stage. Although this was mentioned to close colleagues, her patients and supervisees were never told of her illness. She vanished from institutional life, and her illness was only spoken of behind closed doors. A veil of silence descended. One patient, Tracey, was part of the training programme.

Sally started behaving oddly in the therapy sessions, making strange unconnected and bizarre interpretations. Many sessions began to be cancelled, always by leaving "weird spooky messages" on the answering machine. She started wearing a wig when her hair fell out. Any attempt by Tracey to talk about this in the sessions was met with a stony silence, or an angry retort e.g. "don't look at me like a doctor" Tracey attempted to talk to other members of the association, in seminars and to her supervisor, but these were always met by a brick wall of refusal to engage. She often left the seminars in tears of frustration, and her own standard of work deteriorated . This was noted and criticised, despite the issues in her therapy being raised. The whole situation became Kafkaesque, and Tracey felt she was going mad, or falling unwell with cancer herself. Her therapist then stopped therapy abruptly, giving a few days notice, and never giving a reason. Some months later, Sally died, with Tracey only learning of this by reading the death notice in the newspaper. Any attempt to discuss the matter with office bearers failed. Her supervisor eventually validated her responses, but stated that Sally had cut off from the association. No colleague was allowed to come to the funeral, and it wasn't discussed posthumously. Eventually, she left the training course, despite nearly finishing the requirements. Tracey never returned to training, and remains scarred to this day, acting a little like Coleridge's Ancient Mariner, repeating the tale of the traumatic events to those who will listen.

In line with the notion of seeking the views of colleagues, all the members of one psychoanalytic organisation were sent a written request for qualitative feedback on a number of questions related to ageing and psychotherapeutic practice (Foulkes, 2016). The responses were interesting, and are detailed below.

Effects of ageing

Some people, a minority, described sudden breaks from practice as a result of ageing. However the majority described positive effects, such as, "I less need to

be psychoanalytic", or "I less need to follow strict rules … with a greater sense of freedom".

Changes in Practice

Most clinicians said that they had instituted changes as they got older. Generally, this involved cutting down the time that they saw patients. There were fewer number of patients seen and these were seen less frequently. More time was taken between seeing patients. Most therapists worked fewer days in a week, and this was viewed very positively. A greater number of breaks were taken, and these were often of greater duration than in the past. Less pressure was felt as a result of these changes, with a greater sense of satisfaction in the work. Perhaps surprisingly, a number of responses indicated that supervision had been sought, to "help hold me".

Planned changes in practice

Most therapists envisaged a planned tapering of practice over some years, choosing not to take on new patients as old ones finished their treatments.

Suggestions for assistance from the Association

This section provoked the most anger, with a number of responses citing dissatisfaction with their association: "I don't think of the [association] as being helpful at all". Suggestions were varied but included: a discussion group for those contemplating retirement; a series of seminars on issues related to ageing and retirement; and help for those suffering ill health or a terminal illness. A considerable minority of people believed that older therapists were discriminated against and that this should cease. An example given was the questionnaire itself.

Although the low response rate (around a third of those therapists viewed as being in an older age group of 65 years or older responded) meant that it wasn't clear if the responses were representative or not, they did indicate a trend. A considerable number of therapists who identified themselves as older perceived little difficulty with the process of ageing at present, and didn't seem too concerned with the future impact of ageing or their ability to adjust accordingly. The reader can see this as hopeful optimism, blindness to reality, or something in the middle.

Conclusions

How do we strike a balance between hope and despair? Between denial and ageism?

On the one hand, most therapists report a sense of wellbeing, an ease, a freedom, as they age. They feel they can enjoy this potentially rich time of their lives, both professionally and personally. On the other hand, enduring significant illness and disability is harsh. And facing the deaths of loved ones and the knowledge of one's own mortality is painful indeed.

Having a balance is important. To be in the sleep of denial, whilst others around live your nightmare until you wake up, is no way to be. But to feel there's nothing but a black hole facing you prevents enjoyment of life. Nothing is as bad as feeling crushed.

So maybe there needs to be an awareness of the effects of ageing, whether present or potential, without succumbing to them. Keeping alive the light of hope without blinding oneself to the darkness. Dylan Thomas, in his poem about his father's death, urges us:

"Do not go gentle into that good night,
Old age should burn and rave at close of day,
Rage, rage against the dying of the light"
(Thomas, 1951)

We might argue whether acceptance or anger is the best way to face ageing, but we sleep unless we acknowledge that a dying of the light is even occurring.

So each of us must go out and find our own balance, what suits us best, but never losing sight of our patients' needs.

References:

Abend, S.M. (1982). Serious illness in the analyst: countertransference considerations. *Journal of the American Psychoanalytic Association*, 30, 365–379.

Cruikshank, M. (2009). *Learning to be Old: Gender, Culture and Aging*. New York: Rowman and Littlefield.

Eissler, K. (1975). On the Possible Effects of Aging on the Practice of Psychoanalysis. *Journal of the Philadelphia Association of Psychoanalysts*, 11, 138–152. Reprinted (1993) Psychoanalytic Inquiry, 13, 316–332.

Dartington, A. and Pratt, R. (2007) My Unfaithful Brain—a Journey into Alzheimers Disease. In R. Davenhill (Ed.), *Looking into Later Life: a Psychoanalytic Approach to Depression and Dementia in Old Age*. London: Karnac Books.

Denis, P. (2013). Growing older as an analyst: Problems of ethics and practice based on personal experience in G. Junkers (Ed.), *The Empty Couch: the taboo of ageing and retirement in psychoanalysis*. London: Routledge.

Freud, S. (1914 [1972]) Letter to Abraham of 25.8.1914, in Schur, M. *Sigmund Freud: living and dying*. London,Hogarth Press.

Freud, S. (1915). Thoughts for the Times on War and Death. (*Standard Edition,14*) London: Hogarth Press.

Glisky, E. (2007). Changes in Cognitive Function in Human Ageing, in D.Riddle (Ed). Brain *Ageing: Models, Methods and Mechanism*. Boca Raton: CRC Press.

Junkers, G. (2013) The Ageing psychoanalyst: Thoughts on preparing for a life without the couch, in G. Junkers (Ed.). *The Empty Couch: the taboo of ageing and retirement in psychoanalysis*, London, Routledge

Junger, S. (2016). *Tribe: On homecoming and belonging*. New York: Twelve

Kottler, J. and Carlson, J. (2016). *Therapy Over 50 : Aging issues in psychotherapy and the therapist's life*. New York: Oxford University Press.

Lear, N. (2006). *Radical Hope: ethics in the face of cultural devastation*. Cambridge: Harvard University Press.

Ogden, T.H.(2004). On holding and containing, being and dreaming. *International Journal of Psychoanalysis 85* (6), 1349–1364.

Peisah, C. (2016). Successful ageing for psychiatrists. *Australasian Psychiatry 24*(2), 126–130.

Power, A. (2016). *Forced endings in psychotherapy and psychoanalysis: attachment and loss in retirement*. East Sussex: Routledge.

Quinodoz, D. (2010). *Growing Old: a journey of self-discovery*. English translation by David Alcorn. East Sussex: Routledge.

Quinodoz, D. (2013). Later, perhaps … transience and its significance for the psychoanalyst. In G. Junkers (Ed.) *ibid*. London: Routledge.

Randles, J. (2011). *The aftermath: after the therapy ends.* Conference proceedings of the Royal Australian and New Zealand College of Psychiatrists Congress, Adelaide.

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

Segal, L. (2014). *Out of time: the perils and pleasures of ageing*. London: Verso.

Taleb, N.N. (2007). *The Black Swan: The Impact of the Highly Improbable*. New York: Random House.

Thaulow, J.F. (2013). Narcissistic challenges for ageing analysts. In G. Junkers (2013) *ibid*

Thomas, D. (1951). Do Not Go Gentle into That Good Night. In M.H.Abrams (Ed.). *The Norton Anthology of English Literature*, London: Norton.

Varchevker, A. (2010). Mourning in later years: a developmental perspective. In E. McGinley and A. Varchevker (Eds.). *Enduring Loss: Mourning, Depression and Narcissism through the Life Cycle*. London: Karnac Books.

Willock, B. (2007). Thoughts for our times on transience and transformation. In B. Willock, L. Bohm and R. Curtis (Eds.). *On deaths and endings: psychoanalysts' reflections on finality, transformations and new beginnings*. New York: Routledge.

Winnicott, D.W. (1963). Dependence in infant-care, and the psychoanalytic setting, in Winnicott,D.W. (1965). *The Maturational Processes and the Facilitating Environment*. London: Hogarth Press.

Wittenberg, I. (2013). *Experiencing endings and beginnings*. London: Karnac.

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