“Youth! Youth! There is absolutely nothing in the world but youth!” To Dorian Gray (Wilde, 1891) the idea of getting old was such an anathema he split off his ageing self and projected it onto the feared and hated portrait kept out of sight. Some negotiate the last chapter of their lives with equanimity, but to many, ageing represents a wound to self-esteem. The images we have of old age carried in our conscious and unconscious lives are for the most part negative. This negative public perception is reflected in the negative self-image old people too have of themselves particularly when depressed. Evans in this issue draws together psychoanalytic and socio-cultural factors in the understanding of late life depression and suggests a group model for its treatment, particularly in those whose narcissistic investment has left them vulnerable to the changes and losses of old age.

In a similar way that a deficiency of positive mirroring in infancy can lead to an inadequately developed sense of self (Kohut, 1971) so too in later life the distaste and fear with which we view old age can amplify the older person’s sense of horror and disintegration.

In the west we inhabit a youth-centred and youth-dominated culture. In a production oriented, positivistic, post-modern society value is placed on whatever is young and active, old age is viewed as the absence of youth. We praise old people for not ageing well, but for seeming younger than they are. Zoja (1983) describes how the traditional roles of older people have been expropriated—wisdom by professionals; story telling by the media; memories, in some cultures guarded by the old, are now stored in computers.

The older generation is often viewed as a medical and economic burden. We are regularly reminded of the financial drain that the care and support of people in retirement is on (younger) tax payers. By way of guilt or sentimentalism the physical and social needs of old people are given some provision. However, minimal attention has been paid to their psychological needs. By denying an emotional life to the elderly the imagined pain and fear of old age and life’s end can be conveniently denied for the rest of us. To be old in the 1990s might be a worrying prospect. To be old, dependent and mentally ill could be a terrifying one.

Caring for older dependent people is difficult, demanding and stressful work (Terry, 1997; Ardern, Garner & Porter, 1998). Most is undertaken by people with little or no training. In the private sector some staff are employed on very poor terms and conditions. It is easy to understand how this institutionalized abuse can be displaced onto vulnerable residents. Resentful and demoralized, staff may be more likely to mistreat residents. The unconscious nature of this abuse will, by definition, be disguised. To expose complex dynamics within and between people requires extreme sensitivity and expertise if the cycle of blame and retaliation is not to be fuelled.

Psychoanalysts initially following Freud’s notion of the ineducability of people over 50 (Freud, 1905), and subsequently unable to avoid the Zeitgeist of the twentieth century have paid relatively little attention to the second half of life. Jung (1929), spoke of “a psychology of life’s morning and a psychology of its afternoon” and of taking on older patients in treatment. Nevertheless, when he wrote of the main archetypes he wrote least about “senex”. Perhaps to these great minds the prospect of their own diminishing powers was disturbing.

Mental health professionals who have in so many ways championed the cause of older people, may unwittingly fall prey to some of the subtler prejudicial ideas (Garner, 1998). In part this may be because we see an abnormal population of older people experiencing great difficulties but we find it more comfortable to focus on disease processes and social problems than to face the anguish of our patients. The countertransferential feelings evoked by these patients; the fear that they may become dependent on us (Martindale, 1989) or that we may become like them, is too painful to contemplate.

Our patient is a part of society. He is not unaware of our fears and stereotyping which are his own. He does not wish to join a club “full of old people” or be admitted to a “geriatric” ward. He too, by pro-
cesses of cultural introjection, has conscious and unconscious negative images of old age and therefore of himself. What is considered "virility at 25 becomes lechery at 65"; it may be less threatening to younger adults to see old age as lacking sexuality—perhaps derived from oedipal reactions to our own parents (Berezin, 1972). It is not surprising therefore that old people often adopt a negative view of sexual desire and the prophecy becomes self-fulfilling. The patient engaged in life review from this denigrated position may view all of his life experiences as worthless.

In contrast, positive images and models of age do exist. Old age and creativity are not strangers to each other. Pablo Picasso (1881–1973) remained vigorous in his artistic and emotional life until he died. Henri Matisse (1869–1954) overcame the handicaps of age and illness in his bedridden final years by embarking on an original kind of work using abstract designs of cut-outs in brightly coloured paper (gouaches découpées). Guiseppe Verdi (1813–1901) wrote Falstaff, a powerful evocation of a lusty old age, when he was himself 79. There are many more examples but it would be simplistic and unhelpful to react to the denigration of later life by idealisation. To erect an iconography of age against which most people would fail by comparison would compound feelings of inadequacy.

Evans writes that the task in old age is to maintain integrity or sense of self despite the negative images of ageing, projected onto the old. Psychiatrists, and psychotherapists can assist in that task. Some psychoanalysts have taken up Erikson's developmental life-cycle approach (Erikson, 1966) which incorporates the concept of adult development and consider that people of any age come to therapy when developmental adaptation breaks down (Hildebrand, 1982). Older people should perhaps be credited with greater ego strength; they tend to have an increased capacity for delayed gratification and for getting on with things; they take into the senium not only the difficulties and problems they had when younger but also the strengths, internal resources and coping strategies they have used over the years. It is upon these that clinicians could capitalize (Garnier, 1998).

Evans uses group therapy as an adjunct to physical treatments in the management of refractory depression. This presents the patient with an opportunity to glimpse his fellow group members behind the projections and eventually to see them and himself in their true image. Psychiatrists and all involved in the treatment of patients in later life must hold up a more positive mirror; realistic and honest mirroring, to assist in the process of self-reflection.

References


