Clinicians describing psychotherapeutic work with older patients almost invariably reflect the sense of resistance they experienced at the outset, citing a variety of obstacles to starting the work, barriers to performing the psychotherapeutic tasks, and societal and cultural stereotypes that inhibited them in their interactions with older patients. Butler and Lewis (1977) discuss the mental health profession’s nihilism and negativism regarding the older patient. They consider them manifestations of “professional ageism” and therapist countertransference and list the following six issues:

1. The aged’s stimulation of therapists’ fears regarding their own eventual old age (and, we would add, anxiety regarding death)
2. Therapists’ conflicts about their own parental relations
3. Felt impotence stemming from a belief in the ubiquity of untreatable organic states in the elderly
4. Desire to avoid “wasting” their skills on persons nearing death
5. Fears that an aged patient may die during treatment
6. Desire to avoid colleagues’ negative evaluation of efforts directed toward the aged

The therapist’s own anxieties in treating older patients must first be confronted and understood, particularly in their expression as counter-transference in the therapeutic process. In a comprehensive review, Rechtschaffen (1959) stated:

The anxiety aroused by hostility toward a parent figure may lead to a watering down of the therapeutic process and to an exaggerated emphasis on supportive and covering-over procedures. Defending against his own anxiety, a therapist may propose only the most benign interpretations, and may assume an attitude of reverence toward an older patient that is out of keeping with the patient’s actual readiness to examine himself. (p. 82)

THE MYTH OF RIGIDITY

Kahana (1978) has thoroughly discussed the problem of the older person’s so-called rigidity as a significant attitudinal barrier on the part of the therapist. He describes how Guntrip (1975) had a second analysis relatively late in life and was able to recover, when he was in his 70s, valid and therapeutically significant childhood memories that were helpful to a further understanding of his life. Grotjahn (1955) has found in a number of cases that resistance against unpleasant insights is frequently lessened in old age. Lifelong struggles and the demands of reality often characterize defenses. In much the same fashion, Wheelwright (1959) finds aging patients to be surprisingly flexible. He compares his older patients to his younger ones and finds that patients in the second half of life may be less competitive and possessive because they have met a number of their life goals. He describes them as becoming more subjectively oriented and more concerned with who they are. Kahana describes the work of Fozard and Thomas (1975) who reviewed the results of psychological testing with physically healthy people over 50. In all the psychological functions measured, only one could be interpreted as displaying rigidity. That was a tendency toward slower reactions to stimuli due to the increase in time required for central information processing. Kahana (1978) summarizes the clinical evidence against the imputation of rigidity of thought process to patients over 50 in the following way:

Thus, the evidence against a general imputation to patients over 50 includes reports of psychological improvement based on earlier psychoanalysis, reports