Transforming Loss in Late Adulthood

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# TRANSFORMING LOSS

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Abstract

This paper asserts that individuals are capable of flourishing in late adulthood despite enduring multiple losses. Older adults are a rapidly growing segment of the population, yet they remain largely underserved by the mental health community. In order to promote competent mental health care services for older adults, this paper reviews prevailing grief theories, explores numerous losses from a biopsychosocial perspective, suggests a variety of therapeutic interventions, and recognizes the challenges of late adulthood from an Adlerian perspective. As a result, readers can become more adept at facilitating the process of transforming loss and enhancing quality of life in late adulthood.
Introduction

Our later years are marked by life transitions, multiple losses, and relinquishment of past roles. While acknowledging diversity, a number of the most common losses that older adults face are loss of partner, loss of cognitive and physical capabilities, and relocation to a care facility. Deriving benefits from loss in old age may appear inconceivable, yet old age is not inherently synonymous with demise. This paper explores thriving in the face of multiple losses and facilitating growth in those who are struggling to surmount the demands of late adulthood. This is imperative because the needs of this “invisible” population are going largely unmet by the mental health community.

Loss is devastating in itself, but older adults’ ability to cope is often compromised by ageism. Ageism marginalizes older adults, and may break down those who would otherwise be triumphant by placing additional obstacles in their paths and thwarting their efforts to thrive in old age. In the aftermath of loss, support from the community can be instrumental in their ability to adjust. Unfortunately, many older adults have lost their partners, primary support networks, do not live in close proximity to family members, and may not have access to or fail to utilize mental health services, leaving them isolated and vulnerable. A seasoned counselor of older adults, Buckley (1972) found that most of her clients experience a profound feeling of “separateness” and of being abandoned by the larger society (p. 756).

“According to the U. S. Census Bureau's ‘middle series’ projections, the elderly population will more than double between now and the year 2050, to 80 million. By that year, as many as 1 in 5 Americans could be elderly. Most of this growth should occur between 2010 and 2030, when the "baby boom" generation enters their elderly years” (as cited in U.S. Department of Commerce, 1995, para. 3). Despite the growing need to meet the demands of this specialized
population, geropsychology is a field that only a small number of clinicians pursue. Qualls, Segal, Norman, Niederehe, and Gallagher-Thompson (2002) revealed that “the vast majority (69%) conduct some clinical work with older adults, at least occasionally, but that fewer than 30% report having any graduate coursework in geropsychology, and fewer than 20% any supervised practicum or internship experience with older adults” (as cited in APA, 2004, p. 236).

In order to promote heightened competency in providing specialized mental health care to older adults, this paper provides an overview of prevailing theories of grief and growth resulting from experiencing loss, the biopsychosocial aspects of losses faced in old age, assessment protocols that inform the most effective intervention strategies for assisting individuals who are undergoing these losses, personal considerations to enhance care delivery, and how Adlerian theoretical concepts can contribute to understanding the challenges of late adulthood. Whichever theoretical perspective adopted, this paper increases the reader’s capacity to tailor therapeutic interventions that fit the unique needs of the individual.

**Theoretical Foundations of Grief and Loss**

From traditional to postmodern, wide arrays of models are presented in order to expand the knowledge of clinicians working with clients facing grief and loss. According to Encyclopedia of Death and Dying, “grief refers to the process of experiencing the psychological, behavioral, social, and physical reactions to the perception of loss” (2011, para. 2). In an effort to explain reactions to loss, grief theorists refer to tasks, processes, and stages. Formulaic in nature, traditional theories insinuate that there is a correct way to grieve and a pathological way to grieve. Contemporary theories, however, are cognizant of how sociocultural factors impact adjustment to grief.

Hooyman and Kramer distinguish Freud, Lindemann, and Parkes as the theorists who
paved the groundwork for grief research and practice (2006, pp. 22-25). Freud developed the first major theoretical perspective on grief in *Mourning and Melancholia* (1953, 1957). The crux of his theory is that individuals must cut all ties from the deceased in order to reestablish “normalcy” through the intensely psychological process of what, according to Hooyman and Kramer, is termed “grief work” (p. 22).

Hooyman and Kramer designated Lindemann (1944) as another prominent grief theorist who viewed grief as an immobilizing state comprised of five psychological and somatic symptoms, including: somatic distress, preoccupation with thoughts of the deceased, guilt, hostility, and loss of usual patterns of behavior (2006, p. 24). Hooyman and Kramer go on to note that Lindemann proposed that grief resolution could take place in little more than a month with intensive therapy and deemed anything longer as pathological. A follower of Freud, Lindemann believed that complete detachment from the deceased was necessary, but acknowledged that individuals have unique responses to grief, which are heavily influenced by their personality and support networks (p. 25).

Bowlby applied attachment theory to explore how the nature of childhood bonds with one’s parents subsequently impacts their ability to cope when separated by death or loss. Carr et al. (2000) noted that Bowlby believed that not all losses trigger the same amount of grief and that individuals respond differently to loss (p. S198). Bowlby’s colleague Parkes (2002) also applied principles of attachment theory and found that those who had secure attachments to their parents in childhood suffered less duress, while those who experienced separation distress as children had a more difficult time coping with bereavement later in life. In addition, Parkes found that individuals who learned to avoid attachment in childhood also had a difficult time confronting their feelings during bereavement (as cited in Hooyman & Kramer, 2006, p. 27).
Task model theorists propose that a number of tasks must be completed in order to fully heal from grief. Worden (1982, 1991, 2002) developed the Grief Tasks model, asserting that the following tasks must be accomplished in order to heal from grief: (1) accepting the reality of the loss, (2) experiencing the pain of grief, (3) adjusting to an environment in which the deceased is missing or a loved person is absent, and (4) withdrawing emotional energy from the past relationship and reinvesting it in other relationships (as cited in Hooyman & Kramer, 2006, p. 38). Schneider’s (1984) Growth-Oriented model identifies three tasks: (1) awareness, (2) acceptance, and (3) reformulation, in which advancing to the next stage represents a critical point in the healing process (as cited in Hooyman & Kramer, p. 38).

In her influential book, *On Death and Dying*, Elizabeth Kübler-Ross (1969) developed the notorious five stages of grief model to describe the painful gamut of emotions involved in grief surrounding death. She is convinced that if one does not complete all five stages, they will be unable to move forward with their lives. Although these stages often mirror the experiences of survivors of loss, Hooyman and Kramer object to assuming that Kübler-Ross’s research with dying individuals is applicable to survivors as well (2006, p. 37).

Hooyman and Kramer refer to several grief theorists who criticize both task and stage models for their rigidity and intolerance of personal variations during the grief experience. Non-linear, cyclical theories have been developed to correct for this discrepancy by encompassing a wide range of unique experiences (2006, p. 37). Such approaches may better approximate bereavement by acknowledging that individuals experience a current of emotions, and rather than chastise individuals for not grieving in a timely and succinct manner, they respect variation.

Postmodernists sharply disagree with the insinuation that grief work is necessary for true healing. Stroebe and Schut (2001) note that “persistent negative affect intensifies grief…yet if
positive states are maintained relentlessly, grieving is neglected. Alternation between these psychological states emerges as essential” (p. 67). Central to this theory is the importance of “meaning making”, which is seen as an essential coping tool. Davis (2001) identifies two components of meaning making: comprehending the loss and discovering the advantages of loss. “Whereas making sense of the loss involves the task of maintaining or rebuilding threatened worldviews, finding benefit seems to involve the task of maintaining or rebuilding the threatened sense of self” (p. 146).

While traditional psychoanalysts would deem laughter as an impediment to the grieving process, Keltner and Bonnano (1997) researched how smiling and laughter can assist individuals in coping with loss. By analyzing participant’s facial responses, they were able to establish that smiling and laughter allows individuals to dissociate from distress and enhances intrapersonal and interpersonal relationships, which improves long term functioning during bereavement (p. 687).

The Dual Process model developed by Stroebe and Schut in 1999 suggests that individuals adopt a “loss orientation” to process the loss and a “restoration orientation” to adapt to life without the loved person or object. “Oscillation between positive and negative affect and (re)appraisal facilitates and provides pathways whereby one can cope with the different dimensions of grieving” (Stroebe & Schut, 2001, p. 67). In other words, by moving between these two states, individuals experience respite from a constant flood of painful emotions to endure bereavement.

Although phrased in many different ways, a majority of researchers, such as Bozath (1994) and Rando (1988, 1993) concur that the primary phases of grief are avoidance, confrontation, and accommodation (as cited in Hooyman & Kramer, 2006, p. 40). Rather than
resolution, “accommodation” reflects the fact that one’s life is forever changed by loss and that grief may remain in the background as a permanent fixture. This approach declares that it is not necessary to permanently sever ties, but that it is possible to go on living with loss.

Hooyman and Kramer (2006) reflect on the shifts that grief theories have undergone throughout the years. Early psychoanalytical theories introduced by Freud depicted grief as long term with a definitive end. Mid-century theorists viewed grief as a short term crisis that could be ameliorated in a short span of time with therapy. Current trends propose that grief is a long term process in which individuals may never return to previous functioning. And an emerging “new wave” of grief theory is culturally-sensitive and appreciates the complex nature of grief (p. 36).

Theoretical Foundations of Growth from Loss

Rather than concentrating predominantly on devastation and distress, alternate developments in grief research explore the positive side of loss. “Religious, philosophical, and folk traditions for thousands of years recognized the possibility that the struggle with major losses in life can be the source of enhanced meaning in life and the impetus for positive change” (Calhoun & Tedeschi, 2001, p. 157). Several theorists have pondered about what distinguishes those who experience growth in the throes of loss versus those who deteriorate. The Stress and Coping, Resiliency, and Posttraumatic Growth models have emerged to identify individual and mediating factors that influence reactions to grief and loss. Although passionate about adopting a positive outlook, supporters of these approaches do not diminish how devastating loss can be and recognize that not all individuals will experience growth. Instead they focus their efforts upon exploring what individuals can gain from loss.

Stress and Coping models demonstrate that those who actively challenge themselves to redefine and positively reframe loss can harness their stress to adjust to loss more effectively.
Folkman and Moskowitz (2000) propose that positive affect can coexist with stress, thereby reducing its harmful effects. They contend that implementing coping skills that promote positive affect during stress involves creating meaning for the event (p. 648). Likewise, Gross and Munoz (1995) found positive affect to be a preventative measure against clinical depression because it interrupts ruminative thinking patterns (as cited in Folkman & Moskowitz, p. 649).

According to Epel et al. (1998) and McEwen (1998), research indicates that positive affect benefits individuals on a physiological level through the neuroendocrine system and has the potential to “…protect them from the maladaptive neural, endocrine, and immune responses to chronic stress that can lead to disease” (as cited in Folkman & Moskowitz, p. 649).

The Resilience model is a strengths-based perspective that views individuals as capable of adjusting to loss and growing in the face of adversity. Unlike Stress and Coping models, the Resilience model acknowledges the impact of cultural, community, and familial resources upon the grief experience. Age is a particularly relevant factor affecting resiliency. Stroebe and Schut (2001) explain that because loss is an anticipated part of growing older, individuals over 60 are often better equipped to cope with it than their younger counterparts (as cited in Hooyman & Kramer, 2006, p. 70).

The Posttraumatic Growth model, developed by Tedeschi and Calhoun (2004), focuses upon the benefits that commonly arise in the aftermath of a life changing event. Posttraumatic growth is “…the experience of positive change that occurs as a result of the struggle with highly challenging life circumstances” (p. 1). Tedeschi and Calhoun believe that undergoing the painful and often lengthy process of grief work stimulates the active cognitive reprocessing that is necessary to achieve the full benefits of posttraumatic growth. According to Tedeschi and Calhoun, “…posttraumatic growth is not simply a return to baseline-it is an experience of
improvement that for some persons is deeply profound” (p. 4).

In order to substantiate their theory, Calhoun and Tedeschi developed The Posttraumatic Growth Inventory (PTGI) (1996) to assess three of the most common positive responses to traumatic losses. Some examples are feeling more self-assured, experiencing the enhancement of relationships, being grateful for each day, as well as experiencing existential and spiritual growth (Taku, Cann, Calhoun, & Tedeschi, 2008, p. 158). Although The PTGI has strong empirical support, after years of analysis, Calhoun and Tedeschi acknowledged that posttraumatic growth deserved further study due its complexity. They called for additional research to ascertain the cognitive processes associated with posttraumatic growth, while at the same time recognizing that growth takes place on more than an intellectual level. They also acknowledged that the significance of cultural influences and social networks are not assessed in the PTGI. Furthermore, they saw the value in conducting longitudinal studies to determine if posttraumatic growth endures over time in order to substantiate their initial findings (2004, pp. 99-101).

Janoff-Bulman (2004) believes that Calhoun and Tedeschi’s model may not adequately address the complexity of posttraumatic growth and proposes three separate models to provide further clarification. The first is strength through suffering, in which individuals discover that they are stronger than they thought, leading to increased self-confidence. The second type of growth Janoff-Bulman identifies is psychological preparedness, which helps prevent re-victimization. “It appears that we know bad things happen; we simply do not believe they will happen to us. In other words, we are psychologically unprepared for misfortune.” And the third category of growth is existential revolution, in which individuals develop a greater appreciation for life (p. 32). Calhoun and Tedeschi agree that the processes involved in different types of
growth are worth distinguishing: “It may be that the former was able to cope with the trauma by exerting some control whereas the latter was faced with a greater need to acknowledge an absence of control” (2004, p. 100).

This theoretical movement redirects the focus of grief research to investigating the positive side of loss. Researchers such as Folkman and Moskowitz, Stroebe and Schut, and Calhoun and Tedeschi believe that loss can stimulate many positive changes, such as acquiring a greater appreciation for life, strengthening bonds with others, and discovering unrealized strengths. They demonstrate that reframing loss can facilitate healing and lead to a more enriching life.

The following sections explore the complexities of losing a partner, physical capabilities, cognitive faculties, and relocation to a care facility. Separation of these losses is not meant to imply that they are self-contained, isolated experiences; they are interwoven and are compounded over time. Becvar (2001) remarks:

Loss marks the end of one life chapter and signifies the beginning of a new one.

Loss has the capacity to open doors to greater awareness, to enhance sensitivity, and to increase compassion. It may even lead to great wisdom. (as cited in Hooyman & Kramer, 2006, p. 76)

One’s approach to these pivotal transitions is deeply personal and holds the potential for growth and new possibilities.

Freeman (1984) notes that older adults, more than any other age group, experience loss uniquely and with an added level of complexity because 1) they are more likely to experience unrelated, multiple losses over a short period of time at which many of their personal and environmental coping resources have diminished; 2) the ability to resolve losses can facilitate
acceptance of or compound death anxiety; and 3) the way an individual defines loss is critical to how they will proceed. For instance, some will feel defeated after the first loss and lack the perseverance to surmount future adversity (p. 288).

**Loss of Partner**

Losing a partner is often an inevitable byproduct of age, requiring a restructuring of most facets of life. Individuals undergo a pivotal shift in how they experience the world. “A partner’s death brings the loss of (1) a many-layered relationship, which may encompass best friend, lover, companion, and confidant(e), as well as rituals, traditions, and interdependencies; and (2) a central part of the surviving person’s identity” (Hooyman & Kramer, 2006, p. 307).

There are numerous ways that the nature of a partner’s death can complicate the bereavement process. Sudden or traumatic deaths, such as accidents, homicides, and suicides can result in excessive anxiety and unresolved issues for survivors. Such events can result in survivors questioning whether the world is a safe place. Due to the stigma, those whose partners commit suicide may experience a compromised support network, particularly if they find solace in spiritual and religious practices. Partners often experience a great deal of guilt about their culpability as well. In addition, the location of the death, whether or not their loved one suffered, the length of illness, and the individual’s preparedness for their partner’s death are potential complicating factors in cases of death resulting from illness (Hooyman & Kramer, 2006, pp. 307-313).

The nature of the relationship that the individual had with the deceased has an impact on coping effectively with loss. It is often believed that tumultuous relationships with unresolved issues result in more severe distress than amiable relationships. Carr et al. (2000) investigated marital quality to determine its impact upon bereavement and found the reverse to be true. Their
research revealed that stronger bonds and higher levels of dependency actually resulted in greater psychological distress and yearning than conflictual marriages (p. S197). Bowlby’s (1980) attachment theory lends credence to their findings in that “…the dissolution of emotionally and socially significant ties may elicit the strongest psychological reactions” (as cited in Carr et al., p. S198).

**Gender**

Studies have shown that, in general, men and women mourn the death of a partner differently. Martin and Doka (2000) and Walter (2003) found that there are various responses to grief which are gender-related: “… (1) intuitive, in which grief is experienced and expressed in an affective way, stereotyped as female; (2) instrumental, in which grief is expressed physically or cognitively, labeled as male.; and (3) a third pattern that blends the proceeding two” (as cited in Hooyman & Kramer, 2006, p. 69). Hooyman and Kramer point to the utilization of support networks as being particularly relevant when examining gender disparities in grieving (p. 69).

Hooyman and Kramer (2006) cite several sources who have found that, compared to men, women tend to be more emotional, are more likely to seek support, have lengthier bereavement periods, and experience greater difficulty in rebuilding their lives (pp. 67-68). They also found that widows are less likely to establish new relationships due to being hesitant about resuming the role of caregiver and fearing the loss of another partner. In addition, they have a smaller pool of potential mates to choose from (pp. 312-313). However, they also found that widows are more likely experience growth after losing a partner (p. 67).

Hooyman and Kramer (2006) found that men are more apt to distract themselves by engaging in activities rather than expressing their feelings and seeking support (p. 68), which may be favored in societies that promote expedient recovery from grief. Yet many studies
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indicate that men are at a higher risk of serious medical conditions, death, and suicide after losing a partner in some part due to lack of support and increased isolation (p. 69). Hooyman and Kramer believe that widowers have a higher propensity to remarry because their identities are more associated with their relationships, particularly after retirement (p. 309).

Socioeconomic and Cultural Factors

A lifetime of socioeconomic strain can intensify the bereavement process. Losing a partner may result in losing a source of income, challenging the bereaved to perform duties that they are not accustomed to. Carr et al. (2000) found that increased anxiety levels were highly correlated with taking on responsibilities that were once performed by the deceased partner (p. S204). In addition, economic hardship may prevent some from obtaining needed services to cope with the added distress resulting from widowhood.

Likewise, cultural traditions and beliefs can be influential in dictating how one navigates widowhood. When one grieves in accordance with tradition, they tend to receive support from their community and relief from participating in cultural rituals. Cultural deviation, however, often compounds the grief process. In Western societies where prolonged bereavement is discouraged, individuals may estrange themselves from their support networks or be forced to put on a strong front to reduce others’ uneasiness. Spirituality and religiosity are potentially influential as well. Frantz, Trolley and Johll (1996) found that “… more than 80 percent of the approximately three hundred adults who had suffered the death of a loved one said that their religious and spiritual beliefs helped them during their grief, with a strengthened belief in the afterlife being a significant benefit of their experience” (as cited in Hooyman & Kramer, 2006, p. 74).
Social and Family Factors

After losing a partner, interpersonal and social relationships often become strained. The topic of death is uncomfortable and awkward for most. When no longer part of a couple, he or she may feel out of place at social gatherings. Although talking through grief may be therapeutic, others may not want to listen as it forces them to face their own mortality. Family dynamics adjust to compensate for the lost family member, which can result in turbulence or togetherness. In addition, families may experience more tension as children take on the challenges of caring for the other parent.

Obstacles to Healthy Grieving

Prolonged bereavement often results when individuals engage in excessive rumination and experience what is termed “complicated grief”. Although grief is complex by nature, individuals suffering from complicated grief often experience serious impairments in daily functioning and find themselves unable to move beyond the death of their partner, leading to sometimes debilitating psychological and physical symptoms.

Nolen-Hoeksema and Jackson (1996) explain that rumination impacts individuals many ways. It leads to globalization of negative experiences, impairment in performing daily activities, and reduction in problem-solving skills (as cited in Stroebe & Schut, 2001, p. 66). They also found that “people with ruminative style early in bereavement were found to have higher depression levels 6 months later…those with a more distractive style became less depressed over time” (Stroebe & Schut, p. 64).

Hooyman and Kramer (2006) state that complicated grief, previously known as traumatic grief, “…involves prolonged feelings of devastation and trauma as a result of the separation from a loved person or object” (p. 53). To avoid confusion with posttraumatic stress disorder,
complicated grief is the preferred term among experts in the field. Complicated grief can present itself in several ways: 1) separation distress and searching behavior to the point of functional impairment, 2) traumatic distress, including bewilderment, outrage, and disengaging from others, and 3) development of somatic symptoms of the deceased, for instance, experiencing heart pains after losing a partner to a heart attack (Hooyman & Kramer, p. 54).

Losing a partner has far-reaching implications. Adjustment may involve severing all ties or it may involve accommodating the loss. A number of factors that may facilitate or complicate bereavement have been examined. How these factors coalesce to lead to recovery is a highly individualized process. Rather than proposing a proper way to grieve the loss of a spouse, clinicians must respect each client’s unique experience.

**Loss of Physical Capabilities**

Declining physical capabilities are among the losses characteristic of late adulthood, challenging the strength of one’s mental health, relationships, and social world. In The Centers for Disease Control (CDC) and The Merck Company Foundation’s (Merck) (2007) publication *The state of aging and health in America 2007*, it was found that “…at least 80% of older Americans are living with at least one chronic condition, and 50% have at least two” (p. 12).

Deteriorating mental health and deteriorating physical health form a synergistic relationship, each potentially exacerbating the other. When assessing older adults for mental illness, Matteson seeks to ascertain if physical ailments are complicating, causing, or reducing mental health symptoms in order to determine the most efficacious interventions (2010, p.14). As health declines, a role reversal ensues, a regression to dependency after a lifetime of independence and being a provider. In addition, social and interpersonal relationships are potentially compromised by physical limitations.
In order to distinguish whether symptoms indicate serious illness or medication side effects, psychologists should have a basic understanding of classic age-related physical changes inherent in the aging process (APA, 2004, p.243). In his extensive work with older adults, Matteson has found that the most commonly missed medical diagnoses are: dental, gastrointestinal, malnutrition, infection, pain, and endocrine disorders (2010, pp. 14-19).

Hooyman and Kramer (2006) cite a large body of research that demonstrates the devastating impact that prolonged grief can have on the mind and body (p. 85).

**Emotional and Behavioral Impact**

Declining health and physical abilities threatens one’s self concept as being capable and empowered. Kelley (1998) observes that:

When elders move from being independent to being dependent, from being healthy to having a chronic condition, from feeling in control to feeling powerless and uncertain about each day, from feeling attractive and energetic to feeling tired and undesirable, they lose much of themselves, along with their ability to perform normal daily functions. Because they live with the pain and illness daily, they cannot return to normal functioning or “get beyond the loss”.

(as cited in Hooyman & Kramer, 2006, pp. 319-320)

In 2004, Knight developed the contextual, cohort-based maturity/specific challenge model (CCMSC), as an alternative to the prevailing loss-deficit model of aging. While the loss-deficit model depicts late adulthood as a time of loss and decline, the CCMSC model insists that, although more likely, loss is no less devastating in old age. In addition, Knight (2006) takes issue with the loss-deficit model for not seeing beyond loss. The CCMSC model asserts that there are always ways for older adults to improve and maximize their capabilities (p. 10).
Another aspect of physical decline from the above quote by Kelley is desirability. The media instills deep-seated fears of aging by inundating the public with products that promise to reverse aging with wrinkle creams, hair transplants, and drugs that restore sex drive, portraying older adults as undesirable and asexual. These products are geared towards those who still have a hope of reversing the aging process, but commercials for older audiences insinuate that they are already past the point of no return. According to the media, rather than striving for vitality, older adults should invest their time in finding a good life insurance policy and absorbent diapers.

**Loss of Independence**

It can be devastating when an individual reaches the point where they are no longer able to perform activities of daily living. The reversal of roles from being the caregiver to receiver often results in feelings of uselessness, loss of self esteem, loss of control, and loss of pride. The presence of strangers providing care services in the home may be met with great resistance. Financial stressors, conflicting expectations between the older adult and care provider, and varying familial and cultural beliefs regarding care come into play. In addition, treating health conditions involves a substantial time commitment, such as arranging transportation, and making sense of often confusing insurance benefits (APA, 2004, p. 244).

Older adults may feel that their family members should be their care providers. When family members provide care, caregiver stress often results in substantial pressure. For instance, choices must be made about which child should be responsible for caring for the ailing parent and/or how often, or partners with their own medical issues may not be able to provide adequate care. These situations of heightened anxiety and stress can potentially lead to neglect and abuse (APA, 2004, p. 244). Therefore, mental health providers have an ethical and legal duty to protect their clients and should routinely assess safety in situations of heightened caregiver
stress.

“Among older adults, falls are the leading cause of injury deaths and the most common cause of injuries and hospital admissions for trauma” (CDC & Merck, 2007, p. 34). Psychologically, the anticipatory fear of falling significantly impacts quality of life, resulting not only in physical deterioration due to lack of exercise, but also decreased social involvement, and if serious enough, relocation (CDC & Merck, p. 35). Over-protectiveness on the part of well-meaning caregivers can exacerbate the situation and lead to further isolation, depression, and loss of social skills. Ideally, older adults should be consistently challenged to develop new skills and maximize their capabilities (Freeman, 1984, p. 289).

**Social Implications**

Physical decline can magnify the negative repercussions of an already dwindling support network. The inability to engage in social activities and keep up with one’s former pace may lead to embarrassment about growing older and more vulnerable, particularly in societies that revere highly active lifestyles. The added level of effort and motivation necessary to engage in social activities can tax one’s already compromised physical and mental health.

Conversely, reactions from social networks also have a significant impact upon successful adjustment to decreased physical capabilities. Faced with this situation, family and friends may not know how to react; they may deny limitations or avoid interacting with the individual. If enough invitations are declined, he or she may be excluded from future outings. Friends and family who are healthy may have a difficult time appreciating the mental and physical exertion that it takes to engage in more than basic daily activities. These reactions may fuel fears of abandonment and increase mental health symptoms.
Cultural Factors

Westerhof, Katzko, Dittman-Johli, and Hayslip (2001) conducted a study with individuals from the United States, India, and Congo/Zaire to examine cultural variances in perspectives of health in older age. By studying these diverse cultures, they sought to challenge the Northern American and Western European “deficit” model of aging, which has been virtually uncontested. “This model holds that aging primarily involves coping with or adjustment to a wide range of losses in life, especially in the domain of physical functioning. When we find that the meaning of biological decline differs between cultures, one might question whether such gerontological theories are as universal as they sometimes pretend” (para. 3).

Westerhof et al. (2001) noted that traditional psychological theories focus primarily on personality and self esteem, often separating the mind and body as well as the individual from their social context (para. 5). They hold that individuals actively construct “health-related selves”, whereby their health becomes integrated into their self concept and impacts their health status in the present and the future. “North American and Western European studies on the meaning of aging have shown that individuals often associate aging with losses in health” (para. 64).

The findings are valuable in that they challenge prevailing views about health in old age by widening the cultural lens and investigate definitions of health from a biopsychosocial perspective. Signifying the influence of how cultural beliefs impact views on growing older, “…findings suggest that aging not only means losing one’s health and autonomy…aging can also mean to ’cash in’ the credits of support one has built up in one’s family and even to end life in a good way” (para. 65).

Loss of physical capabilities has a pervasive impact, touching most facets of one’s
existence: our moods, behaviors, cognitions, and activity levels. Acceptance of physical limitations can be particularly challenging in societies that emphasize the importance of being able-bodied. When addressing the needs of older adults struggling with declining health, it is important to adopt a holistic approach that recognizes the mind, body, and environmental influences.

**Loss of Cognitive Abilities**

This section examines the impact of cognitive loss on a number of levels, from the concrete and biological to the personal and unquantifiable. The loss of cognitive abilities is often assumed to be an undeniable, dreaded byproduct of the aging process, however, The Alzheimer’s Association Medical and Scientific Advisory Council (2005) assures individuals that “recent research is proving several myths about cognition to be incorrect — notably, the beliefs that aging is a time of irreversible mental decline and that dementia is universal and inevitable” (as cited in CDC & Merck, 2007, p. 13). Experiencing or anticipating cognitive decline or “losing it” significantly impacts quality of life.

Himes, Oettinger, and Kenny (2004) explain that “cognitive health refers to ‘a combination of mental processes we commonly think of as ‘knowing’ and includes the ability to learn new things, intuition, judgment, language, and remembering...’” (as cited in CDC & Merck, 2007, p. 13). There appears to be an overall consensus among researchers that, in general, older adults are able to learn new information but at a slower rate. On a positive note, The AGS Foundation for Health in Aging (2005) notes that “in formal tests of performance, older people also slow down with age but, they make fewer mistakes. We tend to be more cautious and less willing than younger people to make a mistake in judgment, which is a valuable characteristic in many real-life situations” (para. 9). Additionally, Cartsensen and Turk-
Charles (1994) found that “older adults retain emotional material better than neutral material”, which is beneficial in therapy (as cited in Knight, 2006, p. 6).

**Emotional and Behavioral Impact**

Living with a cognitive impairment can take a considerable toll on one’s psyche. In the mental health community, there is a tendency to separate the mind from the body rather than focusing on the whole person. One’s identity is often associated with one’s state of mind, thus cognitive decline may be interpreted as a loss of self and can lead to depression and anxiety. Depression and anxiety can manifest themselves as cognitive disturbances and can also compound the effects of existing cognitive impairments. Consequently, self-concept suffers, self-esteem plummets, and isolative behavior increases.

**Loss of Independence**

Himes, Oettinger, and Kenny (2004) emphasize that “at all ages, having a clear and active mind is important, and is particularly important for older adults because it can mean the difference between dependence and independent living” (as cited in CDC & Merck, 2007, p. 13). Cognitive decline can have an impact on one’s ability to perform daily tasks. When cognitive impairment becomes severe enough, not only do individuals become dependent upon others, but caregivers may have to make painful decisions, such as taking the car and keys away, as well as other precautionary measures, at the expense of the individual’s independence and freedom. This considerable strain on relationships can put vulnerable adults at risk for abuse and neglect and calls upon clinicians to report abuse and advocate for the safety their clients.

**Social Implications**

The loss of cognitive function often impacts one’s ability to communicate and comprehend, potentially threatening social and interpersonal relationships. With severe memory
loss, loved ones can become strangers, making the world a very lonely place. Individuals often experience shame and remorse and lose interest in socializing. Relationships may become strained when friends and family become uncomfortable seeing their loved one’s reduced functioning as well as facing their personal fears of experiencing the same fate.

When the mind is perceived as the whole self, loss of cognitive function and the fear that it invokes, can have a deleterious impact upon one’s quality of life and lead to mental health symptoms. In addition, social and interpersonal relationships, which are important coping mechanisms when under duress, can become compromised by increased dependency and isolation.

**Relocation**

Relocation can profoundly impact older adults’ quality of life due to loss of independence and control, loss of privacy, suffering from chronic pain and illness, and isolation. “Transition into an institutional life is a significant watershed and often a traumatic event in late life that requires significant adaptation to a host of new environmental stressors (Choi, Ransom, & Wyllie, 2008, p. 544). “According to the U.S. Bureau of the Census…the rate of nursing home use increases with age from 1.4 percent of the young-old to 24.5 percent of the oldest-old. Almost 50 percent of those 95 and older live in nursing homes” (as cited in Breytspraak, 2008, para. 1). For clarification, LinkAge 2000 defines the “young-old” as those between 65-74 years, the “middle-old” between 75-84 years, and the “oldest-old” as being 85 years old and older (2007, para.1).

Since 1992, Relocation Stress Syndrome, also known as “transfer trauma”, has become a recognized diagnosis in the North American Nursing Diagnostic Association (NANDA) classification scheme (2001). Melrose (2004) illustrates the relocation experience utilizing Kao,
Travis, and Acton’s (2004) three-phase model (pp. 10, 16). In the first phase, pre-institutionalization, preparations are made for departure (selling house, giving away possessions), as well as making decisions that may surrender legal rights. Secondly, the transitional stage involves the first few months of life at the facility, often filled with intense emotional distress over a loss of autonomy. Lastly, during the post-institutionalization phase residents focus upon establishing themselves in their new surroundings and maintaining bonds with loved ones (p. 16). Melrose recommends that, in order to reduce the effects of transfer trauma, staff working in care facilities should engage in active listening, promote autonomy, and build upon residents’ past victories to help them cope in the present (p. 17).

Choi, Ransom, and Wyllie (2008) conducted a study to examine depression in nursing home residents. Of those reporting depressive symptoms, residents attributed depressive symptoms to a litany of concerns: “…loss of independence, freedom and continuity with their past life, feelings of social isolation and loneliness, lack of privacy and frustration at the inconvenience of having a roommate and sharing a bathroom, loss of autonomy due to the institutional regimen and regulations, ambivalence toward cognitively impaired residents, ever-present death and grief, staff turn-over and shortage, and stale programming and lack of meaningful in-house activities” (p. 536). Residents reported that coping mechanisms were “…religion, stoicism, a sense of reality, positive attitude, and family support” (Choi, et al., p.536). In addition, they found that participants preferred programs at the institution designed to decrease isolative behavior rather than psychotherapy (Choi, et al., p. 536). The authors also provide recommendations about how care providers can reduce the incidence of depression by integrating environmental adjustments that promote the well being and the dignity of residents.
Loss of Independence and Control

Older adults often experience a great deal of anguish when they associate moving to a facility with no longer being productive and valuable members of society. “Even though many of them had had to depend on others for meeting their daily needs prior to entering the nursing home, they perceived their institutionalization as the beginning of their loss of independence and autonomy, an event that was not likely to be reversed and that really marked the end of the lives that they had led previously” (Choi, et al., 2008, p. 540).

Schulz (1976) investigated the importance of control over visitation schedules among institutionalized older adults, finding an increase in well-being when participants were able to control the frequency and time that they had visitors. Interestingly, the group that had visitors but did not have control in planning when the visit took place did not differ significantly from the no-treatment group in terms of well-being, indicating the significance of how having a sense of control positively impacts the well-being of older adults living in care facilities (p. 563).

Chronic Pain and Illness

Meeks and Tennyson (2003) and Williams (1999) report that “The higher prevalence rates of depression among nursing home residents than among their community-dwelling peers are expected, given their higher rates of physical illness, pain, comorbidity, disability, cognitive problems, and nutritional deficits” (as cited in Choi et al., 2008, p. 536). Knight (2006) points out that the focus of therapy with older adults suffering from chronic medical conditions shifts to reducing rather than completely ameliorating symptoms (p. 10).

Loss of Privacy

Having others perform activities such as bathing and toileting may feel like a violation of personal boundaries and dignity. Matteson states that “72% of aggressive episodes occurred
when staff touched a resident or invaded their personal space”, and that “dressing and toilet activities accounted for 50%” (2010, p. 23). Unfortunately, due to staff shortages, low morale, and/or lack of training, these duties may be carried out in a substandard manner.

Living with a roommate can be a large point of contention when possessions are stolen, sleep schedules vary, or the televisions and music are played too loudly. As mentioned in the previous research, sharing bathrooms appears to be a particular source of frustration as well. Aggressive behavior towards other residents may be perceived as the only means to reestablish power and control in environments where they feel they have none (Matteson, 2010, p. 25).

**Isolation and Loneliness**

Individuals living in an institution often have infrequent, limited, or no visitors. They may be estranged from support networks and feel abandoned by their families. Family members may emotionally distance themselves if they feel guilty about sending them there. Proximity issues may result in infrequent visits as well. Due to a lack of outside contact, these “elder orphans” often deteriorate quickly after entering institutions (Matteson, 2010, p. 6). Several factors that are inherent in institutional living can exacerbate loneliness and isolation. Due to the state of the health of residents, forming bonds often means grieving successive deaths, turning social withdrawal into a protective measure. Furthermore, fear of death or developing a cognitive impairment may result in avoidance of others with acute conditions, reducing the likelihood of engaging in social activities at the facility.

The repercussions of relocating to a care facility cannot be understated. When older adults lose their home, their sense of independence and a lifetime of accomplishments are often taken out from under them. Without adequate support, residing at a care facility can deplete individuals psychologically, socially, and physically, resulting in the deterioration of life quality
and possibly shortened life spans.

**Therapeutic Approaches**

This section covers a variety of interventions that may be effective in addressing the needs of older adults as well as the personal challenges that clinicians face when working with this population. When working with older adults, clinicians are often faced with the challenge of facilitating recovery and growth in clients confronting a myriad of painful losses. What distinguishes those who remain resilient in the face of cumulative losses and how can this process be cultivated in those struggling to surmount life’s transitions? Working with older adults necessitates authentically believing that individuals are capable of thriving despite diminished physical, cognitive, and support systems at their disposal.

Major barriers to mental health care among older adults are underutilization of services and under detection by primary care providers. In 2005, the US Department of Health and Human Services found that “fewer than 3% of older adults receive treatment from mental health specialists.” And even when such services exist, there are often no openings for new clients (as cited in Gatz, 2007, p. 53). Primary care providers can be the gateway to obtaining mental health care for older adults and the APA recommends that they be trained to conduct mental health screenings as part of their routine visits. “The ability to communicate, educate, and coordinate with other concerned individuals may often be the key element in providing effective psychological services to older adults” (2004, p. 251). Those who need additional care should be provided with referrals to community organizations and seen for follow up.

According to Knight (2006), cohort differences are particularly relevant when working with older adults. Knight cites research indicating that cohort effects can impact personality, intellectual skills, and ability to cope with adversity. In fact, he believes that cohort effects are
“...as influential as learning about cultural differences before working with clients from another country” (p. 5). Therefore, he recommends that clinicians acquire knowledge about the characteristics of different eras to enhance their ability to better understand older clients.

**Assessment**

“When a person’s individual and informal capacities are depleted by several large losses, whether through age, chronic illness, poverty, or historical disadvantage, professionals need knowledge, skills, and values to assess his or her needs and develop culturally competent interventions” (Hooyman & Kramer, 2006, p. 361). As the first step in all therapeutic endeavors, assessments are conducted to ascertain presenting problems, assist in designing interventions and goals, and to build therapeutic relationships.

Knight (2006) finds that clinicians often attribute presenting problems to age, overlooking medical ailments, mental health, and current stressors (p. 8). A crucial aspect in making an accurate diagnosis, particularly with older adults, is to rule out organic causes, particularly if they do not have a prior history of mental illness. Because medical conditions and medication side effects can mimic mental health disorders, medical records should be reviewed before making a formal diagnosis. Corroborating evidence from care providers and family members is also instrumental, particularly in cases where the individual suffers from cognitive impairments. As part of the assessment, Satre, Knight, and David (2006) suggest integrating a visit to locations where individuals reside. “A working knowledge of an older client’s social context is essential for delivering appropriate interventions based on both classic behavioral and social learning treatment models because aspects of the environment often reinforce maladaptive behaviors” (p. 490).

Assessment tools commonly utilized with older adults have been contested for several
reasons. Hunter (1960) remarks that “The majority of present-day psychological tests lack adequate norms and are inappropriate in content and method of administration for use with the aged” (p. 125). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (2000) is the premier reference guide for diagnosing individuals, but is designed for use with mental health disorders that occur in children, adolescents, and adults. Ageism and low performance expectations on the part of the clinician may also impact diagnostic determinations, resulting in inappropriate diagnoses, and correspondingly, inappropriate treatments.

A thorough risk assessment should also be conducted because the initial assessment may be the first and only encounter the clinician has with the individual. Elders, particularly those experiencing grief and loss, are at high risk for suicide. The American Association of Suicidology reported that white men over 85 have the highest potential of committing suicide: “In 2007, the suicide rates for these men was 45.42 per 100, 000. That was 2.5 times the current rate for men of all ages…” (2009, para. 5). Duckworth and McBride (1996) reveal this shocking research: “One study investigating the incidence and treatment of depression in 543 older suicide completers revealed that 87% received no treatment for their depression, that those who were treated were given medications that were lethal in overdose, as opposed to safer serotonin reuptake inhibitors, and that those seeing their general practitioner were less likely to be treated with antidepressants than were those seeing a psychiatrist” (as cited in Hooyman & Kramer, 2006, p. 339). These statistics reveal the need for suicide assessment training not only among mental health providers but for all care providers who serve the elderly population to prevent further deaths.

Interventions

Is maintenance therapy the most there is to offer the aging population or do we believe
that they can reach their potentials? We may ask ourselves how anyone can prosper in the face of multiple losses and indisputable mortality. Denial and avoidance of their loss and half-hearted optimism invariably erodes trust and presents barriers to developing quality therapeutic relationships. Clinicians working with older adults must whole-heartedly believe that he or she has the capacity to succeed and exceed expectations. In Guidelines for Psychological Practice With Older Adults (2004), the APA explores a variety of therapeutic interventions utilized with older adults and did not deem any particular therapy as being superior. Instead they suggest customizing interventions to fit the needs of each individual (p. 249).

Cognitive behavioral therapy is empirically supported for use with the elderly population in areas such as depression, anxiety, substance abuse, insomnia, and coping with disabilities and chronic pain and can be adapted based upon the social context and cognitive functioning of the individual (Satre et al., 2006, p. 489). Gatz (2007) points out that although there is more evidence about cognitive behavioral therapy than any other therapy, several discrepancies may compromise its validity. For instance, many of the studies were conducted in group formats, which may not be representative of individual practice. Also, in contrast to research conditions, practitioners in the community do not strictly adhere to formalized manuals when working with clients, and they often combine psychotherapy with psychopharmacology, which is not a widely researched treatment approach (p. 53).

Molinari (1999) utilizes reminiscence and life review to facilitate the process of resolving remaining conflicts and reflecting on life. “Life review therapy is systematic guided reminiscence to help older persons integrate disparate aspects of the self, to assist with current problem-solving strategies, and to bequeath a legacy” (as cited in Hooyman & Kramer, 2006, p. 328). Molinari suggests providing a supportive environment conducive to sharing memories in
addition to cognitive behavioral techniques and homework, often creating an autobiography or photo album to revisit and capture significant events in their lives (as cited in Hooyman & Kramer, p. 329).

The Strengths Perspective Counseling model, developed by Langer (2004) focuses on facilitating client empowerment and maximizing capabilities rather than pathologies. Those who practice this approach emphasize the utilization of inner strength to control and manifest one’s sense of well being. The Strengths Perspective model contends that: (1) individuals are capable of making their own decisions and directing their lives, (2) individuals have more control over outcomes than they believe, and (3) individuals are always striving to meet their needs at both a basic and higher level (p. 615).

Folkman and Moskowitz (2000) are proponents of problem-focused coping for the management of specific stressors. Problem-focused coping focuses on assisting individuals to establish new and more realistic goals in the context of their circumstances. As a result, they become more focused and have opportunities to experience mastery and control, giving them courage to surmount future obstacles.

Calhoun and Tedeschi’s Posttraumatic Growth model, which was developed in 2001, focuses on the potential benefits of loss. Due to the seemingly paradoxical approach to grief and loss, they recommend 1) being very careful of word choices so as not to offend the client, 2) to explore how a client’s worldview may have changed as a result of the loss, and 3) to be fully present and avoid short circuiting the grief process by prematurely introducing optimism (2004, p. 93). Rather than setting out to achieve posttraumatic growth, Calhoun and Tedeschi recommend that clinicians learn how to recognize opportunities to encourage growth when they present themselves (2004, p. 93).
Rando (1985) implements rituals in combination with traditional therapy to facilitate the grief process. Bossard and Boll (1950) comment that in 1950 a recognizable shift began to take place in family rituals, resulting in diminished community participation (as cited in Rando, 1985, p.237). Rando remarks that when funeral planning became commercialized, mental health professionals began to initiate rituals that were once fulfilled collectively (p. 237). According to Rando, rituals serve several purposes: First, they provide tangible and focused ways to express thoughts and feelings. Secondly, they reduce the likelihood of globalization and complicated grief and provide guidance in facing their grief, and lastly, they allow others to participate and to commemorate special occasions (pp. 238-239). “Ritual behavior often reaches the unconscious levels in a personality more rapidly than verbalization because it appeals to the right side of the brain. This is in contrast to verbal stimulation which taps the left side of the brain” (Rando, p. 238).

Group work is often implemented in community and institutional settings to assist older adults and their family members in coping with the impact of loss. Elders particularly benefit from the social support that groups provide, as they become increasingly isolated during bereavement. Although credited with changing many lives, Hooyman and Kramer (2006) note that group therapy lacks empirical support and requires further study to determine optimal timing and to address cultural and gender biases, as almost all research on group therapy has been conducted with Caucasian females (p. 332).

Freeman (1984) presents the Ecological approach, which takes into account not only an individual’s capacity to cope with adversity, but also how responses from their environments impact their ability to cope. She recommends utilizing genograms as assessment tools to assist individuals in understanding their circumstances from a broader context. Genograms are
pictorial representations of family relationships that “…facilitate the life review process because it illustrates genealogical relationships, significant family events, occupations, losses, cut-offs, role assignments, and communication patterns in the client’s life process” (Freeman, p. 292).

The ecomap also uses pictures but focuses primarily on support networks and ones functioning in the areas of social, work, family, and other relationships (Freeman, p. 292). These tools can be particularly helpful in uncovering unrecognized losses and normalizing one’s responses in light of their history. Freeman recommends the following interventions: encouraging risk taking and learning new skills, establishing new relationships, and having a transition period to slowly ease into new roles and situations arising from loss.

Clinicians face an added level of complexity when working with older adults that requires specialized care. The variety of intervention strategies suggested allows clinicians the flexibility to tailor therapy to suit the unique needs of their clients. Further research and training is warranted to find the most optimal ways to address the emotional needs of the aging population.

Personal considerations for practitioners

When working with the older population, practitioners would benefit from exploring their personal beliefs about what gifts, if any, later years hold. Hooyman and Kramer (2006) advise that “…service providers must guard against and oppose institutional and personal ageism, recognize the lifelong potential for growth, be committed to alleviating later-life suffering, be positive, and maximize the older person’s decision-making ability and sense of personal control” (p. 323). They also note that a number of personal challenges that compromise providing optimal care, such as chronic bereavement, vicarious traumatization, compassion fatigue, and burnout (p. 349). Conversely, Calhoun and Tedeschi (2001) found that clinicians may experience vicarious growth through listening to how loss has enriched the lives of their clients,
which in turn encourages their own spiritual and existential growth (2001, p. 169).

Professionals working with the aging population should be cognizant of how their personal attitudes and beliefs about aging and older adults may compromise their ability to provide compassionate care. In age-fearing-death-avoidant cultures, few are immune to believing that life only goes downhill as we age, and mental health practitioners are not excluded. The APA faults stereotypes and ageism on the part of providers as barriers to providing quality care. Goodstein, (1985), Perlick and Atkins (1984), and Settin (1982) note that “Such views can become self-fulfilling prophecies, leading to misdiagnosis of disorders and inappropriately decrease expectations for improvement, so-called ‘therapeutic nihilism’, and to the lack of preventative actions and treatment” (as cited in APA, 2004, p. 239). The APA also cites several studies indicating that positive stereotypes such as viewing the elderly as cute and childlike can be equally harmful as well as disempowering (2004, p. 240).

Knight (2006) challenges these stereotypes and believes that the accumulated wisdom of older adults is advantageous in therapy. “The development of expertise through life experience will, in general, be an asset when working with older adults” (p. 21). He recommends that practitioners prepare themselves to work with clientele who may be more sophisticated than they are, which can be either threatening or present an exciting learning opportunity (p. 22).

Hooyman and Kramer (2006) recommend that practitioners develop self awareness about their own issues with death and loss to avoid countertransference, to conduct themselves objectively, and to ensure that they are serving their clients’ and not their own needs. One should set aside time to address any unresolved issues surrounding loss. They also encourage practitioners to engage in physical, psychological, spiritual, emotional, and professional selfcare for mutually beneficial experiences.
Adlerian Applications

This section demonstrates how the Adlerian concepts of lifestyle, tasks of life, social interest, and teleology are applicable to late adulthood. Penick (2004) maintains that although Individual Psychology’s roots are largely based upon child development, its principles are also well suited for older adults (p. 219). Penick encourages “purposeful aging” and endorses the use of Adlerian techniques to facilitate striving in our later years (p. 219).

Lifestyle

Lifestyle is a fundamental Adlerian concept that refers to the conclusions that individuals draw in childhood about what must be done to gain acceptance and how the pursuit of those beliefs is a guiding force throughout life. “The foremost task of individual psychology is to prove this unity in each individual—in his thinking, feeling, acting, in his so-called conscious and unconscious, in every expression of his personality” (Ansbacher, 1956, p. 175). What ideas were formed in childhood about how “old people” think, feel, and act? And how does that impact individuals as they grow older? When conducting lifestyle assessments at any age, discovering one’s perceptions about what old men and old women are like may be indicative of how he or she will adapt to old age and presents opportunities to challenge negative beliefs about aging that create distress. In addition, the information may assist in mediating potential relationship issues that may arise in late adulthood.

Tasks of Life

A significant part of life is spent balancing work, love, and social demands. Occupational, physical, cognitive, and social transitions alter the primary life tasks which come to the forefront in later adulthood. Ansbacher (1992) notes that “… at later stages of our lives, the three tasks of life that required social interest have essentially been solved and fade into the
background. Opportunities for life tasks such as spiritual and self-exploration become relatively more important” (as cited in Penick, 2004, p. 222). Those who struggle with the transition often experience feelings of worthlessness and meaninglessness when they cease to engage in what were previously defining roles. Freeman (1984) points out that “when an elderly person is no longer filling one or more pivotal roles due to retirement, disability, or changes in family functions, he or she may experience the situation as a loss. The loss of status and function can also result in a loss of identity and self esteem” (p. 290). Freeman goes on to say that some individuals may become more demanding of their family members in order to avoid relinquishing what little control they have, while others may view loss as pervasive and withdraw from roles that they are still capable of fulfilling (p. 290). Hunter believes that:

In old age there seems to be an increased need for love and affection due probably to physical dependency upon others. Similarly in the face of approaching death, the need for emotional security increases. On the other hand, the need for expression of interests may decrease. (1960, p. 122)

**Teleology**

A main premise of the Adlerian approach is that individuals are constantly striving towards a goal, or in Adlerian terms, teleology and goal directedness. According to Bar-Tur and Prager (1996) and Penick and Fallshore (in press), “No evidence suggests that the importance of purposeful behavior diminishes with age” (as cited in Penick, 2004, p. 222). Although individuals can also strive for maladaptive goals, coping effectively with late adulthood involves striving in new directions that correspond rather than collide with one’s changing capabilities.

The Adlerian approach sheds light on how life’s landscape transforms in late adulthood. There are a number of ways that Adlerians can enlighten individuals about their strengths as well
as their stumbling blocks. By instilling encouragement and optimism, individuals can learn to
greet transitions in their later years with acceptance rather than resistance.

Social interest

Late adulthood often involves a shift in the nature of social interest. Ansbacher (1992)
suggested that Adler’s concept of community feeling is a more appropriate concept than social
interest to describe and understand the goals, purpose, and meaning achieved by older
individuals. One important difference in the terms is that “…’community feeling’ includes a
spiritual state with a wide range of referents, while ‘social interest’ is an action term limited to
human beings” (p. 407). “Yet community feeling as identification with life in general, during the
decline of one’s own life, stands for what is today widely recognized as the way for meeting old
age and death calmly and cheerfully” (Ansbacher, 1992, p. 410). Watts and Carlson (1999) see
the merit in conducting studies that explore how the nature of social interest changes over the
lifespan as no social interest research had been conducted with older adults (as cited in Penick,
2004, p. 228).

Conclusion

All human beings have the potential to thrive regardless of their age or the degree of
adversity that they face. It is our role as clinicians to facilitate this growth process. With a
rapidly increasing population of older adults in need of mental health services and the overall
lack of adequate training to address the complexity of their needs, raising the level of competent
geriatric mental health care has never been more critical. After reviewing the contributions of
grief research, the dynamics of various losses, intervention strategies, and how the Adlerian
approach can provide further insight into the challenges of old age, readers can become more
adept at meeting the unique needs of the aging population.
Unfortunately, traditional approaches reinforce ageist views that insinuate the futility of encouraging growth in older adults. As a result, older adults are often marginalized in the mental health community and efforts are confined to maintaining rather than maximizing current functioning. Even in a field that is specifically designed to assist those in need, older adults remain virtually invisible. This is apparent in the overall lack of research with older adults as well as an insufficient number of formal training programs that address their specialized needs.

The contributions of the aforementioned grief theories enrich readers about the continuum of responses to loss. In the aftermath of loss, some will deteriorate and some will strive. Proponents of traditional grief theories propose that severing ties from the deceased or lost object is necessary for healing from loss, while contemporary theorists recognize that building a new life involves integration rather than detachment. Another field of grief research proposes that loss can be an impetus for growth and renewal.

An accurate assessment is integral to the therapeutic process as it guides treatment goals and the selection of intervention techniques. A variety of intervention strategies are introduced to offer flexibility in selecting techniques that best suit the needs of clients. Adlerian concepts are highlighted to illustrate the transitions involved in later life. Working with a population that is facing death and serious loss can be extremely demanding work, making the segment on personal development relevant and worthy of attention.

Further exploration is warranted in a number of significant areas that can impact an individual’s adjustment to loss. Of particular relevancy is how culture, family dynamics, and spiritual and existential beliefs are interconnected and can impede or facilitate this process. Being respectful and cognizant of how these factors impact the grief process is essential.

As we approach our older years, we may seek mental health services to cope with grief
and loss. The mental health community must provide comprehensive geropsychology training programs that prepare clinicians to provide optimal care. It is necessary to reach out to the aging community by sending a clear message that they can surmount adversity in old age, thereby increasing the likelihood of utilization of services. Schmidt (1985) illustrates the Aderlian perspective when he declares “‘Not our appeal to the community feeling of the aging is important but that we come to their help with our community feeling’” (as cited in Ansbacher, 1992, p. 409).
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