PART ONE

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CHAPTER 1

Using Process Dimensions in Psychotherapy: The Case of the Older Adult

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This chapter focuses on the understanding and use of process variables in psychotherapy with older adults. The chapter begins with a general discussion of the meaning of process dimensions in therapy and the reasons why this domain in psychotherapy has been, until recently, neglected. It includes a description of a new paradigm of psychotherapy research and practice based on process characteristics, a discussion of specific process themes in geriatric psychotherapy, and a discussion of the use of process as a therapeutic strategy.

PROCESS VERSUS CONTENT

Although the concept of process versus content is familiar, at least implicitly, to most practicing psychotherapists, this concept has not been adequately treated within traditional psychotherapy research that has tended to focus exclusively on content dimensions of the therapy process either in defining problems or in describing procedures and techniques. Process versus content in psychotherapy is essentially a focus on the how versus the what within psychotherapy. Within problem definition, for example, a content description of a personality problem would focus on the symptomatic profile (the what) whereas a process understanding would examine the dynamics (the how) that give rise to a particular personality problem. Process includes the unique set of interpersonal characteristics, coping style, and the myriad ways a person deals with his or her world and the people in it. A content definition of a psychological problem tends to describe what the problem looks like (e.g., depression), whereas a process portrayal
of the disorder gives a sense of the meaning of the depression, such as psychological loss and grief. Thus process diagnosis involves a “moving picture” of the dynamic meaning of a problem whereas a content diagnosis gives a “still picture” of the problem. In my experience more than 80% of diagnostic understanding lies in process rather than in content descriptions. The understanding of the dynamic meaning of a psychological problem gives the therapist a road map for treatment strategy. A content symptomatic description of a disorder is helpful in problem identification, but gives little guidance for therapeutic strategy.

Process dimensions are also important in the area of therapeutic techniques. Contemporary research (Wampold et al., 1997) has begun to clarify that it is not the technique as such (content), but the manner of administration of the technique (process) that accounts for effectiveness in psychotherapy. We later discuss the mounting evidence for the superiority of therapist variables over technical variables in the efficacy of psychotherapy. This point is easy to appreciate if, for example, we imagine how RET techniques differ in the hands of Albert Ellis than in the hands of his followers, or how cognitive restructuring techniques are handled by Aaron Beck versus his followers, or the empty chair technique in the hands of Fritz Perls versus his disciples. Despite the natural force of these comparisons, therapist process variables have been under researched.

Research is now consistently supporting the role of process dimensions or common factors, in the efficacy of psychotherapy. In this article we will:

1. Review evidence for the significance of process variables both for research and clinical purposes.
2. Present a rationale for the neglect of process variables in the current philosophy of science that prevails in psychology.
3. Examine the characteristics of a process approach/paradigm to therapy.
4. Outline and illustrate selected process themes in working with older adults.
5. Discuss process itself as therapeutic strategy.

TRADITIONAL RESEARCH ON THEORIES AND TECHNIQUES OF PSYCHOTHERAPY

For the past several decades, psychotherapy research has focused on the efficacy of psychotherapeutic treatment using a clinical trials method comparing theoretically based (content) treatment approaches and techniques. More recently, two critical findings have emerged:

1. Despite earlier statements to the contrary, in general, psychotherapy is both efficacious and effective (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). Note that the term “efficacy” typically is used to refer
to research on psychotherapy conducted in laboratory conditions, whereas the term effective is reserved to studies of actual psychotherapy in natural and minimally uncontrolled situations.

2. There are no consistent treatment differences to be demonstrated in psychotherapy research.

Luborsky et al. (1980) in a series of studies, has demonstrated that treatment differences are found between treatment methods and control or no treatment conditions and between placebo and no treatment controls; however, no differences can be systematically detected between psychotherapy treatment evolving from different theoretical positions. Wampold et al. (1997), in a recent meta-analytical study, made several improvements in both the logic and statistical analysis of meta-analytical strategy and has demonstrated that differences between psychotherapy approaches cannot be reliably detected in any series of research studies. Interestingly, he finds that placebo control conditions are about 50% as effective of bona fide treatment conditions. Wampold (1997) goes on to critique the current emphasis on validated treatments, which strangely seems to ignore the preponderance of research that fails to support treatment differences. He also asks why proponents of validated treatments would wish to homogenize therapies and therapists through the use of manuals, when we know that treatment differences are of little importance. Indeed, when differences are found in particular studies, little attention is paid to the clinical significance and magnitude of the differences or to the alternate hypothesis that in these cases of difference they may in fact be due to underlying common elements in the therapeutic process, for example, the therapeutic relationship itself. The use of a manual, in diminishing therapist differences, may also diminish therapist effect and therefore deny the most important treatment ingredient that has been demonstrated to date—the therapist variables.

Therapist and relationship variables are the primary examplar of process dimensions in psychotherapy. Relationship and interpersonal variables have been neglected in classical psychotherapy research as well as in the current content-related content and technical focus on validated treatments (Czogalik, 1995). Over the years, however, there has been a strand of research that, at least minimally, has investigated the role of therapist and interpersonal factors in the effectiveness of various aspects of psychotherapy. Sexton and Whiston (1994), reviewing research on the quality of the counseling relationship over time, have isolated a series of process dimensions that have variable effects on the effectiveness of outcomes of psychotherapy. In most of these cases, however, process variables are evaluated in their relationship to outcome measures. It is entirely appropriate, however, to use the process itself as a measure of efficacy and effectiveness. In the experimental or quasi-experimental/clinical trials research of psychotherapy that will be familiar to most contemporary psychologists, the several weeks of duration of treatment of the therapy under investigation is completely ignored as a source of data related to effectiveness in favor of a simple (often single) outcome measure that purports to be sensitive to changes in
therapeutic process. Process data can often detect the reasons why outcome comparisons proved nonsignificant or, conversely, process data can often explain why and where the change in outcome took place within the therapeutic trajectory.

A limited amount of research is well-known within the interpersonal relationship domain [e.g., Rogers’ (1957) work on the therapeutic conditions and, more recently, Bordin’s work (1979) on the so-called therapeutic alliance]. Both of these research domains represent an emphasis on process research but are often overutilized and are limited in the range of explanation they give to effectiveness. In the case of Rogers’ therapeutic conditions, for example, it has been found that while these conditions may indeed be necessary as a prelude to psychotherapeutic change, they may not in every case (although perhaps in most cases) be sufficient to produce change (Kolb, Beutler, Davis, Crago, & Shanfield, 1985). During the past few years, a range of less well-known studies focused on process dimensions of psychotherapy and different interpersonal, reciprocal aspects of the therapeutic relationships. In an earlier categorization of counseling relationship research, Gelso and Carter (1985) made the distinction between research into the real relationship, (for example, the work of Rogers on the facilitative conditions) and what they described as the unreal relationship, mainly the transference aspects of the therapeutic relationship. Also with the real relationship, focus has been placed on the role of counselor self-disclosure with emphasis on a range of modifying variables that variously influence the effectiveness of disclosure (Watkins, Savickas, Brizzi, & Manus, 1990). Another critical area of research has been in counselor or therapist intentions (Hill, 1990). Certainly, within the world of empirical research, therapist intentions and intentionality are little studied. However, in our naturalistic, day-to-day experience, we routinely “scan” the behavioral and verbal world for the intention of the other person and adjust our response and behavior accordingly if implicitly. It seems unlikely that clients do not also behave and modify their behavior in accordance with their view of the intentionality of the therapist or, vice versa, therapists judge the intentionality of their clients as a routine matter.

Within the so-called unreal relationship, the concept of transference, both in its effects and as an explicit therapeutic tool has been acknowledged by many theoretical positions from the classical psychoanalytic, through the psychodynamic, through behavioral concepts of generalization, and cognitive concepts of “working models.” More recent formulations that extend across this theoretical range view transference as a nonpathological but natural phenomenon that exists in everyday life and to some extent in all circumstances. It is highly reasonable that a person judges and adjusts behavior to future conditions based on past experiences. Thus, in both psychodynamic and cognitive psychology there is a recognition of models (working models) in attachment literature (Ainsworth, 1989), that are used as templates in new situations. Therapists also are likely to use transferential behavior. In the traditional discussion of this topic, therapists are deemed to have countertransferences to their patients or clients; in fact, there
is an equal possibility that the therapist will initially experience transferential reaction to a particular client who triggers associations with the therapist's earlier life experiences.

Another useful process variable is the working alliance itself as developed by Greenson (1967) and later Bordin (1979). This concept has been used in a series of variations by process researchers and is well documented in current therapy research literature, although it is not always recognized as a process dimension of psychotherapy.

Finally, and perhaps most importantly, there is a small but much needed line of research dealing with the reciprocal nature of the relationship between therapist and client. The term reciprocal, as differentiated from the notion of interaction, is a dynamic concept that represents a circular and, perhaps spiral notion of continuing recursive influence within the relationship between any two human beings (including the relationship between therapist and client). This concept of reciprocity is different from the conventional or statistical notion of interaction, which tends to be linear and static. The notion of reciprocally interacting behavior connotes the idea of a moving picture versus a still photo described by linear and even statistically interactive behavior. One area of specific interest within reciprocal research is the notion of complementarity in the relationship of client and therapist (Kiesler, 1987; Kiesler & Watkins, 1989). Complementarity, for example, is illustrated in the relative positioning of control within the relationship and also the negotiation of the central relationship issues of how friendly/hostile to be within the relationship. Finally, topic initiation and determination (Tracey, 1986) has considerable power within the therapeutic relationship. Mutual understanding on this issue had significant relationship to effectiveness of the therapeutic relationship. This seems close to the often-asserted need for the client to feel understood in order to be willing to continue in therapy.

**Psychology’s Philosophy of Science: “What You See Is What You Get”**

While psychology had its origins within the field of philosophy, it has become distinctly detached from and unaware of its own philosophical bases. Psychologists are frequently quite innocently unaware of the particular philosophy of science that undergirds the scientific practice and research of contemporary psychology. This philosophical background may help clarify the current emphasis in research methodology and the neglect of alternate research paradigms that may offer a much closer link with the day-to-day experiential practice of psychotherapy. Modern psychology and its research methods evolved from modernism and the philosophy of positivism or empiricism. In the post-Renaissance and Enlightenment times, science and its methods were influenced by positivism and empiricism. This philosophical position, in reaction to fear of magic and religious superstitions of earlier times, placed total reliance on
measurable external data, and de-emphasized the internal domains of experience as unmeasurable and therefore unverifiable. This scientific approach owes much to early British philosophy in the late 1700s, namely Empiricism, a tradition that developed into Positivism and Logical Positivism (Warnock, 1969). A scientific movement developed that limited scientific evidence to data that was measurable in observable and behavioral terms. This philosophical background, as a basis for the philosophy of science, has remained the dominant force within much European, British, and American psychology. Although, over the years, there have been significant alternative philosophies such as the introspectionism of early European psychology, psychoanalysis, existential positions in philosophy and science and the ideographic emphasis of some American psychologists such as Gordon Allport. The dominant philosophy of science that formed the basis for experimental and clinical psychology was dominated by a behaviorist philosophy and practice that was driven by empiricist view of the world. We needed empirical data to demonstrate truth. It therefore makes complete sense that psychotherapy research has focused on overt behavioral techniques that ostensibly derive from different theoretical positions and whose effectiveness and efficacy are demonstrated by behavioral outcome data. Thus, the fledging science of psychology, becoming detached from an understanding of its philosophical roots, set out to find respectability in the methodological world of the then modern, Newtonian physical sciences.

Psychology as a discipline, a profession, and a research area is still largely dominated by this empiricist philosophy. It is highly probable that the seemingly unbridgeable gulf between science and practice is maintained by the inflexibility of this empiricist philosophy. In actual daily practice, few psychotherapists who practice continuously find it adequate to explore therapeutic processes simply in terms of behavioral outcomes. Not only is this at odds with the actual experience of psychotherapy, but it also contradicts our day-to-day life experience. From morning to night, we examine communication with one another in terms not only of overt language but also we search for meaning, intention, and motivation. Our overt and covert behavioral response is heavily influenced by these internal (and not empirically verifiable) modes of behavior.

In the postmodern era, these alternate viewpoints are common not only in philosophy but also in the physical sciences. It is meaningful that, for example, the area of theoretical physics (surely a temple of empiricist philosophy) is an area where the traditional Newtonian empirical test of reality is most in question (Von Bertalanffy, 1975). Psychology lags behind not only science in general, but behind many of the social sciences in reviewing and extending its own, often misunderstood, philosophy of science. Psychology has been impoverished by its neglect of process dimensions in behavior, by its lack of attention to fine grain behavior and to the subvocal and nonverbal dimensions of communication. There are a number of ways in which process dimensions assist both in the understanding and changing of human behavior. Some of these ideas and strategies are based on the conceptual and research work of others but many are drawn from direct clinical experience in working with older adults.
TOWARD A NEW PARADIGM OF PSYCHOTHERAPY PRACTICE AND RESEARCH

This section briefly lists and describes a series of key differences that exist when psychotherapy is viewed from a process point of view:

1. **Phenomenological versus essential.** Process psychotherapy pays attention to the actual experienced world of the older client. The therapist sees the world through the client’s eyes. This is perhaps the best basis for the concept we have denoted as *empathy* that leads to a client “feeling understood.” There are several theorists who have emphasized this aspect of psychotherapy. These include Carl Rogers and his work on empathetic understanding, the phenomenological emphasis of an existentialist philosophy (such as Rollo May) and, more recently, an emphasis on social constructivist viewpoints within psychotherapy.

2. **Inductive versus deductive.** Process-oriented psychotherapy starts with observation rather than theory. This is not an atheoretical position but rather asserts that “theorizing” versus “theory” (note the process difference) is based on immediate observation of behavior versus hypothetico-deductive assumptions that drive the psychotherapy process. Most practicing psychotherapists, whatever their self-stated theoretical position, eventually become inductive in their practice; to do otherwise, seriously restricts the amount of observational data the therapist is able to gather.

3. **Ideographic versus nomothetic.** Most psychological research can be described as nomothetic, that is, the individual is described only as part of a class or group. This is part of the reason why much psychological research is of limited value to clinicians. From a process point of view, a clinical phenomenon (e.g., psychological effect of position and family) exists even if it does not assume a normative role of central tendency within a large group. Many important psychological dynamics have been neglected in research and ignored in development because they exist only in small numbers within the overall population.

4. **Reciprocal versus static dynamics.** Much of the psychological understanding of human behavior portrays a linear and static picture of human interaction; even the statistical concept of interaction falls within this linear description. In fact, human interaction is a “moving” phenomenon with many reciprocal dynamics. In what we often refer to as “just conversation,” communication specialists (perhaps more expertly than psychologists) indicate the enormous complexity that is present in even the simplest human verbal exchange. This defines not just the simple back-and-forward interaction, but a constantly changing picture in which every communication is influenced by the reciprocal nature of the previous communication. A metaphor for this reciprocal dynamic may be expressed using the term of circular, but the concept of spiral is more apt in that it includes the forward movement of the circular reciprocal activity. The enormous complexity in human communication makes it evident that
it is insufficient to simply ignore the process dimension of ongoing psychotherapy in favor of outcome indicators. This is not to denigrate the importance of outcome variables, but simply to indicate that to miss process variables is to miss the most significant portion of the variance in understanding in psychotherapeutic change.

5. **Intentions versus behavior.** As has been indicated earlier, we naturalistically scrutinize each other and our clients for the intentions that drive the verbal and nonverbal behavior. Verbal communication is at many levels. How often after an organizational meeting do we gather for a covert discussion of the “real” meaning of a statement by an administrator or colleague?

6. **Verbal versus nonverbal and subvocal.** Intentions, motivations, and meanings are mediated both through direct verbal and nonverbal meanings. We also need to pay attention to the subvocal domain: that is, the meaning of the words within the words rather than simply the nonverbal domain. To use the same example, it is the varieties of meaning within the verbal narrative, which we analyze after a formal meeting.

7. **Micro versus macro level behavior.** Psychology, guided by a narrow empiricist philosophy has tended to emphasize macro level behavior and has neglected the “fine-grain” behavior to which we so often attend in daily life and especially (if implicitly) in the practice of psychotherapy. Again, communication theorists have made greater gains in understanding this fine-grain nonverbal, subvocal level of behavior. In our traditional behavioral analyses and behavior modification, it would be useful to ensure that the behavior of focus is in fine detail. For example, in encouraging and rehearsing social or dating behavior, frequently therapists will start at too large “denominations” of behavior: asking a person out for a date or an evening dinner may be too large an increment to change easily. Attention to micro, fine-grain levels of behavior would make the initial behavior goals much more reachable. This might include, for example, maintaining a glance, paying attention to movement and attitude as a basis for subtle behavior cues (e.g., smiling, maintaining eye contact, opening brief conversation).

A final point can be made about the influence of these process characteristics on research methods. It is common to suggest that research methods might be usefully more qualitative. However, this characteristic in many ways is the least essential of the non-empirical paradigm. Whether the behavior is counted or not counted is of minimal importance. A more critical issue is the nature of the evidence that is required to demonstrate change. So, for example, it may well be that research might be more descriptive of the process of psychotherapy as it occurs (quantitatively or qualitatively). Research might also in similar ways therefore pay attention to process as well as outcome (describe and measure what occurs within the psychotherapy session as well as what occurs at the end/outcome of the psychotherapy session). Research should pay attention to detailed narrative analysis where the moment-to-moment processes are related to each other and an inductive formulation can portray a
theoretical understanding of what occurred in the therapy session. There are many available content analytical techniques, some of which are in computer scoring modalities. Finally, clinical research aided by the above techniques would do well to pay attention to ideographic phenomena and de-emphasize nomothetic trends (if I am the only person with a broken leg I can affirm most strenuously that I do have a broken leg even though others do not!). This cataloguing of ideographic experiencing is an important need within research or diagnostic areas. As contrasted with typical content-oriented empirical research, the clinical experience of psychotherapists is portrayed often derisively as “only antidotal.” This process of collecting the informed observations of experienced therapists, perhaps more formalized, becomes a valuable alternate research method. It is noteworthy that in Great Britain a formal system of gathering clinical opinions of physicians on particular health problems has been formalized into a national database of process data by the British Medical Association. This approach can also include the valuable analytical data that is produced in the clinical supervision process where teams of clinicians view video recordings of a psychotherapy session and give their consensual observations of the meaning of the process. Such observations, from a process and phenomenological point of view, can easily be further formalized as a significant form of psychological research.

**Process Themes in Geriatric Psychotherapy**

A selection of process dimensions that are clinically significant in psychotherapy with older adults. These are presented to complement content or outcome variables, in a more complete understanding of the psychotherapy process as described earlier. I am indebted to the work of the late Bill L. Kell and colleagues (Kell & Burrow, 1970; Kell & Meuller, 1966; Meuller & Kell, 1972) in a series of monumental if relatively unknown, works that provide a rich portrait of process dynamics.

**Ambiguity and Uncertainty**

In a world that prizes decisiveness, feelings of uncertainty and based on the ambiguity of human situations become difficult for both therapist and older clients. In many occasions, this ambiguity and resulting uncertainty is understood as a problem that needs to be solved rather than a source of information in the processes at hand. Very frequently, it is not that a client, or indeed the therapist, is indecisive but rather that they are undecided. In other words, the situation is complex and the ambiguity and associated uncertainty capture that complexity precisely. Understanding this is critical for the work of the therapists. Therapists who are intolerant of uncertainty and ambiguity will put pressure on older clients to resolve decisions such as moving to assisted
harming rather than allowing the time to explore the situations and emotions involved. In many ways, psychotherapy is about decision making. We are often in the position of deciding: What to do about a significant relationship? What vocational direction best fits our talents and desires? Whether to retire or continue work? Whether to continue to see ourselves as a patient or as a healthy person? When these and similar decisions are life-involving, that is, involve a major change in our life trajectory, then it is understandable that they can be inherently ambiguous. It follows, therefore, that uncertainty or *undecidedness* is an appropriate expression of the complexity of this decision. Most major decisions involve pros and cons and balancing pro and con aspects of a decision is the dilemma of life decision making. Most of us have experienced the stress of deciding on an important life decision when there are significant advantages and disadvantages on both poles of the decision. For example, when a person is deciding to enter or leave a significant relationship, such ambiguity exists. Therapists not infrequently place considerable pressure on abused spouses, for example, to leave the abusive partner without sufficient recognition for the intense internal ambivalence that is necessarily experienced in such cases. Failure to attend to this process dimension will usually lead to the client leaving the therapist who is applying so much pressure. In fact, the optimal therapeutic posture in such ambiguous decision-making situations is to permit the client to move “backwards and forwards” across the advantages and disadvantages of each pole of the decision without pressure to decide, or without the therapist being committed to or requiring a particular outcome. Under these conditions, which seem to slow down the process of therapy, the client is able to move forward more expeditiously in a manner that validates the complexity of their decision and allows them to be unencumbered by shame at being “indecisive” while focusing their complete energy on the decision itself.

**UNDERSTANDING AND HANDLING IMPASSES**

Case files frequently contain instances of terminations that were the potential beginning points of psychotherapy rather than legitimate end points. In some cases, client and therapist have “politely” agreed to terminate their relationship without either party feeling truly satisfied with the process or outcome of their work together. In other cases, the therapy termination is characterized by confusion, puzzlement, or some other form of interpersonal conflict, which is often ascribed to client dynamics or personality problems. The dynamic concept of impasse is the notion that when therapy breaks down, far from being a moment of unmitigated failure in the psychotherapeutic process, these moments are often the precise point that leads to the central therapeutic issues for this client. The moment of conflict, which seems intractable, is precisely pointing to the manner in which the client, or indeed the therapist, deals with this type of interpersonal process or challenge. The psychotherapeutic process, if successful, is a poignant example of a truly intimate relationship and it therefore is not
unusual that, if successful, it will lead to a strain on the therapist-client relationship. Intimacy, while being enormously fruitful and satisfying, is inherently anxiety provoking. It is therefore not surprising that at moments of approaching intimacy, due to the skill rather than the failure of the therapist, the client will generate a conflict to forestall further intimacy. So, for example, the older adult in the nursing home will abruptly terminate the psychotherapeutic session, expressing angrily his wish that the therapist leave immediately, or that the therapist is “bothering” him. At moments like this, therapists often feel disempowered (an accurate perception) and therefore experiences a failure in his or her therapeutic skills. The experienced therapist will recognize these moments as being therapeutically of great significance and, while not pushing intrusively forward at that moment, will reflect on this seeming failure as an indication of therapeutic progress and as perhaps the most poignant and meaningful diagnostic clue in the therapy to that point. Initial symptomatic diagnoses of the observable problem will now be completed with a more dynamically meaningful diagnostic profile of the processes that make sense of the symptomatic picture. Another example of impasse in psychotherapy with older adults is when the therapist avoids the topic of the client’s approaching death. In this situation, there may be a genteel and unspoken collusion in the avoidance of this topic as the client “protects” the therapist from anxiety. This may lead to an impasse in the therapeutic process that points to the therapist’s dynamics rather than the client. Once again, this is a critical moment in therapy and effective supervision might restore the therapist to therapeutic potency, allow him to regain his composure and provide further assistance to the older client.

ELICITING BEHAVIOR

An important source of dynamic diagnostic information about the client is revealed in the behavior that is elicited in the psychotherapy process. Basically, the concept of eliciting behavior is that most human beings, short on self-esteem, rarely assume that they will get what they need by directly asking for it. That leads us to develop intricate and complicated strategies for getting our needs met without risking potential rejection involved in asking directly. Perhaps the supreme need is to feel loved, and most human beings find it difficult to ask directly for love and affection. This leads us to develop indirect strategies that provide affirmation of affection and regard. Most adults entering psychotherapy have come to confront the growing disadvantages of the life style of eliciting behavior that they have developed in earlier life. Those individuals, for example, who have been psychologically, physically, or sexually abused, will have developed some degree of hypervigilance in the area of trust. Actually, they have developed coping or survival skills to meet their needs in a world in which trust is doubtful, if not impossible. Later in life, however, this eliciting strategy which perhaps served them well in earlier more vulnerable times now becomes a major impediment in the formation of an intimate, mature relationship in which trust
is a critical ingredient. The process of therapy then becomes, in part, an understanding of the intricate and unique eliciting behaviors of the client and the development and rehearsal and risk-taking of new, more direct and effective interpersonal behaviors. The major vehicle the therapist has in understanding these eliciting behaviors of the client is as they are played out in the therapeutic process. Namely, it is the client’s distrust that the therapist experiences in relationship with the client, and the various strategies, sometimes destructive, that the older client uses to maintain the relationship, that will allow the therapist to come directly, and phenomenologically, to understand the client’s world. Indeed, these eliciting behaviors might precisely be the source of the impasse discussed earlier. Therefore, it is critical for the therapist to use process awareness to uncover and ameliorate these eliciting behaviors.

Perhaps the most common understanding of eliciting behavior is under the rubric of manipulation. It is understandable and natural to feel manipulated when we come to realize that someone is indirectly trying to get what they need from us. Manipulation is an emotionally loaded word, often deriving affective intensity from the person who feels used and angry in such a relationship. It is not uncommon for therapists to feel manipulated and to devote much energy to uncovering and challenging the manipulation. However, this is a reactive stance toward manipulation and, understanding manipulation more empathetically, as an eliciting behavior, helps the therapist understand, work with, and find alternate and healthier methods of interpersonal communication.

**Therapeutic “Failures”**

Both the failure to detect impasses and therapist reactivity to eliciting behavior cause breakdowns in the therapeutic process that are frequently experienced by the therapist as a failure. Indeed, if the story ends here, then often the client or the therapist will leave the therapeutic process and both parties will feel dissatisfied. However, as indicated, these moments of nonrecognition and reactivity are symptomatic of the central therapeutic tasks that lay before the client. With appropriate self-awareness, often derived from effective clinical supervision, the therapist cannot only be restored in working with the client, but indeed, can be empowered to more completely understand the client dynamics that are now seen as the central theme of the therapeutic effort. In fact, the issue that can be described as a mistake, with good recovery, can intensify the quality of the therapeutic relationships. Anger and reactivity can quickly turn to empathetic understanding and therapy can move even more rapidly and effectively than if the therapeutic “mistake” had never occurred.

**Transferenceal Dynamics**

Although transference has been frequently viewed as a clinical and problematic phenomenon, it may be viewed, naturalistically, as a universal feature of human cognition and relationships. It is perfectly meaningful that human
beings assume that the road ahead will not differ from the road already traveled. It is understandable, for example, that an older person who has experienced betrayal, and abandonment will assume that future relationships cannot be trusted. Or, when an older adult has learned an emotional style in relationships (e.g., anger is permissible, tender emotions are not, or the converse of this), then they will anticipate this same emotional style and system of constraints in future relationships. Although this phenomenon can assume a clinical and problematic level, in itself it remains a normal and naturalistic process. Even in the world of geriatric psychotherapy, tranferential phenomena have a particularly poignant meaning in the client-therapist relationship in which therapists are often considerably younger than clients. It is not unusual that an understandable transferential instinct will cause a therapist to “parentify” the relationship with older clients thus disempowering their own role and authority as therapists. Conversely, some therapists may “infantilize” the older client, reversing the age difference in a manner that increases their own comfort but again disempowers, in this case, the older person. These transferential movements tend to create a therapist-client relationship that is anemic and innocuous and will soon die of its own lethargy and ineffectiveness. In clinical supervision of geriatric psychotherapy, confronting these tranferential moments becomes critical in the continuance of effective therapy. It can help the younger therapist recognize that, despite chronological age, an older client approaches the therapeutic process in a needy and psychologically childlike manner. Many of the issues of older clients concern, not with dealing with late life, but rather with unfinished emotional issues from earlier life that are still psychologically active. It is critical that the therapist assume the authority to provide understanding and guidance for this older client as he or she deals with unfinished issues that may be chronologically from earlier life, but experientially, are very much in the psychological present.

**DYADIC AND GROUP PROCESSES**

It has been suggested that most problems are interpersonal in nature and, clinically, this seems to be the case. Even a “detached” behavioral problem like depression, when understood in its dynamic meaning as well as its symptoms, is frequently about loss, abandonment, deprivation, or grief, all of which involve interpersonal processes. It is important that therapists become sensitive to interpersonal and group processes that are available to them in the therapy process. Even though the therapist may be at the bedside of an individual older client, it is important to pay attention to dyadic relationships that occur in this person’s world, either with a roommate in the nursing home or indeed, psychologically, with absent family members. The lack of physical proximity of significant friends and family members sometimes obscures the psychological importance of those relationships. While a older patient may have a seemingly indifferent reaction to an ever-present adult daughter, for example, they may be obsessed by an unfinished and guilt-filled relationship with an absent child who pays scant attention.
Being attentive to dyadic and group processes in the world of the client becomes critical in having a comprehensive diagnostic view of the client’s world. One advantage to providing therapy services in nursing homes, for example, is that the therapist is more likely to perceive, understand, and confront the various dynamic interactive processes that occur. The therapist may come to understand, for example, that the difficulties that an older person is having in the nursing home are directly related to the eliciting interpersonal style. They may seek help from staff in an abrasive and confronting manner and bring reactions which at times could even be abusive or at least neglectful. Even if we are not able to physically observe interactive behaviors in the world of the client, it is critical to process these possibilities in our minds as we ask detailed, pertinent and detailed questions about the interpersonal world of the client. This detailed phenomenological questioning allows us to see the world through the eyes of the client and develop an empathic and sophisticated understanding of the dynamic interpersonal processes that have shaped this older client’s feelings and behavior.

Subvocal and Nonverbal Processes in Dementia

Traditional psychotherapy has been so preoccupied with overt, macrolevel behavior and external language that it has often dealt inadequately with the more complex linguistic world of the dementia patient. Human beings, as well as psychotherapist, are so attuned to the apparent importance of language in maintaining relationships that we often assume that when language is ended this also signals the end of internal processing, emotional life, and the possibility of continued relationship. This almost intuitive position is curiously at odds with our actual human experience of intimate relationships. We understand that a precise signal of the intimacy of the relationship is that it is not language-dependent. In other words, we can judge the significance and depth of the relationship when we can be together physically without words. How strange it is that the therapist assumes that psychotherapy is not possible at the moment when conventional language becomes impossible. It is almost the case, metaphorically speaking, that when the person no longer is able to hold conversations using language then everyone, including professional staff, seem to become emotionally detached. A tragic example of this is when a person loses language because of a stroke and even close relatives abandon their emotional relationship with the person because of a loss of language communication. Being attuned to the nonverbal and subvocal processes in communication is critical in maintaining a therapeutic stance with patients suffering from dementia. It is in this way that we can stay psychologically connected with them and enter their emotional world while tolerating the deprivation of our understandable felt need for logical language. With dementia, language disappears but emotions remain vibrant and poignant; it is not by accident that depression is very frequently a comorbid problem with cognitive decline. If we understand depression as an interpersonal phenomena, then we can
clearly understand its presence in cases where emotional intimacy has vanished along with logical language.

**Developmental Processes**

Much of human experience is developmental in nature in the sense that it is gradual, incremental, and follows an orderly and predictable path. Much of what is designated as developmental psychology in our field would indeed be better described as *developmental behavior*. There is little emphasis on internal psychological development within the field of developmental psychology. Work such as that of Erik Erikson begins to deal with these internal, psychological aspects of human development. Even in Erikson there is the tendency to limit development to a lifespan perspective, so that we look at the unfolding of human experience over the *years* and throughout the lifespan. However, from the therapist’s perspective, the developmental principle and process occur within discrete human experiences, such as grieving, the process of separation and divorce, making a life decision, and the development process of training in psychotherapy itself. In each of these domains of human experience, there can be described a developmental trajectory. As the therapist understands and is increasingly in tune with this trajectory, he or she can help the client manage the process in a more empathic and precise manner. The therapist who is sensitive to developmental processes, for example, is attuned to the concept of *readiness* in the client’s life and can avoid the inappropriate anxiety that leads to rushing stages that inherently take time. Having a sense of the developmental process in an experience the client is facing, allows the therapist to “look over the head of the client and down the road.” This posture is highly effective in keeping the therapist in tune with the client and not missing moments of therapeutic potential, not rushing a client to make decisions they are not ready for, and generally, paradoxically, increasing the pace of the psychotherapeutic change. Older adults, for example, frequently go through a painful but orderly process of determining their living environments as they become more physically and psychologically debilitated. These choices are bound up with internal developmental processes and a person needs to progress to a moment of decision. For example, to have been in the position of caretaker, nurturer, and provider all of one’s life, can make the transition to the more “passive” setting of assisted living or nursing home a significant psychological transition for an older adult. Recognizing this internal developmental process helps with therapeutic timing, support, and, ultimately, effectiveness.

**Process as Therapeutic Strategy**

The term technique in psychotherapy is both multifaceted and ambiguous. In a typical text on techniques of psychotherapy the term *technique* means several
different things. In many cases, such as in behavioral techniques, the word technique denotes a *procedure*, an actual physical sequence of steps as, for example, relaxation techniques or systematic desensitization. In another sense, technique can indicate verbal procedures including, for example, verbal reinforcement or, in a different context, reframing techniques, where the significance of an event is reconceptualized in the interests of affirming the client. Yet another sense of therapeutic technique or strategy might be described as *therapeutic posture*. Within psychotherapy, therapeutic posture is frequently a better descriptor for the various therapeutic strategies that we have described. These approaches are somewhat less behaviorally defined and more ambiguous than procedural behavioral techniques. Indeed, therapists may feel less ambiguity and more comfort in using behavioral, procedural techniques. In moments of ambivalence and uncertainty, a therapist might feel drawn to a specific and discrete activity such as diagnostic testing or relaxation techniques. However, such a decision may constitute a “flight” from the central therapeutic issue. The very ambiguity and uncertainty, as stated earlier, may give an entry point to the central therapeutic issue. If we consider therapy to be a naturalistic experience rather than a technical invention of psychology, we might use the natural developmental process as a paradigmatic model for the therapeutic or healing process. After all, as self-psychology would suggest, human beings grow into psychological health through the normal healthy interpersonal connections they have with significant persons in their life. The emerging self is supported and becomes intact through the mirroring and affirming processes of critical parental figures and other significant persons in the person’s life. What seems to be important in life and perhaps also in therapy is the psychological “posture” assumed by critical and significant persons in our life. It is not the behavior, simply, of parents that influences our well being, but rather the perceived *quality* and meaning of that behavior that adds to human psychological health. Therefore, it is not surprising that one important domain of psychological technique and strategy is a sophisticated understanding of the nature and quality of the relationship and the necessary psychological posture of the therapist toward a client. This also makes sense of the sustained body of research that suggests that the critical ingredient in the efficacy of psychotherapy has little to do with theoretical or technical treatment differences and much more to do with what has been described as “common factors” or ingredients, namely, aspects of the therapist or relationship variables. From this point of view, training in psychotherapy becomes less a technical exploit than assuring a sophistication in the understanding and subsequent utilization of dynamic psychological processes. Thus, for example, it is the therapist’s understanding of the older adult’s need for control that allows the therapist to position him- or herself in a way that is maximally therapeutically effective, as opposed to becoming entangled in reactive control struggles with the client. It is, likewise, an understanding of the older adult’s need for “parental” support that encourages the therapist to assume their full authority (as opposed to authoritarian style) available to the client. These aspects of therapeutic posture are implicit rather than explicit in the moment-to-moment management of the therapeutic relationship. Such psychological posture is present
within the various other procedural techniques that may be used to the benefit of the client, for example, in relaxation training, behavior rehearsal, and directives. As was mentioned earlier, it is perhaps the “feeling understood” that is the critical element in the therapeutic goal initiation and discussion that takes place between the therapist and client.

Many important moments of therapeutic posture may take place in what seems to be perfectly common, ordinary, everyday conversations with the client. However, it is feeling dissatisfied with “just talking” that often will lead the anxious therapist to “escape” into procedural business. In fact, as communication specialists have demonstrated perhaps better than psychologists, there is no such thing as “just talking” (Peyrot, 1995). Human conversation is an immensely complex phenomenon with many levels. In any given conversation, there are often many levels of meaning. While the topic of a conversation may be in a specific content area, we are frequently using the process of this conversation to send signals that reaffirm our therapeutic posture toward the client. This covert approach is particularly helpful when clients are at a self-protective stage that would not allow self-awareness or direct discussion of problem areas. With an extremely narcissistic older client, for example, (and narcissistic seems one of the most resilient personality problems to survive in late life!), it is unlikely that we will directly confront the narcissistic behavior. To do so would probably produce resistance to further discussion and block any further progress. In this case, therefore, the conversations and communication about selfish behavior will be indirect and focus on less overt aspects of the narcissistic behavior, such as testing out the interest that the older person might have in altruistic behavior toward close friends.

**CONCLUSION**

Process dimensions of psychotherapy are perhaps the most central and least emphasized aspect of therapeutic process. They receive attention, if implicitly, in all effective psychotherapy and can be utilized instrumentally to greatly increase the power of the therapeutic experience of older persons.

**REFERENCES**


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