

# COUNTERTRANSFERENCE: ONE PERSON'S EXPERIENCE IN WORKING WITH THE ELDERLY

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*This narrative describes the author's countertransference in working with elderly clients, and describes how it transformed her worker-client interactions, clinical skills, and personal life.*

## Introduction

For my second-year field placement at Columbia University School of Social Work, I chose to work with the elderly. I quickly learned that this was an unpopular and unusual decision. A former supervisor who works with emotionally disturbed, often violent, teenagers on an inpatient unit said, "I could never do that." Fellow students questioned my decision with surprised looks on their faces, and when I walked into the aging/clinical practice class at the beginning of the year, there were only six other students (out of a class of over 300). In these ways, even before I began my field placement, I was learning about the aged.

The aged are marginalized in American culture due to our dislike for and devaluing of aging and dependence. Our culture recognizes youthfulness, independence, and productivity. We do not want to think about becoming older or dependent or dying. In fact, we fear death and, while it plays a role in our movies and music, we suppress our fear of dying in real life until we are forced to deal with it. And, even then, we say, "I never thought I would end up like this." Pipher (1999) asserts that "if we aren't around dying people, we don't have to think about dying" (p. 40). We do everything we can to avoid thinking of dying. We fight any signs of aging by getting facelifts and dying the gray out of our hair, and then when we see each other, we say, "You haven't changed a bit."

Perhaps one reason why choosing to work with the aged is uncommon and met with such surprise is because people do not want to think about dying. In particular, it is too difficult and even frightening to deal with the countertransferential emotions that come

up when dealing with older people. The purpose of this narrative is to describe countertransference with older adults and document one person's experience in dealing with this issue relating to elderly clients. I will illustrate with case studies of several clients and describe the countertransference I encountered, how it affected treatment, and the importance of recognizing it.



## Study Site: The Homebound Elderly Program

The Homebound Elderly Program (HEP) is a grant-funded, outreach program that provides psychiatric social work services to homebound elders in the neighborhoods of Washington Heights and Inwood in New York City. HEP serves a socioeconomically and culturally diverse population. The program is composed of a program director (gerontologist), a psychiatrist, two part-time social workers, an internist, and two case aides. HEP serves homebound residents who are 60 or older and have a psychiatric diagnosis. For example, some clients are paranoid and/or delusional, others are depressed and/or anxious, and most are socially isolated. The services HEP offers are psychiatric evaluation and follow up,



psychopharmacology, and social work services, including psychotherapy, family counseling, and concrete services. The clinical intervention is conducted in the clients' homes. However, since HEP continues with clients as their situations change, whether they are hospitalized or in rehabilitation for a short time, I am able to be a consistent resource across the continuum of care.

### **Case Selection**

I selected four clients—Gladys, Ely, Betty, and Elicia—as exemplars of my work at HEP because they are the clients I worked with the longest. I worked with Ely and Betty from my first week at HEP through my last, nine months later. I began working with Gladys and Elicia much later, both for a total of five months. Being cancer patients, however, Gladys' and Elicia's circumstances changed more rapidly. Ely and Elicia are both married Holocaust survivors who immigrated to the U.S. as teenagers. Gladys never married and Betty became a widow a year ago. Both are also Jewish, which is representative of most of my clients at HEP.

While the majority of my clients have experienced mental illness throughout their lives, the first two I present, Gladys and Ely, are dealing with psychiatric difficulties for the first time. Both were active and involved in the community but are now feeling depressed or anxious due to significant medical illnesses.

### **Case Studies: Gladys**

Preston (as cited in Genevay & Katz, 1990) states, "If you are exceedingly fortunate, you will have someone who can look your dyingness straight in the face and share your terror" (p. 31).

Gladys is a homebound 86-year-old woman who never married and lives alone with part-time home care. She suffers from severe vision impairment, secondary to macular degeneration, and depression, related to social isolation and deteriorating health. Her depression, which included

suicidal ideation, began with the onset of her medical problems and worsened when her best friend recently moved to California. As she began a course of anti-depressant medication, I worked with her to assess for suicidality and explore her feelings about death, loneliness, and dependence. We worked together to expand her network of friends, which seemed to improve her depression, and to link her with vision-impairment services, such as low-vision equipment and audio books.

Two months into our work, Gladys was diagnosed with metastatic lung cancer. This is Gladys' third bout of cancer in the past several years. She and her doctor mutually agreed not to administer treatment. We then re-contracted to discuss her feelings surrounding the topic of her illness and death and plan (advance directives) and prepare (process expectations) for her death, addressing her fears and concerns. We discussed hospice care and how tough making the decision not to pursue treatment was for Gladys. Working with Gladys on these issues brought up a number of countertransferential feelings for me, including denial, fright, and inadequacy. Gladys would show her anger towards me when, for instance, I would hesitate to be candid with her, and I learned quickly to maintain awareness of my own feelings while in session with her.

In one of the first sessions, Gladys mentioned having thought of jumping out of her fourth floor apartment window. She often masked her uneasiness with sarcasm and humor. She meant it, but I was in denial and chuckled a bit with her. My own fear of discussing death had quieted me. When I returned to the office, I told my supervisor, who advised me to call Gladys to assess for suicidality. She said she was not thinking about ending her life now but did not know how she would be thinking later on. She contracted with me for the night not to harm herself. Recognizing my fears and how they were



hindering professional intervention, later I was able to discuss her death in more depth.

When Gladys and I spoke about her death again, I felt exasperated, as though I wanted to run out of the room. As she spoke about her deteriorating health, I realized I yearned to disconnect myself from what she was saying and to change the subject. Realizing this helped me to stay focused with what she was saying, to resist bypassing important issues, and to allow her to explore the topic completely. In recognizing and acknowledging my own reluctance, I was able to see hers as well, which prepared me to authentically relate to how she was feeling. I shared that it was difficult to tolerate talking about death and that I felt very sad. Afterwards, she expressed feeling less alone and relieved to have someone with whom she could talk, and she also reported she no longer pondered suicide. My honesty and candor strengthened our relationship and freed her to speak about the difficult issues she was facing.

In our second-to-last session, Gladys asked me suddenly, "Do you think I am ready to die?" I paused as I grasped for a response and eventually resorted to the textbook answer, "Why do you ask?" Technically, this would have been appropriate, but I had failed to relate to Gladys genuinely and she knew it immediately. She scoffed and turned away, hurt and angry that I bounced the question back to her. She might as well have been in the room alone. I experienced so many emotions. Again, I feared facing her imminent death, and I feared getting too close to her as we were terminating our work together. I recovered by letting her know that I did not think that was a question I could answer. I then rushed to reassure her that some of her thoughts and actions showed that she was facing death quite bravely. At the end of the session, I asked to go back to her question and acknowledged that I had angered her. Without explanation, she rebuffed the invitation to talk about it more.

I realized later that I had disconnected

from her in the beginning and then again in the end. First, I failed to acknowledge the sadness and shock I was feeling, which she would have felt validated and comforted to hear. Certainly, she must feel similarly. Then again, I disconnected from her by telling her I upset *her*; I conveyed that she had experienced emotion, not me. In retrospect, I felt saddened that she needed to ask someone about her being prepared to die. It seemed to show how vulnerable and lonely she was with making such tremendous decisions, such as declining treatment and accepting hospice care. I also felt scared to reveal my emotions to her and then terminate at the following session. The finality of her death meant that our termination would be different from those others I had encountered in working with teenagers.

I also realized that her question was a reward: We had developed a trusting relationship and she risked exposing her vulnerabilities. She was likely worried about dying alone, wondering if I would miss her, questioning her decision to reject treatment, and scared about her future and about death. Tolerating the sadness and joining her in these thoughts would have supported her and facilitated a conversation that she needed.

### Ely

Similar to Gladys, Ely was active in his community until his health, and that of his wife, began to deteriorate. Ely is a 79-year-old homebound, married man and Holocaust survivor. Although he had never had any psychiatric difficulties, he began to suffer from depression and anxiety. His depression began when his frail, homebound wife broke her shoulder about one year ago. He began antidepressant medication and improved slightly. He felt depressed that he was not able to care for his wife who cared for him the past 50 years. He describes that she took care of the house and cooked all their meals. He is also concerned that his cognitive abilities are declining and he suffers from significant hearing loss.



Ely and I have been working together for eight months to improve his coping skills and his depression. To reduce his isolation, we also contracted to expand his social network. We also discussed his completing a memory-disorder evaluation at a nearby clinic in order to settle his fears about his declining cognitive capacity.

Countertransference issues in Ely's case included feeling that our efforts were futile. A sense of hopelessness would consume me as I talked with Ely. I felt like nothing could be done to help him. He was homebound by choice and, I felt, needed to get out more often. But, he did not want to leave his wife and felt he could not enjoy activities outside the apartment without her. He complained of inadequate nutrition every day and that the Meals-On-Wheels food was sometimes leftovers from the day before. We discussed ready-made foods he could buy, yet he complained there is nothing to buy at the grocery. Although he could easily afford it, he would not order a nice dinner, insisting the restaurants nearby are terrible.

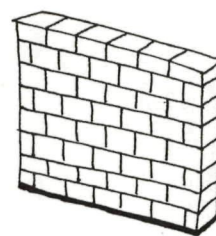
Ely's depressed mood interfered with our efforts to resolve these issues. He met my questions with a flat affect and at times would completely shut down—he would close his eyes, fold his arms, put his chin to his chest, and appear to be going to sleep. I felt angry, frustrated, and, mostly, ineffective. I dreaded home visits with him, feeling as if I were conversing with a brick wall.

Once I became aware of my emotions, I used them to relate to him more authentically. I said, "Ely, I can only imagine how hopeless you feel. I sit here with you; I feel the hopelessness, too. I'm very uncomfortable and can only imagine how difficult it is to feel that way all the time." Ely opened his eyes and looked into mine. The next session he agreed to go out for a walk, and over the next month completed four visits with me to the memory clinic. A scientific man by profession and perhaps reserved by nature of his personality, Ely still did not express his

emotions easily, but our work progressed nonetheless.

Other emotions I was dealing with in working with Ely were feelings of being inadequate and inferior to him. He asked me personal questions, suggesting that he viewed me as a friendly visitor, not as a mental health professional. Work with several of my clients, in fact, provoked these feelings in me. Gladys once said to me after discussing our age difference, "You're a good kid." To my clients, it seemed I would appear to be a kid and I always felt less than professional. It was important, again, for me to recognize these feelings so I could explore their source and not let them unduly affect my work. I realized that, not only was I born at about the time they retired from their careers, but I am essentially speaking a different language than they. Their generation pre-dated Freud and the "talking cure" (Pipher, 1999, p. 98). Likewise, it may be uncomfortable for elders to have someone visit their home, greet them warmly, and then erect boundaries to focus the conversation only on them. I had been providing textbook treatment when connection was needed.


Ely would ask, "Where do you live? Have you had a good experience at Columbia University? What do you plan to do when you graduate?" I viewed this as a resistance to treatment, believing he does not think I can help him and therefore wants to make friendly conversation. Examining my countertransference more closely, however, I realized that my feelings of inadequacy and inferiority were keeping me from recognizing that my elderly, homebound clients need more than "textbook" therapy. They need connection. My feelings and reactions are important communication for them and sharing them facilitated the relationship. While helping clients uncover the meaning of questions they ask is important. I could do better than say, as I had with Gladys, "Why do you ask?" I, thus, began to answer some of Ely's questions and relate my feelings to him. I acknowledged that gradu-





ating was bittersweet because I was completing my degree, yet I had to say goodbye. I expressed that I was curious about the time in his life when he was finishing graduate school and wondered if he wished it were he finishing school. I expressed the warmth and care that I felt and told him that I would miss him. We were then able to begin talking about our relationship in preparation for termination.

### Betty



Betty, a 79-year-old homebound widow, suffers from anxiety and depression due to multiple recent losses: Her husband of 50 years; her sister who was placed in a nursing home; her estranged only child, who financially abused her and then became suicidal; and her 10-year-old cat, which she viewed as the only companion she had left. Betty was my first client at HEP. We worked together for nine months to decrease her anxiety, organize her thoughts and feelings, explore some of her fears, expand her social network, and develop skills to cope with her grief and bereavement. Protective Services for Adults had been contacted for financial management services, home care, and heavy-duty cleaning. We slowly put the pieces of her life back together, first setting up basic services and then reaching out to family members and friends. In family therapy sessions, she and her son had worked through some of their hurt feelings and had redefined their relationship. Betty's son later accepted a referral to receive treatment and was no longer considering taking his own life.

Working with Betty was easy in some ways because I felt so emotionally and instrumentally needed. However, because she was my first elderly client, my work with her made me think about my own mortality. Her situation was so dire that I would rationalize my fears of ending up like her by saying, "I will never be like that!" Katz and Genevay (1987) discuss this phenomenon and assert that "as helping professionals in the field of aging, we are inevitably affected by the

interface between our parents' dying, our own dying, and our work with dying people" (p. 29).

Fear of my own mortality and that of my family members became a theme for work over the year. Several years ago, just after our wedding, my husband and I completed our will and our health proxies. I thought I was one of few people my age who could handle the idea of death, but I was ultimately unprepared for the emotions I would feel as a result of being in the "trenches" as a social worker. I realized I became more rigid with my clients when they spoke about death, as I had with my husband. Throughout the year, my husband and I had confronted death each day, as my father-in-law is very ill. I had difficulty tolerating the intense emotion and fear of the unknown. Dealing with death also meant preparing for my parents' deaths and talking with them about their future years. We talked about advanced directives, how death had been handled in our family, and, as we are geographically distant, a desire to be closer.

Betty's anxiety and sense of panic and urgency also created strong countertransference for me. I began to feel panicked myself and would rush back to the office to begin working on concrete service problems, such as why her food was not delivered on Sunday and when her home care would begin. I began to realize this sense of panic made me impatient with other professionals involved in the case. Instead of recognizing how Betty's anxiety was affecting me, I was reacting to it and, in effect, compromising our efforts to decrease her anxiety. I was then better prepared to recognize my emotions, manage my tendency to take on her emotions, and mirror them back to her. Our relationship improved, as did her ability to see how her anxiety affects others.

### Elicia

Elicia, a 71-year-old married woman, became depressed and anxious after being



diagnosed with advanced metastatic cancer of the spine. She and her husband are Holocaust survivors. Both responded to the news of Elicia's cancer by becoming severely anxious. They called their doctors daily with urgent requests, asked questions but did not listen to the answers, and complained often about the inadequate care they were receiving. They alienated the professionals working with them. I worked with this couple on reducing their anxiety, helping them to navigate the health care system more appropriately, begin talking about their fears of dying, assessing options for treating the cancer, and relating how their Holocaust experiences and subsequent family upheaval may be affecting their decisions today. Elicia began chemotherapy treatment to reduce tumor burden after we had worked together for a couple of months, and she was still receiving treatment when we terminated our work together.

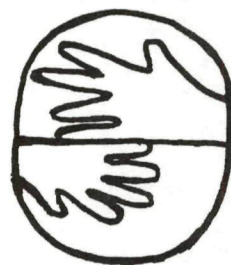
At one point we discussed what death meant to Elicia and she talked about her beliefs as a Jew, that death was final. I was at odds with how to help her; I am a Christian and have always viewed death as a transition to a better place, finding peace. In addition to wrestling with issues of death, due to my countertransference with Betty, I was now grappling with what I believed to be the consequence of death. It was a challenge to help her feel better about her death when she viewed it as a final ending. As with the above examples of countertransference, merely recognizing the issue was a tremendous help. My role became clear: She needed someone to sit with her and be able to tolerate and connect with her about the topic of death and dying. It is important to acknowledge that "we can provide a high quality of care by being with the dying without embarrassment or feelings of inadequacy" (Genevay & Katz, 1990, p. 29).

Elicia began to tell me that she felt she was ready to die and did not feel up to enduring more side effects of chemotherapy.

She discussed how her family members were telling her, "Give yourself a chance." None of them except her husband and son knew that the doctors felt the cancer was too advanced to be cured and that palliative chemotherapy to reduce the pressure on her spine, for example, was the only possible outcome. The couple's anxiety and weariness created miscommunication. Elicia did not explain her disease or prognosis clearly. She would only say, "It's really bad. I'm finished." Her husband and son, who had been told her prognosis, were avoiding it. Her husband would tell me, all in the same sentence, that he did not think she could withstand the treatment side effects but that he wanted all the treatment they could get. I felt helpless as I watched her family steer her towards more pain and suffering in treatment rather than give her the permission she may have been searching for to go peacefully and on her own terms. I knew I was watching her loved ones deny her wishes due to their own fears and need to hold onto her.

My feelings of helplessness caused me to shy away and disconnect when I should have advocated for Elicia with her family. This realization enabled me to redefine my role and begin helping Elicia to talk candidly with her family. I encouraged them to attend to what she was expressing to them and the contradictions in what they were saying and doing. Ultimately, Elicia realized that pursuing additional treatment was a decision she felt too uncertain to decide alone, without her family's support. She agreed to pursue the chemotherapy treatments.

I recall daydreaming in a later session while her husband was telling me about the results of the chemotherapy. I recall feeling bored and wanting to go home. After thinking more about my daydreaming, I realized that my boredom was indicative of hearing his denial and being tired of it. Still, he was telling me that, although she is suffering from numerous complications from chemotherapy, he still wanted to continue with the treatment





even if the doctor disagreed. In retrospect, if I had been more aware of my countertransference as we were talking, I would have pointed out the contradiction and reflected that I wondered if he felt overwhelmed by her suffering and, on some level, wanted to stop the treatment but was scared. I might also have revealed that, while he was talking, I was unable to share his emotion and wondered if that might be because he has conflicting feelings.

### Discussion

Perhaps some of what I have experienced in my work at HEP resonates with those who do not want to work with the elderly. Regardless, the potentially detrimental impact of countertransference indicates that there is a serious need for clinicians to be specifically trained to work with older people. Considering the rapid growth of persons age 75 and over and, particularly, those 85 and over (Butler, Lewis, & Sunderland, 1998), many more well-trained clinicians will be needed. Furthermore, the type of professional training social work offers needs to take into account the special needs of this population. Genevay and Katz (1990) discuss implications for training in the following:

*We have been trained to deny that each of us faces loss, disability, and dying—so that we can focus on the client's needs. But this membrane is permeable! We can connect our feelings and experiences with those of the patients and clients we serve; and we can provide better diagnosis and treatment in the process. Out of our own observations of ourselves and our aging families, we can become more effective professionals and more sensitive to the people we help. (p. 13)*

Equally, it is crucial to realize that when

we are unable to recognize and acknowledge our own feelings, the client "tends to feel the problem is all in her" (Miller & Stiver, 1991, p. 2). For example, Gladys felt alienated when I denied sharing my emotions with her. As cited in Genevay and Katz (1990), Siegel describes how such disconnection can make dying a lonely experience: "Suddenly being thrust into a situation where everyone behaved only positively while around me made me realize to what extent I was no longer part of this world" (p. 31).

There are many misperceptions in our culture about working with the aged and about the dying process. For instance, helping a person as they experience illness and dying can be a very intimate and rewarding experience. "By understanding and integrating our feelings into our work, we have the potential for helping older people and their families to face dying with dignity and integrity—both grieving for their losses and integrating their life experiences into a meaningful ending" (Katz & Genevay, 1987, p. 31). As well, elders teach us about our own mortality and how to face death in our own lives (Katz & Genevay, 1987).

Pipher (1999) discusses the meaning of taking care of the dying in our personal lives: "It is also a joy to help those we love. It is a chance to stay connected, to return love, and to grow ourselves ... We care for the old because it is good for them, and for us" (p. 198). Rolland (1994) asserts that "clinicians exposed to serious illness have an opportunity for increased intimacy and greater appreciation of the present for themselves and their family" (p. 279).

Learning to pay attention to my countertransference, most often disguised as discomfort, continues to bridge the gaps in my ability to process difficult issues with patients. It is clear that my own feelings are as important as those of my patients as I am often responding to or mirroring their underlying emotions. Since writing this paper, I completed my degree and began working



in a hospital on a medical-surgical floor with primarily geriatric patients. One of my first clients, an irritable, elderly man suffering from cancer, said to me, "You have a very tough job working with people like me."

Indeed, soon after taking the job, I began to feel the stress taking its toll. Difficult to manage was the fact that I was witnessing tremendous distress each day involving death, dying, and changes in level of care, such as when a patient learns that she now requires long-term care. The difficulty stemmed from my family's experience, as well as my own, when my father-in-law died shortly after I began the position at the hospital this year. I had felt fearful of the future, sadness and grief, and wondered how our family would move on without him. After his death, things seemed chaotic and unpredictable.

In retrospect, I felt overwhelmed by my patients and would focus on case management to avoid processing their emotions with them. It became clear that I needed to be more prepared for my days at the hospital to prevent feeling so overwhelmed. I redefined my expectations for an average day and recalibrated the concept of normal. Simply re-examining the average day working with acutely ill elders provided a mechanism to cope and an understanding that enabled me to feel my days were less anxiety provoking and more predictable. Recognizing that death is sometimes a daily occurrence in the hospital helped to normalize the experience for me.

Despite the personal grief my father-in-law's passing had brought me, I came to acknowledge that death is a natural and normal occurrence. I learned again the importance of being aware of my own feelings in order to help families through this transition. Their distress triggered my own pain and caused me to want to back away from them and disconnect. Even after such poignant experiences with my clients at the Homebound Elderly Program, when I learned the consequences of disconnecting with my patients mostly to protect myself, I felt myself

wishing for someone to page me so I could leave the room. The endeavor to remain aware of my emotions while working with patients is an ongoing effort. It has to be.

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