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Special Feature Article

A Psychotherapeutic Approach Appropriate for Older Adults: Supporting a Way of Life not Opposed to Living, Aging, Suffering, and Dying

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Abstract

Older adults experience anxiety, irritability, hypochondria, and depression due to increased physical and cognitive dysfunction and physical illness. Effective psychotherapy for them can provide advice on their daily activities and lifestyle, while listening carefully to their everyday experiences in a way that pays attention not only to symptoms but also to the unavoidable "four pains:" living, aging, suffering, and dying. Living engages in the light and shadow of older adults' life stories. It is important to listen carefully to the shadow side of each story, and not just notice the light side. Regarding aging, older adults nowadays are "younger," when it comes to their physical, cognitive, and social abilities, compared to older adults of earlier generations. However, their lives can be disrupted by the obsession with youthfulness. In an expectation to be "youthful and active forever," it may be difficult for the elderly to accept their state of life. In this case, the therapist's guidance should remind older adults that aging is a natural process, and opposition is not needed. When an elderly patient shows signs of hypochondria and complains of numerous symptoms, if there are no abnormalities in their medical examination, then a therapist should inform them that nothing more can be done to find the true cause. As such, older adults should be reminded instead that they should accept their mind and body in the natural state. They should be advised to stay active and keep in shape, even when they experience anxiety. Moreover, the therapist should inquire not

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only about elderly patients' (negative) symptoms or anxieties but also about (positive) instances of health and personality, and direct them to the physical feeling undermined by symptoms. Finally, when it comes to death and dying, it is essential to approach topics such as fear of death and what will happen after death. It is also important to allow older adults to inquire into the therapist's view of life and death, and afterward have an honest discussion with the therapist. When facing a crisis in the second half of life, (i.e., a deadlock such as conflict or depression), self-transformation remains possible if one recognizes one's limitations by sharing one's life experiences, and if one lets go (to some extent) the obsession with the symptoms. An elderly person's daily life reveals their nature. Hence, as a companion of older adults' daily existence, the therapist should support a way of life not opposed to living, aging, suffering, and dying, while allowing them to enjoy fundamental desires that are natural and healthy.

Keywords: aging, older adults, psychotherapy, suffering, Morita therapy

Introduction.

The elderly are more likely to be obsessive because of the decline in physical and cognitive functions associated with aging, illness, and other factors, and have a neurotic mind, that is, anxiety that their physical and mental state is not adapting to their environment (adjustment anxiety[3]). They are also more likely to suffer from anxiety, agitation, psychotic symptoms, and persistent depression. In psychotherapy for the elderly, it is essential to note not only their symptoms but also their lives and ways of living, paying close attention to the inevitable “four pains:” living, aging, suffering, and dying.

Some elderly patients suffer from hearing loss, presbyopia, cataracts, or slow movements. Care should be taken to speak slowly into their ears, walk slowly when entering and leaving the examination room, and open the door for them. The therapist should adjust to the patient's manner. The author often says, "Well, here goes!" with elderly patients at the same time when they have difficulty standing up or sitting in a chair.

Often, therapists are younger than the patients. A young therapist might not understand the difficulties of a much older patient. In such cases, the therapist should take the attitude that they ask for instruction from the patient who has more experience.

When therapists examine elderly

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patients, they not only talk about recovery from symptoms, but also about various aspects of life and daily living. These are the unavoidable "four pains." In this paper, "birth" in “four pains” will be read as "living.” In psychotherapy for the elderly, it is good to be aware of living, aging, suffering, and dying[7].

I. Living

The elderly have their own life stories. Personal accounts of conflicts with parents (especially conflict with mothers, which often affect later life) as well as anecdotes show their struggles, like "My husband coughed up blood and had lung cancer." "My child is 46 years old and single, which is my burden." (Child is not independent); "I worry about what will happen to my child after I die." (child's illness/disability); "I get upset when I see my 98-year-old mother-in-law who never changes." (relationship with mother-in-law); "My sister-in-law spends my inheritance and pension." (relationship with relatives); "My son-in-law, who is the next president of our company, is unreliable." (problems with work and family business); "I feel lonely because I don't know anyone since I moved here." (regional characteristics); "I am troubled because my neighbors keep so many cats." (relationship with neighbors); "The dog I was caring for died of kidney disease." (pets); and many others. Life has both light and shadows. In interviews with the elderly, it is important to focus on both light and shadow sides.

II. Aging

"I get tired easily when I go out." "I don't want to use a cane." "My hands get cold even in summer." "It's hard to hear the voice on the phone when I wear a hearing aid, so I refrain from making phone calls." "I'm worried about how long I will be able to take care of myself." "I have enough time and money now, but I've lost interest. I am worried about how long I will be able to take care of myself." Comments and experiences like these reflect aging as an accumulation of awareness in daily life that one can no longer do the things that one used to do without hesitation.

In 2017, the Japan Gerontological Society and the Japan Geriatrics Society proposed a new definition of the elderly in their "Working Group Report on Definitions of the Elderly."[5] The definition proposed that 65-74 years of age should be defined as "pre-old," 75 years of age or older as "old," and 90 years of age or older as "oldest-old" or "super-old."

Behind this increase in the age of the "elderly" is evidence that the elderly of today are medically and sociologically "younger" than the elderly of the past. For example, trends in the incidence of diseases show that the prevalence of all

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diseases studied (except pneumonia, mood disorders, and bone fractures in females) decreased over time for both males and females. In particular, the treatment rates for cerebrovascular disease (Fig. 1), osteoporosis, and ischemic heart disease declined significantly in all age groups. The long-term care requirement rate also decreased over time in both males and females (Fig. 2). Regarding physical aging, walking speed (Fig. 3), grip strength, and serum albumin concentration were all significantly higher in the elderly compared to 10–20 years ago. In the longitudinal data of psychological aging, the average score of WAIS-R (intellectual functioning) has been on an upward trend over the past 10 years, and the average score in 2010 is closer to the average score of the younger age group (5-10 years younger) (Fig. 4).

However, it is difficult for the elderly to live if they are obsessed with the need to stay young and active. As we enter a super-aging society, there are targets for "lively elderly people" and healthy longevity, and particular attention is paid to lifestyle, exercise, diet, and the creation of a sense of purpose in life. However, behind these calls may be anxiety about dementia and being bedridden, avoidance of aging, and obsession with health and youth. It is imperative to tell the elderly that aging is a natural process and they do not have to defy it. This should not be mistaken for an anti-aging concept, but rather an approach of "aging as maturity." Life would become effortless if we could change from a culture of pushing ourselves for more and more, to one of embracing "aging," knowing our limitations and accepting them with a sense of understanding that "I am no longer what I used to be."

Loneliness is another major issue for the elderly population. “My only daughter doesn't receive my phone calls. I'm lonely.” "One of my friends from junior high school is busy with her great-grandchild, and the other one has dementia." "Eight of my friends from the card game club passed away, and one of them can't come anymore, so now there are only six of us. I did not know how hard it was to get old." "It's really sad that there is no one around me to talk to.” Comments like these show the importance of ensuring that the elderly talk about their emotions and feelings of loneliness at the clinic.

The super-elderly (individuals in their 90s and 100s, also known as the “oldest-old”) do not necessarily feel bad even when something bad happens to them, they often take it peacefully. For the younger generation, loneliness appears to be a bad or unhappy feeling. However, the super-elderly do not feel lonely even when they live alone, and

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feel well connected with others.

Narrative interviews were conducted with the "oldest-old" (aged 95 years or older) living in Tokyo, and thematic analysis revealed the following themes:[2] 1) "Unshakable beliefs and social Ties," meaning the oldest old strongly believe in diligence and compassion and maintain strong relationships with people around them. Despite their small social networks, they are concerned about future society. 2) "Natural acceptance," meaning they accept themselves and their lives, including their impending deaths. Despite their functional decline, they control their lives by making very small decisions. 3) "My day-to-day life has precious moments," meaning they live on a moment-to-moment basis, cherishing simple events.

As a concept that explains the psychology of the "oldest-old," gerotranscendence[8] was proposed by the Swedish social gerontologist Tornstam (1989). The gerotranscendence of the "oldest-old" is not a continuation of the values and behavioral patterns that have been emphasized in their lives up to middle age, such as productivity, efficiency, individuality, independence, wealth, health, and sociability; rather, gerotranscendence is a developmental stage unique to the "oldest-old," in which they change from holding a materialistic and rational worldview to a cosmic, transcendental, and irrational worldview. In the gerotranscendence of the "oldest-old," the boundaries between the present and the past become blurred; they take pleasure in small experiences rather than big events (the dimension of cosmic connection). They become less self-centered and more altruistic; they continue to take care of their physical needs but are not bothered by them (the dimension of self). They are less interested in superficial relationships, need solitary time, do not seek more wealth than they need, and are less likely to separate right from wrong (the dimension of the relationship between society and the individual). The assessment scale for gerotranscendence[4] is shown in the Table 1. Gerotranscendence seems to increase naturally with age and not with experience or effort. Moreover, gerotranscendence is not a psychological trait acquired by overcoming something, but rather occurs during the natural aging process.

The concept of gerotranscendence is very similar to that used in Morita therapy, founded in 1919 in Japan. Morita therapy, based on the Eastern view of human nature, can be used as a basis for psychotherapy to support living, aging, suffering, and dying[6]. Table 1 lists the terms used in Morita therapy that correspond to

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gerotranscendence.

III. Suffering

”I can't help but worry about my symptoms.” “The pain continues and I can't get rid of it.” “My head is dizzy, the back of my eyes is heavy, and my legs are dull.” When statements of suffering like these are heard, if there is no abnormality in the examination and organic disease has been ruled out, the therapist may ask, "Aren't you doing what you can't do, looking for a cause you can't find?” Subsequently, the therapist may give advice such as, "No matter what you do, this is your body and you just have to live with it.” However, the therapist must be careful not to impose. It is also helpful to take the approach of empathy, by using statements like "I am with you.”

Once a patient is out of the painful state (to a certain extent), it is important to guide them to take the necessary actions in daily life to adjust and shape their life, even if there are symptoms such as anxiety. For example, giving advice such as, "No matter how much you suffer or how much it hurts, if you casually continue with your daily life, your suffering and pain will decrease," or "Try to live your daily life pretending to be a healthy person instead of a sick person” can be helpful.

Therapists often ask elderly patients questions like "What do you look forward to doing?” and "What are you doing in your relaxation time?” They ask them about their health, happiness, and personality. It is effective to advise the patient to regain the physical feelings in their life, which tends to be limited by symptoms, by suggestions like "Why don’t you take a bath comfortably" or "Please taste tea carefully.”

As one gets older, even if one does not have dementia, one becomes aware of one’s forgetfulness, or other people may point it out. This can be seen in statements like "I forgot the date of the concert at the facility" or "I lose the focus of my thoughts. I am worried because I cannot grasp the current situation and I cannot get my ideas together.” In such cases, it is useful and important to rely on something such as a memo or the help of others. Therapists may give advice, such as, "Sometimes it is necessary to rely on others," and "It is a pleasure for those around you to be relied on.”

Elderly people have limitations in their behavior, living, and cognitive functions. We should accompany them, encourage them, and give them simple and concrete behavioral prescriptions and advice for their daily life situations. The therapist should not try to make major changes, but small changes and adjustments to their lives. While accepting the shadow side of life, we focus on and draw out flexible life forces

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and desires, helping the patient seek a gentle way of life together. It is also important to teach behavioral prescriptions in an easy-to-understand manner for family members.

IV. Dying

"When I'm alone in my room in the evening, I feel anxious about what will happen if I can't breathe anymore." In the context of anxiety in the elderly, there is more physical discomfort and a real fear of death than in the young, and it is not always easy to pass it off. We can use statements like "Fear of death is a natural feeling that all human beings have," or "We cannot deny that we are afraid of dying" to show empathy and to think and worry together with elderly patients.

Conclusion.

As treatment progresses, the topic of consultation will change from symptoms to daily life, then move to lifestyle and personality issues as the treatment deepens. In life crises that occur after middle age, such as conflict or depression, if the patient can learn about their own limitations by talking about their own experiences, and if the patient can give up the symptoms they have been clinging to (to a certain extent, such as promoting acceptance of the symptoms without changing them), the patient will be able to accept the symptoms and achieve self.[1)]

Treatment naturally comes to an end when symptoms improve, and the patient's daily life and lifestyle are modified. For younger patients, treatment is often terminated with the recovery and stabilization of social functions, such as returning to work or school. However, in the case of the elderly, this may not be the situation. In some instances, such as depression, decreased motivation, anxiety, irritability, hypochondria, and insomnia the patient's symptoms may be terminated. However, illnesses, functional declines (deafness, bone fractures, cancer, frailty, dementia, etc.), and family problems (death of spouse, etc.) may lead elderly patients to continue medical care. In any case, the therapist should be aware that the patient's condition may change over time. Therefore, it would be advisable for the therapist to support a way of life that does not defy living, aging, suffering, and dying, while responding to the patient's needs and sharing the patient's journey through aging, way of life, way of dealing with illness, and the natural desires that underlie it, as a companion of the patient's life.

There are no conflicts of interest to be disclosed in relation to this paper.

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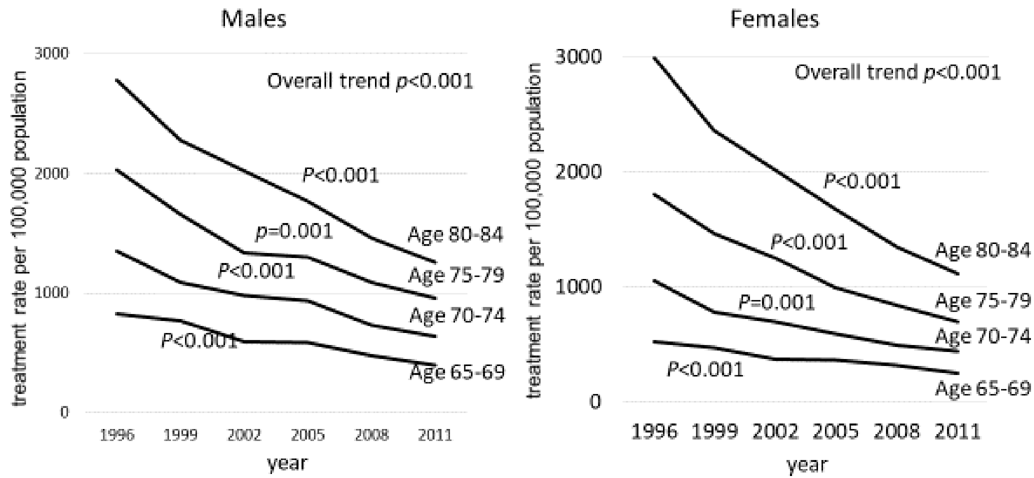

Figure 1 Trends in the treatment rate for cerebrovascular disease
(Taken from Reference 5)

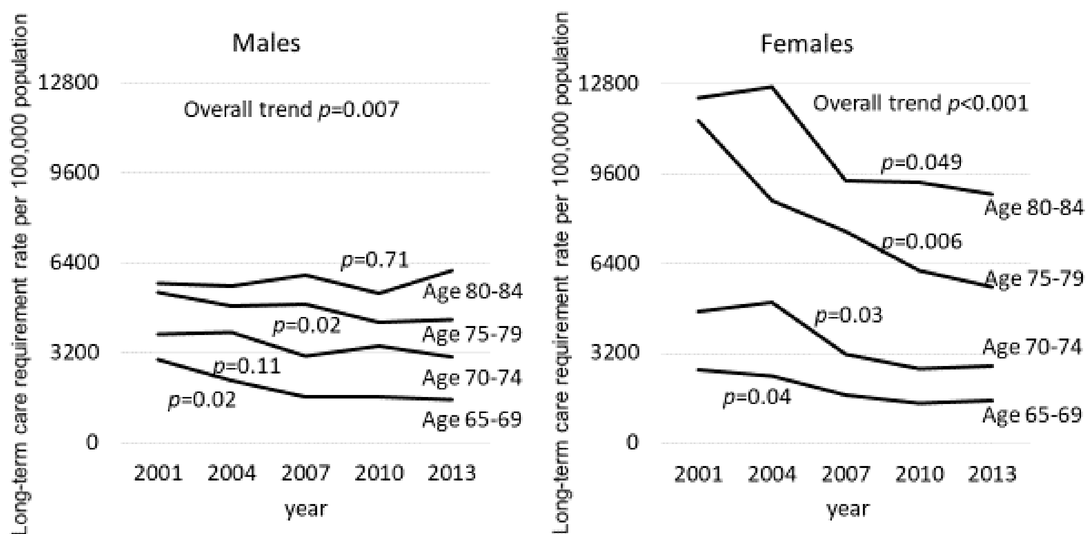

Figure 2 Trends in the long-term care requirement rate
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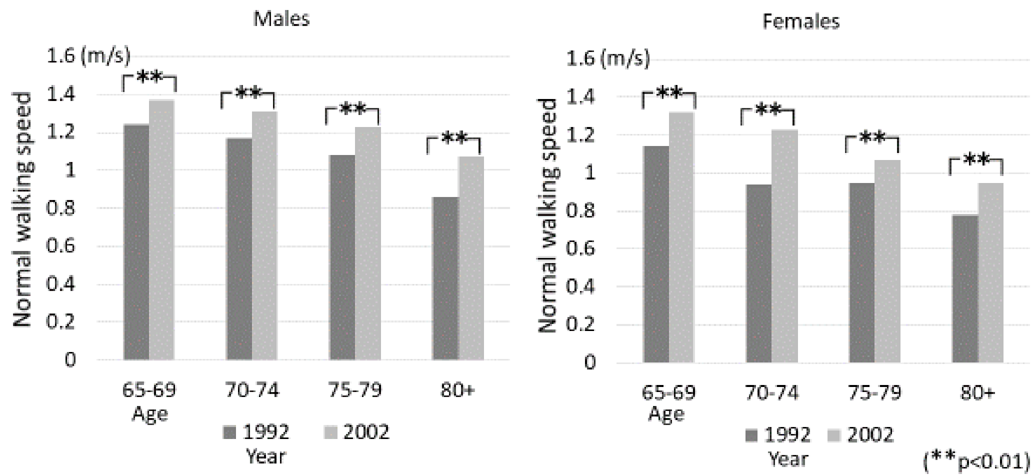

Figure 3 Trends in the normal walking speed (physical aging)
(Taken from Reference 5)

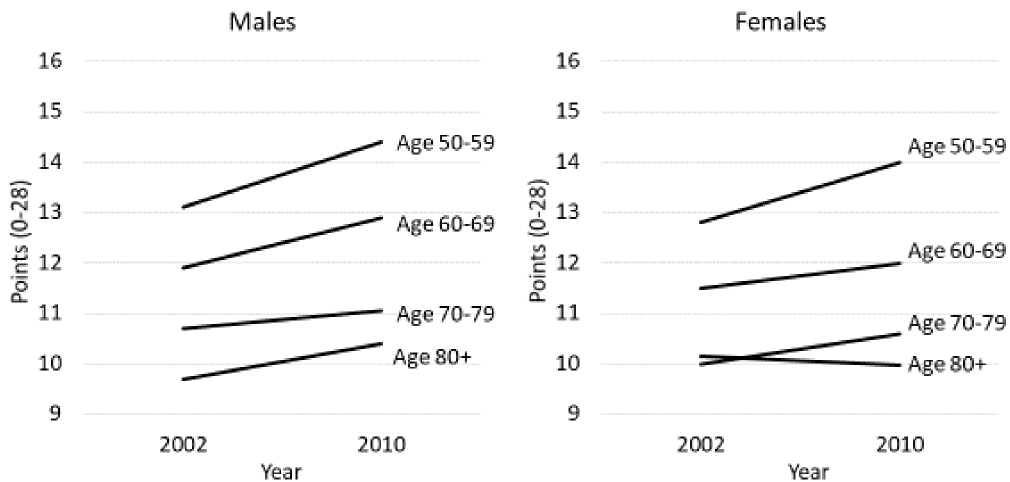

Figure 4 Trends in the WAIS-R digit span (psychological aging)
(Taken from Reference 5)

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Table 1 Japanese Gerotranscendence Scale [4] with Morita Therapy terms added (*italicized*)

Subscale	Content
Awareness of "gratitude" and "thanks"	Awareness that one's existence is supported by others strengthens; gratitude toward others.
Introversion	Recognizing the positive aspects of being alone. Do not feel lonely even when alone. A positive attitude without stimuli from the outside world.
Breaking away from dualism *(Ryomen-kan)*	Recognize the invalidity of or resolution of conflicts between the concepts of good and evil, right and wrong, life and death, and the present and past.
Religious or Spiritual Attitudes	Recognize religious or spiritual content, such as the existence of God and Buddha, the afterlife, and the feeling of being alive.
Break free from the social self (From obsession *(Toraware)* to honesty *(Sunao)*)	Decline in social self-assertion, such as vainglory, self-assertion, and maintenance of self-obsession
Basic and innate affirmation(innate desire; *Sei-no-yokubo*)	Positive evaluation and positive feelings toward oneself. Affirmation of innate desires.
Altruism	Change from self-centeredness to respect for others.
Doing nothing and taking things as they come (as-is, *Arugamama*)	Acceptance of things as they are: "not thinking," "not caring," and "not straining."

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