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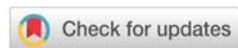
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## Some psychotherapeutic wisdom in the clinical care of the elderly patient

**Abstract**

Psychodynamic psychotherapy provides some key principles and cautionary notes which are relevant to the care of the medically-ill elderly patient. Understanding these may improve the clinician-patient relationship, while their neglect them may impair the clinician-patient relationship.

These include losses caused by physical impairments arising from a current or past physical illness, loss of spouse, of home, of independence and of status; the latter include financial and symbolic losses. Less often recognised, is the possibility that a current loss may trigger memories of previous losses so that the patient may now become distressed, anxious or even clinically depressed. Such losses may hark back many years, and include the death of parents and siblings and other childhood losses and traumas.

Clinicians, who often are much younger than the elderly patient they are treating, may not have the life experience to understand that losses or traumas in the patient's life which occurred many years ago might be psychologically relevant to the patient now. This may contribute to the clinician's unsympathetic or insensitive attitude to the patient.

Most elderly people are aware of the inevitability of their own death. Often, this might not be feared as much as the dying process itself, i.e. concerns about pain, helplessness, 'inability to breathe' and the loss of control over one's body and mind. Thoughtful, attuned discussion by clinicians may help allay these fears.

There may also be 'anticipatory' grief related to future losses. This typically relates to milestones and achievements of children and grandchildren that the patient knows he/ she will not participate. Clinicians may feel helpless because they cannot influence this inevitable reality. However, much useful therapeutic work can be done if the clinician listens attentively and empathically to the patient's expressions of distress and regret.

3. Increased vulnerability and dependency. This is often makes the patient feel anger, hostile and resentful. If the patient expresses such feelings, he is likely to alienate the staff and family, which further increases his sense of vulnerability,

"We often pay lip service to the idealized images of beloved and tranquil grandparents, wise elders, white-haired patriarchs and matriarchs. But the opposite images disparages the elderly, seeing age as decay, decrepitude, a disgusting and undignified dependency" [1].

These contradictory images or caricatures of elderly people may evoke emotional reactions in clinicians in ways that impair their ability to respond to the elderly patient in a way that is both respectful and clinically appropriate.

All clinicians working with the older patient should be aware of some basic considerations about the psychological states of mind of the older patient derived from the psychodynamically-informed psychotherapy of the elderly patient [2].

1. Establishing rapport takes time and requires a careful assessment of the whole person. Memory disturbances, impaired vision, hearing, speech and comprehension, chronic pain, including musculo-skeletal pain and limitations in the patient's ability to sit, stand or lie still for long periods mean that the clinician must consider the patient's ability to participate in a clinical interview and examination. Incontinence of urine or faeces may also interrupt a therapy conversation or patients' anxieties about the possibility of such 'accidents' may distract them from participating in the discussion. These same considerations apply to the patient's ability to comply with the requirement that they be relatively motionless during radiology and other technical investigations.

2. Loss is a common concern for most patients. Typically, an elderly person will have endured many losses in his/her life.



which then aggravates his resentment. If the patient is too afraid to express such feelings in words, he may have recourse to angry or defiant behaviour, in which case the staff's response may be punitive. Either way, the anti-therapeutic cycle is perpetuated.

4. Transference- Counter-transference issues. Clinicians need to be aware that in the patient's mind they (clinicians) are likely to be seen as authority figures. If the patient's life experiences with authority figures are of humiliation, punishment, abandonment and betrayal, the patient is more likely to be suspicious of and uncooperative with clinicians.

On the other hand, the elderly patient may relate to his doctors and nurses as they might to a young child, especially an idealised young child who is endowed with goodness and potential for achieving a hopeful future. Such feelings may contain aspects of the patient's feelings towards their own children, including feelings of disappointment or regret and hopes that were not realised in that relationship. This may cause tensions in the clinician-patient relationship.

For the clinicians, the state of the elderly patient may evoke in them anxieties about their own past, current or future helplessness and dependency, anxieties which they might try to deny by behaving unkindly and dismissively toward the patient. The clinicians' relationship with their own parents and grandparents may also be replayed in the relationship with the patient. These may range from excessive solicitude and unreasonable efforts to investigate and treat all the medical conditions the patient may have, including inappropriate resuscitation measures, to neglect and even cruelty.

## References

1. Butler R (1975) *Why Survive?* New York, Harper and Row. 1
2. Porter R (1992) *Psychotherapy of the elderly* In J Holmes (ed) *Text book of Psychotherapy in Psychiatric Practice*. London, Churchill Livingstone 69-87.

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