Perspective study

Some psychotherapeutic wisdom in the clinical care of the elderly patient

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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,
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