“Psychodynamics and Old age Liaison Psychiatry”

Dr Matt Hagger
Consultant Liaison Psychiatrist
Royal Free hospital
Thursday 25th November 2021

Contents

* The APP and two books…..
* Related blogs…..Psychodynamics in Old age
* Liaison Psychiatry
* Clinical illustrations (dotted throughout)
* Psychodynamics in Liaison settings
* Dementia in the acute hospital
* Referrals to liaison
* Initial assessment
* Concepts: Splitting and Projection

Contents continued

* Counter-transference
* Containment
* Narcissism
* “Acting out”
* Reviews in Liaison
* Conclusions & Suggestions
* Questions & discussion

Some background……

* APP: association for psychoanalytic psychotherapy in the NHS: Older adults section
* **“Talking Over the Years: A Handbook of Dynamic Psychotherapy with Older Adults” (2004) (Evans & Garner)**
* **“Psychodynamic Approaches in the Care of People with Dementia: Undiscovered Country” (Published August 2018)**

Psychodynamics in older adults….

* http://thehearingaidpodcasts.org.uk/5-01-psychodynamic-approaches-to-care-for-older-
* adults/

* https://britishgeriatricssociety.wordpress.com/2018/05/16/from-uncertainty-to-understanding-can-psychodynamic-theories-improve-our-care-of-older-adults/#more-5356

A quote……

* *"The success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety" Menzies Lyth 1960*

* **“A Case-Study in the Functioning of Social Systems as a Defence against Anxiety”**
* ***A Report on a Study of the Nursing Service of a General Hospital***

Liaison Psychiatry

* Origins in USA……
* Expansion in UK in recent years; models e.g. RAID/ service lines
* Analysis and Evidence e.g. LSE/ RAID research
* Current NHS & social care pressures
* Liaison challenges; A&E and wards
* Liaison practitioners; clinical; education; ambassadorial; challenge stigma (Bolton 2012)
* Expansion in old age liaison teams…..Ageless teams…..
* Bio-Psycho-social- (philosophical)- spiritual; all approaches complement each other; different emphasis at different times……

Clinical illustration……..

* *The liaison psychiatry team is asked and see JACK, a man in his 70s who is agitated on the ward. Staff describe him as disinhibited and one or two fairly quickly use the word "nasty" about him such is the depth of feeling he appears to be inducing in others.....*

Psychodynamics in Liaison

* Primarily about relationships; thoughts and feelings with emphasis on unconcious processed
* Always present; affecting all reactions & behaviour
* Origins of liaison psychiatry re psychodynamics; “Drifting away” (Jackson 1990); often overlooked
* Complexities: multiple interactions around an individual patient; also anxieties within and between teams

Continued……..

* Anxieties about serious illness, frailty, ageing & death
* Impact on Liaison practitioners; awareness and blind spots……
* Psychodynamic perspective help understand the referral, what might be going on for the pt
* *A calm seemingly „benign“ patient with dementia sitting in bed may be experiencing intense emotions themselves and be surrounded by emotional turmoil on the ward.....*

Continued……..

* Bringing in your own perspective
* Relationships within the liaison team and with hospital staff & teams
* The milieu of the general hospital
* How are people (with dementia) viewed & treated?
* Liaison team may have to bear some of others feelings/ process e.g. anger, sadness, frustration…..

Clinical illustration continued

* *More difficulties arise when nursing home placement was discussed with him and his family, as his experience of spending times in childrens homes when younger is re-activated. He feared that staff wherever he was would behave in a sadistic way. Those who had looked after him felt that he seemed wary of them when they attended to him.....*

Dementia in the acute hospital…

* Can be very distressing……
* Industrialized nature of Modern medicine (Illich 1976); pathways & protocols
* The individual person…..
* Striking a balance "Intelligent Kindness" (Ballatt & Campling 2011)
* Staff "Irradiated with distress" (Obholzer 2000)
* "Re-thinking dementia" (Kitwood 1997)
* National dementia strategy: Butterfly scheme

Working in environment with little hope of recovery……..

* No current cure; potency of “Therapeutic nihilism”, can be subtle
* Adjusting one’s own expectations…..”Professional narcissism”
* Foreboding, dis-satisfaction with past, loneliness (Ardern & Garner 1998)
* Staff can identify with & experience similar feelings…..acting out
* Ignore professional opinions, side with pt or family members Main (1957) "The ailment" ordinary human feelings in care givers Sutton (2001) "Double jeopardy" in dementia of losing ones mind and being treated mindlessly

Clinical illustration……

* *Jack is known to have dementia and from initial assessment his overall condition has been worsening over some time. He is particularly agitated when receving personal care and has lashed out at staff, at times causing injury. The ward charge nurse appears to be at her wits end as some staff have gone off sick and it is difficult to replace them.*

Referral to Liaison

What is going on for the patient now and also the referring team?
maybe much to decipher.....
reasons for referral from rational to incomprehensible.....
Liaison team handover.....ask questions....gauge reactions.....
Seniors in team pick up on this.....containment
Thinking and reflection time.....un-cautious manic activity
Is something hateful going on? Pt tapping into archaic dynamics.....
When medication prescribed who is it (actually for)?

Clinical illustration

* *Allen, man in his 80s has been admitted with a chest infection. He presents as a loud and boisterous personality on the ward. His family tell one of the ward doctors that his memory has been getting progressively worse over some years and he is repetitive. There is a sense that his family are fearful of him and this may have prevented them going to the GP. They also seem traumatised in some way that is difficult to put a finger on.*

Initial assessment

* *"Oh sir…….just one more thing" (Lt. Columbo)*
* what are your thoughts/ feelings when reading the notes, talking with team, seeing patient
  for the first time?
  what is and isn't being said?
  Stress (chronic),
  regression.....detachment....Infantilization (Terry 1998)
  Personal and family history: patterns and repetition

Psychodynamic concepts

* Psychodynamic concepts
  Splitting & Projection: primitive defence mechanisms develop in early life to cope with internal and external anxieties
  Projection attributing an unwanted part of oneself onto another
  "Projective identification" implies strong response by projection finding a home in the other
* Processing projections e.g. unconciously whilst continuing to work

Continued…..

* Splitting: unconcious struggle to manage conflicting parts of oneself
* Could be reflected by different feelings/ reactions in different team members
* Individual moments with a patient/ family to interactions between teams
* Fragmentation within dementia and more primitive mechanisms at work
* Confused speech as a form of projection
* Resurgence of conflicts/ anxieties from earlier life/ heightening of defence mechanisms (Waddell 1998)

Clinical illustration

* *A member of the liaison psychiatry team sees Allen and speaks with staff and his family. He seems prickly and domineering with the liaison clinician. More of his personal history emerges; that, he came from a large family and grew up in impoverished circumstances. He worked in a steel yard throughout his life and become a foreman who used to order people around. His family and the treating team staff do begin to feel listened to in a containing sense so that a range of views is gathered. A dementia specialist nurse also becomes involved and there is an attempt to use tools such as "My life story" to help him but also to assist the treating team in seeing him differently.. They have already engaged with some aspects of his personality and as they start to learn more about him a different dialogue emerges. There is more recognition of what dementia means for him and why he has been so determined to exercise control in such an aggressive way.. There is still pressure from some staff and some family members to prescribe tranquillizing medication but equally resistance to this from others*
* *Best interests meeting; acknowledgement of difficult feelings.*

Counter-transference

* Broadly feelings experienced towards the person
* How patient reacts towards you as healthcare professional and earlier life experiences
* Empathy “Tuning in” can be part of this also
* Contradictory feelings……

Clinical illustration

* *Janet, a lady in her late 70s is admitted and treated for various medical problems. She is crying constantly on the ward saying that her husband has just died a few weeks before but it soon emerges that actually it was some years ago. She is very anxious and often repeating herself. Several staff members have themselves left work in tears and feel overwhelmed looking after her. Other patients whilst sympathetic have complained at times that they cannot sleep. When she is moved to a side room she becomes even more distressed, convinced she is going to die. This leaves the ward staff in a quandry.....*

Containment

* Key concept in dementia work and psychodynamic approach
* Hold uncertainty whilst being able to continue to think
* Baby needs parent who recognises anxiety, can tolerate and process it
* Enables one to contain oneself better
* Decisive action versus bearing with
* “Unbearable situations”: wishing to care versus wishing to get rid off (Ardern & Garner 1998)

Clinical illustration

* *From informant history it appears she was not talking about her husbands death in the time prior to admission. More history emerges; her husband died in the same hospital and that at the time of his death her cognitive problems were emerging. Family and friends describe some of the difficulties she has had with grieving. There is a sense that admission has re-activated her feelings. Some of the challenges around talking about death in hospitals are evident in this case. It is compounded by dementia which has been described as a form of dying whilst the person is alive.*

Containment continued……

* Difficult thing to measure……
* "presence": being in touch with difficult feelings
* Often intrinsic process…..easy to be pulled out of focus…..role-reversal situation ie young looking after the older person
* Few forums…… supervision, reflective practice
* Care giver provide receptive frame of mind, modify and re-communicate things back to pt/ family (Waddell 1998)
* Fear of separation and abandonment in dementia: Rustin (1991) powerful self-knowledge as care giver
* Containment key quality of a service (Martindale 1988)

Narcissism

* struggling to relate to others with all the feelings e.g. envy, separation and dependence that this can entail, thinking that one has all the characteristics within oneself to manage
* Our own and the patients; relationship to ageing (Cohen 1982)
* Anxieties and narcissistic rage

Acting out

* Tendency to think or talk impulsively, related to an underlying feeling
* Unconcious urge, aggressive, repetitive
* As a care giver ability to sit with things…… whatever they are……..

On-going review in liaison….

* Find out more both background info and also how they are in hospital
* Psychodynamic can help more 3D view of someone (Ardern 1995)

Conclusions

* Liaison teams important role in Dementia from individual patient up to team interactions and whole system
* Enriching individual understanding
* Containment in a pressurised situation
* Humanising effect, thoughtfulness in work….dialogue about dementia
* Consider the uniqueness of a person and their relationships with others

Suggestions……..

* Reflection…… self/ group/ team
* Balint groups
* Schwartz rounds for hospital service……

Thank you

* mhagger@nhs.net
* Tel: 0207 794 0500 ext 23110

* References for book chapter