Palliative care in chronic psycho-geriatrics;
A case study\textsuperscript{1)}

1. Introduction

Due to ageing of the Western population, there is a growing prevalence of chronic psycho-geriatric disorders like ‘dementia of the Alzheimer type’ and ‘vascular dementia’ (1 - 3). The genuine, though multifarious cognitive function disorders of psycho-geriatric patients co-occur often with mood and behavior disorders as well as with social problems. In case of palliative care, this complex co-pathology determines the wide range of psycho-social needs of individual psycho-geriatric patients and their social environment. In our psycho-geriatric reactivation program we are confronted with the special aspects of palliative care for this type of patients. About 25% of our total reactivation population dies during the course of the program; according to the literature this percentage is 13-32% (10 - 13). We found out that the method and expertise used in the reactivation program were relevant in arranging the palliative care of these patients in their terminal phase of life.

In this paper we will focus on our experience with palliative care of patients who deceased during the course the reactivation program. The psycho-geriatric reactivation is conducted in a Dutch ‘psychiatric-skilled’ nursing home. First we will present a case-study followed by an explanation about our reactivation program and the underlying method Dynamic System Analysis (D.S.A.). We will conclude with a discussion about the practice implications of D.S.A. for palliative care of psycho-geriatric patients with functional-psychiatric co-pathology.

2. Case-study

2.1 Case history

Patiënt Mrs. M. was a 91 year old lady. In the early eighties she had suffered from a depression, since three years she had vivid nightmares related to second worldwar experiences. Three weeks before admission she suffered from a bronchopneumonia. After her protracted recovery Mrs. M. no longer wanted to go to the day-clinic; she stayed in bed almost all of the day. To the home-care team Mrs. M. showed increasing verbal and physical aggression. They had the impression that Mrs. M. didn’t sleep much during the night. Her food and liquid intake was also below the minimum. She was admitted to the psycho-geriatric reactivation program because the circumstances and supportive system at home became insufficient. Mrs. M. agreed to admission.

2.2 Admission

We saw an anxious woman, looking her age, 55kg, length 1,67 m, mild dehydration and clear consciousness. She consented to the admission because: “at home it was miserable, maybe I can become strong again”. From her visits to the day-clinic it
was known that she kept a distance from the other patients most of the time; Mrs. M. received a single room.

2.3 Observation and controlling phase

The first phase of the reactivation program developed reasonably well.

According to protocol multidisciplinary observations were conducted on four dimensions: cognitive, psychological and biological functions and social context.

With regard to cognitive functions the disorders of basic-skills proved to be mild and not extensive and varied somewhat over time (long-term and recent memory disorder, desorientation in place). There were no signs of delirium.

Concerning the psychological functions Mrs. M. suffered from severe functional-psychiatric pathology. She had symptoms of agitated depression, paranoia, and occasional outbursts of aggression. Her personality seemed broken up in multiple ‘selves’. There was only a loose or no connection between them and she was not in control (dissociation). One self was strongly combined with vivid reminiscences of traumatic war events; another self showed a strong competent but dominant woman; yet another showed a caring, responsive motherly self, but there was also an overt aggressive, untouchable, intolerant self. The switch between the ‘selves’ took place without observable cue from outside. In communication with the team members Mrs M.’s overall attitude varied between a cooperative and a passive - submissive copingstyle. In her life history (hetero-anamnestic by her son) we found out that she was born in the Dutch East Indies, nowadays Indonesia. Her father died very early; she had hardly known him. Her spontaneous, caring East-Indian mother died at the age of 84. Until her wedding (when she was 32 years old) she had worked as a schoolteacher. During World War II she has been kept prison in a Japanese concentration camp together with her son. She did get a highly ambiguous position in the camp as the chief of a shed. She was responsible for order. On each disruption Mrs. M. became the same punishment as the perpetrator. She had undergo terrible tortures. She almost never spoke about them directly even now. Her son describes her (up to 3 or 4 years ago) as a dominant, very active, caring and positive woman, but nevertheless avoidant and introverted in emotional respect. This is a typical history for frail elderly patients with a complex post-traumatic stress disorder.

Concerning social context Mrs M. lived alone in a private apartment. Her husband died 6 years ago. Her 2 brothers and 2 sisters were all dead. Her only son payed a lot of attention to her and was the only important volunteer aid available.

With respect to her biological functions she had in 1995 a cerebral vascular accident; she suffered from constipation, heart failure and a status after a recent bronchopneumonia. She was very tired and lacked stamina.

To control her behavior disorders (agitation, dominance and aggression) efforts were focused on establishing a cooperative relationship with her. This was ac-
complished by the nursing staff, music- and psychomotor-therapists, supported by psychopharmaca (a combination of paroxetine, pimozide and periciazine). The nursing staff used a so called ‘All Bad/All Good’ approach, which ideally implies that they make a maximum effort to give personal attention and to minimize regu-

lating constraints, the latter, if inevitable, conducted by a nurse of another team. The main goals in this phase were to diminish the (negative effects of) personality-splitting and overt aggressive outbursts and to regulate the nightmare-based sleeping disorder.

2.4 Rehabilitation phase

In this second phase the psycho-geriatrician and psychologist had each weekly sessions with Mrs. M. to create (counter-) transference and to check and support her introspective abilities. Remarkable was the difference between lucide introspection in the present and the avoidance of the past. The interfering influence of the cognitive function disorders did not become clear. The music- and psychomotor therapists were looking now for cues to elicit the more positive ‘selves’ of Mrs. M. and to find ways to restore her defense mechanisms buffering against the traumatic life experiences. Her nightmares were under control. In short, the progress in regaining psycho-social abilities to autonomous functioning was slow. The extent of the underlying psychopathology as well as her frail somatic condi-
tion contributed to these limited results. Mrs. M. developed repeatedly a bronchopneumonia, with complaints of increasing heart failure. Her physical condi-
tion worsened and the cognitive functions deteriorated too. In the mean time the reactivation-team supported her only son in comprehending and working through his mothers behavior. The aim of discharge was unfeasible by now. Her son as a proxy decision-maker provided informed consent for changing the treatment policy to palliative care.

2.5 Palliative care

Because of her complex psycho-social disorders the actions of the multidisciplinary interventionplan were still indicated, but they served other goals. From now on they focused on the patients comfort. The specific aims were to support Mrs. M. and her son on the difficult pathway to her death, to minimize troublesome behavioral symptoms, emotional perceptions and reminiscences as well as the somatic discomforts, and to enhance positive feelings. A minister was added to the team and Mrs M. turned out to be sensitive to ritual forms of ac-
tivities, especially religious ones. Predictable, controlled every day care routines, tuned by the staff to her preference’s (e.g. washing procedure, kind of food and beverages, the furnishing of her single room, favorite music on tape, religious ceremonies, regular individual contacts bij team members) helped her to bear her
anxious, fearful reminiscences. This also gave her opportunities to be herself and to enjoy herself. Because of her progressive heart failure she was more and more confined to her bedroom. She stopped eating in spite of special meals, based on her desires and a few days later she stopped drinking. She talked about ‘going with the Jews’ and about her funeral. In spite of maximal compliance to her dominant and avoidant personality-traits, the multiple selves, as well as to the deteriorating cognitive functions, she sometimes had impulsive outbursts of aggression directed at members of the nursing team and at her son. However, most of the time she could calmly accept her fate. The son’s perception of his mother and the perception by the treatment team were exchanged and tuned to each other for the sake of providing the best care. It helped him to cope with his new role – in the past his mother had made the decisions- the illness and near-death of his mother. It also helped him to evaluate his own live, (in)directly affected by his mother’s traumatic war-experiences. He realized that he suffered from some ‘second-generation’ problems of traumatic war-experiences. He was advised to consult a psychologist himself.

At the end Mrs. M. was sleeping most of the time in her bed; sometimes she was restless and could not choose between bed or chair. The diazepam medication previously started was supplemented with a low dose of morphine to relieve the pain. She reacted very well on this medication and a few days later she calmly died.

### 3. Reactivation program

The psycho-geriatric reactivation program is designed to manage, functional-psychiatric and related social problems of psycho-geriatric patients with mild to moderate cognitive function disorders. The intervention program is tailored to the needs and abilities of the individual patient and aims at discharge (14). Discharge implies that the patients are returning to their home or go to an elderly-home like for assisted or independent living; this concerns about 52% of the participating patients. The reactivation unit consists of 15 beds (five single rooms, one room with two beds, and two rooms with four beds). There is one living-room with a kitchenette. In addition, there are several therapy-facilities. The reactivation program is based on a multidisciplinary approach and intersects psychiatry and ‘nursing-home’ medicine. The program (duration 3-6 months) comprises integrated cure and care interventions, particularly therapy, nursing and welfare. Therapies - i.e. psychotherapy, music-/psychomotor therapy and somatotherapy- are predominantly directed toward reducing the severity of functional-psychiatric pathology and functional impairments which threaten autonomous functioning. The therapeutic team consists of: a psycho-geriatrician, music-/psychomotor-/creative therapists, a physical and occupational therapist, speech therapist and dietician. Nursing - i.e. rehabilitation, support, different behavioral therapy approaches, reality and orientation training and somatic care - attempts to uphold self-care and
coping strategies using individual and group support. Welfare – carried out by an occupational therapist, a minister, a social worker and volunteers - focuses on social activation and social support, and is directed towards consolidation of the (re-)gained abilities to autonomous functioning.

Furthermore, the reactivation process is characterized by the following three phases. The observation and control phase aims at managing dominant disorders within about four weeks, in particular for disorders detrimental to vital functions (e.g. sleeping pattern). The second rehabilitation phase focuses on (re-)establishing and stabilizing abilities to autonomous function by enhancing or restoring self-knowledge, self-control, self-care, development of new behavior, as well as adaptation. In the third, consolidation phase, the goal is to prepare for and work through the discharge. It is this third phase that changes in palliative care if the patients condition deteriorates to a terminal phase in the course of the program.

All disciplines are trained especially in conducting the method of Dynamic System Analysis. They followed courses (about 10 days) on secondary or college level offered by the foundation Psy-Ger-On.

4. Integral psycho-social, biological method

The reactivation program is based on the method of Dynamic System Analysis. It is developed by Bakker (14, 15) specifically for interventions with psycho-geriatric patients with complex co-pathology. The method is inspired by the cybernetic system principles of Von Bertalanffy (16) and the theory of dissipative structures of Prigogine (17). Earlier, the basic system principles were transformed to general health care and psychiatry in the Netherlands by Querido (18), Lit (19), and Milders and Van Tilburg (20), respectively. The DSA method is elaborated and tested for psycho-geriatric reactivation (21). A computerized version is available as well. The DSA approach forms a counterbalance against the paramount importance of the biological orientation of the majority of (psycho-) geriatric scientific research, literature and practice. Next to biological factors the DSA method emphasizes the subjective experience of the unique individual patiënt, his/her psychological abilities as well as functional-psychiatric pathology and the social context. Specific attention is given to the psycho-dynamics in combination with cognitive function disorders. With regard to decisions about cure and care interventions the psychodynamic hypothesis is as important as the biological one. Recently two extensive cross-sectional studies - the Groningen Longitudinal Aging Study (GLAS) and the Maastricht Aging Study (MAAS) - confirmed the independent influence of psycho-social factors on autonomous as well as cognitive functioning, apart from the mutual interference with the biological factors (22-27). The DSA method applied to the psycho-geriatric reactivation program discriminates between four main-dimensions. The (dys)abilities, pathology and interventions can be ordered according to these four dimensions, taking into account their mutual interference. The dimensions are Cognitive functions (the basic skills, particularly memory, ori-
• Coping style
• Personality
• Perception
• Life events

- Psychological functions (cognitive aspects)
- Cognitive functions (basic-skills)

• Memory
• Orientation
• Language
• Praxis
• Gnosis

5. Practice implications of DSA

A delicate ethical subject for debate in palliative care of psycho-geriatric patients with more or less deteriorating cognitive functions is the transition from ‘aggressive clinical management’ to ‘beneficience based clinical management’. The latter focuses on maximizing comfort of the patient instead of on recovery or extending life (2). A fundamental principle of palliative care is the provision of a patient–centered care, based on the patients perspective particularly every day routines (4). From the perspective of informed consent specific attention has to be payed
to the proxy decision-maker role of family member(s) (1,2). In concrete terms palliative care includes predominantly somatic interventions like oxygen, morphine, hygienic measures complemented with social support (1). For palliative care of psycho-geriatric patients in their terminal phase it is important not only to deal with the somatic aspects but also to understand the subjective feelings and mood of the patients (3,5); the more so if the patient is suffering from severe functional-psychiatric pathology as in the presented case-study. Applying the DSA method tot Mrs. M’s situation, the insight in psychodynamics in combination with an empathic and gentle intuitive attitude made it possible to provide palliative care that fitted in to her varying needs. Her behavior was comprehended in terms of manifestations of a complex post-traumatic stress disorder with a depressive, paranoid and aggressive mood, dissociative symptoms, and both dominant and avoidant personality traits. To prevent desperate and unbearable suffering, to support the patient and/or to mitigate the psychiatric symptoms adequately it is important to recognize and understand these phenomena. To interpret the psycho-social phenomena of Mrs. M. as adaptations which regulated her painful reminiscences, made it possible for the team members to respond flexibly to her changing needs and every day routines all through the course of her illness. Moreover, for the multidisciplinary team the DSA method served as a clear handle to direct their professional interventions. The same holds true for the support of the social system i.c. the son in his role of proxy decision-maker and as second generation victim. It also offered a guideline for the type of psychopharmaca to be prescribed: paroxetine and perciazine for the depressive and aggressive symptoms, pimozide for controlling the vivid reminiscences / nightmares as well as the paranoid symptoms.

To look after the four main-dimensions of the DSA facilitates the professionals to weigh the pro’s and cons of the transition from reactivation to palliative care within the same (DSA) framework (2,4). It prevents the use of a too narrow perspective in addressing the intense psychological as well as somatic problems occurring in palliative care with this type of psycho-geriatric patients (5). To realize a comprehensive informed consent, DSA provides the physician with a clear insight to explain to the patient or proxy decision-maker the prognosis with ‘rigorous clinical management’ in comparison with ‘beneficence-based clinical management’ i.c. palliative care.

The basic assumptions of the reactivation program seem to be of value to provide palliative care for psycho-geriatric patients with functional-psychiatric co-pathology. To establish its value for a palliative care program and to find out which patients benefit most from this kind of intensive palliative care program, scientific research is recommended. The research should focus on the determination of prognostic patiënt characteristics and the efficacy and cost-effectiveness of the actual used types of palliative care interventions (5,28).