EIGHT REASONS WHY
DOCTORS FEAR THE ELDERLY
CHRONIC ILLNESS, AND DEATH

Jonathan Lieff
Boston, Massachusetts

There is a widespread and well-documented prejudice against the elderly, the handicapped, and the dying in modern American culture, as well as in some other contemporary societies. Since nearly all of us inevitably join at least one of these three minorities, this attitude is, at the very least, self-defeating.

Citizens 65 and over now account for at least 11% of the general population, or 25.5 million in the U.S. 1980 census (Reisberg & Ferris, 1982). The very oldest are the fastest growing group, with the above-85 sector increasing at a rate 3 1/2 times greater than the general population (Dagon, 1982). The numbers of elderly over 100 in the United States are noted as between 40,000 and 100,000. In most regions the percentage of psychiatric services to the elderly are extremely low, reflecting the general false assumption that emotional support to the elderly is difficult if not impossible. Nationally, the figures have been quoted as 2% for outpatient services and 4% for inpatient visits (Cohen, 1980; Dagon, 1982). Another study showed that 56% of psychiatrists spend no time at all with elderly patients (Amhoff, 1970). It is also the case that fewer elderly are treated at the major teaching medical centers than at other hospitals because teaching staff find the elderly "less interesting" (Gurel, 1973). These statistics are all the more disturbing when it is realized that the elderly have a much greater incidence of both new and sustained psychiatric illness than any other age group.

For each 100,000 of the population, the elderly have a new incidence of psychopathology of 236.1 compared to 93 for
the middle-aged, and 2.3 for the young (Butler, 1973). Butler, the director of the National Institute on Aging, states that soon 80% of the mental health needs of the elderly will be unmet. The elderly contribute 20% of the nation's suicides; at least 10% of the community-based elderly suffer from severe depression; at least one million elderly have severe organic mental disorders; and the incidence of psychosis is much greater after 65 and greater still after 75 (Finkel, 1981). An APA Task Force Report states that "in sum, 15 to 25% of the older persons demonstrate significant symptoms of mental illness" (Finkel, 1981). An additional problem is the poverty-level income of many elderly which has often forced them into dangerous inner-city areas where they are subject to increased crime and abuse. The Medicare insurance program, which was created to assist senior citizens, in Part A, limits lifetime inpatient coverage to 190 days, and, in Part B, limits guaranteed outpatient coverage to 50% of other insured adults.

There is surprisingly little scientific knowledge about old age, death or psychotherapy with the elderly, and little scientific research describing and comparing natural and pathological old age. For example, until recently, it was not generally known that senility was a specific disease among the elderly, and not a concomitant of normal aging. Efforts have been made by thanatologists and various death-and-dying psycho-theorists to confront our "death denying culture." Nevertheless, Kastenbaum and Costa (1977), in their excellent summary article, show that there is a lack of sound psychological research into the phenomenon of death. Perhaps the most recent research finding of great importance is that children are much more aware of death-related concepts and feelings than previously thought (Rochelin, 1973; Kastenbaum, 1977; Yalom, 1980). One clinician and psychiatric theorist, Kubler-Ross (1969), has proposed a theoretical framework that may aid in understanding the extreme range of emotional problems of individuals exposed without preparation to death-related issues. Further, Ernest Becker in The Denial of Death (1974), Yalom in Existential Psychotherapy (1980), and Lifton in The Broken Connection (1980) have postulated modern psychiatric theory incorporating the impact of death anxiety.

It is difficult to document scientifically the effects of psychotherapies on any age group, but many who have observed psychotherapy with the elderly, including the author, have found that therapeutic efforts can be extremely rewarding and efficacious for elderly clients, including those who are severely physically and emotionally ill (Lieff, 1981;
Lieff & Brown, 1982a). Although some who have worked with the dying have indicated anecdotally that psychotherapy significantly helped adjustment to death, a recent well-performed randomized prospective outcome study provided objective evidence of psychological benefit. Spiegel et al. (1981) have shown that group psychotherapy for patients with metastatic terminal breast carcinoma was associated with 1) clarification of reactions to the illness and the medical milieu; 2) development of an antidote to the isolation inherent in the dying process due to culturally-based reactions; 3) detoxification of the emotional impact of death itself; 4) focusing efforts toward better use of the remainder of life. Using the last period of life for devotional activities as emphasized in Eastern approaches to death can also be enhanced by using individual and group psychotherapy such as described by Yalom (1980) and Kubler-Ross (1969) by Grof with psychedelic therapies (1975), and by various traditional meditative and spiritual-therapeutic approaches.

POSSIBLE EXPLANATIONS OF ATTITUDES TOWARD DEATH

Over the last eight years I have had the opportunity to develop a wide range of services for the elderly, the handicapped, and the dying.* Throughout these experiences I have been able to observe the reactions of doctors, who came in contact with difficult elderly multi-problem patients (Lieff & Brown, 1982b), as well as medical students, medical residents, fellows, and faculty concerning the problems of the elderly (Lieff, 1981). It has become abundantly clear that health providers, and particularly doctors, demonstrate an avoidance toward the dying, elderly, and handicapped patients. The following discussion is an attempt to describe and explain these attitudes.

1. Ageism

The widespread prejudice against the elderly was only recently termed "ageism" by Robert Butler (1969, 1975). Ford & Sbordone (1980), who studied doctors' attitudes toward the elderly, noted that "negative views toward the elderly are found in first-year medical students and are of greater magnitude than their prejudices related to race." Others have found that being educated in medical schools...
serves only to increase this prejudice (Spence, 1968). It is apparently common in academic settings to refer to elderly patients by pejorative names; to treat an elderly client with chronic medical illness complicated by psychiatric illness is considered to be a "bad learning experience" or a "bad teaching case." Those faculty who collude with students in terming elderly psychiatric cases as non-teaching cases may provide ample pseudo-psychological rationale by performing inadequate dementia workups and prematurely labeling many elderly as "organic brain syndromes."

Cyrus-Lutz & Gaitz (1972) found that psychiatrists were defensive and silent about their attitudes toward the elderly, perhaps a sensible response to a climate of irrational prejudices that impact on a large number of patients. Doctors may become angry when chronic illness and elderly psychiatric problems do not respond to treatment. Several studies have suggested that the older the physician, the more negative the attitude (Ford & Sbordone, 1980). These reports described the presentation of vignette case studies to a wide sample of psychiatrists who were asked for their diagnosis, prognosis, and treatment. The stories given were identical with only the age changed. Markedly different prognosis and treatment were noted solely on the basis of age, with no possible scientific justification.

A doctor who is trained conventionally in the setting of an acute medicine hospital can be expected to feel uncomfortable in dealing with the emotional problems of most elderly patients. Nevertheless, there are nurses, social workers, and therapists who have taken the lead in servicing the elderly, as well as physicians who are sincerely interested in working with the elderly, and derive satisfaction in this service. They know that they can learn from others who are groping with the fundamental issues of loss, grief, death, dying, poverty and severe illness.

2. Discussion of Death is Morbid and Destructive

There is a common belief that thinking and talking about death creates a negative mental framework or negative self-image which may somehow interfere with the best possible care of the elderly patient. A physician who avoids discussing an obvious terminal illness, believing that this is better for the patient's own good, can inadvertently become so involved in clinical or laboratory details that he or she may fail to focus on the obvious importance to the patient of impending death. A physician can come to a private or even
unconscious decision about a patient's future, and without
sharing this conclusion, subtly change the relationship with
the patient, leaving him/her isolated and frightened (Kas­

A study of physicians showed that those who service many
terminal patients were most likely to inform patients as to
their prognosis, and to spend some extra time talking with
them about their many concerns (Rea, 1975). This study
noted that "many, if not most, of the physicians were
deeply troubled by the topic," yet most were also sensitive
and compassionate about the issue. Kastenbaum and Costa
(1977) noted further that physicians "with much experience
in working with terminally ill people were more open and
compassionate than were physicians in general," and that
many physicians have "considerable resistance ... in deal­
ing with death-related questions." They state that we can
perhaps paint a picture of the average physician as deeply
troubled by a constant contact with death, and yet, even
though defensive and evasive, feels sincerely compassion­
ate toward the suffering patient. Kastenbaum and Costa
(1977) conclude that "awkwardness and discomfort with the
terminally ill has been demonstrated so consistently and
with such a variety of research approaches that this general
conclusion can scarcely be doubted."

In Death, Society, and Human Experience, Kastenbaum
(1977) describes the medical staff's ideal approach to han­
dling death. A number of characteristics emerge as very
desirable to the typical group of doctors and nurses who
attempt to place the pain and uncertainty inherent in the
death of a patient into a normal medical ward work sched­
ule. Death is smooth and easy if few people observe it; if it is
quiet and uneventful without emotion; if the staff does not
have to sit and talk about the patient's fears; if very good
attention is paid to the care of the body without wasting
time; and if little concern is given to the quirks and person­
ality of the patient. Administrators seem also to want appro­
priate gratitude for excellent care, including acceptance by
both patient and survivors that the "staff did everything
they could," while keeping the total cost of the terminal
care process low.

In contrast to these staff-centered concerns, Kastenbaum
enumerates "patient-oriented standards" which have as
goals the remission of symptoms, pain control, and not
avoiding the patient. He notes that the patient's sense of
basic security and protection, as well as the desires and
intentions of the dying person, be clearly understood by the
staff, perhaps even written as a document by the patient and placed in their medical records. The staff should also be able to discuss with the family and amongst themselves all issues concerning the emotional needs of all concerned. In this setting opportunities would be arranged for the optimal interaction of the dying patient with crucial people in the last days and moments. Although it initially appears to be difficult to include these guidelines in the current American system due to underlying cultural fear and avoidance patterns, the use of the hospice model as developed in other parts of the world may be a satisfactory approach to clear and non-defensive care for the dying.

Psychiatry is supposed to deal with the underlying emotional realities affecting medically ill patients, including an understanding of the impact of death upon our lives. However, as Yalom (1980) notes, "death is overlooked, and overlooked glaringly, in almost all aspects of the mental health field: theory, basic and clinical research, clinical reports, and all forms of clinical practice. The only exception lies in the area in which death cannot be ignored—that of the dying patient." Perhaps the underlying dynamic in this problem is the fear that discussion of one’s unknowable ending may somehow precipitate a deterioration into an unfathomable emptiness and depression, a kind of "fear of fear itself." Yet, unlocking this Pandora’s box of fear and concern can have efficacy in alleviating the misconceptions, isolations, and fears inherent in the death process.

One recent study (Spiegel et al., 1981) involving patients with breast cancer, included group psychotherapy sessions for half the patients specifically dealing with the question of their imminent death. The results convincingly demonstrated that discussing impending death greatly alleviated anxiety and helped the majority to gain increasing satisfaction in their last months. Although there is almost no education about death and dying for students in medical schools, nurses seem to have taken a lead in introducing this new material into their profession.

3. Patients have Complex Multiple Problems

Verwoerdt (1981) has noted that most cases involving the elderly are complex, including medical, neurological, psychological, and social issues. This is certainly true for most patients who are handicapped or have chronic illness. Complex mixtures of multi-level problems require treatment spread across a variety of disciplines. Specially planned
programs involving multi-modality therapy, coordinated teamwork, and recording of case material (Lieff & Brown, 1982b) are appropriate. Three levels of treatment are commonly needed in patients with difficult multi-level problems: transcendence of physical problems, understanding the psychological complex, and the development of meaning and purpose in life. Frankl (1969) has noted these three important levels of therapeutic effort, but most medical doctors do not receive the training that would provide this integration.

**Physical problems.** When treating patients who are severely handicapped by physical illness, the only therapeutic solution is to help the patient change attitudes and adapt to the realistic situation. In the Lenox Hill Program in Boston we have provided rehabilitation and psychotherapy for many patients with spinal and head injuries from accidents, gunshots, and suicide attempts, as well as patients with Huntington's disease, Wilson's disease, multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis, and other degenerative illnesses (Lieff & Brown, 1982b). Many of these patients have had severe emotional difficulties as well, and have been unable to adapt to ordinary rehabilitation programs.

Since the physician attempts to help reinstate patients to a normal mode of life, it is very difficult for him/her to accept and treat patients who will never have use of their body for ordinary functions such as sex, eating, talking, etc. Most therapists and the general public consider these as essential to "adjustment" or "happiness." Patients that continue living for many years in this condition are especially difficult and painful for a physician to treat effectively. What is very intriguing is that many of these patients have "adjusted," achieved "satisfaction in life," and have "meaningful lives with fulfilling relationships." This adaptation, or evolution, involves the creation of a totally new attitude with values that transcend the physical material body. This transcendence of attachment to the functions of the body also seems to be one of the goals of those who practice spiritual disciplines.

Watching a patient driving alone in an electrical wheelchair outside of a facility can be revealing. A common reaction may be pity and sadness when viewing a person for whom many normal functions of life are unavailable. In reality, these people may have transcended extreme physical pain, and, through the destruction and rebuilding of ego, may have achieved a rare freedom. Although some doctors dread dealing with such patients, it can be inspiring to meet them
working with unconscious levels

when they are able to enjoy fulfilling lives while transcending bodily limitations. It is even possible that such individuals have learned some spiritual principles which we usually might expect to be acquired only by "aspirants" who still possess all normal bodily functions.

Psychological level. There are many patients with unconscious complexes that interfere with their social and occupational functioning and which are based upon intrapsychic and social habits from stages of upbringing. Some psychiatrists have specialized in dealing with this particular group, but encounter problems when these unconscious levels underlie social, medical, and spiritual problems at the same time. The psychiatrist must either be familiar and willing to work on these many levels or must coordinate in a close and ongoing way with other specialized workers. Many doctors experience difficulty with the elderly, handicapped, and chronically ill when they lack appropriate training in effective teamwork with social workers, holistic therapists, community workers, and spiritual groups.

Level of meaning and purpose. Frankl (1969) has defined boredom as a major symptom affecting the "meaning and purpose of life" level of illness. It is equivalent in importance and scope with anxiety, the treatment of which became the study of conventional psychoanalysis. It is difficult for some doctors to deal with patients when they themselves are not accustomed to acknowledging this deeper level of dissatisfaction, and so they do not often refer the patient to specialists who could address problems of meaning and purpose. With the elderly, the handicapped and the chronically ill, it is the rule, not the exception, that the proper integration of all therapeutic services is crucial.

4. Doctors have Unresolved Feelings about their own Aging

Being a doctor in this unique era of dramatic cultural change is made more difficult by the assumption that he/she should somehow be an expert in many aspects of human life, rather than just the mechanical and mundane subjects studied in medical school. The number of elderly people in society has increased to such an extent that despite the pleasant misconception of the "good old days" when life was easier and grandma and grandpa supposedly lived in beautiful harmony with full extended families, today it is quite common to have three- and four-generation families with unique sociological problems. Most adults must now deal with the problem of helping elderly parents and grandparents, yet
there are still too few resources or institutions which are, in fact, helpful.

The doctor, like the rest of us, must help develop new patterns of living arrangements, home-care services, nursing home programs, and chronic care for ill and needy elderly. The growing numbers of elderly will require more creative housing, group homes, and the like to cope with elderly dementia, depression and severe medical problems. Patients and their families generally turn to the physician for solutions to these problems, but now, in times of economic uncertainty, it is difficult for us to envisage adequate future housing and care for the elderly. The typical doctor is perhaps no better prepared to take care of his own elderly parents and grandparents, nor to envision a solution for himself/herself fifty years from now. But they are expected magically to provide solutions. As a reaction to this very painful problem, some doctors may turn away and avoid dealing with elderly patients, especially those troubled with emotional reactions.

One other aspect of this may be the issue of dependency in the visualization of one's own aging. The doctor is trained to stay in charge and to try always to help, and it is therefore usually difficult for physicians to accept help or become dependent when elderly. In one study there was an inverse correlation among medical students with the psychological measurer of being "authoritarian" versus "having death anxiety." Students who chose psychiatry were less "authoritarian" and had more "death anxiety" than those in surgery (Livingston, 1965). In any case, it has been noted that doctors have a harder time than most with retirement, and often die working. If it is hard for most elderly persons to find a proper meaningful role in our society, it is certainly possible that it is even harder for an elderly doctor.

5. Lack of Knowledge of the Final Course of Human Life

The Western scientific tradition has given us very little information upon which to evaluate the last stage of human life. The doctor, attempting to base opinions and treatments upon acceptable scientific knowledge, has nowhere to turn for information about the purpose of the ending of life, and of death. Recent researchers such as Moody (1976) and Ring (1980) have attempted to show that there are indications from "near death experiences" that show "soul transit" as described by major religions. The implications of such research in describing a reality of the soul or atman,
and the possible reincarnation of this soul, are very difficult for the medical and scientific community to accept at this time.

Theorists, such as Erikson (1963) and Lidz (1976), attempt to include the termination of life as a psychological developmental stage. But what psychological development leads to death? Lifton (1981) has described modes upon which man attempts to attain immortality: a biological mode, living on through family and relatives; the creative mode, leaving lasting impact upon our world through art, music, literature, or scientific creation; a theological mode, living on a higher plane; and a spiritual experiential mode of intensely realizing the existence of a greater reality. But, it is hard for a doctor to generalize these theories into a useable body of knowledge upon which to base patient treatment. In traditional religions, particularly Eastern religions, stages in life are defined by different levels of concern and behavior. In the last stage, the realization of the spiritual life and transcendence become the focus of all of life's activities. American culture at its current stage of development has no clear system of meaning and value for life in advanced age.

6. Psychotherapy tends not to have a Spiritual Orientation

The issues of the elderly, the handicapped, and the dying almost always deal with the fundamental issues of the meaning of life and our experience with transcendent realities. It has been argued that any psychotherapeutic point of view includes assumptions about reality, no matter how "neutral" or "non-directive" they appear to be (Bergin, 1980). Under scrutiny, Rogers, whose client-centered therapy posits a very "neutral" approach, is noted to have many underlying assumptions that interact with the patient's belief system. Truax (1966) showed Rogers as clearly providing positive and negative reinforcement via subtle verbal cues towards selected responses of his patients. If a patient believes in or experiences the existence of God or a greater reality, then it is significant for the therapist to understand this, rather than reduce this perspective to the avoidance of sexual and aggressive impulses and anxieties. It is very important that the doctor who deals with the elderly and very ill be prepared to deal realistically with the impact of religious belief and experience upon all other levels of treatment. Most doctors are not so prepared.

Bergin (1980) although not dealing specifically with the problems of the elderly and their interactions with psychia-
trists, does stress the role of religious consciousness in psychotherapy. He classifies clinical pragmatism as "straightforward implementation of the values of the dominant social system." This clinical situation functions "within the system," with the clinician forming "an alliance with the person and society to eliminate the disturbing behavior." Bergin describes a "second major value system as humanistic idealism," which espouses social reform. Although both of these systems in practice espouse good values, he goes further to state that 'they are not sufficient to cover the spectrum of values pertinent to human beings and the frameworks within which they function. Noticeably absent are "theistic values," i.e., values determined by an appeal to a greater reality. Bergin shows that "pragmatic and humanistic views manifest a relative indifference to God, the relationship of human beings to God, and the possibility that spiritual factors influence behavior." This means that they "exclude what is one of the largest sub-ideologies ... those who try to guide their behavior in terms of their perception of (God's) will."

Many psychiatrists and humanistic psychologists do not accept or experience such a greater reality and have a problem dealing with religious issues of death. Bergin found that the majority of psychologists do not profess to believe in a God, although 90% of the population does. "The main findings show that the beliefs of mental health professionals are not very harmonious with those of the subcultures with which they deal, especially as they pertain to definitions of moral behavior and the relevance of moral behavior to society integration, familial functioning, prevention of pathology, and the development of the self" (Bergin, 1980). This creates a great disparity in many therapeutic relationships. A similar problem exists for those patients undergoing meditative training who are in treatment with therapists who have no understanding of these experiences. The "agnostic" therapists profess to have a standard of ethics and values based upon their psychological observations of other people (Ellis, 1980), often ignoring the vast history and experiences of spiritual people in every culture and religion. In many ways psychoanalysis has positioned itself as an arbiter of values concerning God and religion without a clear underlying basis for such decisions. In the context of such conventional training, a doctor, not otherwise prepared, may have great difficulty with patients who need to integrate religious or spiritual experiences into their treatment program.
7. **Doctors have been given Roles as Priests**

In traditional societies the priest, rabbi, swami, or imam will preside over birth, marriage, death, and other significant turning points in life. In our present culture the physician is often the one we may turn to when death is near. In reality, he may be least able to help. Although the doctor becomes the arbiter of life and death in many cases, medical education contains little formal spiritual training. Doctors have acquired a kind of priestly status, yet are given little ethical or moral training beyond obeisance to academic and guild organizations.

8. **Helplessness with seemingly Unsolvable Problems**

From the very first days of medical school, doctors are trained to have answers for difficult problems. It is important for a medical student to feel that he possesses some definite answer, some definite help to bring the patient. Only later, when he feels more informed and more secure, can he take a more realistic view of his limitations. When dealing with a difficult elderly and dying patient, the doctor may experience a psychological impotence. Doctors are not taught a clear method for helping patients accept death. Rather, doctors are taught to keep people alive at all costs and strive to work with patients in an optimistic and confident manner, in order to instill confidence in patients. The feeling of helplessness in the face of death is difficult for a doctor to handle, thereby making it easier to turn away from such patients than to accept defeat.

Inherent in our medical system is the fact that dying is not acceptable without a medical cause. All death certificates must include a reason for dying. Doctors, realizing privately that they do not know the reason for most deaths, assign obvious reasons such as "cardiac arrest" or "respiratory arrest," certainly accompaniments of any death. The doctor is not allowed to not have a reason for the death, even if the reason is purely tautological. In a medical system that lacks a spiritual basis for making decisions, it is not acceptable to die without a medical cause. This is just one of many ways in which the doctor is rendered helpless in a system which is structured to help him hide these feelings of helplessness.

**CONCLUSION**

Most health providers are dedicated, honorable, hard-working persons who have chosen their professions because
they want to be of genuine service to humanity. But the role of a physician in a culture groping for values and meaning in life is especially difficult. Deficiencies in medical training, a tendency to treat the patient as an object, especially in large institutions, and a feeling of helplessness in cases of terminal illness, place the doctor in many untenable situations. At a time of increasing needs among the elderly, the handicapped, and the chronically ill, the physician faces additional challenges. Granted these difficulties, it seems appropriate to suggest that psychological and spiritual considerations be given more attention in such professional work. Perhaps by studying more closely the value and meaning of the last stage of life, and the potentials this creates for the dying person, the medical profession can evolve more sensitive approaches to terminal care that will help and inspire new ways of dealing with life and death in the future.

REFERENCES


DAGON, E. Planning and development issues in implementing community-based mental health services for the elderly. Hospital and Community Psychiatry. 1982, 33, 2, 137-41.


FRANKL, V. The will to meaning. New York: Plume Book, 1969.

References


LIEFF, J. Interdepartmental training program for the geropsychiatrist, Presented at the American Psychiatric Association national meeting. May, 1981.


Requests for reprints to Jonathan D. Lieff, M.D., Psychiatry, Boston University School of Medicine, Boston, MA 02118.