Awareness of ageism, motivation, and countertransference in the care of elders with Alzheimer's disease

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Abstract

This article focuses on the importance of a practitioner's awareness of ageism, motivation, and countertransference in working with elders with dementia. These factors have the capacity to significantly affect a professional's performance. Additionally, they may also affect the type and quality of services a memory-impaired client receives. Ageism is discussed at the micro, mezzo, and macro level, and practitioners are urged to develop an increased awareness of the effects of ageism on client/service options and as well as practitioner's beliefs. Monitoring professional motivation and being aware of countertransference are important considerations in practitioner-client relationships. Professionals are encouraged to incorporate personal introspection and consultation or supervision to ensure that clients receive the most appropriate service available. Case examples are provided to illustrate concepts.

Key words: ageism, countertransference, Alzheimer's disease, dementia, practitioner-client relationship, motivation

Professional literature has documented significant research in the areas of practitioners' attitudes toward older people as well as professional gerontological knowledge. In particular, recent research has focused on the attitudes and knowledge of social workers,[1-4] physicians,[5-12] nurses,[13,14] lawyers,[2] allied health professionals,[15,16] and students.[3,13,17-19] This body of literature suggests that on the positive-to-negative attitude continuum, professionals' attitudes toward older people fall in the neutral to negative end of the attitude continuum. Accompanying these neutral-to-negative attitudes among current and future practitioners is a general deficit in gerontological knowledge.[3,5,9]

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While the gerontological knowledge base of many professionals is limited and attitudes toward older people are not positive, their knowledge of dementia and their attitudes toward elders with Alzheimer's disease (AD) are of potentially greater concern.[3,17,20] In one study, respondents indicated that they preferred to work with drug addicts, homeless persons, persons with HIV/AIDS, and alcoholics significantly more than with elders with AD.[3] While all these groups are in need of various services from the professions, it is surprising that a preference to work with elders with dementia would rank lowest among 15 vulnerable and in-need groups.

Knowledge of and attitudes toward elders with dementia vary among many other groups. This is most evident in the various ethno-cultural communities.[21] In particular, there is an expanding body of literature that describes attitudes toward elders and elders with dementia within the African-American,[23-29] Asian-Pacific Islander,[30-37] Hispanic/Latino,[38-47] and American Indian communities.[48-53] Attitudes toward elders with dementia vary considerably among these ethno-cultural groups. However, it appears that while many of these ethno-cultural groups may honor the aged, many perceive dementia as a source of personal and familial stigma. For some of these groups, social stigma is attached to dementia as it is to serious forms of mental illness. Others believe that dementia may be a divine punishment or retribution for personal or familial sin.[21] These notions may be particularly common in many Asian-Pacific Islander and Hispanic/Latino groups. Still other members of these ethno-cultural groups perceive symptoms of dementia as synonymous with aging. Clearly, basic knowledge and recognition of dementia vary dramatically among individuals, various ethno-cultural groups, and the many professional disciplines.

This article discusses the potential impact of ageism, motivation, and countertransference on a professional's

interaction with an elder with dementia. Heightened awareness of these factors may allow practitioners to provide more objective services to clients.

Awareness of ageism

As noted, the knowledge and attitude variation toward elders and elders with dementia is evidenced not only within the various ethno-cultural communities, but also among members of the health, allied health, business, and legal professions. While many health and allied health professionals pursue a specialization, few choose a gerontological specialization. Still fewer choose to work with elders with AD or other forms of dementia. Perceived lack of prestige among peers along with perceived lower financial compensation have been suggested as possible explanations for this lack of interest in a gerontological specialization.[3,12] However, a principle component that underlies this diminished interest to work with elders and elders with dementia seems to be *ageism.*

Ageism is discrimination that is "rooted in stereotyping and generalizing about people on the basis of their age..."(p. 13).[54] Some might reference ageism with gerontophobia.[54] In its varying degrees, it is present across most social sections, including the various professions. It is not uncommon to hear professionals and other people express the inaccurate belief that most, if not all, older people are forgetful and that forgetfulness is an inevitability of aging.[55] Individuals may often add disparagingly innocent comments to their descriptions of older persons; especially those whom they perceive as exceptions to many inaccurate ageist beliefs. "Amazing that she still has all her wits" or "Surprisingly he's still as sharp as a tack" are common examples of these value-laden remarks. Equally common is the ageist perception that older people are useless, have no future, and are unproductive members of society.[56]

As a result of ageist perceptions and beliefs, resources for elders are often limited. Ageist perceptions often find their justification in multiple benevolent campaigns that single out younger age groups as more deserving of attention and service. These campaign activities are sanctioned by government, public organizations, elected officials, and private enterprises, most of which possess limited resources to invest in service provision. While seeking to "put children first" is a noble cause, the underlying assumption of this goodwill may be that the needs of those who are not children are less critical, may have less of a future, and therefore might be less worthy recipients of scarce resources and attention. While there are numerous bake sales, sponsored walks/runs/marathons, and other fund-raisers for children's agencies, there appear all too few events that support needed services for older adults and the memory-impaired.

In addition to resource investment based on age, other unarticulated beliefs are common among various professionals and nonprofessionals, and are shared within the various ethno-cultural groups. Research regarding ageist beliefs and perceptions among European-American groups, African-American groups,[23] Hispanic/Latino groups,[43-45] and Asian-Pacific Islander groups[30] indicates that many within these communities subscribe to the notion that dementia is a natural and inevitable aspect of aging. These beliefs suggest that sooner or later everyone becomes memory-impaired; and because it affects all, it is not of concern until it affects my family members or me. These and other ageist beliefs, along with a lack of accurate information, pervade much of our culture. Sadly, the notions appear equally common among professionals and nonprofessionals.

While most who work with elders and elders with dementia will have an awareness of the social dimensions of ageism, it is more difficult for the practitioner to be aware of the pervasiveness of ageism as it filters through to the personal level and affects the individual. When practitioners are faced with various intervention choices, are interventions chosen solely because of client need, or does the choice of intervention primarily revolve around the age of the client? Do other factors come into play? Are intervention choices for older adults weighed on scales similar to the scales used for younger persons? For some practitioners, it may be difficult to justify expensive or intensive intervention for an 80-year-old person while it may be less difficult to do so for an 18-year-old person. Yet this is precisely the difficult terrain of ageism. It becomes even more of an ageist conundrum when various groups are in competition for scarce resources to meet specific needs. Within most service sectors, the resource pot is very limited due to funding, expenses, and reimbursement sources. Practitioners who work with elders and elders with dementia may be acutely aware of the ageism that exists at the policy level, yet unaware of the personal ageism that underlies their thought processes in decision-making for appropriate care of older persons or the older client with memory impairment.

Case example

> *Mr. B had been diagnosed with AD previous to a recent and life-threatening episode with influenza. Extremely weak, dehydrated, and unable to walk, a physician admitted Mr. B to the local hospital. When his medical condition stabilized sufficiently for discharge, his physician recommended that he be discharged with physical*

therapy and other supportive home health services. While his Medicare HMO authorized the hospital admission and some home health services, it would not authorize physical therapy due to his impaired memory. The hospital discharge planner had advocated for this service, but the HMO's utilization reviewer unrelentingly held to her position that "patients with dementia cannot follow commands and therefore don't qualify for physical therapy."

Challenging ageist beliefs, whether on a micro, mezzo, or macro level, heightens awareness and allows individuals, groups, and social structures to gain a more accurate understanding of the aging process. Challenging ageist beliefs further promotes an awareness of the need for an equitable distribution of resources. It seems rational that, in a more equitable world, resources would be provided because of unmet needs, not because of the merits of youth. Challenging ageist beliefs inherently associated with dementia, on micro, mezzo, and macro levels, provides an opportunity for increased awareness and resource development among individuals, groups, and social structures. This is particularly critical for individuals, groups, and social structures that have little knowledge or exposure to aging populations or believe that intervention with the memory-impaired is pointless activity.[3]

Certain practices, such as housing and employment discrimination based on age, are illegal but often difficult to remedy. Still other less tangible forms of ageist discrimination among individuals and within groups and social structures are more difficult to identify. Some of these forms of ageism insidiously permeate much of contemporary society and affect the lives of many older persons. There appears to be a social complacency toward many of these ageist practices while other forms of discrimination based on race and creed are perceived as intolerable. Because individuals, groups, and social structures are often unaware of the value they place on an older individual's life because of age or ability, culpability for individuals, groups, and social structures seems diminished. Amazingly, even when attention is focused on identifiable ageist beliefs and practices, many may still opt to place greater value on some specific age groups than on others.

Awareness of motivation

By definition, motivation is "a set of physical drives, desires, attitudes, and values that arouse and direct behavior toward the achievement of some goal" (p. 309).[54] While most individuals are affected by conscious and unconscious factors, awareness of motivation offers insight into understanding why individuals do what they do. Some professionals may choose not to work with older persons and persons with dementia because they admit that they are not knowledgeable of this population. Many will find no interest in gerontology. Others may suggest that financial gains and professional respect do not provide sufficient compensation for this type of specialization.[3,12] Some may opt not to work with older persons because they do not wish to be reminded of the aging process; a type of denial that allows them to reduce personal threats to their narcissistic self. Some may choose not to work with older individuals with dementia because a personal family member suffered from Alzheimer's disease or some debilitating illness. These individuals may not wish to revisit painful personal history. Many others can offer no explanation for their disinterest in aging populations.

Awareness of motivation for working or not working with elders and elders with dementia, although important for all practitioners, is essential for the practitioners who choose to work with these populations. Yet some practitioners who provide services to older persons and persons with dementia may be unaware of their own motivation for a career in service of these vulnerable groups.

In addition to practitioner awareness of motivation for a career choice in service of these vulnerable groups, practitioners must develop awareness of their motivation for specific interventions while working with specific individuals. Practitioners who provide services to elders with dementia may make complicated decisions for their clients with far-reaching effects. These decisions may be based on client data they have collected as well as data that is provided to them by the client's family, other professionals, and organizational referral sources. The practitioner's decision-making process is affected by many factors and is not limited to the clinically empirical data. Personal motivation, conscious or unconscious, is an influencing factor in the process. Several factors affecting personal motivation are briefly discussed, including practitioner's personal history, the concept of beneficence, the professional's use of power, family wishes, fears of liability, client's assets, and practitioner's codes of ethics.

While there is little agreement in the literature to support specific conclusions about why some practitioners choose to work with older persons and persons with dementia, there appear some recurrent themes. This body of literature offers insight into the motivations and predictors of people's willingness to work with elders and elders with dementia among specific professional groups. Wilderom *et al.*[12] found that medical respondents who perceived they had sufficient knowledge to

work with an aging population were more willing to do so. They also found that those who had meaningfully interacted with older persons in earlier stages of their life were more motivated to work with older persons in their professional careers. Other research supports these findings. Green *et al.*[8] found that having enjoyed a quality relationship with an older person predicted an interest in working with that group, while Gomez *et al.*[13] found that those who had cared for or lived with an older person were more motivated to pursue a career specializing in gerontological services. Kane[3] found that respondents who had a preference to work with elders with AD were not only willing to work with older people, but preferred to work with older persons instead of younger persons. This study further identified other motivations for working with memory-impaired elders, including having experienced close interpersonal contact with an elder who had AD, perceiving oneself to have sufficient gerontological knowledge and skill, and having positive attitudes toward various aspects of long-term care.

Motivation affects many factors in the provision of services to older people with AD and other forms of dementia. Most people will suggest that the motivation for work with elders and elders with dementia is rooted in beneficence (*i.e.*, the practitioner's desire to do good things for clients or to do what is in the client's best interest).[58-60] No doubt, most practitioners were attracted to a particular helping profession by their interest in the work or function of the profession as well as a perceived opportunity to perform meaningful service for specific groups. Yet the line between beneficence and paternalism is sometimes difficult to define and negotiate.[59] Frequently doing what is in the client's best interest may be a matter of perception, and the appeal to beneficence is generally adopted when there is a tug of wills between practitioner and client. In these situations, practitioners may deem particular services necessary while those same services may be perceived by clients as intrusive, infringing, unnecessary, and paternalistic.[59] Practitioners who have specialized in the care of memory-impaired individuals will recognize that there is a specific body of knowledge and skill that is necessary to maintain an informed balance between a client's preferences and a client's need for safety.

Yet even the practitioner who honestly attempts to balance client preferences with an informed understanding of a client's need for safety is capable of misusing power. By virtue of their position, practitioners exercise the power of influence and authority over clients. While the helping relationship centers around trust, empathy, and expertise, memory-impaired clients are especially vulnerable to the misuse of power when they opt to assert their autonomy or when their preferences result in noncompliance with a practitioner's decision. The literature documents repeated misuse of legal procedures such as guardianship among medical professionals to ensure client compliance rather than as a method to ensure appropriate client care.[58,61-64] In many of these cases, guardianship proceedings were initiated only when clients were resistant to practitioner attempts to intervene. Had clients been compliant, guardianship would not have been initiated.

Case example

Mr. C had been an opinionated individual most of his 80 years. He had lived alone following the death of his wife and had no contact with his children. He was admitted to the hospital for an accidental overdose. He informed the ER physician that he "got mixed up sometimes" and couldn't remember if he had taken his medication. This error resulted in a double dose of his medications. A psychological consultation confirmed some memory deficit. His attending physician believed that Mr. C was no longer capable of living alone and urged him to consider relocating to an assisted living facility. Initially, Mr. C agreed, but at the time of discharge he had reconsidered placement and insisted that he be returned to his residence. At this point, Mr. C's attending physician informed him that if he did not relocate to the assisted living facility, he would be forced to initiate a petition for guardianship to ensure placement.

Client's families are also capable of affecting a practitioner's motivation and intervention decisions. Families may become extremely visible at various times in a memory-impaired client's life, particularly if the client is female and possesses assets.[58,59,61-63] Practitioners, while respectfully listening to family concerns, may be manipulated or coerced to understand "what's really going on" in the life of an older person with memory impairment. These family positions may be convincing and arouse the practitioner's suspicion of the elder's cognitive capacity and ability to care for self. The wishes of family members may be so well articulated and audible that they drown out the preferences of the older client. Practitioners may find it difficult as well as time-consuming to patiently hear and understand the elder client's preferences, especially if the elder's position is not as concisely and forcefully articulated as that of a concerned and well-intentioned family. When the central figures in the client's family unanimously agree about "what needs to happen," it is not unusual for a practitioner either to

adopt or comply with family wishes. In these cases, the practitioner's motivation may be converted from the primacy of client need and preference to the appeasement of a vocal family. In these cases, the family's good will, along with the practitioner's support, provide the justification for a specific intervention strategy that may or may not be in harmony with client preferences or need. In some of these situations, the client's preferences are ignored and the client is rendered powerless as he or she is forced into compliance. No doubt it is sometimes easier for the practitioner to hear the concern of the younger and more articulate family members and to discount the preferences of the elder client, especially if the elder demonstrates even the mildest confusion. In cases where there is discord and a lack of agreement among family members regarding the best intervention, practitioner motivation may be influenced by the fear of litigation.[59,65] In these cases, practitioners may choose the intervention that offers the least exposure to malpractice suits and other types of litigation.

The fear of litigation may sometimes direct practitioner choices and is a significant factor in practitioner self-interest. Practitioners would do well to remember that expert legal consultation can be extremely beneficial to reducing practice liability and managing risk.[66,67] However, practitioners need to remember that the most effective method to reduce exposure to liability is to ensure that the interventions they provide meet the expected standards of care, that they do not commit fraudulent acts, and that they remain focused on the well-being of their clients.[59,66,67] Motivation to provide service that is solely directed at risk management is a strategy that may ultimately increase liability exposure as it is self-motivated rather than client-oriented. Clearly, intervention must be informed by more than risk-management strategies.

At times, practitioners may be motivated to make intervention choices based on a client's ability to pay. There is some research that suggests that some practitioners adopt intervention strategies for older persons based on the older person's ability to pay and/or the types of reimbursement resources to which the older person may have access.[68] In these cases, practitioners may simply be reasonable in seeking affordable services for clients that are covered under health insurance or Medicare, and therefore realizable options for clients. This may be perceived as finding the best services available based on the client's access to resources. At other times it may appear as self-serving behavior from a potentially negligent practitioner. From the perspective of third-party observers, motivation in these cases may be difficult to assess, and confusion between practitioner self-interest or client-oriented service may be possible. While the particular practitioner's motivation may be noble, the practitioner may find it difficult to convince others of its virtue. Practitioners would do well to remember that the best intervention is not necessarily the intervention that the client can afford. Clearly, intervention decisions may need to be informed by resources. However, when practitioners base their decisions on reimbursement issues, their motives may be suspect.

Most practitioners subscribe to a profession-specific code of ethics that can assist them in identifying ethically acceptable and unacceptable behavior.[69] These codes of ethics assist practitioners in navigating hazards such as professional self-interest over client interest.[69,70] Codes of ethics also address professional integrity and a professional's duty to serve the public.[69,70] Practitioner behavior is often evaluated against these ethical standards in cases where there is a question of appropriate professional behavior. If practitioners honestly evaluate and conform their practice methods to the standards of their specific professional codes of ethics, they can then offer clients the best certainty that they are receiving the most appropriate service. Additionally, their specific codes of ethics allow practitioners to evaluate their motivation in practice.

Countertransference

Practitioners evaluate the data they gather by passing it through an internal filtration system. This internal system may be influenced by personal histories, experience, knowledge, attitudes, and beliefs. Additionally, ancillary data they receive from the client's family, other professionals, and organizational representatives is also filtered through the internal filter of the data providers as well as the practitioner's internal filter. When all of this information passes through multiple and uniquely personal filtration systems, there may be some distortion of fact as a result of personal histories, experiences, knowledge, attitudes, and beliefs. Some internal filters will allow the information to be evaluated with little or no distortion. Other internal filters may distort the data as it passes through multiple personal layers. A practitioner with an awareness of their personal history and experience, as well as how these may influence their performance or decision-making process, stands a better chance to provide services objectively based on the client's need. Yet, some clients may bring forth from the practitioner various emotional reactions. These emotional reactions may significantly color the practitioner-client helping relationship and may prompt practitioners to make less objective intervention decisions.

Among mental health practitioners, awareness of the effect that clients elicit from the skilled helper has been a

key component of effective practice and training, especially in traditional psychodynamic models. When a practitioner in a helping-relationship with a client is affected by the client, including the client's behavior or disclosure, the result is identified as countertransference. Barker[54] defines countertransference as "a set of conscious or unconscious emotional reactions to a client..." (p. 109). Hepworth, Rooney, and Larsen[57] identify countertransference as "feelings, wishes, and unconscious defensive patterns of the practitioner that derive from past relationships, interfere with objective perception, and block productive interaction with clients" (p. 565). They further note that these practitioner reactions distort perceptions and contaminate the helping relationship.[57]

Other literature identifies types of countertransference in relation to the origin of practitioner reaction. These practitioner reactions may be understood as either objective or subjective responses.[71] Objective countertransference is conceived as a response that is shared by most practitioners as a result of interacting with a particular client. Subjective countertransference is a response from a practitioner that is predicated upon the practitioner's unique personal past history. An example of subjective response might be a practitioner's dislike of a particular client that other practitioners find likeable. The practitioner may or may not be conscious of the reaction or the reason for the reaction. In some consciously subjective responses, the practitioner may indicate that a certain client reminds them of Aunt Mary or Uncle Ken. Some particular clients may end up receiving special services that are not regularly provided to other clients. Still other clients may receive less than the usual amount of service from a practitioner whose personal history has an Aunt Mary or Uncle Ken with characteristics that remind them of a particular client. Other practitioners may be less conscious of why they feel as they do about particular clients.

Subjective countertransference reactions with older clients may be a result of unresolved personal history, especially feelings toward parents. Practitioners may over-identify with specific clients, client families, or situations. This may result in a practitioner either becoming emotionally detached or emotionally absorbed in a client's situation. When clients experience these feelings toward practitioners, it is known as transference. In some situations, older clients are experiencing transference when they interact with a practitioner as a parent might interact with a child. In these same situations, the practitioner may be relating to the client as a child relates to a parent in a subjective countertransference response.

There are many other objective and subjective responses including dreading or anticipating contact with a particular client, being consistently tardy with a specific client, feeling hostile toward a specific client, being overly concerned about losing a specific client, being overly solicitous with a specific client, having erotic fantasies about a client or client's family member.[57] Practitioner awareness of these feelings as well as the connection to their unique personal past history is essential to provide more objective intervention.

Case example

Mrs. M is 76 years old. She was born in Eastern Europe and married a United States military officer at the end of World War II. Two years after relocating to Florida, Mrs. M began to evidence symptoms of memory loss and disturbances in executive functioning. Mrs. M was evaluated and diagnosed with AD. Mr. M assisted Mrs. M with personal care for many years. With time, Mr. M experienced a decline in his physical health and obtained a home health care company to provide personal care for himself and Mrs. M. Because of his specific physical needs, Mr. M required a nurse to provide skilled nursing services at home. Mr. M was depressed about his physical decline and would often remark to the nurse that in this hopeless and helpless state he was useless to his wife. Although the nurse eventually obtained a psychiatric referral and in home social work/counseling services for Mr. M, she dreaded providing care in this specific case. She would put off this visit till the end of the day, and would perform her tasks as quickly as possible. In this particular case, the nurse was aware that her own father had committed suicide when his wife had become terminally ill.

Semel[71] notes that various subjective responses from practitioners may be a result of a fear of death, sometimes referred to as death anxiety. Countertransference responses may be predicated on the practitioner's sense of personal mortality as viewed in the client, or it may be related to a loss sustained in their personal lives. No doubt, older clients and a heightened awareness of the aging process will prompt many practitioners to consider their personal life span and that of family, friends, colleagues, neighbors, and others. These can be difficult issues for a practitioner to resolve in his or her life. This may be complicated further when practitioners who specialize in the care of elders with dementia are constantly faced with some very harsh human realities and regularly encounter the loss of clients through dementia's progressive loss of self and ultimately death. Some of these

losses may be especially painful to the practitioner and difficult to move past. These painful experiences may be a result of emotional attachment and enmeshment with particular clients.

Professionals who work with memory-impaired elders may experience varying degrees of burnout as well as caregiver burden at certain points in their careers. In some cases, multiple client losses may bring up material that is tied to their personal history of loss. In instances where the losses are deeply experienced and depression occurs, help may be required from a practitioner who is skilled in assisting people who need to work through emotionally charged material. These sources of skilled help may include psychotherapists, psychiatrists, and clergy.

While some may be less receptive to the power of countertransference, it has been suggested that practitioners do a disservice to clients when they have little awareness of a client's impact on them or their subjective responses to clients. Negative subjective responses to clients that are not monitored may in fact alienate clients or cause client resistance, and ultimately convince clients to terminate service.[72] Because practitioners may have unresolved feelings associated with various events and persons in their own lives, these reactions may be reflected and reenacted in their interactions with clients. When clients perceive hostility, arrogance, anger, or demeaning behavior, they may abruptly leave the helping relationship feeling misunderstood and frustrated. In these situations, their perceptions, while accurate, may be misconstrued to be a result of something they have done or not done rather than the result of the practitioner's personal life history. This may be no less true for some cognitively impaired clients who have awareness that their abilities are compromised and experience frustration in their attempts to be heard and understood. While the client may not be articulate, the client is still aware of the experienced feeling.

In many of these situations, practitioners may also be experiencing unidentifiable frustration. While the memory-impaired person may be searching for words, the practitioner may have access to various adjectives for the client. These professional descriptions may portray the client as difficult, demanding, contumacious, resistant, argumentative, or aggressive. Not infrequently, when the practitioner begins to pejoratively label clients, whether in speech or documentation, there is an issue of countertransference that requires attention.[57,71-74] While these clients may possess some characteristics that prompt the practitioner's reaction, the practitioner may have written an entire script about the client based on a unique personal history or past experience with an entirely different individual.

While subjective and objective responses (countertransference) are common within any helping relationship, they can easily interfere with a practitioner's ability to provide the most objective service as well as the client's willingness to continue within the helping relationship. Practitioners must therefore develop strategies that will assist them in dealing with issues of countertransference.

Hepworth, Rooney and Larsen[57] suggest that practitioners can effectively deal with issues of countertransference through a heightened sense of awareness in the practitioner-client relationship. Practitioners must monitor their internal states, including their thoughts, feelings, behaviors, and reactions. This awareness may prompt the desirable activities of introspection and a consultative dialogue with colleagues. For those who work with elders and elders with dementia, awareness through introspection is necessary. They suggest that introspection involves analytical dialogue with oneself in order to have a greater awareness of the sources of one's feelings, thoughts, reactions and behaviors.[57] This introspection may productively generate awareness questions such as: "Why do I feel impatient when I am with this client?", "Why do I dislike this particular client?", "What did I accomplish when I argued with that client?", "Do these feelings, reactions, behaviors, or thoughts remind me of someone else in my life?" These introspective methods may assist the practitioner in gaining significant insight and awareness not only into their unique personal history, but its effect on their current relationships with clients. These insights may offer practitioners the opportunity to improve service delivery and strengthen the helping relationships with their clients.

In addition to introspection, consultation and dialogue with colleagues may be of great value. Supervision from more experienced practitioners is an excellent method to bring insight into a practitioner's relationships with clients and to resolve any issues or concerns. Most practitioners, especially at the beginning stages of their professional careers, received some type of supervision in which cases were discussed and information shared. These techniques were informative and valuable in the beginning stages of professional careers and allowed the new practitioner to ensure that his/her performance met the necessary standard of care. These methods continue to offer practitioners, even veteran practitioners, the advantage of an unbiased perspective. In dialogues with colleagues, peers, or supervisors, the practitioner can allow someone who is not experiencing subjective responses to a client to evaluate performance as well as service options. In the end, the client is better served through objectivity. The practitioner also experiences the benefit of uncovering a potential source of personal understanding for specific reactions, behaviors, thoughts, and feelings.

Summary

This article has suggested that practitioners who work with elders and elders with dementia need to develop an awareness of the pervasiveness of ageism as well as an awareness of personal motivation and countertransference. While ageism exists on micro, mezzo, and macro levels, practitioners can challenge sources of ageism by identifying the inequities that exist because of age-related perceptions. These biased perceptions suggest that some people are more valuable than others as a result of chronological age and ability. Practitioners may develop a fuller understanding of personal motivation by understanding the reasons for their career specialization as well as the reasons they implement specific types of intervention. Practitioners may evaluate their personal motivation by evaluating their performance in relation to their profession's distinct code of ethics. Finally, practitioner countertransference may be a powerful source of influence on the helping relationship established between a client and a professional. Practitioners must acquire greater awareness of the effect of their personal histories and experiences on the helping relationship. Particularly helpful in dealing with countertransference are introspection and consultation.

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