Psychiatry and the Aged: 
An Introductory Approach

Formulated by 
the Committee on Aging

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The GROUP FOR THE ADVANCEMENT OF PSYCHIATRY has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the field of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1945 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health in good human relations.

GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

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I. INTRODUCTION

Current knowledge suggests that the treatment of psychiatric disorders in older persons is often difficult, if not impossible, without adequate medical, social, and economic support. However, general medical care and manipulation of the social environment of mentally ill old people is rarely psychotherapeutic in the absence of psychiatric assistance. Although environmental changes in accord with his desires and expectations may be necessary or helpful to ameliorate the symptoms and improve the behavior of an aged person, such potentially helpful changes may be harmful if made in a callous, mechanical way.

This report is intended as an introduction for psychiatrists in training, general physicians, medical specialists, and workers in allied fields who are confronted by a growing number of aged patients. It presents selected facts, defines terms, briefly reviews the mental disorders common in old age, and surveys the psychiatric principles and goals in their treatment.

II. BASIC DATA AND DEFINITIONS

Aging

All living things have a life cycle. Growth and development—unless interrupted by accident or disease—reach a peak of maturation and are followed by decline in functional capacity and eventual death. Decline that is not clearly related to pathogenetic events is generally called aging, or senescence. The senescent process may be genetically determined and inevitable. Among the many theories of aging is that of Geschickter, who defined “normal aging” as “a gradually increasing discrepancy between the demands of specialization by the tissue and the available metabolic support”.

Under optimal conditions human decline usually parallels chronological age, but it may be accelerated by the action of a variety of physical, chemical, and living assaulting agents. This speeding up of the aging process in response to stress is generally regarded as pathological, as disease. In actuality, it is difficult to state when aging is normal as opposed to pathological.

The rate of aging varies between individuals and also within the individual. The organism has many “clocks”; organs, systems, and parts age at different rates.

Aging may include growth or development of certain functions and structures while others decline. Knowledge and skill can grow through experience and training even as physical strength and speed of learning decline. Despite decreased efficiency in sensory, motor, homeostatic, and perceptual functions or responses there
BASIC DATA AND DEFINITIONS

may be gains in certain complex human functions such as judgment or wisdom. An individual may reach his psychological, social, or occupational "peak" or "prime" despite biological decline. Total functioning is often a balance between the amount of decline and the amount and type of "experience," skill, or learning acquired. In this report, the term aging refers to decline, involution, or loss of functional capacity of the individual as a whole or in part as it may affect total functioning.

Old Age

There is a fairly close relationship between chronological age and functional capacity. Some degree of mental and physical decline has taken place in all persons by the age of 65 and tends to increase thereafter. For this reason the 65th year is generally accepted as the beginning of old age. From the functional point of view many persons are relatively "young" at 65 years of age. Nevertheless, the almost universal incidence of notable functional decline after 65 makes this age a useful reference point for discussing the problems of aging.

The definition of aging as a loss in functional capacity likens an aged person to one who is sick, impaired, or disabled. In many ways, though by no means in all ways, the aged person is weak and debilitated. He is likely to be inefficient. He has less biological flexibility to cope with routine affairs and routine changes. His reserve for facing emergencies is reduced. He is often a social liability.

Progressive decline or "loss" of resources that are available to the aged person may occur because of normal or pathological changes in the individual or because of socially induced changes in role. Usually they occur for both reasons. No attempt will be made in this report to describe in detail all of the functional losses that constitute or contribute to the aged state, or to indicate the infinite number of combinations in which they may occur. A few phenomena are presented to illustrate what may be important in appraising personal efficiency and ability to obtain gratification, in arousing awareness of decline, and in determining how the older person reacts to aging and in what ways he provokes stressful ex-

ternal attitudes toward himself. Limitations of activity and change in relation to himself and others may become significant obstacles to the older person's continued successful adjustment and may diminish his capacity for social adaptation.

In this report physiological functional losses are considered under the headings: (1) capacity to survive (longevity); (2) central nervous system functioning; (3) sensory functioning; and (4) motor functioning. A fifth topic of importance is the changing interaction between the individual and his society along with social adversity and decline of personal power. This is briefly discussed as psychosocial change.

Physiological Changes

Survival Capacity. There are considerable differences in longevity of various species and in the rates of aging of individuals within a species. Prolonged survival depends upon elimination of "natural" enemies, and also upon the type and quality of the nurturing and the complex later experiences of the individual. It is probably safe to generalize that physical stresses—whether of climate, calories, or radiation—decrease the capacity to survive.

In non-humans, longevity has been roughly correlated with the ratio of body weight to brain weight, to heart rate and rate of metabolism, to delayed maturation consequent upon restricted calorie intake, to climate, and to duration of gestation. Other things being equal, the life span of man appears to be genetically determined and can be fairly accurately predicted by Raymond Pearl's "TIAL" index—Total Immediate Ancestral Longevity. This index is obtained by addition of the ages of the person's parents and four grandparents. As Lansing says, "A minimum score could scarcely be less than 90, and a maximal score would approach or slightly exceed 600 (assuming 15 years as an average age of initiation of production for the former and an average age at death of 100 years for the latter). In general, Pearl found that marked longevity was associated with high TIAL scores."

Genetically deter-
minded life-shortening or vitality-preserving factors interact with environmental influences to determine the length of life.

Central Nervous System.

(a.) Brain tissue loss or dysfunction: Brain weight decreases with age, and the slow or rapid loss of tissue may eventually yield decrements in neurointegrated functioning. At a certain point of decrease in "functional neuronal mass" the individual requires assistance because of his inability to make social, and ultimately, even biological, adjustments. Electroencephalographic studies have indicated that slowing of the alpha rhythm may occur with advancing chronological age. Psychological dysfunction is frequently found in association with such slowing. Focal electroencephalographic disturbance, primarily in the anterior portion of the left temporal lobe — whether the person is right- or left-handed — has been noted in about one-third of symptom-free persons over the age of 60. This cerebral dysrhythmia may reflect circulatory deficiencies. Although a "normal" finding in many older persons, the clinician must remain aware that it may be a signal of later difficulties.

Experimental evidence indicates that with aging there is a decrease in speed of response and in speed of performance of simple mental operations as well as in the speed with which difficult discriminations are made. These evidences of slowing are greatly in excess of the slight decrease in the speed of peripheral nerve conduction.

(b.) Intellectual functioning: The problem of measuring intelligence in older subjects is a complex one. There is not universal agreement regarding the definition of "intelligence." Because intelligence tests include a variety of components that are weighted differently, their scoring may prejudice results in favor of younger people. Even tests that are "standardized" for elderly subjects must be used with caution until further work has been done.

If the tests in general use are accepted as valid measures of intelligence, there is found to be a decline in intelligence with advancing age. The extent of decline differs for the various compon-
Sensory Losses.

(a.) Vision is one of the most important senses affected by advancing age. Lens changes that result in presbyopia are well known. As the capacity for lens accommodation decreases, the functional size of the pupil may also decrease and there is a change in speed and capacity for dark adaptation. Consequently, the vision of older persons is more impaired by low levels of illumination than that of the young.

Visual changes with chronological age also include a decline in color-matching ability. The decline after age 20 is gradual. The differences between adjacent decades are statistically small. Accompanying the decline in color-matching ability with age may be alteration in one’s choice of colors. Changes in color preferences may thus be physiologically as well as psychologically determined.

Cataracts, glaucoma, and retinitis often produce increasing disability with advancing age.

(b.) Hearing impairment is another very common and important sensory change in aging. Hearing loss impedes easy communication with others. It contributes to actual isolation and to feelings of isolation or rejection. In combination with loss of vision it severely limits the person’s ability to deal with life’s everyday problems, reduces his capacity to carry on the activities of daily living, and decreases his ability to obtain pleasure through reading, listening, and watching.

(c.) Taste and Smell. The considerable decline in olfactory functioning of the aged may contribute to decreased enjoyment of food and drink. Taste changes tend to occur because of a loss in the number of sensory organs for sweets. Some previously enjoyed foods therefore become less palatable.

Loss of Motor Strength. Loss of muscle mass and strength with age are inevitable, but the rate of loss is a highly individual matter. Older men who have continued to do hard physical work or exercises, or who have been motivated to continue in sports such as golf, swimming, or horseback riding, may show relatively little loss in motor strength. Cultural factors, sedentary responsibilities, obes-

Psychosocial Changes

Socio-economic Factors. Individual psychological growth is profoundly influenced by the culture and, in turn, influences cultural developments.

In societies that are not technologically advanced, attitudes toward the aged appear to be related to subsistence economy. When the aged are a burden and a danger to social survival, there are ritualized and conventional modes of permitting them to die. In our society aged persons are generally kept alive as long as possible. However, our efforts to provide economic security for the rapidly increasing older population in this country through public income maintenance measures—social insurance, veterans’ and public assistance programs, and work-connected public and private pension plans—have not kept pace with the technological advances that tend to increase the proportion of aged.

These advances have brought about sweeping socio-economic changes affecting the well-being of older people. The size of families has decreased, and movement from place to place for reasons of
employment has led to dispersal of family members. Geographic separation has decreased family availability for the care for aged persons. Many are without families, or have relatives whose health, age, and financial circumstances preclude their assuming the care of others.

Within the past decade attention has been focused on the search for workable solutions to the problems of older persons as a distinct group in our population. The inadequacy of existing methods of care and the absence of specific necessary services point to a need for new publicly-supported, community-based facilities that offer aged persons comprehensive psychiatric and medical care and a wide range of socially supportive services.

*Psychological Factors.* Even in the absence of the decrements of physiological and psychological capacity and function that accompany aging, psychosocial problems may develop in chronological old age.

Each phase of life has its own tasks and problems. In each there are unique personality assets and liabilities. The need for protection and care in infancy and childhood, the emotional crises that accompany emancipation in adolescence, the reaction to the accumulation of economic, social, and family responsibilities and obligations in early maturity, each present special problems of adjustment. Age transitions are often ritually emphasized and elaborated to encourage the change and to communicate the social expectations. With increasing chronological age, changes in behavior are expected of a person by society and by the person himself. A knowledge of the changing expectations of society acts as a motivating force in the individual toward learning, fulfilling, and enjoying his role. Social institutions are generally geared to help him understand his status, recognize his obligations, and gain satisfactions from socially constructive or acceptable behavior.

The young person usually has strengths that enable him to resolve conflicts in role expectations, to overcome obstacles in achievement, or to find substitutes for unattainable goals. In old age, however, the changes in role and status in conjunction with functional decline may result in personal crises or enduring malaise. New, special problems arise when the problems of youth or middle-age are resolved or become inconsequential.

In later life, previous sources of mastery and gratification — achievement and social value, family and social relationships, control and good use of bodily capacities — may dwindle or be lost. For many, aging is accompanied by a waning influence over one's environment, by a loss of friends and relatives, and by physical and emotional deficits for self-maintenance. Each loss requires rearrangement of the equilibrium that had been established by the individual for comfortable functioning over many years.

Retirement from jobs because of age or illness and departure of children into their own family lives and concerns cut aged persons off from the social and occupational interests that have absorbed their energies for many years. Many older people become increasingly alone. Even if they are financially independent, severing interdependent relations between generations makes it difficult for the aged to interact emotionally with their children. Although they may receive the continued respect and devotion of their children, older persons may feel displaced because the opportunity to give helpful advice based on lifelong experience is limited by the rapidity with which their experience, skills, and basic concepts have become outmoded. When there is an impatient march into the future and a restless spirit of change, the wisdom of an older generation appears to decrease in value. Under these circumstances, and with accompanying biological changes, the aging may tend to disengage themselves from social and family activity. Such disengagement may be a result of increased fatigability and lessened ability to deal with complex stimuli; it may serve to protect persons from feelings of failure in a changed society and a technology that demands other resources than are at their disposal. It may further represent a decrease of interest in the goals and pursuits of the new generations. It may also represent hopelessness, the result of society's failure to respond to the repeated attempts of older people to obtain badly needed assistance, or to their maladaptive attempt to attract help.
Losses of family and friends disrupt interdependent relationships that are useful in maintaining emotional equilibrium or security patterns. The loss of persons who are meaningful to them will often lead the aged to search for new associations, but it may be hard for elderly persons to find them—there are no replacements for families. Furthermore, the attempts of an aging individual to re-establish equilibrium by investing interest in new persons may meet resistance. Older persons who have lost erotic and productive capacity may be rebuffed by those in whom they display interest.

Aloneness and loss of mastery over one’s own functions and one’s environment may precipitate or exaggerate fear or anger. In the face of personal impairments, the loss of protective and supportive persons within a family or a small community may lead to behavior that is socially disruptive and overtly troublesome. Similarly, what was made tolerable to the individual himself by the presence of his spouse or family may, upon the loss of someone close to him, become intolerable suffering.

Under these circumstances, aged persons commonly complain about “loneliness” and “boredom.” These states may be symptoms rather than causes of depression in aged persons who yearn and search for aid as an answer to their emotional problems of dependency. Such problems may have been aggravated by the loss of individuals who satisfied their dependent needs. These persons may not have the inner resources to make an adequate life for themselves, to search for and to make new friends, or to develop new interests. When mobility and income are reduced, and when friends or a “place” in society are realistically less available, the search may seem overwhelmingly difficult to persons who found living under optimal conditions a trial.

The psychiatrist is interested in the individual, his family, his society, and the effect each has upon the other. He is interested in experienced suffering and its elaboration in thought and phantasy, and in observed behavior disturbance and social friction. These matters will be touched upon later in the sections on psychiatric disorders and treatment.

III.

DIMENSIONS OF THE PROBLEM:
STATISTICAL BACKGROUND

The Aged in the General Population

The needs of the aged and their urgency are illustrated by the facts presented in this section on population growth, longevity, and the prevalence of psychiatric disorders in the aged. The number of persons who now reach old age has increased greatly. This is due almost entirely to the prevention of death at early ages or in maturity rather than to the preservation of aged persons themselves. This is graphically shown in available statistics that compare the average life expectancy at stated ages for the period 1900-02 to that in 1959. Average life expectancy for the very young has been appreciably increased; for those over 5 years of age the increase has been small; for those who live to be 80, the increase in life expectancy is negligible. Accidents are an important cause of death among aged persons, as important as pneumonia and diabetes, according to Rodstein. Persons over 65 account for 72 per cent of all fatal falls, 30 per cent of all pedestrian fatalities, and nearly 30 per cent of all accidents due to burns and fires. This high accident rate can be explained by failing vision, memory, and powers of attention, often complicated by emotional strain.

In 1963 there were 18 million people in the United States 65 years of age and over. This is an increase of over 40 per cent from the 12 million in the 1950's. It is estimated that by 1970 there will
be over 20,600,000 and by 1980, 25 million in the 65-and-over age group. In 1963 nearly 9 million were over 75 years old and about 1 million over 85.

The increase in the number of persons 65 years and older from 3.1 million in 1900 to some 18 million today has resulted in a change in the population’s “age distribution.” In 1900, 1 person in 25 was 65 years of age or older. Now 1 of every 11 persons in the United States is in this age group. By 1975 this proportion will probably be 1 to 9 for the United States; this proportion is already found in many of our states and cities.17

The majority of the aged are women; they outnumber men in a ratio of 12 to 10. At age 85 and over, the ratio becomes 16 to 10 because of the higher death rate of the male at this and at any age. Over two-thirds of the aged population live in urban areas and one-third in rural areas. The aged comprise a higher proportion of the rural population than do their city counterparts because of the movement of the younger group away from the farm and the small town. One-half of the aged women are widows; about 20 per cent of the men are widowers. Because men have a higher death rate about 70 per cent of the women over 74 years old are widows.

Four-fifths of the aged men and two-thirds of the aged women live with relatives. For men this is usually the marriage partner; a woman is as likely to live with a child as with a husband.

One-third of all families defined as poor are headed by a person aged 65 or over; aged persons account for an even larger proportion of the poor who live alone. For the year 1962 the median income was $1,130 for the nonmarried (widowed, divorced, separated, or never married) who make up about one-half of the population 65 and over; for the married, who tend to be younger, the median income was $2,875; almost three in every ten couples had an income under $2,000. The prevalence of poverty would be greater were it not for old-age survivors, and disability insurance. Seventy per cent of persons aged 65 and over received OASDI benefits at the end of 1962; the proportion is expected to increase to about 90 per cent by 1975. About a fourth of all persons aged 65 and over were employed at some time in 1962. Many worked to supplement their OASDI benefits; the majority worked part-time—perhaps owing to legal limits on earnings.18

Despite the large number of aged persons receiving OASDI benefits, many still live on very low incomes. This is especially true of the nonmarried group. OASDI benefits are practically the sole source of cash income for more than one-third of this group; for more than 1 in 6 of these persons public assistance is an important supplementary source of income. Aged widows and other nonmarried women—one and one-half times as numerous as nonmarried men—account for the unfavorable economic position of the nonmarried group.

About 32 per cent of the aged population now receive old age assistance (OAA) — financed by joint contributions of federal, state, and local governments — either because they are ineligible for social security benefits or because these benefits or other income is too small for their maintenance. The proportion receiving OAA decreases steadily as the proportion receiving OASDI benefits increases. Nevertheless, persons aged 65 and over continue to constitute the second largest group dependent on public support; only dependent children receive more public aid. To some extent the downward trend in OAA has been offset by an increase in public assistance specifically provided to meet medical bills rather than maintenance.19

Prevalence of Mental Disorder

Most aged persons live in their own homes or with relatives. Most of them function fairly well. However, the incidence of psychiatric disorder in aged persons is high, and the problem of care presented by a sizable number now constitutes a major public health concern. Aged mentally ill patients are found wherever the aged live: in private dwellings, old age homes, nursing homes, general hospitals, psychiatric hospitals, and facilities for long-term illnesses.20,21,22 About 4 per cent of the persons over 65, including those mentally ill, are in institutions.

Aged Mentally Ill or Impaired in the General Community, House-
hold surveys reveal large numbers of mentally ill older persons who are not otherwise visible. Special studies indicate that many aged persons feel socially displaced or deprived, suffer because of financial distress, or are mentally disturbed. In one metropolitan community survey, 11.5 per cent of persons aged 65 or over were found to be mentally ill. Almost 3 per cent were said to be suffering from "psychosis," and about 7 per cent from "psychoneurosis." These estimates are probably low.

In another household survey of persons 65 years of age or over, it was found that 6.3 per cent were so disordered mentally that they met clinical criteria for involuntary mental hospital admission. These people showed a rising proportion of mental illness with age, starting at 3.2 per cent in the 65-69 age group and increasing to 9.5 per cent in the 80-84 age group. More than 30 per cent of those over 85 years of age who were interviewed were found to meet the clinical criteria for involuntary certification to mental hospitals. In all age groups the proportion of the mentally ill was greater among men than among women. These estimates may be low; a number of persons who were believed to be confused were kept from the survey interviewers by relatives.

Other studies indicate that from 10 to 20 per cent of persons over 65 in the community have a significant degree of memory defect, disorientation, and decline in intellectual performance.

**Aged Mentally Ill in Non-psychiatric Institutions.** A questionnaire on the extent of "confused and disoriented" patients in sectarian homes for the aged was sent to administrators of such institutions in widely scattered urban areas in the United States. The replies indicated that "confused and disoriented" patients who were management problems made up from 40 to 50 per cent of the population in some homes. The average age of residents in homes for the aged over the country is about 80.

One early five-state survey of nursing home residents, who are predominantly older than 65, revealed that 60 per cent could be classified as clearly "mentally confused." Comparable percentages in other settings were 48 per cent in chronic disease hospitals, 44 per cent in voluntary and public general hospitals, and 27 per cent in domiciliary care homes. The figures given for general hospitals correspond to those reported by Robert Monroe in his statistical analysis of over 8,000 general hospital records. There is a high proportion of aged persons with chronic brain syndrome in nursing homes has been confirmed by studies of representative population samples. Direct examinations of aged persons who are in old age and nursing homes indicate that the mental functioning of at least 80 per cent is seriously impaired, and that 3 to 6 per cent of aged residents in nursing homes are sufficiently disordered to meet the clinical criteria for involuntary certification to a mental hospital.

**Aged Mentally Ill in Psychiatric Institutions.** Of all first admissions to psychiatric hospitals in the United States, 45 per cent are of persons 60 years of age or older and 27 per cent are of persons 65 years of age or older — an age group that represents only 9 per cent of the total population. Based on an analysis of the records of one state hospital, the average annual rate of first admissions in the period 1926-1935 was 54 per 100,000 population for all ages as compared to 116 for persons 65 or older; in 1945, it was 79 per 100,000 for persons of all ages, and 178 for persons in the older age group. First admissions of persons aged 65 or over to New York State hospitals comprise about 30 per cent of all admissions. Those who survive and continue in residence constitute about one-third of the state hospital population.

The above facts and observations indicate that a significant number of older people suffer from mental disorders and need either psychiatric care and treatment or psychologically oriented supervision, protection, or counsel in every setting in which they are found.

The dimensions of the problem are expressed, in nonstatistical terms, in a summary of the findings of a recent survey of the psychiatric and other medical characteristics of the aged population of metropolitan New York admitted to voluntary nonprofit homes for the aged, proprietary nursing homes, and state mental hospitals at 65 years of age or over. These findings confirm the overlapping nature of the problem in various settings; they highlight, in addi-
tion, the comprehensive medical and social services necessary in the institutional care and treatment of aged persons with mental disorders. The key points follow:

1. Homes for the aged and proprietary nursing homes, as well as state mental hospitals, are important centers for the care and treatment of mentally disturbed older people. The vast majority of aged in these homes have mental impairments similar in type and frequency to those found among older patients in state hospitals. However, the proportion with severe mental impairments is greater in state hospitals.

2. Most older institutional residents are physically as well as mentally impaired.

3. There is a wide range in the mental and physical condition of older residents not only in each type of institution but also from one institution to another of the same type.

4. Striking differences as well as striking similarities are found in the physical functioning of older residents in the various types of institutions. Homes for the aged have the highest proportion who function well; nursing homes the highest proportion with the worst physical functioning. The proportion with poor physical functioning is high in all three types of institutions.

5. There is a close relationship between the mental and physical functional status of older institutionalized persons, particularly among residents of homes for the aged and nursing homes.

6. The mental and physical functional status of older institutionalized persons is greatly influenced by the prevailing “climate” in a specific institution. When environmental factors are favorable, this is reflected in better functioning; when they are less favorable, older residents with similar impairments function less effectively.

7. Most mentally disturbed residents of homes for the aged and nursing homes require adequate psychiatric supervision if they are to receive the care and treatment they need in these non-hospital facilities.

8. The mental and physical disabilities of older people account only in part for their admission to institutions. Closely related factors are the lack of, or breakdown in, socially supportive services or medical facilities in the community that might have enabled some aged persons with impairments to remain in their own or a relative’s home.

There is, from time to time, public excitement about the idea that psychiatric hospitalization of the aged is unnecessary and should be avoided. The charge is made that families are avoiding their responsibilities by “dumping” their aged kin into institutions. In actuality — contrary to popular misconception — aged patients in mental hospitals often have no families, or have families who are themselves aged, ill, or struggling for survival. In such cases, institutional care meets their own and the community’s need for provision of the required medical attention and related services. The facts appear to show that there is no abuse or misuse of the hospitals by “dumping” aged persons, by either families or the community. Rather, there is a lack of other equally suitable or better resources. Recent experience indicates that many mentally disturbed older persons who now seem to require hospitalization can be treated outside psychiatric hospitals, if they are provided with psychiatric supervision or direction. Their own homes, foster homes, nursing homes, or old age homes could then serve them equally well. For this kind of protective service, however, an economic base is required that assures board and shelter and other essential personal care, in addition to general medical attention and social services.

The aged pose a direct as well as an indirect psychiatric problem. The experience of social and health agencies supports the view that there is probably a high incidence of “minor” mental disorder in the aged who have disturbed family relationships. Although their effect upon families and the general community has not been evaluated, clinical evidence indicates that the families of aged persons as well as aged persons themselves often require psychiatric help.
IV.

CLASSIFICATION OF THE MENTAL AND EMOTIONAL DISORDERS OF THE AGED

The aims of classification are to indicate etiology, provide direction as to treatment or management, and offer clues as to prognosis. Classification should assist in understanding, prediction, and control. All present classifications of the mental and emotional disorders of the aged leave much to be desired.

Many of our so-called diagnostic terms are useful primarily for statistical purposes. Nomenclature may provide useful information about etiology, behavior, reaction type, or general prognosis, yet be misleading about the nature of the process and the effective treatment. Restrictive categories may result in the lumping together of major and minor adjustment problems, or of reversible and irreversible reactions or conditions. Differences in physical status, environmental conditions, and habitual modes of adaptation to internal and external stress must be considered. “Labels” often obscure or mislead rather than clarify.

However, it is convenient to subdivide the patients whose mental disturbances emerge as significant in old age into two major groups: (1) those who have disorders of affect or content in the absence of brain damage; and (2) those who have disorders in the presence of brain damage as reflected by brain syndrome. These are the true psychiatric problems of the aged that confront the psychiatrist and the community. They are described and discussed in the following sections of this report.

In addition to these two groups, there is a large number of persons who have grown old in hospitals or who have long-term and chronic mental disorders that began before chronological old age. This group, whose problems are more in the provinces of general psychiatry and hospital psychiatry than of geriatrics, is not the subject of this report. The group consists mainly of chronic schizophrenics, most of whom require continued care within a protective setting. Also in this category are some persons with recurrent affective disorders, mental deficiency, and chronic alcoholism. These persons have in effect, or in actuality, remained in mental hospitals from relative youth until old age. Many are examples of the “institutional syndrome.” They have acquired symptoms referable to their removal from normal social stimuli and interactions by long residence in a socially barren and empty hospital community. In some states, if persons in this group are meek and mild, or well-adjusted to institutional life, they are considered candidates for transfer to non-hospital facilities. This is not truly a “return to the community” but merely a shift in institutions. If more time and attention were paid to these patients, there might be an improvement in the capacity of many to function socially.

Aged Persons with Disorders of Affect or Content

The Late Developing or Recurrent Psychoses of Later Life. This group of mentally disordered aged consists of those with endogenous psychoses and the disorders of content — thinking — that are revealed, or appear to develop, in later life. Any of the mental disorders of youth may persist into old age, to be modified or complicated by events in the senium. Many of these persons are indistinguishable from the aged group with life-long disorder, except that they escaped long-term hospitalization. This is owing to better general health, economic resources, family protection, and special skills, or to the fact that the symptoms failed to mobilize community action. In most of these older people, the depressive, elated, agitated, or mixed alterations of thought and behavior anticipated old age but for a variety of reasons have not required or resulted in hospitalization.
psychotic reaction may have behaved in dramatically depressed ways in the past, or have been phobic, querulous, and highly dependent upon and manipulative of family or friends. Sometimes depression is manifested in preoccupation with the diet, bowel movements, or general health of a child or grandchild. It may also be hidden under somatic complaints or in dissatisfaction with oneself or one’s possessions. Agitation or psycho-motor retardation is frequent. Anorexia, insomnia characterized by awakening in the early morning, and constipation are marked. Loss of interest and a tendency to shun company are present. When depressed these patients may be more malleable and likeable than when they are well, perhaps because they are quieter, less demanding, or less overtly hostile. An outstanding characteristic may be clinging, ingratiating, punitive dependency upon another person; the spouse, a child, another relative, or a friend. The dependency, however, may be so punitive and onerous as to provoke hostile rejection by the other, although symptoms may sometimes abate when this person is present. In general, behavior with the “protective other” is usually of a type that eventually becomes difficult for the spouse or relative to tolerate. This burden often precipitates a crisis that leads to application for psychiatric assistance. The pattern of behavior displayed by the patient toward this other person (who usually brings the patient to the doctor) is often highly informative as to what the depressed person in his anxiety, anger, and helplessness is reaching for in order to gain or restore a sense of security.

Psychoneurotic Older Persons. The “psychoneurotic” aged are common rather than rare. With this group should be included the obsessive-compulsive patient and the patient with a so-called “psychosomatic” or psychophysiological disorder. Although certain psychophysiological reactions tend to “burn out” or decrease in intensity and to be seen less frequently in the aged, such other reactions as constipation, anorexia, indigestion, and insomnia may increase in number.
These persons often merge into the brain-syndrome group as they age. Their symptoms may then become florid and exaggerated, and their depressive reactions may become relatively severe. In others, with no brain syndrome, a relatively severe depressive reaction may appear for what seems to be the first time. However, a history is often obtained of episodes of mild, spontaneously remitting depressions in the late teens or early twenties. These patients often give transparent clues, by way of their flow of conversation, to their lifelong desire for protective, supportive, reassuring persons. This desire and need has previously been present and more or less continuously operative but, as noted earlier, was masked or minimized by family and community interactions. In the absence of the "natural" opportunity for the continuation of these "parasitic," "love," or other patterns, the behavioral trends emerge as disturbed or disturbing.

Aged Persons with Brain Syndrome

The "organic" group of aged mentally ill constitutes the largest group of institutionalized older persons with mental disorders. In this group are (1) persons with relatively uncomplicated brain syndrome and (2) persons with disorders in which the brain damage is accompanied by disturbances of affect or content. Most of these persons are physically impaired or ill. They are the "stereotype" of old age. They pose the most immediate problems of medical, psychiatric, and social care of any group of aged persons. Because it is masked by physical complaints and illness, the mental impairment may not be recognized or may be ignored. Inadequate diagnostic classification systems may also contribute to the neglect of mental disorders of brain-damaged persons.49

In this group are patients whose brain dysfunction appears to be reversible and those in whom there is presumably irreversible damage. The complete social recovery of persons with brain syndrome cannot be expected; the condition calls for continued supervision and protection. Also, these persons require continuous or intermittent general medical care which they are often unable to afford or find. In general, severe brain syndrome patients die within a few years. Institutionalized patients with this condition usually require care for the remainder of their lives. Concomitant disorders of affect or content, however, are often highly responsive to short-term psychiatric care.

Systems of Classification. In many state hospitals, it is still the fashion to classify persons presumed to have brain dysfunction, and who are therefore by definition "psychotic," into groups according to etiology of the dysfunction. Thus, some are "due to disturbance of circulation" and these persons have "psychoses with cerebral arteriosclerosis." Other dysfunctions are "due to disturbance of metabolism, growth or nutrition," and persons with this disorder have "senile psychosis." The differentiation of these two groups is sometimes difficult, for the pathological changes cannot be clearly distinguished and may often be associated. Less emphasis upon questionable etiologic factors and more upon complete description of behavior are desirable.

"Brain syndrome" is now the term used to indicate disorders that are assumed to be the immediate result of diffuse disturbance of cerebral tissue function in the aged. These disorders are characterized by impairment of orientation, memory, and intellectual functions. Judgment and liability of emotion are also usually affected. The syndrome may be acute or chronic and it may be mild, moderate, or severe. For the purpose of more complete classification the diagnosis can be qualified according to presumed etiology, and also in terms of the type of psychotic, neurotic, or behavioral reactions that may be present.

By "chronic" is meant brain disturbance due to irreversible brain damage; "acute" refers to reversible and potentially transient brain disturbances arising from what Adolph Meyer called "cerebral mal-support." Where acute and chronic brain syndrome appear to co-exist, the diagnosis usually is listed as "chronic." Such classification makes difficult the statistical evaluation of the effects of care and treatment. Combined classification on admission to a hospital as "Brain Syndrome, Acute and Chronic" would be more realistic. The extent to which the degree of chronic brain syndrome is modified with treatment may be masked by
reversal of acute symptoms in an unknown number of “acute plus chronic” cases listed simply as “chronic.”

Acute brain syndrome can co-exist with chronic brain syndrome and represents a reversible component of a complicated disorder. It can also occur alone in aged persons whose functional neuronal mass is reduced. They are likely to manifest signs of brain syndrome with a temporary interference of blood supply or failure of other systemic support that will not affect persons who have not suffered loss of central nervous system tissue. Fluctuations can probably be best classified as “Brain syndrome, chronic, with intermittent periods or episodes of brain syndrome, acute.” When possible, Chronic Brain Syndrome should be qualified according to the cause of the impairment of brain function. Various underlying pathological processes may be present simultaneously. Genetic, metabolic or additional conditions other than vascular occlusion are assumed to be causes of cerebral “senile deterioration.” It is likely that among the causal factors is chronic or intermittent cerebral mal-support of the types that provoke the quasi-delirium known as acute brain syndrome.

In the traditional differentiation of “cerebral arteriosclerosis” (CAS) from “senile deterioration” (SD), the diagnostician is encouraged to consider cerebral arteriosclerosis as the probable cause of cerebral disorder that begins in middle age or early old age and that progresses by acute increments. There may be partial recovery from each of these. There is relatively good preservation of personality characteristics despite the progressive step-like impairment. A more steady, insidious progression of disorientation, memory loss, and impairment of intellect beginning in middle or later old age (the eighth or ninth decade) is to be considered presumptive evidence of “senile” deterioration. Thus, the age at which a patient seeks help may influence the physician’s diagnosis.

The prevalent use of the patient’s age as a determining criterion of predominant pathology is, however, contrary to good diagnostic procedure. Age, like sex and ethnic group, may be of assistance in orienting the physician in his “differential diagnosis,” but such personal characteristics are not signs of a disease upon which diagnosis should rest. A follow-up study of aged persons has shown that, whatever the original diagnosis, with increasing age more and more persons are classified as SD.42

Measurement of the severity of disorders, which can be used for interpatient comparison, as well as notations about the course or response to therapy, is desirable. As yet there is no agreement on how to determine degree of disorder. Persons considered to have “mild chronic brain syndrome” by the admission officer of a state psychiatric hospital may overlap with those who are called “severe brain syndrome” by an industrial psychiatrist. Also classification of these disorders should separate the “organic component” — brain syndrome — from the psychological (or psychosocial) and affective manifestations that are determined by the previous personality and by the immediate situation of the patient.

Quantification of brain syndrome is possible, for instance, by means of a standardized rating system of mild, moderate, and severe brain syndrome, derived from scores on a 10-point “mental status questionnaire.” The response to simple questions that test orientation for time, place, and person, recent and remote memory, and general information identify those with no to mild brain syndrome, (0-2 errors); moderately advanced brain syndrome, (3-8 errors); and severe brain syndrome, (9-10 errors).43, 44

The questions are:

1. Where are we now? (place orientation)
2. Where is this place located? (place orientation)
3. What month is it? (time orientation)
4. What day of the month is it? (time orientation)
5. What year is it? (time orientation)
6. How old are you? (memory—recent or remote)
7. What is your birthday? (memory—recent or remote)
8. Where were you born? (memory)
9. Who is the president of the U.S.? (general information, memory)
10. Who was president before him? (general information, memory)

Such rating methods may make it possible to identify patients as presenting “pre-brain-syndrome” disturbances and mild, moderate,
or severe degrees of mental functional impairment. This would permit measurement of progression of the disorder with time or as related to care and treatment. Rating methods such as those developed by Halstead and Reitan\textsuperscript{45,46} may permit more subtle and precise measurement of brain damage, with or without clear-cut brain syndrome.

Recommended Criteria for Diagnosis of Brain Syndrome. The suggestions that follow are made to assist in the diagnosis and classification of aged patients:\textsuperscript{47}

For the diagnosis and classification of brain syndrome, the following characteristics should be noted as present:

a. Disorientation for time, place, or person.
b. Evidence of impaired immediate recall.
c. Deficits of recent and remote memory.
d. Weakening of intellectual functions as indicated by difficulty and errors in doing simple calculations or in recalling simple items of general information.
e. Defects of grasp and comprehension: These defects may be discernible as difficulty in retaining, and reacting to, questions or commands. They may also be identified through faulty reaction to the situation or the interpersonal transaction, revealing that it is not understood. This can be briefly called situational disorientation.
f. A reliable history, from the patient or other sources, of episodes, intermittent or persistent, of occurrences of the above.

In the absence of stupor, coma, catatonia, excitement, complete deafness, marked language difficulty, or other factors which make examination impossible or its results questionable, the four signs “a” through “d” are diagnostic of brain syndrome. All four factors should be present on examination. In chronic brain syndrome, one of these deficits is rarely found without the others, although some may be less obvious or severe than others. If only one or several of the signs are found, developing brain syndrome may be suspected. The diagnosis is probably best made only when all the signs are found to be present in some, even though slight, degree.

In addition to and supporting the above, consideration may be given to such clues as emotional lability, focal neurological signs

(including aphasias, agnosias, and apraxias), slovenliness or poor habits, poor judgment not clearly related to emotional disturbance, and apathy. When these signs appear to be irreversible and related to brain damage — as opposed to brain dysfunction of a reversible or transient nature — the condition is termed chronic.

Acute brain syndrome: The characteristics of acute brain syndrome are similar to those described above, but this is a transient and potentially reversible condition. It is usually related to a febrile, debilitating, or exhausting illness; there is usually evidence of dehydration or malnutrition. Common conditions provocative of acute brain syndrome are infection, pain, fractures, heart failure, coronary thrombosis, drug intoxication, malignancy, and emotional overreaction. In the aged, however, fever, tachycardia, leukocytosis, or obvious physical signs may be absent even with acute illness. This may lead to a mistaken presumptive diagnosis of chronic brain syndrome. Blood chemistry — glucose or non-protein nitrogen, physical examination, anemia, nutritional history, or a history of drug ingestion are often clues to the acute nature of the disorder. With acute brain syndrome, all the signs of brain syndrome are not necessarily present simultaneously. There are usually fluctuations in degree of disorientation, misinterpretations, and occasionally hallucinatory phenomena. At times the disorder may be quiet; at other times it is characterized by restlessness, “helpless” confusion with bewilderment and puzzlement, or by a tendency to wander, both physically and verbally. In some cases, as an exaggeration of pre-existing chronic brain syndrome, the disorder can attract attention to underlying or developing illness, signs of which may or may not have been noted previously.

In almost all cases, the existence of acute brain syndrome in the aged may be taken as presumptive evidence of the simultaneous presence of developing chronic brain syndrome. Attacks of acute brain syndrome often contribute to a step-like progression of the more chronic form. In each person who has an episode of acute brain syndrome attempts should be made to determine whether chronic brain syndrome is present.

The differentiation of “cerebral arteriosclerosis” from “se
Classification of Disorders

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ile brain disease” or “senile deterioration” in the development of chronic brain syndrome. Cerebral arteriosclerosis is a term used to qualify a type of chronic brain syndrome when the disorder appears to be the result of diffuse brain damage related to acutely and episodically occurring focal brain damage. The most frequent cause of focal brain damage is cerebral thrombosis or carotid artery occlusion. Vasospastic episodes, anemia and anoxemia of the brain, and hypotensive crisis in hypotensive persons or in persons with myocardial infarction or cardiac failure may be responsible for brain damage. So-called “small strokes” may occur, but the claim that they are frequent is questioned by many clinicians. Episodes attributed to “small strokes” may actually be exacerbations of acute brain syndrome related to intermittent infection, anxiety, or other contributory factors to transient cerebral insufficiency. Episodes of hypertensive encephalopathy may leave areas of focal damage. Cerebral hemorrhage is rarely a cause of chronic brain syndrome because few persons survive after such an event.

Diffuse brain damage appears to be necessary for the emergence of signs of chronic brain syndrome. Single episodes of cerebral thrombosis, hemorrhage, or embolism appear to give rise to signs of focal rather than diffuse damage unless there is cardio-vascular, pulmonary, or other systemic disease that contributes to generalized cerebral damage through influence upon blood supply or metabolism. The effects of expanding intracranial lesions, when cerebral intercranial pressure is high and decompenation is occurring, or when the lesions are multiple, may be mistaken for “cerebral arteriosclerosis” in aged persons. The concept of functional neuronal mass may be helpful — brain syndrome can be considered to have emerged when neuronal mass has been decreased to a critical point. Patients can evidence many strokes before the emergence of brain syndrome, despite signs pointing to focal of brain damage.

Cerebral arteriosclerosis may slowly and chronically impair circulation and lead to loss of tissue. Brain damage under such circumstances cannot be differentiated from loss due to other causes. Therefore, a diagnosis of cerebral arteriosclerosis requires evidence of cerebral infarction — focal neurological signs or a history of stroke, whether mild or severe. Although the age of the patient cannot be considered a diagnostic sign, at the time of the first stroke he is usually under 65. There may be a history of several such episodes in a patient with brain syndrome.

The patient with cerebral arteriosclerosis is usually aware of loss of physical and mental powers and reacts to his losses with feelings of depression. Depression is a common reaction to severe or threatening illness of any kind. It is especially notable in those whose personal integrity is threatened by the effects of brain damage. Attempts to repair, ward off, or defend oneself against the threat of disintegration are occasionally abetted by anosognosia. This is the term applied to brain damage in which the patient “does not know and knows not, that he knows not.” Under such circumstances even gross physical defects, such as hemiparesis, may not be attended to, or admitted to or come to the patient’s awareness.

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ile brain changes are presumed to have been operative as etiological factors in the production of chronic brain syndrome when there are no focal neurological signs present on examination and when there is no history of stroke. This disorder is usually noted to begin after — rarely before — age 65; it is more common after age 70 and is almost universal in the ninth decade. It is often insidious in onset; its progression may be introduced by vaguely defined emotional disorders or by clear-cut depression. When diffuse brain damage develops slowly and environmental circumstances are supportive or when there is a minimum of stress, the individual may be able to compensate for functional loss with relatively little emotional upset. Good early education, high occupational and economic status and the early acquisition of socially acceptable patterns of behavior tend to “protect” against troublesome behavior. There may be excellent preservation of function, especially on a social level, despite severe brain syndrome. Social behavior may be so well preserved as to mask severe memory deficit and disorientation.

Example: A 77-year-old physician was brought for examination by his wife. He maintained, with her implicit agreement, social control of the situation. He helped her off with her coat and hung up both hers and his. He courteously introduced himself and his
wife, entered the consulting room willingly on invitation, and then implied that he was at the psychiatrist's service. In conversation gently directed toward eliciting his reason for arrival and complaints, if any, he remained courteous, articulate, and vague. He could not account for his presence in the doctor's office and did not remember the examiner's name, the location, or the day, date, or year. He admitted readily to memory difficulty with obvious but well-controlled anxiety, and philosophized about his retirement from practice, which he suggested was temporary. In conversation about his family, he could not recall the ages, occupations, or location of his children, the names of his grandchildren, or when he had last seen them. He welcomed the opportunity to reminisce about the hospital in which both he and the examiner had spent their medical lifetimes. He left happily, after discussing the giants of yesterday known to them both, in a highly selective and repetitive — although interesting and entertaining — way. On leaving, he twice attempted to exit by wrong doors, but graciously assisted his wife with her coat. In a very mannerly way he said goodbye to the examiner, thanking him for his courtesy and assistance. This closed an episode of warm and pleasant contact with a man who was able to clothe, wash, and feed himself, and in a limited way to travel alone (by asking others which train or bus to board), but who was otherwise totally incapable of caring for himself. Moreover, from the history given by his family, this man's behavior was characterized as withdrawn and depressed, with frequent paranoid outbursts and suspiciousness. Classification: Brain syndrome, chronic, associated with senile deterioration. Prognosis: With respect to the brain syndrome, poor; at best it may remain the same. For life expectancy, poor; for improvement of depression and paranoid trends, good.

Chronic brain syndrome with psychosis: As indicated by the foregoing remarks and the above case illustration, chronic brain syndrome is a mental disorder of major importance to the person and to society. The diagnosis may be qualified by the phrase "with psychosis" and the type of psychosis then specified, in the case of persons whose behavior is seriously disturbed or disturbing in ways determined by more than disorientation and memory defect. Thus, the above patient could be described as "with psychosis, depressed and paranoid."

The psychotic reactions most commonly seen with chronic brain syndrome are paranoid states and depressions with or without agitation. Involutional types of depressions, with guilt feelings, self-depreciation, with expressions of unworthiness, rumination over old faults or sins, with exacerbation of hostile thoughts about relatives and friends, as well as true suicidal thoughts or attempts, rarely occur in conjunction with CBS. It is almost as though a severely brain-damaged person does not have sufficient resources for the elaboration of so complex a psychological system. Nevertheless, with illness and pain, especially in males, suicide is not rare even in the presence of brain syndrome.46 True depressions in aged persons may be erroneously diagnosed as chronic brain syndrome with affective disturbance. This is particularly likely if the attendant psychomotor retardation, preoccupation, poor concentration, and the patient's insistence that he is deficient or defective are not recognized as emotionally determined. Therefore, the physician should always insist upon substantiation of the psychiatric evidences for brain syndrome.

The old clinical sub-types of "senile psychosis" tend to overlap with chronic and acute brain syndrome as follows:

1. Delirious and Confused: Often synonymous with delirium. This is an acute brain syndrome occurring in a patient with chronic brain syndrome. Most of these persons, if not all, are physically ill, or have metabolic disturbance due to dehydration, malnutrition, trauma, or exhaustion.

2. The Depressed and Agitated: Depressed persons with emotional agitation or restlessness associated with their disorientation and with anxiety. Wishfulfilling delusions or hallucinations may be present. These may be evanescent—present when the patient is with members of the family and evanescent when the physician or strangers are met.

3. The Paranoid: The persons who with chronic brain syndrome show angry, hostile, fault-finding, complaining behavior, some of
which is discernible as poorly organized delusional thought and bizarre, self-aggrandizing phantasies, often about persecution.

4. Simple Deterioration: A term usually denoting relatively uncomplicated cases of brain syndrome in which there is memory loss with little or no affective reaction and little behavioral disorder, other than wandering, nocturnal restlessness, disorientation, and gross memory defect.

5. Prebyophrenia: literally, "old mind," is the term usually applied to those persons with brain syndrome in whom confabulatory trends are prominent and who appear to retain superficially good social habits despite sweeping memory defects. Among them are those who seek out the rocker, enjoy sitting in the sun, and cheerfully greet the doctor or nurse each day.

Psychiatric Diagnosis as an Indicator of Mortality. A five-year followup survey of aged institutionalized persons with known psychiatric and other medical characteristics reveals that diagnoses of brain syndrome in old age and its sub-classifications according to associated mental conditions are highly predictive of the likelihood of death within a given period of time. The aged persons studied fell into three psychiatric categories: no mental disorder, 10 per cent; mental disorder but no brain syndrome, 5 per cent; brain syndrome, 85 per cent.

Although chronological age was found to be related to mortality rate in this group of aged persons, it was less directly related than was psychiatric diagnosis. Persons with purely "organic" disorders had the highest death rate for each year; those diagnosed as having an associated disorder of affect or content had the next highest rate; those with no brain syndrome fared the best. Moreover, the death rate within each followup year was found to be directly related to the severity of brain syndrome reported by the psychiatrists.

These findings illustrate the usefulness of careful diagnosis of brain syndrome in old age and the implications of improved methods of subclassification.

V.

GOALS AND EXPECTATIONS OF TREATMENT

In the care and treatment of the aged, we are moving away from a pessimistic or nihilistic attitude toward their emotional disorders, including those whose emotional disturbances are accompanied by brain syndrome. Yet, we are still likely to swing between expectations that may be too pessimistic or too optimistic.

There is much that can be done with older patients, more with some than with many younger persons. The psychiatrist may be able to help preserve functioning even when he cannot restore losses. His restorative efforts may include advice and aid in the provision of therapeutic environmental conditions. He may be able to exert a salutary influence upon persons in the environment whose changes in attitudes then contribute to a rehabilitative or supportive milieu.

In the care and treatment of the aged the psychiatrist may have his own set of goals and expectations, as do the patient, his family, and the community. For the psychiatrist, the goal is usually maximum possible restoration or preservation of function with minimal injury or distress to patient, family, and environment. He works to decrease suffering, augment function, increase productivity, and decrease interpersonal disturbance.

The patient usually hopes that the psychiatrist will relieve his uncomfortable symptoms and alter the environment to suit him. At the same time the patient may fear the psychiatrist as one who may commit him, impose restrictions on him, or do him harm.

From the standpoint of the family, the primary expectation is
GOALS AND EXPECTATIONS OF TREATMENT

usually that its own distress will be relieved. The family’s distress, however, may result either from injury inflicted upon it by the patient or from observing the patient’s distress or disability. Or, it may be from mounting guilt and hostility based upon long-standing ambivalent feelings toward the patient that are intensified by his illness.

Some families who care for aged persons are overwhelmed by the problems that arise and themselves become disturbed. A vicious circle is established, with mounting expressed or unexpressed hostility on both sides leading to increased injury to aged and family alike. Often this disturbance affects the third generation as well. As Holt stated in 1955, a program designed to increase the level of mental health among the aged might, by relieving the burden on the children, indirectly benefit the grandchildren as well. She added that there is reason to believe that parents’ feelings toward their own parents powerfully affect their attitudes toward their children.

The community is concerned primarily with its own protection and survival, although increasingly it is trying to provide what the patient needs for his best interests.

In dealing with the complaints of the patient, the family, and the community, the psychiatrist is aware of the interaction of all and of his need to respond to all. This requires attention to the patient-doctor relationship, and also work with the family, nurse, physician, social worker, occupational therapist, or others who may be concerned or useful.

The aging process itself, the nature of the illness, and the nature and quality of the patient’s milieu will often dictate what may be reasonable goals and expectations.

The aging process: The “younger” the patient, functionally speaking, the more effective is direct work likely to be; the “older” patient is less able to use directly the skills that are uniquely possessed by the psychiatrist. Such a patient will require more skill, attention, supervision, and understanding from those who are with him day and night. How “young” or “old” a patient is, however, is not to be gauged by his years. He may be “young” at 78, or “old” at 60. Youthfulness implies the relative preservation of intellectual functioning. It also implies relative flexibility in personality functioning and the potential capacity to adapt to new situations and altered circumstances.

The nature of the illness: Illness, personality, or aging may contribute to stereotyped or rigid reactions. Illness and personality rigidity or inflexibility are not always theoretically distinguishable. Clinically, however, there is often considerable difference between the patient with rigid character organization, and the patient with “neurotic” or behavioral disturbances. This is particularly true if ego-alien symptoms or undesirable behavior are of fairly recent onset and appear to be due to specific precipitating events or circumstances. Those with rigid, inflexible personalities may, of course, also develop acute symptoms. There are distinctions to be made, however, between different forms of illness occurring in varying personalities who are experiencing the universal decline that we define as part of the aging process.

For example, a depressive reaction is not the same illness for one individual as for another with the same diagnosis. For one older person, the illness can be understood dynamically as a reaction to the loss of an ambivalently held love object. For another, the depression can be understood as a reaction to the inability—perhaps because of failing physical health or compulsory retirement—to reach goals, such as vocational achievement, that he has regarded as crucial; and as a loss of powers and opportunity. For a third older person, the depression may represent a protest that he is no longer able to maintain his self-esteem and self-confidence in the absence of a previously held social or economic role—that he has lost status. Such differences will make for different goals and expectations in treatment.

Also, behind these differing reactions are personalities with varying strengths and varying defensive or reparative techniques. One patient may be essentially strong and “mature”; another may be weak and “infantile.” The illness may reflect the pre-morbid personality, and the goals and expectations will be determined partly by that personality.
The patient's milieu: Another factor that influences the goals and expectations of treatment is the nature of the patient's milieu; that is, the nature and quality of human and material resources available to him. To provide a simple example: aging patients who cannot hear well may be comfortable among those who considerably speak loudly and slowly enough to be heard, and who can tolerate certain of the patient’s idiosyncrasies about hearing. Among those whom he cannot hear, however, he may be disturbed and unpleasant. Already frightened and with decreased confidence and self-esteem because of his deafness, the patient must often contend also with deliberate exclusion and misunderstanding by those about him.

In many such ways, an injurious interaction between patient and environment — or a beneficent relationship — can influence the outcome of psychiatric intervention. Detailed attention to the environment is often of special importance in working with the aged.

Treatment considerations: In some instances, the major direct goal is to provide “relief” for the family rather than for the patient, whose condition may be relatively intractable. This is a legitimate and important aim, the achievement of which may require considerable sensitivity, skill, and medical knowledge. An example is the unmarried middle-aged daughter who makes plans that involve devoting herself to her senile mother, to the point that she permits herself no personal freedom. Her subsequent feelings of frustration may lead to aggravation of the mother’s disturbance and perhaps to her own illness. The daughter’s emotional state is initially masked by the fact that she presents the mother as the patient. Recognition and treatment of the daughter’s emotional disturbance may prove to be the most effective avenue of treatment. The immediate goal is to help the daughter, possibly by helping her to recognize her own conflictual feelings. Discussion and change of these feelings may then lead to more realistic planning on behalf of both parties.

At the other end of the treatment spectrum is the older patient who can be helped by way of exploratory or expressive psychotherapy. This is feasible when aging is minimal, when “ego strength” is adequate, and when the other conditions prevail that make a patient suitable for expressive psychotherapy at any chronological age: motivation, accessibility, adequate environmental support, social mobility. This form of treatment appears to have helped many older patients. For them the goals are elimination of symptoms and augmentation of function.

Preservation or restoration of the aged patient’s functioning may require willingness to take calculated risks. Overprotection, like oversedation, can be harmful. Often an essential goal in direct or indirect psychiatric treatment is to counter an attitude of excessive caution, and to share the burden of responsibility for accidents or the aggravation of known somatic disease. Nurses in particular, who are trained to avert avoidable mishaps, may be especially cautious, and require psychiatric support and guidance to permit indicated calculated risks. Grown children are frequently overprotective of their parents. The goals and expectations for the patient often will depend upon the capacities and willingness of family members or caretaking persons to participate in the treatment process. A psychiatrist can be of help to involved caretakers, particularly to families, by aiding them in working out indicated “calculated risks” in a socially feasible manner and by supporting them in taking those risks that preserve an aged person’s liberty and sense of dignity.

The psychiatrist is interested in what makes it hard for an older person to seek or get help. To what extent is the individual himself responsible for the difficulty, and to what extent does it result from a lack of community resources? What is the older person searching for? Will finding work and an opportunity to be useful help him most? Or is he searching for parental figures? Does he remain alone, searching in phantasy? Or does he place frequent telephone calls to his children, appear miserable and depressed, behave cantankerously, or complain about those things that are provided for him in good faith and with some sacrifice on the part of the giver?

Earlier in this report reference was made to the tendency of aged persons to search for protective persons. Techniques of treatment
that use the dependent relationship they seek to set up with the psychiatrist (as well as others) have been developed to relieve anxiety and improve behavior. In contrast to considering the patient's dependence as an obstacle to help, it is used as a resource. Group therapy has been advocated as effective and economical for mentally ill, institutionalized aged persons. Psychiatrists can do such work themselves, but also are needed to educate and supervise other professionals who have such skills.*

VI.

CONCLUSION

The elder person is a product of his culture. He is the culmination of lifelong intrapsychic phenomena with specific neurotic patterns. He has assets, limitations, and physiological needs.

A treatment program may require that the patient be supported within, or removed from, inimical environmental forces, or it may require that the environment be altered so that he may maintain himself within it. It may require, through psychotherapy, certain intrapsychic changes. Treatment may also require cure or amelioration of physical impairments, or compensation for them.

Since aging is always accompanied by gradual social, anatomic, physiological, and psychological losses, most older persons have experienced comparable sequences of intrapsychic events. Individuals of our culture do not always fully accept older persons, particularly if they are mentally disabled. In our society, the common attitude toward the aged is usually one of impatient tolerance. Impatient tolerance, isolation, limited opportunities, or forced retirement are often subjectively experienced by the aged as rejection or social deprivation. When physiological losses are added, there may often follow diminished self-confidence, feelings of uselessness, reduced enjoyment of living, and accentuated feelings of insecurity — if not frank anxiety, panic, or depression.

Neurotic character structure tends to exacerbate, potentiate, or energize the indispositions that accompany aging. Persons with “sado-masochistic” or “narcissistic” orientations, with lifelong unconscious hostility toward elders and others in authority, with long-

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* See references 51, 52, 53, 54, 55, 56, 57.
standing inability to assume more than a pseudo-parental role, with exaggerated defensiveness, or with poor adaptive capacities are especially likely to have problems in old age. Such persons may require emotional support that is not readily available to them. They may turn resentment or hostility against themselves, or they may strike out against those around them, provoking rejection reactions and inviting isolation. Marginally adaptive maneuvers that have been used for a lifetime will be less effective, or the maneuvers will fail under adverse conditions.

Psychological processes are often amenable to change. Self-esteem may be enhanced by the patient's realization that, with help, his lot may be improved. Even minor improvement may be subjectively experienced as a victory over destructive forces. This experience may have special significance at a time when victories are few and hard-won. The pleasurable feelings resulting from such mastery may lead to greater capacity to deal successfully with his personal and interpersonal, intrapsychic, and environmental problems.58

The aims of psychiatric treatment or supervision are to decrease personal suffering, to allay its divisive or painful effects upon the patient's family and community, and, in general, to improve the patient's mental, social, occupational, interpersonal, and pleasurable functioning to the maximum possible extent. The prognosis will depend less on the age of the patient than on the severity of his brain syndrome, the rigidity and type of his character structure, the extent of physical impairment, and the availability of needed therapeutic, economic, and social resources.

Few older patients are truly rigid, unchangeable, stubbornly negativistic, or unresponsive to skilled concern. They are likely to be hurt easily or to be wary of situations in which their limitations or presumed unacceptable will be painfully exposed. The psychiatrist must avoid being overprotective; at the same time, he will help to assess both the personal assets and fixed limitations of his aged patient and gently but firmly guide him to utilize his assets and to help him and those around him to recognize and more comfortably accept and circumvent the irreversible defects. The psychiatrist will work toward removing intrapsychic, physical,
REFERENCES


REFERENCES


42. Goldfarb, Alvin I.: Unpublished data from the Office of the Consultant on Services for the Aged, New York State Department of Mental Hygiene, on a continuing survey of 1,000 aged institutionalized persons.


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PSYCHIATRY AND THE AGED


SUGGESTED READINGS

The literature dealing with psychological and psychiatric aspects of aging is now extensive. References in the text have been chosen in part on the basis that they may lead the reader to previously published papers through their references and bibliographies. In addition to the sources cited above, there are a large number of source books and works of historical interest with bibliographies that can help direct the student to the areas of his special interest as well as favor serendipity. Some of these works are listed below, with no intent of presenting a complete or even representative bibliography.


The following journals regularly include papers of psychiatric interest.

Geriatrics, devoted to the diseases and processes of aging; published monthly by Lancet Publications, Inc., Minneapolis, Minn.

Gerontologist, featuring theoretical articles, review papers, historical contributions, and accounts of current projects; published quarterly by the Gerontological Society, St. Louis, Mo., an organization devoted to research on aging.

Journal of the American Geriatrics Society, official journal of the Society; published monthly by the Williams & Wilkins Co., Baltimore, Md.

Journal of Gerontology, containing reports on current investigations; published quarterly by the Gerontological Society.
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<td>Urban America and the Planning of Mental Health Services—November 1964</td>
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