Mental Health and Aging: Approaches to Curriculum Development

Formulated by the Committee on Aging
Group for the Advancement of Psychiatry

Mental Health Materials Center
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STATEMENT OF PURPOSE

THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields 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 1946 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 fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and 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.

MENTAL HEALTH AND AGING: APPROACHES TO CURRICULUM DEVELOPMENT was formulated by the Committee on Aging, which acknowledges on page xii the participation of others in the preparation of this report. The members of this committee are listed below. The following pages list the members of the other GAP committees as well as additional membership categories and current and past officers of GAP.
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The Committee on Aging had the assistance of many GAP members, guests, and consultants in preparing this monograph. We are especially indebted to members of the GAP publications committee whose critiques of drafts helped us with revisions.

The need for a monograph on curriculum development in geriatric psychiatry became evident during the chairmanship of Prescon W. Thompson, and the project was completed during the chairmanship of Charles M. Gaitz. Margaret McKenna, and Mark Kline. Ginsburg Fellows, made strong contributions as did Jack Weinberg before his untimely death. Dr. Mohsain Essa, while a Fellow in geriatric psychiatry at the Texas Research Institute of Mental Sciences, contributed to the early drafts. Special thanks go to the other GAP members who helped in our formulations, and special appreciation to Carolyn B. Robinowitz, Eugene B. Feigelson, and James S. Eaton Jr. Stanley J. Brody of the University of Pennsylvania, who served as a consultant, was very helpful in viewing the monograph from the perspective of community medicine and social work as well as preparing a portion of the annotated bibliography. Sidney Gimpel of Sandoz Pharmaceuticals worked with the committee, giving useful advice based on his many years of experience with psychiatrists and other mental health professionals. Finally, we express our appreciation to our other colleagues and teachers who contributed to our conceptualization of the needs of patients and therapists and the teaching techniques that will enable us to improve the quality of care and life of the elderly.

Charles M. Gaitz, Chairperson
Committee on Aging

DEDICATION

Jack Weinberg was a member of our Committee as well as President of GAP when he died. Jack was a good friend of many of us—he was our teacher, our mentor, our advisor, a good friend of the elderly, an advocate at all levels of government and professional organizations of training, research, and service to older adults. His death was untimely and unexpected; he was 72 but acted and lived like he was 50. One of his last wishes was to see this monograph completed. It was accepted by our Publications Committee a few weeks after Jack’s death. We will miss Jack, are grateful to him for all he has done, and especially wish to remember him on the occasion of the publication of this GAP report.

Jack’s interest in working with older adults was not a chance choice. These selections never are. Jack was born in the Kiev area of the Ukraine. There were pogroms in Jack’s town and when the alarm was sounded, everyone in the family had his or her responsibility to insure that whatever and whoever could be protected would be so shielded. Jack’s task as a child was to lead his older blind grandmother to a safe place, where she would be unharmed until the pogrom was over. Jack learned his empathy for the elderly at an early age—it became his life pursuit.

We wish to dedicate this pioneering report to Jack Weinberg’s memory and his many contributions to the field of geriatric psychiatry. Jack, you are gone but not forgotten.

Committee on Aging
PREFACE

This monograph strongly urges the inclusion of geriatric psychiatry in the curriculum of training residents in psychiatry. It is not a textbook of geriatric psychiatry nor was it intended to be. Although it is written specifically for directors of training in psychiatry, the concepts and their application will also interest psychologists, social workers, nurses, occupational therapists, recreation therapists, and others who are likely to be involved in the direct care of elderly persons.

The monograph has been prepared to serve as a resource guide and provides theoretical and practical information regarding the organization and content of a training program. Part I includes A Perspective on Aging and the Aged, and discussions of Program Format and Curriculum. Part II provides listings of Education Program Components. We intend, in the near future, to prepare a casebook to serve as a guide illustrating alternatives in patient care.

Implementation of all recommendations is not likely but the broad perspective and coverage will enable directors of training to select those aspects they believe to be especially important and feasible in their settings. It is all but impossible to establish a priority regarding issues of content, methods, and training sites. These may be resolved by such determinants as faculty and student attitudes, and availability of resources.

The annotated bibliography should be especially helpful and time-saving. The introductory portions of the monograph should stimulate interest, and convince teachers and students that special training in geriatric psychiatry results in benefits to both therapists and patients. Work with elderly patients can be gratifying once resistances are overcome and therapy undertaken. The sections describe alternatives, and should help trainers delineate aspects uniquely applicable in individual residency training programs.

PART I

"It has long been an established truth, that literary men (other circumstances being equal) are longer lived than other people. But it is not necessary that the understanding be employed upon philosophical subjects to produce this influence upon human life.

Business, politics, and religion, which are the objects of attention of men of all classes, impart a vigour to the understanding which by being conveyed to every part of the body, tends to produce health and long life."

A PERSPECTIVE ON AGING
AND THE AGED

GENERAL CONSIDERATIONS

Myths, misinformation, and inconsistencies dominate discussions about psychiatry and the elderly. There are more than twenty-five million people over 65, but they are often discussed as if there were a single typical older person, and they are all alike. So prevalent is this reductionistic approach to older patients that the admonition of H.L. Mencken is a good point of departure. To paraphrase, Mencken points out that, while for every complicated problem there is a simple solution, that simple solution always fails. Simple “solutions” in addressing the psychiatric needs of older persons are not really solutions at all, and this fact should be kept in mind when designing psychiatric training programs.

Discussions about the need for geriatric content in curricula often begin with ethical considerations. That the elderly have the highest frequency of mental disorders of any age group, but are the part of the population least likely to be seen by mental health specialists, highlights the point. Psychiatric services are often not available to many older people. Medicare benefits for psychiatric care are limited, and very little help exists in the form of geriatric community psychiatry or consultation to nursing homes. The effects of such neglect are heightened by the rapid increase in the number of elderly people.

In a broader social context the situation of older people in America has been called a crisis in slow motion—a crisis which has been building for more than seventy years and which will continue for the next fifty years. In effect, one is dealing with an
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historically new phenomenon, a new population within our very midst. This is reflected in census data which reveal that in the year 1900 only three million (four percent of the population) were 65 and older. By 1975, 22 million (ten percent) were in this age group. By 2010 the elderly will number 33.2 million, and by 2030, because of the post-World War II two-decade baby boom, 51.6 million will be 65 and over. All of those who are going to be 65 and over in 2030 are alive today! The average life expectancy has increased from 49 years in 1900 to over 71 in 1975. The crux of the problem lies in the gap created by rapid growth of the over 65 population and the accompanying failure to develop necessary and appropriate social structures, support systems, community services, and research and training programs to meet their needs.

This situation, however, does have practical and scientific significance as well as ethical dimensions. From a practical standpoint, the elderly represent the fastest growing part of the population, the age group with the greatest prevalence of mental disorders, and a group that at age 65 still has a long life expectancy. As the aged experience better physical health and receive improved third party insurance coverage, psychiatrists will need to be prepared to respond to increasing service demands by older patients.

From a scientific standpoint, research with the elderly can provide opportunities for gaining new clues about basic clinical problems. For example, study of the elderly might contribute to recent theories which attempt to tie together family, psychosocial, environmental, genetic, and neurochemical factors in the production of schizophrenic symptoms. Important clues about the basic disorder of schizophrenia may be available in those who first experience it in later life as paraphrenia. Also, perhaps new insights into the etiology or treatment of manic-depressive disorders might be developed by studying changes in clinical pictures that may accompany aging. There are also benefits from the study of how certain treatment modalities affect mental illness in later life. For example, the extrapyramidal side effect of dystonia which occurs at times with phenothiazine use is much less likely to occur in older adults than younger ones, but tardive dyskinesia occurs more frequently. An understanding of such differences, as well as other age-related responses to drugs, could lead to more information about drug action independent of age at the same time that it helps us understand neurophysiological changes which occur with age.

Despite these myriad reasons for working with the elderly, residency training in psychiatry rarely includes sufficient training in geriatric psychiatry. Part of this lack is due simply to curricular, administrative, and time restrictions as discussed in "Geriatrics and the Medical School Curriculum." It takes time, money and willpower to change a curriculum. Many staff members and educators are apathetic about the elderly. They are not aware of the favorable prognosis with most older people and the scientific work being done in the field. There are also realistic time restrictions. Finally, there are administrative decisions, such as when to offer such training during the residency period. If courses and clinical experience in geropsychiatry are offered late in the residency, residents often have developed biases that are difficult to change.

Other reasons for negative attitudes in working with the elderly are discussed in THE AGED AND COMMUNITY MENTAL HEALTH. The aged arouse the psychiatrist's fears about his or her own old age. The psychiatrist may feel that since the old are nearer to death than the young, they are less deserving of attention. Moreover, if the patient dies while in treatment, the psychiatrist may feel that his efforts have been wasted. The elderly also stimulate conflict about the psychiatrist's relationships with parental figures. The psychiatrist may erroneously believe that he has nothing useful to offer older people because he cannot change their behavior, or he may regard them all as "senile." He may believe that his psychodynamic skills will be wasted on the elderly. Finally, the psychiatrist's colleagues may be unsupportive or even derisive in response to his efforts on behalf of aged patients.
Underlying all these factors is the basic attitude of the mental health profession toward the elderly. Freud, for example, had this to say about psychoanalytic treatment and age.5

The age of patients has this much importance in determining their fitness for psycho-analytic treatment, that, on the one hand, near or above the age of fifty, the elasticity of mental processes, on which the treatment depends, is as a rule lacking—old people are no longer educable—and, on the other hand, the mass of material to be dealt with would prolong the duration of the treatment indefinitely.

Curiously, Freud wrote this in 1905 when he himself was near fifty, at the beginning of a period during which his own mental processes seemed most elastic, and at a time when he seemed "educable" and productive. Ironically, too, some of the major influences upon Freud should have made him reconsider his thoughts about old people. In a discussion with Ernest Jones, Freud commented that OEDIPUS REX was the greatest masterpiece of all time. Freud apparently saw in OEDIPUS REX the most brilliant dramatic portrayal of the Oedipus Complex, one of the cornerstone concepts of his then pioneering psychoanalytic theory. What Freud did not acknowledge, however, was that Sophocles was in his eighth decade, seventy-one years of age, when he wrote OEDIPUS REX. Freud also expressed to Jones that THE BROTHERS KARAMAZOV was the greatest novel ever written and went on to say that there was "no chance" in the fact that Dostoevsky's work treated the "same theme" as Sophocles's OEDIPUS REX. Again, one wonders whether Freud knew that Dostoevsky was approaching his sixtieth birthday when this masterpiece was completed.

About fifteen years after Freud expressed these views on old people, Karl Abraham wrote a paper on "The Applicability of Psychoanalytic Treatment to Patients at an Advanced Age":

Abraham went on to say:

The prognosis in cases even at an advanced age is favorable if the neurosis has set in its full severity only after a long period has elapsed since puberty, and if the patient has enjoyed for at least several years a sexual attitude approaching the normal and a period of social usefulness. The unfavorable cases are those who have already had a pronounced obsessional neurosis, etc., in childhood, and who have never attained a state approaching the normal in the respects just mentioned. These, however, are also the kind of cases in which psycho-analytic therapy can fail even if the patient is young. In other words, the age at which the neurosis breaks out is of greater importance for the success of psycho-analysis than the age at which treatment is begun. We may say that the age of the neurosis is more important than the age of the patient.

Abraham conveys not only a sense of therapeutic optimism and personal gratification in working with older patients, but stimulates as well a number of basic questions about the factors which influence the course of, and the prognosis for, mental disorders. Such questions cannot be addressed adequately without attention to age. Once it is possible to understand
people psychodynamically it becomes easier to see the ethical, practical, and scientific advantages in the treatment and study of older people. The recognition of these values prepares the way for inclusion of a focus on aging in the core psychiatric curriculum.

FACTS AND FALSE ASSUMPTIONS ABOUT THE ELDERLY

Psychiatrists working with elderly persons quickly discover that stereotypes clutter their opinions and attitudes. Ideally, these should be exposed and shattered earlier in their careers, and certainly during residency training. Once the core curriculum has been changed, the geriatric rotation may well provide the resident with some interesting surprises. First, stereotypes will be shattered. A few examples follow.

Intellectual functioning — A widely held opinion is that intellectual decline is an inevitable concomitant of aging. In reality, extensive research, including longitudinal studies, have found that older persons who maintain their general health and keep intellectually active in later life for the most part experience little significant cognitive decline with aging; indeed many continue to grow through ongoing accumulation of new understanding. There is a subgroup of older people who develop mild, nonprogressive memory loss and/or intellectual impairment which has been referred to as "benign senescent forgetfulness." But this more typically occurs late in old age, and not by the majority of the elderly. This is not to say that in the majority of older people changes fail to occur; reaction to time, for example, slows, but vocabulary may increase. The important point is that apparent intellectual change should be evaluated as a symptom suggesting an underlying problem which may respond to treatment, rather than being dismissed as an anticipated outcome of the aging process. As a corollary, senile dementia (Alzheimer's disease) is not an inevitable development with aging. It is a disease of unknown etiology, affecting probably fewer than five to six percent of persons over age 65. It is also one of the most over-diagnosed and misdiagnosed disorders, commonly confused with illnesses in the elderly ranging from hypothyroidism to depression. Thus, while senile dementia is a devastating disease that requires considerably more clinical and research attention, it remains the exception rather than the rule in later life. Meanwhile, complaints about memory changes can be misleading. When a young adult misplaces keys or forgets a name, little attention is paid. But the same normal forgetfulness in the aging may elicit inaccurate conclusions about cognitive deterioration. Preoccupation by the older individual about failing memory more typically signals an underlying depression than dementia. Similarly, as many as fifteen percent of older patients who present symptoms of dementia actually are depressed (pseudodementia).

Longevity — Longevity issues should not be restricted to measures of life expectancy at birth. Furthermore, although life expectancy in middle age has not increased dramatically, life is certainly not nearing its end at this age. Since the average life expectancy in America is 75.3 years, a person at age 65 is not at death's door. At that age men have a life expectancy of slightly less than sixteen years and women a little more. A person who reaches the age of 75 may expect to survive an average of ten more years, and the number over 100 continues to increase. Clearly, there is ample time for most older people for both life and treatment.

Remission and brief therapy — In late life, remissions can follow exacerbations just as in the case of younger adults who suffer from a range of psychiatric disorders. Hence, the opportunity to
alleviate symptoms continues throughout the life cycle. Moreover, brief therapy can be as effective with the elderly as with the young; elderly persons have survived many crises and may need comparatively little help in mobilizing coping mechanisms. Psychodynamically, many older people have heightened insight, which facilitates the therapeutic work.

**Nursing home placement**—A common belief is that large numbers of elderly persons are too impaired to reside outside of nursing homes and hospitals. This belief is reinforced among physicians because the first clinical exposure of medical students and residents to older persons is very often to a hospitalized sick and debilitated population, confirming the skewed image of the elderly. Frequently they are viewed as a group in transit to an institution. But at any time, only five percent of the over 65 age group are institutionalized (4 percent in nursing homes, 1 percent in hospitals). Ninety-five percent—more than 20 million people age 65 and older—are at this moment not in these institutions but in the community. It is crucial that the five percent not be confused with the 95 percent.

**Concern about death**—Most elderly persons have had a number of acquaintances who have died. Fear of and preoccupation about death, except in those with a terminal illness, is not the rule in later life, but may reflect an underlying depression associated with an important loss, either of a loved one or of self-esteem. Actually, concern about death is more typical in the middle years, when one often first becomes profoundly aware of his mortality. In late life, the denial of death once again sets in, often as a constructive defense mechanism allowing the elderly person to move on through life with less anxiety.

**Sleep**—Older people do not necessarily require less sleep than younger adults. While there are REM and other stages of sleep changes with aging, other differences may reflect disorder rather than new age specific patterns. Hence, just as with younger individuals, early morning awakening may signal depression, and difficulty falling asleep may point to anxiety in the older adult.

**PSYCHODYNAMIC CHALLENGES AND OPPORTUNITIES FOR CREATIVE WORK**

If clinicians rely on stereotypes of aging, they will erroneously assume that elderly psychiatric patients will have dull, monotonous, repetitious histories. Actually, the range of case material provided by the elderly is as diverse and challenging as that of any other age group. The three case examples which follow illustrate both the rich clinical data elderly patients provide and also the potential for effective intervention.

**Case 1**—An 82-year-old woman was referred for an evaluation to consider a nursing home placement. Memory changes were described as being so severe she could not even recall the death of a daughter two months earlier. Constant fatigue and poor appetite were also described. Her “senility,” as it was called, was getting worse.

The woman was evaluated initially in her apartment. When a family portrait was presented to her, she gave a fairly good history for each person in the photo except one—the recently deceased daughter—for whom she appeared to have no recall. Thirty minutes later, however, the woman broke into tears, explaining that her daughter had visited her daily for years until she had died suddenly and unexpectedly from a heart attack. Further discussions revealed that the patient had become extremely dependent on the daughter, whose death left her with mixed feelings of grief and anger. Unconsciously, she experienced her daughter’s death...
as a form of abandonment. Unable to deal with the anger, she repressed the death of her daughter and became depressed.

Physical examination and laboratory studies revealed dehydration, an iron deficiency anemia, and a low grade duodenal peptic ulcer. The consultant considered that, in addition to her symptoms of depression, anemia was probably contributing to her fatigue, the ulcer to her appetite problem, and the dehydration, with associated electrolyte imbalance, to an acute brain syndrome which aggravated her memory disturbance. A combination of medical care, social service involvement, and psychotherapy brought significant improvement in her overall health and functioning over the next year and enabled her to remain in her apartment.

The case is interesting because it demonstrates the challenge of differential diagnosis often found in work with the elderly, and because it shows the importance of comprehensive psychological, social, and physical assessment in the treatment and follow-up care of elderly persons.

Case 2: A 78-year-old woman came to an outpatient clinic demanding to see a psychiatrist. She had found herself getting increasingly angry and annoyed, and she felt it was time to do something about it. She had also previously been deteriorating of vision over the past few years; the decline had not been halted despite extensive ophthalmologic intervention, including surgery.

Not long into the initial interview the psychiatrist became the object of her anger. The patient said she doubted the psychiatrist could do anything about her state of mind, and that the doctor was probably incompetent anyway. It became apparent that the patient was repeating in this new relationship what had recently occurred in other relationships: she would approach persons for help, only to berate them and drive them away. Her severe visual impairment had placed her in the position of needing considerably more help from others than ever before, and stirred up long-standing conflicts about dependency. She had always seen herself “in the driver’s seat,” and would strive to turn a situation where she was passive into one where she could be active. She had several living siblings, many of whom had invited her to visit, but she consistently responded with “Who wants a blind lady?” and said she “was not accepting any invitations.”

Despite her difficulties, she continued to display a tremendous degree of energy, initiative, and resourcefulness. For example, this 78-year-old nearly blind woman on her own used public transportation two nights a week to attend a course offered by an inner city university. What was especially unusual was the course she selected to attend—“How to Become a Funeral Parlor Director.” When asked by the psychiatrist why she was taking the course, she replied, “To perform your funeral!” Her actual loss of vision, “the lights going out,” symbolized death to this woman, and as had been her pattern, she responded with an attempt at action, saying she was “going to get the upper hand on death, gain control over it, by learning how to be a funeral parlor director.”

Over a two-year period, individual psychotherapy helped the patient better handle her feelings and her behavior in those situations in which it was realistic and appropriate for her to depend on others. Her considerable energy and resourcefulness were constructively channeled, and she came to terms with her anger as she worked through the transference issues with the therapist. The therapy objectives involved dealing with the patient’s rage around her dependency both within and outside the framework of the transference. A turning point had clearly been reached when she accepted an invitation to visit her family.

In addition to illustrating the need to separate external dependency needs from internal dependency conflicts in later life, this case also reflects the capacity to respond to crisis and to grow even late in the life cycle.

Case 3: A 66-year-old man was discussed in consultation with the resident manager of a senior citizens housing project. The man
was described as bizarre and very provocative. The manager expressed the belief that it would perhaps be better for everyone if he no longer remained in the building. His behavior disturbed other residents. For example, when he walked through the building he would be seen sprinkling perfume on himself, tapping pennies to his wrists, and touching a Bible and a bar of soap to his lips.

The psychiatric consultant explained to the manager that the bizarre traits of this man were symptoms, that symptoms are usually signals of underlying problems, and that people under stress sometimes indirectly give out messages seeking help in the form of symptoms. The psychiatrist further suggested that the next time the manager meets the man she ask him how he is doing, and she might inform the man that she had been concerned about him and wondered if he would like to talk to a doctor who comes to the clinic to help people with their worries and other problems. To her surprise, when she carried out the suggestion, the man accepted her recommendation to see a psychiatrist.

When interviewed, the man presented the previously described appearance and demeanor. Not long into the interview the meaning of some of his symptoms became clear. He described hallucinations of smell which he attempted to dilute by sprinkling perfume on himself. He expressed considerable guilt about sexual fantasies he had about women other than his wife, who had become nearly bed-bound with illness and physically unattractive to him. His bizarre way of dealing with this guilt was to attempt to control and cleanse his thoughts with the Bible and the bar of soap on his lips. Understanding the significance of the pennies taped to the man’s wrists was considerably more difficult and challenging. The therapist noticed, however, that whenever the older man would talk about the terrible odors he smelled, he would rub the pennies. The therapist began to see the association and to recognize the significance of this symptom:

another name for a penny is a cent which in the primary process thinking to which he had regressed was equated to the homonym scent. The patient’s primitive symbolic approach to gain control over his olfactory hallucinations was to smother these scents (cents) under tape on his wrists and use the perfume and soap. Meanwhile, comprehensive medical evaluation disclosed no organic basis for the symptoms.

While details of these therapeutic discussions were not shared with the manager of the building, she was told that this deeply troubled man was tormented by his terribly distressing hallucinations of smell which he tried to control in the ways described above. The manager’s uneasiness about the man, largely due to her fear of the unknown, was replaced by compassion and concern. In further consultation sessions with her, such topics as the nature of chronic illness, including severe emotional and mental problems, were discussed. The manager was able to recognize her tenant’s problem as a chronic psychosis and came to understand the implication of this diagnosis.

This case highlights the role of community in relation to the mentally disturbed. Over the subsequent ten-year period the management of the building changed six times. Each new manager “rediscovered” this man, seeing him as an urgent problem who would probably require placement into another setting. The psychiatric consultant intervened in each instance, and the individual still remains in the building. He voluntarily seeks periodic check-ups for psychiatric support and psychotropic medication. His behavior is now better understood and he receives support from management and from his neighbors, with benefit to all.

These clinical examples illustrate how geriatric psychiatry can be of value not only in diagnosis and the treatment of older adults, but also to their significant others whose support is often essential in their care.
EVALUATION, DIAGNOSIS AND THERAPY OF THE ELDERLY

Aging and adaptations to life

A crucial component in the treatment of the elderly is the therapist’s knowledge of the normal, healthy aging process. Without such knowledge, the therapist is less able to identify actual illness in the lives of older people. Similarly, it is important to keep in mind the range of opportunities, problems, crises, and issues that are often manifested in old age.

In order to differentiate deviation and pathology from the normal reactions to aging, the therapist should understand the baseline characteristics of the usual and customary behaviors, feelings, and psychological mechanisms of the elderly. These “normal” characteristics involve description, understanding, and awareness of how underlying tensions express themselves at different points in the life course. In order to establish such baseline data, ideally the student should have contact with nonpatient elderly. Unfortunately there are many stereotypes about the elderly—the chief one being that all of them are ill. This is not true; aging is not the same as being a chronic patient. Psychological complaints and tensions can manifest themselves through somatic discomforts, but these need not constitute disease processes.

During the life course there is a sense of continuity and flow. Elderly persons who have made prior satisfactory adaptations to earlier life crises and developmental advances are likely to view their future life course realistically and with hope of ongoing satisfactions. This view involves the maintenance of values and goals, support systems from relatives and friends, adequate sources for leisure activities, sufficient economic resources, and good health. Crises do occur as one gets older, and losses of various kinds are inevitable, but past success in dealing with previous discontinuities will usually allow the older adult to deal capably with future traumas without pathology.

Losses of key family members and friends, of occupation and vocational activities, of work associates, and of physical and sexual vigor are challenges but do not necessarily lead to illness and psychopathology. Various defenses and coping strategies are used to deal with these traumas of aging. If the traumas are too overwhelming, if they seriously threaten the integrity of the ego and the self, or if external circumstances are too disruptive, treatment is necessary. The therapist should understand what is ongoing, the strain on internal and external resources, and how much pathological deviation has taken place. Diagnosis, evaluation, therapeutic intervention, and prognosis then can be considered for the individual in his or her unique circumstances. Therapeutic considerations involve physical assessments, the anxiety levels and their sources, and the capacity to deal with stress. Also to be considered are the patient’s social participation, involvement in family and community, and sublimations. It is important for the patient to recognize that he or she is not inevitably alone, helpless, isolated, and hopelessly incapacitated. New attachments and ongoing activity can help to facilitate adaptations to ongoing life. Intellectual, social, emotional, and physical stimulation are vigorously sought by the elderly who manifest the healthiest and most successful aging. This stimulation can be achieved by modifying job activities or avocational interests, or by returning to interests which had been put aside earlier. Community service, voluntary or compensated employment, and contacts with younger people enhance self-esteem and allow the older adult to feel a continued sense of usefulness. Particularly important is the maintenance of intergenerational ties with significant others.

Older persons continue to have a rich and full inner life. They dream, have creative and fulfilling fantasies and activities, are filled with important experiences, and have wisdom. They can be insightful about themselves and about others. Remembrances,
introspections, and appreciation of personal conflicts that are either repetitive or new can help in understanding the maladjustments of everyday later life.

The therapist's respect for and appreciation of the older person's feelings of frustration, anxiety, anger, guilt, rage, shame, and humiliation can be extremely helpful. Recognition of the ongoing concerns of the older adult can assist in dealing with increasing normal infirmities and incapacities. Successful aging does not mean that all is positive, that all is trouble-free, that all is healthy. The maintenance of a balanced perspective enhances the possibilities that one can adapt to the new circumstances involved in the normal losses and changes.

If the clinician has an appreciation of these factors, she or he can appropriately assess deviations from the normal and hence make appropriate diagnoses of the pathological, and can determine what, if anything, can be done to alleviate the ills of those who need help.

**Mental disorders and crises**

To separate illness in later life from the normal changes of aging, it is important to know the scope of disorders and crises that can confront older adults. For the sake of expediency, major problems and issues will be presented below in outline fashion. Keep in mind that epidemiologic data with any age group can be misleading, which points out the need for further research as much as for better clinical understanding. A case in point is in the prevalence of depression in the elderly, where, depending on whether depression is identified by survey or by clinical diagnosis, reports of the frequency of the disorder vary from six to sixty-five percent. Further findings follow:

- Mental illness is more prevalent among the elderly than among younger adults. Seven studies to date show that 18 to 25 percent of older persons have significant mental health problems; these studies indicate that about 10 percent of older people have neurotic disorders.

- Suicide is more common in the elderly than in any other age group.

- Psychosis, the most serious form of mental disorder, increases significantly after age 65—even more so beyond 75; it is more than twice as common in the over 75 age group as in the 25- to 55-year-olds.

- Senile dementia is considered by some authorities to be the fourth leading cause of death. It causes brain failure which, in turn, makes one more vulnerable or less adaptive to organ dysfunction elsewhere in the body.

- Eighty-six percent of the elderly (more than twenty million) have chronic health problems of all causes; the problems of four million result in serious impairment. Many of these older people experience significant psychological reactions from stress caused by losses of health.

- The psychiatrist who works with the elderly must be aware of the capacity of many physical illnesses to cause and even present with mental disturbances. Rates of organic mental disorder in the elderly, which may range in their manifestations from mild cognitive impairment to psychosis, have been estimated at two to twelve percent in various studies.

**Service delivery issues**

Complicating these health problems are a set of crucial service delivery and social issues.

More than eleven percent of the population are 65 and older, and the prevalence of mental disorders among them is greater than among younger adults. However, at best only four percent of patients seen at public outpatient mental health clinics are 65 or older; fewer are seen in private clinics. Furthermore, if the time devoted to the elderly in these clinics were to be measured, the data would probably indicate that less than one percent of the total time given to patients would be provided for older people. Younger patients are usually seen at least weekly, while the average older individual is seen only for consultation or possibly for infrequent follow-up visits.
Although the elderly are underserved at outpatient clinics, a staggering thirty percent of public mental hospital patients are over 65. This has, in part, been due to skewed Medicare coverage with limited reimbursement for outpatient care, as well as to shortcomings in other reimbursement and support programs as they relate to the elderly.

More than a million people (5 percent of those over age 65) are in institutions (nursing homes and hospitals), with another three million at risk. The risk of institutionalization increases with age from five percent of the 65-plus, to ten percent of the 75-plus, and to twenty percent of the 85-plus. The absence of an adequate number and range of alternative living arrangements has made inappropriate nursing home placement unavoidable for many older citizens. Meanwhile, the nursing home industry grows, consuming over twenty billion dollars annually by the early 1980s. While at any one point in time only five percent of the 65 and older are institutionalized, the risk that someone in this age group will spend a long or short period of time hospitalized or in a nursing home is one in five.

Social problems

Social problems that can affect mental health or the handling of mental illness can be appreciated from the following:

- The impact on the family is significant, especially since an increasing number of the aged's children are themselves senior citizens.
- The opportunity for man-woman relationships diminishes with age due to differential mortality rates. At age 65 there are four women to every three men; by age 85, women outnumber men two to one. Seventeen percent of men 65 and older are widowed, 30 percent in the over 75 age group. With women, 54 percent age 65 and older are widowed, a startling 70 percent of the over 75 age group have lost their spouses.
- Isolation causes obvious problems; 13.4 percent of men over age 65 live alone; 32.4 percent of women 65 and older live by themselves.
- Sixteen percent of the elderly are below the poverty level; another sixteen percent are just barely above it.
- To the extent that basic quality of life components such as adequate housing and transportation to access one's community are lacking, self-esteem, stress level, and social engagement are all adversely affected.
Geriatric psychiatry should be an integral part of the graduate education of psychiatrists, and not treated as elective material. Elderly patients tend to benefit most from treatment by psychiatrists experienced in working with older people and familiar with some of their relatively unique problems. The primary goal for these educational experiences, therefore, is to train adequate psychiatric manpower to provide appropriate diagnoses and treatment (both direct and indirect) for elderly persons. A shortage of adequately trained and skilled personnel is a major contributing factor to the underservice and inappropriate service of the elderly. Elderly patients should receive diagnoses based on history, signs, and symptoms; treatment should be based on the diagnosis, need, potentialities, and resources available. Chronological age should not be the decisive factor for determining treatment, although age and other factors influence the approach to treatment. How geriatric psychiatry is incorporated into general residency training programs in psychiatry is a matter of individual choice, and availability of faculty and facilities. Although there are general goals, program directors modify their programs to take advantage of the specific opportunities in their setting. The educational experiences discussed below are designed to meet these goals.

All educational efforts can be described in terms of the knowledge, skills, attitudes, and behaviors to be achieved. Thus, psychiatrists need sufficient knowledge to be able to understand and recognize the biopsychosocial phases of adult development, including normal variations as well as deviations. They should know and recognize the signs and symptoms of physical and mental illness in the elderly and know how to differentiate between organic and functional conditions, recognizing the interplay of psyche and soma. They should be aware of special problems of the elderly (e.g., sensitivity to medication) and gain knowledge of, and experience in, the various modes of psychiatric therapy for the elderly.

This knowledge leads to development of skills in assessment and treatment of elderly patients and also in work with other health and mental health professionals and social agencies. Students develop skills in indirect care (case and program consultation, program planning and development, and supervision of services networks) as well as direct care.

Examination of attitudes is an essential component of any educational program. While lack of knowledge can contribute to misdiagnosis and mismanagement of the elderly patient, caregivers (including training program directors, teachers, and supervisors) must be convinced that elderly persons deserve care and that care can work! Thus, programs should offer opportunities designed to demonstrate that working with elderly people can be a satisfying and constructive experience and that age is not the critical factor in predicting outcome of treatment of many psychiatric disorders.

Once the need for residency training in geriatric psychiatry has been acknowledged, the specific components of that training program must be established. The scope can, of course, be as broad or as narrow as overall priorities or funding dictate.

**METHODOLOGY**

There is an immense amount of knowledge in geriatric psychiatry. While theory can be learned from lectures, seminars, journals, and texts, the goal of applying knowledge to changes in behavior requires more experiential approaches designed to promote attitude change, comprehensive understanding, and skill practice.
Knowledge of a nerve muscle in the laboratory is not an adequate knowledge of physiology, nor is the knowledge of psychodynamics of the repressed unconscious an adequate knowledge of human motivation and behavior. Teaching psychiatry as a medical specialty is in itself one of the most comprehensive tasks in the field of medicine because of the multiplicity of biopsychosocial factors which may have to be taken into account in the diagnosis, treatment, and prevention of mental disorders. A comprehensive, fully adequate knowledge of aging is not yet available—either of physiology or of psychology—but efforts toward comprehensive integration of what is available are both useful and necessary.

The material for the study of personality is largely clinical: people in hospitals, clinics or offices, or in their homes. Yet, life in the hospital ward does not represent the fullness of living. A student may acquire a good grasp of a conceptual model of human behavior well suited, for example, to understanding the origin of paranoid thinking in an elderly person, yet that student needs further instruction to bring this bit of theory into practical focus, to understand how an obsessed person may still be able to manage a household and her daily affairs. Living knowledge of the mechanism of neuronal, cardiovascular, and musculoskeletal functioning, as well as the process of sentiment formation and ego defenses, needs to be worked into a comprehensive perspective to eliminate or reduce the distortions inherent in the special learning situation.

Teaching geriatric psychiatry does not require the development of new techniques. Depending on local facilities, interests, and talents, different approaches can be used to impart this body of knowledge and influence attitudes about aging and aged persons. Effective methods of teaching are already available, and much can be adapted from experience acquired in teaching residents to care for children, adolescents, and young and middle-aged adults. Quantitative rather than qualitative aspects probably deserve consideration. For example, proportionally greater attention is needed to overcome resistance and negative attitudes stemming from a culturally-determined prejudice against aged persons; to that end, considerable effort should be expanded to demonstrate the “treatability” of persons who happen to be chronologically old.

Both educators and students should be sensitized to what life is like when there are motor and sensory impairments; this can be accomplished by literally spending time in a wheelchair, navigating under diminished vision, and communicating in the environment characteristic of those with hearing impairments. A variety of simulations, role-playing exercises, and learning situations have been developed to achieve these goals. Although faculty and students may be initially hesitant to participate in these exercises, they can be amazingly helpful once the initial reluctance is overcome. They support the development of understanding and empathy (participants really “know” what it feels like), provide a safe place to confront anxiety and other strong feelings in graduated doses without the fear of harming a patient and can be used as a series of building blocks to deal with issues and affect, as well as transference/countertransference, often with humor (this is funny) and at a “safe distance” (it’s just pretend).

Learning by doing is, nevertheless, probably the most important learning technique. The personal experience of treating elderly persons is vital for attitude change and skill development. However, providing care for elderly persons, even in a variety of settings, is not enough. While a clinical setting offers the laboratory for learning, students and teachers alike need to deal with their own feelings about age and aging. Open discussions about relationships with parents, grandparents, and patients who are chronically ill and perhaps dying are helpful in this regard. These discussions combined with efforts to look at personal feelings and fears about aging, sickness, and dying can modify resistances to work with elderly patients.

The care of elderly persons gives residents an opportunity to learn more about themselves, particularly the impact of
culturally determined attitudes on influencing the therapist's role in therapeutic relationships. Such possibilities, of course, exist with patients of all ages, but working with the elderly will make the realization especially clear, in part because the negative stereotypes of aging are so obvious in our youth-oriented society. Elderly persons are likely to have a complex interaction of social, psychological, and health factors. Residents working with them have an opportunity to understand how they respond to patients with a multiplicity of problems, particularly when they can provide care but not cure. This experience is analogous to working with children, particularly those with multiple handicaps, and involvement with parents and other family members.

Sharing experiences offers opportunities for residents and teachers to look objectively at themselves and their patients and, in turn, leads to the development of more positive attitudes about working with elderly patients. Discussions with teachers and actual work with elderly persons provide opportunities for residents to learn that stereotypes and prejudices often interfere with forming a therapeutic alliance with patients, regardless of age. This knowledge can be of benefit as it influences attitudes not only about caring for elderly persons but also about patients with chronic illness, poor prognoses, and certain other characteristics that traditionally lead to rejection and therapeutic nihilism. Enlightened, openminded psychiatrists given the opportunity to work with elderly persons will accept age and other variables as challenges, not as rationalizations to explain why some of the patients who are most in need of help have been ignored.

Residents should have opportunities to work with patients in a variety of service facilities. They may already realize that comprehensive care of mentally impaired persons requires attention to a variety of factors affecting both the development of an illness and its resolution; social, psychological, and physical health factors play an important part, regardless of the patient's age. Elderly persons, however, are especially likely to require comprehensive care and a broad approach to diagnosis and treatment. Not only are they likely to have physical health problems, but they are particularly vulnerable to social and psychological stresses. Only when residents are fortunate enough to participate in a comprehensive care program can they see convincing evidence of the effectiveness of such an approach. On the other hand, residents working in other limited, unidimensional settings quickly learn that failure to meet needs, whether these are social, psychological, or health, will have a bearing on the outcome of treatment. Teachers are thus given an opportunity to demonstrate clearly the shortcomings of unidisciplinary approaches and conceptualizations which result in inadequate diagnostic evaluations and treatment. While work with aged patients will make this quite clear, these experiences, in all likelihood, will influence the treatment approach to patients of all ages.

Approaches vary. Geriatric content may be treated separately or may be incorporated into already existing seminars. The necessary direct clinical contacts with older patients may occur by chance, but there will be more likelihood of success if these contacts are planned appropriately. The options reflect clinical/didactic rotations of varying durations and levels of intensity. As a beginning, for example, a resident might be assigned two or three older patients with different degrees of impairment (one or two in the community and one or two in an inpatient institutional setting) to be followed for four to six months. Levels of still greater scope and duration (e.g., one to two years of full-time work with mentally disturbed elderly) can prepare the resident for specialization in geriatric psychiatry.

Attention to aging need not be a mutually exclusive element added at the expense of other components in the curriculum. On liaison or consultation services, for example, some of the patients selected for treatment can be elderly. The elderly provide abundant case material from whom one can learn about the interplay of physiological and psychologic disorders and about drug-drug interactions. Residents engaged in group therapy can
include one or two older people (ideally a man and a woman); older people in a group may allow for the group structure to resemble more closely the intergenerational family and thereby contribute to a greater range of transference reaction among group members. As part of the resident's community psychiatry rotation, experience working with a multidisciplinary team, and doing outreach or home visits can be gained as easily with older adults as with younger ones. The possibilities of giving residents clinical experience working with elderly persons are numerous by making modest changes in program but major changes in emphasis.

Knowledge gained through work with older adults may improve the resident's skill with younger patients. Thus, an 80-year-old patient may present the therapist with an unparalleled opportunity to look at the course of early life conflicts and problems over a period of many decades—a 70-year follow-up of sorts—giving the therapist a chance to follow the clinical picture of a mental disorder across the life cycle. The older patient, as historian, can expand the resident's understanding of the dynamic interplay of disorder and development. The richness of the clinical experience and the knowledge gained will determine the value of the geriatric component of the residency.

Availability of instructors varies from one residency to another. Not every teacher has to be a member of the psychiatry faculty; faculty from other departments can be enlisted to describe and demonstrate information applicable to the care of aged persons. Psychopharmacologists, anatomists, pathologists, internists, and endocrinologists have much to contribute in teaching the facets of their specialization related to aging. Social gerontologists, psychologists, community planners, and anthropologists drawn from other university and community settings can make important contributions.

Educators have debated about when to include certain aspects of training in the overall residency training sequence. Some argue that outpatient experience and experience with normal persons should precede inpatient clinical experience. Similarly, some would argue that residents should work with children before they work with adults and elderly persons.

Consequently, some residency programs might provide an introductory didactic course on developmental changes across the life span with a heavy emphasis on the middle and late years of life. Clinical experience with elderly persons may be offered concurrently with other services. Consultation, exposure to aged persons in various settings, collaboration with community agencies, etc., obviously should be included in the training programs but the timing will depend on a number of factors, including the qualifications, experience, and availability of the residents.

It is difficult to make specific recommendations as to how much time should be devoted to geriatric psychiatry in a general psychiatry residency training program. Teaching and learning about elderly persons may occur in many settings and at many times; to what extent it occurs depends on the emphasis of the experience. An awareness of aging and its associated implications for psychiatrists should be interwoven in all aspects of training, especially because it is unlikely that a large block of time cannot be assigned to geriatric psychiatry. Nevertheless, geriatric psychiatry should be identified specifically in residency training programs and given specific time assignments even though the length and duration (part time or full time for one month, three months, or a year), will be determined by many factors. The specific assignments increase the attention given to such programs and to their credibility. When training directors become convinced of the importance of training in geriatric psychiatry, we expect that they will modify their programs sufficiently to assure achievement of the above objectives.
SETTINGS FOR TRAINING

Achieving the goals and objectives of any training program depends to a considerable extent on the teaching and learning settings. Many psychiatric inpatient and outpatient facilities are underutilized by elderly persons, especially those who are members of minority groups. Training is enhanced, therefore, when residents are offered opportunities to work with aged persons in a variety of settings such as where they live and where the potential exists for providing services. Training programs limited to the usual psychiatric facilities must take these factors into consideration when a decision is made to incorporate geriatric psychiatry.

The importance of working with older people in a natural habitat is further emphasized by observations that behavior and testing is strongly influenced by environmental factors. For example, elderly persons are inclined to be uncooperative about examinations or tests they consider irrelevant or meaningless. Overtly or covertly, they may not give them enough attention and effort. However, the usual questions of orientation, memory, and abstract thinking can be asked in the course of an interview rather than in a structured “test.” A home visit may not only give a therapist additional insight about a person’s capacities to cope with the demands of daily living but also have much meaning to the patient.

Accessibility of aging persons for examination and treatment is often a problem because of transportation problems and limited physical mobility. Residents will learn about the relationship of environmental factors to psychological adjustment by going to the settings where elderly persons live, play, and engage in a host of activities. Also the residents can acquire knowledge enabling them to make distinctions between normal and abnormal behavior and to establish some guidelines for defining mental illness in elderly persons.

Some of the settings where residents should observe and contact older people include senior citizens centers, social agencies, facilities for congregate living of relatively well aged, and health facilities other than those providing primary psychiatric service. Residents should also become familiar with long-term care institutions as a large proportion of the persons being cared for in these institutions are aged. They should learn more about the characteristics of these institutions and how these institutions can be included in the continuum of settings available to provide services to aged persons, as well as have opportunities to provide care to persons living there.

General hospitals are important settings where residents have opportunities to learn the impact of physical illness on psychological adjustment as well as the interplay of psychological attitudes, compliance and participation in treatment, and the response to therapeutic intervention. Rehabilitation centers, both freestanding or hospital units, are also important settings as more than half the patients in many centers are over 65 and present multiple physical and motivational problems. Psychiatrists often serve as members of a therapy team. Individual and group therapies and family counseling can be quite effective. In general hospitals, residents see the anxieties and conflicts of a person about to have an amputation for gangrene, and the fears that are accentuated when a patient is isolated from his family and familiar surroundings and placed in an intensive care unit for treatment of a coronary occlusion.

These residents will learn about the capacities for, and modes of, adaptation to stresses characteristic of the later years of life. Changes in physical health status, changes in social roles, retirement, loss of significant friends and relatives by death, changes necessary because of reduced financial income, reduced social contacts because of physical immobility, and the impact of impaired mental function are but some of the stresses that residents will become aware of where they work with elderly people, perhaps more so when these older people are seen in
facilities other than the usual health and psychiatric institutions.

Physicians have been criticized because they do not provide enough attention to persons residing in long-term care facilities such as nursing homes or state mental hospitals. A large proportion of the individuals in these facilities are aged and have serious psychiatric, as well as physical, health problems; yet these generally go unrecognized or untreated. Even though various social and health problems may be "solved" by placing persons in long-term care facilities, criticism of the facilities and their staffs does not resolve this lack of medical attention. Psychiatry residents who have an opportunity to work in such facilities will be sensitized to the problems faced by staff, patients, and patients' families and are likely to discover that much can be done to alleviate suffering and improve the quality of life. If psychiatrists accept responsibility for persons in long-term care institutions and combat some of the hopelessness implied in warehousing the aged and mentally impaired, significant progress can and will follow. Furthermore, psychiatrists experienced in working with patients in long-term care facilities are qualified to determine which patients require such care and which patients should be treated elsewhere.

Residents will learn that even though the provision of adequate housing for aged persons requires a wide range of facilities and services, it is an essential part of a treatment plan. Exposure to different kinds of facilities will give the resident an opportunity to observe the effect of a good match of person and environment as well as the devastating effects of a mismatch when elderly persons are living in facilities that provide either too few or too many services. Residents must learn what is available in various settings. Most importantly, they will observe that many old people are still quite independent, self-reliant, capable of caring for themselves and living full lives. (This is not to deny that some aged persons require almost total care and that long-term care institutions provide badly needed services for those who need close supervision). Providing varying degrees of support enables individuals to live in private homes or congregate living arrangements that provide only minimal support.

Learning to collaborate with family members and other caregivers, health and mental health professionals, and social and health agencies is another aspect of exposure to diverse settings. Although psychiatrists are not required to handle all the problems of patients directly, they should take a leadership role in developing a broad-based treatment approach. This can be accomplished only when the psychiatrist understands what other caregivers can contribute and has learned to work with them. Though the ultimate objective is to benefit the patient, residents will discover that sharing responsibility for the delivery of service helps them in that it reduces the demands for direct service, and allows each participant caregiver to use skills fully.

Exposure to a variety of setting will also sensitize the resident to racial and ethnic differences. Psychiatric facilities are generally underused, especially by minority aged persons, but mental health workers who make home visits or contact elderly persons at health clinics, senior citizen or nutrition centers are often able to establish rapport and make appropriate referrals for psychiatric consultation and treatment. Residents will find that persons who have needed, but not obtained, psychiatric service may be helped with simple steps, and that a home visit may be especially appreciated by a member of a minority group. A Spanish-speaking elderly person, for example, may become involved in a treatment program when approached by someone who speaks Spanish and who has the backing of a leader in the Spanish-speaking community.

In conclusion, one way to develop training programs is to tie them to specific service needs. In addition to conventional service settings, with responsibility for meeting the needs of all age groups, there has been a proliferation of federally mandated and/or supported special service settings specifically addressing the health and mental health needs of the elderly. Unfortunately, in each case, manpower and training efforts geared toward
mental health problems and prevention have been rudimentary or absent. The special sites include:

- Community mental health centers providing specialized services for the elderly.
- Nursing homes—Studies indicate over 70 percent of the patients in nursing homes, most of whom are elderly, have significant mental health problems. Despite more than 20 billion dollars spent on nursing homes, mental health manpower and training issues have been practically ignored.
- Senior citizen centers—Opportunities for prevention are particularly available.
- Housing and Urban Development housing for the elderly—It is estimated that 18 to 20 percent of older people in senior housing projects have serious mental disturbances.
- Board and care homes and single room occupancy hotels (SROs)—Many of the inhabitants have chronic health and mental health problems.
- Senior nutrition sites—Another setting for prevention activities.
- Emergency rooms and liaison-consultation services in general hospitals.
- Evaluation and assessment units in primary care settings.

Two key findings about manpower development and training in geriatric psychiatry reflect the impact that aging and mental health manpower and training efforts can have on the quality and delivery of services to the elderly.

- Several community health centers that have personnel designated to address the mental health needs of older people have found an increase of 50 to 100 percent in utilization and delivery of services to the elderly.
- Attention to training at nursing homes has significantly reduced staff turnover, thereby improving both the quality and the continuity of care.

This monograph has documented a need for psychiatrists qualified by training and attitude to care for elderly persons. Psychiatrists should know about aging and also about the unique characteristics and qualities of aging patients and of therapists that affect the therapeutic process. Working with elderly patients is effective and satisfying, but stereotypes about aging and the aged, negative attitudes, and other obstacles must be overcome.

Many options are available, and no single approach, technique, or setting is inherently better than another. Each training program must seek its own unique opportunities and personnel. Inevitably, there will be limitations in implementing a program in geriatric psychiatry that can be only a part of a general psychiatry residency curriculum.

Part II of the monograph will present a guide to learning objectives, with a focus on knowledge to be acquired and how attitudes affect treatment. Several examples of how geriatric training can be incorporated into psychiatry residency programs are given. Training directors should find the information in the annotated bibliography especially useful. Part II also offers a wide perspective and goes beyond what a single program is likely to achieve. Each program will have an individual approach—no single text or article is “ideal,” nor is any program likely to achieve all of the knowledge or attitude objectives.

This monograph should convince trainees and trainers in psychiatry residency programs that a special emphasis on geriatric psychiatry is needed and can be rewarding, and that there already exists a body of knowledge to be taught. Teaching techniques and methodology are important aspects, but it is even
The information provided in this monograph has been assembled with psychiatric training as the primary focus. Much of what is included, however, is relevant to training in all of the disciplines of caregivers who work with elderly persons. We hope that those who are responsible for curriculum development and training will share this opinion.

REFERENCES

PART II

EDUCATION PROGRAM COMPONENTS
A GUIDE TO LEARNING OBJECTIVES

The following is an inclusive listing of the kinds of information, skills, and attitudes a student should develop to work adequately with older patients. Obviously these objectives cannot be met by one course or during a short time period, but they can serve as a guide to the teacher in selecting the kinds of material and experiences which should be included.

Knowledge—The student should possess knowledge in the following areas:

1. The normal psychological changes occurring with age and the differentiation of these from psychopathologic changes.
2. Age-related histologic and chemical changes occurring in the central nervous system.
3. The study of personality and aging.
4. The common types of defense mechanisms and their use in facing the stresses of late life.
5. The effects of aging on the personality and neurotic disorders.
6. The interplay of generational and intergenerational relationships as they affect the mental health of the aged individual and family members.
7. Affective disorders as they occur in the elderly in terms of pathogenesis, classification, and clinical presentation, and the differentiation of these from dementia.
8. The etiology, presenting symptoms, and differential diagnosis of the following psychiatric disorders as they occur in the elderly:
Mental Health and Aging

a. paranoid disorders
b. schizophrenia
c. anxiety states
d. phobic states
e. sleep disorders
f. sexual dysfunction
g. hypochondriasis
h. alcohol and substance abuse
i. adjustment disorders
j. psychophysicologic disorders

9. Diseases involving cognitive dysfunction in the elderly including the pathogenesis, presenting features, and differential diagnosis of the following:
   a. delirium
   b. reversible dementias
   c. primary degenerative dementia
      1) Alzheimer’s disease
      2) Pick’s disease
   d. subcortical dementias
   e. multi-infarct dementias
   f. Wernicke-Korsakoff’s syndrome
   g. infectious encephalopathies

10. The pathogenesis and differential diagnosis of Parkinson’s disease.

11. Current research into the pathogenesis and treatment of primary degenerative dementia, including:
   a. aluminum theory
   b. genetic theory
   c. slow viruses
   d. autoimmune theory
   e. cholinergic function

12. The use of psychologic tests for evaluation of the elderly and for assessing treatment outcomes.

13. The alterations in pharmacokinetics occurring with aging and their relevance to the use of psychotropic drugs.

14. The side effects of psychotropic drugs occurring in the elderly and drug-drug interactions.

15. The patterns of drug use in the elderly including misuse of prescription drugs and over-the-counter medicines, compliance, and institutional drug prescribing.

16. The side effects of nonpsychotropic medicinals on the central nervous system.


18. The phenomenon of bereavement and its differentiation from atypical grief responses.

19. Important demographic changes occurring in the elderly population and their implications for health care.

20. Problems in delivering mental health care to the elderly and ways to deal with them.

21. The multiple causes of psychiatric stress and disturbance in the elderly, particularly regarding available human relationships, environment, housing, economic status, transportation, and access to social and medical services.

22. Risk factors for suicide in the elderly.

23. Special issues of research design and methodology as these apply to the elderly.

24. The social, economic, and emotional significance of retirement, the use of pre-retirement planning, and post-retirement activities.

25. Cross cultural differences in aging communities and their effect on care needs.
Skills—The student should possess skills in the following areas:

1. Accurate assessment of the elderly psychiatric patient. In addition to general aspects of assessment applicable to all age groups, attention should be given to such areas of particular geriatric concern as the differential diagnosis of depression and dementia, adverse drug reactions, and the interaction of concomitant psychiatric and medical problems, and the psychosocial milieu of the older person.

2. Effective psychiatric consultation with elderly patients in general medical settings and geriatric sites such as nursing homes, elderly day treatment programs, and senior citizens housing projects.

3. The development of a comprehensive problem-oriented treatment plan for elderly psychiatric inpatients and outpatients, with special emphasis on one co-existence of multiple problems of later life.

4. The use of standard psychotherapies as they apply to the older patient.

5. Appropriate psychopharmacologic management of the elderly using the standard psychotropic drug classifications, but also the various categories of agents used in attempts to enhance memory and cognitive functioning.

6. Multidisciplinary team issues as they relate to the special problems and constellation of problems in the elderly.

7. Appropriate diagnostic evaluations and utilization of indicated treatment modalities for the whole range of psychiatric disorders of younger adulthood that also affect the elderly as well as such special disorders as late-life paraphrenia, Alzheimer’s disease, and multi-infarct dementia.

8. Performance of a physical examination at the level of a primary care physician with special competence in the examination of the central nervous system and evaluation of special tests as the computerized tomography scan.

9. Utilization of referral to other professionals and services within the aging network in the community.

Attitudes—The approach of the student to the elderly patient must include:

1. An empathic, positive manner.

2. Self-awareness of attitudes toward the aged and the aging process.

3. Overcoming one’s own prejudicial attitudes (ageism), especially if they conflict with discharge of duties.

4. An awareness of countertransference issues that a student may experience in the likely young physician-elderly patient relationship.

5. Recognition of the need to share responsibility for care of patients and to accept input of other caregivers in supporting manner.

6. Overcoming undue pessimism about psychotherapy with elderly.

7. An empathic and nonavoidant approach to the dying patient and his family.
The following descriptions illustrate some of the points we have made about sites of training and methodology. As Finkel* points out, attitudes toward geriatric training are changing, but changing slowly, and as can be seen by the brief descriptions of the following representative training programs, geriatric training is taking place in a wide variety of approaches, methods, and settings. The examples given are illustrative of residency programs that currently include training in geriatric psychiatry. We made no attempt to survey all residency training programs, and, in all likelihood, other programs also offer similar experiences for their residents. We are grateful to the psychiatrists who were kind enough to report on activities in their programs as of April, 1982.

University of Pittsburgh Western Psychiatric Institute and Clinic

The Western Psychiatric Institute and Clinic has a geropsychiatry inpatient service. This is a thirteen-bed unit currently; in the next year or so it is to be increased to a twenty-six-bed unit with appropriate design and accoutrements for older people. A four-month exposure on this unit is offered to all psychiatry residents in their first two years. Residents have an option of choosing the four-month period on either the Geriatric Psychiatry or Adolescent Psychiatry Service. Consistently, two residents per four-month period choose the geriatric service. In addition to the inpatient care, an outpatient exposure is also provided. Through the Geriatrics Clinic at WPIC, the residents spend one afternoon per week offering follow-up care to patients whom they have discharged or patients who have been followed in the clinic previously. This one afternoon per week is actually a requirement for all residents. Those residents who elect the Adolescent Psychiatry Inpatient Service devote one afternoon per week of that rotation to the Geriatric Clinic. Therefore, the clinic rotation represents the minimal experience which general psychiatry residents have with geriatric psychiatry. The second additional feature of the geropsychiatry rotation, both for adolescent and geriatric psychiatry rotaters, is attendance at a seminar/lecture series. This is a once-a-week, one-hour session which they attend throughout the four-month period. The format for these meetings is a mix of lectures and seminars. The geropsychiatry inpatient experience entails an active involvement in a multidisciplinary inpatient unit. The resident handles the medication and medical care of patients as well as obtaining an active involvement in the case management of the family and community concerns of the patient. There is much to be gained in this experience for the resident in learning to function as both a leader and a member of a multidisciplinary team.

During the postgraduate year three, general psychiatry residents are given four one-and-a-half-hour lectures, tapping varied interests and expertise of faculty. Topics covered include affective disorders, organic mental disorders, psychosocial concerns, and the psychological assessment of older patients.

There are other elective opportunities available in geriatric psychiatry. Medical students may select a four- to eight-week elective. A resident may become a fellow through the NIMH-sponsored Geriatric Psychiatry Fellowship program. Through the Benedum Geriatric Center, which is a jointly sponsored outpatient facility for older patients with primarily medical and/or psychiatric problems, an academic nursing home facility may be established. This would provide additional opportunities for training.

*See citation 3 in References.
Both the inpatient rotaters, as well as the residents on the adolescent program who have had only the outpatient opportunity, have been very positive about their experiences. Because many of the residents are in their first year of training, sometimes in the first four months of their first year, a problem has been recognized; that is, the specialization implicit in geropsychiatry is a bit out of "sync" with their own priorities in general psychiatry. By the end of the four-month rotation, however, the residents usually have comfortably made the bridge between general psychiatry and geropsychiatry.

The above information was provided by Robert S. Marin, M.D.

McLean Hospital

All general psychiatry residents have a required rotation in geriatric psychiatry. This is either for the postgraduate year one residents or for the PGY-3 residents who do internship before coming to McLean.

PGY-1 residents have a two-month full time experience on an inpatient geropsychiatry ward. They are responsible for the care of four to six patients, do two or three admission interviews and physicals each week, and work intensively (two to three hours per week of psychotherapy) with one or two patients. The seventeen-bed ward admits patients sixty and over with a variety of psychiatric disorders who may also have complicating medical and neurological illness. In addition to a multidisciplinary staff of psychiatrists, psychiatric nurses, and psychiatric social workers, there is a half time internist who sees all the patients and participates in their management. A neurology consultant also sees all the patients and a neuropsychologist consults as needed. Rounds are held three times a week and there is a weekly teaching conference in which one patient is discussed in depth.

PGY-3 residents may take the two-month full time inpatient rotation or may spend six months as a one afternoon a week consultant to the geriatric team of a local community mental health center. In that role, they make home visits, nursing home visits, consult with nursing home staff, and carry out psychiatric evaluations and treatment of patients who come to the mental health center. In the next year PGY-3 residents will have the alternative of spending the six months at McLean's developing outpatient program in geriatric psychiatry. In this setting, the emphasis is on evaluations, short-term treatment and some ongoing psychotherapy.

PGY-4 residents have the option of an elective in geriatric psychopharmacology or a full year's fellowship in geriatric psychiatry. The psychopharmacology elective involves seeing all cases on the inpatient geropsychiatry ward rounds, and being involved in ongoing patient care. The fellowship involves all of the clinical experiences described above—inpatient, outpatient, and community. In addition, the fellow spends a significant amount of time on a research project and on teaching geriatric psychiatry to junior residents and medical students.

The PGY-1 residents are uniformly and without exception very enthusiastic about their two-month experience on an inpatient geropsychiatry ward. It helps them cement their identity as physicians and psychiatrists, emphasizes the overlap of medical and psychiatry problems, and allows them to discard their "ageist" stereotypes through positive experiences with elderly patients whom they can treat and help return to function. The PGY-3 residents never liked a similar two-month inpatient experience because the whole PGY-2 year is spent on inpatient wards, and they were tired of it. For that reason we offered, and they enthusiastically chose, the six-month community elective. This has provided an experience which is unique in the McLean program since it provides greater independence in a community setting without all the backup of a high-powered teaching hospital. The PGY-4 elective in geriatric psychopharmacology has been sought after and filled now for several years. The PGY-4 or 5
Fellowship in Geriatric Psychiatry has been filled and is now attracting McLean residents who trained as a PGY-1 or 3.

The personal philosophy of the training director is embodied in these different experiences. First, the clinical services can be provided without trainees. Therefore, they are there to be trained and not to be exploited. No trainee is asked to take on more cases than he can handle and attempts are made to select interesting and diverse cases. Second, trainees are treated with respect and are granted substantial independence and responsibility. Third, close supervision is provided to enhance the training experience and to allay fears of being over their heads. Fourth, every effort is made to provide a positive experience so that trainees will not hesitate to see elderly patients in their subsequent clinical work. Finally, learning how to approach a difficult case is emphasized and not just basic knowledge content. Knowledge will change, but learning skill will always be useful.

The above information was provided by Benjamin Liptzin, M.D.

The University of Texas Medical School at Houston

All psychiatry residents have a minimum of two months in PGY-1 and/or PGY-2 on the Geriatric Section, a multidisciplinary, multiactivity health service enterprise.

The Section's ongoing activities are, in the main, fivefold:

1. Patient Care

   This consists of an acute care, specially designed inpatient service and outpatient facility, an intermediate and long-term care service, as well as a community-based facility. A resident's initial contact with geriatric psychiatry is primarily with the inpatient and outpatient services, where he/she, under supervision, will enhance his/her knowledge of the following with respect to the geriatric patient with psychiatric illness:

   a. psychiatric assessment for purposes of determining diagnosis, etiological considerations, need for psychiatric admission, and psychopharmacotherapy;

   b. physiological evaluation for evidence on reversible etiologies for psychiatric states;

   c. the spectrum of available treatment modalities, with emphasis on developing skills in optimal psychopharmacotherapeutic technique, and

   d. administrative management of the Section's multidisciplinary health care team, consisting of representatives of psychiatry, nursing, social service, occupational therapy, dietary, and chaplaincy.

   Patient care includes daily rounds and conferences. The rounding team is multidisciplinary and a resident, under supervision, serves as head of the multidisciplinary treatment team.

2. Teaching

   Residents round with the attending geriatric psychiatrist, who is also the Director of Clinical Services of the section, five days a week. On Saturdays, the resident rounds with attending faculty member. First part of rounds is with medical students, registered nurse, social worker, occupational therapist, and chaplain; then all the patients are visited in the ward headed by the resident with the treatment team.

   The resident receives a weekly, one-hour supervision session. There is also available 29 component videotaped lecture series in gerontology and geriatrics, produced by the Section on Geriatric Psychiatry and UTMSH Department of Biomedical Communications, and on file in the school's Learning Resources Center. The rounds and case conferences serve as teaching vehicles for principles of clinical practice.

3. Other Activities

   The Section is actively engaged in research and providing teaching to other professionals about gerontology and
Mental Health and Aging

The Section also receives many invitations to speak to lay groups interested in aging and the aged. Residents may, but are not obligated to, participate in these activities.

The above information was provided by Alvin Levenson, M.D.

University of California, Los Angeles Department of Medicine, Department of Psychiatry

A geriatric psychiatry ward serves as a training site for psychiatric interns (two at a time) and psychiatric first-year residents (also two at a time). In addition, each year the ward's clinical management is largely conducted by a third-year chief resident, who becomes quite proficient in geriatric psychiatry (at least inpatient care) by the end of his/her residency. Interns' and residents' rotations are for three months, and are required of sixteen out of each class of twenty new residents (eight complete the rotations as interns; eight do so as first year residents; four are exempted). For the extra residents, experiences in the geriatric day hospital and/or geriatric clinic are encouraged but not required, but they are required to carry at least two long-term elderly outpatients during their senior year. An alternative inpatient unit that could accommodate these extra four residents is in the planning stages.

The Geriatric Neuropsychiatry Inpatient Service is a 20-bed ward devoted to evaluation and treatment of cognitive, affective, and behavioral problems associated with aging. Advanced training is offered in clinical and laboratory diagnosis and treatment of chronic and acute medical illness in the elderly; clinical diagnosis of affective, cognitive, and behavioral syndromes of aging; neuropsychological and general psychological assessment; family assessment and short-term family therapy; psychopharmacology and electroconvulsive treatment of the aged patient; legal and administrative aspects of geriatric neuropsychiatry; community resources for the elderly; and group and individual psychotherapeutic techniques for aged patients. The advanced trainee gains clinical exposure in these aspects of care in his/her role as clinical supervisor of interns and residents acting as primary care physicians. In this role the advanced trainee is involved in home evaluation, medical and psychiatric evaluation and treatment, family evaluation and treatment, and community referral and follow-up of all patients admitted to the ward. The depth of involvement in each aspect of each case may vary with the trainee's interest and time availability. A continuous weekly seminar on the basic science of aging, clinical laboratory, as well as psychopathology and treatment in the aged patient, is presently under development. Faculty supervision in all of the above areas is offered by the full time ward director (a psychiatrist), a full time ward neuropsychologist, and several other faculty members currently involved on a part time basis. Medical supervision is offered by faculty of the Division of Geriatric Medicine, Department of Medicine. Advanced trainees are encouraged to design and implement clinical research during their training period, with consultation and supervision offered by clinical faculty and faculty members in the Department of Psychiatry and Biobehavioral Sciences.

The above information was provided by James E. Spar, M.D.

Illinois State Psychiatric Institute and Rush-Presbyterian-St. Luke's Medical Center

After completing two years of training, residents are assigned to a full time six-month rotation on a new sixteen-bed geropsychiatric unit, where they are closely supervised by a staff geropsychiatrist. Residents are also expected to treat at least one or two elderly outpatients under the close supervision of a staff or consultant
geropsychiatrist. Throughout the entire year, all third-year residents participate in a weekly seminar which includes twelve didactic lectures covering Principles of Geropsychiatry, and approximately six months exposure to Principles of Psychotherapy with the Elderly, with utilization of videotaped psychotherapy conducted by senior geropsychiatrists. During the last three months of this year, training is devoted to consultation liaison geropsychiatry in preparation for the residents' six-month part-time training at the Johnston R. Bowman Health Center for the Elderly, which is a specialized acute rehabilitation and skilled nursing facility designed especially for the elderly.

During the fourth year, psychiatric residents may select geropsychiatry from a number of possible electives. The elective in geropsychiatry provides experience in research, additional supervised training in inpatient, outpatient, and consultation liaison geropsychiatry, as well as an opportunity to serve as a consultant to a social agency, nursing home, or a member of a specialized geropsychiatric outreach program which provides comprehensive assessment and treatment coordination of elderly people in the natural setting of their own home.

In addition to this training for psychiatric residents, we have been able to have input into the training of Rush medical students and residents in family practice at Rush-Presbyterian-St. Luke's Medical Center. Medical students are offered a course in geriatric psychiatry, and family practice residents at several hospitals affiliated with Rush are provided a seminar regarding assessment and treatment of geriatric patients.

The above information was furnished by Laurence Lazarus, M.D.

Texas Research Institute of Mental Sciences

The Texas Research Institute of Mental Sciences (TRIMS) is the primary research and training center of the Texas Department of Mental Health and Mental Retardation (TDMHMR). One component of the tripartite mission of research, training, and service at TRIMS is the training of psychiatrists for public service. The TRIMS psychiatry residency program was established to provide specialized training to residents in psychiatry who plan to pursue careers in public service or administration in institutional settings. More traditional training programs tend to prepare psychiatrists for private practice only; the TRIMS program, however, prepares psychiatrists to serve in public mental health care delivery systems. The program was accredited in 1977 by the American Medical Association Liaison Committee on Graduate Medical Education.

Since TRIMS instituted its own general psychiatry residency program five years ago, every PGY-3 resident has a four-month, one-day-a-week, supervised clinical assignment in the TRIMS geriatric psychiatry outpatient clinic. The resident obtains experience working with a multidisciplinary mental health service delivery team, learning how to apply principles of comprehensive psychogeriatric assessment and treatment.

The PGY-3 resident also participates in a weekly didactic clinical psychogerontology seminar presented by the TRIMS multidisciplinary geriatric faculty. This course acquaints the resident with the biological and psychological processes of aging. Some of the basic topics covered are: 1) late-life psychopathology, 2) diagnosis of late-life mental disorders, 3) clinical manifestations of late-life psychopathology, 4) functional psychiatric illness in the elderly, and 5) psychotropic drug therapy for the elderly. The interrelatedness of the psycho-socio-biological loss/stress system of late life is emphasized in these didactic and clinical experiences, enabling a resident to select appropriate choices of clinical assessment techniques in intervention modalities. By the completion of the PGY-3 year, the resident will become not only more sensitive to the needs and issues of the aged, but more competent to treat elderly persons.

The first four years of training in the TRIMS program provide at least as much training as a resident ordinarily receives in any
complete conventional program; theoretically, the resident would be prepared to enter private practice after these four years. The fifth year of this program allows the resident to progress beyond traditional training standards to become a specialized psychiatrist in the area in which he chooses to concentrate for the whole year, choosing from one of six specialties: administration, child psychiatry, family therapy, geriatrics, forensics, and biology. Upon completion of this year, the resident will be able to step into a role in the health care delivery network and function effectively as a highly trained and experienced psychiatrist. One such student, the year after completing TRIMS residency in geriatrics, was selected by The University of Texas Medical School at Houston to establish a geriatrics section within their department of psychiatry.

As an example of a more intensive training program, the Gerontology Center of TRIMS is currently conducting a Fellowship in Geriatric Psychiatry and Psychology which is supported by an NIMH training grant. The objective of this two-year program is to train psychiatrists and psychologists who will be committed to working with the elderly and prepared to take leadership roles in developing effective service and training programs in universities, medical schools, hospitals, and community mental health centers.

The above information was furnished by Charles M. Gaitz, M.D.

University of Washington

During the first two years of psychiatry residency at the University of Washington, the only direct training in geriatric psychiatry is provided on the Geropsychiatric Inpatient Service at the Seattle VA Medical Center. This service has twelve inpatient beds and treats patients over the age of 55 with a variety of psychiatric problems which require hospital care. Resident rotations on this ward are three to six months long. Residents with a particular interest in training in geriatric psychiatry can select this assignment as part of their inpatient experience; other residents are simply assigned to the ward.

During elective time in the last two years of the residency, residents can elect to spend from one to six months on rotations focused on geriatric psychiatry. All the clinical electives teach the fundamentals of geriatric psychiatry and also stress the frequent need for integration of services for adequate aftercare for the geropsychiatric patient. Residents on all clinical electives are taught and supervised by experienced geriatric psychiatrists. These electives include:

- The Family Services Clinic is a University of Washington outpatient clinic run by Dr. Burton Reifler and provides multidisciplinary evaluation for older adults who reside in the community and who appear to have psychiatric problems. Residents function as a team psychiatrist, evaluating and following new patients as they enter the clinic. As the name of the clinic implies, a great deal of support and evaluation of the older adult’s family is also done, and the resident participates in this as well.
- The Geriatric Multidisciplinary Team provides consultation to the medical, surgical, and psychiatric inpatient services of the Seattle VA Medical Center. Team members include psychiatrists, internists, social workers, psychologists, and dietitians. When residents are participating, they perform the psychiatric evaluation of patients and frequently coordinate the plans for outpatient treatment.
- The Geriatric Clinic at the Seattle VA Medical Clinic is staffed by internists and geriatric psychiatrists and evaluates and provides care for older veterans with behavioral problems or complicated medical problems. Residents can spend a half day a week participating in this clinic.
- Outreach for Older Adults is a county program that evaluates older adults in their homes. Residents can spend one to two
days a week traveling with this team in the greater Seattle area
providing psychiatric evaluation of older individuals actually
in their homes.

- Research in geriatric psychiatry is also possible under the super-
  vision of Dr. Burton Reifler at the Family Services Clinic or Dr.
  Murray Raskind at the Geriatric Research, Education and
  Clinical Center at the Seattle VA Medical Center.

For the fourth year resident with a clear interest in geriatric
psychiatry, there are currently two additional training opportu-
nities. These residents can enter the NIMH geriatric fellowship, a
two-year training program that utilizes the above training sites as
well as emphasizing participation in a research project. It is
currently anticipated that this fellowship will not be available
after July 1983. The second training opportunity is a VA geriatric
residency position which is coordinated by the Geriatric
Research, Education and Clinical Center at the Seattle VA
Medical Center. This is a one year position for advanced residents
wanting specific clinical and research training involving older
patients with psychiatric problems.

Within the didactic material presented to the general psychi-
atriy residents, geriatric psychiatry is simply integrated into the
other blocks of material. For instance, when affective disorders are
discussed, the diagnosis and treatment of depression in older
individuals is included simply as a part of that discussion.

The above information was provided by Robert Barnes, M.D.

The scope of training can, of course, be as broad or as narrow as
overall priorities or funding dictate. Each training program has
to make decisions about curriculum, training techniques, and
settings. Interests and qualifications of faculty and availability of
facilities will influence selection.

The following sections are not designed to be a dogmatic
approach to a training program; rather, each contains recommenda-
tions of specific areas within a given topic which could be
incorporated into a single teaching module. Each section is
followed by an annotated bibliography which a residency
program director can consult for more definitive information in
designing teaching plans. In short, these sections should be seen
as suggestions to be adopted and adapted by each training
program director to fit his or her particular needs.

Normal healthy aging

Every training program should offer information about and
understanding of the normal aging processes, including the
psychology, sociology, economics, and politics of normal aging.
Common tasks of adaptation to old age, including adjustment to
retirement, relocation, choices of living arrangements, and
proximity to family need to be discussed not only in terms of the
patient's general physical and mental wellbeing but also in terms
of maintaining his/her continuity with earlier life and
improving the quality of his/her present life. The trainee should
be taught techniques for reassuring or reestablishing threads of
continuity between the present and the earlier life through modifi-
cations of job activities, vocational or avocational interests, newly

The above information was provided by Robert Barnes, M.D.
acquired interests, or return to earlier interests which were abandoned in adolescence or in mid-life. Alternative roles in old age, such as community participation, community service, volunteer and paid employment opportunities, educational opportunities, opportunities for service on community boards and in programs for the elderly, and social and recreational opportunities should be explored. The trainee should also acquire means for assessing and using therapeutically the inner life of older persons which is full of fantasy, dreams, creative thoughts, and wisdom. Finally, experience in personally becoming acquainted not only with the elderly ill but also with elderly healthy persons is of utmost importance to the trainee. Visits to elderly persons in their homes or in other sites, such as multiselvice centers and community recreation programs, will enable the student to become knowledgeable about the entire range and scope of the aging experience including healthy and successful aging.

Suggested References


The third volume of this three-volume work is devoted to adulthood and the aging process. There are twenty-four chapters discussing various facets of the psychoanalytic dimensions of aging. Chapters by Gutmann, Busse, Groines, and Pollock specifically present considerations of interest and concern to students and practitioners of geropsychiatry.


This volume addresses the topic of adult development, particularly mid-life issues. The initial discussions on the history of the life cycle in antiquity, or the pioneer developmentalists, and contemporary researchers in development theory is very useful for students, residents, and general psychiatrists. The current concepts of adult development, though not specifically of the later years, and the use of adult developmental diagnosis in psychotherapy and education are concise and original.


Buhler maintains that to use life meaningfully is to spend it in a way which contributes to a feeling of fulfillment—which may be considered as an experience of completion, a hope of satisfaction toward which we have directed our lives. Theoretical considerations and statistical data relating to factors determining human development are included. Clinical case material is used to illustrate concepts, and it concludes that persons who age with zest tend to be those individuals who assign themselves certain tasks and live on in a rhythm between assignments, recreation, and rest.


Butler discusses the part reminiscence plays in the aged as part of a normal life review process brought on by the realization of impending death. This review is characterized by the return of past experiences to the consciousness, and particularly the resurgence of unresolved conflicts, which can be looked at again and possibly reintegrated. If successful, this review can give new significance and meaning to life and increase the likelihood of an individual approaching death with less fear and anxiety.

This is a basic reference work. A discussion of "Healthy, Successful Old Age" (pages 17-33) points out that old age can be an emotionally healthy and satisfying time of life with a minimum of physical and mental impairment. The concept of healthy old age is developed with attention being given to the anticipated physical, intellectual, social, and emotional changes that are to be expected as one ages. Historical factors in adaptation and popular myths about aging are emphasized, along with a brief review of contemporary psychosocial theories of aging.

"Older People and Their Families" (pages 119-133) discusses the modified and extended family system and the role of grandparenthood. Further, the elderly married couple is examined in terms of the value of intimacy and companionship, as well as the difficulties in older marriages.


The writer maintains that throughout life, but especially in the later years, a balance is struck between external and internal depleting and restorative forces which are derived from the body, the mind, and society. Evidence supports the position that an "inner awareness" of these depleting physiological processes exists and is an essential part of the ego's conscious and unconscious perceptive functioning. The processes of depletion trigger specific defensive maneuvers by which the aging person copes with gradually increasing depletion anxiety. Cath elaborates on the implications of these theories for anxiety prevention and therapy.


This is a basic reference which includes chapters on "Processes in Aging," by K.W. Schaie; "The Adult Development of Intellectual Performance: Description, Explanation and Modifi-


This is a reissue of Erikson's original work that was combined in Psychological Issues in 1959. Each of the three papers were subsequently dealt with in depth, and this book includes a bibliography that allows the reader to then follow up on each of the chapters.


This study describes the aging process by studying individuals who were free of physical disease and major psychological disability. The sample consisted of 47 men, 65 years or older, with a median age of 71 and ranging from 65 to 91 years. The average follow-up was 11.1 years. The primary aim of the study was to determine those biomedical and behavioral changes which can be attributed to normal aging. Two additional goals were to study characteristic experiences associated with adjustment to aging and to identify factors related to longevity and survival.


Dr. Greenleigh points out that middle age is considered the most powerful stage of life and one with the most complex problems. It is a period of transition with stresses that could lead to psychological disturbances and also to new self-direction and growth. This paper discusses the perception of middle age as a "stage" of development as it is perceived by others and differentiates male and female roles regarding child rearing, occupational changes, relationships to elderly parents and to adolescent children; the handling of the "empty nest" syndrome and climacterium; reevaluation of marriage; changes in perception of
time; consequences of separation and losses, and patterns of grief; problems of widowhood; evolution of sexual activity; bodily changes; dealing with financial pressures. Special emphasis is given to the need for a mid-life assessment to determine directions for continuing commitments and personality development. Psychopathologic disorders and therapy for middle-agers are discussed.


The social role construct is examined. Leisure activity must be added to the three broad social role categories of family, work, and community. Havighurst indicates that an ethic of leisure is evolving to parallel the ethic of work that has dominated western culture during the past century. The special situation of the elderly in the role of student is also discussed both in terms of the positive dimensions of the elderly as students and of problems that adult education programs have encountered.


This provides a comprehensive discussion of both theoretical and practical issues, including the interface of individual and environment, urban and rural environments, population mixes (age context, economic context, racial context), and involuntary relocation, morbidity and mortality. A comprehensive account of planned housing and related services is elaborated.


This is an integrated account of the life cycle of men which evolves through a sequence of eras, each lasting roughly 25 years: childhood and adolescence, 0-22; early adulthood, 17-45; middle adulthood, 40-65; late adulthood, 65-plus. The section on late adulthood discusses the changes in the character of living brought about by numerous biological, psychological, and social changes, and includes a comprehensive account of the intrapsychic and external tasks that must be mastered in late adulthood.


Neugarten looks at some of the problems that characterize personality as a field of inquiry and at some of the conceptual and research problems that relate specifically to issues regarding continuity and change of personality over a life time. The author also discusses adult personality from the developmental perspective, theories of adult change (psychoanalysis and egopsychology, social-psychological theory, and cognitive theory), time and the life span, and studies of age-related change in personality.


This collection of reports drawn from longitudinal and interdisciplinary research on aging is guided by two questions: (1) What are the basic physical, mental, and social processes of normal aging? (2) What accounts for the variations in these processes? Individuals studied were relatively healthy, noninstitutionalized, ambulatory, community residents who were able to come to the Duke Medical Center for examination. The initial study was 71 persons who were 60-90 years of age; examinations of these individuals, including medical, psychiatric, psychological, and social parameters, have been carried out periodically since its inception. The second longitudinal study was begun in 1968 with 502 persons 45-70 years of age and was designed specifically in an attempt to separate the effects of aging from cohort differences and from changes in environment over time.


The important point made is that sexual activity may continue to be very significant in the life of the elderly person. Indicators are
that the likelihood of continued sexual expression in the later years is much greater for persons who have been highly interested and active sexually in their younger years. However, the unavailability of a socially sanctioned partner and of privacy can often be limiting factors.


This study delineates five patterns of adjustment and points out that the way in which persons grow old depends to a large extent on their character structure, on dominant needs, defense and adaptive mechanisms, and on whether they can meet their needs and support their defenses under their current circumstances. Each of these five groups (the “mature,” the “rocking chair” group, the “armored,” the “angry men,” and the “self-haters”) was studied in terms of aggression and passivity, ego organization, defensive mechanisms and mental functioning, attitudes toward self and others, conceptions of parents and life, attitudes toward aging, and acceptance of self and of past life.

Assessment of the geriatric patient

The assessment of the geriatric patient is the basis on which any optimal treatment program must be planned. Thus, any geriatric teaching unit in a residency training program must necessarily include student exposure to specific assessment of the patient’s functional status and also an analysis of such factors as the patient’s overall physical and mental health, home environment and self-care capacity, and social and economic resources.

Initial evaluation must be made of the current severity and degree of limitation arising from the individual’s physical illness, where applicable, as well as the number and type of medications taken. Psychological assessment should focus on cognitive performance, degree of functional psychiatric symptomatology, and positive features of mental health, such as life satisfaction, family and community participation, productivity, and engagement.

The physical environment in which the patient lives, or to which he may be expected to return, needs to be assessed in terms of its relative safety, receptivity, complexity, isolation, and so forth. Ideally, this should be accomplished through a home visit, with special attention paid to the possible difficulties the patient may encounter and, therefore, require counseling or home modification to overcome. The individual’s ability to cope with these difficulties or changes is to a large degree dependent upon his or her capacity for self-care. An assessment, therefore, should also be made of the patient’s ability to care for his or her own body and to run a household independently.

This capacity for self-care is more or less influenced by the social and economic resources available to the elderly individual. In light of this, the patient’s social skills, along with the availability of caregivers and participation in, and support from, such informal social networks as peer groups, neighborhood groups, and racial or ethnic groups, need also to be evaluated. Current income and additional financial services must also be investigated.

After acquiring these assessment skills the student should then be shown how this information will lead to a rational program of intervention, symptom reduction, and the teaching of skills and network building which can restore the individual to full, healthy functioning.

Some time should also be spent educating the mental health trainee about important medical-legal issues when dealing with the elderly patient, for example, that of responsibility. The professional should be able to assess whether the patient is competent to make decisions concerning his own body and his own estate. Equally important is the consideration of how much responsibility a professional can legally and morally delegate to the family in terms of making decisions concerning the patient’s status and affairs. If the patient needs involuntary treatment or placement,
legal steps must be taken. However, in many instances the patient needs voluntary treatment and/or placement, yet may be suffering from a mild brain syndrome and still be legally responsible. In these instances the professional may end up dealing with the family inappropriately while allowing them to make decisions for and about the patient which legally should be made by the patient. When a patient has a terminal illness which has in no way affected his mental status, the family frequently decides not to tell the patient the truth about the illness, even though controversy rages over the ethics of such a decision.

These are difficult issues and can cause both ethical and legal problems for the mental health professional. However, the professional who judges the patient incapable of making decisions about his treatment or affairs must accept the responsibility of either instituting, or having the family institute, conservatorship or guardianship proceedings since, in the absence of such a person, the legal question of valid informed consent would invariably arise. Similarly, to honor the family's desire not to inform a competent patient about the true nature of his or her illness removes from that patient the ability to make decisions concerning his or her own life and might lead to later litigation.

Despite such problems, or perhaps because of them, the mental health trainee should be made aware that it is his or her ultimate responsibility to assure that the patient's rights are protected to the greatest possible extent.

Suggested References


This book deals with several problem areas concerning the mental health of the elderly. Although assessment and treatment are dealt with separately in chapter 5 and chapter 9 of Part I, respectively, they are incorporated into discussions in the other chapters as well.


This book deals with various problems of aging in a down-to-earth, practical approach. In the section on evaluation, treatment, and prevention, the authors have put together a very practical format that can serve as a guideline for anybody interested in this field.


This article places particular emphasis on differential diagnosis of depression and dementia in the elderly with a review of assessment instruments and techniques.


This book covers a number of areas, including evaluation and assessment of the various conditions peculiar to the aged. Of particular interest is chapter 9 which reviews the US-British differences in diagnosis and evaluation of this population.


This special issue contains reports originating from the U.S.-U.K. cross-national studies which were initiated in 1965. The current reports are for the age 65 and over.

The reports include a brief history and progression of the study to its current status, the various diagnostic differentials between the two countries, a brief report of the Geriatric Mental Status (GMS) interview schedule and the outcome of the use of the GMS and a psychological test battery to elicit psychopathologies.

Psychiatric diagnosis in the elderly has been examined in order to extract the information which leads to later modification of the diagnosis. Initial diagnoses of neuroses and toxic states were least stable, 14 out of 29 changing to a different category. Information from relatives and further interviews contributed most to the modification of the initial diagnosis, though affective and neurotic syndromes were particularly susceptible to change resulting from conceptual differences, and dementia to change consequent on physical examination. It is concluded that an adequate initial interview of a patient and his next of kin will achieve a diagnosis which is correct in its major category on 95 percent of occasions.


This manual is directed toward the assessment of the degrees of impairment in the older person, affecting various areas, including financial, mental health, and physical health. It is a subjective questionnaire that taps these areas broadly. This will alert the caregiver or assessor to then focus on more detailed and objectively quantifiable assessment of the impaired areas.


This book provides in-depth discussions of major clinical problems affecting the major organ systems. Etiology, diagnosis, treatment, course, and prognosis are discussed.


The chapter on assessment begins with “Why should one assess old people?” and proceeds through the problems peculiar to evaluation of the aged, including various technical aspects of assessment. This includes the use of structured interview schedules, various neuropsychological tests, and other specialized investigations, such as the EEG, as a total process of assessment. Although it does not consider the duration of the assessment period nor the location of the assessment procedure (in- or outpatient), this article is nonetheless a useful guide for a trainee.


With more individuals surviving to advanced ages, the “old old” (persons over 75) become a larger cohort and will be increasingly sought as respondents in order to be properly represented. Inclusion must be made of the impaired, the frail, and the institutionalized, as well as alert and healthy, community residents. To gain maximum results from the interview, preinterview approaches should be paced slowly enough to permit these older respondents to reassure themselves about the interview; instruments should be adapted to be short, varied, and clear, employing familiar terms whenever possible; special adjustments should be made to accommodate those with such conditions as intermittent or chronic confusion, or problems of sight, hearing, or speech. For example, chronic confusion may not necessarily bar discovery of how the patients feel; impaired speech may not bar all communication, and interviews should be attempted; appropriate affect may be independent of facility in speech. Impaired older people can often be interviewed successfully, providing extra time is spent and instruments and approaches modified to their needs. Precaution should be taken to bar interference in the interviews from over protective “helpful” relatives and attendants. These points are studied and illustrated by materials drawn from a study of two homes for the aged.


Various issues pertaining to geriatric practice are discussed including assessment, evaluation, and treatment of patients, as well as other areas such as the biology, dynamic, and nosological
aspects of aging. Chapters 3-7 address specifically the hows and whys of assessment.


This book is an attempt by the editor "to bring together authoritative treatments of a variety of related subjects dealing with dementia and diffuse brain disease." Assessment and evaluation are dealt with in chapters 1, 2, 4, 5, and 6.


This chapter briefly covers the relationship between competency and hospitalization, including historical background, definitions, and guidelines as to who may be declared incompetent. It also deals with issues of guardianship and the restoration of competency. Though this chapter covers these areas without reference to age, much of the discussion is applicable to the practice of geropsychiatry.

**Physical/psychological problems of the elderly**

**Primary health care skills for the trainee—**Psychiatrists often must assume continuing responsibility or, occasionally, initial responsibility for the diagnosis and treatment of an elderly patient's physical disorders. To do this adequately, the trainee needs a thorough grounding in the most commonly occurring health problems of old age, especially cardiovascular disease, congestive heart failure, cardiac arrhythmias, hypertension, chronic pulmonary disease, diabetes, various forms of arthritis, and common digestive disorders. Information about the availability and advisability of various treatment approaches is also important to any overall health care management plan.

**Psychiatric problems, diagnosis and treatment**

To treat the common disorders which arise during or continue into old age, the psychiatric resident should be trained in diagnostic procedures and therapeutic modalities which are applicable to this age group.

Only a handful of psychiatric disorders make up the bulk of geriatric problems, and the trainee should be well acquainted with them. Teaching content should include interviewing strategies and the use of quantitative scales for assessment of such items as depression and anxiety. Discussions should also focus on the clinical syndromes of various disorders, including 1) depression and mania and their differing manifestations in old age, 2) paranoid reactions, 3) hypochondriasis, 4) acute and chronic...
anxiety states, 5) transient situational disturbances, 6) sleep disturbances peculiar to old age and the relationship of other disorders to normal sleep patterns.

Therapeutic modalities which should be considered include individual, family, group, and milieu therapy as well as behavior modification, pharmacotherapy, and somatic therapies.

**Suggested References**


A large portion of this comprehensive text is devoted to issues of diagnosis and treatment with chapters furnishing concise reviews of specific aspects.


This book is a product of the Palo Alto group of family therapists who apply problem-solving approaches in the tradition of Jay Haley. Discussion of their theoretical stance and basic therapeutic strategies is followed by detailed case examples of treatment of late-life problems.

**Organic brain syndrome**

This condition affects an increasingly large proportion of cohorts of elderly persons. It represents a source of serious impairment itself and an impediment in treating other conditions.

At least fifty percent of the residents of nursing homes suffer from organic mental disorders, which comprise a specific subset of psychiatric problems of old age, and whose diagnosis and treatment are unique. Psychiatric residents should become acquainted with the generic symptoms of disturbed brain function, such as disorders of orientation in time and space. This symptomatology can be confirmed through written performances or through visual spatial memory, that is, the ability to perform serial mathematic tests and to correctly order in time sequences of events.

Diagnostic procedures to evaluate the physiologic status of the brain should also be discussed. The focus should be on the common illnesses causing reversible, as opposed to irreversible, organic brain syndromes, and the pathology, course, and outcomes associated with Alzheimer's disease (senile dementia), and multiple infarct disease. Treatment procedures for the reversible organic brain syndromes, as well as the current status of such drugs as the vasodilators and the ergot alkaloid derivatives, should also be included in the teaching unit.

**Suggested References**

An extended discussion of organic brain syndromes grouped into six categories: 1) Delirium and Dementia, 2) Amnestic Syndrome and Organic Hallucinosis, 3) Organic Delusional Syndrome and Organic Affective Syndrome, 4) Organic Personality Syndrome, 5) Intoxication and Withdrawal, and 6) Atypical or Mixed Organic Brain Syndrome. This discussion utilizes the latest nomenclature and looks at essential features, associated features, age at onset, course, complications, etiological factors, predisposing factors, and differential diagnosis.


This book contains brief overviews of general diagnostic approach, specific organic mental disorders, and treatment considerations.


Articles address classification, differential diagnosis, neurological, neuropsychological, and other laboratory investigative procedures. Dementia, delirium, disease constellations, and drug use underlying brain disorders are discussed.


Detailed information is provided on the current state of knowledge about Alzheimer’s Disease (senile dementia) and related disorders. Nosology, epidemiology, etiology, and pathophysiology are discussed. Conflicting views and criticisms are presented along with new research approaches.


Several authors discuss the diagnosis and differential diagnosis of ODS and Alzheimer’s Disease, prescribed and experimental drugs, psychological, behavioral, and psychosocial treatment approaches, course, prognosis, social policy, and research directions.

“Chronic Brain Disease: An Update on Alcoholism, Parkinson’s Disease, and Dementia,” C.E. Wells. Hospital and Community Psychiatry, 33:111-126, 1982.

The author reviews clinical and pathological knowledge regarding chronic brain disease with particular attention to the dementias. Methodology, diagnosis, etiology, and treatment are discussed.

STRATEGIES FOR THE DEVELOPMENT OF AN EFFECTIVE TREATMENT FOR SENILE DEMENTIA, T. Cook and S. Gershon (eds.). New Canaan, Conn.: M. Powley Assoc., Inc., 1981. (322 pp)

This is a review of the state of the art of treatment approaches for senile dementia and it delineates strategies for new directions for dementia treatment research.

Substance abuse including alcoholism

Alcoholism is a serious problem for many elderly people. A major teaching emphasis for psychiatric residents and other mental health workers should be on the underlying causes of its inception at this time of life: social isolation, lack of meaningful activity in retirement, and easy availability of alcohol, as well as the contributing factors of anxiety and depression. The resident should also be exposed to the specific pharmacologic properties of alcohol and to treatment approaches including social reengagement, treatment of anxiety and depression by other means, and rehabilitation measures.
Suggested References


This article is a useful overview of literature in the field of alcoholism in aging. It gives some information on diagnosis and treatment of alcoholics and is written by one of the few people with extensive clinical experience in this particular field.


This volume gives a very complete and up-to-date bibliography on literature in the field of alcoholism in aging. It is a useful resource for anyone wishing to acquaint themselves with the field. The introduction is a helpful guide to the current research in the field of alcoholism in aging.


This article provides much epidemiological and clinical data about elderly alcoholics.


This article gives a good description of the “reactive” elderly alcoholic and the kind of psychosocial stresses that predispose some people to abuse alcohol in late life.


This short paper reviews the literature and presents additional data on alcohol and drug problems. Drug abusers include users of opiates, inadvertent drug misusers, and deliberate abusers of non-opiates. Two to ten percent of the elderly are alcoholic, many beginning alcohol abuse after age forty. Some of the implications regarding treatment and etiology are discussed.

Pharmacology

Drug misuse in the elderly derives from several sources, including multiple drug dosages, poor drug supervision, and inadequate understanding of drug action, as well as voluntary abuse, especially of psychotropic drugs. The psychiatrist can deal more effectively with these problems by gaining a basic understanding of the pharmacokinetic factors leading to altered drug metabolism in old age: changes in absorption, metabolism, storage, and excretion of drugs; drug-drug interactions: altered prescribing patterns on the part of the physician; self-medication patterns (including use of over-the-counter drugs), and the specialized features of the psychoactive drugs; and of drugs used in the treatment of common medical disorders, especially antihypertensives, diuretics, and cardiac drugs. This basic information should be supplemented by recommendations for simplified prescribing and drug-taking regimens, principles of introducing new drugs, and patient/family drug education programs.

Suggested References


This book covers not only the areas of medications in the management of geropsychiatric problems, it also deals with aging and psychopathology as this is related to the elderly.

This book is a collection of chapters dealing with various aspects of human and nonhuman aging as these relate to the pharmacological practices specific to the elderly population.


This book is a report of a conference on psychopharmacology and the management of the elderly patient held in June 1973 at Duke University; in short chapters it covers several areas of particular importance to geriatric psychiatrists.


This book succinctly reviews practical drug issues and choice of drugs for treatment of all of the major mental illnesses of the elderly.


In this article both peripheral and central anticholinergic syndromes are described, as well as the effects of aging on the various neurotransmitter systems. Because of prolonged distribution time and longer drug half-life in the elderly, serum steady state takes longer to equilibrate, while acute drug effects, such as sedation or hypnosis, may be delayed. Failure to consider these elements could easily result in an overestimation of a patient's medication requirements. Determining the appropriate dosage for the elderly requires more than allowing for a smaller body mass or less body water. Mechanisms of drug action and target neurotransmitter system also should be considered.


This book covers a wide area including a chapter on psychopharmacology and geriatric patients, written by Carl Salzman, Bessel van der Kilk, and Richard I. Shader. It is a very useful reference.

**Coping with losses and changes**

The mourning-liberation process is an established way of dealing with losses and changes intrapsychically and externally throughout the course of life. As an individual gets older the losses and changes due to alterations in health, family disruptions, retirement, and loss of friends and close relatives through geographic separation or death increases. Aging itself is a loss/change in the individual's own self-organization and perception. In order to deal with these losses/changes, the mourning-liberation process evolved and is utilized. When there is an inability to employ this coping process, pathological and deviant responses occur. These include depression, sadness, melancholia, and suicide. In addition, we may find regressive behavior including psychophysiological responses.

An understanding of the mourning-liberation process, its phases, how it differs from various forms of depression, its affects, and how this process can be used therapeutically are of great importance in working psychotherapeutically with the older person.

**Suggested References**


Expanding and developing his earlier research findings, the author presents his ideas on a mourning-liberation process as a basis for successful aging—the mourning for one's past results in a
liberation so that the present and future can be dealt with creatively. The creative life is one in which relations with children, grandchildren, spouse, siblings, and self are fulfilling, mutual, and health promoting. Aging is viewed as ongoing development, and not as pathology or debilitation. Clinical entities and their psychotherapy are described in order to illustrate the applications of psychodynamic principles of treatment of the elderly.


In his early edition of contributions on death, the author has brought together several excellent articles by authors including Carl J. Jung, Herbert Marcus, and Maria H. Nagy. Issues dealt with in this book remain current and views expressed are still pertinent today.


In a challenging statement the author advocates that grief, in all its forms, is a legitimate and proper subject for study. Grief as an antecedent to serious somatic and psychologic illness is seen with increasing frequency. This affective state is connected with the loss or threatened loss of a significant object and results in a psychosocial stress. Health and disease is conceptualized in terms of object maintenance.


This classic paper forms the basis of all subsequent psychodynamic research on the topic of mourning and melancholia. The mechanisms of normal and pathological mourning and melancholic depression are enumerated and explanations offered about these interesting clinical and pathological entities. Although no reference is made specifically to the mourning or depression of the aging individual, extrapolation allows application to the disorders of the elderly.


This bibliography is an extensive compilation on areas relating to death and dying. The articles are arranged alphabetically by author, and the book includes a useful index.


This symposium dealt with some aspects of death and dying. It includes a paper that documents the effect of telling a patient he/she has a terminally fatal illness ("Attitudes of Patients with Advanced Malignancy" by Samuel L. Feeler).


This publication includes presentations by several psychiatrists who had been involved with patients who had to grapple with issues of living and dying. Several important topics, including loneliness and the wish to die, are discussed through the vehicle of four case studies.


Based upon research over a period of twelve years, the author has studied how adults react to the experience of bereavement. There is a review of the potentially detrimental effects of bereavement on physical and mental health. Bereavement is seen in the context of the alarm reaction. Although there is no section dealing with aging, this report is an excellent introduction to the field of grief and bereavement.


Viewing the mourning reaction as an evolved universal transformational process that allows adaptation to the loss of a significant other, the author reviews antecedent work referable to mourning. The phenomenological stages of the mourning
process are described and, where possible, explanations are offered on what can be observed externally and internally.


This article by a leading Australian authority deals with the preventive aspects of intervention when dealing with mourning. It reports the outcome of intervention, emphasizing the efficacy of helping a bereaved person work through his/her grief.


This classic is a landmark study of death and dying in which the author recounts her experiences and theoretical formulations on the subject.


This book examines the medical, ethical, and legal aspects of death and dying with the assumption that the patient must be the center of any decisionmaking. Included in Veatch’s discussions are analyses of the definition of death, the justification offered for withholding the truth from a dying patient, and the issues relating to organ transplants and treatment research.


This book is based on the author’s work with dying patients at the Massachusetts General Hospital. He discusses annihilation anxiety, the requisites for “purposeful death,” and examines carefully many fallacies about dying which have been perpetuated simply by virtue of remaining unexamined. He includes extensive case material, and also addresses one chapter specifically to terminal old age. Particular emphasis rests on the role of denial as a way to prevent the disruption of significant relationships. He also outlines a series of psychosocial stages which parallel individual phases in denial and acceptance of death. The work is a balanced intersection of theoretical and clinical observations, easy to read, and readily applicable to work with the elderly.

Case management

The skills and techniques needed for effective case management range from educating the patient in self-care to coordinating all the support services necessary for the patient’s individual treatment. Initially, a residency training program should provide a clear explanation of the case manager’s role and touch on how to understand the roles of, and open lines of, communication with other service providers. The resident should learn how to design, monitor, and modify treatment plans as a reflection of continuing assessment of the patient’s progress on each of the functional areas addressed by that plan. Patient self-care education, that is, the individual’s recognition of signs and symptoms of his/her own disease, side effects of medication, and positive response to treatment, is another important aspect of case management training. The emphasis throughout should be on preparing the elderly individual for independent living rather than on simply helping him/her adjust to a hospitalized existence.

Suggested References


Major issues and concepts of collaborative interdisciplinary training and practice among the health professions are detailed here, including status, knowledge base, domain, ideology, team roles, and competency, and recommendations are made for furthering effective interprofessional behavior.

Literature on medico-social changes since World War II and their implications for planning care of the elderly, particularly outside of hospitals, is reviewed. The responsibility of the medical practitioner is seen as one of mobilizing all forces to keep the individual healthy and functioning at home. A coordinated program for geriatric care is detailed, including suggestions for case-finding and identification of level of assistance required. Also covered are elements essential to effective organization of health care for the elderly, such as transport, record-keeping, and visiting. Appropriate roles are delineated for a multiprofessional health team, seen as an imperative in care of the aged.


A great variety of protective and supportive services, such as homemaking, nutrition, and visiting, are examined. The planning goal, as outlined here, should be a comprehensive, coordinated program of medical, psychiatric, and socioeconomic care, stressing continuity for enhanced quality of life for the elderly.


The physician's responsibilities to the elderly patient include consideration of the contributions to a patient's well-being in economics, housing, transportation, and recreation, as well as drug usage and hospitalization. To do this, the physician must learn to participate as part of a health team, which involves the skills of a spectrum of community, social, and health service professionals. Aspects of preventive geriatric care meriting detailed attention by the physician include socialization, physical activity, nutrition, foot care, accident prevention, prevention of iatrogenic disease, and preservation of a variety of essential physiological functions.


The elderly with dementia fall into basically two groups, the first with relatives caring for them and the second with no reliable social supports. Godber suggests that the object of care for the first is the delivery of regular relief services not only to the individual but also to the family to enable caregivers to shoulder the burden of care consistently. Needs of the patient living alone are seen to require provision of a supportive and protective environment, such as sheltered housing. Coordination of the roles of specialists with geriatric knowledge, general practitioners familiar with total family functioning, community health nurses, and supportive families is described.


An integrated psychiatric service for the aged is seen as requiring a broad variety of services, including diagnostic facilities and instruments, assessment measures, residence options, and inpatient care, to correctly address the different combinations of physical and mental impairment among this population. Two mental status diagnostic instruments, the Mental Status Questionnaire and the face-hand test, are reproduced and their use described. Varying levels and settings of care and supportive services, and coordinated in flowchart format to demonstrate appropriate flow of patient management.


The concept of primary physician is redefined to signify the physician who may or may not first see a patient for a particular ailment, but who assumes the responsibility for the major medical guidance and continuance of care of that patient. This definition and function is seen as focal in providing care of older individuals. A variety of special problems of treating the elderly is outlined, as is the contributory role of allied health personnel and the importance of a team approach in delivery of service.

**Informal and personal support systems**

Social supports include both the formal community supports discussed in the next section and the informal and personal supports available to particular patients.
Personal social skills—these include the ability to live independently, to relate to others appropriately, to make friends, to reach out to others for help when necessary.

Membership in informal support groups—numerous public and private organizations exist within the community that both directly and indirectly offer support to those elderly who are willing and able to take advantage of it.

The family—The family provides a major share of support and care for infirmed, aged individuals. Therefore, it is exceedingly important for the therapist to deal with the family when considering supports for the elderly patient. Family involvement can help the patient to better negotiate various aspects of the support systems. Training in family systems theory and in the dynamics of family change as the family deals with aging and disability is very valuable to psychiatrists working with families. They must be aware of the components of different supportive systems to help those families who are willing to be involved deal with the system. Additionally, psychiatrists must learn to what degree they can assist patients to acquire social supports, when the family is unavailable or unwilling to help, and to what degree they can or should rely on other resources to do this.

Suggested References


This is an excellent review of the social situation and the supports available to the elderly. The author reviews the demography, the life expectancy, the family composition, the living arrangements, the economic status, and the health status of the elderly. She then discusses the evolution of public interest in the elderly and the various legislative programs which have been developed. A review of the processes and theories of aging are presented as a background to discuss several critical issues, including life crises, dependency, and continuity, as these concepts affect the aging person. She concludes with a consideration of the kinds of training that are necessary to develop adequate social work services for the elderly and the kinds of services and approaches necessary to adequately meet the needs of the elderly population.


This book is an expose of the formal social support system of the elderly in this country. The author discusses the “tragedy” of being old in America, growing old, and becoming poor in the midst of an affluent society. Butler also examines in depth such aspects of aging as the right to work and retirement, housing programs, available services, health care programs, the mental health care system, and nursing homes. The author then turns to the victimization of the elderly through crime committed by the younger population and the politics of the aging network in this country. He concludes with a series of recommendations framed to enhance the quality of life of the elderly of this country.

Community support systems

Individuals working with the elderly must become thoroughly familiar with four basic types of community support agencies which may provide additional services to elderly patients.

Economic or financial supports—Social Security payments, Veterans Administration pension for eligible veterans, welfare payments for the indigent, and Supplemental Security Income (SSI) for those who qualify are the major sources of public financial support for the elderly. The SSI program enacted in 1974 establishes a national base income for all elderly, blind, and disabled. Unfortunately, neither this program nor any of the
other public support systems raises them above what is generally considered poverty level.

Direct Social Services—There are over 700 Area Agencies on Aging set up under the Older American’s Act (1973) to coordinate social services for the elderly and to provide funding for needed services which were not available. These social services include Senior Citizen Centers, elderly nutritional projects, support services, day care centers, transportation services, Meals on Wheels Programs, home repair services, recreational centers, homemaker services, senior aide and companion programs, and foster care programs. Depending on the locale, these services are available in limited quantities to all elderly regardless of their financial state or their ability to pay.

Indirect Community Support Services—These supports help to protect the rights of the elderly and help the elderly negotiate and enforce their rights, and include information and referral services, elderly advocacy programs, consumer advocacy programs, legal assistance for the elderly through Law Enforcement Assistance Administration (LEAA) funded law clinics, and adult protective services which are also primarily funded through LEAA grants.

Voluntary Support Organizations—Involvement in religious groups, various senior clubs and different types of senior interest groups allows the elderly to better deal with the inactivity of retirement and maintain a sense of greater meaning to their lives.

Suggested References


This book is a comprehensive review of the Social Security System. The author begins by defining and describing Social Security and the various forms of Social Insurance. He then discusses how the Social Security Program is functioning in relation to the various changes that have occurred during the 1970’s, including a discussion of the financing of the Social Security System. The number of elderly who are receiving Social Security benefits, the kinds of jobs that are covered, the protection available for the disabled, and the issue of income security after retirement are discussed. The amount of compensation that people receive and the methods for determining this are detailed. The author then considers whether Social Security is retirement insurance or an annuity and considers whether women and minorities are fairly treated. He compares welfare, private pension plans, and Social Security. Finally, the author considers various alternatives for funding the Social Security Program and then makes recommendations for future changes in the program.


This chapter presents a discussion of the various kinds of community support systems available to the elderly. The authors detail various kinds of informal and formal supports available within the community and discuss the need for more formal supports in relation to the enhancement of the mental health of the elderly. They present the model developed by the Massachusetts Mental Health Center of the geriatric team as an alternative for dealing with the mental health problems of the elderly. They also discuss other formal mental health-related support systems. Finally they offer recommendations for changes to both Medicare and Medicaid to enhance the development of adequate social support systems for the elderly.

Long-term care: services

As an adjunct to their knowledge of community support systems, psychiatrists should be familiar with long-term services that assist
in the care and rehabilitation of his geriatric patients. These services are wide-ranging and include nursing homes, and homes for the aged, as well as day hospital programs, visiting nurse programs, hospital-based home health care programs, ambulatory care programs, and private home-delivered health and social services. The trainee should gain a direct understanding of each one’s function and scope by following patients in a variety of these settings. The training program should also include a discussion of the ways in which case management and patient response differ between crisis-oriented treatment plans and long-term care.

**Suggested References**


This book deals with long-term care of the elderly and covers a broad area as the author’s definition of long-term care suggests. Although it emphasizes the social needs of long-term care patients, whether they are in private homes or institutions, this book is a valuable source of general information for the health professional. Information about reimbursement and economic considerations of long-term care is also provided.


One of the issues dealt with in this wide-ranging chapter is that of rehabilitation. Under the heading of “Social, Institutional and Environmental,” the authors touch on such areas as home care, institutional care, psychiatric care facilities, nursing homes facilities, day hospitals, and outreach programs as these relate to the various aspects of rehabilitation, including long-term care.


The author discusses a number of topics relevant to chronically ill and disabled patients and reports significant research findings. Social, physical, and psychological needs are examined and an extensive bibliography is also provided.

**Rehabilitation and adaptation to chronic illness**

Various rehabilitation techniques and procedures are available to improve functional capacities. These include physical therapy, speech therapy, and occupational therapy. Psychiatrists should be acquainted with the potentials of these therapies and learn how they can benefit patients who also are elderly and have psychiatric problems.

**Suggested References**


This review covers the areas of medication, ECT, and individual and group psychotherapies as these pertain to the geriatric patients. It gives a clear discussion of social, institutional, and environmental interventions covering currently important areas such as the issues relating to nursing homes. This discussion also integrates these issues with the problems of rehabilitation. They are “selective rather than comprehensive and illustrative rather
than exhaustive," and give a sufficient bibliography on rehabilitation of geriatric patients.


This book discusses theoretical and practical approaches necessary to help aged persons and covers briefly several areas including rehabilitation. One of the pluses of this book is the clarity of presentation.


This article deals with basic concepts, definitions, objectives, and goals as these relate to rehabilitation in the elderly. It also covers general, as well as specific, needs for specific handicaps as these occur in the aged. Though this review only deals with four disabling conditions, the principles set forth are succinct and cogent. Although not dealing with mental health needs specifically, the authors refer to psychological issues as they intertwine with somatic and environmental issues.

Hospice care

Hospice care is receiving considerable attention as a meaningful approach to care of terminally ill persons. Thus far, in the United States of America, such programs have cared for young more than aged persons, but applicability to care of the aged is obvious. Physicians and other health professionals should learn about this approach.

Suggested References


This book defines principles of hospice care and discusses psychological and sociological aspects of death and dying. It also describes some existing hospice programs and some of the barriers in implementing hospice programs.


This is an anthology compiled for those who confront the emotional realities of life-threatening illness. A chapter, "Hospice Care in Terminal Illness," written by Robert Woodson, discusses treatment of physical, psychological, social, and spiritual pain. It also contains a brief discussion of philosophical and organizational components of hospice care, including care by an interdisciplinary team, home care service, work with family members, use of volunteers, and coordination of services.


This book describes hospice programs and environments, including administration and evaluation. It also includes chapters giving concise but thorough discussions of patient-family relationships, control of symptoms, and the development of a multidisciplinary team approach.


This book reflects the author's broad knowledge, and provides an historical perspective of the hospice movement and a detailed account of outstanding programs. The vignettes about patients demonstrate the effectiveness of hospice care. Readers will find the extensive bibliography quite useful.
Liaison consultation

Hospital medical and surgical staffs often request psychiatric consultation, and many of the patients are elderly. Consequently, psychiatrists must be familiar with psychiatric responses to serious illness, and this can be obtained by having direct experience with the staffs of hospital units with a high density of elderly patients, e.g., cancer wards, chronic renal and cardiac units, oncology, and hematology units.

Suggested References


Though there is increasing commitment toward the care of the aged, few actual attempts have been made to include gerontology into the training curricula for medical students and residents. This is a report of a successful attempt in introducing the study of gerontology and the services of a gerontologist as a “consultant” to a medical school curriculum. Initially, the program was part of a psychiatric liaison service; later, as the idea of geriatric training gained acceptance, it was introduced into the medical school’s curriculum. The authors describe techniques used to introduce the service as a useful consultation option.


This article describes a model for providing liaison between geriatric and psychogeriatric services. It discusses some of the advantages and disadvantages of such a unit.

Leadership skills for operating a multidisciplinary team

Psychiatrists may be expected to serve as leaders of multidisciplinary teams, and need training to be effective. Leadership skills are essential to assure smooth operation of a multidisciplinary team. Leaders have a particular responsibility to define roles and responsibilities of team members and to facilitate communication and group decision making. Such skills should be acquired if the psychiatrist is to effectively manage multidisciplinary efforts in behalf of the elderly.

Suggested References


This article presents a different aspect of leadership skills by emphasizing the need to be aware of, to consider, and to take steps to adapt to, a changing political climate within a community. Astrachan points out how these changes can affect the functioning of a program and draws attention to leadership skills needed to deal with the various external agencies that would influence a multidisciplinary team.


This article describes a dysfunctional team in an inpatient unit of a state hospital, and it stresses the need for the team leader to be able to lead, to understand, and to remedy the antitherapeutic interstaff interactions as they may occur.
**AUDIOVISUAL TRAINING MATERIALS**

**PFEG1, 28 min/16mm/color/1974, Ronald Kleiser, Focus International, New York, NY.**

This film depicts a Christmas visit to a blind, stroke-crippled grandmother in a nursing home evolving into a touching document of love and a testament to the special part grandparents play in our lives. The family’s difficult visit to the institution is sensitively handled, and the oldest grandson is able to break through the silence imposed by failing faculties to reach his grandmother and affirm his life.

**ROSE BY ANY OTHER NAME, 15 min/16mm/color/1979, Judith Keller, Adelphi University Center on Aging, Garden City, NY.**

In this film, irresistible Rose, a resident in a nursing home, enjoys the nighttime companionship of an elderly man down the hall. The staid administrator warns her that she will have to leave the home if she continues her “unbecoming conduct.” Rose continues; the film ends, and the audience is left to discuss the whole problem of sexuality in the nursing home.

**AGING, 22 min/16mm/color/1973, CRM/McGraw Hill Films, 110 Fifteenth Street, Del Mar, CA 92014; Audiovisual Center, Indiana University, Bloomington, IN 47401; Audiovisual Extended Services, Pennsylvania State University, University Park, PA 16802.**

This is a general overview illustrating that there are many patterns of aging and that commonly-held stereotypes regarding the old are untrue. It presents some of the major sociological and psychological theories of aging (“activity,” “disengagement,” and “holding on”) and also a brief discussion of other patterns, such as: the “constricted,” “apathetic,” “suckerance-seeker,” “disorganized,” and “focused” approaches to aging. It concludes with a short review of current experimental work on the biological determinants of aging.

**AGING AND ORGANIC BRAIN SYNDROME, 28 min/16mm/color, McNeil Laboratories, Fort Washington, PA 19034.**

Alvin I. Goldfarb, M.D., Associate Clinical Professor of Psychiatry at the Mt. Sinai School of Medicine at the City University of New York, and Shervert Frazier, M.D., Professor of Psychiatry at Harvard Medical School, appear in this film. They discuss the diagnosis and treatment of organic brain syndrome and illustrate the use of two specific tests, both simple office techniques, to determine the presence and severity of the ailment. The role of the physician and use of psychotropic drugs in treatment is also covered. A free 32-page monograph that expands on diagnostic techniques and treatment procedure is available.

**AGING WITH GRACE AND HARRY, HAZEL AND FRED, 28 min/16mm/color/1977, Biomedical Communications, University of Arizona Health Sciences Center, Tucson, AZ 85724.**

This film illustrates, through excerpts of interviews of a unique group of older people, couples married for 50 years or more to the same partner, the mutual caring and nurturing in later years of life. It focuses on individual strengths, such as autonomy, high self-esteem, adaptability, optimism, and substantiality in relationships. A study guide is available.

**BEHAVIORAL MANIFESTATIONS IN THE AGING PATIENT, 16 min/16 or 8mm color, Sandoz Pharmaceuticals, East Hanover, NJ 07936.**

Dr. Carl Eis dorfer, University of Washington School of Medicine, demonstrates symptomatology evident in many elderly people. The film stresses how nursing home staff can help in diagnosis and treatment of elderly residents. It illustrates the positive effects of expanded gerontological training.

**DISTURBED BEHAVIOR IN THE ELDERLY, 13 min/16mm/color, McNeil Laboratories, Fort Washington, PA 19034.**

This film is an illustration of the approach of Drs. George Smith and Clarence Taylor to the care of the disturbed elderly in a rural community. It includes their method of diagnosing organic brain syndrome, two patient presentations, and an explanation of management of psychotic symptoms of these patients by appropriate drug therapy.
ELDER-ED: THE WISE USE OF DRUGS, 20 min./16mm/color/1978, National Audiovisual Center, General Services Administration, Order Section, NACDO, Washington, DC 20409.

This film discusses prevention of some of the common problems of use of medications by elderly persons, covering drug problems, communication with physicians, as well as purchasing of drugs, and informed use. It was produced by the Prevention Branch of the National Institute on Drug Abuse as one of a series of model education programs about the wise use of drugs.

EVERYBODY RIDES THE CAROUSEL, 71 min. (3 parts, each 24 min.)/16mm/color/1976, Pyramid Films, Box 1048, Santa Monica, CA 90406; Mass Media Ministries, 2116 North Charles Street, Baltimore, MD 21218.

This award-winning animation of the eight stages of the human life span, described by psychologist Erik Erikson, illustrates the fundamental levels of human development, each age contingent and building on the other, weaving continuity with change.

FACING IT, 25 min./16mm/black and white/1974, Transit Media, P.O. Box 313, Franklin Lakes, NJ 07417.

This film documents experiences of staff and residents in an institution where a program of reality orientation was initiated as a therapeutic approach for patients with organic brain disorder. It presents the elements of an organized therapeutic approach applied in actual situations.

INTERACTING WITH OLDER PEOPLE, Part I, 30 min.; Part II, 26 min./16mm/black and white/1971, Directions for Education in Nursing via Technology (DENT) Project, c/o College of Lifelong Learning, Wayne State University, Detroit, MI 48202.

Techniques to promote interaction with other persons to enhance fulfillment of their psychosocial needs are identified, and attitudes of hospital staff in dealing with the aged are examined.

LOOKING FOR YESTERDAY, 29 min./16mm/color/1978, Edward Fell Productions, 4614 Prospect Avenue, Cleveland, OH 44103.

This film suggests ways to understand the inner world of the severely disoriented aged. It recognizes the use of creative listening, mirroring of body language, and emotional expressiveness to communicate with the confused aged, and illustrates the participation of not only therapists but also other residents of a long-term care facility and their families.

MASTER LECTURES ON THE PSYCHOLOGY OF AGING, Audiocassette Tapes/1979, American Psychological Association, 1200 17th St., N.W., Washington, DC 20036.

This series of lectures comprised the fifth course of the Master Lecture Series, presented during the 86th Annual Convention of the American Psychological Association in Toronto, Ontario, Canada, August, 1978. It includes seven taped lectures:

- "The Biology of Aging," Leonard Hayflick
- "The Sociology of Aging," George Maddox
- "The Psychophysics of Aging," Larry Thompson
- "Methodological Issues in the Study of Aging," Jack Botwinick
- "Cognitive Functioning of Older Adults," Irene Hulicka
- "Personality Changes in Adulthood," Bernice Neugarten

PSYCHIATRIC CONSULTATION WITH THE GERIATRIC PATIENT, 12 min./16mm/black and white/1969, Association Films, 866 Third Ave., New York, NY 10022 (from Roche Film Library).

A psychiatrist's view of a geriatric residential facility is presented with particular attention to the role of a consultant psychiatrist in educating staff to the problems of caring for the impaired, dependent elderly.

RESCUE FROM ISOLATION, 22 min./16mm/color/1972, Mid-American Resource and Training Center, 5218 Oak Street, Kansas City, MO 64112; Gerontological Film Collection, Main Library, North Texas State University, Denton, TX 76203; Transit Media, P.O. Box 313, Franklin Lakes, NJ 07417.

This film documents problems of social isolation of elderly persons not motivated or physically able to take advantage of
community resources. It presents an answer in the form of a psychogeriatric day hospital which is seen as a practical, comprehensive, and realistic option for both the elderly individual and family.

SUCCESSFUL TREATMENT OF THE ELDERLY MENTALLY ILL, Audio-cassette, Duke University Medical Center, Box 3003, Durham, NC 27710.

These tapes present separate discussions of somatic therapies, group psychotherapy, and individual psychotherapy. A guide for each is also included.

THE THERAPEUTIC COMMUNITY, 28 min/16mm/color/1969, University of Michigan Television Center, 400 Fourth Street, Ann Arbor, MI 48109; Gerontological Film Collection, Main Library, North Texas State University, Denton, TX 76203.

This film illustrates mental and social improvements made by geriatric patients in a psychiatric institution as a result of initiation of an innovative program of activity and participation. Dr. Wilma Donahue, of University of Michigan-Wayne State Institute of Gerontology, moderates this award-winning presentation.

TIME OF DEATH: IMPACT OF DYING PATIENTS ON HOSPITAL STAFF, 16 min/16mm/color/1976, Focus International, Inc., 505 West End Avenue, New York, NY 10024; Extension Media Center, University of California, Berkeley, CA 94720.

This film focuses on the anxiety and emotional defense experienced by professional and nonprofessional staff caring for dying patients. It confronts viewers with bedside fear, rage, and anxiety, and emphasizes the recognition of emotional stress on those working with the aging as well as the need for sensitivity in interaction with terminal patients.

THE TREATMENT IS THE CRISIS, 51 min/16mm/color/1971, Transit Media, P.O. Box 315, Franklin Lakes, NJ 07417.

This in-depth study of Parkinson's disease focuses on the use of the drug L-DOPA, with discussion of the pros and cons of treatment which can result in severe depression and other psychological crises. It includes a group therapy session with L-DOPA patients and their families with two detailed case studies.

THE TUESDAY GROUP, 14 min/16mm/color/1972, Edward Feil Productions, 4614 Prospect Avenue, Cleveland, OH 44103.

This film documents an actual group session of severely emotionally and physically impaired elderly and illustrates confusion and fantasy, and therapeutic techniques with the group.

WHEN PARENTS GROW OLD, 15 min/16mm/color/1973, Learning Corporation of America, 1350 Avenue of the Americas, New York, NY 10019.

Excerpts from the feature film, "I Never Sang for My Father," have been edited specially to illustrate the painful emotional crises of parental old age and death.

WHITHER OR WITHER MENTAL HEALTH, 30 min/16mm/color, Gerontological Film Collection, Main Library, North Texas State University, Denton, TX 76203.

Health and social sciences are presented as an interrelated synergistic system and dramatizes the way actions in one agency affect other agencies and the entire community.

WORKING WITH DEATH, series in three parts/16mm/color/1975, American Video Network, 660 South Bonne Brae St., Los Angeles, CA 90057.

This series of three separate films illustrates feelings and experiences of terminally ill individuals, their families, and the members of the caregiving professions working with them. Death and the Doctor (20 min) focuses on the attitudes and experiences of six different physicians. The Dying Patient (19 min) examines the reactions of patients dealing with life-threatening illnesses. The Family (15 min) reveals the stress experienced by family members of the dying person. The series is geared to foster communication between the physician, health care team, patient, and family.

WORKSHOP ON AGING, Super 8mm in Fairchild 70-20 cartridges, color, Sandoz Pharmaceuticals, East Hanover, NJ 07936.

- Organic Brain Syndrome I (18 min) discusses the confusing labels of organic brain syndrome and the attitudes of hopelessness and apathy that elderly patients often encounter and explores the
primary manifestations of OBS and the possible underlying causes of different organic brain syndromes. One patient is presented to demonstrate primary symptoms and proper interviewing techniques.

- **Organic Brain Syndrome II** (15 min) focuses on differentiation of acute and chronic organic brain syndromes based on distinguishing points from the interview, history, physical exam, laboratory studies, and behavioral and cognitive evaluations. It identifies multiple conditions that may induce acute OBS. One patient is presented to illustrate a mild organic brain syndrome secondary to hyperthyroidism.

- **Depression I** (15 min) explores various forms of depression seen in the elderly ranging from "existential depression" to unipolar depressions, and identifies primary manifestations of "agitated" and "retarded" depressions. Two patients are presented for illustration of depression as legitimate sadness in old age and as reactions to excessive losses.

- **Depression II** (15 min) covers basic diagnostic and management issues raised by elderly depressed persons. Need for early diagnosis and prompt treatment is emphasized. Discussions of possible varied causes of depressive disorders in the elderly are enhanced by two patient presentations to demonstrate "agitated" depression and the coexistence of depression and organic brain syndrome.

- **Paranoia** (15 min) explores late-onset paranoid states and their various possible causes and discusses a medical approach to diagnosis and management of paranoid elderly persons. One nursing home patient is presented to demonstrate needs of paranoid individuals in a long-term care institution.

- **Behavioral Problems in the Elderly I** (15 min) illustrates common behavioral problems in elderly nursing home patients. Causes of behavioral problems as well as strategies and considerations in the management of such problems in the elderly are reviewed, and three patient presentations demonstrate the range of problems and treatment techniques.

- **Behavioral Problems in the Elderly II** (15 min) illustrates behavioral problems which are encountered in the elderly. It also explores effective management strategies and analysis of the behavioral problem, involving comprehensive patient evaluation, including physical, psychological, social and environmental factors. The film includes three patient profiles.

- **Issues in Death and Dying** (15 min) deals with dying and death. The central theme is directed to the patient's final experience in living and surviving. Several patients are presented to illustrate the variety of ways in which the dying process can evolve. The issues rest not so much on the patient's terminal care, but rather on the successful role that the physician and other health professionals can play in the complex process of the living/dying/state.

**FURTHER READING**

**Publications of the Group for the Advancement of Psychiatry:**

- **S-10** URBAN AMERICA AND THE PLANNING OF MENTAL HEALTH SERVICES—Nov. 1964.
- **78** THE FIELD OF FAMILY THERAPY—March 1970.
- **R-79** TOWARD A PUBLIC POLICY ON MENTAL HEALTH CARE OF THE ELDERLY.

* S refers to Symposium.
Recommended texts:


Other suggested readings:


A. Verwoerdt (ed.). CLINICAL PSYCHIATRY (Baltimore: Williams & Wilkins, 1975).


Hospital and Community Psychiatry. Special Issue on Aging, 33:2, February 1982.


E. Eisdorfer and W.E. Fann (eds.). PSYCHOPHARMACOLOGY OF AGING (Jamaica, N.Y.: SP Medical and Scientific Books, 1980).


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