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MINOR MALADJUSTMENTS OF THE AGED

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One person in ten in the United States is now sixty-five years of age or older. About 1/2 million of these 20 million people are between sixty-five and seventy-four years old, 6 million are from seventy-five to eighty-four and 112 million are eighty-five or more years old. They are obviously a heterogeneous group ranging in age from sixty-five to over ninety years of age, in various states of physical health, functional status and vigor, who vary in education, occupation, ethnic group, and cultural background. They reside in private homes, hospitals, nursing homes, or old age homes, are for the most part poor, but differ widely in economic supports and social status. Many have had psychological or emotional problems over a long period of time and bring into old age mental diseases first noted in youth; others become mentally impaired or psychiatrically ill for the first time in their old age. In some of them, it is a previously existing disorder that emerges as significantly troubling or troublesome because of age related changes in social status, role, or health. In the past twenty-five years there has been increasing interest in the treatment of old persons with psychiatric disorders of all kinds, including those which reflect brain damage.

There are many reasons for the increased attention to the psychiatric

disorders of the chronologically old. Among them is the vast number of the disorders, the public health problem created by the depressed old and those with syndromes reflecting brain dysfunction or damage. Medicare financing has increased the demand for services and has helped make more service available. Also, there is growing interest in long-term illness and the deteriorative or degenerative diseases of aging now that infections, metabolic disorders, and many acute conditions are coming under better control. In addition, the sudden rapid advance in pharmacotherapy and the expansion of knowledge about the biochemistry of the psychoses have made possible greatly improved care of disturbing, disturbed and depressed old people, and have added to the efficacy and safety of electroconvulsant treatment. Of special importance is the impact created by the availability of phenothiazines and similar "antipsychotic" drugs since the mid-1950s, and the revolution in the treatment of depressive disorders with the introduction of monoamine oxidase inhibitors and the antidepressant, tricyclic, drugs in 1957 and 1958.

At the same time, there has been growing recognition that drugs and physical modes of treatment, even when they can be specifically helpful, are not entirely sufficient for best results. Moreover, in a host of conditions medication is at best merely adjunctive. To this has been added the confrontational attitude of the departments of mental hygiene, or their equivalents, on a country-wide basis, to discourage the use of state hospitals for persons who may become problems of long-term care, who appear to

have serious and acute physical illness, or are not clearly “psychotic.” Right or wrong, such action has pressed “back to the community”—to general hospitals, community mental health centers, private physicians, nursing homes, old age homes and various agencies a host of new problems.

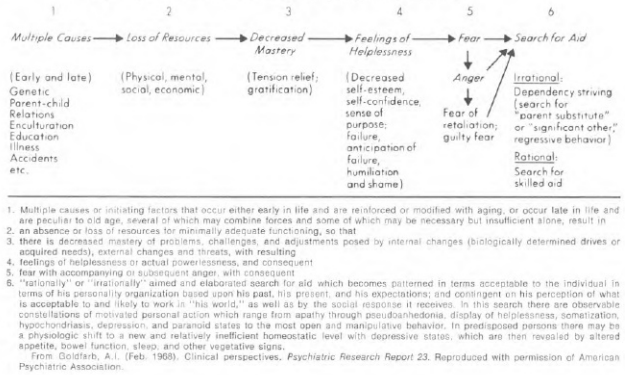

Figure 37-1.
Components of disorder: psychodynamic sequence.

Activities programs, special services and dyadic or group therapies are expanding because they appear to improve sociability, social integration, and the mood of old persons with psychological or emotional problems, even when they are also brain-damaged as reflected by accurately measured brain syndrome. This has led to expansion of efforts, over the past twenty-five years, to provide psychotherapeutic relationships in private practice and for old persons in hospitals, old age, or nursing homes, as well as by way of clubs, centers, and educational facilities. New subdivisions of old disciplines are

emerging to help manage, care for, and provide special services for the old and aged.

At the present time psychiatrists, psychologists, social workers, nurses, administrators, and even laymen acting as volunteers or by way of self-appointment to quasi-professional status are engaged in such activities. This chapter will discuss, from the psychiatric point of view, some of the problems, views and solutions emerging.

A conceptual scheme useful in the practice of psychiatry with elderly persons is outlined. This scheme permits the organization of information in an eclectic way without sacrificing opportunities for understanding of psychodynamic factors or opportunities for psychodynamically oriented psychotherapy. It encourages treating the disturbed or disturbing behavior of elderly and aged persons, whether with brain damage or without, as if it were motivated and purposive goal-seeking. It also places emphasis upon the therapeutic value of the personal relationship, and upon the importance of the relationship for the initiation, maintenance, and supplementation of other modes of treatment required by a special condition. The schema around which this chapter is developed is outlined in Figure 37-1. As noted in Figure 37-1 many factors may reduce the adaptive capacity of old persons.

Geropsychiatry

A part of the burgeoning of interest in the old and impaired has been the growth of a subspecialty of psychiatry called “geropsychiatry” in the United States and “psychogeriatrics” in Great Britain. The latter term is preferred by the World Health Organization. This small group of specialists has been concerned with defining how psychiatrically or psychodynamically oriented health care delivery as well as specific psychotherapy can be most clearly delineated for the purpose of training, effective application, and advances through research.

Geropsychiatry is the branch of psychiatry concerned with the mental disorders of old age, but particularly with those that first emerge as significant in the chronologically old. Defined in this way, the field of the geropsychiatrist may include those persons who have aged in the hospital because of schizophrenia, manic-depressive psychosis, or other disorders resistive to treatment, whose course was complicated by institutional neglect, or for whom there has been necessary provision of either a protective hospital community life or hospital-type care in the community. The psychiatric problems that are related to aging, which first emerge in old age, or which having existed before first emerge as significant, or take on new and special importance in old age, are the geropsychiatrist’s chief area of interest. Many of these disorders are not yet easily classified. They occur in the old and in the aged under a variety of conditions, and in various residential settings.

The major psychoses and specific disorders that occur in the aged, although within the field of geropsychiatry, are covered elsewhere in this volume. Consequently, the emphasis here is on the variety of disorders that have not been nosologically specifically dignified, and upon psychodynamic factors common to all.

Psychodynamic or interpersonal factors, as now understood, may play no, or only a small, contributing role to the genesis and development of mood-cyclic, recurrent depressive or schizophrenic reactions. The afflicted person, his family or his physicians, however, may see logical connections between such factors and the disease, which actually do not exist and alterations of which make no prophylactic or therapeutic difference.

Mood-cyclic disorders, recurrent depressions, and schizophrenic episodes, whatever their original causes, may in old age be equivalent to and provoke the same responses as disabling accidents, illness, material or social loss. They contribute to decrease in the person's adaptive capacity and also may exacerbate or aggravate other illnesses or impairments and may themselves be exaggerated or exploited in the reconstituted adaptational pattern.

Old Age

Chronologically old persons, as the term is used here, are persons more

than sixty-four years of age. This choice of age is an arbitrary one but it has legal and traditional basis and it does indicate that point of life at which time impairment of mental and physical functions, decline, and changes stigmatic of aging, become increasingly manifest.

The Aged

The truly aged are persons who when chronologically old have also suffered a decline in physical or mental functional status to a degree that interferes with the socially acceptable performance of routine activities. Aging is decline in functional status based upon irreversible structural change. Examples are changes in the lens of the eye which limit function and create a need for prosthesis, deafness related to sensory neural changes, loss of connective tissue elasticity, decline in homeostatic efficiency, loss in muscle fibers and strength, and probably of greatest importance, the loss of cells in the central nervous system. Also, the effects of disease may grossly decrease functional capacity. Decrease in the functional status of the heart, lungs, kidneys, bladder, or bowel in old age may result in poor support of the brain. The loss of functioning neurons in the central nervous system may be sufficiently great to give rise to organic brain syndrome. Other losses, the loss of income, even of savings, and the loss of status, role, and the prestige and power these carry, may be psychologically and emotionally traumatic, and also mean that real protective or comforting services and alliances are

removed. With old age, there are losses of persons by death, geographical removal, illness or preoccupation with personal problems; these losses may constitute the disappearance of protective, reassuring, and supportive relationships without which the individual feels abandoned, vulnerable, and weak. To the socioeconomic, psychological, physical, and mentational losses are usually added losses or absences of resources for optimal adaptive functioning that occurred prior to old age. Genetic factors, enculturation, education, occupation, the experience and special social factors which were operative early in life play a part in determining the adaptive status in late life, There are therefore differences in individual ability to substitute for losses with aging, to be flexible in the choice of ends or goals with change in status, and to make optimal use of remaining assets when loss of resources has occurred.

The Well-Adjusted Old

The well-adjusted aged appear to have carried into late life the capacity to gain gratifications, to relieve their tensions—both the biologically determined and those acquired through enculturation and life experience—so as to maintain their self-esteem, self-confidence, purposivity, and a satisfying sense of personal identity and social role despite losses that may occur with aging. This differs from the maladjusted who, either because of earlier influences upon their personality development or differences in life

experience at whatever age, do not have the resources to deal constructively and efficiently with life problems.

Well-adjusted persons of sixty-five or over appear to have emotional needs that do not differ greatly from those of younger persons. They have a minimum of complaints. They desire friendships, of varying types of intensity of intimacy, with both sexes. They want to keep busy at work, or at play equivalents, which are within their physical capacities, are commensurate with their intelligence and background of training, and from which they derive a sense of accomplishment. They look for, and object to frustration of, opportunities for the relief of biological tensions, such as hunger and sexual desire. In addition, they may crave, in varying degrees, appreciation, marks of affection, and reassurance that they have made an impression upon this world by means of words, deeds, or by having reproduced themselves. In this way, self-esteem, which in the past rested upon and was reinforced by current performance, can be maintained by the assumption of special status or personally gratifying "life-review." In all this, there may be some difference from adjustment in youth, characterized by mellowness—a lack of haste or pressure, an inner patience, and a philosophic tolerance growing out of a satisfied curiosity. Obviously, emotional problems may be encountered among elderly well-adjusted people. They may meet these successfully alone or may require counsel, guidance, information, or even psychotherapy, as may any younger person under social stress.

Relatively well-adjusted older persons usually are found in their own homes. Old persons who live with relatives usually do so because of financial, physical, or psychiatric need for care. There are many relatively well-adjusted persons in old age homes or other protective settings, but, again, such residence usually denotes need for care and associated psychological problems. The use of a protective setting even when the indication appears to have been physical is usually a clue to the coexistence of psychiatric problems. Persons in nursing homes or other protective settings for the ill are often psychologically and emotionally disturbed—sometimes, in reaction to the illness, often, because there have been such problems long preceding the illness or impairment, which appear to have led to the use of a congregate care facility, because these result in excess disability and to complications in the provision of care.

Protectors Against Low Morale and Maladaptive Behavior

Genetic factors undoubtedly have an influence upon early development. The fortunate child has healthy and well-to-do parents who tend to provide the nurturance which favors nature and leads, through the provision of good schooling, helpful enculturation, and assistance toward remunerative and sustaining occupation, to health-reinforcing experiences. Even in the absence of optimal inheritance, good nurture favors healthy development. Thus, good mechanisms of physical, mental, emotional, and social adaptation when

taught and encouraged early in life tend to become well established, automatized, and to persist throughout the lifetime into late old age.

Relative affluence, high educational level, relatively high or respected social status, and good physical health appear to favor good social integration, minimal complaining by the persons, and a minimum of complaints about them. This is summarized in Table 37-1.

Not only are money, well-established adaptive patterns, and health instrumental in maintaining an individual's good feelings about himself and his world, but these factors appear to be closely related to how he presents himself and to the social relationships he has established. All of these factors —and particularly social relationships—may be highly protective against personal neglect and a need for congregate facilities. Protective factors defend him from losing self-sufficiency and becoming more openly dependent upon others.

Table 37-1. The Factors Which Protect Against Low Morale

FACTOR	PROTECTIVE DEVICE	PROTECTIVE EFFECT	RESULT
Relative Affluence	Economic security: food, shelter, services, mobility, medical care	Freedom from fear and anger	Limited need for family and friends
	Physical security: power physical	Assertiveness	

	comfort pleasure		
High Educational Level	Well established mechanisms of: psychological, social and emotional adjustment	Self-confidence Self-esteem Self-direction: interests purpose	Responsiveness to needs of family
	Diversity and range of interests	(Sense of identity)	
Social Status	Social security	Social independence	Capacity for solitary self-enjoyment
Good Health	Power	Physical independence	Ability for independent production or pleasurable activity
	Mobility		
	Physical comfort or pleasure		
	Physical security		

High morale in the aged is favored, not guaranteed, by early opportunity in finances, education, social position, and health. Goldfarb, A. I. "Responsibilities to Our Aged," *Amer. J. of Nursing,* Vol. 64, no. 11 (1964) 78-82.

In sum, good adjustment in old age is characterized by relatively good physical and mental functional status in which the person evidences that good personal habits of physical, psychological, emotional, and social action have been well established or automatized; these in turn favored and were reflected by past good occupation and role acceptance and achievement,

which themselves have usually stemmed from the existence of favorable early opportunities and good education. The persons who do best in old age appear to have had good endowment and favorable socioeconomic and personal circumstances that enabled them to develop and continue adaptive ways of life.

The Maladjusted Old Person

In contrast to the well-adjusted chronologically old are those we identify as maladjusted, who have "low morale," as evidenced by many complaints; physical, emotional, economic, domestic, personal, psychological. These may be elaborated and organized in special ways which we identify as psychiatric disorders or syndromes. But also, the maladjusted are persons who express distress and malcontent, and about whom there are complaints by the family and often by social community, as well. Also, as put by Meyer, the physician, in labeling these persons as being ill with this or that disorder, then signals his professional complaint about the patient, which he elaborates in medical terms, to denote what is wrong about the patient that needs, as he sees it, correction.

Poverty, physically or emotionally determined strong needs for support from relatives, friends, or other persons, especially when these decrease self-sufficiency and make for overt material need in addition to implicit and

emotional dependency contribute to low morale, and to complaints of loneliness, boredom, mental distress, and pleas for aid. Contrary to general ideas about the importance of physical health, from the point of view of protection against low morale and maladjusted behavior, it is better to be rich and sick than poor and healthy. While this is undoubtedly related to the protective powers of material wealth, it probably also is so because relative affluence and social class are indices of education, prior occupation and habits, and ways of life that contribute to intrapsychic homeostasis and good social relations.

There is a wide range of maladjusted behavior in old persons. These difficulties are not always clearly part of recognized psychiatric disorders or syndromes. Their association with poverty, physical impairment, disability, and illness makes for their higher frequency in protective congregate residential settings of all kinds and poses great administrative, special medical, and comprehensive health care problems of such sites.

Minor Maladjustments

There is now a trend to categorize the predominant number of psychiatric disorders of the old as minor, in the sense that they do not primarily require psychiatric attention because they are related to physical or mental impairment, are social problems, in that they require long-term

protective care or appear to fall into the category of psychoneurotic and character disorders modified or accentuated by aging and the problems of the old. Many of the minor maladjustments of the aged may in actuality be major disorders that are being relatively well handled by old persons, that are well tolerated by their social environment, or which are mistakenly diagnosed, but well treated, or which are ignored and, beneficially or otherwise, neglected.

Traditionally, psychoneuroses have been considered the minor, and psychoses the major, mental disturbances. However, an individual may be psychotic from the medical and psychiatric point of view and yet make a good, or at least passable, socioeconomic adjustment, whereas, on the other hand, many persons whose disorder is defined as psychoneurotic may undergo extreme suffering and may present great problems of disability requiring long-term care. Brought along into old age are many mental disorders which did not trouble the family or the community, or which were tolerated or even protected, because of special circumstances or the person's occupational adjustment or special skills. Psychoses, psychoneuroses, and behavior disorders of every variety may be revealed late in life when circumstances change or when attractive appearance, opportunity, skill, or position is lost. Also, an old person may be chronically or acutely ill or malnourished. Any one of these troubles, or a combination of them, adversely affects cerebral functioning. This adds to the problem of differentiating between what is to be considered a minor and what a major disorder.

Symptomatic evidence of organic brain syndrome, associated memory loss and confusion seemingly related to cerebral arteriosclerosis or senile sclerosis may incorrectly be assumed to be a major disturbance of mentation premonitory of inevitable progression to disability, emotional dyscontrol, personality change, behavioral disorganization, and the loss of productive capacity and social adaptability. Strong emotion alone, however, may result in exaggeration of relatively minor defects of comprehension, orientation, memory, and judgment—and may lead to a mistaken impression about the severity of the disorder and to the belief that treatment is useless. With minimal brain damage, fear and anger may be so floridly elaborated as to descriptively appear to warrant the label "psychosis." Conversely, persons who appear to have moderate to severe brain damage, and whose behavior is grossly maladjusted, may improve on the establishment of good patient-doctor relationships in a properly supportive environmental setting or in response to relatively minor medical procedures, because the disorder is actually of the functional variety, expressed chiefly by way of exaggeration or exploitation of the impairment. In addition, mood-cyclic disorders or recurrent depressions themselves may be, in old persons, troublesome episodes which limit their adaptability, the nature of which they understand and to which they react as to any handicaps or losses of effectiveness. Insightfully or not, they simply respond with depression about the depression. For these reasons, it is better to talk of behavior disorders or

disturbed behavior in older persons with or without vegetative nervous system signs and with or without chronic brain syndrome, rather than to attempt to make differentiation between psychoneuroses and psychoses.

Traditional diagnostic procedures, however, are not to be discarded as useless. The measures of depression, especially the presence or absence of vegetative signs—appetite, bowel, sleep disturbance, and diurnal variation of mood—are clues to therapy and of great psychotherapeutic importance. The cognitive defects found in depressive disorders which appear to be chiefly related to preoccupation, decreased attentiveness and poor concentration are not the same as those which reflect brain damage. Evidence pointing to severe brain damage is a grave prognostic sign. From a practical point of view evaluation should include (1) whether potentialities to harm self or others exist; (2) to what extent nuisance value is present; (3) the extent and quality of the patient's suffering; and (4) to what extent they may be modifiable.

In all cases, a psychotherapeutic trial, in addition to good nursing and medical care, is indicated. A detailed knowledge of the symptomatology is less important than data which point to the modifiability of those medical, environmental, or personality factors that influence and maintain the disorder. Of utmost importance is the fact that many disorders are indistinguishable from those seen in younger persons and respond equally well to the same treatment procedure, even when a relatively mild degree of

organic brain syndrome is actually present.

There is a great difference in outlook, as well as need for treatment, of persons with severe degrees of brain syndrome, as compared to those with lesser degrees of the syndrome. The needs of persons who have organic brain syndrome with affective disorder also differ on the basis of the type and severity of the mood disturbance. Consequently, all persons who work with old people, whether in their own homes or residential care facilities, should have knowledge of how persons with no, little, or considerable amount of brain syndrome can be differentiated, and of how brain damage complicates or is complicated by mood disorders.

Brain Damage or Brain Dysfunction and Maladjustment

The sufferer, his family, or the social environment and the doctor usually agree that the patient's loss of resources for good adjustment is serious when there is brain damage.

Patients with moderate to severe brain damage may mistakenly be thought to be depressed if they are listless, lacking in initiative, and relatively meek and mild; in actuality, depression may be present in the moderately brain-damaged. Brain damage and its reflection brain syndrome, however, may not be faced by family or friends until it causes gross disturbances; it is not uncommon to be presented with a complaint that the patient has shown

decreased memory for one year, when careful history-taking reveals five or more years of decline in functional status.

The declines in functional capacity related to cerebral damage or dysfunction can be measured in a variety of ways to help determine the degree of impairment or disability. Such measure can help in planning care and predicting the course of illness and longevity.

By impairment is meant the loss or limits of function, determined by the structural damage or biochemical disturbance. By disability is meant the decreased capacity of the impaired individual to function as a self-sufficient, sociable, and socially integrated person. Persons with a high degree of physical impairment may be minimally disabled; persons with a slight degree of physical impairment may be severely disabled because of the coexistence of brain damage, or because there are emotional and psychologically motivated exploitation or exaggeration of the impairment; not infrequently impairment of cerebral type is utilized in this way and masquerades as more severe than the lesions dictate. Such states can be termed conditions of "excess disability."

Consequently, it is imperative that there be careful definition of the impairments, disabilities, or syndromes in terms of how they are measured if the treatment approaches are to make sense and be properly evaluated in

respect to their value, and if the outlook for improvement or recovery is to be fairly evaluated.

Organic Brain Syndrome

This is the term now preferred for the psychiatric constellations of signs and symptoms that reflect brain dysfunction or brain damage. This term covers what was previously simply called "brain syndrome" and includes all the conditions at one time categorized as "senile dementia"—variously subdivided—and "cerebral arteriosclerosis with psychosis, type specified." It is also referred to by some, chiefly neurologists, as "organic mental syndrome." The World Health Organization has recently advocated calling it the "psychogeriatric syndrome" and agrees that every effort should be made to evaluate its degree of severity, when present.

Organic brain syndrome may be acute, that is to say transitory and reversible—or at least partially so—because the cognitive disorder is a reflection of central nervous system dysfunction or, it may be chronic, because the brain is permanently and irreversibly damaged; the damage reflected by brain syndrome is a diffuse cortical loss of brain cells, often especially marked in both hippocampal areas. Many investigators are convinced that chronic organic brain syndrome is pathologically indistinguishable from Alzheimer's disease.

Organic Brain Syndrome, Acute

Acute organic brain syndrome is an acute confusional state which may reflect cerebral tissue dysfunction. Examples are infections with fever, tachycardia, or other effect which may affect the brain, alcohol or drug intoxication, or withdrawal; avitaminosis—as in the Wernicke-Korsakolf syndrome (thiamine chloride)—and pellagra (nicotinic acid); hepatic dysfunction, renal disease or electrolyte imbalance, especially when there is a low potassium level; poor support of cerebral nutrition, metabolism, circulation, or oxygenation, as in diabetic or hypoglycemic states, and with low blood pressure related to myocardial infarction, shock, or surgery; interference with circulation on account of stenosed carotid vessels, polycythemic vera, cerebral edema, or poor oxygenation with severe anemia, pulmonary disease, or cardiac failure. These causes of brain dysfunction are potentially reversible states and the brain recovers, if intervention is timely. Usually, the underlying disorder can be quickly identified by physical examination or laboratory study, and therapists must be alert to indications of fever, cardiac or pulmonary dysfunction, dehydration or electrolyte disturbance, as well as to a history of head trauma, drug ingestion, surgical operation, and the like. At times, a cryptogenic disease, such as carcinoma of a bronchus, or carcinoma of the colon (especially if cortisone-producing), or pancreatic insulin-producing tumors may result in cerebral dysfunction. Multiple drug use is a very frequent cause of acute organic brain syndrome.

Medications for diabetes, hypertension, glaucoma, and Parkinsonism, the antihistaminics, antidepressants, or antipsychotic drugs are common offenders, as are digitalis, sedatives, hypnotics, and analgesics. Overmedication, errors made in self-medication, and often the simultaneous intake of medicines prescribed by a number of different physicians who know nothing of each other but are seen by the patient over the same period of time, make iatrogenic acute organic brain syndrome a common syndrome. Also, alcoholism is not uncommon in the old.

Organic Brain Syndrome, Chronic

Organic brain syndrome, chronic, is the irreversible disorder which reflects brain damage. It may follow repeated episodes of acute cerebral dysfunction or may be the result of insidiously progressive cerebral cellular loss— cell loss which undoubtedly occurs with aging in all persons and whose rate probably varies from time to time. It probably also varies from person to person and may increase in old age either for reasons of genetic origin, or because of disease of early onset but late effect, or with the diseases in later life.

The organic brain syndrome is characterized by disorientation for time, place, person, and situation; memory loss, both remote and recent; inability to recall, learn, and to retain for recall general information of the simplest type,

and inability to do calculation of the simplest type. In the American Psychiatric Association Diagnostic Manual of 1968 the syndrome is described as also including poor judgment and shallow, labile affect. These are, however, not invariably present and are quite difficult to measure, and do not appear to be valid reflectors of brain damage.

Organic brain syndrome, chronic, is not a psychosis or disease, it is an impairment which reflects damage to the brain; it is a deficit which can be compounded and complicated by emotion, so that disability may exceed the basic defect. Affect, thought content, and behavior may be seriously disturbed in the presence of or in reaction to this cognitive defect with variable symptomatology. It is of paramount importance to recognize its presence, so that the type of relationship that reassures, supports, and sustains such persons can be established.

The Measurement of Organic Brain Syndrome

There are a number of ways in which organic brain syndrome can be measured. Among the best is the Mental Status Questionnaire and the double simultaneous stimulation of face and hand (the Face-Hand Test). This has been validated and found to be reliable by the simultaneous examination of over 1200 institutionalized patients by psychologists, psychiatrists, and internists who followed the patient's course over a nine-year period.

The Mental Status Questionnaire is shown together with its relation to the areas tested in Table 37-2.

Scoring, recently modified on the basis of continuous clinical experience with non-institutionalized patients, is shown in Table 37-3.

*Table 37-2. Mental Status Questionnaire—"Special Ten"**

QUESTION	PRESUMED TEST AREA
1. Where are we now?	Place
2. Where is this place (located)?	Place
3. What is today's date-day of month?	Time
4. What month is it?	Time
5. What year is it?	Time
6. How old are you?	Memory-recent or remote
7. What is your birthday?	Memory-recent or remote
8. What year were you born?	Memory-remote
9. Who is president of the U.S.?	General information-memory
10. Who was president before him?	General information-memory

* Modified from Mental Status by Kahn, Pollack and Goldfarb. Goldfarb, A. I. "The evaluation of geriatric patients following treatment," in P. H. Hoch and J. Zubin, eds., Evaluation of Psychiatric Treatment. New York: Grune & Stratton, 1964.

It should be noted that the Mental Status Questionnaire can do more than evaluate the degree of brain syndrome. It can provide information about behavioral patterns. Patterns of evasion, defensiveness, hostility, and confabulation are discernible when the Mental Status Questionnaire is properly annotated and interpretively reviewed. Misnaming of place or mistakes about time can yield considerable information about the emotional state and adaptational striving of the person.

The Face-Hand Test

The Face-Hand Test is a brief, simple procedure of double, simultaneous stimulation, first described by Fink, Green and Bender as a diagnostic test for brain damage in which errors of response are reliably associated with brain damage in adults. The subject sits facing the examiner, hands resting on knees. He is touched or brushed simultaneously on one cheek and the dorsum of one hand, the order shown in Table 37-4.

Table 37-3. Scoring of M.S.Q.

NO. OF M.S.Q. ERRORS	PRESUMED DEGREE OF O.B.S.
0-2	Absent or Mild
3-5	Moderate
6-8	Moderate to Severe
9+	Severe
Non-testable*	Severe

* In the absence of deafness, language difficulty, or other impairment of rapport. Goldfarb, A. I. "The evaluation of geriatric patients following treatment," in P. H. Hoch and I. Zubin, eds., Evaluation of Psychiatric Treatment. New York: Grune & Stratton, 1964.

A patient who learns to report correctly, consistently—verbally or by sign—where he is touched after the bilaterally symmetrical touching trials, Numbers 5 and 6 in the table, is presumed to be free of brain damage. Persons may not report the touch to a hand (extinction), may localize the hand touch to the cheek, the knee, or elsewhere (displacement), may point to the examiner's hand (projection), or outside himself in space (exsomethesia). All of these are errors.

*Table 37-4. Order of Stimulation Used in Face-Hand Test**

1. Right cheek—left hand
2. Left cheek—right hand
3. Right cheek—left hand
4. Left cheek—left hand
5. Right cheek—left cheek
6. Right hand—left hand
7. Right cheek—left hand

8. Left cheek—right hand

9. Right cheek—right hand

10. Left cheek—left hand

* As modified from Bender, Fink and Green by Kahn and Pollack. Goldfarb, A. I. "The evaluation of geriatric patients following treatment," in P. H. Hoch and J. Zubin, eds., Evaluation of Psychiatric Treatment. New York: Grune & Stratton, 1964.

The test is done first with the patient's eyes closed, and if he makes errors it is repeated with eyes open. It is of interest that when incorrect replies are made with eyes closed, there is only infrequently improvement with eyes open. The test is very highly correlated with brain syndrome as measured by the Mental Status Questionnaire, and as determined by psychiatric impression. It is somewhat less reliable in alert, well-educated persons, and persons with depression, agitation, or hypomania, than is the Mental Status Questionnaire. The fact that the patient may respond to this test correctly, although a cursorily done Mental Status Questionnaire suggests severe chronic brain syndrome, should influence the examiner toward hopefulness about affecting functional ability despite impairment. Decrease of any affective disorder present may reveal more resources and adaptability than the history or the present mental status otherwise suggests.

In addition to these simple measures, the patient may be asked to first spell simple words—cat, dog, let—forward and backward. This can usually be

done when mild to moderate brain syndrome is present, but is difficult for the more severe. Ability to spell such words as tract, crowd, left, seven, or banana, is impaired with moderately severe and severe brain syndrome and may prove to be stumbling blocks for the mild to moderately impaired. The subtraction of seven from 100, the repetition of more than four digits backwards, the recall and recounting of short, simple anecdotes are usually beyond the capacity of persons with organic brain syndrome. However, difficulty with these tests may be indicative of depression of affect alone and may not signify organic brain syndrome if the M.S.Q., Face-Hand Test, and tests of spelling are well performed.

Measures of Decreased Functional Capacity

Measures of how well the person can conduct himself in the activities of daily life can be used as an adjunctive measure of organic brain syndrome. Ability to travel alone, to shop and cook; to do ordinary housework; to bathe oneself; dress, undress, and wash independently; get about on foot or by wheel chair unassisted; transfer from bed to chair alone; be continent of bowel and bladder, and tend to one's toilet needs is one such list of routine daily activities. By this fist, the incontinent and bedfast are considered severely impaired, the nonambulatory are often moderately to severely functionally impaired, those who can dress, undress, and wash may be moderately impaired, but those who can bathe, shop, and cook are usually

mildly to moderately impaired, while those who can travel alone probably have no or only minimal mental impairment.

"Functional" versus "Organic" Disorder

As noted, many tests of cognitive functioning that are part of the psychiatric mental status actually measure deficiencies in memory, abstraction, attention, concentration, that accompany or are part of depressive syndromes. Thus, difficulty in doing serial seven abstractions, in attending to, recalling, and repeating a short story, in repeating digits forward and backward, or in associating freely to specific words, are not measures which necessarily reflect brain damage.

Depression, Mistaken for Organic Brain Syndrome

The discussion of organic brain syndrome is somewhat detailed because in the heterogeneous group of old persons who have no obvious "major" maladaptive process are not only those with problems related to social, economic, and health losses, but also many whose difficulties are related to loss of mentational capacity.

It is of great importance to know whether the mentally ill person who appears to be bewildered, puzzled, indecisive, helpless, does or does not have organic brain syndrome, and to what degree. This can usually be determined

at once, in the first interview, although psychiatrists unfamiliar with the patterns of organic brain syndrome may need a longer "period of observation" which should be, actually a period of physically, mentally, and emotionally supportive treatment.

In the purely functional disorders, there is no true confusion—there is no disorientation —although memory and cognitive capacity may be below par along with attention, concentration, initiative, and motivation to respond, learn, and perform well. A functional disorder in the presence of measurable organic brain syndrome generally indicates that the degree of organic brain syndrome may test as more severe than its actuality. Affective disorder, paranoid or other schizophrenic reactions with organic brain syndrome are usually as responsive to treatment as when there is no organic brain syndrome. It is important to recognize that cognitive defects may be present with depression but depression does not explain disorientation or, in the ambulatory, physically well patient, incontinence. Attributing diagnosis of an entity which can be termed "pseudodementia" it constitutes a mistake in diagnosis.

Organic Brain Syndrome

Organic brain syndrome may begin with decreased recent memory and inability to learn, and then, rapidly or slowly, go on to include deficits of

remote memory which are fully as great. It is in the early, developing phase that confabulation is most obvious. It seems true, however, that confabulation is evidenced more by some types of persons than others. In many, it appears to be a masking from the self, as well as from others, of the deficits, the acknowledgment of which is impossible in the same sense that the loss of a loved one cannot initially be believed. A part of the self has gone, has been taken away; this is grievous and must be mourned, but is first greeted with disbelief, later with anger, still later dealt with constructively piecemeal, and perhaps finally accepted, in that preoccupation and concern with the defect is relinquished and, if adequate assets remain, attention and engagement in the pursuits possible are more wholeheartedly resumed.

As shown in Table 37-5, the various ways of assessing intellectual, that is to say, cognitive, defects, performed by well-trained and experienced clinicians, are generally concordant, and these measures do appear to be directly related to brain damage as assessed by post mortem, course of illness, and longevity, the electro encephalogram, pneumoencephalogram, and arteriogram. In the recent past, based chiefly on Rothschild's data, it has been stated that the degree of organic brain syndrome is not directly related to brain damage, gross or microscopic. However, when the clinically determined intellectual deficits of the cases cited by Rothschild are compared to the pathologic findings, there is concordance. When the degree of disturbance of overt behavioral reaction is compared to pathology, then

concordance is absent. In short, brain damage is related to cognitive defect, but not to disturbance of mood, thought content, and overt behavior. This is in keeping with the evaluation and longitudinal follow-up of the large series of cases reported by Roth, Kay,' Norris and Post, and with the clinical assessments and follow-up studies of Goldfarb, Kahn, Fisch, and Gerber. In all these studies, severe cognitive defects were predictive of poor outlook, shortened life, and evidence of damage to the brain.

In persons with organic brain syndrome, mood or content disorder may be absent. When it is present, it may be inversely related in severity to the measurable degree of organic mental syndrome: “It takes brains,” to elaborate psychotic or psychoneurotic behavior. The absence of mood or content disorder is not informative of the degree of brain syndrome. The degree of overt behavior disturbance, however, can be severe with any degree of organic mental syndrome; when organicity is severe, the person may be anything from quiet and co-operative to violently excited in a disorganized, restless, uncontrollable way.

Table 37-5. The Expected Relationship of Special Characteristics of the Aged

	CHARACTERISTIC DEGREE OF DEFECT				
Intellectual Deficit, clinical	None	0-to Mild	Mild to Moderate	Moderate to Severe	Severe
Mental Status	0	0-2	3-5	6-8	9+

Questionnaire No. of errors					
Face Hand Test Errors					
eyes closed	0	0	0-2	2-4	4
eyes open	0	0	0	1-3	4
Activities of Daily Life (self-sufficiency)	Good	Good	Fair	Poor	Very poor
Mood Disturbance	0-4+	0-4+	0-3+	0-1+	0
Thinking Disorder	0-4+	0-4+	0-2+	0-1+	0
Behavior Disorder Overt	0-4+	0-4+	1+-4+	24-4+	24-4+
Incontinence					
Bladder	0	0	0-1+	0-2+	1+-4+
Bowel	0	0	0	0-2+	1+-4+
Electroencephalogram Amount of slow waves	Normal	Normal to Minimal Abnormality	Normal to Minimal Abnormality	Diffuse Abnormality	Normal or Diffuse Abnormality
Ventricular (Angiogram or P.E.G.)	Normal	Normal	Moderate Dilatation	Moderate to Considerable Increase	Great Enlargement
Air Over Cortex (P.E.G.)	None	None	Slight Amount	Slight to Considerable Amount	Slight to Considerable Amount
Average Brain Weight, Grams*	1300	1221	1221	1153	1025
Life Expectancy (for age)	Normal	Normal	Normal	Usually Decreased	Decreased

* Calculated from the post mortem data of D. Rothschild by Goldfarb and Jahn.

It may at times be difficult to do satisfactory testing. When one measure is of questionable validity, others may be more helpful. It is wise, in general, to make a number of different assessments, so as to clarify the needs of the patient and to make more accurate evaluations of the probable outcome. Functional disorders—the affective or content disturbance —should be treated vigorously even when brain syndrome is present. Drugs, psychotherapy, even electroshock therapy may be given, as in younger persons with similar conditions. The physical state of the brain reflected by organic brain syndrome is taken into account when pharmacotherapy is used, since it may require special caution, and if EST is given, special attention is paid to the premedication, anesthesia, curarization, oxygen needs, and to comfort in the recovery periods, not only as a protection of life and physical integrity, but also to avoid disturbances that can lead to acute organic brain syndrome. The advent of acute organic brain syndrome may lead to excess enthusiasm in treatment if it is mistaken for worsening of the functional disorder. In the group which shows moderately severe to severe organic signs, the general medical condition must be very carefully investigated and meticulous attention to symptomatic as well as specific medical care is required while the presence of fear, anger, and its elaborations are taken into account; comprehensive care should be provided with psychiatric "knowhow."

Operational Definition of Chronic Brain Syndrome

Organic brain syndrome, chronic, can be defined as that point at which the deficit in function of a person with brain damage emerges as disruptive of the personality for the individual, for society, or both. It probably emerges first as a loss of resources, to which the person reacts or which he attempts to integrate into his way of life; at a later point of progression, it becomes manifest as "maladjustment." Our tests appear to be "positive" at this point.

The feelings of helplessness that follow or are associated with the decreased ability to cope with life's problems is a complex component of decreased feelings of worth, loss of self-confidence, loss of the sense that one can achieve pleasures, and the loss of sense of purpose. This may be felt as a sense of failure compounded by humiliation or shame because of poor performance, as well as by guilt for failure to perform as one should. This is followed by fear and anger, further complicated by guilty fear and fear of retaliation. The helplessness and emergency emotion are then generally revealed by complaints of types and patterns determined by the person's value systems and concept of social responsibilities and responses.

The Patterns of Complaints

Chronologically old persons commonly referred to the psychiatrist are complaining, quarrelsome, restless, negativistic, depressed, agitated, or angry; some may be regarded as threatening on a verbal or physical level,

suicidal, or assaultive. Somatic complaints and paranoid ideas are common, and suicidal attempts are not infrequent. Less frequently than is popularly believed, sexual behavior unacceptable to the community is the reason for referral. This may vary from exhibitionism to not unreasonable desires to remarry. Not uncommon are complaints that a chronologically old husband is overly assertive sexually; this is often joined by complaints that he accuses his wife of disloyalty and infidelity. Complaints about impotence are also common, as is advice sought about how to handle a rejecting mate who says about sex, "You [or we] or I am too old for that now."

Quiet, subjective suffering on the part of older persons is often missed or neglected, even as it is in younger ones. Psychoneurotic behavior of all kinds is found in aged persons; dramatization, exploitation, and aggravation of disability or weakness are common, and obsessional characteristics are frequently troublesome. Among somatic expressions of emotional distress commonly encountered are headaches and vertigo, constipation, anorexia, insomnia of various types, including early morning waking—these may be the sole manners in which the presence of an actually severe depressive reaction is communicated. A sense of heat in or burning of the skin, intermittent sweats, flushing, and fatigability are frequent complaints. Subjective depression with guilt, self-depreciation, hostile and paranoid thoughts are frequent open complaints. Frank anxiety does occur, but it is far less openly than covertly expressed. The most common reason for referral in shelters for

the aged appears to be behavior which has “nuisance” value; noisiness, querulousness, physical complaining, and somatic preoccupation which is unresponsive to the usual medical and nursing care available, and clinging, demanding, or hostile behavior. These seemingly unrelated and heterogeneous complaints in the individual can be understood as complaints of a frightened or angry person whose feelings of helplessness have led to an adaptive maneuver—of a person’s search for aid, dependency striving, or attempts to establish personal relationships promissory of protection, care, and security. The evolution of such patterns and their relation to the losses that occur with aging were suggested in Figure 37-1.

The host of complaints about mood, physical functioning, and the behavior of others to oneself, their variability in persons who appear to suffer from the same basic disorder, and their shift, sometimes with great rapidity even in the same persons, with time, circumstances and social environment, become more easily understood if they are listed under a number of headings. They are apathy, pseudo-anhedonia, somatization, display of helplessness, depression, either relatively pure, or with psychomotor retardation or agitation, elated (manic) states, paranoid states, exploitive-manipulative behavior, and coercive behavior. These patterns may overlap, coexist, occur in sequence or clusters. The patterns alone or in combination, from the adaptational point of view, can be regarded as motivated attempts at problem-solving. Each of the patterns as a whole, and its parts, can be

described—"understood"—in psychodynamic terms. That is, the patterns can be regarded as symptoms which symbolize the patient's problems and wishes, justify his search for aid or emotional support, are of a type that he believes can and will earn the kind of care desired, and are also extra-punitive, as though to punish a selected social target for neglect and into action. This is illustrated in Figure 37-2. These common patterns, then, can be discerned to contain all of the intrapsychic elements of the so-called hysterical reaction. They are listed in an order which, at least roughly, is related to the degree in which they appear to be influenced by the emergency emotions, fear and anger. The influence and amount of fear decrease as one moves from apathy to depression, where the influence of degree of anger present is quite large and then tends to increase as the patterns tend to change or include depression, elation, paranoid trends, and conditions that are more clearly manipulative or coercive. These common patterns, obviously, cut across formal nosologic-diagnostic lines. This is because individuals apparently differ first in the genetic predisposition to elaborate emotion pathophysiologically. Some persons appear to have recurrent or cyclic pathophysiologic events which are reflected by mood or behavior changes that tend to be adaptationally elaborated, as here described. In them, the intrapsychic determinants of the pattern appear to give rise to physiologic changes which then reinforce the behavioral disorder. In others, the pathophysiologic changes are akin to the hormonal metabolic changes of the

hypertensive or the diabetic and act as causes for the elaboration and emergence of the adaptive syndromes.

These patterns are briefly defined and discussed below.

Apathy

Apathetic patients are listless, enervated, without initiative or spirit; behavior is predictable and stereotyped. They complain of weakness, lethargy, poverty of feeling, loss of interest and initiative. They tend to be withdrawn, slow in speech and movement, to remain seated quietly, or to retreat to bed, usually assuming the same spot and the same posture. Conversation is entered into reluctantly. Problems are denied. Pressure to speak or to take part in activity may receive token compliance followed by protests and possibly angry resistance. Apathetic states in which the individual withdraws are common and such patients are frequently referred to as "regressed."

As used at present, the term "regression" appears to be more a lay blanket than a scientific concept. Even when used to denote one of several concepts—as return to a prior level of psychosexual development and libidinal cathexis, as abandonment of developed or acquired ego functions, or as the use of early developed defenses against anxiety—it lacks precision unless properly qualified. The lay use of the term to describe and explain

away withdrawal, sullen or negativistic behavior, and incontinence or slovenliness of complex etiology, as a return to the pleasures of infancy, is unwarranted. This is true even when brain damage complicates the behavior.

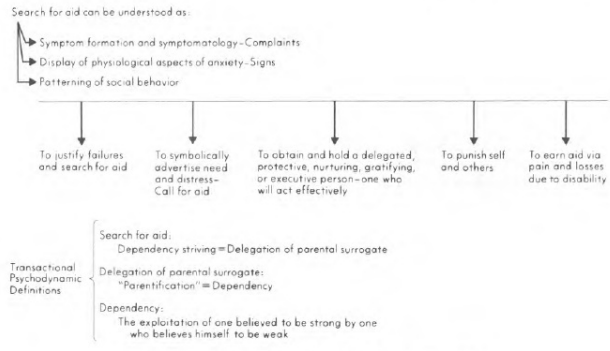

Figure 37-2.
Motivational components of "the search for aid."

The concept of regression can possibly be helpful when it is clearly defined to mean that the aged patient may make use of a developing deficit, such as that related to brain damage, as a means of protest, or to signal distress, despair, or helplessness, and that the defect or disorder may become integrated with the pattern of behavior. The human tendency to integrate symptoms of physical illness and impairment into the personality as a mode of communication and to solve an interpersonal conflict is actually either repair, growth, compensatory action, or an attempt at problem-solving by fight or withdrawal—alone or in combination—its efficiency or adaptive value and its details should not be obscured by a blanket term.

Weinberg has suggested that patients with decreasing ability to contend with the world withdraw as a defensive maneuver to avoid being overwhelmed. More recently, in analogy to computer failure, Dovenmuehle has spoken about "information overload" and patients' attempts to avoid this. Also, the theory of disengagement advanced by Cummings and Henry is a similar concept envisioning that aging persons tend to relinquish their involvement, or "engagement" with their social world, while simultaneously society removes itself from them in a transactional process.

Apathy would seem to be the caricature of such "natural, acceptable" behavior—however, recognizing apathy as an adaptive, signaling maneuver adds a dimension which provides a clue to therapy. In the case of Mrs. B., the apathetic state masked a depression. She mourned the death of her eldest son, was angry at his son—her grandson—for "deserting her" and at her younger son for not meeting her emotional expectations. Her history was one of mood-cyclic disorder. The withdrawn, "apathetic," listless behavior is part of a search for assistance by the suffering patient.

She behaves as though she could bring back a dead son, change her grandson, improve her remaining son, so that he can replace the lost one, by signaling her grief in an uncomplaining, disarming, yet emphatic and forceful way, while suffering the disadvantage and pain of her helplessness and at the same time pursuing her less admired son by being burdensome, and in this

way pressing him to do better—for and with her. In this, like all of the patterns of search for aid described, apathy as a symptom complex has the characteristics of the hysterical neurosis, whether or not it is itself part of the so-called psychotic condition.

Pseudo-Anhedonia

The pseudo-ahedonic patient behaves and talks as if to say, "I have no feeling. Nothing matters. Do what you will, and do what you will to me. Nothing can bother me anymore; you can't hurt me, you can't please me, nothing matters." That the ahedonic protest is not real is evidenced by the patient's insistence on being "left alone"—not pressed or pushed into activities—by his reluctance to follow instruction and the tendency to skillfully resist, and explain away the value of efforts to help him. As with apathy, the behavior as a symptom is punitive, self-punitive, symbolic, justifies its own existence, and "earns" sympathy.

Display of Helplessness

A third pattern is display of helplessness. The patient points to his weakness, his ineptitude, his "anxiety," or his mental impairment. Physical impairment is exploited, exaggerated, illness is exacerbated by ill-advised behavior and self-neglect. The somatic concomitants of fear and anger are experienced as further frightening, and frustrating, and enraging, and are

paraded, pointed to, demonstrated, queried about. For example, Mrs. E., a seventy-six-year-old widow complains of palpitations, of discomfort in the left shoulder and mid-spine, of weakness, and of intermittent tingling of the fingers. She holds herself tensely, the right shoulder much higher than the left, has labile blood pressure with a diastolic that never exceeds 98 m.hg., but has intermittent tachycardia without irregularity. She fears to live alone and has a companion for as many hours a day as she can afford. She feels alone, neglected, visits the one child who has room for her as often as possible, and stays "as long as I can feel welcome." She is sure she has a serious illness which affects her spine and her heart, that she should not exert herself, cannot tolerate social activity, cannot lead a normal life. This pattern of invalidism and complaining has persisted for eleven years. It began two years after the loss of her husband, grew slowly worse, and was accentuated on the death of a son. She "tried" but left four physicians. She now visits her psychiatrist monthly and appears to feel gratified by his monitoring of her pulse, blood pressure, and his noncommittal contribution of mild sedative medication.

Subjective distress is denied by Mrs. E. A concomitant or strong emotion has become her obsessive rumination and complaint.

Similarly, Mrs. U. complained about inability to swallow and ascribed all of her personal problems to this somatic difficulty. Other patients may

complain of shortness of breath, a weak feeling in the chest, tingling in the fingers and toes, giddiness or sinking feelings, abdominal (frequently hypochondriacal) pain, pain in the back, in the thigh, down the leg, or in the arm. These appear to be preferred communications about concomitants of fear or anger, which emotions the patient ignores or fails to report.

Somatization

With somatization the patient appeals for aid on the basis of bodily disease, discomfort, or impairment for which no adequate nonpsychiatric medical basis can be found. Frequently, complaints of pain, impairment, or disability are related to actual sensory or motor losses, and systemic or organ decline. Among these are osteo- or rheumatoid arthritis, cardiac malfunction and angina pectoris, emphysema, gall bladder disease, hiatus hernia, osteoporosis with vertebral collapse, herniated nucleus polyposus, and meralgia paresthetica. But, with time, it becomes obvious that despite the importance of the somatic changes present, there is, as in display of helplessness, exploitation, aggravation, and sometimes exacerbation of an underlying structural disorder because of the fear or anger of the patient. Included under somatization may be the seemingly fear-free insistence that the whole problem is the pain in the back, arm, or chest. Weakness of extremities, of sight, hearing, or brain function may be paraded as disabling in the absence of any impairment. The difference from display of helplessness is

that it is not always the concomitants of fear, anger, or impairment that are displayed but there is seeming displacement of concern to bodily functions and the use of impairment to explain and account for disability to oneself without clear expression of feelings of helplessness.

Hypochondriasis

A fifth pattern is hypochondriasis. Here, the motor pain or harmless symptom, or lesion visible or palpable only to the patient, is seized upon as evidence of life-threatening disease or disorder. The wart or harmless sebaceous cyst becomes, in the mind's eye, a cancer. Similarly, rectal pain or emotionally caused constipation is interpreted as proof of the presence of malignancy, urinary frequency is interpreted as related to intractable diabetes or to probably malignant prostatic hypertrophy. Headache, to the sufferer, presages brain tumor. Also common, and sometimes unfortunately shared by physicians, is the patient's conviction the cognitive defects which go along with depression of affect are caused by, and proof of, senility, or cerebral arteriosclerosis, and impending social death.

Depression

In depressive states, there is usually a subjective and reported sense of low spirits, "depression," and at times of actual sadness. There is inertia, loss of interest, loss of purposivity and motivation to act; there is preoccupation

with distress and malaise, and with somatic symptoms, such as heaviness in the chest, dry mouth, bad taste; attention is decreased, thinking may be slow and labored, as may movements, or there may be racing, anxious thoughts and motor agitation. There are also one or more of the other patterns described together with subjectively experienced and reported feelings of despair, hopelessness, loneliness, boredom, feelings of being neglected, abandoned, unwanted; a lowering of mood. In predisposed persons, this pattern may have been preceded by, although it is usually considered to be followed by and come to include, specific vegetative signs. These are anorexia or bulimia, constipation or diarrhea, a longing for sleep, prompt falling asleep at night followed by insomnia of premature or early morning waking type with depressive rumination, diurnal variation of mood—the worst being in the morning. When the vegetative signs, diurnal variation of mood, and cognitive signs of depressive affect are present, the condition is usually labeled as psychotic. History of prior attacks is almost always elicitable (although many may have masqueraded as physical illness, such as arthritis, or gall bladder trouble, or spastic colitis), and in many such persons there is a clear history of mood-cyclic disorder, which may or may not have been previously recognized and/or treated.

Paranoid Ideation or Behavior

Paranoid ideation or behavior is common with depression of any

severity, with or without the genetic predisposition to the so-called psychotic varieties, but may also be seen in relatively "pure culture." It may be the emergence in old age, of a schizophrenic disorder previously subclinical in its manifestations. The patient is openly or covertly angry, is convinced he has been, is, or will be taken advantage of, has been maltreated, or is threatened and vulnerable; he feels he is referred to, talked about, avoided, rejected, and neglected. Frequently, complaints of boredom and loneliness may mask paranoid trends; they are often developed as more or less subtle accusations about spouses, children, relatives, neighbors, or society. At times the paranoid nature of complaints is blatant, yet not truly schizophrenic, but rather the florid elaborations of fear and anger in a patient whose discriminatory capacity has been reduced by brain damage—the loss of cerebral neurons in appreciable degree.

Mr. K., a sixty-nine-year-old man, was disoriented for time and place although he masked it well; he failed to recall appointments, promised and incurred obligations. He was forgetful at home about lights, the stove, appliances, door locks, and misplaced money and objects. He questioned repetitiously about minor matters, and rationalized in a confabulatory way about his behavior. This led to verbal explosions on the part of his wife. These appeared to offend, hurt, and finally to anger him, and led to sharp outbursts on his part about her nagging, often culminating in statements that perhaps they should separate for a while. Mr. K. then began to state with apparent

conviction, and maintained for several hours at a time, that Mrs. K. was not his wife but an impostor, a member of his wife's family who was attempting to mislead and misinform him. Shortly after such an outburst, during which he asked Mrs. K. to leave, I saw them together in my office. She asked him why he treated her in that way. At first, he denied doing so, then, "You acted like I was a stranger," he said, blushing and smiling in an embarrassed way. "So I acted like you're a stranger. I thought you were one of them" (her family, whom he dislikes). "And now," said she, "you recognize me as your wife of forty years?" "Yes," he replied with a laugh. After a pause he went on to say: "You see, I'm a man. I want to be the man in the family. If you treat me like we aren't. . . like I'm not. . . then I feel depressed." "Did I ever . . ." she asked. "No," he interrupted her and said with remarkable yet truthful inconsistency, "I never let you."

In the presence of mental deficit, which decreases his capacity to perform routine daily tasks, and which lowers his self-esteem, erodes his confidence, leaves him feeling lost, alone, and in need of a helpful wife, this man appears to pay little attention to, or tries to forget his difficulties. When, as he sees it, they are harshly pointed out to him by his wife, he feels doubly distressed. He is a man in need, without the helper he had believed was there, and more, she has changed into the opposite, a critic, a demanding person, an impatient female who is the converse of friend, ally, intimate, re-assurer, or supporter. This stranger must be driven away, so that the space she occupies

can once more be filled by his wife.

Mr. K. demonstrates what has been described as the "illusion of doubles" described by Capgras and Reboul-Lachaux in 1923. As later outlined by Todd in "Capgras' syndrome" the identity of a person well known to the patient is challenged with the statement that a double has replaced the original. Vie later expanded ideas about the syndrome by calling attention to the "illusion of positive doubles" in which there is an affirmation of imaginary resemblance leading to false recognition, in contrast to the illusion of negative doubles where imaginary differences lead to negation of identity. The perception of "imaginary differences" and "imaginary resemblances" is frequent in the aged and can be understood as based upon their subjective distress, their unhappiness with an existing relationship, their desire to change it, and their attempts to signal their needs to alter the transactions and to find in others what is now lacking in the people about them. In this, we see an elaboration of the ideas expressed by Hughlings-Jackson in 1886, when he spoke of the man with a damaged brain who called his nurse by the name of his wife. He ascribed the failure to recognize the nurse to organically determined decrease in discriminatory capacity (dissolution); he attributed the mistaken identification to elaborations by the intact brain (evolution) based on experientially determined aspects of personality. Past experience, response to the present situation, and hopes or expectations, all contribute to the patterning of behavior.

Exploitive-Manipulative Behavior

Exploitive-manipulative behavior is frequently regarded as "normal," as part of "a way of life." Nevertheless, it is often a seemingly new symptomatic pattern which is akin to, often a component, a precursor, or sequel of a clear-cut depressive disorder.

Coercive Behavior

Coercive behavior is most easily epitomized by the often openly, but sometimes disguisedly stated, "Love me; if you won't love me I'll kill myself." It is manifested in innumerable and at times highly complex ways. A common form is that of the dominating, controlling person whose coercive behavior is masked as parental or marital concern or filial devotion. It may be obvious, as in confrontational antisocial dependency when the person states that he is simply taking by force what should have been freely given, although its emotional core and basis may be forgotten because of the anger it provokes in the social community. At times, coercive behavior becomes clearly homicidal. It is as though the patient said, "On second thought, if you don't love me I won't kill myself, I'll kill you, and then maybe also myself." For example, a man hospitalized for help because of drug abuse pleaded he was not receiving adequate care. While shaving, he was pressed by a nurse to go out on a unit walk, despite his remonstrances that he was not sufficiently well. He turned on her, razor in hand, and said, "Leave me alone or I'll cut my wrists. No. I

think I'll cut your throat." More subtle were his refusals to take medicine, to eat, to care for himself hygienically unless he "could gain the proper co-operation of the staff to ease him by medicines."

Coercive, exploitive, paranoid, and complexly elaborated depressive reactions are only seen when brain syndrome is mild to moderate. With moderately severe brain syndrome, apathy, pseudo-anhedonia, and display of helplessness are seen, but even these become less clearly elaborated as severity increases. With severe organic syndromes, fear and anger tend to disorganize behavior or to lead to immobilization. The degree of brain syndrome, however, should not be determined by qualitative evaluation of behavior and never by the quantitative level of disturbed or disturbing behavior, except "paradoxically"—i.e., the more complexly elaborated and seeming severely "psychotic" the disturbance of mood or thought content, the more likely it is that the organic mental severity is of relatively slight degree.

Treatment, Care, and Management

The goals of psychiatric therapy are to decrease the complaints of the patient by increasing comfort, and productivity in work, within the limits of the person's past capacities and current limitations, restore sociability and social integration, and to restore the capacity for self-provision of pleasure to the greatest degree possible.

Review of Figure 37-1 suggests that we can approach treatment, care, and prevention from the viewpoint of etiology, both early and late, by seeking assets to replace, substitute, or compensate for loss; by decreasing challenges to mastery; by dealing with the subjective state called “helplessness”; and by treating the emergency emotions and the behavior to which these lead.

It is not required, however, that a specific etiologic factor or group of factors be determined for rational and definitive treatment. This is fortunate because identification of the necessary factor may be difficult or impossible at this time.

The events of infancy or childhood that decrease or distort resources for personal comfort and social adaptation or genetic factors may be factors of great importance in the evolution and maintenance of many of the maladjusted patterns in the aged. Such factors can be subsumed under what Berezin points to as “the timelessness of the unconscious.” They are theoretically modifiable by psychodynamically oriented psychotherapy whether reconstructive (psychoanalytic) or brief. But, few old persons may have the physical strength and time to avail themselves of such benefits, should they be available. Even when such factors are strongly presumed present, expediency may require search for and attention to other factors, the modification of which will make a beneficial difference.

From this point of view, the decrease in self-assertion that can be traced to enculturation "at the mother's knee" may be the necessary but not sufficient factor contributory to accessions of anger seen in an old person who otherwise cannot override the psychological inhibitions which seriously limit his activity for relief of tension from biologic or acquired needs. Therefore, modification of circumstances to eliminate the contributory factors may yield much improvement.

Thus, it may be more expedient to decrease challenges that create difficulties or social obstructions to the realization of goals desired than to re-educate the patient emotionally. This is akin to saying what was once said about effective treatment of certain psychosomatic disorders; that the therapist was effective when he helped the patient to achieve a satisfactory marriage—satisfactory in that the troubled patient found a parentally supportive mate. Much success in psychotherapy, although otherwise rationalized, may be achieved in these "incidental" ways. In fact, the psychiatrist, as noted below, may become the supportive figure with cost of little time and effort.

Also, unless "a complete physician" he will do well to work as part of a team which includes an internist and a neurologist to assist in the search for factors which are most easily dealt with to the benefit of the patient. Examples are awareness of effect of antihypertensive medication upon

catecholamines and of the effect of most medical conditions upon cerebral functioning. Moreover, because psychological and emotional changes may be most easily brought about through the use of special services other than psychiatric, they are themselves vehicles for psychotherapy; therefore, the psychiatrist must be ready and able to work with others. For the sake of brevity, the various components are illustrated and the type of treatment indicated is charted. The social and material supports available to the patient have bearing on the provision of treatment.

Good basic services are essential before special programs and psychiatric skills can be brought to bear meaningfully on the patient's problems. Where the patient lives, with whom, and under what conditions, is of considerable importance in dealing with his specific problems. Many old persons live in their own homes. Others live in congregate settings for reasons of health, finances, or because of housing problems.

Own Home

Old people in their own homes include a large number of persons who have problems of pre- and post-retirement for which they may need little more than skilled counseling.

There may be psychological and emotional complications of financial, housing, social, and domestic problems.

Old persons in their own homes who accept referral or who themselves call on a psychiatrist for help can usually be managed and helped with as little, or as much, family involvement as younger individuals.

A large number of old persons, however, are brought by family or friends or have psychiatric consultation or aid thrust upon them by personnel of an agency or residential setting. Under such conditions, the question often arises as to "who is the patient": The referred and the referrers alike appear to be suffering and treatment procedures must often be flexibly and tactfully molded to suit. At times, a spouse or child of the old person needs treatment and can accept it only in the guise of conversation about treatment of the other, or because of its value to the elderly "patient." Frequently, one encounters folie a deux, in which both husband and wife share paranoid trends and depression, and one or both has organic brain syndrome as well. Here, both must usually be treated, each with the necessary medication, and conversation either sequentially in the same "hour" or together. It is usually wise to see first one, then the other, and then—even if briefly—both together, at which time interchange between them may offer valuable clues to therapy needed, as well as an occasion to provide opportunities for controlled ventilation of each, and support and reassurance to both.

Work with family members may be the most important aspect of treatment. For example, the old person may desire to live—however

unrealistic this may be—with a selected child as a solution to the health, housing, or financial problem. The available child, although capable and willing, does not suit the parent, who may express this verbally or nonverbally. Another problem is a variance of views as to how the problem of the parent should be resolved. These examples illustrate that parent-child conflicts, sibling rivalry, and interfamilial processes may make the older person the focus of a family fight.

Many social agencies are helpful to old persons in their own homes. Under this term can be included the family services of social service organizations, their special division for old persons, church organizations, "Y's," and some special subdivisions of governmental departments of welfare, health, or hygiene.

*Table 37-6. Components of Disorder and Psychiatric Treatment Approaches**

COMPONENT	ILLUSTRATIVE EXAMPLE	TREATMENT APPROACH OR METHOD OF PSYCHIATRIC VALUE
Multiple Causes		
*(a)*Remote (early)	*(a)* 1. Genetic factors	Psychoanalytic, reconstructive or distributive analysis for recognition and correction of genetically-dynamically caused disorders, psychotherapy, counsel, guidance

	2. Familial, educational, and cultural influences	
	3. Occupational effects	
	4. Diseases	
(b) Recent (in old age)	*(b)* 1. Physical—disease, accidents, aging	Disease prevention Accident prevention
	2. Mental—psychological brain syndrome acute mild chronic moderate severe	Avoidance of smoking, air and water pollution Specific and symptomatic treatment of disease
	Emotional concomitants of structural change	In youth and middle life, development or reinforcement of good habits of psychological, emotional and social adjustment
	3. Social and economic factors	Preparation for change of role, status, or income
Loss of Resources for Action and Protection	1. Temperament Depressive diathesis	Pharmacotherapy or physical therapy for shift in "homeostatic level"
	2. Decreased self-assertion "Psychologic inhibition" (Decreased capacity for sexual activity and pleasure)	2. & 3. Psychotherapy of an "insight developing," "character changing" type
	"Psychotic" or "neurotic," traits or specific character, psychophysiologic, or psychiatric disorders	
	3. "Way of life," well established mechanisms of psychological and emotional reaction	

	(b) Cardiovascular-renal disease: angina, failure, etc.	Medical treatment: nursing aids
	Sensory disturbances	Surgical corrections
	Musculoskeletal impairments	Prostheses, spectacles, hearing aids, dentures, artificial limbs
	Prostatism Cystocele Brain syndrome, acute or chronic Reactions to losses Neuro-endocrine (homeostatic) impairment Environmental demands Loss of family, friends Change of status, of role Loss of prestige Decreased income	Psychiatric treatment Environmental changes Clubs, organizations Social service aids Community organization toward occupation and social use of aged Social Security; Medicare, Medicaid, etc.
Decreased Capacity for Mastery	Decreased ability:	See above
	to relieve tensions of biologic or acquired origin	Medical assistance with regard to bowel and bladder function, etc.
	to obtain gratification	Information about sex
	to experience pleasure based on successful action or thought	Social service aid in reaching groups, occupational and recreational facilities
		Educational programs
Feelings of Helplessness as evidenced by: Fall in self esteem, and in self-confidence Loss of purpose and sense of identity	"I can't do . . .(self-confidence) "I am no good" (self-esteem) "I have no role, use . . ." (sense of purpose; loss of identity) "I will fail" (am failing) "How humiliating . . ." "I am ashamed of myself" "What is the meaning of it	Decrease of feeling of helplessness by way of above and below

	all?" "What good am I?"	
(a) Fear and Anger (and subsequent guilt; fear of retaliation; depression of mood, with physical shift and vegetative signs in the predisposed)	Signs of emergency emotion immobilization in thought or action	Pharmacologic treatment Electroshock treatment
	Disorganization of thought or action	Treatment via relationship: dyadic or group
	Agitation or retardation	
	Depression or elation	
(b) Affective Disorder		
Search for Aid A patterning of signs and "symptoms" consistent with the person's experience and acceptable to him as likely to succeed in the actual or fantasied milieu that he perceives	Patterns of sign and symptom display which symbolize: "I'm hurt" "I'm bored" "I'm lonely" "I'm blue," i.e., I want him (her, my parent, daughter, husband) to care for me as I was cared for by my father (brother, mother, husband, this daughter, etc.) in the past "I'll love you, therefore you must love and help me" "I need a friend (lover, confidante, husband, wife, parent, child, boss, assistant, secretary, companion) to understand, love, fulfill, work with, join	Response to "dependency strivings" Provision of a paternal figure (significant other), "magician," sheltered milieu, friend, ally, dominatee, confidante, etc.

	with, play along with, enjoy things with (etc.) me."	
Dependency Striving Patterned Symptoms and Signs	Apathy Pseudo-anhedonia Display of helplessness Somatization	Controlled personal relationship
Delegation of another to parental role (Significant other)	Hypochondriasis	Acceptance of delegation of another to parental role (Significant other)
	Depressive, paranoid, and exploitive-manipulative states Psychiatric Syndromes and Disorders	Pharmacotherapy Electroshock treatment Milieu, total push, and special hospital services

* Prepared for "The Dependency Construct as an Aid to Psychiatric Care of the Aged" paper presented at the American Psychiatric Association Meeting in Detroit, May, 1967.

Some social agencies offer specialized services to impaired and ill persons; these include "meals on wheels," day centers or senior citizens' clubs, counseling, group therapy, home-maker and nursing services. The population served varies and includes many seriously impaired and disabled persons, as well as old persons with a wide variety of psychiatric disorders.

Old persons with moderately severe or severe brain syndrome usually require protection. This is usually best provided in a good old-age home or good nursing home. That such places today are not as good as they should be

means that they should be improved, not that this truth can be ignored. Where money is freely available, a one-bed nursing home or hospital can be set up; at best, these usually do not provide the opportunities for social integration and for the various vehicles for psychotherapy that a congregate setting can provide. An old person with brain syndrome kept "at home" may not recognize his own home for what it is and may complain as frequently and bitterly that he wants to leave and go home as he will when in the residential hospital or home. "Home is where the heart is," and his wishes are for thirty years ago, wherever he may now be geographically located; it is the problem of staff in protective settings to establish those relationships which help the patient feel at home. In this sense, it is easier to make a supportive community in a hospital than it is to make a hospital of the community. "Community," in any case, has no meaning for the brain-damaged aged who can in no sense be an active citizen, however much he may have been in the past.

Old Age Homes

Old age homes are, in the United States, voluntary, nonprofit institutions, usually under sectarian auspices, but nonsectarian in admissions for the residential care of old persons. For the most part, they exclude the obviously mentally ill, the severely mentally impaired, and the physically acutely ill. They range in size from very small—ten to twelve beds—and with

limited facilities, to very large—500 or more beds—with infirmary facilities of general hospital quality. Waiting periods for admission to such homes are usually too long for the impaired, disabled, and chronically ill, because of the high demand by such persons for services and the limited number of beds available. Fully ambulatory aged with little need for personal care have shorter waiting periods. Old age homes constitute protective settings in that they offer a structured, safe environment with readily available medical care, and are prosthetic milieus in that they serve to replace, substitute for, and compensate for the losses in physical, mental, and functional status in aged persons. Residents of old age homes theoretically have gone there for social reasons; in actuality, it is need for medical and nursing care, or emotional support and supervision that lead to application and admission. Many are obviously psychiatrically ill. At least 10 percent have a disabling degree of mental impairment (organic brain syndrome). Financing of patients is chiefly from welfare funds. The age of patients on admission is now close to eighty years, and the average age of residents is of course above this.

Nursing Homes

Nursing homes are proprietary institutions for the long-term care of chronically ill or permanently impaired persons. They vary widely in quality of care provided. The best are similar to good, large old-age homes, but do not directly provide medical care, which must be independently arranged. Old

people in nursing homes range from the physically ill and impaired to the obviously mentally impaired (persons with organic brain syndrome). Many have depressions or paranoid conditions. One study in the New York City metropolitan area revealed that about 50 percent of the residents, strictly speaking, could be considered certifiable for psychiatric hospital care. About 50 to 80 percent of the patients are paid for by welfare funds, so that nursing homes are basically subcontractors to government agencies for long-term care. The average age of admitted persons is close to eighty years of age. Medicare financing has resulted in a change of many nursing homes to "extended care facilities." These are merely nursing homes which are enjoined by law for reimbursement eligibility to have a certain minimum of rehabilitative services for persons acceptable from general hospital stays on the basis of likelihood to recover and return to their own homes; in general, this excludes persons who have come to hospitals with a psychiatric diagnosis of any kind. There are some public nursing homes. Large public institutions often actually resemble old age homes in their character, quality, staffing, and programs.

Senior Citizens' Hotels

In recent years, there have been emerging facilities that purport to be "retirement hotels." They have become "welfare-approved" and accept Old Age Assistance stipends in payment. They have in actuality become old age

homes of poor quality because of small staffs and the paucity or lack of trained staff, such as nurses and aides; also, no medical care is available, except by personal arrangement. As it is in old age and nursing homes, the population of such "hotels" is becoming progressively older and more impaired and ill.

State Hospitals

State psychiatric hospitals do not require definition. There is currently debate about which old persons should be served by these units. Goldfarb in 1959 recommended that State Departments of Mental Hygiene or their equivalents should undertake supervision of the problems of infirm and mentally impaired and emotionally disturbed aged persons, that this should be achieved by way of the expansion of State Hospital systems. Included would be small, geographically well-placed geropsychiatric diagnostic treatment centers with a strong medical treatment component, as well as special psychiatric services. It should be stated, however, that in recent years these social institutions have been closing their doors to the chronologically old who need, or would seem to need, long-term "custodial care." This is essentially a device not to provide for the long-term comprehensive health care needs of mentally impaired and usually also physically ill, as well as poor and bereft of family, aged persons. For purportedly benign and enlightened reasons, but actually because such care is expensive and difficult to organize

and administer, these patients are being thrust back to the community, which is encouraged to develop, with local and federal funds, as well as some help from the state, the agencies and facilities for care.

The best place for psychotherapy of those with relatively severe organic brain syndrome is usually within a good protective setting. The twenty-four-hour care needed by these persons and the capacity to tolerantly and constructively deal with their demanding, hostile, clinging, or angry behavior is too much for family members, and also tends to embitter them and endanger the best of prior relationships.

There should be no debate as to whether old persons should remain in their own homes or go to protective group residences, such as old age homes, nursing homes, or long-term-care hospitals. Such debates are usually based on generalizations which cannot apply to each individual. If they are in relatively good health or, when they are not, have an able and protective family, or enough money to purchase the staff and aids they require, they can remain at home. Remaining at home, however, under all circumstances may not, in balance, be as wise as use of a modern, well-staffed, well-equipped, comfortable old-age home. Prejudice against “institutional life” may deprive an old person of social, recreational, and material benefits he cannot gain in his own residence or community. These may not be good enough at best and at worst may keep him prisoner with a minimum of aids in an unpleasant

domicile in a dangerous neighborhood.

Also, physically or mentally ill persons may constitute problems of twenty-four-hour care that can physically and emotionally exhaust the ablest, strongest, best-intentioned, and most available family members. Many persons with brain damage of even greater severity may be meek, mild, free of troublesome stormy episodes, and with a great capacity for congeniality and enjoyment of their homes. Such persons usually can make a good and happy adjustment to a good institution. Others with the same or less brain damage may be bitter and unhappy wherever they may be. In the latter event, the institution is preferable to the private home, if the congregate care facility is staffed by persons with the understanding of how to respond to the emotional, as well as physical needs.

Psychiatric Assistance to Staff

Close and constant caretaking relationships to old persons may provide anxiety and anger, because of the burdens of the task and the fears brought on by close contact with very old age, illness, and death.

Also, there may be fear or anger because of recapitulation in actuality or thought of unpleasant relations with one's own parents, and because of its demonstration of what, one day, may happen to all who live long enough. Overwhelmed and angry personnel may take a seemingly reasoned but

actually resentful, nihilistic view toward the care and treatment of the old, or, conversely, may react by over-solicitousness and ingratiating, seductive, flattering, and infantilizing behavior. The old emotionally ill person may be viewed as a worthless, cantankerous "bitch," an "oversexed dirty old man," or as a fetchingly cute and eccentric little doll or a droll, amusing, likeable old rake. Whatever basis for either view, such hostility masked as compassion and sentimentality masked as sentiment often prevent professional appraisal and may be obstructive to proper relationships for treatment.

In hospitals and congregate-care settings, the psychiatrist is usually more useful as a guide, advisor, and therapist for staff than he is on a dyadic basis with individual patients; seminars, conferences, individual meetings with staff members, based on brief contacts with the patients, are often the best means of delivering good care to old persons.

The psychiatrist can also be of aid to general physicians, internists, and surgeons, by directly and indirectly helping them to evaluate the degree of brain syndrome and the intensity of affective disorder in their patients. He helps them by clarifying the differences in the management of predominantly organically impaired persons.

In a residential setting for protective care, the influence of the psychiatrist in guiding personnel toward these ends is of importance; of great

value is his work with staff to maintain their morale and optimal emotional health as it may be affected by their work.

Psychotherapy

Historical Background. It has been said that the history of science is science itself. It is tempting to believe that a history of psychotherapeutic approaches to older persons would be revealing of the complete art. Unfortunately, the number of authors and their works is too large to be listed. Like philosophies, they appear to be "the products or expressions of the general condition of society" and their times. For example, Liébault and Beaunis, as quoted by Bernheim in 1886, were interested in the susceptibility of old persons to hypnotism. Table 37-7, modified from Bernheim, compares the suggestibility of an old-age group in this respect with five other age groups in their series of 1012 persons. In persons sixty-three years of age and over (the number of these is not specified), they found that in 11.8 percent somnambulism, in 8.4 percent very deep sleep could be hypnotically achieved, and in only 13.5 percent was there no influence possible.

Bernheim calls attention to the fact that in childhood and up to age fourteen all subjects without exception can be influenced by suggestion of the hypnotic type, and that the proportion of somnambulists is very high; by contrast, in old age the number of somnambulists is observed to decrease, but

always remains at a relatively high figure (7 to 11 percent).

Table 37-7. Suggestibility to Hypnotism,by Age Group (percentages)

AGE	SOMNAM-BULISM	VERY DEEP SLEEP	DEEP SLEEP	LIGHT SLEEP	SOMNO-LENCE	NO INFLUENC
Up to 7 years	26.5	4-3	13	52-1	4-3	
7-14 years	55-3	7.6	23	13.8		
28-35 years	22.6	5-9	34-5	17.8	13	5-9
42-49 years	21.6	4-7	29.2	22.6	9-4	12.2
56-63 years	7-3	8.6	37-6	18.8	13	14.4
63 onward	11.8	8.4	38.9	20.3	6.7	13-5

Hughlings-Jackson's 1886 discussion of the *Factors of Insanities* emphasized that many maladies could be recognized as the combined effect of dissolution and continuing evolution in the nervous system. "The shallower the dissolution the higher the range of evolution remaining, conversely the deeper the dissolution and the lower the range of evolution remaining." The elaboration of symptoms in a mental condition in which the brain is damaged is illustrated by the man who imagines his nurse to be his wife. His "not knowing" is a sample of the result of the disease (dissolution): his "wrong knowing" is a sample of what is left intact of his highest cerebral centers. Illusions, delusions, extravagant conduct, and abnormal emotional states in an insane person signify evolution, not dissolution, they signify the

elaboration of thought by the remaining intact brain where misinterpretation must occur because of damage to the brain and these must vary "according as the person ... is a child or an adult or an old man, clever or stupid, intelligent or unintelligent, educated (trade, etc. included) or non-educated." This variance from person to person must be obvious when the damage is not so great as to obscure it ("when the dissolution is but of little depth"). Hughlings-Jackson also forecast our information about confabulation, which is usually prominent early in brain damage and tends to disappear later, by pointing out that with rapid "dissolution" there is greater activity in the remaining "range of evolution." In discussing drug intoxication, he emphasized that not only could there be direct action on the central nervous system, but also indirect action by poisons through their effects on supportive systems. Unfortunately, he illustrated this by the actions of belladonna upon the supportive systems and eyes. This last may serve to show how brilliant observations may be "explained" by incorrect theories derived from convictions of a period of time.

Freud, in 1898, said, "The psychoanalytic method demands a certain nature of clear-sightedness and maturity in the patient and is therefore not suited for youthful persons or for adults who are feeble-minded or uneducated."

The newer attitudes were foreshadowed by Byrne, who, in 1916, opened a lecture on the "Psychotherapy of Old Age and Chronic Invalidism"

with the words:

> In spite of the fact that methods have long since been reduced to principle, it is amazing to find scientific psychotherapy so little utilized by the profession in the treatment of old age and chronic invalidism. This is all the more shocking when one considers the not inconsiderable success obtained without and within the profession by individuals who realize the value of optimism and healthful suggestion, even though they know practically nothing about the scientific application of even these psychotherapeutic measures.

Byrne reminded his audience that where cure is not possible, suffering can be alleviated and destructive processes retarded; the fundamental of treatment, he felt, *"is adjustment of the individual's life and activities to the capacity of his organs"*—to be achieved by optimal activity and "the influence of mind upon body" . . . of emotion upon the circulatory and digestive mechanisms. He spoke of the importance of understanding, patient, supportive staff who would be reassuring, encouraging, attentive, and constructive in helping the aged to live, to make optimal use of their remaining assets and he detailed "how to do it." He did not advocate "tender loving care," but outlined that old persons should be addressed by last name and their dignity maintained, their illnesses meticulously attended, and their social integration encouraged.

In the psychoanalytic literature, there was a lack of clear definition of what is meant by old age. In 1919, Abraham, for example, referred to persons in their forties and fifties as being of "advanced age." Perhaps this is because

he was himself at the time only thirty-one years old. He recommended psychoanalytically oriented therapy for older persons, but was careful to point out that poor vocational and sexual past performance, as well as early onset of symptoms, were unfavorable prognostic signs. He emphasized the tendency of many older persons to regard the doctor as a father figure from whom will come suggestions and guidance. In 1925, Jelliffe encouraged psychiatric interest in the psychotherapy of persons in the seventh or eighth decades of life. With only one exception, however, his illustrations of successfully treated persons are in the sixth decade of life. Of interest is the exception, a seventy-two-year-old merchant whose temper improved, and whose hypertension appeared meliorated, through therapeutic sessions. He advocated treatment, saying, “Pessimism closes the door—optimism, even if an illusion, is worth the effort.” Kaufman" and Atkin, in 1940, appeared to regard the climacteric as the onset of old age, and they too referred to persons in their forties and fifties as old or aged.

The importance of considering the older person in relation to the family and to the community was emphasized by Flügel in 1921; in his *Psychoanalytic Study of the Family,* he made clear that it is for the well-being of society that there be respectful and helpful attitudes toward older persons, and that the success of a culture may be measured by the extent and quality of its provision for its aged. Kardiner, in 1937, outlined the social forces which underlie attitudes toward the aged. The relationship of the subsistence

economy to the ability and willingness of the family to protect and preserve the aged, and the occurrence of a child-parent reversal in attitude and action, were cogently discussed by him. He gave an example of successful treatment of one older person, which included manipulation of the social environment. Unfortunately, the ages of the persons used as illustrations were not given.

Psychiatric difficulties of the fifth and sixth decades, to which many of these workers referred, are now better understood as problems of the middle years when many a person sees, or thinks he sees, the true trajectory in life, and views it with disappointment, horror, or fright, without being able significantly to alter his course. This development has nothing to do with involution, either physical or mental, as some have claimed, but it may nevertheless herald the beginning of chronic invalidism or of a mental state, which, even if not itself chronic, may create a social situation which steadily worsens.

After World War II, however, a number of authors, notably Cameron, Rockwell, Wayne, Herkimer and Meerloo. Grotjahn, Stern and Goldfarb, reported specifically on the individual psychotherapy of the aged. Others, among them Zeman, Ginzberg, Allen, Clow, Linden, Silver, and Hollender, reported on hospital, group, and milieu treatments. A number of reviews of theoretical and practical value have appeared and a number of investigators, notably Busse, Birren, Stotsky, Berezin, Goldfarb, Perlin, made sound medical-

psychiatric contributions on which therapy can learn.

The fruitfulness of basic study of this age group was affirmed many years ago by the following findings in one institution for the aged. Klopfer deduced that brief psychotherapeutic sessions would be effective; Perlin noted that psychiatric interview was not always helpful in the proper selection of residents; Ballard observed that certain types of older persons do not repeat suicide attempts; Shrut noted that change of residence to an institutional type was related to increased anxiety and fear of death. The continuation of youthful attitudes and tendencies to remain active into old age, despite illness, was demonstrated by Oberleder. Also, Kahn noted that alert, assertive individuals seemed less prone to develop physical symptoms; and Pollock reaffirmed the importance of good early socioeconomic circumstances and of at least minimal education in preserving intellectual ability with the progression of years.

Since then a great deal of work has come from the Geropsychiatric Institute at Duke University under the direction of Busse and later Eisdorfer. Verwoerdt's study proved that sexual activity persists until late life and confirmed the information gathered by Rubin that those who begin early and continue activity throughout the lifetime, tend to finish later. Palmore and Pfeiffer have shown that persons with "a good start" may fall into an elite group who in later life do well. Pfeiffer confirmed the usefulness of

psychotherapy in older persons. The investigative team headed by Simon, Lowenthal, and Epstein have contributed much information on the "paths to the mental hospital" demonstrating, as did Blau, that families do not "dump their aged" into such institutions; illness and need for care result in appeals for such aid after a long history of other attempts at solution. These studies have expanded the work done by Birren and his group at NIMH and that of Goldfarb in New York State.

Rechtschaffen wrote an excellent critical review of the literature on psychotherapy of the aged through 1959. In his discussion he stated,

> . . . current thinking seems weighted toward the belief that most older persons, as compared with younger, profit most from supportive approaches in which the therapist plays a more active role. Therapeutic approaches might be arranged along a continuum of the degree of patient participation, as follows: (1) insight approaches, (2) supportive approaches, (3) direct gratification and environmental modification, (4) illusion-of-mastery therapy.
>
> In general the trend has been to use approaches toward the last-named end of the continuum with the following characteristics of the aged being offered as reasons: the increased dependency which arises from realistically difficult circumstances; the immodifiability of external circumstances to which a neurosis may be an optimal adjustive mechanism; irreversible impairment of intellectual and learning ability; resistance (or lack of resistance) to critical self-examination; the economics of therapeutic investment when life expectancy is shortened. There is considerable disagreement as to what weight the various factors actually carry.

The "illusion-of-mastery" therapy of Goldfarb in actuality was a description of what appeared to be taking place in effective dyadic or group psychotherapy with aged persons. It was not advocacy of foisting an "illusory relationship" on the patient. The therapist accepts the patient's delegation to parental status, does nothing to destroy this illusion, and permits the patient to feel secure, protected, triumphant, and in control of the powers he believes this chosen figure possesses. If the therapist fails to permit this, he "loses" the patient who goes on to seek out one he can regard as a parental surrogate in whom he can confide, for whom he can confess, or from whom he may believe he has produced punitive action, or whatever response he must see as present if he is to be convinced he has found the desired, potentially protective person. He may search for and find this in his spouse, a confidante, a friend, a mistress, his barber, a physician, or a charlatan. Further, Goldfarb was convinced that with persons of any age most, if not all therapy, other than that which can become completed "reconstructive" (to use Rado's term) or psychoanalytic therapy, is actually hypnoid in type. That is to say, in all psychotherapy the suggestibility of the patient is wittingly or unwittingly increased by the therapist even as by Liébault, Beaunis and Bernheim, who then makes use of the powers delegated to him to the benefit of the patient. In psychoanalytic or reconstructive therapy, this comes to be understood, "worked through," by the analysand, and the therapist as a figure who has been parentified is relinquished in reality, although his influence and

precepts may be psychically incorporated. Viewed in this light, many so-called insight approaches are actually merely reassuring and supportive, and provide direct gratification or constitute environmental modification through the existence of the psychotherapist as a special figure in the patient's social environment who fulfills the patient's need to find and hold him.

What kind of a parental surrogate the patient needs to feel reassured, what kind of behavior he will regard as supportive is signaled by the associational flow of the patient. It is my opinion that the common denominator of the wide variety of successful therapeutic methods is that they provide the patient with an illusion of mastery. If the therapist has come to understand what reassures and what supports the particular patient, the patient comes to feel "loved" and feel assured of protective aid, should he ask for it. This may lead some therapists to try to play a role, but the therapist should be chameleon-like. His "coloring" is determined by what the patient wishes to see, and he need play no role but merely avoid destroying the patient's illusions about him. In our society, with middle-class patients, behaving "like a doctor" may suffice.

Sprague stated, "The therapist may serve the patient in a number of ways," and divided the roles of the therapist into active and passive. Among the passive roles are those of listener and target for the patient's ventilation of emotions. Among the active roles are those of indicator, comforter,

explainer, desensitizer, analyzer, lecturer, negotiator, manager, decider, and philosopher. But, in Goldfarb's opinion, the therapist is first the listener and target, and then may permit the patient to believe that he is a reflecting mirror, or comforter, punisher, forgiver, by following the patient's symbolic productions and responding to this as required to maintain the relationship. With time and patience, he can also provide active direction of "helpful" nature through the trust and power placed in him as the parental surrogate, not thereby playing a role but by being the wiser, more constructively oriented person who is sought for.

In group therapy, the same general principles also apply. Stimulating improved social relationships in brain-damaged persons requires a special type of staff leadership. Patients establish relationships first with the leader, just as in dyadic therapy, and later, if at all, with peers through the common bond with the leader.

For an aged person, a relationship such as is described here is the important factor in the prevention or mitigation of fear and anger. They help him to cope with the disorganizing, or personally and interpersonally disturbing effects of emergency emotion. It is true that many aged institutional residents are more frightened and angry than truly demented;

their behavior is disorganized by emergency emotion. The best restraint

or corrective for confused, agitated patients appears to be the presence of interested, alert attendants who recognize that much, if not all, of the seemingly meaningless behavior of even brain-damaged aged persons can be managed if such behavior is regarded as a motivated and socially directed problem-solving attempt. Careful testing for intellectual assets may reveal their presence. Structured, flexible, non-demanding and nonthreatening group programs may reveal the patients' resources in even more gratifying ways—by encouraging and eliciting constructive behavior.

Feelings of Helplessness and Dependence

The recognition of helplessness and dependency in persons as making therapy possible has clarified some of the problems of psychiatric treatment of aged persons and has contributed to their solution. Although some aged persons are in a position to review their patterns of behavior and gain insight into their dynamic determinants so as to make sweeping changes in themselves, most must be helped to regain or to utilize more efficiently their old effective patterns of action and to do so with a sense of purpose, restored interest, and pleasure. The psychotherapeutic interrelationship in which the older person regards the therapist as the parent or child-parent, and the utilization of this relationship for the patient's benefit, have been demonstrated. The need for flexibility in the approach to treatment has been repeatedly emphasized. Appointments may be infrequent, sessions brief.

Environmental manipulation and the role of ancillary personnel in treatment may be even more important than the sessions with the therapist. The need to work with the family or the persons who have assumed responsibility for the care of the relatively dependent person and the usefulness of the social worker in this respect have been emphasized.

Therefore, there is now increasing need for the instruction of personnel of all types in the care of aged persons with mental disorder. Some current teaching of theory and practice, however, may lead to misguided therapeutic efforts with the chronically ill and aged. Emphasis, in teaching and practice, upon the patient's achievement of self-sufficiency and independence may result in the therapist's failure to recognize the patient's helplessness and dependency as a motivational force and nucleus for socially acceptable, effective patterns of behavior.

Therapists at all levels can be helped to grasp that psychiatric care of the aged can be directed toward (x) the correction of factors which initiate or maintain the mental suffering and social disturbance; (2) decreasing the environmental obstructions to gratification or relief from tension; (3) assisting the individual toward gratifying experience and aid in relief from tension; (4) decreasing feelings of helplessness, anxiety, and anger, or altering mood; (5) converting socially disturbing reparative patterns to more acceptable behavior, or (6) responding to the irrational as well as rational

search for assistance and emotional support, so as to decrease personal suffering and environmental disturbance, and to favor increase in functional efficiency. Not all of these are equally feasible or desirable with aged persons. While each of these may increase capacity for "mastery," the first three may actually do so, but the second three may be achieved on an illusory basis.

This is so because with increased age, added socioeconomic losses, and physical or mental decline of the individual, personal opportunities and activities may be limited and sociomedical opportunity to exert corrective action is decreased. There remains the continuing opportunity to respond appropriately to the irrational aspect of the patient's search for aid: his dependency. The concept of dependency as a transaction cultivated by the person because it is emotionally gratifying, eliminates or decreases fear, anger, and feelings of helplessness, contributes to self-confidence and self-esteem, and lends meaning or purpose to life, assists the therapist in the beneficial use of this relationship. Professional awareness and judicious acceptance of the patient's dependency leads to diminution of its overt manifestations, to increased self-sufficient behavior, and quasi-independent action.

For its proper use, the dependency relationship must be clearly defined. It must be understood that fife experiences, including that called psychotherapy, may yield a shift from one pattern of dependency to another,

or of one pattern of nondependent function to another, but that the shift from dependent personality functioning to non-dependency may not be feasible. Dependent psychodynamic patterns can be distinguished from nondependent patterns by their focus upon the instrumental use of others to elicit and maintain self-esteem, self-confidence, and a sense of purpose of personal identity. Subcategories of dependent and nondependent social relationships —simple, masked, pseudo-, and asocial or antisocial, can be defined as shown in Table 37-8. A socially desirable and personally helpful strengthening of a pattern or a shift from one pattern to one more socially acceptable can often be achieved.

Recognition that helplessness and emotional dependency of patients is of value for therapy helps to define goals of therapy on a practical, realistic basis, rather than in mystical terms, or within an ill-defined framework which is contemptuous of the patient's weakness, regards him as regressed, or depreciates his search for magic or for a powerful parental figure.

Psychotherapeutic Approach

As suggested by the schematic representation, an old person who has lost resources for adequate, gratifying mastery of material, intrapsychic, or interpersonal problems may, because of feelings of helplessness, fear, and anger, search for aid, that is, strive to find and hold a person in relationship to

whom he may regain feelings of ability "to do," about which he feels proud, which restores his sense of purpose, and gives him pleasure. This postulate points to the psychotherapist to help the patient to feel he has found the desired person and won the longed-for relationship. This can be achieved if the therapist can behave so as not to destroy the person's belief he has found and won what he seeks; this is done without role-playing if the therapist simply does nothing to contradict the patient's verbal or nonverbal indication that the therapist does fulfill that role. This is tantamount to saying that the child-like submissive state of mind of the patient, the sufferer, the helpless one, is one of readiness to accept suggestion. The non-contradictory acceptance of the patient's readiness to be directed is an implicit suggestion to the patient that he continue in this role; this heightens the patient's suggestibility. Implicitly, the relationship enjoins the patient to be on his good behavior, to work to win and hold the therapist's good will. This is the state of craving for magic from the magician in which the patient seeks to learn and use the rites which will bring the magic-maker under his control. Improved behavior results, and then the improved behavior tends to increase self-confidence, self-esteem, and to connote that the therapist has been helpful. This heightens motivation to use the therapist and the pursuit of his help becomes a more and more important goal, giving the patient a sense of purpose. Feeling successful in this, and feeling successful in following the implicit but unstated suggestions of the therapist to do well so as to win him,

so as to have him, is essentially a hypnotic relationship which leads to successful activity outside the therapeutic relationship, within the limits of the patient's resources. An added dimension is that the patient, in going through his behavioral struggle to win the therapist, comes to feel understood. This, as Stekel put it, is to feel loved, and as we may now put it, it is to feel secure, to have the power to control another. If the therapist goes on to utilize the states of parent-magician-the-one-to-be-obeyed, he may constructively instruct the patient to examine his own behavior so as to improve it. Such discriminatory self-examination may be beyond the capacity of persons with even mild brain damage, but is more likely beyond the capacity of most persons because of their fear to become acquainted with their dependency-striving outside, not to speak of inside, the therapist's office.

Table 37-8. Personality and Social Characteristics of Dependent and Nondependent Personalities

NONDEPENDENT PERSONALITY	DEPENDENT PERSONALITY
PERSONALITY CHARACTERISTICS	
Sense of Purpose is geared to internalized desire for self-realization and biologic drive for survival and reproduction; thus self-assertion serves to improve self and society.	*Sense of Purpose* is focused on seeking, winning, and controlling a "strong" protector with useful attributes.
Self-Esteem is enhanced by recognizing self as an effective individual with ability to gratify own needs, and to engage in mutually rewarding social relationships with	*Self-Esteem* is contingent on gaining and maintaining the approval of others, or from belief that intrinsic worth derives from class, clan, or family association.

others.

Self-Confidence is achieved by mastery of his environment, and augmented by outside recognition of His ability and achievements.	*Self-Confidence* is based on success in attracting and holding others, on ability to gain a friend, ally, and helper through own efforts.
Pleasure comes from relief of tensions and satisfaction of needs in a personally and socially approved manner, and from contributing to tension relief and gratification of others on a cooperative problem-solving or sensual level.	*Pleasure* comes from accomplishments and services designed primarily to please others, in order to dominate and manipulate them.
SUBTYPES AND SOCIAL CHARACTERISTICS	
1. *Independent:* Rational, cooperative functioning in social relationships; actions and emotions attuned to individual goals and appropriate to the situation.	1. *Simple:* Transparent, easily recognized and freely admitted, usually without guilt or shame and sometimes with pride.
2. *Masked Independent:* Same as above, but less obtrusive.	*2. Masked Dependent:* Exploitation of others is disguised or rationalized as virtuous and socially useful, self-imposed subservience to delegated parent figure as "martyrdom."
3. *Pseudo-Dependent:* Rational social functioning modified by outward conformity to dependent behavior to avoid interpersonal complications.	3. *Pseudo-Independent:* Brave facade of masculinity or femininity and maternity; when disappointed in delegated parent figure, defiant self-assertion usually with controlled anger.
4. *Asocial:* Openly exploitive behavior aimed at individual gratification with little regard for its effect on others.	4. *Antisocial:* Demands the help of others as his right, resorts to force or takes what is not given freely.

Taken from Goldfarb, A. I., "The Psychodynamics of Dependency and the Search for Aid," *Occasional Papers in Gerontology,* No. 6., Institute of Gerontology, The University of Michigan-Wayne State University, August, 1969. Pp. 1-15.

Put in practical terms, a number a factors can be singled out as having a therapeutic influence. These are:

1. The delegation to the therapist of great powers.

2. The patient's belief in the therapist's increasing interest in him.

3. The rise of satisfaction that goes with the belief in the therapist's interest and understanding, which are believed to be, or responded to as, love.

4. The belief that the therapist's interest is based on understanding and guarantees continued care.

5. The rise of satisfaction from having an ally, friend, protector, or parental figure who is more or less constantly present, since the feelings are carried along and incorporated. It is as though a magician had been found and was being controlled.

6. Gratification from having won over or triumphed over the therapist; this is life proof of one's own strength, wit, or cunning, and may be equated with the idea that one knows or has learned the complex rites that gain control over the magician's powers. This gratification is often gained when the therapist gives some specific practical aid, such as prescriptions for medication, recommendation of special diet, or helps make minor changes in the environment, such as a shift in room or roommate, in an institution, or in an item of family care.

7. Gratification from feeling favored by the therapist over another-—the patient before, the patient after, or the colleague who is not a patient—a victory in sibling rivalry, gratification in lording it over others, silently or aloud, because one has

been “chosen.”

8. Gratification from true success in performances that were motivated by a desire to please the therapist but that have real value. For example, success in occupational therapy — the making of a rug or an ashtray about which the therapist can be told, or that can be given as a gift to the doctor—or success in a sheltered workshop, as evidenced by output and remuneration.

9. The similar gratifications obtained with others about which the therapist may be told, or that may be kept as a secret to tell the therapist someday, or that are referred to the incorporated therapist-parent in the conversations with him that take place only in the thoughts of the patient between visits.

10. Triumphant feelings on the part of the patient from having withheld information of hidden trouble; pride in self-sufficiency as evidenced by silently and uncomplainingly enduring pain, in relation to the approving incorporated parent, because this is what could please the therapist—if he knew about it.

11. Accentuation of guilt fear (conscience) with some decrease in aggressiveness, because the angry feelings are becoming known to another. Pride and rise in self-esteem on the basis of self-control because of this, and an increase in self-confidence of this self-control.

12. Decrease in the guilty fear because of the permissive or reassuring

attitude of the therapist who appears to regard the discomfort of guilty fear as expiatory self-punishment which earns forgiving.

13. The change of disorganizing fear to organizing anger as there is decrease in the fear of punishment and of the belief that anger is best.

14. The change of disorganizing anger to organizing fear, and the alerting of self to dangers; self-propulsion toward best behavior on the basis of exposure to the consensus, to the leader's comments, and to one's own second thoughts.

Pharmacotherapy

Pharmacotherapy is dealt with in detail elsewhere in this book. In older persons with no brain damage the same medications are useful as in younger persons for similar conditions, but the doses are usually smaller and medications such as anti-depressants started more cautiously. Antihistaminics and analgesics, sedatives and hypnotics, are also useful to decrease fear and anger with good effect. The choice of medication can sometimes be made on the basis of whether fear predominates and is accompanied by anger, or whether anger now predominates and contributes to fear. At times, trial and error can clarify whether an antianxiety (fear-decreasing) medication is necessary or a tranquilizer (sedative, anger-decreasing, antipsychotic) meliorative is the most useful. Also, for persons

whose autonomic nervous system concomitants of emergency emotion appear to have triggered a sustained shift in biochemistry or homeostasis, anticholinergic antidepressants or phenothiazines may be helpful, depending upon whether the reaction is depressive or schizophrenic in type.

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