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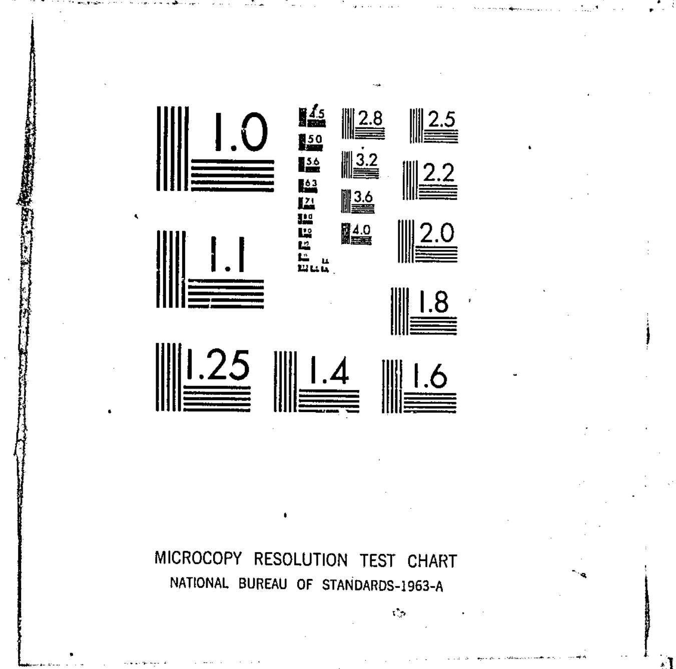

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MENTAL HEALTH PROBLEMS OF OLDER AMERICANS:

AN INTRODUCTION FOR VICTIM COUNSELORS

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Introduction

Many counselors experienced in helping crime victims have remarked on an oddity about their clientele: they are a very diverse selection of people, and yet, as victims, they act--or react--in quite similar ways.

In this respect, the elderly victims of crime are not a separate class. If anything, they contain a wider mixture of social and personality types than other age groups, and yet they respond to sudden stress in the same ways that all of us do. What differentiate elderly victims from others are certain tendencies within the general pattern. Elderly victims tend, for example, to be more frightened for having been victimized, and yet, strangely, they often appear to handle the experience a little more calmly.

With younger victims, it seems, the counselor is dealing with two immediate "facts"--a crime and its victim. With the elderly, a third "fact", old age, can act like a filter between the violation and the violated, influencing the course of events that follow. To adjust appropriately to that added influence, the victim counselor should understand some of the emotional characteristics of the elderly as well as those of the victimized.

Our summary of the psychological attributes of older Americans needs four introductory comments.

First, it is no more than an overview, drawn largely from the recent writings of a dozen or more men and women

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prominent in the field of geropsychiatry (the treatment of mental illness in the elderly).[1] However brief our overview, we hope that it conveys the revolutionary message of geropsychiatry--many of that the afflicted elderly need not resign themselves to a hopeless existence.

Second, the articles and reports from which our overview is drawn cover a wide range of issues, discussing the mental good health of the elderly as well as a variety of settings and methods for treating their mental problems. Nonetheless, consensus among researchers and practitioners is high--there seems to be a basic agreement about what are the emotional attributes of old age.

Third, there appear to be a number of parallels between the experience of becoming a crime victim and of becoming an older American. If victim counselors find the emotional problems of the elderly to be strangely familiar, perhaps that is because old age is felt to be a kind of victimization for many people in our society.

And last, our tour over this terrain will be conducted in three stages. First, we will consider the sense of loss which is the dominant theme in the psychology of older people. Second, we will examine the most common ways in which older people adjust badly to their losses or remain maladjusted in old age . Third, we will highlight some of the main, therapeutic techniques used in aiding the elderly to make better adjustments.

"A Season of Loss": The Psychological Attributes of Older Americans

There are at least two understandable approaches into the topic of geropsychology (the body of knowledge about the mental and emotional characteristics of the elderly). One is to describe the major classes of mental travails that one finds in older people, as in this summary:

> The mental health status of the elderly can be divided into:
>
> Life Crisis Reactions -- Common emotional problems, such as depression, anxiety and frustration, that are byproducts of adaptation to old age.
>
> Functional Disturbances -- Psychiatric disturbances that may affect the day-to-day functioning of the older person but in which there is no actual impairment of brain function. They may include schizophrenia, depression, anxiety states, alcohol disorders or paranoid reactions. Those with functional disorders require extensive treatment and, in many cases, hospitalization
>
> Organic Disorders -- Mental disorders associated with organic brain defect in which brain cells have been either impaired or permanently damaged. Those with organic brain disorders typically require institutionalization.[2]

While we encourage readers to retain the idea of "crisis," functional disturbances" and "organic disorders," we think it more enlightening to introduce our discussion with a recurring theme, one that explains most (but not all) of the signs of mental distress in old age.

Dr. Eric Pfeiffer has presented that theme very succinctly: "Old age is a season of loss"[3]--a time of lost status and self-esteem, of loved ones lost forever, of lost powers over the mind and body.

Before considering these categories of loss in more detail, one should appreciate that any one of them--the loss of a job, for example, or of a spouse, or of sight--is a wrenching experience for any normal person. The effect should therefore be staggering when the losses befall such a person in rapid order.

There is abundant evidence that the elderly, who often absorb a succession of adversities in just this way, are very hard hit by the experience: twenty-five per cent of all suicides are committed by the eleven percent of Americans who are 65 or older[4]; 24 per 10,000 elderly suffer psychopathologies, as against, for example, 8 per 10,000 in the 25-34 age group[5]; a "prevalence of depressive mood" is found in 10 to 25 percent of the elderly, while another 5 to 10 percent suffer from a "depressive syndrome," which is a more debilitating condition.[6]

Troubling indicators, to be sure. But considering the losses which the elderly endure "...one must in fact marvel that not all old people become depressed. Most of them do not."[7] Some researchers, like Dr. Robert N. Bulter, director of the National Institute on Aging, have studied certain kinds of older Americans, that unheralded majority who are tolerably well, physically and psychologically. From these studies, and from the remarkable responsiveness of the psychologically-troubled elderly to treatment, one learns that the "season of loss" is not a hopeless state. Old age is, of course, the terminal stage of life, the universal reminder that death comes to us all. But the common impulse

to shun the elderly and thereby to put death out of one's mind turns out to be like a child's fear of the dark--there are some genuine unpleasantries out there, but far fewer than we imagine.

As to the first category of loss, produced by the social forces which help to define old age, Dr. Domeena C. Renshaw has written, "Aging with dignity in a young country is no easy task".[7a] The American Dream often seems nowadays to involve a competition between two cultural forces, "the youth culture" and "the work ethic"--but note that both contestants are in a conspiracy to make the un-young, non-worker an un-American. Having grown up with those biases, the American retiree is among the first to consider himself out-of-date and obsolete. After all, he has taken a major cut in income, and isn't income a primary measure of an American's worth? And if American housewives are made to feel uncomfortable with the question, "What do you do?," imagine the discomfort of the out-of-the-job-market retiree.

The toll on the elderly's self-worth is high. A mere six percent of them feel that one's sixties and seventies are the best years of one's life, and these years were judged the worst by thirty-five percent of the elderly.[7b]

There is in all this an irrational stigma against old age, a stigma which is neither new nor confined to America. Sigmund Freud, an Austrian, for example, expressed doubts about the "educability" of those over 40. Robert Butler likes to point out that the father of psychiatry introduced the terms by which his

intellectual contributions are best known--the id, ego and superego--when Freud was 67, two years into his "retirement" age.[8]

The toll which retirement exacts of ordinary people is hinted at in a survey of the elderly who reside in Hillsborough County (Tampa), Florida. Researchers found that most of these residents had settled there as couples, on retirement, but that for 80 percent of the couples, one spouse, usually the husband, had died within the first six months.[9] And there is evidence that retirement is bad for the health of the elderly of other lands; in the Soviet Union, for example, gerontologists speak of the sometimes-fatal illnesses they call the "pension diseases."[10]

No one dies of a broken heart, or so it is said. But studies on the second category of loss--that of one's spouse and friends--indicate clearly the existence of a "broken heart syndrome."[11] This and more overt forms of self-destruction, ranging from alcoholism to outright suicide, speak to the inability of some elderly to mourn their losses and then carry on.

The effects of the diminishing social network of older people are seen not only in mortality tables but in the problem cases of elderly-serving agencies, cases in which loneliness, depression and isolation are common features. The reminiscing of some elderly people is obviously one device to revive a social life that belongs to the past, and so, perhaps, does another persistent trait of the elderly: their attachment to their old neighborhoods, to familiar things and settings. Victim

assistance workers in the Flatbush section of Brooklyn sometimes wonder at the stubbornness of some elderly residents who refuse to move away from those high-crime precincts. Victim assistance workers in Tampa, on the other hand, do not find that resistance so peculiar, for they can see the results of those moves in the sometimes-lasting grief over a distant home forever abandoned. What is so upsetting about the residents of some retirement communities is that after their divorce from the world of work and other social institutions, they have grown entirely dependent on an informal support system for psychological nourishment, a system which some find difficult or impossible to re-establish in a new environment.

The third category of losses, the physical and mental impairments, seems to be misunderstood by most of us. We put too little stock in the importance of , say, hearing loss, and overinflate the significance of the mental disabilities of old age.

Robert Butler's studies of normal, healthy older people found, among other things, that "cogitation" was actually greater among this group than among a younger, normal group. What seems to have differed most notably was that the elderly's speed of response, their reaction time, was slower.[12] That diminished cerebral agility and the obvious physical changes of old age--the gray hair, wrinkles, lessened physical strength and so on--may be all that aging *per se* brings on. Thus, as long as growing

old remains a period of good health, entailing nothing more than the natural slow-down of the organism, one should not expect debilitating physical change in old age, certainly not in the early old age of one's 60's, and not necessarily in the later old age of one's 80's and 90's. A possible exception to this is the "...dramatic reduction of the body's tremendous reserve capacities. These reserve capacities are used whenever illness or emotional upsets arise."[13]

Another way to make this last point is to say that one's psychological "buffer" to deal with sudden shock seems to grow thinner in old age. It is not that the elderly tend to respond more turbulently to stress than others, for often it is quite the reverse; many seem to accept psychological jolts in a spirit of resignation which, in younger people, might seem pathological. If we attribute this characteristic to the aging process itself (and it may be partly a socially-conditioned response), it may be the only "natural" characteristic of old age that presents major problems for the victim counselor.

Of course, not all the threats to well-being in our older years come naturally, from the normal weakening of our bodies. There are, predictably, an increased number of attacks from without to be faced. Accidents, infections, the effects of chronic disease, all assault the elderly more often than others, a fact which is not always accepted in good grace. One man in the group studied by Dr. Butler was very old indeed when he first went to a doctor with a

complaint. The physician explained that the pain in the man's left knee was what a person his age should expect, to which the patient replied, "Now look here, doctor, my right knee is also one hundred and one and it doesn't hurt. How do you expl in that?"[14]

One may admire those who follow Dylan Thomas' advice--

> Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light[15]

--and yet far more elderly endure their physical misfortunes in the manner invoked by Reinhold Niebuhr: "Oh God, give us the serenity to accept what cannot be changed..."[16] Although we tend to be more irritated by the elderly who are given to rage, the ones who have taken to serenity probably produce the larger social problem. For example, 50 percent of the elderly studied in one area of Chicago were found to be in need of medical care, but only half of these identified themselves as being ill. The rest thought they suffered merely from "old age."[17]

Perhaps the most troublesome physical ailments which prey on the elderly are those which attack the five senses, especially sight and hearing. These sensory deprivations are frightening--they inevitably induce feelings of isolation and helplessness.[18] Victim counselors appreciate these feelings after they have worked with an older person who, for example, was unable to see the potential mugger from a distance and thereby avoid him. With the environment becoming more threatening and the person's ability to assess

that environment through his senses becoming more limited "... one must again wonder why all such older patients do not become paranoid."[19] Note that the "paranoid" fears distinctly the elderly's are not those of paranoid schizophrenia, an illness which may last into old age but almost never begins there.

Another way of indicating the significance of "sensory deprivation" in the elderly is to report what that deprivation, produced in an experimental situation, does to healthy, college-age individuals: "...they develop confused, disoriented, and hallucinated behavior characteristics suggestive of senility."[20]

There, the repellent word is out: senility. Of all the losses which the elderly endure, the one which ranks highest in importance to the non-elderly seems to be the loss of certain mental faculties. The fact that senility or something like it can be induced experimentally in the young is an appropriate way to introduce a myth-laden subject.

Note that senility--or senescence, to use Dr. Francis J. Braceland's less perjorative term--is an imaginary disorder. One can see one form of senescence in a picture produced by a modern brain-scanning device, four black flower pedals meeting at the center of a slightly-oval, rounded circumference, the dark portions within the outline of the skull depicting tissue that has died. When this occurs, the resulting malady is called "Organic Brain Syndrome."

There is a curious fact about the human brain: unlike the living cells of the heart or any other organ, those of the brain are original equipment, not recent replacements of cells which have been worn out (and which had once replaced earlier cells, and so on, covering many generations of cellular life). Thus, the introductory "hello" of an 80-year-old-woman originates in brain tissue which is as old as she--and which will not be replaced should it stop functioning--whereas the aged hand one shakes in the transaction is made of tissue that at least in part, was born yesterday

The brain-scan pictures vividly demonstrate that the terminal decay of brain cells almost always follows a pattern, one whereby cells in certain interior parts of the organ are almost always the first victims of the brain-damaging process (the exception being the kind of brain damage brought on by a stroke, which affects muscle-controlling cells in the exterior part of the brain). It does not much matter if Organic Brain Syndrome is caused by undernourishment (which is often the effect of arteriosclerosis, or hardening of the arteries) or by malnutrition (which explains why alcoholics sometimes start becoming senescent in middle age) or by disease, the effect is largely the same, causing the loss of certain, specific capabilities in the mind's computer. That explains why the symptoms of Organic Brain Syndrome are quite consistently similar among its victims, and remain so as the syndrome progresses. The most striking of these symptoms are memory loss (starting with a loss of recall for recent events) and a sense of disorientation and confusion.

We will return momentarily to those symptoms. But one form of senescence/senility was just described as a "disease," and that deserves a comment.

According to recent medical research,[21] Organic Brain Syndrome is often the product of a disease and not in a figurative sense. After one eliminates cases involving inadequate blood supply to the brain and cases involving nutritional abuse, one is left with many OBS cases which seem to be caused by submicroscopic life forms that thrive on a diet of certain human cells. Add these findings to the other causes of Organic Brain Syndrome and one must conclude that this whole class of senescence is as susceptible to prevention and cure as are, for example, the common cold, polio, and cancer. Moreover, even before new medical discoveries are made to treat Organic Brain Syndrome, there have been enough advances in its treatment by health and mental health professionals to give rise to a reasoned, new "philosophy" towards senescence in general: it can be "slowed, stopped, or even reversed."[22]

Now back to the all-too-familiar symptoms of senescence. Though accurately descriptive of Organic Brain Syndrome, forgetfulness and the related symptoms are also good indicators of quite different maladies in older persons. Among the alternative inducers of senescent behavior, we have already touched on one--sensory deprivation. Thus, in a few cases at least, senescent behavior can be made to disappear with the use of a hearing aid or a pair of eyeglasses.

Probably the most frequent cause of non-organic senescence

is depression, with its accustomed retreat into a still, private world of melancholy. Perhaps the senses, through disuse, end up functioning poorly for the depressed older person, thus causing the signs of senescence. Perhaps it is not so complicated--the symptoms simply indicate that the person has quit, has given up, has become emotionally apathetic.[23] Robert Butler has seen this syndrome in depressed elderly people going through a life crisis; when the acute sense of loss is eased or resolved, the senescent behavior goes away.[24]

Sometimes "senility" appears to exist only in the eye of the beholder. The foregetful adult, on reaching old age, is now labeled senile, though his mental faculties have not changed. Or, as Francis Braceland has speculated, the "mental filing cabinet" of an older person may be very full and therefore difficult to sort through efficiently.[25] Or, it may be that the older person who repeats a remark he just recently made is actually displaying a loss of interest in the here and now--we call him a little senile while he, in effect, is calling us a little boring.[26]

One should not make an overly-stark distinction between organically-based senescence and that brought on by other things, like depression or sensory deprivation. There may be an overlap, an interplay. There is evidence, for example, that Organic Brain Syndrome preys especially on those who have led psychologically-troubled lives.[27]

Futher, there is a lively debate in the field of geropsychiatry about the propensity of the old to "disengage" from

the world of people and things: is that process voluntary or forced on the elderly?[28] When grandmother wants the company of grandchildren in ever-smaller doses, is that preference produced by biology or by social conditioning? If it is the former, perhaps we will view some features of senescence as a gift of nature, not a curse.

Yet, for the present, it is sufficient to understand that senility, like cancer, is a too-inclusive concept, wrapped around with demonic associations which inhibit us from responding to its many forms in a calm, reasonable and therapeutic manner. In learning to change our attitudes toward the senescent elderly, we can take lessons from the inspired skeptics like members of the Senior Citizens Robbery Units in the New York City Police Department. Practically all of these officers can recount cases involving elderly crime victims who were incoherent, disoriented, totally unable to recall what had happened, but whose "senility" faded after an hour or more of reasurring talk.

Unfortunately, the same officers can recite even more cases in which the senescent victim remained so, no matter how skillful or patient the intervention. As far as these officers can tell, there is no way of detecting at the outset which of the victims suffer from Organic Brain Syndrome and which are presenting temporary or reversible symptoms. So the officers in these cases act on trust, that it is worth trying to help every older person recover a lost mastery over his mind, a faith that yields enough good

results to become self-sustaining. In that, one can see a professional attitude toward the many losses of old age which is as rational as it is radical.

Coping Poorly with Losses: The Common Signs of Psychopathology In Old Age

Most of the problems which the elderly present to mental health professionals have one surprising similarity: rarely do they involve an older person's internal conflicts, that source of widespread human suffering which launched the psychotherapeutic revolution of this century. Instead, it is the older person's problems with his social environment that most often render him a victim of psychopathology, of mental disorders. His emotional problems are "situational" in nature, most often arising from his difficulties in coping with change, in adjusting to loss.

One often contracts the maladjusted elderly (the primary subject of this section) with those who display robust mental health in older years, like the redoubtable Winston Churchill, who was well into his 60's when he "mobilized the English language and sent it into battle,"[29] and had just turned 70 when the Allies launched their final campaigns into Nazi Germany.

Yet there are, between the inspirational and the dismaying elderly, many older people whose emotional well-being is a matter of grave uncertainty to those in the helping professions. Probably not disturbed in a pathological sense, such elderly are nonetheless disconcerting in their methods of accepting misfortune or in their pretense that it never happened. The victim counselor, for example, is often troubled that some of his elderly clients display little outward sense of anger toward their assailants.

There are behavior patterns that are not easily dealt with. Nonetheless, we feel obligated to describe them because the victim counselor probably sees more of this uncheerful calm than the

psychopathologies associated with old age.

The patterns we are describing seem to partake largely of the "depressive mood" that affects 10 to 25 percent of the elderly, in Eric Pfeiffer's estimate.[30] Such a "mood" does not serve to interfere significantly or persistently with the person's work, social or interpersonal activities' when depression does interfere with those activities, the behavioral scientists call it a depressive "syndrome."[31]

The milder, depressive state is suggested in another of Dr. Pfeiffer's observations. While speaking of "psychiatrically disturbed elderly patients," Dr. Pfeiffer says that their defense mechanisms, their techniques for keeping upsetting stimuli from overwhelming them, "... provide more of a passive protection for the individual rather than an active coping mechanism aimed at changing adverse life circumstances,"[32] a description which seems to cover both the basically functional, depressive elderly as well as their more disturbed peers.

Clearly what one sees in those who opt for some form of "passive protection" is one of several methods of coping during the final life stage, a stage which is perhaps as beset with stressful change as is adolescence.[33] One should be circumspect in finding fault with any of the ways of coping that the elderly have adopted. As Dr. Francis Braceland cautions, "That way is sometimes pathologic and obviously misguided, but it probably was chosen to avert a disaster."[34]

But is the "depressive mood," as one of those coping tools, truly misguided? Call it "habitual pessimism," and most would

answer yes; label it "Stoicism" and many would change their minds. The case for gloomy expectations cannot be dismissed out of hand:

> Therefore, since the world has still
> Much good, but much less good than ill,
> And while the sun and moon endure,
> Luck's a chance, but trouble's sure,
> I'd face it as a wise man would,
> And train for ill and not for good.[35]

The poet's and the philosopher's case for the Stoic outlook may have found some unexpected support from some social science research -- unexpected to the scientists, that is. Reporting on a study of the victims of a Midwest tornado, Dr. Bill D. Bell concluded, "... the ansiety levels (and reported physical and emotional problems) of the young exceeded those of the aged, regardless of damage sustained. The results suggest the coping potential of the aged disaster victim to surpass -- in most instances -- that of their younger counterparts."[36]

These are encouraging findings, and much to be preferred to indication that the elderly are often undone by disaster. Nonetheless, we fear the findings are misleading. Lower "anxiety levels" and lower "physical and emotional problems" certainly describe above-average "coping potential," but one can also find an above-average coping potential in people who have been subjected to pre-frontal lobotomies. In other words, certain kinds of unruffled coping under great stress can be very costly in terms of the person's overall well-being.

There seems to be a good deal of confusion among victim counselors, especially those who work with the elderly, over the nature of the composure they see in certain clients. The following is

characteristic of how this confusion leads to disagreements among even the most knowledgeable of counselors:

> In discussions with rape crisis center workers, project staff did not find concensus of opinion regarding overall effects of rape on older women. Some held the view that many older women better tolerate stress (especially after a lifetime of experience in a high-crime, high-stress neighborhood) and therefore are less traumatized by rape than are their younger counterparts. Others feel that older women react initially with a strong "front". but later, after sympathetic supporters leave, become depressed and fearful. Still others believe that older women are severely and permanently traumatized by the violent aggressive attack. 37

In our view, there are within the seemingly unfazed, elderly victims of calamity at least two kinds of coping skills at work, one of which has far more recuperative value than the other. Here we are discussing the exercise of genuine emotional maturity which some older people use to good effect in times of misfortune. An article in the sports pages about a 72-year-old man depicted the kind of temperament we might all wish to have in dealing with the adversities of later life. Herewith is an abbreviated version of the newspaper story on Harry Young:

Mr. Young, we are told, had a lifetime love of boats and boatbuilding, He built his last vessel, a 37-foot wooden motorsailer when he had time, which was during the winter months. The boat was launched in 1961, six years after Mr. Young had laid her keel.

In the 18 years since, Mr. Young sailed her five times from the Chesapeake Bay to Florida and the Bahamas. More than once, he and his wife were able to live aboard her six months at a time. He took good care of this boat and saw to it that her hull and

decks developed no leaks.

But according to the article, the craft is now for sale. Mr. Young told an interviewer, "I try to be a practical man. My boating years are coming to a point where I want to pull in my ears some. My eyes aren't good and they're not going to get any better. Any my strength isn't as great as it was.

"I love to travel, but if I keep going up and down the [coastal] waterway every winter I won't get to see the rest of the world... It's good for the boat to get a younger man.

"If I'd sold her earlier, I'd have remorse. But she's done for me what I built her to do. We had our winters in the South and they were very, very pleasurable."[38]

One may be sure that among the elderly victims of every sort of disaster, there are many Harry Youngs, each of whom has much to teach us about facing pain and loss honestly and wisely. But therapists like Dr. Martin Symonds have seen older people whose coping skills do not rely on a clear-eyed assessment of reality -- not in everyday life and certainly not in moments of great stress.

These are the other group of elderly people who demonstrate little panic or emotional upset in times of crisis. Their equilibrium is maintained largely by expecting so few rewards in life that they tent to transform serious misfortunes into minor events, employing a kind of stoicism that flattens the emotional content of all experiences, good and bad, into a bland existence.

This choice of coping skills depends largely on the use of "denial" (about which we will have more to say later), a psychic filter designed to keep out unpleasantry. When a shockingly unpleasant event befalls someone with these coping skills, a

reinforcement device is often brought into play -- repression, the mind's capacity to drive a particular, threatening experience from the realm of consciousness.

Thus, one often finds that the elderly victim of severe, acute stress is unable to recall much if anything about the stressful event itself. Had the social scientists who tested the coping skills of elderly disaster victims asked those who scored well to recount the details of the disaster, we strongly suspect that they would have uncovered high levels of forgetfulness -- far higher than is normal in the elderly population. That extra qualtity of memory loss connotes the denial syndrome, and with it, a will to survive but not to thrive, to carry on in a state of resignation.

Thus, calmly-coping older people who have grown stoically indifferent to their private calamities are a source of concern to those in the helping professions who, by training and temperament, are at odds with the philosophical doomsters and with their elderly converts reconciled to let their lives end "not with a bang but a whimper."[39] At base, there is an antagonism to despair which binds together the health, mental health and allied profession and makes them painfully sensitive to those defense mechanisms in the elderly which are defeatist in nature, and which provide little lasting protection.

As insufficient as is this psychic armor, however, many in the helping professions choose to leave it along, for reasons that will be explored in a later chapter. For the present, it is enough to suggest that much of the "coping skill" victim counselors see in

their elderly clients is in fact not very skillful, and not very promising because the prognosis for a good recovery is with persons who react in this fashion, it often leaves the counselors with a sense of dissatisfaction.

We turn now to the most common psychopathologies of old age, involving behavioral syndromes that clearly impede the ability to function. In general, it is useful to know that "... the range of psychiatric syndromes arising for the first time in old age tends to be somewhat narrow," and "... there is a predominence of relatively simple defense mechanisms or coping devices" evident in those psychiatric syndromes.[40]

To present the symptoms of mental disturbance, we have taken six "syndromes" suggested by Dr. Pfeiffer and, under each, have indicated some relevant coping devices and what they signify.[41] Like all attempts to name and classify psychiatric disorders, ours has the virtue of making some sense out of a jumble of information, but also has the vice of suggesting relationships between the various disorders that are speculative at best. So strong is today's scientific skepticism toward efforts to cluster psychiatric disorders into related groups that even the basic labels of "neurosis" and "psychosis" (designating certain minor disorders and certain major ones) have been scrapped by many mental health professionals.

Thus, the reader is encouraged to be wary of our own attempts to classify the more serious psychiatric problems observed in the elderly into various "syndromes" and "coping devices." We might have simply listed them all as a string of unconnected items except

that the mind rebels at comprehending and memorizing such laundry lists of information. Between the options of explaining the illnesses too chaotically or too neatly, we have reluctantly chosen the latter course.

Anxiety. The threshold syndrome one often finds arising in old age is acute (short-term) and chronic (continuous) anxiety. In one sense, "anxiety" is quite the reverse of a "disorder;" it is a normal physiological and emotional signal, telling us that we are suffering from internal stress, and so we can say that some of our greatest satisfactions -- the challenges we have overcome, our triumphs over adversity -- were all preceded by anxiety. It is the organic indicator of stimulation in life.

Anxiety can often be observed in physical symptoms, such as excessive sweating and a rapid heart rate. The reason for this is that the stress/anxiety syndrome entails a biologically-engineered coping device, a protective mechanism within us that urges us to choose "fight or flight" when confronted with threats, like the threats of physical danger or threats to our self-esteem, our sense of integrity. A massive, worldwide, public heal to problem arises in that neither fighting nor running away is a practical response to many of the threats accompanying human existence -- like a family's threatened security when the breadwinner is laid off -- and so for many of us, unresolved stress builds up and our anxieties rise to a high level. Then the acute symptoms of a forthcoming challenge, much as the wet palms before an athletic contest, can become more-or-less permanent, indicating chronic anxiety. Although the triggering device is the same in both forms of anxiety,

there is a crucial difference between stress that can be released through agression or flight and that which finds no release, the kind that makes us feel impotent.

It is the nature of old age that many of its stresses are especially difficult to resolve. With so many changes coming to the elderly -- almost all counted negatively, as losses -- change per se offers no stimulation, just a dreaded reminder of their increasing powerlessness. Little wonder, then, that there are many older people in a state of continuous anxiety, like the elderly woman who complains about her "nerves," or the old man who seems to become overly upset at any less-than-good news, or the many older people who seem constantly fretful and worried.

Later, we will single out one source of anxiety that particularly afflicts the elderly, the fear of crime. Here, we will mention only one special varient, called "separation anxiety."

Most of us are acquainted with separation anxiety even if we have never seen the term. In its most familiar form, it is the tearful panic one sees in young children who beg their parents not to leave them in the care of a babysitter. Somehow, the youngsters are half-convinced that when the people on whom they depend walk out the door, they will never return -- that the separation will be permanent. That is an ordinary (if not realistic) concern in many normal children.

The normal anxieties over permanent separations in old people are, of course, based on realistic assessments

of their situation. Though the elderly have long since outgrown a dependency on parents, their independence is hardly total, so their fearful anxieties increase as their contemporaries die off and other "dependable" sources of gratification disappear. Cause-and-effect may seem obvious here, but its significance has been overlooked so often that one psychiatrist has been constrained to write, "It seems to me that with the aging patient, the consideration of the separation anxieties is of even more importance than it is in our usual consideration with patients much younger."[42]

Situational disturbances. In a previous section, we indicated that the "season of loss" was the most persistent enemy of the elderly's emotional well-being. Indeed, adapting badly to loos can be said to be at the root of all the pathological syndromes discussed in this section. Yet there are some coping devices which can be highlighted as relating quite directly to the experience of loss, to the "situational disturbances" of old age.

The most prevalent coping device, evidently, is denial, a method of dealing with unpleasantness by denying its existence. It is seen most often in the elderly's failure to acknowledge problems, by not admitting, for example, that one has grown hard of hearing. Plainly, denial can be a useful mechanism for dealing with insoluable problems, but maladaptive when applied to correctable situations.[43]

Sometimes denial is displayed in a less stubborn form, as a preference to not acknowledging certain problems. For

example, a survey of elderly crime victims who had been contacted by victim assistance programs in their communities revealed that most were frightened a great deal by the event. That finding was hardly surprising, but this one was: about one-fourth of the frightened and fearful victims did not tell the victim assistance staff about that problem.[43] In these cases, one cannot say that "denial" was at work, for the victims reported their feelings and their behavior to the researchers. But their earlier inability to volunteer that information to people who wanted to help ease their distress suggests a kind of guardedness in many elderly people that would-be helpers should be alert to.

A second method of coping with a season of loss is "overcompensation" -- a pattern of hoarding or clinging to trifles. A love of objects may not be repaid in the currency of human affection but they may offer a permanence, a sense of security, which has vanished from the social life of many older people. Sometimes the things doted on are reminders of loved ones now gone. Sometimes they indicate more primitive connectors to life, as when a nursing home resident squirrels away little packets of sugar.[45]

While on the subject of the elderly's relationship to objects, we should describe a special coping technique that one finds particularly in elderly crime victims. By way of background, there are many elderly people who display tendencies almost the opposite of "hoarding" -- people who have lost interest in acquiring new things and are beginning to scale down their attachments to old possessions. The older person who gets pleasure in

giving family heirlooms to offspring is working, in a sense, to remove unnecessary ballast in the boat; that person is most likely investing his final years in the personal association which survive and in summing up, in resolving his life experience.

But a mature "disinvestment" in possessions should be distinguished from behavior which we call "pessimism insurance." The latter is most often seen in burglary victims who have been so hurt by the violation and so shocked by the loss of personal valuables that they begin to give away everything remaining which they once cherished, in a vain effort to make themselves impervious to future thefts, to future losses. The "insurance" works -- they have nothing left to lose -- but the premium is costly, leaving them little to live for.

The underlying motivation for the coping devices we have reviewed this far seems to be one of reducing the impact of excessive losses, either by screening out evidence of new loss or by transferring feelings away from people or things which have proven their impermanence.[46]

Evidently related to the last of these is "obsessive-compulsive" behavior sometimes seen in the elderly. Here the focus is on creating and maintaining a neat, orderly and predictable physical environment, seemingly as an antidote tc a disorderly, unpredictable social environment.

With one particular kind of loss -- that of memory -- one often finds a fifth coping mechanism which is transparent in its motivation. This is "confabulation," the use of "memories" which have been invented on-the-spot. In milder forms, the

confabulation is a seemingly-logical bridge between two or more things which are recalled, and the made-up material is simply a way of gluing the remembered pieces together. In more acute forms, the "stories" predominate over the remembered facts. Either way, the confabulator is attempting to keep a facade of normality by engaging in conversations that are not repeatedly broken up with "I can't remember." Not only is memory loss embarrassing for the victim of Organic Brain Syndrome but there is a fear that, if confessed, the disability will drive loved ones and companions away.

Rarely are the confabulator's inventions true fantasies, although there seems to be a kind of gray zone at times, as when the senescent oldster continually "recognized" passing strangers. More common are the fabrications done for social effect, trying to creat the appearance of a well-preserved, well-functioning memory bank.

Three additional coping mechanisms seem to be particularly associated with the situational disorders of old age.

The first of these arises from the anger one naturally feels when a satisfactory world begins to lose its satisfying components. When that anger is kept within, it becomes anger-at-oneself or guilt, (and guilt is the prime instigator of depression, a syndrome we will come to shortly.) Anger also finds other inappropriate objects to vent itself on, notably outsiders who are made into scapegoats. This coping device is called "projection," and is familiar to many a family member, doctor or nurse who offers care to a "cranky" older person.

The second coping device is dependency, as when a hospital or nursing-home patient keeps up a drum-beat of complaints so that the staff will take care of him. Such a person is in Charatan's words, "... analogous to the hurt small boy who runs to mommy, who 'will kiss it better.'"[47]

The older person who feels and acts more helpless than he actually is may simply be seeking help in adjusting to loss. It is usually a maladaptive coping technique because it invites grudging help -- which is hardly enjoyable to get -- and because the help may actually impede the distressed person's forming a resolution of his sense of loss.

Finally, there is "withdrawal" as a coping device in the season of loss. Perhaps a first stage of depression, it nonetheless can be distinguished from depressive moods and syndromes as having about it little of the melancholy we associate with depression. Some observers speak of the "disinterest" of some elderly persons, others of their "detachment."[48] In each case, the words are selected to put the bahavior-pattern in non-judgmental terms. Seemingly, there are some forms of withdrawal that pay back more than they take away -- that reduce the person's vulnerability to further emotional harm while permitting them to remain sufficiently involved to get pleasure out of life. An example might be the nursing home resident who scales down an active friendship with another resident now in the terminal stages of illness. To such functional uses of withdrawal, one must add the counter-productive cases of withdrawal, as with the nursing home resident who will not invest in any friendships or engage in any group activities.

Depression. Many older persons have much to grieve and be sad about, and for a few, a condition of unhappiness becomes self-directed anger, leading to a depressive syndrome. As noted earlier, the syndrome may be described as "... a persistent disturbance of affect [defined below] sufficiently severe to interfere with the individual's work, social and interpersonal activities."[49]

"Affect" (pronounced AF-fekt) describes a mental state, an emotion or mood as contrasted with the behavior which is prompted by that mental state. The term "affect" often comes into discussions of depression because there is often so little behavior to discuss; depression is frequently characterized by an avoidance of social interaction, by an avoidance of action and activities altogether, by behavior which is a kind of non-behavior.

The coping one sees in the depressed elderly is not complicated. Its forms and purposes are suggested in a newspaper article on the death of Kate McDougall, an 85-year-old woman, from which the following phrases and sentences have been extracted:

"... resisted making new friends. She never went out. . . 'This is a weary world,' she used to say. . .McDougall bore the arthritis without complaint. She kept up her reading -- Harper's, Atlantic Monthly, National Geographic. . . was a faithful correspondent. . . remained alert to the end. . . bristled at the notion of nursing home . . . She was pronounced dead by Dr. Dennis Hand. . . 'She was very depressed, just waiting to die,' says Hand. . . 'she may have committed suicide just willing herself to die'. . . .The visitors found the apartment immaculate. . . never married. . .The closest she came to children of her own were the two Meloy brothers. . .

'After they died, she just lost interest in living,' says Dorothy Gehr, a former neighbor. . . But the crowning blow, say friends, was the apartment with the garden view. She had until September 1 to get out. . . As McDougall became increasingly ornery and withdrawn, Gehr baked cookies for her. 'I forced her to be my friend,' says Gehr. 'I hated the thought of her being alone.'"[50]

A sorry but instructive story. Ms. McDougall's was evidently a depressive syndrome near the borderline of a depressive mood. She had not declined into senescence; she had not abandoned caring for her constructed environment; she had not lost all interest in friends or the world beyond; she had not committed suicide by way of any direct, overt act; and yet there is no doubting the severity of her depression. Although one often finds more symptoms of depression than Ms. McDougall displayed, she would have us understand that an elderly person can deal with past losses and future threats by disengaging selectively, not necessarily on all fronts.

Some might argue that depression is not a "coping" skill at all, and certainly not when it causes the person to will his own escape from life. In our view, it is imperative to consider depression as a coping device, albeit a poor one, even a dangerously poor one. For it does often work as a kind of novacaine, numbing the psyche and thus protecting it from further pain. While there are known methods to dissolve the protective numbness of depression, employing those techniques can subject the person to greater agony and can actually propel him into suicide. For this

reason, the victim counselor and other would-be helpers should respect depression as a technique to stave off agony and panic, and should deal carefully with depressed clients. Recommendations for how to do so are provided in the chapter following this one.

Hypochondriasis. Most people think that a hypochondriac is a person who rushes to the doctor at the slightest suggestion of illness, and thus, is someone terrified of illness and death. The symptom of excessive worrying about one's health is indeed the most pronounced sign of hypochondriasis, but terror is evidently not its motivating force.

Instead, most psychiatrists agree that the hypochondriac is someone who has become his own best friend, indeed, just about his only friend. It is in this way related to coping devices that make things the objects of affection when there seem to be no people to serve that role. Hypochrondriasis is encouraged in old age not only as a substitute for vanishing loved ones and friends, but also because older people often get pleasure from basic tasks of their bodies-- "... eating, excretion and sleep become surprisingly rich experiences."[51]

Thus, the hypochondriac's caring for his body, his eagerness to have physical complaints treated by doctors, is analogous to the behavior of an overly-protective parent toward his children. For this reason, the hypochondriac may be subject to "regression", a coping technique whereby the person reverts to a earlier stage of emotional maturity, sometimes seen in the very senescent elderly. That the hypochondriac also may become a complainer suggests that "dependency" is a closely-related coping device, as may be "projection," should he

find a kind of satisfaction in blaming others for the body's apparent ailments.

All of this suggests that many of the coping devices of old age are closely intertwined, at least in the motivating force behind them.

Paranoid reactions. Whereas the hypochondriac is responding to an ungiving, unloving environment,[53] the paranoid is responding to an affirmatively hostile environment.

Two things seem to trigger the paranoid defense: "... a perceived threat from the environment and an incomplete cognitive understanding of that threat."[54] Recall that the confabulator supplied some missing ingredients in his conversations by drawing on his imagination; so does the elderly paranoid, but this time with the imagination of a scared person, easily persuaded that the dimly understood social forces around him have malicious intentions towards him.

The onset of this kind of paranoia in old age does not involve the schizophrenic's illusionary "bogeymen," but is centered on the actions of real people -- an offspring is stealing his money, a nurse is poisoning his water, and so on. Note too that sensory deprivation, especially hearing loss, is a very common ingredient in this kind of "circle-the-wagons' mentality.

Alcoholism. Dr. Pfeiffer has suggested alcoholism as a separate psychiatric sundrome. It does indeed occur frequently in old age as both a cause and a symptom of retreat and resignation. One need not detail its service as a coping device -- its numbing and depressive effects are sought after by millions

of Americans of all ages -- but it is worth indicating that when a person first becomes an alcoholic in old age, it is usually preceded by a period of social isolation, a weak social support system, inactivity and the like -- and may, for reasons, be especially prevalent in retirement communities where there are few social activities and the residents tend to remain strangers to one another.[55]

As indicated earlier, escessive alcoholic comsumption produces brain damage, either causing or speeding up Organic Brain Syndrome and its debilitating effects.

* * *

These are the psychiatic syndromes identified by one geropsychiatrist. A review of the articles of Eric Pfeffer and his colleagues suggest that three other conditions of old age in America should be identified for crime victim counselors, for each could be called an "environmental syndrome" having a substantial impact on the mental health of the elderly. These are the elderly's fear of crime, the "dumping" of elderly mental patients into the community, and the attitudes of the older generation toward the mental health professions.

The fear of crime. In 1967, Dr. Bennett Gurian visited a group of elderly housing project residents in Boston, and asked what he, as a psychiatrist, could do for them. The responses were a series of questions: "Well. . . could you walk with me to the grocery store? Could you put a lock on my door? Could you see that my Social Security check is not stolen from my mailbox?

Can you help me not be afraid in my apartment?"[56]

These strange responses seem to convey the anxieties of a whole generation of older people. A 1974 Louis Harris poll of the nation's elderly found that crime was perceived as their foremost personal problem, even outranking poor health and economic insecurity.[57] Perhaps, therefore, it was not farfetched of Dr. Gurian's elderly informants to link crime prevention and mental health services, nor was it wrong-headed of him, in setting up a geriatric unit in a community mental health center, to equip it with a van to help the isolated elderly to cash their checks and do their shopping in safety.[58] The urban elderly in particular (and the elderly are a particularly urbanized generation) have much emitional relief to gain from programs they perceive as reducing their vulnerability to crime.

To argue, as some have, that the elderly's fear of crime is irrational (actual victimization rates are much higher in other age groups) is to miss a crucial point: feeling that they are no longer up to surviving a criminal assault -- physically, emotionally or financially -- many elderly people virtually barricade themselves in their apartments, and thereby begin or compound a process of isolation and emotional decline that is the price they pay for being safe.[59]

As to their actual safety on city streets, one need merely consult with the "decoy units" that have been established in many urban police departments. A police officer posing as an old man, they will tell you, is one of their most effective lures to find muggers. Indeed, the only decoy character that generates more

arrests is a female officer simulating an old woman. In the face of those extraordinary facts, there is no reason to belittle the elderly's pervasive fear of crime or its capacity to make them live in misery. Instead, crime and the fears it inspires deserve to be treated as a pre-eminent example of the social forces at war with a contented old age -- indeed, for many urbandwellers, it is unquestionably the root layer of an existence ridden with psychopathology.

<u>Dumping elderly mental patients into the community</u>. The psychiatric syndromes reviewed earlier are all ones that first arise in old age, and constitute the greatest part of the mental health problems found in the elderly. Nonetheless, there are any number of disturbed people whose psychological disorders have followed them over many years into old age. Most numerous among these are people with less-serious emotional maladies. It is well to remember that the "cranky old man," and the "nasty old woman" one occasionally meets were in all likelihood a crank and a nasty person in their younger years as well. Nonetheless, old age may well have intensified these characteristics.

In this, one is witness to a process that affects us all. As each generation goes into old age, its collection of personalities becomes increasingly richer in variety, but sad to say, that includes an enrichment of some personality traits which inspire anything but affection.

Many social service workers have learned to cope with difficult older people by developing a kind of admiration for their unique, interesting styles of cussedness. It is often not as easy for

non-specialists to develop a compensating interest in older people whose chronic mental illnesses are of a very severe nature. And these troubled people, the ones who are quite obviously very disturbed individuals, pose special difficulties for crime victim counselors.

For decades, such people were called mental patients and were warehoused in mental institutions. When, in the 1960's it was forcefully pointed out that most such inmates presented no threat to themselves or to others, huge numbers of them were suddenly released from one institution after another, all across the country. Thus, the number of elderly patients in state mental institutions was 56 percent fewer in 1974 than in 1969.[60]

Although observers like Dr. Robert Bulter are supporters of "deinstitutionalization" policies in theory, they often insist that the manner in which the policies have been carried out is one of "dumping," effectively consigning such people to "welfare hotels," boarding houses and other grim settings "... often in inner city areas where there is a high crime rate."[61]

Thus, victim counselors are not infrequently called on to help elderly victims who are already living in an unhappy state created in their own minds. Much to the counselor's frustration, many of these demended and tormented folk are found to be no longer anyone's "patient;" the economics of the dumping policy serve to cut loose about four-fifths of these people from any psychiatric care.[62]

Perhaps more troubling than the known crime victims among this population are the unknown ones; many, it can be safely

assumed, do not know how to call for police assistance or are unwilling to do so, and it is equally possible that the police regard their chances of solving such cases as being so low that they tend to record them as "incidents," not crimes. For similar reasons, it may be difficult to find out about, much less respond to, the victimization of another group of lost souls -- the elderly residents of our country's "skid rows."

The elderly's attitudes toward the mental health profession. Dr. Bennett Gurion has argued, in effect, that a geriatric unit in an urban, community mental health center should be substantially concerned with crime and the fear of crime, at least as a method of finding the troubled elderly. And, indeed, he has done just that' his unit's van (the "merry old 'mobile") is used not only to relieve the anxieties of walking to and from shops, but it also transports center staff to crime victims and to elderly residents who need to be informed of a family death[63]-- to perform, in other words, the kind of emergency counseling that is the subject of this handbook.

From Dr. Gurion's street-level perception, therefore, mental health services for the urban elderly should consist largely of crime prevention and victim services, both to alleviate those shocks and anxieties and to uncover other psychopathologies. But he has one extraordinary comment to make about putting his theory into practice: "Our mobile service system was totally ignored the first six months when we were identified as mental health center staff. The sign was removed from the van and people then began to use it."[64] Anticipating the same public reaction,

the Victim Assistance for Older Adults program in Tampa, Florida, has, from its initiation, downplayed its sponsorship by the Northside Community Mental Health Center.

Why is it that the elderly have such negative feelings about "mental health" services? Much of the answer can be illustrated from interviews Dr. Prescott W. Thompson conducted, seeking answers to the same question:

"Another man was a poor, unsophisticated fellow who lived alone in a downtown apartment. When I asked him whether he would do to a psychiatrist is his doctor recommended it, his answer was, 'I like it here.' At first I was puzzled by his answer, but then realized that he did not want to be 'put away.' ... In checking the statistics at the psychiatric clinics, we discovered that with older patients the larger majority suffered precisely that fate."[65]

Another reason why the elderly are suspicious of psychiatry and its allied professions is that the older generation grew up in an era when most of society stigmatized psychiatry as being somehow crazier than the patients under its care; for many an older person, a psychiatrist remains a stock character dressed in a frock cost, wearing a goatee, and speaking in a German accent -- a menacing figure happily reduced to a buffoonish caricature. They would rather not deal with him in the flesh.

A third reason for the elderly's distaste for psychiatry is a combination of the first two: psychiatrists may be worthy professionals but work almost exclusively with "crazy" people. The major efforts of the mental health professions to prevent emotional disorders and to help people who are hardly "crazy" is a

service that many elderly people have no familiarity with.

For the victim counselor, these biases common in the elderly can be dealt with with expedients like avoiding the use of psychiatric terminology. However, problems may arise when a lay counselor believes a referral to a psychiatrist or psychologist is appropriate. Of course, it would be unethical to set up a consultation on false pretenses or by withholding from the client a clear understanding of whom he is to see and why. We will consider the issue of making effective referrals to a professional counselor in a later chapter.

Psychiatric Treatment Strategies

> Try I will; no harm in trying:
> Wonder 'tis how little mirth
> Keeps the bones of men from lying
> On the bed of earth. 63

These sentiments, voiced by the same stoic poet quoted earlier, convey the honest hopes of mental health professionals who serve the elderly. It is not within the power of psychiatry or clinical psychology to find substitutes for all the absent gratifications that make old age a season of loss. But the mental health professionals can help the troubled, older person find "a little mirth" with which to re-establish a gratifying existence. Dr. Eric Pfeiffer has put it this way: "It is not realistic to seek to replace all lost object relationships or significant activities, nor is it necessary; replacing a fraction of them restores self-esteem and a sense of continued relatedness."[64]

This section will discuss some of the primary therapeutic strategies that are in use today to help the elderly regain a sense of well-being. Much of this review can serve as background to the victim counselor, helping to round out his understanding of the emotional characteristics of his elderly clients, and preparing him to work jointly with geropsychiatrists and geropsychologists. The rest may suggest counseling techniques that are directly applicable to his own work.

We present the geropsychiatric strategies in three parts. The first deals with a preferred approach to diagnosing mental disturbance in the elderly; the second with treating the disturbances that result from situational stress; and the third with the treatment of other syndromes.

A medio-psychiatric approach to the disturbed elderly

After more than forty years of geropsychiatric research and practice, Dr. Francis J. Braceland has concluded. "A better understanding of the biology of aging is of vital importance if we are to be of real help, and, in addition, more research on stress is required."[65] Some insights have already emerged from the study of biological aging insights that have taught us to be wary of "senility" as the explanation of abberent behavior in the elderly. Modern psychiatry is no longer quick to assume that the irreversible biological changes that often come with old age produce most senescent behavior.

Interestingly, geropsychiatry seems equally reluctant to attribute senescence to the stresses of old age. Dr. Prescott Thompson writes, "It is my experience in providing services to older people that a psychiatrist must be a physician first and a psychiatrist second." Elaborating on the same theme, Dr. Lawrence W. Lazerus comments, "Throughout the evaluation, the psychiatrist maintains a high index of suspicion for undetected medical problems that may be masquerading as psychiatric illness. For example, depression may be the first manifestation of pancreatic or brain tumors, metabolic or endocrine disturbances."[66]

The inference is that a full diagnosis of the disturbed, elderly patient should seek to sort out irreparable brain damage from treatable medical ailments and both of these from treatable psychiatric disorders. "A comprehensive evaluation is essential for every elderly patient admitted to a psychiatric hospital," writes Dr. Lazarus, who then urges that the comprehensive evaluation assess," ... all biopsychosocial factors that may be contributing to the patient's problems."[67] Perhaps he would allow his already-weighty term to include medicine, as in "biomedico-psychosocial;" such is the reach of a <u>comprehensive</u> evaluation.

Focusing on just the psychological contributors to senescence, Eric Pfeiffer stresses that the symptoms are often the product of several forces -- social, economic, the patient's decreasing mobility, and the diminishing quality of his immediate environment, as principal examples.[68] These "multiple system interactions," in his view, make it difficult to assess what ails the elderly patient. For that reason, he and his colleagues at Duke University have been developing and improving a "multidimensional functional assessment methodology" which they call OARS -- the Older Americans Resources and Services assessment method.[69]

All of these observations seem to tell the lay counselor who is dealing with a disturbed elderly person that the counselor should he ever be ready to encourage a client to see a physician, preferably one specializing in geriatrics and, ideally, one who is also a geropsychiatrist. The main danger to be avoided seems

less one of inaccurately assessing some of the client's ills as of incompletely assessing the source of those ills. The counselor should not necessarily expect a "cure" to result from the findings of a neurological exam, or from a medically-recommended change in diet, or from a prescribed medication, but any or all of these may be essential parts of a successful treatment plan.

<u>The "emergency counseling" approach to situational stress</u>

After medical disorders are attended to or ruled out, the geropsychiatrist is most often confronted with cases of situational stress, brought on by the patient's inadequate ability to accept and adjust to losses.

To Dr. Eric Pfeiffer, the most effective approach to deal with this family of disorders is the use of crisis intervention and crisis resolution.[71] Since some of Dr. Pfeiffer's suggested techniques are reflected in our own recommendations, we merely note here that what we have called "emergency counseling" for elderly crime victims is what he calls "crisis intervention and resolution," and it is his and many others' preferred approach to dealing with most disturbed older people as a class. Seemingly, one or more traumatic events is at the heart of many older persons' inability to function well, and crime victimization should be viewed as only one of those precipitating shocks.

The reader may recall that crime victim counselors seek to achieve a limited goal -- to restore the victim to his accustomed state of sell-being prior to the victimization. Psychotherapies

of the kind that ask the client to review his past life, to be "introspective," are thought to be beyond the counselor's skills and, more important, to be basically irrevelant to the client's problems. Dr. Pfeiffer counsels the same limited goal-setting when using similar techniques with the disturbed elderly, to seek "... a return to a previously attained symptom-free status [rather] than an achievement of a never-before attained level of personality integration, although the latter may well result from successful resolution of a situational problem ..."[71]

Dr. George J. Wayne made a similar point, albeit in a less optimistic way:

> The lives of some individuals have been full of neurotic turmoil, with failure following failure. With such persons, introspection may only illuminate and make more conspicuous an intrinsic incapacity for sound fulfillment, steming from deeply ingrained and probably irreversible character defects. The therapist must recognize such a situation, so that he can help the patient become resigned to his basic inadequacy and find some peace of mind. 72

The treatment of other syndromes

Elizabeth Byron has reported on new efforts to reclaim the victims of senescence.[77] The three approaches that are presently in use are applications of "reality orientation" (getting patients to become alert to the immediate environment, including the names of people and things, the time of day, and so on); of "sensory training" (to reawaken senses that have not been used or to sharpen others by way of compensating for impared vision, hearing and the like); and a combination of those two approaches. In her own efforts to combine reality orientation and sensory

training, Ms. Byron has added the therapeutic advice of Norman Cousins, written down when he was suffering fron am illness originally said to be terminal -- that patients should be subjected to a regimen of "love and laughter."[74]

While these techniques deal primarily with the kind of senescence that comes on with sensory deprivation, isolation and the like, there are reports of treating those whose senescence is the produce of Organic Brain Syndrome by retraining active brain cells to compensate for those which are no longer functioning.[75] However, compensatory retraining of the damaged brain should not be considered the sole treatment approach in these cases. As Dr. Charles Harris has reported, "To be sure, brain damage from cerebral arteriosclerosis and senile brain disease in a realistic problem, probably causing 50 percent of the cases of mental disorder in old age. But, even with brain disease, there can be overlaps of depression, anxiety and psychosomatic disorders that are responsive to medical and psychotherapeutic intervention."[75]

Regarding patients suffering from such sensory losses as blindness or deafness, Dr. Frederick Charatan observes that, for them, the sense of touch becomes increasingly important as a means of human contact: "For the old, touch is equated with tenderness."[76]

Dr. Charatan also indicates that some of the psychotropic medications can chemically reduce anxiety and depression in some patience, and that major tranquilizers are effective in certain cases of paranoid bahavior, hallucination and even

Organic Brain Syndrome.[77] Dr. Pfeiffer reports that minor tranquilizers or sedatives, given over a short term -- from one to seven days -- sometimes help in achieving equilibrium in patients who are undergoing what he calls crisis intervention/resolution therapy.[78]

Since paranoid bahavior in an older person typically stems from an inability to correctly interpret what is going on around him, the person suffering those fearful delusions can best be helped by having sensory defects corrected whenever possible, and by having the social environment explained and clarified, by assuring him that the environment is stable and friendly, and, when the physician thinks it appropriate, by administering anti-psychotic agents.[80]

As to the problem of alcoholism among the elderly, there is a "... growing belief among therapists that older alcoholic persons can be genuinely helped by the right kind of care."[80(a)]

We turn, finally, to treatment approaches to depression. The impression one gets from the geropsychiatrists is that the disturbed elderly who are in a state of agitation may well be headed toward depression but are, for the present, susceptible to the techniques of emergency counseling, and that these techniques may avert the onset of depression altogether. For the elderly who are already depressed, the tools at hands are less promising. Dr. Robert Butler, for example, reports, "Another group of patients [who appear "senile"] are depressed older people. This group does not appear to be responsive to

therapy."[81] Elsewhere it has been written, "The consequences of serious depressive reaction, when left untreated, are often irreversible. Diagnosis and early intervention may prevent serious mental illness later."[82]

While some of the therapies mentioned earlier, including the drug therapies, have varying degrees of effectiveness in cases of depression, Eric Pfeiffer describes one therapeutic approach which seems especially well-suited to treating depression. After explaining his goal of enlarging the repertoire of his patients' coping devices beyond depression-withdrawal, comatization, projection and withdrawal, he writes:

> In this regard we have come to regard assertiveness training for older people to be a particularly effective approach. It puts a sense of control and of being in charge of one's own destiny back into the patient's hands and powerfully improves self-esteem. While one has to be careful not to present assertiveness training to older patients as advice simply to become more aggressive and demanding, successfully accomplished assertiveness training can equip the older individual with techniques for dealing with many potentially adverse situations. Assertiveness training can best be accomplished in groups; and, in addition to the specific benefits of increased skills in assertiveness, the benefits of belonging to a defined group also accrue.[83]

This concludes our overview of some of the major treatment approaches now in use with the disturbed elderly. It has been neither an exhaustive survey nor in any way suitable as a guide to therapeutic services. Even as part of the victim counselor's background knowledge, our summation of treatment

strategies for the disturbed elderly will become quickly obsolete, or so we hope. For we share Dr. Francis Braceland's hope that studies in the biology of aging and in stress will continue, will expand our understanding of life in old age, and will lead to increasingly sophisticated methods for helping the troubled elderly.

END