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Foreword

Living with, working with, and experiencing being elderly are pervasive themes in discussion in contemporary professional and lay publications. Predictions for the 21st century may be ephemeral in all other areas but in relation to the size and needs of the elderly, these predictions are probably modest. Census predictors in the 70s, for example, were extremely inaccurate in preparing us for the greatly increased percentage of people over 65, and over 85. Unless these errors were overcompensated for, we may find the predictions for the next century lower than the reality.

A wide range of people need more information about dealing with and being elderly. All health providers, social service personnel, educators—even in elementary schools, questioned about grandparents and great grandparents—police, and the population at large preparing for their own aging or for their aging families, are misinformed and underinformed.

This book should correct that deficit for at least part of the population in need of information about services. The excellent authors Mary Harper has selected to contribute to the book are a veritable "Who's Who" in geriatrics and gerontology. Dealing predominantly with psychological management and care, the authors cover every aspect of services that the elderly may call on during some moment in their aging experience. The writers address the provider of care and offer information that will increase knowledge across the broad spectrum of people's behaviors and populations as well as dealing with modalities of care and their organization.

Health providers are increasingly interested in the elderly for a variety of reasons. Not least is that many of the clients in their institutions, agencies, or private practices are over 65 years old. The population classified as elderly are large consumers of health and medical care and their contacts with health providers are far greater than those of the practitioners, other patients, or clients. Despite these contacts, providers have not been well informed about general and specific age-related and generic responses to health and

social problems, drugs, and the like. Any member of the public who has had an aged relative admitted to a hospital can share a story or two about misdiagnosis, lack of knowledge about secondary symptoms, attribution of problems to age, and drug mishandling. There was in the immediate past both a lack of interest in the elderly client and a lack of available literature to provide information to the provider who wanted it.

Fortunately, this situation is changing and changing rapidly. Harper's book is one of the exemplars of this change and should be a source of valuable information for years to come. The book will serve in several ways. First, as a reference for the entire range of services and problems dealing with the mental health aspects of aging. It is a veritable compendium of information. Second, it will serve as a reference, chapter by chapter, for individuals interested in specific aspects. It will be referred to over and over again for both of these purposes.

Dr. Harper is an original in this field. The chapters she has written for the book provide confirmation for this statement. Her exceedingly thorough introductory chapter alone is worth the price of the book.

Providing both overview and important content, it prepares the necessary background to bring the reader up to speed for better appreciating the specific content areas to be covered by herself and other authors. Harper was one of the founders of the American Association for International Aging, edited the first book pertaining to mental illness in nursing homes, and edited an extremely original, leading edge book on the minority elderly. Her national work advancing education of members of minority groups has been exemplary and her ability to combine strong social values with her knowledge and commitment to the health field, its professionals, and the people the health field serves are outstanding. These strengths are evident in this book.

CLAIRE M. FAGIN

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PART ONE

Behavioral, Social, Emotional, and Mental Disorders of the Elderly

1 An Overview: Mental Disorders of the Elderly

MARY S. HARPER

There is a graying of America and a graying of the world. About 600 Americans celebrate their 65th birthday each day, totaling 2.2 million people in 1987. More than 30 million persons are 65 years or older—12.3% of the population of the United States. By the year 2000, those over 65 years are expected to represent 13% of the population, climbing to as much as 21.8% (66 million) by 2030. The group including the oldest old (85 years old and up) is growing especially rapidly. Currently there are 2.9 million people in this group. By the middle of the next century this group is expected to be several times as large as it was in 1980. More than 25,000 Americans are centenarian (persons 100 years of age and older), a figure that will reach an estimated 100,000 by the year 2000 and one million by 2080 (U.S. Department of Commerce, 1987). The oldest old are particularly heavy users of health care services, utilizing 77% more Medicare benefits per capita than individuals between the ages of 65 and 69 years. Currently, the elderly account for 33% of physicians' time, 25% of all medications, and 40% of all acute hospital admissions (Rader, 1988). Because of the rapid growth of this segment of the population in general, and the old-old and the minority elderly in particular, it is estimated that between the years 2020 and 2030 75% of health care providers' time will be spent with the elderly (Allen & Brotman, 1981).

One may ask, however, why a book focusing on the behavioral, social, emotional, and mental disorders of the elderly? Because the ranks of the elderly population have been increasing steadily, issues about the quality of care for the elderly and the training and research associated with it are of primary concern whenever issues about health care delivery are raised. In most of the widely prevailing clinical practices, however, little attention is given to the behavioral, emotional, social, and mental health aspects of care.

Accurate reports on the prevalence of emotional disorders in the elderly are few. In an extensive search of the literature, conducted by R. W. Redick and C. A. Taube of the National Institute of Mental Health (Redick & Taube, 1980, p. 60), no national studies or surveys exist that could be used as a reliable and valid basis for estimating the prevalence of mental disorders among the population aged 65 years and older. Several prevalence studies of mental illness in nursing homes have been made, however. For example, Teeter, Goretz, Miller, and Heiland (1976) found that 70% of nursing home residents showed serious behavioral disorders. B. W. Rovner and colleagues (Rovner, Kafonek, Filipp, Lucas, & Folstein, 1986) found that 80% of the 454 new admissions to eight nursing homes had major mental illnesses.

According to some studies, 31% of elderly men and 38% of elderly women suffer from affective disorders (McCann, 1976). In one study 90% of nursing home patients with no psychiatric diagnosis manifested severe psychopathology and more than half of the patients were psychotic (Berkman, 1977). In a study conducted by Talbott (1989), an estimated 18% to 25% of the elderly have significant mental health symptomatology. Additional prevalence studies of mental illness in the elderly have been conducted by such researchers as B. J. Gurland and P. S. Cross (1983), N. Osgood (1985), and P. Arbore and S. Moy (1984).

The incidence of functional disorders, notably depression and paranoid states, increases steadily with age (Washlenki, 1982). Among nonorganic disorders, affective illness, especially depression, is a common problem (Breslow, Pfeiffer, & Busse 1973). Twenty percent to 35% of elderly patients with concurrent medical illnesses are depressed (Feinson, 1989; Moffie & Paykel, 1975). The elderly also account for 25% of all suicides, between 5,000 and 6,000 each year—a rate 50% higher than for young people (Sendbuehler & Goldstein, 1977). This portion of our national population of 30 million elderly translates into 3 to 6 million potential patients.

This symptomology, in part, may be due to stresses associated with increased physical illness, loss of significant social roles and support, isolation, and inadequate income. As a result, the elderly are at risk for problems that can lead to such states as depression. A high percentage (60% to 80%) of cases of depression in elderly persons appears to have been precipitated by acute physical stress (i.e., surgery, acute illness, or exacerbation of chronic illness) (Post, 1969). For example, each year 155,000 to 200,000 elderly persons injure themselves in falls, often resulting in hospitalization and/or surgery (Berryman, Gaskin, Jones, Tolley, & MacMullen, 1989). In

their study of 219 women more than 59 years of age, Mossey, Mutran, Knott, and Craik (1989) found that following surgery for hip fractures, 51% had elevated depression scores as measured by the Center for Epidemiological Studies Depression Scale (CES-D), and 20% continued to have elevated depression scores 12 months after surgery. Likewise, 30% to 60% of the 44,000 stroke patients each year have clinically important depression, with the period of high risk lasting for two years poststroke (Lipsey, Pearlson, & Robinson, 1984; Robinson, 1981).

Common Problems and Defense Mechanisms

As mentioned, one explanation for the high rates of psychosocial disorders in the elderly may be the tremendous stresses associated with this age group. Loss is a predominant theme in characterizing the emotional experiences of older people. Commonly, they confront multiple and simultaneous losses—the death of a spouse, friend, child; a decline in health or the illness of a loved one; loss of job, resulting in a change in role, prestige, independence, identity, social/economic status, and life-style. Losses in every aspect of life cause older persons to expend enormous amounts of emotional and physical energy in grieving and resolving grief, in adapting to the changes that result from loss, and in recovering from the stresses of these crises. Some common behavioral responses may include loss of hope, loss of self-esteem, social isolation, loss of power to find alternatives, feelings of burden, and helpless withdrawal. On the other hand, the elderly will retain some life behaviors that help them face the crises of loss, including nurturance and coping mechanisms.

Defense Mechanisms

All the usual defense mechanisms observed among persons of any age are seen in the elderly, but some mechanisms are particularly common, such as denial, regression, displacement, selective memory, selective reception, and compensatory behavior. Nurses and other health and social service providers can be more effective if they understand the specific changes the patient is undergoing. Reactions to threatening situations such as illness, hospitalization, or loss can be divided into two categories: task-oriented and defense-oriented responses. Many of these mechanisms operate outside of

the person's awareness to protect the ego and the individual from anxiety and stress. When a person feels competent to deal with stress and the situation is not too threatening to the self, the behavior tends to be task oriented, which is aimed toward problem solving. For example, if a person who smokes three packages of cigarettes a day is threatened by emphysema, he or she can go to a cessation clinic in order to make an orderly, healthy withdrawal from smoking. Task-oriented reactions are based on a realistic appraisal of the situation and involve a series of carefully thought-out judgments about the course of behavior that would be most effective.

When a person feels inadequate to cope with stress and the situation is extremely threatening to the self, the person tends to engage in defense-oriented reactions. A diagnosis of cancer, for example, may be so overwhelming that a person must temporarily defend against acknowledging this reality. Everyone uses defense-oriented behavior from time to time as a protective measure, often in a combination of mechanisms; the behavior becomes harmful only when it is the predominant means of coping with stress and reality-based behavior is continually avoided. Such a person needs mental health counseling from a trained mental health provider. Following are some common defense mechanisms used by the elderly.

Repression, the involuntary exclusion from awareness of a painful or conflictual thought, memory, feeling, or impulse, is the underlying basis of all the defense mechanisms, and other defenses reinforce it. It protects the consciousness from feelings and thoughts that would cause anxiety and thus disrupt the self-concept. For example, a woman who has a lump in her breast may refuse to go to a physician for an examination; she has recently lost her husband, her house, and her job and feels unable to acknowledge any other crisis at this time, so she represses the knowledge of the lump in her breast.

Rigid personality is seldom acquired as a result of old age, although many elderly may exhibit such characteristics as a defense against a general sense of threat or actual crisis.

Counterphobia is the compelling tendency to expose oneself to danger in an attempt to convince oneself that fear can be overcome. For example, an elderly person with dizzy spells may insist on climbing a ladder to hang drapes.

Suppression is the act of consciously keeping unacceptable feelings and thoughts out of awareness. An individual may suppress thoughts about his diagnosis of AIDS because he is immobilized with fear of rejection by his wife if he tells her.

Introjection is the acceptance of another's values and opinions as one's own.

Identification is the unconscious assumption of similarity between oneself and another.

Projection occurs when one's own unacceptable feelings and thoughts are attributed to others. The person blames others for his or her own shortcomings. A common example is the person who blames his wife and family for his alcoholism and loss of jobs, because he cannot come to terms with his guilt and anger. He thus projects his "failing" onto his wife and children.

Denial is the blocking out of painful or anxiety-inducing events or feelings, and the complete disregard or transformation of a situation so that it is no longer threatening. This is one of the most common defenses against the stress of illness or loss. For example, Mrs. R denies the seriousness of her hypertension (100/95). She refuses to remain in bed, eats fried foods, and refuses to stop smoking, insisting that her blood pressure is all right because she has no symptoms of dizziness and headaches. As the head of a household of six juveniles, she cannot deal with the fear of disability and unemployment and so denies its reality. The noncompliance with her diet is the result of her denial.

Reaction formation is repression of real but unacceptable feelings and reinforcement of the opposite feelings in order to protect one's self from recognizing dangerous feelings. The person develops the conscious attitude and behavior that are the opposite of the true feelings; thus hostility may be concealed behind a facade of love and kindness.

Such defense mechanisms are often used to help a person over a period of crisis; if they become a way of life, however, the person needs guidance in facing reality. Many elderly persons are particularly at risk for using mechanisms because of the multitude of stresses they often face concurrently. The nurse and other health care providers must recognize and understand the need to use defense mechanisms and not criticize the patient for occasional use. The psychological treatment goal is one of obtaining insight and determining restitution possibilities within the limits of the life situation, individual personality, and life-style. The care provider, for example, must help Mrs. R face her hypertension in order to help her recognize the necessity of compliance with her diet and medical regime. In order to enhance the patient's capability to cope and adapt, a nurse or other health care provider must: be a good listener (to verbal and non-verbal behavior); listen, trust, and respect the

patient, regardless of race, age, or socioeconomic level; try to perceive the behavior as the patient perceives it, without passing judgment; respect the patient's privacy and feelings; never argue with the patient; and assist the patient in mobilizing and using his or her resources.

Elderly in the Community

Despite the images of illness, disability, and impending death that society imposes on old age, most elderly are able to remain functional in the community (Ouslander, 1982). The majority of community dwelling elderly report themselves to be in good health, even though more than 60% also admit to at least one chronic condition, and 50% to 70% are judged to have a physical illness when examined. In a study of the day-to-day mental and physical health symptoms of 132 elderly persons, Brody, Kleban, and Moss (1983) found that 56% of symptoms had not been reported to health care professionals, including chest pain, shortness of breath, forgetfulness, dizziness, and trouble passing urine. Likewise, Williamson, Stroke, and Gray (1964) demonstrated that the elderly frequently do not seek medical advice on certain complaints (painful feet, difficulty in walking, trouble in urinating, anemia, and dementia), attributing these symptoms to age and not disease. Thus many elderly people have an enormous pool of tolerated illnesses that have been ignored, normalized, or left to develop. This is particularly true of behavioral, emotional, and mental disorders. Most, however, are likely to discuss their discomfort with a family member or friend—one reason why interviews with family or significant friends should be part of the hospital/nursing home admissions procedure and why caregivers should be educated as to the symptoms of some of the most frequent systemic diseases.

Unlike young persons, when elderly persons become ill the first sign of new or recrudescent chronic disease is rarely a single, specific symptomatic complaint that helps to localize the specific organ system or tissue in which the disease occurs. Rather, older people usually present active illness with one or more nonspecific disabilities, which rapidly produce functional impairment (Besdine, 1983). Some of the functional presentations of disease include incontinence, falling, acute confusion, weight loss, fatigue, apathy, and sleep disturbance. It is therefore often difficult to diagnose the elderly accurately. Table 1.1 indicates some common symptoms and their multiple, possible causes.

Table 1.1
Some of the Symptoms in the Elderly That May Represent a Medical Illness, Psychopathology, or Both

Fatigue	Pain all over
Weakness	Shortness of breath
Anorexia	Diarrhea
Headache	Paresthesia and numbness
Dizziness	Depression
Palpitation	Anxiety
Visual impairment	Constipation
Personality changes	Memory disturbance
Urinary frequency/urgency	

SOURCE: Ouslander (1982)

Impairment in the ability to function independently at home and in one's own community is often a common pathway to a broad array of diseases frequently encountered with increasing age. Functional impairment has been defined as the decreased ability to meet one's own needs, including the functions allowing mobility, cognition, eating, toileting, dressing, personal hygiene, cooking, and managing money (Besdine, 1983). Certainly, an important part of today's health services should be to enable the elderly to remain functional as long as possible in the community, whether living alone or with family.

Medical Assessment

Many of the illnesses of the elderly go unrecognized and/or ignored; this is particularly true of behavioral, emotional, and mental disorders. Only 6% of the elderly utilize the services of community mental health agencies. Up to 50% of the elderly's mental health services are provided by nonpsychiatrists, usually the primary care or family physician, or a general medical provider (Judd, 1989; Shapiro, 1986). This partly explains why valid and reliable prevalence data on mental disorders in the elderly are unavailable.

Many disorders are unrecognized because of the interrelationship between physical and mental disorders. A comprehensive medical-family-social-history is imperative for all elderly patients at each entry into the institutional or community-based health care system. Table 1.2 indicates the essential domains of such an assessment.

Table 1.2
The Essential Domains of Comprehensive Assessment and Mental Health Assessment

Comprehensive Assessment:	
Physical functioning	Mental and emotional functioning
Family and social support	Environmental characteristics
Need for specific medical or rehabilitative therapies	Potential for productive or personally rewarding use of time
Mental Health Assessment:	
Cognitive, behavioral, and emotional status	Detection of dementia, delirium, and depression
Impact of race, ethnicity, culture, and religion	Impact of family functioning

For some patients a detailed psychiatric interview, a neurobehavioral consultation, or comprehensive neuropsychological testing may be indicated. Adverse drug reactions, or the withdrawal effects of selected drugs, frequently cause anxiety in medical patients (Abramowitz, 1984), therefore a careful drug history should be conducted. This should include inquiries about over-the-counter medications and drug items from health food stores, occupational exposures, homemade teas, poultices, expired medications, borrowed medications, any known adverse reactions, liquids (milk, water, colas, etc.) used to take medications, and compliance to medical regime. For example, caffeine, one of the most widely used psychotropic drugs in the United States, is found in many beverages and drug combinations. It modifies catecholamine levels, inhibits phosphodiesterase, breakdown of cyclic AMP in the central nervous system, and sensitizes central catecholamine receptors, particularly for dopamine. Although individual sensitivity varies, symptoms of caffeinism that may occur at doses of only 200 mg (one cup of coffee has 150 mg of caffeine), are identical to the classic descriptions of an anxiety episode (Victor, Lubetsky, & Greden, 1981). Caffeine may precipitate an actual panic attack in patients with the underlying diagnosis (Charney, Heninger, & Jatlow, 1985). In chronic users, caffeine abstinence should be considered as a possible source of intermittent anxiety (White, 1980). Psychoactive drugs have also been strongly associated with the risk of falling