MENTAL HEALTH PROBLEMS OF THE AGING

by ABRAMAM S. LENZNER, M.D.

Hillside Hospital, New York, N. Y.

IN recent years there has been introduced into our vocabularies the term "Golden Age Club." I do not know who invented the term or how it came to be used. To me it appears to be a proclamation of emancipation. The golden age, as any age in a person's life, is a time for *living,* a time for *experiencing,* a time for *feeling,* and a time for *fulfillment.*

Every age has its own special hazards and problems. It is equally true that every age has corresponding rewards and gratifications. A mentally healthy person is one who has been able to utilize his resources in an optimum way to cope with his ambitions, responsibilities, and opportunities. He is able to cope with reality limitations, disappointments, frustrations, or infirmities without being overwhelmed. This is not an all inclusive definition but perhaps can serve as a setting for further discussion. I have spoken occasionally of aging as a triumph—a triumph over all of the diseases, stresses, accidents, and pitfalls of the earlier years. I believe that if we had statistics at hand we would find that the incidence of mental illness among the aged, though large in numbers, would form actually a very small percentage of the total population of people over the age of sixty. Or to put it another way, I should be inclined to argue or speculate that the ratio of mental disease in people over sixty is not higher than the ratio of mental illness below that age.*

One of my favorite patients is a fine 81-year-old woman who at age 40 became acutely psychotic and required commitment to a mental hospital. She remained violently and "incurably insane" for thirty-five years at which time she came to the attention of the Jewish Community Services of Long Island for possible residence placement. I examined her about five or six years ago and found her to be completely recovered and a very charming, witty, and warm person. She made a very happy adjustment to the home where she was placed and became a very welcome member of that household. In

* In a study of 376 admissions to Hillside Hospital (a voluntary psychiatric institution), there were 76 patients (20%) between the ages of 50 and 75. There were 25 patients (6⅔%) between 60 and 75, and 13 patients (3+%) between 65 and 75. The average stay in the hospital for all patients was approximtely six months. The average stay for patients over the age of 50 was three to four months, which reflects the treatability and recoverability of this age group.

this case I think it must be agreed that aging meant an opportunity for health and happiness in a woman who had appeared incurably ill through her middle and later years.

One often hears the remark that old people cannot be treated psychiatrically. Actually old people fall into the same categories of treatability as any other age group, and whether a person is treatable by psychotherapy or not depends entirely on the individual and the nature of his illness. No matter how sick a person may be and no matter what his age, if he is accessible to treatment, if there is adequate motivation for recovery, and if the reality circumstances are not too overwhelming, then that person can be helped with psychotherapy.

For example, a woman in her mid-sixties was brought in by one of her sons who told me that his mother had begun to become confused, forgetful, unable to manage her own cooking, and that she had become very irritable and excitable and depressed. She was extremely critical of her children whom she felt were neglecting her, and her children were equally hostile toward her because of the demands that she was placing upon them. She was a very intelligent woman who told me that she had been suffering from diabetes for many years and also from Parkinson's Disease which made her shake all the time. She wanted me to cure her of her diabetes and of her shaking and then she would be all right. I told her I could not do this for her and that the immediate problem seemed to be to arrange for adequate household help to relieve her of activities which she was unable to handle at this time. I discussed this both with her and her son and suggested they look into the possibilities for a competent nurse-housekeeper. I also asked them to call me in a few weeks so that I could see this woman again. About six weeks later I received a call from the referring physician who told me that this woman had taken an overdose of barbiturate and was now recovering in a hospital. At his request I went to see her. She certainly was quite ill when I saw her again in the hospital, and she looked at me somewhat reproachfully. She had interpreted my remark as meaning there was no hope for her and therefore suicide was the only way.

This woman was able to ventilate somewhat conservatively her resentment toward me, and I was then able to bring to her attention that she had asked me for something that was impossible. I could not cure her diabetes nor her Parkinson's Disease but I suggested that there must be other problems that she was struggling with and that if she cared to talk about these things with me, I would be very glad to treat her in my office. She agreed that there were things troubling her and countered with the compromise that if I would come to see her once more in the hospital, then she would agree to come back to my office. I have been treating this woman in my office once a week for almost a year. Her confusion soon disappeared and much of her memory difficulties subsided. She was able to resume shopping and has been able to manage her own little apartment for over six months. She has joined a local Golden Age Club and is one of its staunchest members. She is able to control her own diabetes and curiously enough much of her shaking has disappeared. As she becomes more active and as she becomes more able to participate in group activities, her tension diminishes and she has long periods when she is completely free of the Parkinsonian tremor. She now remarks about the shyness of other old people who come to the group and how difficult it seems for them to make friends and feel comfortable in the group. She has a more realistic attitude toward her children and they are in a completely harmonious relationship with her. She had always been an obedient, submissive wife and a devoted mother. Although always in comfortable circumstances, her husband was a hardworking, conscientious man who devoted most of his energies to developing a very successful and prosperous business. When he died some four years ago, she was unable to muster her resources for an independent kind of life. There was also some repressed hostility and guilt worked through in treatment, which permitted her then to emancipate herself from her dead husband's side. She is now able to accept her diabetes, accept her shaking, and can also accept the fact that her memory is failing. But with all this she has made this remarkable adaptation to reality and is gaining great pleasure out of her every day living.

In situations of advanced senility, with or without psychosis, there comes a point when the nursing care responsibility for such a person requires a nursing home or institutionalization. At such a time the devoted and sacrificing relative is really the one who needs the most help. The following is such a situation:

I received a call from a young mother of a three year old child. She had assumed responsibility for the care of her grandmother for the past seven years, since the death of her own mother. She described her grandmother as being in her mid-eighties. She was suffering from confused states during which she would wander about the house and become lost. She did not recognize the people about her, complained about the food and had to be almost forcibly fed, had bouts of diarrhea at which time no supply of bed linen was adequate, and she had alternate bouts of constipation when the enemas had to be used. The family physician had been urging that the family consider a nursing home for the past year, but the granddaughter could not bring herself to this decision. Even while talking to me she found a pretext to defer consultation and our phone conversation ended.

I was then called again more urgently. In spite of a well trained and qualified nurse, the situation was completely out of hand and patience. I therefore saw the patient. She was a very sweet old lady with white hair lying feebly in bed. She was able to respond to my questions in an adequate way and I was quickly able to confirm the granddaughter's description of a once active, business woman who now had considerable memory loss, disorientation, complete lack of mental retention, and extensive psychological deterioration. I also ascertained that there was no evidence of any delusional or hallucinatory symptoms and that the patient was not dangerous to herself or others. She had always been quite amenable to nursing care. I spent most of my time with the granddaughter in helping her ventilate her anxieties and guilt and discussing the relative advantages of various nursing homes that she had investigated. It was quite clear that the personal lives of the granddaughter and her husband had been completely subordinated to the care of the revered grandmother. Later I received a call from the granddaughter that the step had been taken. She seemed quite depressed. When her grandmother had left the house she felt as though she were going to a funeral. She wept bitterly and berated herself for the terrible thing she had done.

The granddaughter called me again recently and told me that the family physician had visited the grandmother in her new surroundings. He found the old lady walking about enjoying herself and telling him how happy she was. Here she had friends. They serve such good food, and she was eating everything. She watched television and went to the bathroom by herself. There was no problem about diarrhea or constipation. The granddaughter remarked, "And to think I was eating my heart out worrying about this. Sunday I felt as though it were a funeral and I mourned and mourned. Now I am so elated I feel as though a weight were lifted from my shoulders. I wish I had done this months ago."

I have seen this situation repeated many, many times. Very often in patients requiring private or public mental hospitals, the families are so guilt-ridden and anxious that they have great difficulty in bringing themselves to follow psychiatric advice. There is the instance of a colleague of mine whose mother became senile with paranoid trends and required psychiatric hospitalization. There were the usual qualms about the implication of mental hospital and the feelings of guilt about doing such a thing to a parent. My colleague was able to come to a decision and his mother has been in a nearby private sanitarium for over a year. My colleague's family has been able to enjoy a full and productive life since that time. As to the mother, I see her from time to time in this sanitarium. She always greets me with a smile and tells me how well she is getting along. She can never tell me exactly who I am, but says that inside she knows that I am a friend. Her nutrition is good and she gets good nursing care. She is up and about and within her limited capacities is encouraged to take appropriate occupational therapy. Her once brilliant mind is in an advanced stage of deterioration. Time has no meaning for her. She knows that she is forgetful, accepts it without becoming morbid or frightened. Perhaps the biggest factor in her capacity to function at all is the ordered, regular, secure routine of the mental hospital.

In contrast to this is the situation of the parents of another colleague. Here again it was the mother who became senile, and suffered falling spells during which she would hurt herself. The father is an unusually intelligent, sensitive, keen-minded, active man who is now in his eighties. Those past four years have been spent as nurse, companion, and watchdog in a very unselfish way but with great cost to his own physical strength. His wife can

recognize no one—she spends her time playing with a doll. It is necessary that a large family make great daily sacrifices for the care and maintenance of this fine couple. As can be anticipated, these responsibilities have not been without stress and strain which reflected itself in sibling rivalries and resentments. In my opinion, had this family been able to accept reality of the mother's sick needs, she could have been much more adequately cared for in a mental institution with much less strain and expense on the part of the devoted children.

It has invariably been my experience that senile and psychotic reactions in elderly people are often reversible and virtually curable in the setting of a stable, orderly, properly trained and properly equipped facility, whether it be a state hospital, private hospital, or nursing home. Perhaps we are at a stage in psychiatry and mental health that was prevalent in Central Europe some fifty years ago. It is my understanding that at that time if a person went to a hospital it could only be to die. In part perhaps this reflected the superstition and ignorance of the community. In part perhaps it also reflected a lack of adequate progress in medicine to permit the hospital to be a healing rather than a funereal center.

We have spoken of some of the mental health problems of the aged person himself, and of the problems for the family of the aged person. Perhaps this brings us now to the problems in the community for developing proper facilities of all kinds to meet the diversified needs of the aged. An organization such as the Central Bureau for Jewish Aged in New York City is perhaps in a focal position to assimilate a concept of diversified problems and to develop channels and facilities for their resolution. In my own youth the old folks' home was still a place for the old ones to be cast off and disposed of. I am well aware of the revolutionary changes that have taken place as the result of the highly trained personnel directly concerned with these homes. It will, however, take a great deal of education and further development to erase for the general public the old picture of the old folks' home—a place to die. As these facilities can be expanded and developed and improved, I feel certain that they will represent "a place to live in."

Statistics quoted in "Neuropsychiatric Disorders of the Aged," by Irving J. Sands, M.D. (*New York State Journal of Medicine,* Volume 51, No. 20, October 15, 1951), reflect the growing magnitude of the aging population as follows: (1) Census statistics of 1950 reflect that there were 11.5 million citizens over 65 years of age, or 8 per cent of the total U. S. population. (2) There were 90 males to every 100 females. (3) Two-thirds of the males were married while the majority of females were widowed. Eventually very old people will be females since they outlive males by more than five years. (4) With regard to income 3.5 million have no money or income; ½ of those with income receive less than $1,000 per year, while ⅓ receive less than $500 per year. (5) Of these people over 65, ⅘ live with relatives. Only 1 out of 25 live in institutions.

It should be emphasized again that aging is a state of health and not a disease, and there should be no greater stigma to becoming ill in our advanced years than in our younger years. One must keep in mind the fact that four-fifths or over 9 million of the people over 65 years of age are living in the community and for all practical purposes can be considered as the healthy aged. This means a physical survival and an emotional survival with the accumulation of deep wisdom based on rich experience. Here is a vast group which can benefit immeasurably by the development of a concept of preventive geriatrics.

I should like to enumerate what I consider the needs of the healthy aged person. *First,* might be mentioned a dependable security: freedom from economic hardship, and the availability of public, voluntary, or private medical facilities where physical and emotional problems can be treated in dignity and with proficiency, in accordance with the actual needs. *Second,* the importance of a feeling of being needed, useful, respected, should be stressed. *Third,* is the opportunity for activity and expression in all spheres of occupation, recreation and social relationships. I might mention in passing the psychological studies by Dr. Milton Gurvitz and Mr. Antinoph of Hillside Hospital which indicate that the rate of mental deterioration is in inverse ratio with the amount of mental activity that a person can maintain. *Fourth,* I would consider the feeling that life has been useful and not wasted. Where living relationships can be maintained on a positive and mutually respectful plane between the elders and their children, the labors of a lifetime are rewarded.

With employment bureaus developed on similar lines to those for the handicapped, a large percent of the aged group could be usefully and gainfully employed. We readily accept playgrounds and parks for children and adults, and there is no reason why we cannot develop parallel facilities designed for the special interests and capabilities of another age group. As to recreation, there are Golden Age Clubs through the country and supervised programs are being eagerly accepted by their members. Although I have no statistics, it would not surprise me to find that there is a notable incidence of marriages within these groups.

The pathology of the sick aged includes both organic and psychiatric disease for which a combination of physical and psychological treatment may be necessary and which requires careful investigation if the physician is not to be misled into overlooking potentialities for improvement. Psychiatrically the aged patient may suffer from any kind of disorder, from neurosis to psychosis, not rooted in the organic aging process itself. In this latter regard, I have defined the special psychiatric illnesses of the aged as: "A character decompensation associated with aging and with major changes in life situations." *

Since it is well recognized that mental hygiene problems of the aging require much collaboration, a question arises regarding the respective functions of social worker and psychiatrist.

The social worker can provide a comprehensive picture of the presenting problems for the patient, a description of his current and recent behavior as well as his attitude towards seeing a psychiatrist, and his wishes for the future; she can include a description of the current reality situation as to family, economics, social facts and also as to available knowledge of precipitating factors to the illness; she can be very helpful with a succinct anamnesis, obtain abstracts of previous physical and psychiatric contacts; in terms of her knowledge, she can also suggest facilities that might be available pending the psychiatric evaluation.

The psychiatrist sees the patient in a diagnostic evaluation. He is interested in ascertaining as to whether this is an organic or primarily psychogenic disease. It is important to establish whether the patient is dangerous to himself or others. He is interested in the potentials for integration and adaptation. He attempts to formulate a personality profile as an aid to planning for placement and rehabilitation. This examination also serves as a base for future follow-up studies. In some in-

* Unpublished paper presented to the Central Bureau for the Jewish Aged in 1954.

stances specific psychiatric treatment may be indicated, such as electric shock treatment. He may request special tests for further diagnostic evaluation. He can then discuss with the social worker in a more definitive way the possibilities for disposition.

Where possible patients who have family and personal resources can remain in the community either with the family, independently, or in a properly supervised situation. A *second* possibility is the utilization of foster homes, where individuals can utilize this service. A *third* group includes patients or people who can utilize homes for the aged and infirm, and this is an area which I am sure all of you know a great more about than I do. *Fourth* would be those who are more acutely psychotic who require public or private institutions. Here, as I have mentioned elsewhere, the greatest problem is usually for the spouse or the children or other relatives in overcoming their ambivalence and guilt and accepting the reality needs and advantages of the plan.

To return to the social worker then, she can execute the most practical plan for the patient and for the family in a professionally oriented and integrated manner. The social service worker can have rich opportunities for casework. She is in a position to provide for the patient: economic aid, recreational possibilities, occupational opportunities, supportive professional work, and where necessary help in obtaining further medical and psychiatric resources. With regard to the family members, too, she can help in their education, in their acceptance of the realities, in a general supportive role, and in helping integrate the family into a cohesive unit. With all this we can readily see the tremendous benefits in terms of prevention and the enormous opportunities for research.

Perhaps the greatest contributing factor to mental illness for older people is the feeling of vulnerability—of insecurity—of mounting fear. This is compounded by the anxiety, hostility and guilt of the nearest kin who are torn between a sense of responsibility to their elders on the one hand, and to themselves and their immediate family on the other. As our acceptance of aging grows, as we develop positive facilities for improved care and treatment, as we develop opportunities for expression and fulfillment, the rate of the aging process will decelerate, and the fear of the problems of aging will diminish.