Old Age - Psychological aspects.

"Mental Aspects of Adjustment And Preparation For Old Age"

by

G. H. Hardin Branch, M. D.
Professor and Head, Department of Psychiatry
College of Medicine, University of Utah
Salt Lake City, Utah

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You are already aware of the magnitude of the problem posed by the increasing numbers of persons 65 years of age and older. The various institutes, seminars and meetings similar to this which have been held throughout the country in the past two years indicate that the problem holds a great deal of interest for everyone. This may be because we ourselves recognize the fact that we are rapidly becoming a part of the "aged population." The problem is a universal one. As Stieglitz has pointed out, aging is a part of living and the process of living itself involves metabolic changes which are from the very beginning "aging." Furthermore, as a very charming gentleman from Chicago, Dr. Ellsworth Faris, pointed out recently at an Institute on Gerontology in Salt Lake City, there is only one sure way to prevent growing old and that is to die young.

For the psychiatrist the problem of aging has several special interests. First of all, the entire problem of the hospitalization of the mentally ill is aggravated by the increasing numbers of admissions of persons 65 years of age or over. (Hereafter in this paper, in order to avoid tiresome repetition, we shall refer to "persons 65 years and older" simply as "older persons," though this dividing line is obviously arbitrary and inaccurate.) The statistics on mental hospital admissions are rather appalling. In New York State, for example, in the period from 1920 to 1947, while the general population of older persons doubled, the admissions

of this group to mental hospitals quadrupled (4). In 1940, the first admissions to mental hospitals of older persons represented almost 30 per cent of all first admissions (11). Last year, in our own State Hospital in Utah, 22.3 per cent of first admissions belonged to this group, almost three times the percentage of those admitted in this same age group twenty years ago (7). You are already aware of the terrible overcrowding in most psychiatric hospitals, and it is thus obvious that "other groups of mentally ill are being denied admission for lack of beds now being occupied by the aged" (4).

Does this out-of-proportion increase in hospital admissions indicate that the increased life span given to us by the efforts of workers in sociology, medicine and preventive medicine is simply too much for our psychic structures and that consequently, being unable to tolerate the extra years, we have in increasing numbers developed mental illnesses? This may be one of the factors, certainly, since the individual who is carried away at 40 or 50 by some sort of infection will not have time to develop the organic changes associated with aging to 60 or 70 or 80. Furthermore, it would be predictable that the individual who, throughout his life, was struggling with a sub-clinical mental illness--for example, a schizoid personality or a well compensated obsessive-compulsive neurosis, might, with the diminution in vigor attendant upon old age, be unable to maintain his balance and consequently develop clinical symptoms, whereas previously his psychic economy had remained on the positive side. On the other side of this very interesting coin, however, are some individuals for whom old age actually brings about a cessation of hostilities, as it

were. These persons have been disturbed throughout their lives by their competitive drives, often sexual in nature, and the calm of their later years allows them to achieve a vastly improved relationship with their environments.

Every psychiatrist is only too familiar with the fact that many of the individuals who are patients in our mental hospitals do not actually require the facilities of those hospitals. While they may be forgetful, sometimes irascible and at times mildly confused, they are certainly capable of making an adjustment outside the walls of an institution which is for them simply a place of refuge. The conclusion thus forces itself upon us that this overcrowding of our mental hospitals simply represents a cultural lag in a problem which we are as yet unable to solve. We are using our mental hospitals as depositories for individuals no longer wanted by or tolerable to society.

In some other cultures the problem is faced much more matter-of-factly. The elderly person is either eliminated from the cultural situation since "support of the aged is a luxury that marginal societies find themselves unable to sustain in times of stress" (9) or, by reason of his accumulated knowledge which is still valuable in a stable society, he becomes elevated to the post of magician or priest or valuable advisor. In either case, there was finality to the solution; in the former, the older individual was no longer part of the social picture; in the latter, his position was secure. He had special privileges such as eating certain foods which were taboo to others, engaging in lighter labors or, as Margaret Mead notes, of using profanities which were previously forbidden.

But in our own rapidly changing time, accumulative knowledge is quickly

outdated. Consequently, the oldster has no intrinsic value, and the sad question even arises "whether some very serious losses have come to old people with the advance of civilization" (17).

Much of our present-day social and psychiatric activity is being directed at what is called "discovering the child." So well have we succeeded that most of us are quite self-conscious as parents, being uneasily aware that the frustrations and complexes we are producing in our children are simply setting them up for psychiatric help later on. Perhaps it is now time to examine other aspects of our civilization, seeking for a culture which "does not need to rest unduly upon the period of physical production" (15). Such an examination will inevitably encompass the individual as a total organism, including his later as well as his earlier years.

These matters, however, are more intelligently discussed by sociologists than by psychiatrists. Though psychiatrists must be aware of the social forces contributing to mental illness, their concern must be primarily with the clinical entities themselves. The psychiatric illnesses occurring in the older age group are of two general types. In the first group belong those which are associated with some specific and demonstrable changes in the anatomy of the central nervous system. Arrayed with these but differing from them in etiology are those conditions which are associated with pathology elsewhere in the body, such as psychic changes stemming from cardio-vascular disease, liver disease or some of the severe, chronic and debilitating infections. Since these secondary conditions belong nosologically to the group of toxic psychoses, they can be eliminated from our discussion and we can confine ourselves to the more primary conditions such as Alzheimer's disease, Pick's disease and cerebral arteriosclerosis.

While admittedly a great many patients with these conditions are incapable of social adjustment outside the walls of a hospital, it is both unwise and medically unsound to accept a completely defeatist attitude toward them. Unfortunately it often happens that "the senile case in our mental hospitals has been treated as something of a transient at the end of his journey, warranting good care but not much more" (4). The overcrowding in our hospitals and the shortage of psychiatrists produced a natural tendency for those psychiatrists to devote their major efforts to younger psychotic individuals who will be welcomed if they are returned to society and who have a longer life span of effective living if effective treatment can be provided for them; but when conditions have permitted it, the treatment of allegedly hopeless aged patients has produced gratifying results.

Though the groups reported are small, the results are not only encouraging but put upon us a good deal of pressure to attempt to treat all cases admitted to our hospitals rather than dismissing those in the older age group as being unsuitable for therapy. Clow, for example, found that in a group of 365 unselected patients over the age of 60, almost two-thirds improved on treatment and even in the group with cerebral arteriosclerosis (traditionally assigned as "back-wards" patients), almost 20 per cent showed substantial improvement (3). Even group therapy, ordinarily used on people with more ability to react to social situations, gave encouraging results in 17 women patients, aged 70 to 80 years (10). In four elderly persons who suffered from depression, lack of energy, tension and distress, prefrontal lobotomy resulted in a marked alleviation of symptoms and a great deal of social improvement (12).

In addition to these bits of clinical evidence of abundant reason for hope in the treatment of the psychiatric disorders occurring in the older age group, the final definitive answer of the autopsy table itself raises another question. Any pathologist is aware--and every psychiatrist should be--that the amount of pathology found in the brain of the elderly person is often inconsistent with the amount of mental illness present. Furthermore, we have all seen individuals who made fairly good adjustments to living, without gross evidence of psychic disturbance, until some psychic shock occurred in their lives. Very rapidly, following this, they exhibited the usual symptoms of mental deterioration and upon their deaths autopsy would disclose a degree of arteriosclerosis of the vessels of the brain which apparently had existed for some time, though the mental symptoms themselves had not. Bowman feels that the decline of the average older person is less physiologic than psychologic and that persons psychologically well adjusted can tolerate considerable organic damage (1).

The elderly person is traditionally forgetful, sometimes rather suspicious and often irritable, exhibiting some lack of social control or an intolerance to social restrictions. We are inclined to accept these findings as characteristic of old age in spite of the fact that we have around us innumerable examples of statesmen, artists, scientists and business leaders who do not exhibit them.

The diminution in recent memory, the confusion and the irritability can, to some degree, be demonstrated in psychologic test situations. There is also a tendency to egocentricity but this, like the paranoid ideations sometimes found, is certainly understandable in view of the quite realistic rejection of many of these people by their families and by society in general.

There does appear to be some decrease in the ability to learn and in fact, there is some evidence that "aging is characterized by a reduction in the homeostatic capacities of the organism" (13) so that we might expect some difficulty in adjusting to new situations. On the positive side it is noteworthy, however, that the abilities in vocabulary, general information and reasoning--all elements which have been in constant use throughout the individual's life--remain fairly well intact until a quite advanced age, whereas such unfamiliar activities as solving arithmetic problems, recalling digits and reproducing designs in blocks, tend to decline (8). It is also noteworthy that this decline is demonstrable in most individuals as early as 40; though most of us would feel that in the 40 to 50 age range, we were at least entitled to be placed in the category of "early maturity" as contrasted to the "later maturity" which Stieglitz uses as a euphemism for old age (18). One must conclude from such data as are available that the actually demonstrable psychologic changes in the individual above the age of 65 are not sufficiently marked to justify our classing him as useless and that motivation and his position in the social structure, particularly with reference to his relationship with his environment, are powerful items in determining his degree of social and occupational efficiency. Actually, Pincus has found, by detailed biochemical determinations on older and younger men subjected to stress situations, that the stress-reaction mechanism (pituitary-adrenal) remains relatively intact in older men who show no "overt ill health or infirmity" (14).

The second large group of psychiatric illnesses appearing in the elderly persons is that which we may classify as functional. To this group belong the involutional melancholias, the simple depressions and those conditions mentioned above which have existed throughout the individual's life.

Sometimes there is simply a continuation of an already existing mental illness, merely modified by the aging process. Again there may be, for the first time, an overt manifestation of a subclinical process, kept in compensation while the individual's powers were maximal but now overwhelming an organism somewhat slowed down by the years.

The involutional melancholias should not be considered as peculiar to this age group. On the one hand, they appear as early as the early 40's and consequently cannot be considered as characteristic of old age; on the other hand, their appearance as late as the 60's or 70's--well past the involutional period--makes the misnomer obvious. This condition, as you undoubtedly know, is characterized by the appearance of a severe depression, often with suicidal ideas, in an individual who is classically thrifty, conservative, meticulous and constipated. The person is often agitated, restless and unable to sleep. Though recovery is the rule, a great many of these persons commit suicide while in the depression, and electroshock therapy has offered them an easy and safe escape from their difficulties. The vast marjority, perhaps in the neighborhood of 90 per cent, will recover completely from their depressions with electroshock therapy and the depression usually does not recur.

The patients usually attribute the depression to a specific event. We are, in general, not inclined to feel that the picture is so clear-cut, and careful examination often reveals that the onset of the depression antedated the incident mentioned. A large number of cases, however, do occur in a general situation involving a loss of self-esteem. There are usually job changes or family changes during this period, and I recall an old lady who became acutely depressed when she was not appointed to the Flower-Arrangement Committee of her club. It is scarcely surprising that

the other members felt it was time for a change, after 25 years of one person's artistic efforts, but to that one person it was a supreme rejection. We cannot be sure that this loss of self-esteem is actually a causative factor, but certainly the condition is most common in those individuals who have a tendency to narrow channels and few interests (21).

Similar to involutional melancholia, though occurring always in the older age group, is the so-called simple depression. The situational element is much more clear-cut in this condition; it is often associated with feelings of loneliness which may be realistically based on the death of a spouse, or on feelings of rejection by the patient's family. These are sometimes coupled with a paranoid type of thinking and much loss of self-assurance, and there is frequently an escape into somatic complaints (6). In these patients, as in the involutional melancholias, adequate medical care and sometimes electroshock therapy for the depression itself can produce remarkable results.

It should be emphasized again, that in both of these conditions an attack must be made upon the problem as a whole. Though the electroshock therapy mentioned above can be expected, other factors being equal, to have some specific effect upon the depression itself, the situational difficulties and the physical state of the patient must, at the same time, receive attention in order to avoid recurrence of an intolerable strain on the individual.

Another factor may be mentioned as contributing to these difficulties. Though we recognize to some extent our physical and psychic limitations, we are reassured as long as our environment accepts at least a significant part of our worth. We guard carefully this image of ourselves, assisted by the approval of those around us, and thus we retain our balance. But when there is actually some inescapable physical manifestation of our

deterioration—in the loss of physical or sexual powers, for example—we require even more reassurance from our environment. Since our culture does not often provide this, we are thrown suddenly back upon our own weakened resources, and the result is often depression.

Of somewhat more interest, perhaps, are those conditions which manifest themselves in older people, but actually have been in existence throughout the individual's life. Most of us are able to adjust ourselves to an environment either by obtaining support from the individuals with whom we associate ourselves or from our occupations or in some other way. For example, a schizoid person is by nature seclusive, introvert, shy and socially not too interested. But he may, by close attachment to and dependence on a sympathetic spouse and by limiting his social activities to a few close friends, achieve in both his work and his social activities a degree of adjustment entirely compatible with his needs and our social structure. Thus protected from any intolerable stress he may live his life in reasonable efficiency and comfort. With the advancing years, however, and perhaps with the death of the spouse and the few friends upon whom he has depended, his basic insecurity finds no support in strangers.

As an example, we may mention the child who has been throughout his or her life dependent upon the parent, and at the death of that parent finds his protective structure suddenly dissolved. With no outlet for the hostile side of his ambivalent feelings, he seeks other outlets and may become overly aggressive or paranoid; or he may escape into a multitude of somatic complaints in order to achieve from doctors, nurses and hospitals the dependent, cotton-wool existence which he had enjoyed throughout his life.

Another example of a precarious adjustment, efficient and productive

in a person's earlier years but impossible to maintain under the stress of a physical and psychic slowing-down process, is the subclinical obsessive-compulsive neurosis. Here we see the individual who has maintained himself by being extremely meticulous, overattentive to detail, extremely hard-working and conscientious. He justifiably prides himself upon his efficiency and accuracy. When his memory begins to fail, instead of having sufficient elasticity to adjust himself to his changing abilities, he becomes unsure of himself and usually attempts to compensate in the only way he knows; more attention to detail and even harder work. This process further depletes his energies and eventually he retreats into a sullen, self-pitying attitude and an introspective dwelling on past glories.

Such an individual, a successful executive for a large company, was referred to me recently, since his employers had noticed that his office work was no longer being conducted with his previous efficiency and they wondered if he were competent to carry out his quite responsible duties. He entered my office with a manila folder containing dozens of group pictures and friendly letters linking him with prominent men throughout the country. These were offered to me as rather pitiful evidence of his belief in himself and his belief in his ability to continue to carry out his duties, in spite of the fact that he could not subtract sevens from one hundred and could not write a coherent letter.

Another person of this sort attributed his difficulties to the fact that he had always been "oversympathetic" and was so worried about the war in Korea that he could not give his full attention to his duties. He improved markedly on a simple regime consisting of a short stay in the hospital with adequate attention to his nutritional state and the recommendation that he admit his inability to cope with a stressful, fast-moving

occupational situation and adjust both himself and his interests in accordance with his waning powers.

It is important to note that many of these people do not exhibit psychic symptoms as such, but rather focus their attention upon physical complaints. Sometimes, unfortunately, these are encouraged by the family, who find in them an acceptable excuse for hospitalizing the older person and thus relieving themselves of the responsibility (2). Sometimes, as Robson points out, "The visit to the doctor's office (is the) only diversion of the week, a substitute for the movies" (16). The physician himself is often guilty of producing some of this somatic awareness in his patients. Many of us do not realize that the "little arteriosclerosis" which we use as a diagnosis in a casual, off-hand way may actually mean to the patient that he is deteriorating and one must be extremely careful to avoid concluding that simply because an individual is older than the physician, he must inevitably be arteriosclerotic. There can be no substitute for an adequate, thorough examination of the patient and a consideration of the situational factors involved (19).

One must conclude that the ability of the organism to adapt is as important when the individual is faced with the stresses of age as it is when he is faced with other stresses throughout his life. That individual who can maintain a balanced psychic economy, who is sufficiently well integrated to be able to tolerate changes in his environment without losing too much of his support, who has sufficient outlets for his needs so that the closure of one channel by his declining physical powers does not necessarily mean that he must retire to introspection and egocentricity, has an excellent chance of developing minimal mental incapacity in later life.

Certainly our social structure and our culture, which values so little our senior citizens, offers very little help at the present time in solving these problems. There are numerous individual examples of successful social adjustment and there are extremely interesting experiments in hospitals and in communities (5). Our being here together is indicative of our interest in these activities. We can start with ourselves, however, in improving our own adjustment to living. Modern civilization has added more years to life, but it is up to us to add more to life in the twilight years.