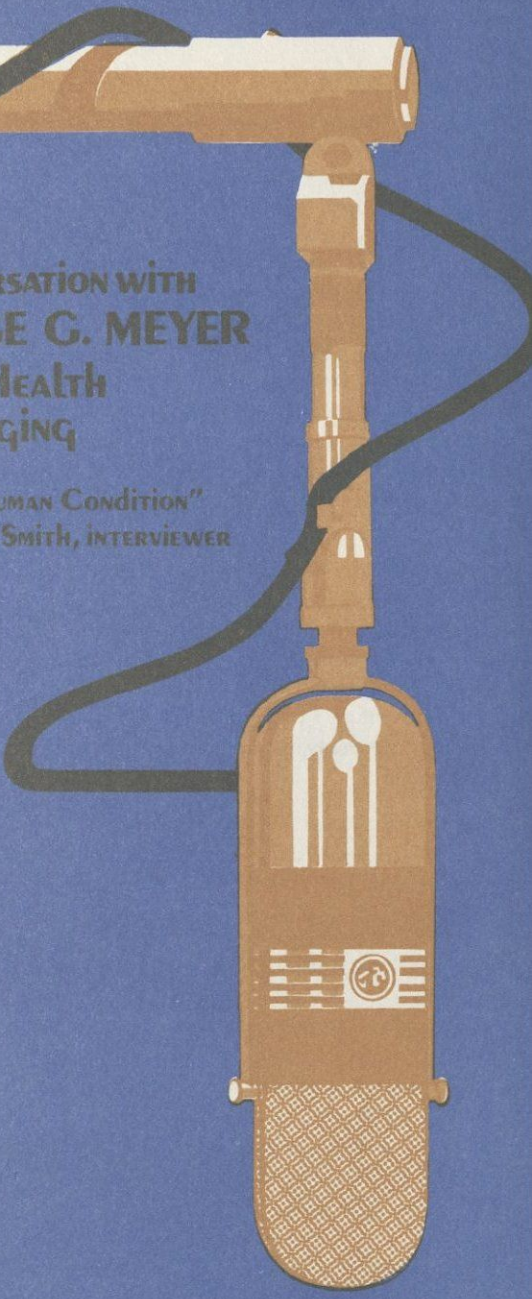
A Conversation with George G. Meyer

Mental Health of the Aging

From "The Human Condition"

Bert Kruger Smith, interviewer



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Mental Health of the Aging

The stereotypical picture of aging is bleak, but it may well be misleading. First, most of the elderly are making it and doing well. Second, when they are not, often the situation and health conditions can be improved. However, all can benefit from a change in the attitudes of the public, of families, and even of health professionals.

Some tend to rush to the diagnosis of senility, of incurability, and to institutionalization for older persons experiencing difficulty—depression, for example, or forgetfulness. We may be too quick to say that the case is hopeless and the individual needs to go to a hospital or a nursing home. In many instances, experience has shown the opposite. There are various steps which can be taken before institutionalization.

EVALUATION

We have been inured to think, "These symptoms are irreversible. They are to be expected of any person this age." And there may be no attempt to look for causes. Recognition of the need to explore more deeply is growing, however. From consultation with personnel of nursing homes, state hospitals, and visiting nurse associations, we learn how often one can uncover a cause for the problem. Our theme should be that we need to look for all the reversible and treatable conditions first.

Senility means different things to different people. We think in terms of the brain's not functioning as it formerly did. And we assume that behavior is caused by something inside the head, usually too little blood supply or deterioration of some sort. Findings of many research studies show that indications of senility (disorientation, memory loss, poor judgment, loss of intellectual capacities, even such labile moods as easily crying or laughing) can have causes other than brain disease or cardiovascular disease. In an older person, such symptoms may be due to something as simple as dehydration or constipation. Having a case of the flu—with the accompanying fever—may cause that person to go out of balance dramatically and suddenly. These are reversible, treatable illnesses with good prognoses.

We must not categorize everything as "senility." The solution lies in getting a good evaluation and attempting treatment rather than assuming nothing can be done.

A good evaluation would include a thorough history and physical examination, including the administering of psychological tests, sometimes X-rays, usually urine and blood tests,

sometimes all of these. But making the assessment is essential. It is important for the physician to be able to say, "This is temporary. This is not progressive. This is not hopeless. You are not losing your mind." Relieving the patient's fear is one of the most important things one can do. Another important thing one can do is to reassure persons that treatment can be provided when treatable physical and mental problems are discovered.

AGEISM: A PREJUDICE

Many of the horror tales that we hear are not to be denied, but rather to be faced as by-products of something that is happening in society. We now find "ageism," which is a prejudice against the elderly. It is a prejudice as bad as any other, but one complicated by the fact that sooner or later it will affect us all. We are all going to become old.

Many in the medical profession have enjoyed good experiences in our families and among our patients and colleagues, so that we can see a balanced view of getting older. We see some of the success stories as well as the atrocities one hears about. The time for each of us to get ready for our own aging is now, no matter what age we are. If we are lucky, we have a family that sets a pattern for dealing with older people in terms of respect, of contact, or role in the family. We need to "Get ready now. Set an example now." At the same time, we need to be aware of what helping resources exist on behalf of those already elderly.

TREATMENT

Treatment can include medications—antidepressant medication, most commonly. Many older persons are seriously depressed. Their depressions are accepted by everyone, but they cause needless suffering because antidepressants can help many older people back to normal.

Depression can be a mask of senility. People may exhibit symptoms of depression when they have other underlying illnesses. And people can appear senile who are, underneath, suffering a treatable depression. So, again, evaluation offers answers.

Assessment can prescribe "talking cures." We all know older people who, when asked about themselves, respond at length about who they were before, who they are now, what they have lost, whom they have lost. And therapy that we would consider appropriate for young adults and middle adults and adolescents is not tried with older people. Experience has shown that therapy works as well with the elderly as it does with anyone else. Older persons have suffered so many losses—their self-reliance and the loved ones in their lives. Once they have an opportunity to unburden themselves and explore what has really happened, many of them have an excellent chance of responding positively to treatment for their depressions.

The families and the elders themselves may feel that the problems are an inherent part of age and must be accepted. The conditions do *not* have to be accepted until all other avenues have been explored.

MEDICATIONS

Medications can have side effects. Everything that one takes over a long period of time can cause symptoms. For instance, there is tardive dyskinesia—a fancy name for an unfortunate side effect of certain medications. The phenothiazine medications have been greatly helpful, but they can—especially after long use—produce this side effect in a small percentage of patients. It can cause the person to have cramps, particularly a kind of cramping of the tongue. It causes the tongue to move rhythmically into the cheek or out the front of the mouth. What is being found so troublesome about that effect is that people who begin to have it continue to have it as an illness. It is somewhat similar to the situation of those suffering from Parkinsonism. Although we can treat Parkinsonism, we cannot reverse it.

The dilemma is that sometimes now we are victims of our success. Very helpful medications can produce unfavorable side effects. We are warning patients more and more about these and involving them in the difficult task of balancing risks with benefits.

In medicine as a whole, and certainly in psychiatry, there is a relatively new concept of "therapeutic windows." It recognizes that every medication has a range for a given illness. A person who has *less* than that range level will not benefit from the medication. A person who has *more* than a top range level will have side effects, will perhaps suffer harm from that otherwise

beneficial medication. So we find a therapeutic range for any given person, and it changes not only between medications; it changes in the same person over his or her life span. We need to stay aware of this factor.

Persons who take a medication for arthritis or for sleeping or for whatever reason probably do not need the same dosage as they get older. If anything, they usually need less, and they tend to suffer detrimental effects from taking too many different medications or too much of any one medication - so they get overdosed.

The concept of the therapeutic window is based on a safe, workable range. It involves not only what one takes into the mouth but also how much we absorb in the stomach, how fast our kidneys excrete these substances, how rapidly our bodies utilize them. And so any individual's therapeutic range may be quite different from someone else's. That range is something which should be determined for any given person.

Sometimes people take medications passed on to them by neighbors or friends; sometimes they have prescriptions from more than one physician. They may take some kind of over-the-counter drug or folk remedy. They may also smoke and drink and use coffee in abundance. There are numerous folk medicines that people in all walks of life utilize. And these are drugs which have to be taken into account.

A physician's evaluation should seek to find not only how much of the prescribed medicine one is taking but also how much medicine all together, including folk medicines. People need to be aware that these are additives to each other, that they may interfere with one another, and that their side effects, especially in the elderly, may accumulate.

RESEARCH NEEDS

We can take one view that we do not know nearly enough; we ought to be better informed about aging. But we can also see that we are so much farther than we were before. Some highly significant longitudinal studies are going on in the United States at centers like the one at Duke University. From these, we are beginning to examine something basic: What is normal for an older person? Up to now, we could compare older people only with themselves when they were younger. What we need to know is, "What is normal for a person at age 65, 75, 85, 95?" That kind of research is very important.

We need more information on senility. Senility can be caused by brain disease. That form is different from senility caused by heart and blood vessel disease. Both are still different from senility that is secondary to some more general metabolic illness, diabetes, high blood pressure, or a number of other sicknesses which cause symptoms late in life that appear as what we think of as senility.

Thus, we need research to differentiate brain disease from body disease which manifests brain symptoms. Research is needed on how to predict a prognosis. We have a lot of information on other illnesses which occur earlier in life, but we carry a prejudice that everything has a poor prognosis when one gets older. The latter may not be so. A cancer, for example, in an older person tends to be more benign in that it grows more slowly than the same cancer might in a person 20 or 30 years younger.

Older persons have acclimated. Their body defenses—what we think of as their immunology, their resistance to illness—are more set than ours. If they have reached age 75 or 85 or 95, their bodies have learned how to cope with a lot of stresses. Their bodies react differently, also. We need a lot more knowledge of how we decide the prognosis for older people in order that we can reassure them and their families and in order that we do not give up on them prematurely.

CHANGES IN ATTITUDE

Needs still exist to change societal priorities, community attitudes, and resistance to involvement among health professionals. The day will come when every fifth person in our land will be an elderly man or woman. Then the impact on society will certainly be felt.

Meantime, there are some bright spots. Increased activism of older persons in their own interest is encouraging. As the proportion of aging persons in the population grows, we hear them saying, "We have needs at our age level. We want transportation; we want occupations; we want housing; we want our medical services to be coordinated in one building; we want the accessibility of other services in that same building."

The American Association of Retired Persons is aggressive in terms of rights and needs and services. The Gray Panthers deserve credit, and their strident voice of demand is welcome to many of us.

American Psychiatric Association meeting sections on geriatrics used to have one or two papers presented, with perhaps one section where people sharing this interest could help each other feel less isolated from their colleagues. At the most recent APA meeting, there were over 60 presentations in geriatrics, and a new organization for geriatric psychiatry was formed. A National Institute on Aging has been established. The field hopefully will no longer be a neglected stepchild of medical practice.

Finally, it is inspiring and heartwarming to hear students in our medical schools express a preference for gerontology. And we see allied health professionals becoming invested—in the fields of nursing, social work, psychology, and certainly the clergy. These helping professionals are becoming more and more conscious of the need to pay attention to older persons and the need to intervene, along with them, on their behalf.

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