PSYCHIATRIC CARE OF THE AGED.

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Age and Ageing

In a paper of this nature it is not proposed to deal with presenile dementias or senile psychotic illnesses, and, furthermore, an arbitrary age of over 65 years is regarded here as representative of the aged. This, however, must be accepted with reserve, since age can be determined at physiological, psychological or chronological levels, none of which, on its own, is entirely satisfactory in terms of the individual differences in the older members of the community.

It would be beneficial if a new, acceptable definition of the aged, incorporating all three aspects, could be postulated. Age is relative, and old age, therefore, is a social concept. Unfortunately society is educated to think only chronologically in this respect. The absence of physiological and psychological senescence *pari passu* with passing years is seldom taken into account, and society loses much in efficiency and experience owing to this attitude.

We are old when society dictates it, yet ageing cannot be determined in terms of time alone, for innumerable factors play a role in retarding or precipitating senescence, including heredity and constitution, exposure to worry and stress, illnesses and infections, obesity, alcohol, lack of exercise, climate and environment. Increasing years generate their own stress, for in this Western Culture activities are directed towards youth, which resents old age, regarding it as slow and non-productive. Any sign of ageing, therefore, such as greying hair, causes apprehension, and all the psychological (and often physiological and mechanical) defence mechanisms of denial or retreat are activated. This is in direct contradiction to Oriental cultures where age is synonymous with authority and experience, and is important and revered. In our society, beyond a certain age we must expect to be obeyed less the older we become, if we are to continue to live happily within the community.

Increase in the Aged in the Population

Advances in therapeutic methods and the study of geriatrics appear to have been partly responsible for the increased expectation of life and the increase in the population of persons over 65. In 1900, in the United States, the ratio of people over 65 to the population was 1 in 25, in 1955 it was 1 in 12. Moreover, in Great Britain today, the admission to mental hospitals of those over 60 now constitutes one-third of the total number. Psychiatric illness has become the largest single cause of chronic infirmity in old age, and a third of the patients in wards for the old suffer from an illness of this nature.

The rise in the incidence of mental disease in the aged, however, has proved far too great to be even partly accounted for by the increase in the proportion of old people in the population. There is a growing realization that emotional disabilities are of considerable importance as precipitating factors in the pathogenesis of disorders of the aged.

Aetiology of Psychiatric Problems

The problem, therefore, appears to be socio-psychiatric: its aetiology arises largely from the present social structure which tends to precipitate the aged into isolation and loneliness, to reduce them to financial stringency, and deny them the primary emotional needs of all individuals, namely love and affection, recognition, security (both emotional and material), and an adequate self-esteem. This personality-crippling attitude is augmented by the inability to compete with youth, because of physiological deterioration and the increasing but variable impairment of memory, concentration, and the higher apperceptive abilities. It is virtually impossible for the aged to learn anew or to change to interests and ventures different from those to which they have adapted themselves through the years. Today they are denied the privilege of looking forward with pleasurable anticipation to old age—the majority can see and experience only rejection, loneliness, a pittance for an old-age pension, and ultimately death, *sans* teeth, *sans* hair, *sans* everything.

Decline in the efficacy of sensory function leads to further isolation and decreases the steady stream of pleasurable sensation; impairment of auditory and visual acuities leads to further isolation from society; economic inflation, the increase in urban population, small dingy rooms, and the ever-present danger of vehicular traffic adds to their fear, anxiety and insecurity. The loss of authority, and the replacement of the aged by youth in society, results in loss of identity with the group and a gradual withdrawal, as well as resentment and unconscious attention-seeking attitudes. This is augmented by memory impairment, especially for recent events, and renders their uncertainty and insecurity the greater.

Symptomatology

It is inevitable that personality disruptions must occur under the stress of physiological deterioration and social pressures, and the adjustments and compensations fail, so that previously suppressed personality traits or neurotic-character defence mechanisms manifest themselves and many of the psychological disorders result in psychoneuroses or behaviour disturbances. This is evident from the fact that the aged persons commonly referred to the psychiatrist are restless, complaining, argumentative, negativistic, depressed, agitated or angry, and, on a verbal or physical level, threaten to commit suicide or assault. Occasional sexual problems and psychoneurotic or obsessional characteristics may predominate, or clinging, demanding or hostile attitudes prevail. Psychosomatic complaints are legion and include headache, vertigo, constipation, anorexia, insomnia, skin irritations or flushes, and abdominal and rheumaticky pains.

Depression is extremely common, presenting with withdrawal from society, loss of interest or purpose, and relative inactivity, or with psychomotor retardation, anorexia, insomnia, weight loss, guilt, self-deprecation, hostility and paranoidal ideas, agitation, and suicidal tendencies.

In the main the doctor is faced with psychoneurotic or behaviour problems which previously were attributed to brain damage, and the quarrelsome old person off-handedly regarded as 'senile', is rejected even more and his symptomatology aggravated further. Whereas brain damage *per se* has contributed to his symptoms, the careful studies of Rothschild showed that the extent of brain damage found at autopsy cannot be exactly related to the amount or intensity of the psychopathology or disordered behaviour in life.

In comparison with the 'problem senescent', there are many well-adjusted persons of over 65 to be found in private homes and infrequently in old-age homes; their emotional needs do not differ materially from those of the younger people, for they, too, desire friendship and varying types of intimacy with both sexes. They desire an occupation in keeping with their intelligence, physical capabilities and background, and need a sense of accomplishment; they object to frustrations of opportunities for the relief of biological tensions and require recognition of achievement. If their self-esteem is maintained in this manner, they will retain an integrated personality structure which is augmented by mellowness, patience and philosophic tolerance. Emotional problems will, of necessity, arise in this group under stress, but these can be alleviated by psychotherapy.

It is important to accept, therefore, that early childhood experiences, repressed anxieties and conflicts, early parental attitudes, personality patterns and neurotic-character defence mechanisms are augmented when the present social structure does not satisfy, or, worse still, frustrates the satisfaction of the primary emotional needs of the aged.

Therapy, therefore, must be both preventive and therapeutic. Physical and psychotherapeutic methods, and occupational, social and environmental manipulation, all form part of the psychiatric approach, but the emphasis must lie primarily upon the psychiatric and socio-economic aspects.

PHYSICAL THERAPEUTIC METHODS

As mentioned previously, the problem is largely psychiatric in a third of the patients in hospitals for the aged. Allowing the patient to remain in bed aggravates the situation, and mobility and activity should be encouraged as far as can be permitted by physical disability. Getting the patient out of bed is useful in avoiding the formation of bedsores in the bedridden, for incontinence is a major problem and the ambulant patient can be kept dry. Night incontinence, which is so emotionally distressing to the aged, requires special measures such as condom drainage in men and rubber rings over commode chairs for women.

A planned active rehabilitation programme by a team is essential in a ward for the infirm, and a high proportion of the patients can be returned to their homes.

Many of the elderly patients present with inanition and thus specially regulated modes of living, with adequate warmth and care are necessary. Poor nutrition, also, necessitates intensive vitamin therapy, in particular thiamine hydrochloride, since brain metabolism is largely dependent on glucose and its breakdown to pyruvate in the presence of the catalytic action of vitamin B_1. Initial parenteral administration of intensive daily doses of vitamin-B complex and vitamin C appears to restore physical and mental energy, which is later maintained by oral dosage. This, supplemented with nicotinic acid, has been shown by Campbell and also Gregory to have a vasodilator action and a saturation effect in the absence of any deficiency, and I have used it effectively in the aged whether poor nutrition exists or not.

Night Sedation

Night sedation is often a necessity, not only in the restless patient but in many of the elderly who believe that a night's sleep is absolutely necessary or who lie awake at night ruminating over their unfortunate lot. Addiction is uncommon in the elderly although habituation is frequent, but in view of the relative sensitivity of the central nervous system of the aged to drugs, this is of small consequence; it is more important to offset restlessness or emotional disturbance. Satisfactory hypnotics depend upon individual reaction to various drugs. Bromides are mild and effective in doses of 1 – 3 dr. Sodium amytal and phenobarbitones are increasingly used, but in my experience the barbiturates generally appear

to have adverse effects on the aged although 'nembutal' and 'seconal' have been recommended in the literature. A useful mild sedative is the combination of an antihistaminic and small-dosage barbiturate in the preparation 'sonergan'.

Tinct. opii is described as indicated in doses of 10 – 20 drops in the patient with anxiety and depressive delusions. Hyoscine hydrobromide has also been advocated, but in my experience the postsedative effect appears to be increased agitation, excitement, and confusional states.

Care must, however, be employed in prescribing analgesics, opiates and barbiturates, as mentioned above, owing to the increased sensitivity and reaction and the possibility of depression of the respiratory centre.

Adjuvant Therapy and Cerebral Stimulants

Adjuvants to general parenteral therapy which have been described as having an emotionally sedative, or general tonic effect, are small doses of alcohol, digitalis and camphor, the latter two improving central or peripheral circulation.

Hypometabolic activities can be stimulated not only with vitamin B, but with products such as cytochrome C, as described by Garnett *et al.*, and triiodothyronine (Lerman). Glutamic acid is described as stimulating cerebral activity in the elderly, but this has not been my experience although 'L-glutavite', which contains glutamate plus vitamins, is reported by Fincle as a stimulant to patients' general interests, activities and socialization.

Acute anxiety states are relatively uncommon in the aged although chronic anxiety, related to fear of death, is prevalent. If anxiety is present the response to tranquillizers such as 'miltown', 'permitil', 'equanil', and 'stelazine', in small doses, or elixir of luminal, 'censedal', etc. is usually good. Agitation and behaviour difficulties are frequently well counteracted by 'largactil', 'sparine' or 'stelazine'.

Depression and Suicide

A special relationship appears to exist between old age and suicide; this is not attributable to psychosis, according to Gruhle, who believes social and psychological factors to be the major causes. Mayer Gross, however, states that the majority of old people seen after a suicidal attempt suffer from a depressive illness, usually an endogenous depression or a depressive episode in the course of an organic disorder; it predominates in areas where individuals live in isolation, either socially, *per se*, or through auditory and visual defects. Suicide rates reach a peak in late middle or old age, and affective disorder is the most common single cause of mental illness in the same age groups. Awareness that suicide is the major danger in depression is important, not only to the psychiatrist but also to the general practitioner, and cannot be stressed too forcibly. Depression is reversible and suicide is therefore preventable. Social stresses and endogenous psychiatric illness must be regarded as factors in the aetiology of depression, but this does not indicate that, once the social stresses have been removed, the depression will automatically lift—far from it, for frequently the depression necessitates ECT; this applies especially in the agitated, paranoid or purely depressive states.

A major advance in the treatment of depression has been the development of the thymoleptics such as 'tofranil' (which also assists in the control of emotional incontinence), 'tryptanol' (which has a sedative effect as well), the monoamine oxidase inhibitors such as 'niamid' and 'nardil' and the psychic energizers such as 'catron'. It would appear from my experience that the MAO inhibitors are more effective in the reactive depressions and tofranil and tryptanol in the endogenous depressions or where obsessive features predominate. The literature is however at variance on this point. The antidepressants are an advance in the treatment of depression generally, but their slowness of action, with the concomitant possibility of suicide, has led to the postulate that ECT, combined with an antidepressant, is the treatment of choice. Due attention, however, must be paid to the need for reduced dosage, since the aged are more sensitive to neurostimulators or depressants.

At the level of general symptomatic therapy, and more in the domain of the physician and general practitioner, is the use of sodium iodide, intravenous saline and glucose, analgesics, antipyretics and antibiotics. Delirious states in acute infective illnesses are frequent in the aged, but abate relatively rapidly with active symptomatic treatment.

Psychosurgery

In cases of affective disorders which continue to relapse, or make little more than a transitory response to ECT, leucotomy has produced good results in selected patients with previously well-integrated personalities.

Psychotherapy

In recent years the literature, containing increasing reference to care of the aged and ageing, emphasizes the need to accept that psychoneurosis exists more frequently than was previously determined, and that seemingly psychotic disturbances may be primarily psychoneurotic and will respond to psychotherapy. The psychoneurosis (the behaviour problem), it is true, may be aggravated by physiological brain deterioration, but excessive emotional upset will impair behaviour, intellect, reason and memory. Accurate diagnosis is therefore essential. In this respect the senile psychotic or the cerebral arteriosclerotic will progress without remission towards a steady decline, becoming less and less associated with society, whereas in the aged, in whom the behaviour disorder or the psychoneurosis predominates, the attitudes vary according to the surrounding emotional climate. Remissions and improvements occur when environment provides for the primary emotional needs and relief of physical and emotional pain. In other words in all the aged, even when chronic organic brain damage is suspected, a trial with psychotherapy should be considered provided other supportive measures are instituted.

It must be accepted furthermore that individuals of over 60 vary in intellect, reasoning, general knowledge, emotion, physical health and strength, social status, economic position, religious attitudes and degree of physiological senescence. It would appear that a previously poorly integrated personality, inadequate vocational adjustments and poor sexual activities, or a hereditary history of early senescence, may be poor prognostic signs.

Nevertheless, the realization that psychogenic factors play as important a role as organic factors has prompted many authors to lay stress upon dynamics and upon psychotherapeutic approaches, and sound medico-socio-psychiatric contributions have appeared from people who work as individuals, in groups, or under hospital conditions.

Before instituting therapy, however, the basic needs and anxieties of the aged must be understood. These vary from individual to individual according to personality development, previous achievement, religious attitudes and socio-economic status, the degree of organic brain damage, and the cultural influences affecting them. In the main it must be remembered that the ability of the elderly to adjust themselves to new activities is slow (and really should have been cultivated at an earlier age), and that there is an increase in fatigability, both intellectual and physical; loss of initiative and drive, a lessened capacity for work, and an increasing tendency to inflexibility, stubbornness, and memory impairment. Further anxieties exist, however, for not only is there both a conscious and unconscious

fear of lack of gratification of the primary needs, but an ever-increasing apprehension and fear of death. It is of paramount importance to understand this aspect, which exists to greater or lesser extent as a primary anxiety in the majority of the aged, despite obvious or unconscious self-destructive impulses in many. This is emphasized by the observation of Shrut that anxiety was increased, as is the fear of death, when the elderly are transferred from home to an institution.

Thus the psychotherapeutic approach must not only provide for the management of personality factors and the alleviation of anxiety and fear of death; it must also go a stage further and provide psychological care for the dying.

Chronic physical illness in the elderly frequently has an emotional component necessitating psychotherapy, and the medical profession should become alive to the complex interplay of physical, intellectual and emotional factors. This requires the acceptance that cure is not always possible (in the aged virtually impossible), but that alleviation of suffering is essential.

Therapy, however, lies not at the door of the aged alone; the fact must be directed further afield—into education in general medicine, to social workers, occupational therapists, and to the public—that psychotherapy is of real value and that a request to the psychiatrist to see an elderly patient with behaviour disorder, far from inevitably meaning insanity and consequent institutionalization, can so easily mean exactly the opposite. Not only that, but the psychiatrist may often alleviate the anxieties extant in the doctor, nurse and family who, handling the aged with or without physical illness, may themselves be disturbed emotionally and reveal their own resentment or anxiety in dealing with behaviour problems of the patient. Thus the general public, too, require rehabilitation to understand that the attitudes and abnormal behaviour are paradoxically an appeal for help, for understanding, and for security, and are motivated by underlying personality patterns and character traits. The elderly are so frequently unable or too proud to verbalize their direct needs for fear of their own loss of self-esteem and ego attitudes; thus their unfortunate indirect approach commonly arouses antagonism, anger, and resentment in the doctor, nurse, family and public.

It follows, therefore, that therapy must be multifactorial and multidisciplined—it must be both therapeutic and preventive.

At the therapeutic level this includes both individual and group psychotherapy, but also calls for a team approach in a total rehabilitation programme involving general medicine, occupational therapy, physiotherapy and social therapy. At the preventive level this includes adult education, professional education and socio-economic changes.

Individual Psychotherapy

Personality dynamics: These are important if individual psychotherapy is to be undertaken. Goldfarb has described the psychotherapeutic interrelationship in which the older person regards the therapist as a parent, and the utilization of this relationship for the patient's benefit. The need for flexibility in approach is important, and Klopfer indicated the value of brief psychotherapeutic sessions. Many authors suggest that although some of the aged are well adjusted, the aim of the therapist is to allow the elderly to obtain gratification, pleasure, and renewed self-esteem by achieving restored interest and a sense of purpose by utilizing the previously developed patterns of behaviour efficiently rather than being frustrated by attempting to obtain new engrams. This can, however, only be effective if conducted in the right environment and with the aid of the team approach.

This is virtually a return to the atmosphere of the formative years in which the personality was moulded by the parent figure, and the accepting, surrounding family, with a reactivation of unconscious security. This is borne out by the dependency of the aged (like all persons) upon others and their uncertainty regarding whether they can acknowledge this or not, or feel resentful and behave accordingly. Thus when emotional or physical needs force them to hospital or old-age homes, one may be passive, submissive, anxious; another accepting, and yet another overtly hostile. The behaviour, however, is primarily that of the original personality make-up and indicative of early repressed anxieties and conflicts.

Determination of early personality patterns is therefore necessary in the assessment of the behaviour of the aged in terms of the situation in which they find themselves. Goldfarb indicates that the patterns of behaviour may be to exaggerate or deny a situation, to utilize illness as an attention-seeking mechanism for security or to prolong its course for the same effect. This may be accentuated with the increased emotional stress of advancing years, and, as emotional instability is more common with physiological cortical deterioration, the resultant pattern is exaggerated. Thus anger, anxiety and fear will reach increased intensity and prove even more disruptive to the personality than is found in youth; therefore, normal outbursts of temper will be more violent, on the one hand, and apathy and depression deeper, on the other. This is dependent upon the person's usual way of combating stress, either by aggression or passive submission. Intellectual awareness and ability to control the situation is lessened, therefore a vicious circle is set up leading to behaviour which is out of proportion to the circumstances causing it.

That this behaviour is dependent upon early formative attitudes is not realized by either the doctor or the family, who interpret it through their own experiences and 'judge' accordingly, without adequate insight, understanding or sympathetic compromise, frequently reflecting their own guilts, anxieties and conflicts. The resultant resentment complicates the picture even more.

As indicated by Goldfarb, however, in some of the aged the behaviour is motivated by a need for help and clusters about the person's specific propensity for the development of a child-parent type of relationship. In some, this is of an affectionate character; in others it clusters about attitudes of domination and submission.

Difficulties arise, however, in the emotional appreciation of a situation involving the elderly, with reference to both their own attitudes and those of the therapist. It is indeed difficult for the therapist to accept emotionally the deprivation of comradeship felt by the widowed or 'widowered' aged—exhortations towards sublimation or the redirection of emotional activities do not really provide the unconscious, yet personal, companionship necessary to all individuals. It is at this level that grandchildren may provide a positive 'feeling' emotional outlet.

At the other extreme it is difficult for the aged, becoming rigid in behaviour, attitude, and thought, to accept emotionally the 'intellectual' explanations of the therapist with regard to personality development in their formative years—for to them this constitutes disloyalty to, or attack upon their own parents, and they inevitably seek to deny the supposed onslaught by refusing to accept their own personality difficulties. Thus the short interview calculated to provide gratification and satisfaction of their needs with a modification of attitudes appears to be more practical than psychotherapy at a deeper level.

Therapy Itself

Having tacitly acknowledged, without criticism, the reality to the patient of any physical complaint, be it or-

ganic, emotionally motivated, prolonged or exaggerated, the therapist inspires confidence, and a positive transference is at once established. An attempt is then made to determine early parental attitudes so that these can either be supplemented or avoided; in this respect one must have the cooperation of the doctor, the nurse and the family to ensure complete compatibility of handling—the environment must be conducive to cohesion in therapy both emotionally and intellectually.

The technique of therapy, therefore, is to:

(*a*) Develop a satisfactory parent, or child-parent relationship and to provide gratification of the primary needs,
(*b*) develop satisfactory religious and spiritual attitudes,
(*c*) diminish unreasoned aggression or excessive apathy and the inevitable guilt and environmental retaliation, and
(*d*) restore productive activity where possible, to promote a resurgence of self-esteem and dignity thus ameliorating or alleviating the mechanisms which arise in defence of the ego, such as anger or hostility, argument, or disagreement, and fear, which are disruptive to the personality.

(*a*) *Child-parent relationships*. Ageing is associated with neurone fallout and deterioration in the neuronal pattern to varying degrees; concomitant with this are enzymatic changes; thus there is a physiological regression to childhood patterns. Illness of any kind results in a regression, in variable degree, to infantile attitudes in which the patients perforce become subject to the dependency on, and authority of others. This results in an unconscious acceptance of the parent-child relationship.

Medicines supplied by the therapist may provide security at an oral level, particularly if the neurosis has had its genesis at this stage. In the Western Culture the child gains extra attention of the parents during illness; therefore, administration of medicine to the aged frequently has the same effect and he or she is now the centre of attention—transitory though it may be, the temporary therapy has induced a stimulating, long-lasting effect.

(*b*) *Spiritual and religious beliefs*. Jung has indicated the need in the person over 35 for a religious belief; this applies particularly to the aged, provided the belief adopted is in an Almighty Being, or God, who is benevolent and forgiving, and not wrathful, for the latter creates increased fear of death and reactivation of guilt—the former provides peace of mind and is a means of alleviating fear, especially if real faith can be inculcated into the religious beliefs. A positive religious approach will frequently assist in the preparation of the aged for death and also provide solace for those who are dying—enabling them to look forward to an eternity in which guilt and fear are removed and a haven of peace provided.

(*c*) *Reduction of aggression*. Anger and fear are disruptive to the personality, for resentment or aggression is provoked. In the aged the attitudes of the environment can cause extremes of this type of behaviour as a result of the fear or anger of the patient. This in turn provokes increased guilt and further resentment, and results in a like reaction by the community. Environmental manipulation and understanding at this level will offset the fear or the anger and restore the individual to a relatively placid attitude. This applies particularly to those who are disabled, depressed or rejected, or it may arise at the time of the consultation, especially if the 'parent figure' is a dominating or autocratic one. Thus an understanding, forgiving attitude by the therapist is frequently of the utmost importance in cases such as these, whereas dictatorial domination reactivates old fears and anxieties, and further personality disorganization occurs.

(*d*) *Promotion of self-esteem*. The aged, in regarding the doctor as a parent figure, revert to the childhood attitudes, but with the foreboding that their concepts and belief in the parent figure will have to be modified as they were forced to be at or before adolescence. The therapist, however, by adopting a consistent parental attitude, will allay this anxiety and can, in so doing, encourage the aged in the pursuit of interests and ventures which are in keeping with those previously acceptable to them. Thus an awareness of the adage that one cannot 'teach an old dog new tricks' enables the therapist to persuade the patient to embark upon ventures that are within his ability, scope and original interests, and will enhance the sense of pleasure of previous achievements. The aged, too, should be encouraged to adjust to a lesser pace of responsibility and activity.

Group Therapy

In the home or in the hospital an active programme directed towards the use of the team approach can produce a social environment in which cooperation and common interests exist. Thus behaviour problems are more easily tolerated. Group therapy, if correctly instituted, is essential, but the emphasis lies upon the alleviation of loneliness and isolation, and included in this is a socio-psychological approach to create a community-in-replica for the geriatric patient in the hospital or old-age home. For the patient in the private home group, therapy can be conducted at the level of the social group or club.

In this respect work therapy or occupation therapy assists in revising long-held goals no longer attainable, abandoning old ambitions, and accepting activities offering substitute gratification instead of a fruitless, frustrating attempt at new skills, which only leads to inferiority and resentment. A sense of purpose is created within a community, which offsets obsessive ruminations, and pleasure is gained from solving problems with a feeling of achievement. Even at this age new friends are created, the feeling of friendlessness is alleviated, attitudes of non-acceptance and rejection are offset, and any competitive attitudes that are present are at a virtually equal level in which inferiorities are not accentuated. Common interests are present and there no longer is a desire to retreat into isolation, rumination, fantasy, depression, or outwardly directed aggression or psychosomatic disorder. Some feeling of authority exists within the same age group, where old people are not replaced by youth and the jokes are common to yesteryear. Thus there is identity within the group, resentment abates, and a feeling of acceptance is promoted.

Physiotherapy

Activity and alertness delay the progress of physical symptoms. This should be encouraged, for the promotion of physical health provides a delay in senescence both physical and mental. In this guise, however, one is using physiotherapy in its wider concept of promoting motor activity with exercises and with occupational games in the group situation. Activity also tends to reduce disorganizing attitudes and to promote interest, thus reducing invalidism of the psyche and soma.

PREVENTIVE THERAPEUTIC METHODS

Socio-Economic

As mentioned above, the aged are faced with rejection, isolation, loneliness, financial stringency, inanition, physiological deterioration and a sense of hopelessness and helplessness; with nothing to anticipate except the ever-present fear of death. They are increasingly resentful

that their contribution to society has apparently gone unacknowledged, and that they have been deserted by a society to which they previously devoted their activities.

Their resentment is in fact justified, for they *are* rejected by society and the aged are, therefore, a problem to society because they constitute an increasing proportion of the population. In 1920 - 22 the life expectation of White men in South Africa was 55 and that of White women 59. In 1950 - 52 the figures were 64 for men and 70 for women, and it is predicted that these figures will continue to rise.

The sociologist, therefore, is faced with the task of preventive rehabilitation. In the old patriarchal system there were few problems with the aged: e.g. the Chinese promoted reverence and regard and there was a purpose to ageing—married women made themselves up to look as old as possible for in this way they expected to be obeyed the more. Our culture, however, does not provide security, comfort and happiness for the aged, and it is postulated here that *unless* essential, vital readjustments are made to our concepts of the aged and ageing, this problem must rise to formidable heights, imposing tremendous emotional and financial strain upon our community.

In this readjustment situation a drastic reappraisal must be made at (*a*) the socio-emotional level and (*b*) the financial level.

At the socio-emotional level relatively small comfortable homes, providing an atmosphere of an accepting small community, are envisaged, to which the ageing can look forward for the comfort and friendship provided. In this respect Hurwitz, Goldman and Deardorff recommend the development of (*i*) apartments for elderly people who can take care of themselves, and (*ii*) good institutions for long-term care of the chronically ill and seriously disabled *regardless of age*.

At the financial level drastic revisions are required—here it is suggested that a compulsory contribution be levied and subtracted at source as soon as the individual is able to support himself economically. Wisely invested by the State and possibly administered on a basis similar to unemployment insurance, this could provide comfort and security and reduce the present inanition and despair. I feel that these are two vital aspects of the problem of the aged.

The creation of facilities for the aged in all respects must eventuate. Public sentiment must be aroused to the awareness that a new health problem has arisen and that the public themselves can contribute by a changing attitude—this will be insurance for themselves as they, too, will soon join the ranks of the aged. In this respect the importance of psychiatric services must be recognized in the geriatric programme, and also the fact that 'brain damage' or 'senility' is not at the root of the behaviour problem, but that the mechanisms used for obtaining attention and security in the aged are very similar to those in the child.

Family readjustments and understanding of the dynamics of the aged must be fostered. Unless active adult education is sponsored, however, to create an emotional and intellectual awareness of the problem and its prevention at an early stage, little will be achieved. The public cannot be made aware of the problem in all its aspects unless they are educated at the responsible level of the State through the medium of the Press. If the State or Provincial authorities fail to adopt an active education programme in this respect the wards of hospitals for the infirm will continue to constitute a financial drain upon Provincial authorities.

CONCLUSION

Ageing is largely a sociological or socio-psychological problem involving group life, social adjustment and adult education in preparing for the ageing process. Ageing begins with birth, and unless youth can be prepared for ageing in all its many facets, the psychiatric problems of the aged will continue. Man must age—let age be a goal to which he has worked throughout life, not a torment. The aged represent a challenge, not a threat to society; a challenge to provide an organized, acceptable social status for those over 65. Provision must be made for education from childhood, financially, environmentally and emotionally, for serenity and peace of mind in the aged, who, after all, were once the architects of our present generation. Psychiatric assistance helps but little unless there is a *total* rehabilitation of the body, mind, and spirit.

BIBLIOGRAPHY

Blumberg, L. (1956): S. Afr. Med. J., **30**, 617.
Caldwell, W. A. and Hardwick, S. W. (1944): J. Ment. Sci., **90**, 95.
Christie, P. (1960): Schweiz. med. Wschr., **90**, 586.
Ferraro, A. (1959): In *American Handbook of Psychiatry*, **2**, pp. 1021, 1046, 1078, New York: Basic Books.
Fincle, L. P. and Reyna, L. A. J. (1958): Clin. Exp. Psychopath., **27**, 7.
Garnett, R. W. and Klingman, W. (1950): Amer. J. Psychiat., **106**, 697.
Glajchen, D. (1961): Med. Proc., **7**, 237.
Goldfarb, A. I. and Turner, H. (1953): Amer. J. Psychiat., **109**, 916.
Goldfarb, A. I. (1956): Amer. J. Med. Sci., **232**, 181.
Idem (1959): In *American Handbook of Psychiatry*, p. 378. New York: Basic Books.
Gregory, I. (1952): Amer. J. Psychiat., **108**, 888.
Gruhle, H. W. (1941): A. Alters Forsch., **3**, 502.
Hurwitz, I. M. (1961): S. Afr. Med. J., **35**, 558.
Klopper, W. (1951): Geriatrics, **6**, 404.
Lerman, J. (1953): J. Clin. Endocr., **13**, 1341.
Mayer-Gross, W., Slater, E., and Roth, M. (1954): *Clinical Psychiatry*. London: Cassell.
Perk, D. (1961): S. Afr. Med. J., **35**, 413.
Rothschild, D. (1937): Amer. J. Psychiat., **93**, 757.
Idem in Kaplan, D. J. ed. (1945): *Mental Disorders in Later Life*. California: Stanford University Press.
Schmied, J. and Ziegler, A. (1960): Praxis, **19**, 472.