Psychological Problems of Aging

ALEXANDER SIMON, M.D., San Francisco

SUMMARY

The increasing number of older persons in the United States is having far-reaching economic, social, political and psychological effects. Patients over 60 make up more than a fourth of current admissions to California's state mental hospitals. Biological, personal, cultural and economic problems are present in each elderly person and must be considered in the treatment of such individuals. Neurotic reactions are much more frequent that the psychoses, and these may be treated by the same therapeutic tools utilized with younger persons.

Not all the psychoses in the aged group are such as to necessitate mental hospital care. Many of the patients could be cared for in suitable nursing homes. An adequate mental hygiene program, maintenance of physical health, opportunities for work, and the development of hobby and recreation centers may help ward off many of the difficult problems that the aged now present.

In this country, in the years just ahead, the average age of the population will increase despite the spurt in the birth rate that has occurred since 1941. The trend toward a population heavily weighted with old people is to be a factor of growing importance in many fields. Old age insurance is to become much more important. Taxes to support the aged and to provide security for other groups will rise sharply. A wave of youths has already begun to flood the schools of the country, starting in the lower grades and extending gradually all through the school system, but the really big wave will be that of persons passing beyond the age of 50 and beyond the age of 65 as the years roll by.

Our total population, which was 106,000,000 in 1920, is now about 141,500,000, and is expected to be 162,000,000 in 1975. The middle-aged group, from 30 to 50 in particular, will increase and will carry the burden of supporting more aged than in the past, and about as many younger people. The number of persons 50 years of age and over has almost doubled since 1920, from 16,000,000 to 31,000,000, and will continue to grow rapidly. It is expected to reach 47,000,000 in 1975. The group of persons aged 65 and over is to be one that will attract more and more attention; there are now 10,500,000 people of that age and there are expected to be 17,500,000 within 25 years. As numbers of old people grow, so will their political power, and with it demands for bigger and better annuities and pensions. All in all, the increase in the number of older persons will have far-reaching economic, social, political and psychological effects.

The problem so far as it affects state mental institutions in California is becoming an increasingly serious one. In 1925, 15 per cent of all patients admitted for the first time to state mental hospitals were over 60 years of age. In 1935 the ratio was 18 per cent; in 1945, 28 per cent. The percentage of patients over 60 years of age in the resident population of the state mental hospitals has increased from 24 in 1936 to 34 in 1945. The more urbanized the community, the higher the rate of admissions to mental hospitals for psychoses of the aged. The rate was 30 to 40 per 100,000 population in 1945 in California. Patients over 60 years of age make up more than a fourth of current admissions to California's state mental hospitals (28 per cent were over 60 years of age, 15 per cent were over 70, and

From the Division of Psychiatry, University of California School of Medicine, and The Langley Porter Clinic, Department of Mental Hygiene, State of California.
6 per cent were over 80). There were approximately 12,000 admissions to the California state mental hospitals in 1945, of which over 3,000 were of persons more than 60 years of age. Of the patients over 60 years of age when admitted, 8.4 per cent die within one month of hospitalization, and 40 per cent within one year. Almost 40 per cent of them, however, are ultimately discharged from the hospital, most of them as improved, indicating that the outlook is not necessarily hopeless and that opportunities for rehabilitation exist.\(^3\)

Aging is a universal, continuous and insidious process, beginning with conception and ending with death. What is understood as "old age" or "growing old," in terms of structure and function, may be observed in one person in his earlier years, and in another many years later; or it may manifest itself locally in special organs such as the heart, kidneys, brain, eyes, ears, or skin, in an extremely irregular and variable fashion. Growth and repair, atrophy and deterioration, are constantly in evidence at any age level and differ in intensity and rate from one person to another so that it becomes most important always to consider biological as well as chronological age. Some persons are old and worn out in adolescence, while others may be old in years and still quite active and useful. Age should, therefore, be considered in terms of structural, physiological, behavioral, intellectual, and emotional factors, and only then can judgments be made of true biological age in contrast to chronological age.

In order to understand any individual, one must understand not only the person but the setting in which he lives. Biological, personal and cultural problems, including sociological and economic problems, are present in every case. This is as true of the older as it is of the younger person. The emotional problems of the aged person are, like all psychological problems, those of adaptation to a changing function and equilibrium within him as well as a changing attitude to him from his environment. Old age can be a problem period, characterized by more or less frustration, and special problems of adjustment can arise. All components of human behavior undergo modification as the individual grows older, and any of these changes is a potential source of frustration requiring reestablishment of the equilibrium between needs and satisfactions. Just as the aged in general undergo progressive impairment of the regulatory homeostatic mechanisms which enable the body to maintain a fairly constant internal environment in the face of fluctuating external conditions, in the same way the adaptive capacity of the individual to withstand psychological stress becomes impaired and defenses formerly adequate may disintegrate.

**BIOLOGICAL FACTORS**

With increasing age, a general reduction in strength, skill, and endurance occurs. This usually causes more difficulty in adaptation in men than women, as it is upon such abilities that the economic independence of the man may depend. Involutional changes, which actually begin early in life, are so subtle and insidious in development that they do not generally manifest themselves overtly until the individual is well past 40 years of age. Disability, while usually gradual in development, may come on abruptly after an illness, an injury, a failure in competition, or after rumination over friendly teasing that "he ain't what he used to be." The older in any case may react to decreasing abilities by withdrawal and retreat into a state of rationalizing his dysfunction with complaints of fatigue, weakness, digestive and bowel difficulties and physical illness. Preoccupation with body functions is often the result of decreased activity and leads to feelings of ill health which become an unconscious means of gaining sympathy and attention. Complaints of fatigue are prominent and usually are in inverse relationship to prospects of satisfactions of needs. Instead of withdrawal, the older may react to feelings of impending disability by aggressive overcompensation to prove to others he is as good as ever. He may try to increase his effort and productivity beyond his capacity to a degree that he exhausts himself, or his verbal repetitions of his prowess and ability may reach the point of annoyance, or he may adopt vigorous physical culture routines to improve his strength.

In a woman it is the decline in youthful appearance and attractiveness which is more important. She places great store on youth, comeliness and fertility, and their passing is a real personal threat. In contrast to the male, she finds an easy rationalization for this threat in the development of physical illness with a variety of physical complaints, since society's attitude is much more indulgent to illness in the female.

Of important sensory functions, hearing and vision are most often affected by aging. With failing hearing and vision, the older becomes deprived of a large share of pleasures, diversions and occupations, and as a result he becomes even more isolated from the activities of his social group. Deafness, in particular, may lead to misinterpretations and misunderstandings, the suspicions isolating him further from his friends and family and making it difficult for him to discharge his social obligations or to function adequately at his job.

The fear of death, present in all of us, is understandably exaggerated in the elderly. Anxiety about living may be translated into anxiety over one's physical health and be expressed in terms of physical symptoms. A fear of ill health, and especially of chronic invalidism, may be constantly present in that such eventualities may be a serious threat to limited funds, force one into a position of dependence on others, or seriously hamper one's activities. Physical health and comfort and emotional security are paramount needs at all age levels, but they become even more essential with advancing years. The younger person has greater hope for recovery when ill and correspondingly less concern about disease, but the older person who is more preoccupied with the state of his health in view of the physical de-
terioration of the aging body, may feel the threat of imminent death.

In the past, tradition has demanded that human beings, as they grow older, should become asexual. But to make such a demand of the aging is as unrealistic as it is to make it of children. While there is generally a reduction in potency in the male and of desire in the female, there is great variability in this. The rate of cessation of gonadal secretion at the time of the menopause may have little, if anything, to do with the onset of so-called "nervous" symptoms at this period of life. Anxiety may become more intense, not because of physiological changes, but because youth is left behind. Women especially may make frantic efforts to maintain a youthful appearance. The aging male may react to waning potency realistically, accepting it, or he may develop exaggerated, aggressive, or passive reactions. His solution may be a passive one in that he attempts to relieve his sexual tensions by indulging in sexual fantasies or masturbation, and, as a result, his former conflicts at adolescence with associated feelings of guilt and anxiety recur. If he attempts a solution by aggressive means, he increases his overt sexual activities to reassure himself of his sexual competence, and to prove to his spouse that he is still an able man he indulges in extramarital adventures, which sometimes prove very embarrassing. Should he fail, there is apt to follow an intensification of feelings of inadequacy and guilt. He may, instead, attempt to solve his problem by a vicarious interest in the sexual problems of others, condemn the younger generation for their "loose morals," and even join in crusades against supposed evidences of modern depravity.

CULTURAL FACTORS

In order to clearly appreciate the problems of our aging population, they must be considered in the cultural setting in which that portion of the population lived and is now living. Cultural changes, while gradual and continuous, are nevertheless slow enough that prevalent attitudes are in many ways different today than they were in the formative years of our present aged group. This is true of our attitudes about the family group. The family is the most important influence in an individual's personality and behavior. Living in an ideal family group provides the source of many satisfactions — physical care for its members, the sex needs of the individual, need for intimate personal contacts. It provides, moreover, emotional and economic security. Father, mother and children all have certain roles to play in this group, and these may seriously be affected by the aging process. The man has a job to do, daily problems to meet, and the responsibilities of a wage-earner; the woman has the care of home and children; and each is carried along by a pressing daily routine. With increasing age a grave readjustment becomes necessary. The children become adult, marry, and leave the home. Time hangs heavily on the hands of a once busy mother. Illness may interfere with the man's ability to hold a job, or the woman's to be a housekeeper; or the death of a marriage partner may force a major readjustment, especially in living arrangements. The older then finds it necessary to relocate himself and to step out of a familiar pattern.

Changes in concepts about the family group have produced problems for the aged. The large family unit consisting of three generations, including grandparents, parents, and children, is a thing of the past. Especially in the urban middle class group, the family is not considered normal unless its membership is confined to parents and children. When children grow up and marry they are expected to leave their parents' home, and as a result the older people are left in comparative loneliness. If one of the parents should die, either son or daughter must add an old member to the family group, which is not designed for such an addition; or else the parent continues with separate living arrangements and increased loneliness.

The attitudes of the younger generation regarding their obligations to the aged are changing, and as a result a great deal of ambivalence and conflict develops. The custom of youngsters', before marriage, turning over their earnings to the parents is disappearing. It is undesirable for the young person to continue his home with his parents after marriage. Newer attitudes about child training have taken from old persons the pleasures of guiding their grandchildren. There is a tendency to treat oldsters with patronizing courtesy, but to exclude them more and more from the social life of the younger group.

So far as living arrangements are concerned, the tendency seems to be for the elderly married couple to maintain an independent household, and for the widowed person to accept living with children or relatives, or in an institutional home, or hotel, or boarding house. With lowered income, the elderly couple often find it necessary to leave the old home to which they are sentimentally attached, to relocate themselves, to leave familiar objects and patterns of living for quarters in neighborhoods of socially inferior rank. The oldster's conservatism resists this change, as familiar objects and persons are important to him. The wife may blame the husband for real or fancied lowering of status; children may assume a changed attitude to impoverished parents; and the oldster may react to his changed status with anxiety, resentment, and somatic complaints. For the woman, the death of a spouse involves economic adjustment and change in living arrangements; for the man, the loss of a homemaker; for either, loneliness and loss of emotional security. When an oldster is forced to move into a child's home, the relationship between parent and child may become reversed, so that the adult offspring now has an opportunity to revenge himself for years of submission to a dominating parent. The elderly man loses the prestige he had in his own home; the woman loses control over domestic arrangements. Each loses status
and prestige. The maladjusted elderly person, like the maladjusted adolescent, may feel unwanted, inferior, unattractive, and unnecessary.

When decrease in family income, decrease in the size of the family group, the death of a family partner, or failing health make existing living arrangements of older persons unfeasible, and one is called upon to advise in such a situation, either in the direction of arranging for the individuals to live independently or to live with children or relatives, one must ask: Does sharing a family home, maintaining a home on a modified scale, living with non-relatives, or living in an institution, offer the greatest possibilities of satisfaction of the physical and emotional needs of the individuals concerned? Living with one’s family may provide natural bonds of affection to incorporate the older emotionally into the family unit. On the other hand, the housing of three generations under one roof offers many possibilities of conflict and frustration, each of which must be handled adequately if the group is to live harmoniously. While maintaining an independent household provides lesser opportunities for conflict with younger members of the family, and less loss of prestige and status, it still presents problems of loneliness and of obtaining physical care for illness when it is needed. The institutional family has many advantages of group living, companionship, and provisions for medical and nursing care, but there may be frictions and frustrations among the oldsters with which to cope.

MAKING A LIVING

Opportunity for work is the crux of most problems in the economic sphere, and such opportunity is severely curtailed in old age, especially in times of economic depression. Luckily, older workers usually stand a fair chance of keeping their jobs, although they have a poorer chance of getting new ones. In spite of the fact that older people, in general, have greater difficulty in acquiring new occupational skills, especially when these are in conflict with well established habits, they do have certain assets which come with age—greater evenness of performance, less frequency of errors in performing a well established routine, and less tendency to quit their jobs. Where physical vigor is important, the olderster may be at a disadvantage; where judgment and skill are required, he has the advantage.

Motivation is also an important factor. Strong motivation can compensate for loss of ability, so much so that in a given situation an old person may be more efficient in learning than a younger one. On the other hand, because of personality reactions to environmental pressures from without he may adopt an attitude of helplessness and be unable to use what ability he has. Older people are apt to develop feelings of lack of self-confidence and of personal inferiority. In our present industrial society old age brings lowered productive capacity, decreasing income, increasing need for support from children or social agencies, and a relegation to the status of “has been.” It is no wonder, then, that loss of economic independence, especially in an already insecure person, contributes to exaggerated reactions of anxiety, tension, depression and helplessness. What is needed are new purposes and motivations at an age when it is most difficult to acquire them.

RETIREMENT

Retirement too often depends on an arbitrary age limit. Abrupt termination of active interests and occupations can have disastrous effects. The retired person misses the externally imposed routine; he loses familiar landmarks and points of reference, and his own sense of personal identity. Retirement is often treated like a graduation ceremony, with dinners, speeches, and tokens of esteem, but with this difference: The young graduate has his life yet to live; the man who is retired feels too often that he is through, that this is in a sense a funeral ceremony. To the fullest extent, collateral interests should be mobilized and revived and, if necessary, even created. Retirement should always be from a job to some other interest.

PERSONAL FACTORS

There are a certain number of traits which are attributed to the personality of the oldster which occur with varying frequency and intensity, and which are dependent on the psychobiological integration of the individual. Symptoms commonly appearing in the elderly are feelings of inadequacy feelings of rejection, depression and self-pity, hypochondriasis, anxiety, irritability, boredom, apathy, guilt feelings, social withdrawal, rigidity, and conservatism. Many of these traits can be understood at a psychological level in terms of satisfaction or lack of satisfaction of definite psychological needs. If the oldster’s need for physical health and comfort is not satisfied, he reacts with discomfort, pain, irritability and tearfulness; if his need for affection and love is not satisfied, he reacts with feelings of loneliness, rejection and depression; if his need for recognition is not gratified, he reacts with feelings of inferiority and worthlessness; if his need for expression is thwarted, he reacts with restlessness or apathy; and if his need for emotional security is not met, he has symptoms of anxiety.

When an elderly person becomes overly assertive and domineering, it may be a compensatory reaction for feelings of inadequacy, inferiority and insecurity engendered by physical and psychological decline. The feelings of depression may arise from increasing isolation and loneliness as friends and relatives dies, and these added to a loss of self-respect and self-esteem, which follows decreasing status and prestige, enhance the depressive feelings.

NEUROTIC REACTIONS—PROPHYLAXIS AND TREATMENT

Emotional conflicts are as apt to occur in the oldster as they are in the young. He is not in a state of inertia, and as he realizes that lifelong wishes are not attained, old unresolved conflicts may reappear
in the form of passive or aggressive reactions. The patterns of his neurotic reactions are dependent on his premorbid personality and the character of his interpersonal relationships with those about him. Psychological tensions are apt to be translated into somatic tensions, which become attached to specific body organs and provide apparently tangible complaints with which to deal. Illness becomes a means of gaining sympathy and attention, a means of restoring at least some lost security and sometimes provides a method of aggressive domination of the situation by arousing guilt in the child. Anxiety reactions are often repetitions of similar earlier patterns, or they may arise from guilt over sexual fantasies, or from feelings of insecurity, from loss of occupation, loss of prestige, or from being forced into a position of dependency on one's children. As older people become more and more isolated, they may become more and more sensitive to slights, and this may become exaggerated enough to be considered a paranoid reaction. Fatigue complaints are frequent and are in inverse relationship to motivation and prospects of gratification. What is needed in such circumstances is not only rest but a wholesome balance between rest, recreation and work.

The neurotic reactions of the aged are much more frequent than the deteriorative psychoses and are not necessarily signs of organic decay. Syndromes of hypochondriasis, neurasthenic-like reactions, anxiety states, depressions, paranoid reactions and sexually deviate behavior may develop. The same therapeutic tools may be used with the aged as with the younger person.

The level of adjustment made by old people is to some extent the product of their immediate environment and the attitudes to them of the surrounding society, but even more it is the result of the kinds of people they were. This means that the most effective ways to assist the aged are those undertaken before they grow old. Maintaining health, economic security, and the building of a mature flexible character structure are the necessities by which the problems of old age are warded off. Adequate food, lodging, and medical care are necessary for security, but if living is to be adequate in later maturity, an appropriate set of attitudes and a wholesome elastic way of life must be set in early years if later ones are to be contented and satisfying. It is necessary to make preparation early enough that no abrupt disruption of habit patterns occurs. One who does that is able to maintain some degree of personal independence and find sources of gratification in even curtailed activity to such a degree that he maintains status and prestige in his own eyes as well as in those of others.

The oldster should be protected from injury and infection. Food fads should be avoided and his nutritional demands should be satisfied. His sight and hearing should be kept at the best possible acuity in order to avoid increasing his feeling of isolation. Regular physical examinations and measures directed at improving health will help in dissipating fear of invalidism and excessive dependence. An active healthy routine with a definite goal in mind will prevent habit deterioration. The oldster should be encouraged to continue at a job as long as possible and to have suitable interests to replace it when he is retired. He should be discouraged from believing he is wise just because of his age, and from interfering in the lives of his children, even if the children are making a "mess of things."

The psychotherapy of older people is not as hopeless as many think; a fatalistic attitude is unnecessary. One principle of therapy is to give them a chance to talk about themselves and their problems. Respectful attention and interest, not maudlin sympathy, is what they want. The therapist must recognize the oldster's need for physical and emotional security and for independence. He must give the patient an opportunity to work out his own solutions and not impose prejudices upon him. Moreover, it must be recognized that such a patient still has capacities for growth and change. An old person does not lose his personality and individuality just because he is old.

One of the most serious problems with which a therapist is faced is that of unsatisfactory relationships within the family group consisting of two or three generations. The problems in parent-child relationships in old age are as serious as those in childhood, except that the oldster constitutes the problem child in this case. If a child refuses to help a parent, either because it would disrupt his own family or because of overt hostility, the refusal is apt to engender severe conflict and guilt feelings in the child, and these must be worked through to some sort of solution. The kind of living arrangement best suited for an elderly person is dependent on the individual needs, physical and emotional, of that person. For one patient it may be an independent home; for another, full institutional care. Such a decision cannot be made lightly. Where the older presents a cultural problem, every effort should be made to fit him into a group with cultural background similar to his own, lest his already existent isolation will be exaggerated. Like the rest of us, the oldster needs provision for his physical health and comfort, affection from those about him, recognition of his abilities and limitations, some means for self-expression in work or play, and economic and emotional security.

**PSYCHOSES OF THE AGED**

The primary presenile dementias include such disorders as Alzheimer's and Pick's disease, but not every organic brain disease beginning in the presenile period is one of these syndromes. Only after such disorders as cerebral arteriosclerosis, cerebral syphilis, intracranial tumors and post-traumatic conditions and other possible specific causes have been ruled out may a diagnosis of Pick's or Alzheimer's disease be considered. The differentiation between the two is academic but may be made by a pneumoencephalographic examination through demonstration of the circumscribed cortical atrophy of Pick's
disease or the more diffuse atrophy of Alzheimer’s disease.

Senile psychosis and psychosis with cerebral arteriosclerosis are the commonest causes for admission of aged persons to state mental institutions in California. In the majority of cases there is evidence only of simple deterioration, but depressed and agitated, paranoid, presbyphrenic (confusion, disorientation, memory defects, and confabulation) and delirious reactions may occur. The depressed patients may respond quite favorably to electroconvulsive therapy so far as the affective components are concerned, but the substratum of intellectual impairment which is the result of permanent organic damage will remain unchanged. This must always be kept in mind when outlining the prognosis for such patients. Recent work on the role of large molecule lipoproteins in atherosclerosis offers possibilities for prophylaxis and perhaps of treatment for the atherosclerotic lesions so commonly appearing in the elderly.1

It has become increasingly evident that organic changes alone are not sufficient to explain the symptoms of these psychoses. The severity of mental symptoms does not necessarily parallel the extent of the cerebral lesions. Aged persons, apparently normal mentally until death, at autopsy may be shown to have changes in the brain as severe as or more severe than those observed in postmortem examination of patients with obvious senile and arteriosclerotic psychoses. It must be remembered, too, that even in organic psychoses like these, premorbid personality integration and situational stresses may play important roles in the mental illness. When it becomes necessary to hospitalize a patient who has one of the psychoses of the aged, the guilt feelings of children must be appropriately handled.

Delirious reactions in senile and arteriosclerotic individuals often occur and frequently go unrecognized. Etiological factors such as the injudicious use of drugs, especially barbiturates, infectious diseases, metabolic disorders such as uremia, diabetes, pernicious anemia and vitamin deficiencies, and post-traumatic conditions should be kept in mind constantly. The syndrome of clouding of consciousness, fear and apprehension and bizarre illusions, hallucinations and delusions may be superimposed on an already damaged nervous system and should be clearly recognized as delirium. In treatment, restraint of the patient should be avoided. If drugs are ordered, the judicious use of paraldehyde is recommended rather than barbiturates. Continuous bath or sedative packs should be ordered for sedation, and special efforts should be directed at combating dehydration and keeping up salt intake. The administration of glucose, insulin and vitamins is frequently indicated. Most delirious patients are frightened. Since they tend to misinterpret various stimuli, the source of stimuli should be reduced to a minimum. A reassuring nurse, familiar persons and surroundings may help more in quieting a delirious patient than any sedation.

MENTAL HYGIENE

The following is the author’s digest of the discussion among the members of the Section on Problems of the Aged at the Governor’s Conference on Mental Health.2

1. An adequate mental hygiene program, leveled at educating the public about the medical and psychological needs and problems associated with the aging process, is very important. Such education should begin in the schools and continue throughout adult life. Young people are not generally well motivated toward studying the problems of advancing maturity since the problems have not yet become personal to them. Education should be leveled first at the group in which the problem is real: the elderly people themselves, and the friends and relatives who find it necessary to deal with them. The general public should realize the large number of aged in our population, and appreciate that they desire some share of attention, just as children and adolescents do. Physicians, nurses, attendants, and social workers all need education along these lines. Until recently, many physicians have shown little interest in the chronic disease problem, and just as there has been developed an increasing interest in the psychological aspects of disease in general, so can an interest in the psychological problems of the aging process be developed with appropriate education. All facilities of the state, including the county departments of welfare, the State Department of Public Health, and other agencies of the state government, should foster and encourage the organization of local agencies in the community to carry on this educational program. Mental hygiene societies, adult education classes, parent-teacher association groups, community chest organizations, churches, etc., should be asked to assume responsibility to give all the necessary encouragement to such a program, emphasizing the importance of the individual’s assuming responsibility himself about the problems of aging to the extent to which it is possible for him to assume it. The family and relatives of sick elderly people are very important in this problem. They are intimately involved, emotionally and practically, since nursing care often falls to them, particularly to the woman in the family group. They need guidance and support and opportunities to ventilate their anxieties.

2. Every available facility, private and public, should be made available to all for the maintenance of physical health and the repair of physical defects before they become pronounced handicaps to mental health. This is considered of prime necessity, and should be part and parcel of a general public health program at both private and public levels.

3. In the economic sphere, opportunity for work is the crux of most of the problems on a financial level for the aged person. It is generally agreed that chronological and arbitrary age limits forcing people into retirement are not the best method of approach, but government, as well as industry, is often
guilty of such an attitude. Industry feels that it is in business to make a profit, and that if the elderly person is more of a handicap than an asset in the industry, it is not fair to burden such an industry with him. There is also the very real problem that such a person with a physical or mental handicap may constitute an industrial hazard for which the company is responsible and liable, and under the present law such liabilities cannot be waived. There is at present no obvious solution to these problems. Further research and investigation are indicated to produce ways and means by which to set up standards to base retirement on a person’s general physical and mental condition rather than on calendar age alone. This should apply to government as well as to industry.

4. Those people who, because of physical or mental handicaps, are unable to work, and those who are looking forward in the near future to retirement, should be encouraged to develop hobbies and interests to take up their time, and communities should be encouraged on private and public levels to develop facilities for recreation, social intercourse, education, and hobby training for the older age group. Such a center in San Francisco is proving extremely popular and beneficial. Use of the adult education departments in hobby training, already popular in metropolitan communities like San Francisco and Los Angeles, should be extended to other localities in the state. Such a program would do a great deal to dissipate feelings of loneliness and isolation, and might help to solve some of the psychosomatic problems presented by the elderly.

5. Throughout the state, especially in the metropolitan communities, there have sprung up many so-called family style boarding homes which are licensed by the state as “foster homes for the aged.” For elderly people who are well enough to live in such a group, and who have the financial means to do so, this may prove an ideal solution for a limited number of the elderly in that they still adhere to some sense of independence. So long as they have opportunities for appropriate care and treatment of physical and mental ills, either from private sources if they can afford it, or public facilities if they cannot, such a program would undoubtedly do a great deal in keeping many of the homeless aged from being committed to large custodial institutions. It is important that aged persons living in such groups have facilities for recreation, education and hobby training available. It is important, too, that people in charge of such family style boarding homes be educated, if necessary by the state, as to the physical and psychological needs of the elderly group.

6. A detailed study should be made of the advantages of developing a so-called “home care” program similar to that which has been developed at Montefiore Hospital, New York City, for the care of patients who have chronic diseases of various kinds. In such a program the home is treated as if it were an extension of the hospital environment. Opportunities are provided for the patient who lives at home to get medical care, visiting nurse services, housekeeping services, transportation, occupational therapy, and social service. Not only could this be a saving in hospital costs, but, even more important, some patients who do poorly in the hospital may respond dramatically well in the environment of sympathetic and affectionate care in their own homes if they are surrounded by attentive relatives. This would require careful social service investigation to be certain that such a program could be successful, and it could be only where there is close rapport between the family and the patient. It would require that the members of such a family needing guidance and support could have opportunities to ventilate their anxieties to physicians or social workers. It is recognized that the majority of elderly people do not need hospital care, and that a large group of them are now being hospitalized might not require it under such a program.

7. For persons who have early signs of mental deterioration but who are still not so sick physically or mentally that hospital care is necessary, and who, because of various emotional involvements cannot be cared for in their own homes by their own relatives, foster homes might be found with the aid, if needed, of social workers through public or private agencies. Such social workers should be considered part of a therapeutic team, together with the nurse and physician, and should be concerned with the treatment of patients on psychological and environmental levels. There should be enough of them that all their time is not taken up solely with the question of eligibility and they should be of a quality to be able to assume the responsibility of appropriate treatment at a social work level.

8. If more medical and psychiatric diagnostic and treatment services could be made available in physicians’ offices, or in the out-patient clinics of general hospitals, many of the patients who are at present being hospitalized might be treated on an out-patient basis for long periods before hospitalization became necessary. This would, of course, be much better and cheaper than expensive hospital care, but for communities in which such facilities are not available, the organization of traveling clinics would be necessary.

9. Elderly patients requiring hospitalization for physical or mental handicaps should not be isolated in institutional homes for the aged, although those could provide, in appropriate cases, advantages of group living and opportunities for medical and nursing care, especially if such homes were geared to individual needs. Such an institution should be built with a majority of its rooms single ones, rather than composed of large wards, to give the patients a modicum of privacy.

10. The wisdom of sending the majority of patients with senile and arteriosclerotic psychoses to state mental institutions, most of which are situated many miles away from the homes of patients, is questioned. The dislocation of an elderly person from his home and family often does much to has-
ten deterioration and early demise. The move from home to general hospital, to county psychopathic ward, to state mental institution is upsetting even to a young person, but more so to the elderly who depend so much for the satisfaction of their needs on familiar objects, people and surroundings. Voluntary public and private hospitals should be enlarged when funds and building facilities become available to provide units adjacent to the general hospital, and these units should contain a proportionate number of beds reserved for patients with the physical and mental problems of old age. The majority of these patients do not of necessity require mental hospital care in the ordinary sense. The depressed and dangerously paranoid could be committed to mental institutions; but for those whose problems are essentially those of physical and mental deterioration, appropriate general medical care is the prime necessity. Patients who were located in treatment units adjacent to large general hospitals could be more easily visited by their relatives, and they could be made part of a general rehabilitation program directed at the problems of chronic diseases in general. This would serve also an educational purpose in enhancing the interest of visiting physicians and young resident physicians in training. If such a program is carried out, and the burden of care of elderly mentally ill patients is removed from the state institutions to the county level, it is assumed that financial assistance should be provided by the state to approved hospitals in proportion to the services rendered. In those counties which would not have facilities to care for such patients, arrangements could be made on a cooperative basis with adjacent counties which had appropriate facilities.

Such a program would give us a good start in helping solve some of the problems presented by an increasingly large elderly group and it should help relieve the heavy burden on the state mental institutions for the care of many patients who require for the most part adequate medical nursing care.

REFERENCES

3. Personal communication from Statistical Research Department, Department of Mental Hygiene, California.