A Broad Clinical Assessment of Psychopathology in the Aged

BARRY J. GURLAND

The perspective of this chapter is one of breadth rather than depth. Any one of the topics touched upon is better treated by other authors. If this chapter has any merit it is to highlight the broadening front of advances in techniques for the assessment of psychopathology in the elderly. The wide range of available techniques presents special advantages and problems. Special effort is needed to keep in mind the contributions and limitations of techniques outside one's own discipline and to integrate the information from these many sources. In the elderly, perhaps even more than in young age groups, a complex assessment is required that cuts across conventional disciplinary boundaries.

Although the term psychopathology strictly refers to the study of the symptoms of mental disorder, in this chapter and in accordance with popular usage, we will use psychopathology to mean morbid psychological symptoms. The task of assessing psychopathology requires that the latter be defined, detected, quantified, and classified, and further, that consideration be given to natural history (prognosis), response to therapy, and etiology. A full assessment of psychopathology in the aged will cover all these steps.

Barry J. Gurland trained in psychiatry at the Maudsley Hospital in London. He is currently Head of the Section on Diagnosis and Psychopathology in Biometrics Research at the New York State Psychiatric Institute, where he also serves as United States Director of the United States-United Kingdom Diagnostic Project. His research interests center around the classification of psychological symptoms and social maladjustment.

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Definition of Psychopathology

"It often seems to be assumed that mental health and illness are objective phenomena rather than convenient constructs . . . [Clausen, 1969]." Not only are they constructs but opinions differ as to their definitions. The characteristics of aged subjects may be arranged along a continuum of consensus on whether or not these characteristics represent psychopathology. At one extreme are characteristics that all experts agree to be pathological. At the other extreme are characteristics viewed as pathological only by a small minority. By attempting to clarify the issues that could influence the placement of a characteristic on this continuum, it may be possible to arrive at an operational definition of psychopathology, which will serve for the remainder of the chapter.

Combinations of Criteria of Psychopathology

There is a high consensus of opinion that psychopathology is being manifested when an old person contemporaneously expresses distress, disturbs others, is incompetent, and shows a change from his previous state (especially when this change is rapid and marked); when this constellation of events is not commonly seen in subjects of that age; when the causes of these events are seen to originate in the subject rather than in his circumstances; when the events are judged to be maladaptive; and when a treatment is available to slow down, or reverse, the progress of these events.

Consensus is enhanced by a combination of the above events, partly because the combination will include various criteria of psychopathology, each with its own band of adherents. More important, however, is the fact that combinations of these criteria summate. Thus, a combination of unusual behavior and personal distress is much more likely to be deemed psychopathological than either criterion alone.

Single Criteria of Psychopathology

Taken singly, each criterion of psychopathology can be found wanting. Personal distress could be a perfectly reasonable transient response to bereavement. Discomfort caused to others could be a reflection of the latter's hypersensitivity. Incompetence might result
from the abnormal demands of a task. Change from a previous state might be for the better rather than for the worse. Perl and Butler (1963) pointed out that in their sample of healthy male volunteers, "positive and constructive changes were reported as developing in the geriatric period. Changes were not uniformly viewed as deficiencies or losses, as it is frequently implied or described in the literature pertaining to old age."

The above list of exceptions to the single criteria of psychopathology could be much longer. However, difficulties in applying a single criterion such as (a) prevalence, (b) etiology, (c) maladaptation, or (d) treatment, particularly need further explanation.

**Prevalence.** The more uncommon a behavior, the more likely it is to be viewed as psychopathological. Some authors have defined the effects of normal aging as those occurring sooner or later in nearly every member of the species, so that they are "unavoidable, constant and present in every species and every individual [Korenchevsky, 1961]." Pathological effects are those occurring in only some elderly and also some younger subjects (Libow, 1963). Common behaviors, even if distressing, may well be regarded as normal accompaniments of aging. This view may sprout from a statistical concept of normality and also perhaps from a reluctance to accept too many problems as the concern of the mental health profession. Yet, several community studies of the elderly have shown that the prevalence of definite psychopathology in the elderly population is substantial (Bremner, 1951; Essen-Moller, Larsson, Uddenberg & White, 1956; Kay, Beamish, & Roth, 1964; Leighton, Harding, Macklin, Hughes, & Leighton, 1963; Leighton, Harding, Macklin, Macmillan, & Leighton, 1963; Lowenthal, Berkman, & Associates, 1967; New York State Department of Mental Hygiene, Mental Health Research Unit, 1960, 1961; Nielsen, 1962; Primrose, 1962; Sheldon, 1948). Furthermore, when Perl and Butler (1963) evaluated 47 "normal" male volunteers over the age of 65, they found that 29 subjects presented diagnosable functional "psychopathology." Depression was the most common symptom. Also common were nightmares, obsessions, hypochondriacal ideas, suspiciousness, psychosomatic symptoms, and anxiety. Thus, the high frequency of a symptom in the elderly does not seem properly to disqualify it from being psychopathological. It could even be that the rare, extremely well preserved old person is the standard of normality and that elderly people commonly show psychopathology (Birren, 1964; Korenchevsky, 1961).

Although mere prevalence may be a poor criterion of psychopathology, statistical analysis of the distribution of characteristics in
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A population may be of greater importance for a definition of psychopathology. The classic illustration of such an analysis is the observation of the "bump" on the lower end of the distribution curve for IQ scores in the general population. Such a departure from a smooth distribution indicates that the polygenic determinants of IQ are not shared in random combinations by the entire population. There is an added cause associated with very low IQ. Since the "bump" is small, the added cause is uncommon. Both the uniqueness of the cause and its uncommonness mark the resultant characteristic as possibly psychopathological, which possibility is reinforced by the incompetence and maladaptiveness associated with a low IQ. However, this kind of evidence has not yet been presented for defining psychopathology in the aged.

Etiology. The assumed cause of a given behavior appears to influence whether or not that behavior is defined as psychopathological. Undesirable behaviors held to be caused by a process within the subject are more likely to be called psychopathological than those regarded as imposed on the subject by others around him (unless the imposed changes became autonomous). This is especially true when the process is regarded as inborn, or is evidenced by gross changes in tissue or metabolism. Thus, many researchers attempt to compare the behavior of elderly subjects diagnosed as having organic changes with those not having such changes, in the hope of thereby isolating and identifying pathological or demented behavior. Yet, the causes of certain behaviors could be explained plausibly by more than one scientific model (Zubin, 1967), and it may be the discipline to which one belongs that determines which model is chosen. For example, an elderly subject with almost no friendly contacts may be seen as being rejected by his community, withdrawn because of a depressive or paranoid process, or disengaged for the purpose of adapting to the terminal phases of his life. Therefore, causal hypotheses are an uncertain guide to the presence or absence of psychopathology.

Maladaptation. A commonly used criterion for psychopathology is maladaptiveness. However, behavior may be adaptive for one purpose and yet maladaptive for another. Perlin and Butler (1963) found that lifelong psychopathology could be adaptive in the elderly. For example, obsessive-compulsive mechanisms were helpful in an enforced retirement vacuum, and schizoid detachment appeared to protect individuals from the inevitable losses of this period in life. Similarly, depressive disorders which might have been adaptive when early man spent long winters in caves (Price, 1968) are handicaps in modern society. In certain cultures and at certain times, halluci-
nating individuals (e.g., certain shamans) may be able to capitalize on their symptoms to improve their adaptation within their group.

Treatment. It may seem paradoxical to suggest that a behavior is more likely to be called psychopathological when there is an appropriate treatment available. It is reminiscent of a scientist who discovers the cure before he finds the disease. Yet, the introduction of antidepressants was followed by the acceptance of many minor complaints as being caused by depression. Conversely, the ignorance of potent remedies may lead to the dismissal of many minor problems of aging as being “normal.” Goldfarb (1962) warned that a lack of clinical orientation may lead to the unwarranted dismissal of signs of depression such as constipation and early morning waking as “natural for old age.”

Applying the Criteria to Certain Characteristics of the Aged

Some illustrative instances of the characteristics that increase with age are (a) cognitive impairment, (b) some forms of depression, (c) social isolation, (d) admission to an institution, and (e) diminished energy. A question is raised about which of such characteristics are part of the normal aging process and which should be attributed to pathology. This question further exposes the difficulties of applying the concepts of normality and psychopathology.

Cognitive impairment. Complicating still further the problem of determining whether a given level of cognitive impairment is pathological is that it is necessary to examine not only the quantity but also the quality of cognitive impairment. There is some evidence that at least two kinds of memory dysfunction may occur in the elderly: a benign, inconsistent failure of recall of information once learned, or a malignant loss of ability to store new information (Kral, 1965, 1966). Ingis (1970) suggested that in pathological memory disorder of the elderly it is the S-system (short-term storage system of Broadbent, 1957) that is disordered, while the effect of age itself is on the retrieval phases of memory. Lauter and Meyer (1959) concluded that while senile dementia appears psychologically to have a different structure from the effects of normal aging, in the light of studies they have reviewed, the idea of a permanent decrease of the intellectual capacity should be replaced by a concept of change in the structure of intelligence with age.

Another difficulty is that self-reports of memory difficulties may partly reflect stereotypes. Lowenthal et al. (1967) pointed out that at first sight a decline in memory appeared to be a normal function of
aging since it was reported by nearly half of the elderly community residents they studied. However, this decline was not borne out by objective testing using the Kent E-G-Y.

Even the criterion of pathology provided by evidence of gross brain pathology (i.e., diffuse or arteriosclerotic) is not without its difficulties. Possible histological substrates to memory impairment in the elderly have been postulated in the form of lipofuscin accumulation (Constantinidis, 1968), or an increase in hypodiploid cells (Hamerton, Taylor, Angell, & McGuire, 1965; Jacobs, Brunton, & Court-Brown, 1964; Jacobs, Brunton, Court-Brown, Doll, & Goldstein, 1963; Jacobs, Court-Brown, & Doll, 1961). Nielsen (1968) found a statistically higher percentage of hypodiploid cells in patients with senile dementia compared with a control group of the same age. Roth, Tomlinson, and Blessed (1967) related clinical assessment and argentophile plaques in the brain at postmortem in 90 elderly psychiatric and medical patients and found cognitive impairment to be significantly correlated with the number of plaques. Nevertheless, this correlation was less for patients with a diagnosis of definite senile dementia, and the authors suggest that senile dementia may therefore have some other, as yet undiscovered, pathological process.

Fortunately, the clinician is usually spared the difficulty of assessing minor states of cognitive impairment since subjects with cognitive impairment are often only brought for treatment when their financial affairs become muddled (Busse, 1959) or when their decline becomes so rapid that there is visible change in less than two years (Post, 1971). The speed of a decline in intellectual functions with age may represent a watershed of the practical and the theoretical criteria of abnormality. A gradual decline in intellectual functions with age is, in practice, accepted by society and health professionals as normal, while a precipitate decline is viewed as abnormal. Similarly, the processes theorized for normal aging tend to be described as gradual (e.g., lipofuscin accumulation), while rapid processes are almost invariably theorized as pathological (e.g., cerebral thrombosis).

Depression. As expected, ambiguities emerged when an attempt was made to apply some of the criteria of psychopathology to the presence of cognitive impairment in the aged. The same uncertainty results from an examination of depressive symptoms. Depression in old age is associated with, and possibly caused by, an increase of psychologically stressful losses (Busse, 1959; Kay, 1959; Post, 1965). The losses may be those of close relatives or friends, job and status, or abilities. Sometimes they are reactions to a decline in cognitive
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ability or in general physical health. Thus, the depressions are partly a reaction to the changing circumstances that normally accompany old age. Furthermore, depression of a mild and transient nature is very common in the elderly (Busse, Barnes, Silverman, Thaler, & Frost, 1955) and have been hypothesized as related to the normal aging changes in the neurophysiology of the brain (Post, 1968).

Social isolation. Similarly, social isolation in old age may be ascribed to various causes, some of which may be seen as normal accompaniments of aging and some of which are clearly pathological processes (Connolly, 1962; Gruenberg, 1954; Key & Roth, 1951). Lowenthal et al. (1967) suggested that isolation in the elderly can result either from role loss or as a consequence of mental disorder. Advancing age brings with it death of companions, decreased mobility, and loss of social attractiveness. In some cases, however, the pattern of isolation seems a lifelong characteristic. In still other cases, the development of withdrawal of social interests, suspiciousness, and antipathy toward others can be seen as a paranoid process arising as a late manifestation of schizophrenia with varying degrees of completeness (Post, 1966; Roth & Kay, 1962), sometimes precipitated by the effects of aging. Whatever the assumed cause, moderate degrees of isolation may be well tolerated by the elderly subject, although in the absence of even one intimate relationship the isolation is often accompanied by feelings of loneliness (Lowenthal et al., 1967).

Institutionalization. Admission to an institution is equally difficult to clearly assign to either the domain of normal or abnormal events of aging. It is only too well known that admission to an institution increases rapidly with age. Yet, surveys show that many old people living in the community have the same symptoms as those living in institutions. Supportive families, a spouse, good community facilities, and a certain amount of social invisibility (Lowenthal et al., 1967) may operate in favor of the elderly remaining in the community. However, the reasons for admission cannot be ascribed entirely to deficiencies in the community. Some old people cannot be maintained without being an overwhelming burden on others even in the best of communities, and these subjects tend to suffer from extreme physical or cerebral organic disease rather than advanced age.

Diminished energy. Diminished energy and reduction in psychomotor speed may result of course from overt physical illness but also possibly from more subtle effects of normal aging. However, Lowenthal et al. (1967) suspected that with advances in treating physical disorders in the elderly, failing energy may become accepted
as normal only in the very old. Here again, it is hard to make the distinction between normal and pathological effects of aging.

Applying the Criteria to the Whole Man

The discussion so far has been limited to considering criteria of psychopathology and their application to the component characteristics of the aged person. However, when considering the issue of normality or abnormality, the whole man must be taken into account. This requires an assessment also of the positive mental assets and strengths that may protect the individual against the impairment of function that otherwise would result from psychopathological symptoms (Jahoda, 1958). Clausen (1969) emphasized that it is important to evaluate the elderly subject’s positive mental health in the areas of interpersonal relations, personal resourcefulness, control over life activities, and accuracy of self-perception. However, the subject whose only defect is that he lacks positive mental health has a defect that, as yet, relatively few would call psychopathological.

A Relativistic, Problem-Oriented Definition of Psychopathology

As Clausen (1968) stated, “mental health is a state devoutly to be wished but desperately difficult to define.” In light of the uncertainty prevailing about the definition of psychopathology, there must be doubt about the scientific value of this term. Psychology is concerned with the whole range of human behaviors. The term psychopathology, distinguishing a part of this range, perhaps has greater value for administrative than for scientific issues. By assigning certain behaviors to the domain of psychopathology, a value and a priority are accorded to the need to change (or find a way to change) those behaviors. Busse (1959) emphasized that “society plays a large role in determining when and if a person is suffering from a mental disorder. At the point when his behavior or depressed thoughts are such as to be an inconvenience to them, he will be considered sick and will be treated accordingly. This reaction of society to the individual is extremely important in elderly patients” (p. 355). Furthermore, the methods whereby change in behavior can be attempted are largely determined by bestowing upon a behavior the designation of psychopathology. For instance, punishment is prohibited in its naked form. More positively, certain public resources are devoted to the modification of psychopathological behaviors. However, as with
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other administrative policies, differences of opinion will abound regarding the definition of psychopathology, fashions will come and go, and standards will vary among cultures.

Despite the administrative rather than scientific nature of the term psychopathology, it serves a useful function in this chapter. The degree of consensus on psychopathology acts as a guide as to which behaviors are definitely, and which are probably, the proper concerns of the mental health professions. An appropriately broad approach may be taken and psychopathology by all shades of opinion may be discussed, but the most serious discussion may be reserved for psychopathology on which there is a high consensus. Furthermore, making explicit the disagreement on definition that inevitably prevails in a discussion of assessing psychopathology may remove some of the sting of this discussion.

While it is useful to take consensus on the nature of psychopathology as a guide to priorities for research and clinical attention, it does not seem useful to invest much energy in defining exact boundaries between pathological and normal characteristics of aging. The latter task is inherently difficult and even futile. In fact, there might even be heuristic value in dropping the concept of psychopathology and turning rather to a consideration of which characteristics of aging are undesirable and which can be controlled. The word “problem” could be usefully substituted for the word “psychopathology.” The goal of this chapter would then be to discuss the broad assessment of problems in the aged. However, a merit of the concept of psychopathology is that it focuses on problems that are within the competence and responsibility of the mental health professions. For this reason the term psychopathology will continue to serve as the focal point of this chapter, but with full recognition of its relative nature—relative, that is, to the state of current knowledge, to disciplinary viewpoints, to the social and administrative context, and to the strengths or positive qualities of the individual.

THE STATE OF THE ARTS OF ASSESSMENT OF PSYCHOPATHOLOGY

General Comparison of Psychiatric and Psychological Techniques

The relative status of psychiatric and psychological techniques requires clarification. This may be achieved by describing the strengths and weaknesses of the two approaches. Hopefully, this will
show that, as in the treatment of neurosis (Sloane, 1969), the paths
of psychology and psychiatry are converging.

At its best, the psychiatric approach to assessing psychopa-
thology is quick and flexible, takes a rich variety of clinically relevant
information into account, including data not easily objectified, and
weighs and sifts these data in a logical manner. At worst, this
approach is unreliable, subject to bias, and narrowed by adherence
to a medical model.

In contrast, the psychological approach, at its best, is reliable,
with all the attendant virtues of making possible meaningful com-
parisons between patients, or groups of patients, and over time; is
quantifiable; is based upon experimentally derived theory; and is
subject to refined statistical analyses. At worst it is time consuming,
remote from the dysfunction that is a problem for the patient, and
vulnerable to distortion by response set and other irrelevant variables.

Fortunately for the patient there is an established tradition of
interaction between the psychiatric and psychological approaches, a
theme which recurs in several of Zubin’s papers (Zubin, 1967, 1968,
1970; Zubin & Sutton, 1970). In particular, there is a recent, strong
movement for psychiatry to apply more of the methods of psychol-
ogy. This trend emerged with a gathering of interest in the degree
and nature of unreliability of psychiatric diagnosis and the clinical
interview (Krietsman, Sainsbury, Morrissey, Towers, & Scrivener,
1961; Ward, Beck, Mendelson, Mock, & Erbaugh, 1962). Such
unreliability arises because judgments on the patient’s behavior are
often highly subjective and because clinicians differ in the scope and
style of their interviewing, in their definitions of psychopathological
terms, and in their diagnostic criteria (Hemsl, Whitehead, & Post,
1968). Partially associated with this unreliability is the heterogeneity
and overlap of symptoms shown by patients in different diagnostic
groups (Zigler & Phillips, 1961).

In an effort to make diagnosis more reliable, the World Health
Organization has sponsored an international glossary describing each
diagnostic category of the psychiatric section of the International
Classification of Diseases in widely acceptable terms. Of equal
importance is the introduction of structured interview techniques that
bear many of the virtues commonly associated with psychological
tests.

Structured interviews to assess the mental state of patients (e.g.,
Spitzer, Fleiss, Budack, & Hardesty, 1964; Wing, Birley, Cooper,
Graham, & Isaac, 1967) provide for consistency in interview style,
uniform coverage of a wide range of symptoms, definitions of psy-
chopathological terms, and reliable data on small units of behavior.
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(including expressed feelings, speech patterns, appearance, and motility). Diagnosis can be reliable when made by psychiatrists who are trained to use a structured interview (Wing et al., 1967). Furthermore, rigorously consistent computer diagnoses can be derived from the ratings of discrete items (Spitzer & Endicott, 1969).

A major advantage of structured interviewing is that it shifts the effort of the psychiatrist from making a diagnosis, which often requires no more than three minutes of interview time (Sandifer, Horden, & Green, 1969), to the meticulous detailing of the patient's psychopathology. The clinical usefulness of individual symptoms or syndromes for classification, choice of therapy, prognosis, and evaluation of outcome may then be examined. The symptoms recorded in a structured interview may be used for classifying the patient in terms of a computer diagnosis, clinically defined syndromes, or factorially derived dimensions; or for locating him on a continuum of depression, for example; or for placing him in an empirically derived typology. Conventional classification may even be essentially bypassed when symptoms are subjected to discriminant function analysis for the purpose of predicting treatment response or outcome. Syndromes of psychopathology can also be expressed in terms of the probability of a certain disorder being present in a given individual, and a whole array of probabilities for a variety of disorders can be obtained. The use of syndromes or symptoms (instead of diagnosis) for treatment selection, outcome prediction, and epidemiological investigation avoids many of the contentious issues associated with diagnosis.

There are other ways in which the introduction of the structured clinical interview has brought psychiatry and psychology closer together. For example, the style and spirit of the structured interview seem acceptable to both psychiatrists and psychologists, and interviewers can be drawn from either discipline. Another way is that certain tests which were developed by psychologists (sometimes from rudiments in clinical psychiatry) can be incorporated bodily in the structured interview, as will be described below.

The current work of the Cross-National Study of Diagnosis of the Mental Disorders in the United States and the United Kingdom can serve as an illustration of the application of a structured interview to the geriatric age group. This project has completed studies directed at psychiatric disorders in the 20–59 year age group (Cooper, Kendell, Gurland, Sarisveris, & Ferkas, 1969; Gurland, Fleiss, Cooper, Sharpe, Kendell, & Roberts, 1970; Kendell, Cooper, Gourlay, Copeland, Sharpe, & Gurland, 1971) and is now concerned with psychiatric disorders in older age groups. About 900 hospitalized psychiatric patients in the younger age group in
New York and London have been interviewed by project psychiatrists using structured interviews. The resulting data have been factor analyzed (Fleiss, Gurland, & Cooper, 1971), and those items that fell clearly into one or another of the factors became the backbone of a shortened mental state schedule with about half the number of the items contained in the original schedule. Items of diagnostic importance not appearing in the factors (either for reasons of infrequency or because they loaded equally on two factors) were added to the shortened schedule. A psychological test, the Mental Status Questionnaire (Kahn, Goldfarb, Pollack, & Peck, 1960), was imbedded in the interview. Other items were also added to expand those areas of psychopathology considered of particular importance in the elderly such as memory disturbance, disorientation, nihilistic delusions, and hypochondriasis. Raters were instructed not to make allowances for the patient’s age or physical illness. Where it was anticipated that behaviors might change as a result of normal aging, a distinction was made in the ratings between gradual and rapid changes. A separate interview was introduced to assess the patient’s physical state. Pilot work on a series of 100 newly admitted patients over the age of 65 to public mental hospitals in New York and London indicates that the interview can be rated reliably and that most elderly patients who can participate adequately in a short, unstructured interview can also tolerate the structured mental state interview described above.

With the emphasis of clinical assessment shifted to a detailed record of symptomatology, one becomes more aware of the nature of the difficulty in assessing elderly psychiatric patients. Some of these difficulties are shared by psychological testing. The older the patient, the more inclined he is to become fatigued during the interview and to have difficulty in grasping complex questions. Thus, interviews must be kept brief and questions straightforward. Since the elderly patient may become anxious and unable to cooperate when put under stress by questions directed at his cognitive abilities, such questioning must be tactful and must not be massed in one portion of the interview.

Some difficulties are peculiar to the psychiatric approach in that judgments are required “on-line” during an interview which, in psychological tests, is left to subsequent analysis. In this respect a major problem is that most interviewers are much younger than the elderly interviewee and thus do not possess the apperceptive mass for distinguishing between normality and abnormality. Generally, the interviewer has more experience with patients less than 60 years of age and can also apply the norms he has learned from observation of
himself and his peers to younger patients. Whereas symptoms from physical illness are infrequently encountered in patients under 60 years of age, such symptoms are common in the elderly. Thus, a decision has to be made as to whether to assign ambiguous symptoms, for example, tiredness, to the realm of psychopathology, physical pathology, or normal aging. We have already indicated that we have tried to limit such arbitrary judgments in our structured interview.

Both psychiatric and psychological tests have sometimes to contend with limited information obtained only from the patient at a single interview. Clausen (1969) pointed out that some of the changes of age may not show up on a short interview, but will appear in social role functioning when observed over time. Multiple interviews, with the patient over time and with other informants, are finding a place in the techniques of both disciplines.

Specific Consideration of the Range of Assessment Techniques

Psychiatric. In the light of the unreliability of diagnosis as generally practiced, it is small wonder that clinical diagnosis has fallen into disrepute and that clinicians pay more attention to the patient's symptoms than to his diagnosis in prescribing treatment. Diagnosis is often used merely as an administrative tool to qualify the patient for insurance benefits or for admission to an institution. Added to this is the clinician's reluctance to apply diagnoses such as schizophrenia, which might carry a stigma for the patient, or to submerge the "whole man" under a label. Furthermore, there is still the frequent belief that diagnosis in the elderly is likely to be an uninterpretable organic brain syndrome no matter what his symptoms are. Clinicians who have a special interest in careful diagnosis have found that the public hospital diagnoses of organic disorder is frequently applied to cases that they would call functional (Butler, Buttin, & Poltin, 1967; Larsson, Sjogren, & Jacobson, 1963). Finally, there are conventions attached to diagnostic labels of the International Classification of Diseases that are unacceptable to many clinicians, namely, that a Kraepelinian medical model is implied.

Diagnosis that is poorly regarded is probably also badly practiced, and thus a vicious circle is established. Conversely, the renaissance of clinical diagnosis in the elderly has in hospitals with a tradition of careful clinical assessment. Roth, Rossé, Key, Peter, Simon, Neal, and many others have shown that such diagnostic groups as senile, arteriosclerotic, affective, schizophrenic, and confusional psychoses all differ from each other in symptomatology and
pattern of outcome (i.e., death and discharge rates). For instance, Roth and Kay (1962) reported in their series of elderly psychiatric admissions that two years after admission the majority of those patients diagnosed as having affective psychoses were discharged, the majority with senile and arteriosclerotic organic disorders were dead, and those diagnosed as paraphrenic remained hospitalized; while the acute confusional cases showed an even balance between the discharged and the dead.Corsellis (1962a, 1962b) added evidence that, contrary to the emphasis that Rothschild (1937, 1942) placed on his own negative findings, pathology in the brain was strongly related to both the clinical diagnosis and the outcome of mental disease in the elderly. Corsellis found in an unselected series of 300 necropsies that wherever a given type of brain pathology (e.g., vascular change, or atrophy, or senile plaque formation and neurofibrillary changes) was postulated as occurring in a particular diagnostic group (e.g., functional, senile, cerebrovascular, or mixed), the pathology was found to a moderate to severe degree in about 75% of the appropriate cases. Conversely, when its absence had been postulated, the pathology was found in only 25% of cases. With the development of diagnostic sensitivity, it became evident that a high proportion of elderly psychiatric admissions had functional syndromes that were treatable. Also, the high prevalence of such symptoms among the elderly in the community became apparent.

Drawing on the writings of others, especially Post (1962, 1965, 1966, 1968), Roth and Kay (Kay, 1959; Roth, 1955; Roth & Kay, 1956, 1962), and Busse (1959, 1960, 1970; Busse & Fleisher, 1969), one can attempt a description of the current state of the art of psychiatric diagnosis in the elderly patient. The experienced clinician can usually distinguish confidently between an affective disorder (including neurotic depression), a neurosis other than neurotic depression, schizophrenia of late onset (paraphrenia), a confusional state and a chronic brain syndrome. Such distinctions can generally be made on the basis of a clinical assessment that includes an evaluation of the mental status and physical condition of the patient, an adequate psychiatric and medical history from the patient and an informant, and a routine examination of blood and urine. Prolonged observation in a hospital is not usually necessary for diagnosis; it is also rarely necessary to invoke specialized psychological or neurological procedures for this purpose.

The characteristic features of the diagnostic syndromes may not be so readily evident in conditions of acute onset. An incorrect diagnosis of chronic and progressive dementia may easily be made in these acute conditions. In the first place, the patient with a functional
disorder may not be able to report his functional symptoms and may be so distressed or preoccupied that he temporarily shows features of cognitive impairment such as disorientation or faulty memory. In this respect, the signs of senile decrepitude, peripheral arteriosclerosis, or the presence of neurological signs do not help in the individual case to decide between a diagnosis of affective or organic disorder. However, a fluctuation in cognitive impairment and the presence of visual hallucinations weigh the diagnosis in favor of an organic rather than an affective condition. In the second place, the major clue to the existence of an acute confusional state rather than a chronic organic condition may be a minor infection which is easily overlooked, or some medication which escapes suspicion because it has been prescribed by a doctor (e.g., digitalis). Important features for indicating the likelihood of an acute rather than a chronic organic condition are a fluctuation in consciousness, fearfulness rather than apathy, the presence of visual hallucinations, and elaborations of misperceptions. Acute cases, whether affective or organic, will probably require hospitalization, but the choice between a medical or a psychiatric ward may hinge on whether the diagnosis is that of an affective or an organic state. The placement of the patient in the wrong kind of ward may have serious consequences for him (Kidd, 1962, 1963).

The distinction between chronic organic syndromes and functional disorders is usually less difficult, because the evolution of the symptoms is easier to perceive. Where cognitive defects precede functional symptoms the diagnosis is probably organic, and vice versa. Occasionally, functional symptoms may be the first sign of an underlying organic disorder, but this possibility can be postponed from consideration in the absence of definite neurological signs or evidence of a physical condition.

Other diagnostic decisions that are difficult, yet important for treatment, involve the recognition of mild affective disorders not accompanied by a complaint of altered mood (McDonald, 1967) and of severe affective disorders (depressive or manic) resembling paraphrenia because of accompanying paranoid delusions and even hallucinations. An affective condition is the more likely diagnosis if the content of the delusions or hallucinations is in keeping with the altered mood.

Early symptoms in organic disorder such as depression, anxiety, importuning, obsessiveness, jealousy, and hoarding behavior may easily be confounded with neurotic behavior. However, depressive syndromes in progressive cerebral disease tend to be intermingled with periods of confusion or euphoria in a “fragmented” fashion (Roth & Kay, 1962), while obsessional symptoms that are provoked
by organic disorders tend to be atypical in that they are often stereotype and not resisted (Post, 1962).

In depressive states the risk of suicide must be assessed, bearing in mind that it is particularly high in the elderly. Sinister features include marked pessimism and hopelessness and delusions of worthlessness and of incurable disease (Sainsbury, 1962). Also important to prognosis, if not to treatment, is the separation of the present dementias from senile dementia and the separation of either from arteriosclerotic dementia. Favoring a diagnosis of arteriosclerosis rather than senile dementia are the presence of focal neurological signs, a fluctuating course, epileptiform convulsions, emotional incontinence, and the preservation of insight. Nevertheless, the clinical distinction among senile, arteriosclerotic, and other dementias is often impossible. Furthermore, the separation of senile dementia and Alzheimer's disease may be of only academic importance since Lauder and Meyers (1963) hypothesized that these are simply different age manifestations of one disease entity.

The neuroses are also difficult to classify, but in any case they are usually seen with an accompanying depression. Neuroses other than neurotic depression appear to decrease in frequency with advancing age (Kessel & Shepherd, 1962), possibly because elderly patients with neurotic symptoms usually come for treatment only when a depression is superimposed.

Clausen (1969) pointed out that "if one merely deals with symptoms, there is no need to conceptualize personality. If, however, one is concerned with a broader conception of mental health, it becomes necessary to consider the enduring organization of tendencies to behavior [p. 117]." However, the presence of a personality disorder is often difficult to assess and even more difficult to classify.

The diagnostic problems mentioned above for the most part concerned difficult distinctions between different psychopathological syndromes. Difficulty may also arise in distinguishing between symptoms that are, or are not, due to mental disorder. Some remarks on this topic were made earlier in this chapter, when discussing criteria for judging whether a degree of cognitive impairment is psychopathological. In addition, Lowenthal et al. (1957) discussed the distinction between symptoms associated with mental disorder and with low mood. The former may occur when the subject feels a personal failure to achieve goals in life; the latter, when the failure is in gaining approval from others. Thus, symptoms that precede mental disorder may refer to the "inner world" (e.g., free-floating worry), while those associated with low morale may refer to the external world (e.g., irritability). Perlin and Butler (1963), in their
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with a "senile quality" characterized by diminished involvement with

their environment; mild impairment in comprehension; decreased

affective interaction; uncomplicated style of communication; and a

tendency to cry or become confused under stress.

Some of these diagnostic dilemmas must be solved by repeated

examination of the patient over time and perhaps after a trial of

treatment. The course of the condition, whether fluctuating,

improving, or steadily deteriorating, may determine the diagnosis.

Confusional states may clear up after treatment of the underlying

physical condition. Acutely disturbed patients with functional dis-

orders may become sufficiently calm to reveal their diagnostic

features. It remains an open question whether the response of

symptoms to, for example, antidepressants, phenothiazines, or lith-

ium, can be used as a diagnostic test. Other advantages may also

accrete from repeated examinations. Epstein and Simin (1969)

stated that the chance of mortality can be predicted better if the

psychiatric diagnosis and physical condition of the patient are known,

together with his progress in the few days following initial evaluation.

PSYCHODYNAMIC. This section draws heavily on the work of

Goldfarb (1953, 1956; Goldfarb & Sheps, 1964; Goldfarb & Turner,

1953), who stressed the importance of assessing the intrapsychic

processes of the elderly patient. This applies to all patients, whether

or not they have environmental and physical factors also affecting

their psychopathology. Aging often leads to a failure of mastery over

life circumstances. Different strategies must be adopted by the elderly

for problems when previous approaches are no longer available or

effective. One reaction may be a loss of confidence and a withdrawal

of interest from goals that are unlikely to be attained (Wheeld.

1963). Wernicke, Pollin, Butler, and Pollin (1961) categorized the

reactions to deteriorative processes in oneself as compensation (e.g.,

obtaining a hearing aid), acceptance, limitation of activities, com-

plaint, and qualification (minimization of loss). However, the loss

of customary gratifications without compensation may lead to feelings

of fear that follow from a sense of helpless vulnerability and also to

resentful anger. There may develop an expectation of further
deprivations or punishment. This expectation may derive from guilt

about being angry, or from a belief that the anger will be visible to

others and met with retaliation. Either way, there is a growing fear

and despair, and the patient seeks help (or dependency). This de-

pendency seeking may be overt or may be disguised as symptoms.

Thus, the clinician must in all cases carefully assess the losses

that the patient has suffered, either as a result of normal aging.
processes, or of pathology, or of both. Helping to restore these losses is important, as are the acceptance and understanding of the patient’s interim need for dependency and his eventual need to regain a sense of mastery. Geldard emphasized that emotional factors may play a large part in the disability of even seemingly gross brain damage. He advised a therapeutic trial of psychodynamically oriented care before a final decision is made to place the patient permanently in an institution.

*Psychological.* An important thrust of psychological testing in the elderly has been toward separating patients with progressive cognitive impairment from patients with other dysfunctions, especially depressive states. This separation is made difficult by the cognitive impairment that may occur in normal aging or as a temporary result of depression. Other difficulties in testing arise from the easy fatigability, sensory impairments, preoccupation, and anxiety of elderly patients and from the effects of electroshock therapy on memory.

Despite the difficulties, psychological tests are valuable for weighing diagnostic decisions and for alerting the clinician to the possibility of a misdiagnosis of cognitive impairment. Roth and Kay (1962) found that their five diagnostic groups differed widely in psychological test scores. They stated that “these differences are valuable adjuncts in diagnosis, particularly in difficult cases... [p. 80].”

Verbal-learning tasks are perhaps the most satisfactory for separating organic and functional states. Inglis (1970) regarded the New Word Learning and Retention Test as being well standardized in the geriatric field. Successful results in differentiating organics, functionals, and normals have also been reported with the Paired Associate Learning Test (Caind, Sanderson, & Inglis, 1962; Inglis, 1959b; Irving, Robinson, & McAdam, 1970), and the Modified Word Learning Test (MWLT; Bolton, Savage, & Roth, 1967; Walton & Black, 1957). The MWLT has been shown to separate organics and other patients with very little overlap (Walton & Black, 1957, 1959) and to correlate with objective signs of brain damage (Walton & Black, 1957) and with the electroencephalogram (EEG; White & Knott, 1955). The Synonym Learning Test (Kendric, Parboosingh, & Post, 1965) also has a very high correlation with psychiatric diagnosis (Hensl et al., 1968; Irving et al., 1970).

Time limitations have an important effect on performance of the elderly (Lorge, 1936), and this effect is exaggerated in the presence of dementing processes. The Digit Copying Test (Clément,
1963), measuring psychomotor speed, has been shown to discriminate between organic and depressive states (Hemsi et al., 1968). Perceptual tasks are as yet of uncertain value for diagnosis. Davies (1968) questioned the discriminating power of several of the perceptual tests, including the Memory for Designs Test (Graham & Kendall, 1960), the Trail Making Test (Reitan, 1955), the Perceptual Mazes (Elithorn, 1955), and the Spiral Aftereffect (Price & Deabler, 1955). However, the Bender Gestalt Test (Bender, 1938) seems more promising (Shapiro, Field, & Post, 1957). Zubin suggested that much of the difficulty in interpreting the results of perceptual tests stems from the fact that traditional perceptual experiments do not allow for the separation of sensitivity to the stimulus from the criterion of decision making in the response. In other words, we are not able to tell whether the sensitivity of the aged person is lower, or whether he requires more information before responding yes or no to the presence or absence of a stimulus. Signal Detection Theory, which permits the differentiation of sensitivity (d') from criterion (Lx) can help in this connection (L. Zubin, personal communication, 1972).

Contrasts between subtest scores (e.g., verbal "hold" versus performance "don't hold" scores) of the WAIS or other test batteries have been widely used in clinical testing, although with variable success in discriminating organic and functional states (Savage & Bolton, 1968). Davies (1968) used a battery of tests of brain damage, for example, the perceptual tasks mentioned above as well as the Digit Code Test (Clément, 1963), Progressive Matrices (Raven, 1938), Mill Hill Vocabulary Test, (Raven, 1943), and the Synonym Test, on a sample of 540 volunteers between 20 and 80 years of age. There were differential declines with age and differential sensitivity to brain damage. He concluded that the Mill Hill Vocabulary Test is an index of the best intellectual level attained, since age does not lower it much, but that brain damage did lower it. Garme (1967) also found the Mill Hill Vocabulary Test to discriminate organic cases from elderly normals and depressives. In Birren's (Birren, Butler, Greenhouse, Sokoloff, & Yarrow, 1963) studies, reaction time, progressive matrices and digit symbol tasks have been shown to decline with age, while comprehension subtests and dichotic ear span decline with subclinical (and presumably, clinical) ill health.

Dr. Alzheimer and Tienst (1963) observed that in senile dementia cognitive deterioration proceeds in stages, but in inverse order to those that evolve in infancy. They suggested that these levels can be used to measure the progress of deterioration in an individual. However, there is as yet relatively little spill-over
from this recent work into the assessment of the disordered dement and presumably the levels they describe are more appropriate to advanced cases.

The use of serial testing over time appears to improve the discriminating power of psychological tests (Kendrick, 1965, 1967), although this is not a simple solution since even patients with chronic cognitive impairment may have superimposed fluctuations in their condition.

It frequently happens that, when the clinician is in doubt, the results of the psychological tests are also in doubt (Post, 1965). Inglis (1966) pointed out that although organic and functional patients could be differentiated on the basis of tests of acquisition (Isaacs, 1962; Isaacs & Walkley, 1964; Newcombe & Steinberg, 1964; Riddell, 1962), “even relatively high correlations between test scores and diagnostic criteria can result in very great errors in classification.”

The prognostic power of a psychological test must also be very high to be clinically useful. Epstein and Simon (1969) found that for the patients in their study, the prediction of death or discharge could be made as well by a simple clinical test of orientation as by the score obtained on the four verbal subtests of the WAIS that were used. However, Sanderson and Inglis (1961) showed “a closer association between test scores and mortality than between mortality and initial diagnosis.” Impaired learning ability related to mortality over the next two years. Kral and his colleagues, Mueller and Cahn, found that low scores on a modified Wechsler Memory scale predicted mortality over a four-year period (Kral, 1962; Kral, Cahn, & Mueller, 1964; Kral & Mueller, 1966).

Much of the work mentioned above has been aimed at discriminating patient groups as defined by the criteria of a skilled diagnostican. Some of this work is extremely sophisticated. Kendrick and Post (1967) used a Bayesian statistical approach to establish appropriate cutoff points for identifying patients with diffuse brain damage. However, equally important work has been focused on the nature and outcome of the memory disorders in the elderly without regard to diagnosis. Inglis (1970) favored such analytic description of behavior itself, since it may lead to discovery of relevant independent variables that can give us power to secure prophylaxis and change.” He added, “There is little to be gained, and much to be lost, by the creation of further psychological tests founded on diagnostic procedures.” Emphasis is placed on determining the steps in the learning-memory processes which are disturbed in the aging individual. The program organized by Inglis (1970) led him to select
objective measures of the main phases of learning by different modalities and by different modes of reproduction. He found (Inglis, 1957) that elderly patients with memory disorders have marked disability in acquisition, although there were also defects in retention (Inglis, 1959a). In line with the above principles, dichotic listening performance has been used (Caird & Hannah, 1964; Caird & Inglis, 1961; Inglis & Sanderson, 1961), to examine to what extent memory disorder in elderly psychiatric patients is based upon a breakdown of the short-term storage S-system.

Psychological assessment techniques are perhaps most powerful when they isolate the components of a disorder in a way that lends itself to rational treatment. Eisdorfer's (Eisdorfer, Nowlin, & Wilkie, 1970) concept of high arousal leading to response suppression in the elderly induced him to attempt to improve the performance of the elderly by administering an autonomic blocking agent. Whether or not this approach will prove useful in clinical work remains to be seen, but it is an excellent paradigm. Similarly, the technique of behavioral analysis as described by Kanfer and Saslow (1967) assesses in a comprehensive way the factors maintaining the patient's disabilities and provides information required to plan the patient's treatment.

Laboratory methods. The appeal of laboratory methods is their potential for precision and consistency, their requirement of only passive cooperation on the part of the subject, and their relative freedom from cultural influences.

Biopsy is the most direct method for the detection of brain pathology. However, it has the obvious drawbacks of an operative procedure, and, in addition, it is limited by the imperfect relationship between anatomical changes in the brain and cognitive impairment. Nevertheless, biopsy may return to favor if specific anatomical changes in the brain are found to be remedial.

The EEG has been found to show abnormalities (mostly slowing of the dominant rhythm) that increase with age and especially in the presence of a dementing process. Roth and Kay (1962) stated that EEGs are of some value in distinguishing between acute and chronic organic disorders. High-voltage, frontally predominating paroxysmal slow waves are characteristic of the acute condition, while chronic states may show slow alpha rhythm. However, Wang (1969) stated that EEG abnormalities of diffuse slow activity in the theta or delta range, although more common in organic than functional states, are not specific for the type of brain disorder. "Dynamic" EEGs (Busse & Wang, 1965) with photic and pharmacological stimulation, or serial EEGs (Wang, 1969), may have more
promise; Obrist (Obrist, Kleemeier, Justiss, & Henry, 1963) noted that a decrease in the evoked cortical response to a stimulus may predict death.

Skull X rays and air encephalograms have not proved helpful in the detection of cortical atrophy in early stages of a dementing process (McCormick, 1962), although clearly there are times when they may localize a tumor.

Cerebral blood flow is only rarely directly assessed, unless an aneurysm or carotid stenosis is suspected and an arteriogram requested. Catherization for direct measures of blood flow and cerebral metabolism is mainly a research tool. Recent development of a noninvasive safe means of measuring blood flow by inhalation of a radioactive isotope (Obrist, Chivian, Cronqvist, & Ingvar, 1970; Obrist, Thompson, King, & Wang, 1967) offers more promise for clinical applications.

The probable relationship between hypodiploid chromosome changes in elements of the peripheral blood stream, similar chromosome changes in the brain cells, and some dementing processes (Jarvik, 1963; Nielsen, 1968) may also eventually provide a clinical assessment procedure.

Certain general physical disorders, detectable in the laboratory, may give rise to an array of functional or organic psychological symptoms, but especially to confusional states. The relevant laboratory tests are those for levels of serum electrolytes (especially sodium and potassium), macrocytic anemias, folate, vitamin B12, and ascorbic acid levels, and tests of hypothyroid functioning including serum iodide levels. More recently, the erythrocyte sedimentation rate has been shown to be of possible importance for the identification of a dementia due to an immune reaction and which may respond to steroid treatment (Chynoweth & Foley, 1969).

The detection of elevated levels of ribonuclease in the elderly was once thought to indicate that some elderly orgonics suffered from a deficiency in brain RNA. Treatments designed to raise brain RNA enjoyed a vogue (Cameron, Solyom, Sved, & Wainrib, 1965; Cameron, Sved, Solyom, Wainrib, & Barlt, 1965). Although the results were disappointing, the close link between theory, laboratory tests, and treatment remains an ideal model to emulate.

Occupying a borderland between laboratory and clinical testing are such techniques as pharmacological load responses (Lehmann & Pan, 1968). The immediate clinical response of a patient's cognitive functions to the administration of a pharmacological agent such as carbon dioxide (or hyperbaric oxygen or barbiturates) may be a predictor of his long-term prognosis and response to therapy.
Social background and attitudes. Problematic behavior in an elderly person may not be susceptible to assessment until information is forthcoming about the patient's social background, his attitudes, and the attitudes of those around him. Recent environmental losses (of close companions, income, home, or status) may lead to impaired functioning in daily activities, possibly because of an intervening depressed mood (Birren et al., 1963). Chronic isolation may also have a deleterious effect. Weinstock and Bennett (1968) found that certain social isolates showed cognitive impairment that improved on admission to an institution, probably as a result of resocialization. Relocation in an unfamiliar environment may also lead to deterioration in certain sensitive subjects. Bloom, Blenkner, and Markus (1969) worked with the Modified Embedded Figures Test in attempting to identify "field dependent" elderly subjects likely to have difficulty in coping with relocation in an institutional environment.

Lowenthal et al. (1967) noted that in indicators of morale, although highly correlated with psychiatric impairment, was quite distinct in kind. Lowered self-esteem may be provoked by the denigrating attitudes of others, to which the aged are particularly vulnerable. Even a self-report of diminished or impaired cognitive functions may merely reflect a stereotype the elderly person has adopted from his social group. Nash and Zimbarg (1969) showed that improvement in short-term memory in the elderly may be partly a function of the subject's expectation. Furthermore, an apparent deterioration in the patient may turn out to be a change in the tolerance level of those around him.

Physical health. There is an intimate link between physical and psychiatric ill health for both hospitalized and nonhospitalized elderly subjects (Lowenthal et al., 1967). This link strengthens with advancing age. Weiss and Schale (1962) found that in elderly subjects attending a municipal psychiatric clinic, many of the complaints manifested were related to the area of physical health. Simon and Neal (1968), in their study of psychiatric admissions (who had become inpatients only after the age of 60) to a receiving hospital, noted that over 40% of the disorders were considered acute psychological responses to some type of acute physiological discomfort.

In acute confusional states a special search must be made for cardiac failure, respiratory disease (which may easily be overlooked), myocardial infarction (which may be painless), electrolyte disturbance, malignant disease, or nutritional deficiencies, as well as a history of ingesting alcohol or drugs, or of head trauma. Albert (1958) noted that cardiac insufficiency may produce only temporary cogni-
tive impairment if the insufficiency is quickly treated, but permanent impairment if it is not treated soon enough.

Even where the diagnosis is undoubtedly that of a chronic organic disorder, the assessment should still take into account the possibility of remedial conditions such as aggravating infection or toxemia, cerebral tumor, syphilis, myxoedema, malnutrition, macrocytic anemia, and other conditions. Among the rarer remedial conditions are B₁₂ deficiencies in the presence of a normal blood picture (Murphy, Srivastava, Varadi, & Elwis, 1969; Strachan & Henderson, 1965) and dementias with a raised erythrocyte sedimentation rate that may respond to steroid administration (Chynoweth & Fehley, 1962).

Disability. In the individual patient there may be a surprising contrast between the number of psychopathological symptoms he manifests and the degree of his physical or social disability (Perlín & Butler, 1963). Therefore, as Gruenberg (1968) stressed, disability must be measured in its own right. Level of disability is not only of value for assessment of the subject's current status but also may be a crucial variable in prognosis. Lowenthal (1964) found that scores on a Social Self-Maintenance Scale (need for safety supervision, ability to relate experiences, quality of social activities, and responsibility for care of own health) and on a Physical Self-Maintenance Scale (toilet activities, feeding, etc.) were predictive of mortality and length of hospitalization.

CONDENSING AND INTEGRATING THE DATA

The assessment of psychopathology in the elderly psychiatric patient requires that he be thoroughly examined with a mental state interview, a proper psychiatric history be taken, his physical condition assessed, and his psychological and other special tests reviewed. Information obtained from an informant who knows the patient is often vital in determining the patient's condition. The clinician must also take into account the capacity of the patient to look after himself at home; the support (financial and personal) he receives from family or friends; the nature of the burdens he imposes on those who must look after him and the psychological effect of this stress on them; the medical, psychiatric, or social services he requires and can receive in the community; the physical layout of his home; and his personality assets and other evidence of positive mental health.

The amount of information required for assessment purposes, the number of sources to be contacted, and the variety of disciplinary
skills at play, all point to the importance of interdisciplinary teamwork in the clinical assessment of the elderly subject. Gofar (1969), in his seven-year follow-up study of elderly subjects in institutions, demonstrated the value of integrating data from the several disciplines represented in his team. He found that mortality was best predicted by the diagnosis of severe chronic brain syndrome, the score on a psychological test (the Mental Status Questionnaire), impairment of the subject's ability to look after himself, and physical incontinence.

The role of the clinician in the assessment team is in flux. One possibility is that his role be restricted to integrating assessment data and translating it into a treatment program. Perhaps even the task of conducting the mental state interview could be taken over by a less broadly trained paraprofessional. There is no firm evidence as yet that paraprofessionals can be taught to elicit and judge psychopathology as well as a psychiatrist or psychologist. What is striking is that the notion has some credence. This is a tribute to the power of the structured interview as a means of conveying to the interviewer much of the skills and experience of seasoned psychopathologists. In this sense, the structured interview is a channel of communication between one interviewer and another, as well as between the interviewer and the patient.

If the clinician is to integrate and utilize this extensive data properly, he will need the benefit of condensed and easily assimilable information. In this respect, there appears to be a gap in the skills presently available in an assessment team, namely, skills in the concise presentation of comprehensive data on a patient. Traditionally, the functions of condensing and presenting data are carried out in narrative fashion by a member of each discipline in the team, or by a junior psychiatrist or psychologist. However, with the mounting information required to plan and evaluate the management of geriatric patients, a more concerted effort must be made to communicate this information in the most efficient form possible. There is a need for a team member with special skills in this area. These skills would include a knowledge of structured interview techniques in all the relevant spheres, of mathematical and computer-assisted methods for reducing data, and of the art of communicating graphically as well as verbally. The communication expert would be responsible for selecting, designing, and processing the structured interviews administered by the various team members. None of this would preclude team members from using unstructured methods and narrative accounts as well, but it would foster the most economic use of the time devoted to the clinical assessment of the elderly patient.
This procedure need not be more expensive in time and personnel than that in current practice in hospitals. The possibility of providing such services in office practice also needs careful consideration, although there are obvious inherent difficulties.

**SUMMARY AND CONCLUSION**

This chapter discussed the need for the clinical assessment of psychopathology in the elderly to transcend traditional boundaries within the field of mental health. For research purposes the elderly subject may be parcelled out among several different disciplines, separated into Zubin's six scientific models, and divided into normal and abnormal compartments. Consequently, the contributions of research to the clinical field may appear in a fragmentary fashion. It is the job of the clinician to put it all together, and in this process he will find it necessary to forgo rigid distinctions between normality and abnormality, the techniques of psychiatry and psychology, and the conditions arising from physical, psychological, and sociological determinants.

The line between normality and abnormality is exquisitely difficult to draw in the elderly. A survey of the criteria for abnormality finds them all to be debatable. It is not surprising that clinicians differ about where to draw this line. Those clinicians mainly in institutional practice probably have a narrower concept of abnormality than those who treat community residents with the whole range of problems for which people seek help. Such differences of opinion flow over into disagreements about methods of assessment, about who should be treated, and about the appropriate targets for preventative efforts. Perhaps the issues could be made clearer by abandoning the term abnormal and its synonyms such as psychopathology, mental disorder, and the like. Those terms were more useful when the recognized patient population included only those with severe symptoms, and when the less dramatic discomforts of aging were regarded as inevitable and not meriting treatment. Decisions about treatment and prevention could now more fruitfully depend upon pragmatic considerations such as the natural history of a given behavior, whether it is distressing or disabling to the patient or to others, and whether there is an effective way to modify it.

A further advantage arising from dropping rigid distinctions between normality and abnormality is that one might perceive more clearly the necessity for drawing upon the whole body of knowledge about aging when assessing the clinical status of the elderly patient.
Similarly, although physical, social, and psychological spheres are convenient constructs for examining causes and effects in the elderly patient, they are so highly interrelated in this age group that one sphere cannot be assessed and understood except in relation to the other two. All these relevant spheres were discussed in an attempt to illustrate the breadth of the approach required in assessing the elderly patient with mental health problems.

The broad and comprehensive approach to clinical assessment avoids the distortion of the specialized and selected viewpoint but raises new problems. In the first place, the techniques of the various disciplines must be amalgamated. In this chapter, a new structured clinical interview specifically developed for geriatric use was described in detail as an example of the merging of the techniques of psychiatry and psychology.

Also, there is the problem of collecting and integrating information from a wide number of sources. The abundance of data which are gathered must be reduced to manageable proportions and presented in digestible form. A team approach seems to be essential, with members of the relevant disciplines being represented in the collection and reporting of the data. However, this procedure is vulnerable to inconsistencies and bias on the part of the various interviewers, to inefficient summarization of data, and to selective listening on the part of the clinician who translates the data into a decision on the management of the patient. Therefore, it was suggested in this chapter that there is a need for a staff member with the skills required to collate and present the data relevant to the management of the patient.

The major theme of this chapter was that the assessment of mental health problems in the elderly subject is facilitated by an erosion of the customary interdisciplinary boundaries in the clinical field. A new role should be created for a professional who is skilled in the science of accurate and efficient interdisciplinary communication.

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