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Assessment, Intervention and
Treatment of Geriatric Psychopathology:

A Comparison of the Medical

and Behavioral Models

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Running Head: GERIATRIC PSYCHOPATHOLOGY

Abstract

The elderly represent nearly a third of the population in public psychiatric facilities. The social and physiological changes associated with aging can lead to a variety of psychiatric disturbances which necessitate institutionalization of the elderly individual. Treatment of these disturbances is likely to be based on the medical model of psychopathology, although findings indicate that behaviorally-oriented therapy may often be the more appropriate course of action. The reported findings carry implications pertinent to the future of geropsychology.

Assessment, Intervention, and
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In 1979, it was estimated that about 40,312 of the 139,546 residents of state and county psychiatric hospitals in the United States were 65 years of age or older (American Statistical Index (A.S.I.), 1979). With the elderly comprising nearly a third of the population of public psychiatric facilities, mental health professionals have begun to realize that psychogeriatric patients differ from their younger counterparts (Gross & Capuzzi, 1981; Ingersoll & Silverman, 1978; Salzberger, 1981). Gross and Capuzzi (1981) explain that the emotional and psychological problems of the elderly are compounded by the process of aging, which brings with it "a set of circumstances not only unique, but telescoped into a brief period of years" (p. 189). These circumstances, which include physical and social-role changes, "force the elderly into changing patterns of behavior and lifestyles developed and ingrained over long periods of time" (Gross & Capuzzi, 1981, p. 189). Ingersoll and Silverman (1978) concur that "the aged are a high risk group in the area of mental health. Anxiety, low self-esteem, and somatic complaints are frequent responses to the losses and stress sustained during the later years" (p. 201). Such responses are integral in the diagnosis of psychiatric illness in the aged individual. Salzberger (1981)

asserts that:

Traditionally, elderly mental patients are given a single psychiatric diagnosis on the basis of predominant symptoms or distinct evidence of organicity. Thus the patient who shows impairment of orientation, memory, judgement, or instability of affect is given a diagnosis of a psychiatric type. (151)

There are several disorders which commonly lead to the institutionalization of the psychogeriatric patient, and while the treatments for these disorders are likely to be based on the medical model of psychopathology, there is growing evidence to suggest that treatments based on learning theory may often be both more appropriate and effective for the elderly patient than those based on the medical model.

The disorders which most frequently necessitate and perpetuate the institutionalization of the psychogeriatric patient can be divided into two categories: those which occur despite intact brain functioning, or the functional psychiatric disorders, and those which occur because of impaired brain functioning, the organic brain syndromes (Pfeiffer, 1977). While the two types of disorders can coexist, they require "differing diagnostic techniques and call for differing types of intervention" (Pfeiffer, 1977, p. 653).

Of the functional psychiatric disorders, depression occurs the most frequently in later life (Gerner, 1979; Pfeiffer, 1977). According to Gerner (1979), depressive

illness accounts for up to 45% of new admissions of those over 65 to psychiatric facilities. The most commonly manifested symptoms of depression in the elderly include episodes of saddened affect, loss of memory, social withdrawal, and physical symptoms such as loss of appetite, severe fatigue, and sleeplessness (Pfeiffer, 1977).

Depressive reactions can be classified as primary reactions, which occur in the absence of other psychiatric symptoms, or as secondary reactions, in which the symptoms of depression occur "on the background of another diagnosis, such as alcoholism or schizophrenia" (Gerner, 1979, p. 98).

Depression associated with the occurrence of manic episodes, or bipolar illness, is present in about 5% of psychogeriatric patients (Jamison, 1979).

Late-developing depressive reactions, and manic-depressive reactions can be viewed as "struggles between the patient and his social environment" (Salzberger, 1981, p. 151). The process of aging interacts with these conflicts, resulting in a loss of self-esteem and self-confidence accompanied by fear and anger. "An irrational search for aid, together with manifestations of helplessness, fear, anger and deficits or defects of affect produces a symptom complex which is basically a depressive syndrome" (Salzberger, 1981, p. 152). Hale (1982) reports that there may be sex-related differences in the ways in which patients respond to and deal with the stress associated with the onset of depressive episodes, and Salzberger (1981) indicates that the specific personality

features of the patient are of the greatest importance in determining the degree of the depressive reaction, or of any type of disturbed behavior due to fears of old age, poor health, and death.

Following depressive reactions, paranoid reactions are probably the most common form of psychiatric disturbance in old age (Pfeiffer, 1977). Pfeiffer (1977) describes paranoia as "the attribution of other people of motivations which do not in fact exist" (p. 656). In the psychogeriatric patient, paranoid reactions are unlikely to be indicative of severe psychiatric disturbances, as they generally are in younger individuals. They are, rather, usually reactions to the attenuated losses characteristic of old age and a form of denial or repression of these losses (Salzberger, 1981). Paranoid reactions may also result from sensory deficits in the psychogeriatric patient (Pfeiffer, 1977). Pfeiffer (1977) describes the paranoid reaction as "an effort to 'fill in the blank spaces' in the cognitive map of the individual regarding his environment" (p. 656). Decreased sensory function, particularly visual, auditory, and gustatory in nature, may lead the patient to mistakenly feel that others are conspiring against him or her, and such feelings of persecution in turn lead to greater alienation of the patient from other persons, particularly care providers.

In addition to depressive and paranoid reactions, hypochondriasis is a fairly common form of psychiatric disturbance in the later years (Blum & Weiner, 1979). The

elderly hypochondriac is preoccupied with physical functions and bodily processes and is prone to iatrogenic ailments, particularly concerning diseased organs or organ systems (Pfeiffer, 1977). In the diagnosis of hypochondriasis, it is of course necessary to rule out the presence of significant physical pathology; but the diagnosis should not be made solely on the absence of physical findings (Pfeiffer, 1977).

Hypochondriasis in old age is viewed primarily as a form of psychiatric maladaptation in which the preoccupation with bodily functions results from the patient's inability or unwillingness to acknowledge psychological or emotional stress (Blum & Weiner, 1979; Pfeiffer, 1977). Blum and Weiner suggest that hypochondriasis in older persons may represent a displacement of anxiety from a more threatening psychological concern, "such as a retreat from fear of society's criticism regarding reduced proficiency, loss of status, and curtailed activities" (p. 183) to an acceptable "sick role", in which it is appropriate to enlist the help and sympathy of others. The hypochondriacal patient, in effect, has made an unconscious choice to present himself as physically rather than emotionally ill, and the physician and therapist need to recognize the patient as ill and someone in need of care (Pfeiffer, 1977).

While depressive and paranoid reaction and hypochondriasis are likely to make their initial appearance in later life, there are several functional psychiatric disorders found in the older patient which are likely to have been long-term or chronic in their presence (Brink, 1982). Such disorders

may be associated with a history of chronic institutionalization and may be instrumental in perpetuating hospitalization of the psychogeriatric patient.

Adjustment reactions, particularly alcoholism and other substance abuse disorders, are among those frequently found in the institutionalized aged, especially those in state hospitals (Pfeiffer, 1977). Although most of the institutionalized alcoholics are chronic abusers of alcohol who continue to abuse the substance, there are new "recruits" to alcoholism (Pfeiffer, 1977). In the elderly, alcoholism can be viewed as an attempt to deal with the various physical and social-role changes associated with the aging process (Gross & Capuzzi, 1981). The use of alcohol as a coping mechanism can become a particularly vicious circle for the elderly patient. Although the use of alcohol may provide temporary escape from a difficult situation, its continued use may prompt a number of new emotional and physiological problems, such as estrangement from significant persons, self-imposed isolation, feelings of guilt and shame, and physical deterioration of the brain and other organs (Gross & Capuzzi, 1981). Schuckit and Pastor (1979) observe that "the aging body, with its decrease in physical and mental reserves, is more vulnerable to the adverse effects of alcohol than the younger one" (p. 211), and chronic alcohol abuse itself can result in organic brain syndromes (Korsakoff syndrome) and other psychological disorders (Pfeiffer, 1977). Paradoxically, alcohol abuse can also result from attempts on the patient's

part to treat some underlying psychiatric disturbance, such as chronic anxiety or a depressive condition (Pfeiffer, 1977).

Schizophrenia, like addictive disturbances, is a functional psychiatric disorder prevalent among the aged in psychiatric institutions. It is estimated that as many as 42% of those over 65 in public mental facilities have been diagnosed as schizophrenic (A.S.I., 1979). While most of those so diagnosed are schizophrenics grown old in institutions (Pfeiffer, 1977), schizophrenia can initially appear in later life, when it is known as paraphrenia (Mensch, 1979). The most discriminating symptoms of schizophrenia include restricted affect, clouded thinking, poor insight, and widespread or bizarre delusions (Mensch, 1979). In the case of chronic schizophrenic, Pfeiffer (1977) asserts that while patients may retain some schizophrenic symptomology, they are "primarily manifesting the devastating impact of long-term custodial care in institutions" (p. 660), and he calls the elderly chronic schizophrenic a "documentary of an era in psychiatry which had few active treatment programs to offer schizophrenic patients" (p. 660). When schizophrenia does develop late in life, it is viewed as an extremely severe maladaptive reaction to age-related stress and emotional conflicts (Mensch, 1979).

While schizophrenia and the other functional psychiatric disorders which lead to institutionalization are characterized by a lack of physiological changes in or damage to the brain, the organic brain syndromes, which are associated with such

changes in brain functioning, account for a high number of admissions of the elderly to psychiatric hospitals (Brink, 1982).

Approximately 37% of those over 65 in public psychiatric facilities are diagnosed as suffering from one of the organic brain syndromes (A.S.I., 1979). The acute organic brain syndromes, which account for 10 to 20% of the total number of cases, generally result from metabolic disorders, drug toxicity, systemic illnesses, and circulatory disorders such as congestive heart failure (Pfeiffer, 1977). The acute syndromes are usually reversible when treatment of the underlying disorder is promptly administered. The symptoms of the acute syndromes can include the rapid onset of anxiety, depression, withdrawal, visual and auditory hallucinations, violent behavior, and euphoria (Ford & Jarvik, 1979; Pfeiffer, 1977). Because the symptoms of the acute organic brain syndromes, as well as other types, mimic symptoms of other psychological disorders, the need for a thorough and accurate assessment is vital in any situation involving the psychogeriatric patient (Pfeiffer, 1977).

Unlike the acute organic brain syndromes, the chronic organic brain syndromes are irreversible in nature (Ford & Jarvik, 1979; Pfeiffer, 1977). There are two classifications of chronic syndromes: arteriosclerotic brain disease, or multi-infarct dementia, and senile dementia, or Alzheimer type dementia (Etienne et al., 1981; Ford & Jarvik, 1979;

Pfeiffer, 1977).

Arteriosclerotic brain disease, or multi-infarct dementia, is the result of localized death of brain tissue related to occlusive arterial disease, with subsequent, multiple infarction of brain tissue (Ford & Jarvik, 1979; Pfeiffer, 1977). The symptoms of arteriosclerotic brain disease typically include both sudden intellectual disturbance and peripheral neurological impairment, usually involving paralysis of the face or limbs on one side of the body, explosive emotional outbursts, and seizures (Ford & Jarvik, 1979). With this type of organic brain syndrome, the intellectual and neurological impairments generally tend to gradually improve following the initial onset of the syndrome, but the improvement may be followed by repeated episodes of infarction in other areas of the brain, with subsequent and cumulative impairment of intellectual and neurological functioning (Ford & Jarvik, 1979). Ford and Jarvik (1979) note that the mortality rate is high in patients with arteriosclerotic brain disease, with over 70% of those affected dying within 2 years of hospitalization.

Senile dementia, unlike arteriosclerotic brain disease, is characterized by "gradually developing generalized intellectual and cognitive impairment" (Pfeiffer, 1977, p. 664). The broader terms of senile brain disease include many disorders, including Alzheimer's disease and Creutzfeldt-Jakob disease (Kaplan, 1979). The senile brain diseases are degenerative conditions characterized by a marked loss

of neurons, granulovascular changes, neuritic plaques, and neurofibrillary tangles (Kaplan, 1979), and the etiology of the brain changes is basically obscure. Simple senile dementia is said to be present when intellectual and cognitive impairments, in differing degrees of severity, occur in the presence of an otherwise normal personality structure, without associated psychopathology of any noticeable degree (Pfeiffer, 1977). Because the clinical symptoms of the various senile brain diseases are similar, diagnosis of any given syndrome can be quite difficult. Many patients receive a diagnosis of Alzheimer's disease, which can also be an early-onset syndrome (Pfeiffer, 1977), when in actuality the definitive diagnosis of Alzheimer's is only available through autopsy (Bootzin & Acocella, 1980).

The organic brain syndromes, including Alzheimer's disease, as well as the functional psychiatric disorders are the major mental disturbances responsible for the institutionalization of the psychogeriatric patient. In the institutional setting, intervention and treatment are commonly based on the medical model of treatment, which rests on the assumptions that abnormal behavior is symptomatic of underlying causal factors, that therapy should consist of removing the basic underlying causes, both emotional and physiological if possible, and that "legitimate" therapy can be administered only by a psychiatrist or psychologist (Bootmin & Acocella, 1980; Cautela, 1966). Under the medical model, treatment typically consists of physical

intervention in the form of chemotherapy, psychosurgery, or electronconvulsive therapy and either individual or group psychotherapy (Cautela, 1966; Eisdorfer & Stotsky, 1977).

Of the physical interventions, the use of pharmacological agents, or chemotherapy, is the most widely utilized for the treatment of psychiatric disorders in later years (Eisdorfer & Stotsky, 1977). The use of drugs as a form of treatment is not without hazard in any patient population, but chemotherapy can be particularly detrimental in the psychogeriatric patient. The management of medication for the older patient is complicated by slowing metabolism in the patient (Eisdorfer & Stotsky, 1977; Salzberger, 1981). While, as Janowsky, El-Yousef, and Davis (1974) observe, the side effects of drugs used to treat the elderly patient are basically the same as those occurring in younger patients, the elderly generally have decreased tolerance to psychotropic drugs. Physiological changes such as decreases in enzymes for drug transport and arterial blood flow may diminish the effects of oral medication. Decreased hepatic capacity to detoxify and a decrease in renal capacity to excrete drugs may cause sensitivity to psychotropic drugs and drug toxicity (Eisdorfer & Stotsky, 1977). As previously noted, such toxicity may itself be responsible for the onset of an acute organic brain syndrome. Drug intervention in the elderly patient must be undertaken with care; as Salzberger (1981) points out, the goal of drug treatment often is not the complete elimination of anxiety or other affective

symptoms because "attempts to achieve such a goal may lead to a drug dosage that carries a high risk of adverse effects and unwarranted dependency" (p. 153).

There are several commonly utilized groups of psychoactive drugs which are employed in the intervention of the psychiatric disturbances affecting the elderly. Each of these substances is associated with its own risks and side effects in geriatric use, and in many cases, the use of these drugs is contraindicated entirely in the psychogeriatric patient (Eisdorfer & Stotsky, 1977).

Eisdorfer & Stotsky (1977) classify the psychotropic drugs used in the treatment of the functional psychiatric disorders according to their areas of effectiveness. The antidepressive drugs are probably the most commonly used in the elderly, and can be divided into two classes: the tricyclic antidepressants and the monoamine oxidase (M.A.O.) inhibitors (Eisdorfer & Stotsky, 1977). The tricyclics, which include amitriptyline (Elavil) and imipramine (Tofranil), are the more widely used type of antidepressive medication (Janowsky et al., 1974). Patients who appear senile, confused, and depressed often respond dramatically to tricyclic treatment. The tricyclics can, however, exacerbate cardiovascular problems, and neurologic symptoms (incoordination, seizures) can mistakenly be diagnosed as cerebrovascular accidents rather than drug toxicity (Janowsky et al., 1974). The tricyclics can also have anticholinergic effects, such as dry mouth, blurred vision, and the onset of confusional

states (Janowsky, et al., 1974).

The M.A.O. inhibitors, such as Tranylcypramine (Parnate), are associated with a number of debilitating side effects, such as anxiety, nausea, impotence, and headaches, and their use is generally contraindicated in the elderly, especially of cardiovascular disease, hypertension, or the use of other medication is present (Eisdorfer & Stotsky, 1977). M.A.O. inhibitors are associated with particularly distressing hypertensive crises when the patient ingests foods containing tyramine; therefore, the diet of any patient on an M.A.O. inhibitor must be strictly monitored (Janowsky et al., 1974).

Like the M.A.O. inhibitors, antimanic medication can cause particularly severe side effects in the elderly. Lithium Carbonate, the major antimanic drug, has remarkable efficacy in treating manic episodes in bipolar depression, but it can easily reach a level of toxicity in the elderly patient (Eisdorfer & Stotsky, 1977). The major side effects include anorexia, tremor, edema, dysarthria, coma, and occasionally death, and the confused state resulting from toxicity may be mistaken for senility (Janowsky et al., 1974). When administering lithium carbonate to the elderly patient, it is particularly important to carefully monitor the daily dosage to prevent overmedication (Eisdorfer & Stotsky, 1977).

To treat functional disorders other than depression, the antianxiety medications are widely used (Eisdorfer &

Stotsky, 1977). The barbiturates and the benzodiazepines are the most widely prescribed classes of antianxiety drugs, although it is felt by many professionals that the barbiturates, due to their high abuse and addiction potential, are absolutely contraindicated in the aged (Eisdorfer & Stotsky, 1977). The benzodiazepines, of which diazepam (Valium), flurazepam (Dalmane), and Chlordiazepoxide (Librium) are the most commonly used, are less addicting and relatively safe for temporary use in the elderly patient (Janowsky et al., 1974). Older patients generally require about half the average adult dose, however, due to metabolic changes associated with aging (Salzberger, 1981).

Treatment for the severe functional disorders, including schizophrenia, typically consists of one of the antipsychotic medications, of which the phenothiazines are the most common (Janowsky et al., 1974). The phenothiazines, which include thioridazine (Mellaril) and Chlorpromazine (Thorazine) can have a number of extrapyramidal side effects, such as tremors, and anticholinergic effects as well (Eisdorfer & Stotsky, 1977). The long-term use of antipsychotic medication is also associated with one of the most tragic side effects, tardive dyskinesia. Dyskinesia, which appears to occur more frequently in the older female, is characterized by involuntary, gross, buccolingual and facial movements (Janowsky et al., 1974).

Withdrawal of medication exacerbates the condition, which is generally permanent. Some professionals feel that

phenothiazines of any sort are contraindicated in the aged because of the risk of tardive dyskinesia (Salzberger, 1981).

Like the functional psychiatric disorders, the organic brain syndromes, associated with cognitive impairment, are commonly treated with a variety of medications. The cognitive acting drugs include vasodilators, such as hydergine; psychostimulants, including pentylenetetrazol; the neuro-peptides; and the neurotransmitters, such as Deanol and lecithin, which has been found to be useful in managing Alzheimer's disease (Reisberg, Ferris, & Gershon, 1981). The side effects of the cognitive acting drugs are generally insignificant in light of their efficacy in the management of the organic brain diseases, and it should be noted that chemical intervention is generally the therapy of choice for the treatment of the organic brain syndromes (Reisberg et al., 1981).

In addition to physical intervention of psychiatric disorders in the aged, psychotherapy and counseling for the psychogeriatric patient are frequently practiced in institutions, as incorporated under the medical model. Psychotherapy can be either administered individually or in groups, and both techniques have their advantages and drawbacks for the psychogeriatric patient (Eisdoffer & Stotsky, 1977).

Individual psychotherapy can have its advantages for the therapist as well as the patient. As Cohen (1982)

observes, older patients are more realistic about their expectations of therapy and are "grateful" of individual attention. Goodstein (1982) explains that the elderly can bring into therapy their vast experience with life and people and are more direct in their comments and open in their expressions. Many elderly patients have common fears of illness, loneliness, aging, and death, as well as craziness and dependence; these differences require certain adjustments in the therapist's style and awareness, but such modifications are not limiting to the quality of therapy, and indeed may enhance it (Goodstein, 1982).

In spite of the positive experiences which can evolve from therapy with the psychogeriatric patient, many therapists carry resistances to undertaking therapy with the elderly (Lewis & Johansen, 1982). Lewis and Johansen (1982) view such resistance as stemming from either cognitive misunderstandings on the part of the therapist of the "phenomenology of normal aging and the nature of age-specific adaptive coping mechanisms (p. 504) or the failure of the therapist to respond to the affective component of the patient's dilemma out of fears of arousing unresolved feelings about the therapist's own aging and death. Cautela and Mansfield (1977) assert that the therapist may feel that his or her time and effort is being wasted when the client is likely to die in a few years anyway. Certainly, such an attitude is not thoroughly pervasive, but it is indicative of a history of general reluctance and hesitation on the part

of the mental health professionals to accept the elderly as candidates for individual psychotherapy.

Some of the problems of individual therapy with the elderly can be remedied by the use of group therapy or counseling. Group therapy offers the psychogeriatric patient the opportunity to see that many of their problems are shared by their peers (Zgliczynski, 1982). In addition, group methods of treatment are less costly and often more readily accepted by the elderly (Eisdorfer & Stotsky, 1977).

Lesser, Lazarus, Frankel and Havasy (1981) suggest that when setting goals for group therapy, the therapist should keep them fairly modest, aiming at first only for the patients to be able to sit through a session and discuss common concerns. If problems such as silence on the part of the participants, pseudoconfusion, the discussion of nongroup issues, or reluctance to attend are manifested by the group, Lesser et al. (1981) suggests using reminiscence therapy, which they found to lead to the earlier establishment of group cohesiveness and interaction than the traditional format of group therapy.

In the institutional setting, the most widely used interventions and treatments for psychiatric disorders in the elderly, chemotherapy and psychotherapy, are based upon the assumptions of the medical model of psychopathology. There is presently, however, an ever-growing body of evidence to suggest that a more appropriate and effective approach to the treatment of the psychogeriatric patient may sometimes

be one based on classical learning theory, or the behavioral model. This approach focuses primarily on changing specific behaviors and on the environmental variables that maintain the behaviors, rather than centering on some underlying cause for the behaviors (Cautela & Mansfield, 1977).

The use of behavioral therapy with the elderly has several advantages over conventional forms of therapy. First, there is no time unnecessarily spent on determining the relevance of long past experiences as the underlying cause of present behavior; rather, the present behavior is the target for change and the focus of the therapy is on the present, immediate intervention of the behavior (Cautela & Mansfield, 1977). Second, older people seem to respond better to behavioral rather than psychodynamic approaches to treatment (Evans & Juareguy, 1981); most of the disorders affecting the institutionalized population have the potential for responding to behavioral intervention, including some organic brain syndromes, depression, and chronic, long-term psychiatric disturbances (Brink, 1982; Cautela & Mansfield, 1977).

The most commonly used format of behavioral therapy is behavior modification based on operant conditioning principles (Cautela, 1966). Under the operant conditioning model, it is assumed that all abnormal behavior, unless organic in nature, is due to faulty learning. To change the abnormal behavior to some desired behavior, the therapist provides positive reinforcement upon the display

of the desired behavior, and either withholds positive reinforcement or provides negative reinforcement when the undesirable or abnormal behavior is exhibited (Cautela, 1966). The most convenient means for providing reinforcement is generally through the use of a token economy, in which the patient usually participates continuously for fairly long periods of time (Cautela, 1966). In the token economy, the ward employees are integral to the treatment program, providing the great majority of the reinforcement. This staff involvement contrasts with that associated with conventional therapies, in which only the psychiatrist or psychologist is actually involved in therapy and the staff provides mainly custodial care (Cautela, 1966).

Behavior modification therapy has been successfully utilized in the treatment of a broad range of disorders and disturbances, from schizophrenia (Atthowe & Krasner, 1978; Hoyer, Kafer, Simpson, & Hoyer, 1974) to the organic brain syndromes (Rinke, Williams, Lloyd, & Smith-Scott, 1978). In a pioneering study, Atthowe & Krasner (1968) found that an entire ward (60 male subjects) of schizophrenic and brain-damaged patients showed significant improvements in a number of areas after participating in a two-year token economy program. Geiger and Johnson (1974) document the improvement of undesirable eating habits in six psychogeriatric patients through the use of a token economy program. Behavior modification has also been used to treat compulsive urination in an elderly subject (Hood, 1981) and to reinstate verbal

behavior in geriatric schizophrenic patients (Hoyer et al., 1974).

In spite of a number of successful treatments, behavioral therapy is not without its share of criticisms, as with any type of treatment. One of the major criticisms of behavior modification programs is that they have little relevance to real life situations, although Atthowe and Krasner (1968) maintain that one can successfully design a behavior modification program in which transfer of training occurs due to social reinforcement. Token economies have been accused of using juvenile reinforcers and of being manipulative, to which Geiger and Johnson (1974) reply that the patients chose the reinforcers themselves, however juvenile, and that in any behavior modification program, the patient should be allowed to discontinue the program if he or she is obviously not making any headway after a given time. Behavior modification, like any form of therapy, should steadfastly avoid any punitive undertones (Bootzin & Acocella, 1980).

The elderly psychiatric patient represents a challenge to the mental health profession. Because of the impact of age-related changes, both physiological and social in nature, the etiology of psychiatric disturbances is unique to the population. Assessment, intervention, and treatment must be tailored toward the special needs of the older patient, whether the model of disorder is medically based or behaviorally oriented. Both modalities have a place in

geropsychology; it becomes the task of the mental health professional to successfully integrate the two, so that whatever the dynamics of a geropsychiatric disturbance, the most appropriate and effective treatment can be utilized.

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