THERAPEUTIC CONSIDERATIONS IN PSYCHOSES OF OLD AGE*

BY GEORGE F. ETLING, M. D.

It is not surprising that the aged as a class are making increasing demands on the medical profession. The continued advances of medical science in the field of acute infectious disease have spared the lives of many young and middle-aged persons who formerly died of epidemic disease. The contributions of research workers in medicine, chemistry and pharmacology have made possible the utilization of vitamins, hormones and important drugs in combating disease processes. As a result, the average individual life expectancy has been increased. The chronic illnesses usually associated with old age now constitute a greater challenge to the general practitioner as well as to the specialist. Malzberg and Elkin1 in their statistical studies agree that there has been a definite increase in the number of patients suffering from the psychoses of old age. Meyerson1 states that "no matter how far off we put the senium, by whatever new therapeutic agents we bring into use, it is obvious that old age will come sooner or later and that in many instances it will be associated with a mental breakdown." With the increase in the number of first admissions of patients with psychoses due to senile and arteriosclerotic processes to State hospitals, it is reasonable to assume that there is a corresponding increase in patients receiving treatment at home by the general practitioner, the internist and the psychiatrist.

The early manifestations of mental changes attributable to cerebral arteriosclerosis are headaches, general nervousness, dizziness, fainting spells, buzzing in the ears, personality changes, and an increasing emotional lability. Henderson and Gillespie2 point out that a very common mode of onset is an apoplectic seizure of major or minor character and that mental symptoms often date from such an episode. Careful examination of the sensorium will elicit definite memory defects which may vary from time to time in their intensity. Cases of this kind may be treated at home under the direction of a psychiatrist. Patients showing more advanced signs of mental impairment, such as increasing irritability, impulsive behavior, delusions of a paranoid nature, apprehension and depres-

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sion, nocturnal excitement, confused, delirious or apoplectic states, will eventually require hospitalization. In early cases where the degree of mental deficit is slight, and there has been no transient disturbance of consciousness or convulsive seizures, Diethelm\textsuperscript{a} feels that the patient may continue to work, but that the working hours should be shorter than usual and interspersed with rest periods and well planned recreation. Occupations in which the patient may endanger himself or others must be prohibited.

A complete physical examination should be made before the general psychotherapeutic regime is established. Foci of infection should be eliminated and cardiorenal disease, hypertension and other coexisting disease processes should be treated in a manner which will not cause the patient any undue concern. The patient should be encouraged to keep up his personal appearance and to continue with his regular habits. Where there has been a noticeable letdown in recreational activities, these should be stimulated and an effort made to keep the patient’s interest at a normal level. The diet should be well-balanced, adjusted to the patient’s needs, and contain a sufficient amount of essential vitamins. Undernourished patients require extra nourishment and stimulating tonics. Overeating should be avoided and prohibited where hypertension exists. Sufficient fluid intake, exercise and abdominal massage aid greatly in stimulating regular bowel elimination. Where constipation is a factor, laxatives or cathartics should be used as necessary. In nocturnal restlessness and insomnia, warm drinks or sedatives such as phenobarbital grs. $1\frac{1}{2}$, sodium bromide grs. 5 or 10, or barbital derivatives such as alurate are indicated. Alcohol should be avoided, as convulsions upon an arteriosclerotic basis are frequently precipitated by alcohol, even when taken in small amounts. Psychotherapy in the form of suggestion and persuasion should be tried in accordance with the intelligence and personality of the patient. In many cases, the unconscious fear of growing old and the awareness of sensorial defects tend to aggravate the patient’s symptoms. A sympathetic explanation of physiological changes and their relations to the patient’s symptoms and reactions is sometimes very helpful.

Although the differentiation between the arteriosclerotic and the senile is at times difficult, the arteriosclerotic may be characterized