Behavioral, Social and Mental Health Aspects of Home Care for Older Americans

Mary S. Harper, PhD, RN, FAAN

INTRODUCTION

When the "report card" for the 20th century is finally written, it will conclude that the greatest factor in shaping the health care delivery systems for the 20th century will be the rapid increase in the number of older Americans.

Actually 5500 people celebrate their 65th birthday each day; that is, about two million persons celebrated their 65th birthday in 1986. In the same year, about 1.4 million persons 65 plus years of age died, leaving a net increase of over 560,000 people (1550 per day). The number of older Americans increased by 2.3 million or 10 percent since 1980 compared to an increase of 4 percent for the under 65 years of age population.

Since 1900, the percentage of Americans 65 plus years has tripled (4.1 percent in 1900 to 12 percent in 1986) and the number increased nine times (from 3.1 million to 28 million).

The older population itself is getting older. In 1986, according to the Census Bureau the 65-74 age group (16.7 million) was over seven times larger than it was in 1900; the 75-84 age group (8.6

Mary S. Harper is Coordinator, Long Term Care Programs, Mental Disorders of Aging Research Branch, National Institute of Mental Health, U.S. Department of Health & Human Services, Rockville, MD.

Home Health Care Services Quarterly, Vol. 9(4) 1988

million) was 11 times larger; and the 85 plus years group (2.7 million) was 21 times larger (AARP 1985).

The elderly population, particularly the disabled elderly, represents one of the biggest challenges to health and social services in this nation today.

The number of persons over 65 years of age is currently about 28 million or about 12 percent of the total population; however, they use about a third of the total health care budget, which is really half of the Federal health care budget, and approximately a third of the nation's one million acute care hospital beds and about 90 percent of its 1.5 million nursing home beds (Libow 1986; HCFA 1986; Saldo et al. 1985).

The elderly population is more at risk of incurring illnesses, multiple disabilities, resulting functional limitations and psychopathology than are younger persons. This results in a large proportion of the handicapped and chronically impaired elderly who have major physical, mental, social, and independent living deficits.

The following data illustrate the status of the elderly in America:

- Eighty-six percent (86%) of all elderly persons suffer from one or more chronic conditions of varying degree of severity (Brody & Ruff 1986; Williams 1986).
- Fifty-six percent (56%) of those over 75 are limited in activities of daily living due to chronic conditions.
- In 1981, 32.6 percent of all expenditures and 51.7 percent of the public expenditures were for the elderly (Kovar 1986).
- Approximately 50 percent of the physically-handicapped elderly also have psychiatric disabilities severe enough to warrant assistance (Brody & Ruff 1986).
- The majority of persons over age 65 and living alone are eventually institutionalized (Weiss 1982).

Therefore, we really have a greying of America which offers challenges to health care delivery systems, educators of health care providers, families of the elderly, public policy makers, third-party payers and the general society.

HOME HEALTH CARE

In addition to the rapid growth in the number of older Americans and the increase in demands for health and social services, there has been a shifting of health service delivery from the hospital to community-based services such as surgi-centers, emergi-centers, adult day care, nursing homes without walls, and home health care. In this article I shall focus on home care and/or home health care.

Home health care is the fastest growing segment of the health care delivery system. The number of home health agencies certified under Medicare increased by more than 50 percent between 1982 and 1984, reaching a total of 5,237 agencies in 1984. The greatest growth occurred in investor-owned agencies: their number increased 300 percent during this same period.

The total number of home care agencies, both Medicare and non-Medicare certified, ranges from 8000 to 10,000 with at least 17,000 providers (American Bar Association Report 1986; Levit 1985; Woods 1984; Morris 1984).

Home health care products and services grossed an estimated $9 billion in 1985, with a projected expansion to $16 billion for 1990 (70 percent of the total is for services) and $24.8 billion by 1995 (American Bar Association Report 1986).

In 1982, Medicare spent $1.3 billion and Medicaid spent $495 million on home health. Other federal programs spent $950 million. While constituting only three percent of the overall Medicare budget, home health expenditures have grown dramatically under Medicare at an annual rate of 34 percent between 1980 and 1984. Since 1980 Medicare home health expenditure has doubled from $772 million to $1.5 billion in 1983 (Doty 1985).

Although home health care has grown by "leaps and bounds," the quality of care has not kept pace with its growth. The quality of care varies from state to state. Only 34 states including the District of Columbia require licensure; six states do not have final regulations as of June, 1986. Currently, no articulated, well-formulated national policy exists that attempts to meet the health and social needs of the frail, older Americans (Palley & Oktay 1983). There is a lack of quality assurance (i.e., standards for quality of care, accreditation, monitoring for safety of care, mandatory training of

home health aides and/or homemakers); only 13 states include in the licensure laws minimum hours and minimum curriculum content requirements for training of home health aides.

In the literature, home health care is frequently described as fragmented and lacking in continuity. Since the implementation of the prospective payment system/diagnostic related group (DRG), in-home skilled nursing increased 196 percent and case management service units increased 365 percent (Harlow & Wilson 1985).

BEHAVIORAL, SOCIAL AND MENTAL HEALTH/MENTAL DISORDERS OF OLDER AMERICANS

Two learned demographers (Taube and Redick 1980) have said that we have never had a good, well-documented prevalence study of mental illness in the elderly. However, I have reviewed at least one dozen clinical experts who quote prevalence rates among the elderly.

Community studies attempting to assess the incidence and prevalence of psychiatric disorders and the levels of psychosocial functioning in the elderly population have reported varying rates, often depending upon the criteria used to define the impairment. Only a few studies have been directed specifically to the measure of mental morbidity in the community elderly population. Abrahams and Patterson (1978) found and incidence of 17 percent for psychological impairment in their Boston community sample of 445 people age 65 years old or older. An incidence of 15 percent for severe and moderate psychological impairment among the elderly in San Francisco was reported by Lowenthal and Berkman (1967).

Blazer and Maddox (1984) of Duke University selected a stratified sample of 1 in 10 persons in Durham County, North Carolina for study. Eighty-five percent of the sample agreed to participate. They found 13 percent (1300 people age 65 plus years or older) of the sample were suffering from an impairment in mental health at the time of the survey, as measured by the mini-mult (a short form of the MMPI), OARS, and questions used in the interview to assess mental health and life satisfaction. Further analysis of the data reveals that approximately seven percent of the community residents

had definite cognitive impairment, 2.3 percent had symptoms of a major depressive disorder as defined by the Diagnostical Statistical Manual (DSMIII) and 14 percent perceived their physical health as poor where it was actually good (Blazer & Hoyt 1979) and (Luke 1982).

Kutner et al. estimated the prevalence of present, recognizable emotional troubles to be in the range of four percent to 18 percent in a survey of 400 New York City residents over the age of 60. In the same sample, nearly 20 percent reported being "frequently troubled by nervousness" (Kutner 1956).

The prevalence of functional psychiatric disorders among the elderly has also been studied by physicians in general practice. Kessel and Shepherd (1962) found that the prevalence of neurosis remained surprisingly constant throughout adult life – at a level of 10 percent of the population at risk among men and 15 percent among women.

It is generally accepted that both mental illness and behavioral and social problems become more prevalent with age. Indeed, rates of severe mental illness, organic mental syndromes, and suicide are much higher in those 65 and over than among any other age groups (Talbott 1985; Osgood 1985; Branch 1981).

It is generally estimated by mental health experts and providers that fully 18-25 percent of the elderly have significant mental health symptomatology and it increases with age (Wasylenski 1982). On the other hand only four percent of the patients using community mental health centers (CMHC) are elderly, and only 1.5 percent of the mental health expenditures go to the community (Taube & Barret 1985).

In the consideration of mental illness and the behavioral and social problems of the elderly in the United States, it is important to remember several things, such as:

- Many elderly persons are not given a psychiatric diagnosis because of the stigma associated with mental illness (Leeper 1985).
- Many elderly are not given a psychiatric diagnosis because of reimbursement policies of major insurers and reimbursement agencies (Gattozzi 1986).

- Many institutions, nursing homes, home health care agencies, community hospitals, major medical centers, and adult day care centers will not accept an elderly patient with a psychiatric diagnosis and/or behavioral problems because he or she might be "troublesome" to the staff.
- Some long-term care facilities will not be reimbursed if more than 50 percent of their patients have a primary psychiatric diagnosis and they are classified as an Institution for Mental Disease (IMD) (Jazwiecki & Press 1986; HCFA 42USC; HCFA 1982; Gattozzi 1986).
- If the patient is on Medicaid and has a behavioral, social, or mental disorder, he may not have access to services in some home health care agencies.
- Many home health agencies (HHA) do not have trained mental health staff or access to mental health consultation.
- Some of the home health care agencies have a policy not to admit patients with behavioral and mental disorders.
- For several reasons, many of the patients in the community will be on heavy doses of psychotropic drugs over an extended period of time without having a behavioral or psychiatric diagnosis (Burr 1985; Nickens 1986). At times, the psychotropic prescription may serve as proxy for a behavioral or psychiatric diagnosis in making a survey and assessing the health status of older Americans.
- Most studies of the health status of older Americans have been self report studies. The elderly generally perceive themselves as being in good health as long as they are able to function in the major activities of daily living. On several occasions, medical conditions and psychopathology not interfering with the functional status of the elderly have been found upon comprehensive physical and mental examinations (Brody 1983). The elderly have a tendency to deny their illness or distress.

There have been several studies which have not found a high prevalence of the classical DSM III psychiatric diagnoses (Regier & Taube 1978).

In order to get a conceptual framework for health and mental

illness in the elderly, I would like to offer the following definitions/ concepts:

- Health for the elderly may be conceptualized as the ability to live and function effectively in society and to exercise maximum self-reliance and autonomy; it is not necessarily the total absence of disease.
- I define mental illness as occurring at that time when a cluster of behavioral signs and symptoms come together and become overly disruptive of the elderly person's ability to function effectively in the mainstream of his/her family and community (Menolascino 1986).

In a national survey of 4003 home health care agencies in 1983, it was found that 70.6 percent did not provide mental health services, although there's a range of 18 percent to 56 percent prevalence rate of behavioral, social and mental disorders among the elderly living in the community; and the prevalence rate increases with age (Select Committee on Aging 1984). It has been estimated that the average age of the patient cared for by the Visiting Nurses Association (VNA) is 76. In a survey of 237, elderly people in the greater Los Angeles area 11 percent of the administrators indicated that their staff needed "post-RN education" in psychosocial skills, and six percent indicated that they needed training in geriatrics (Cruz 1986).

Therefore, in this article, I would like to address the most common behavioral, social and mental disorders in the elderly which offer a challenge for the home health nurse, home health aide, informal caregivers and other caregivers as well as providers of primary care in the community and institutional settings.

I have listed, from my survey, the literature and anecdotal reports, some of the behavioral, social and mental disorders which home health care providers and family caregivers have found both common and challenging:

- Confusion/delirium (Lipowski 1983; Seymour 1980)
- Wandering/restlessness (Snyder 1978; Rader 1985)
- Cognitive/memory impairment, forgetfulness (Reisberg 1984; Thompson 1986)

- Depression/sadness/self-deprecation
- Loneliness (Eisenberg & Rodney 1986; Laurent 1985; Minot 1985)
- Feelings of hopelessness
- Frequent crying spells
- Suicidal impulses/expressions of a wish to die (McIntosh 1985; Shylman 1978)
- Paranoid delusions
- Behavioral and/or emotional problems associated with poor physical health and/or drug-drug interaction resulting in toxicity and other adverse drug reactions (Solomon 1981; Gurman 1987)
- Assaultiveness
- Agitation
- Dementia (Henderson 1985; Hays 1985; Robertson 1982; Larson 1984)
- Hyperactivity (Finestone 1982)
- Confusion associated with post-surgical care of hip fractures and falls (Campbell 1986; Furstenberg 1986; Surgeon General 1983)
- Prolonged grief accompanied by clinical symptoms (Goodstein 1986)

PSYCHOSOCIAL ASSESSMENT OF THE ELDERLY IN THE HOME

In this article, I shall concentrate on psychosocial assessment. I am aware of the fact that psychosocial assessment and physical assessment are not distinct entities. Invariably, we are assessing psychosocial behaviors in every physical examination and/or observation.

The elderly are different from the young in many ways. In general, they have less physiologic stamina for coping with stress, functional losses and illnesses. They tend to have many chronic conditions and functional losses.

Several characteristics of the elderly complicate their assessment:

- Multiple organ pathology
- Polypharmacy
- Presence of significant symptoms (pain may not be a helpful indicator of pathology in an older person). For instance, a myocardial infarct may occur without the usual substernal crushing chest pain. The elderly will frequently describe their condition in non-specific terms, such as "I feel bad all over" (Besdine 1983; Griedman 1986).
- The elderly have a tendency to rate their health status as good.
- Laboratory values are frequently atypical (Gupta 1986; Dye 1985; Shapleigh 1985).
- Multiple chronic conditions
- Responses to stress, grief and anxiety
- Age-related physical, biochemical, and physiologic changes upon which medical illnesses are superimposed. These medical illnesses may then cause, exacerbate and even be confused with psychiatric symptomatology.

In the case of the patient whose chronic and acute medical conditions may produce a myriad of symptoms, it can be a formidable task to distinguish psychological symptoms from physical symptoms. Several studies have shown a close relationship between physical symptoms and psychopathology in the elderly (Pfeiffer 1973; Mezey 1980; Gurland 1982; Ouslander 1982; Salzman 1978).

Symptoms such as fatigue, "passing out," apathy, anorexia, seizures, insomnia, headache, constipation, abdominal and other more diffuse pain represent a wide range of human reactivity to psychological disorders as well as to physical illness (Ouslander 1982; Dorpat 1968; Gurland 1982; Schwab 1967).

Some of the medical illnesses (conditions) associated with depression include (Friedman 1986; Slaby 1986):

- Cancer of the pancreas
- Digitalis toxicity
- Multiple sclerosis
- Steroid toxicity
- Diabetes mellitus
- Arteriosclerosis

- Low serum potassium
- Several losses (next of kin, or precious possession)

Some medical illnesses (conditions) associated with violent behavior include (Friedman 1986):

- Degenerative brain disease
- Delirium
- Hypoglycemia
- Temporal lobe epilepsy
- Homosexual panic
- Drug withdrawal (e.g., sedatives)
- Migraine equivalent
- Paranoid schizophrenia
- PCP-induced psychosis
- Side effects of barbiturates, benzodiazepines and tricylic therapy

Some medical illnesses (conditions) associated with disorders of thought (Friedman 1986):

- Digitalis toxicity
- Alzheimer's disease
- Hypothyroidism
- Anticonvulsant intoxication
- Anti-psychotic medication toxicity
- Alcoholic paranoia
- Bacterial meningitis
- Huntington's chorea
- Anti-malarial toxicity
- Delirium after cataract surgery
- Lead intoxication
- Withdrawal from barbiturates, benzodizepines and tricyclic antidepressants
- Cerebro arteriosclerosis
- Bromide intoxication
- Niacin deficiency
- Schizophrenia
- Elevated temperature

Some illnesses (conditions) associated (presenting) with anxiety include (Friedman 1986; Slaby 1986):

- Caffeinism
- Hypertension
- Hypocalcemia
- Glue sniffing
- Homosexual panic
- Hypoglycemia
- Mitral valve prolapse
- Phobias
- Thyrotoxicosis
- Cocaine intoxication
- Alcohol withdrawal
- Barbiturate and other drug withdrawal
- Internal hemorrhage
- Acute anoxic states (pulmonary, e.g., embolus)
- Prolonged high temperature

The elderly are especially susceptible to the anger, guilt, depression and delirium (confusion) that follow acute and chronic illnesses. For many elderly, acute medical illnesses superimposed upon multiple, preexisting, chronic conditions result in loss of function, independence and self-esteem, and fear of death. One study found that 85 percent of those over age 60 who had committed suicide had had an active physical illness, and that in 70 percent of these patients the illness had contributed to the suicide (Osgood 1984; Osgood 1985; McIntosh 1981).

There is a complex relationship between physical illness, biological age-related changes and psychopathology which must be considered in caring for the elderly in the home.

A multidisciplinary team approach to assessment has been found to be beneficial. A standardized assessment protocol or instrument is very useful. Unfortunately, very few instruments and/or protocols include psychosocial assessment.

The essential and crucial components of comprehensive assessment include (Williams 1983):

- Physical functioning
- Mental and emotional functioning
- Family and social support
- Environmental characteristics
- The need for specific medical or rehabilitative therapies such as incontinence, physical therapy, etc.
- The potential for productive or personally rewarding use of time.

An outline for psychosocial assessment in the home should include (Katzman 1963):

I. Profile of the Elderly
   - name, address, date of birth
   - marital status
   - current household members (age, relationship, sex)
   - income and insurance
   - nearest of kin (responsible adult)
   - occupation (retired, unemployed, housewife, etc.)
   - veteran status
   - self-assessment of life style
   - self-assessment of health

II. Presentation Problem(s)
   - precipitating, predisposing and contributory factors
   - previous physical, behavioral, social and mental disorders

III. Mental-Emotional Status Alterations
   - stressors (bereavement, retirement, decreased income, recent loss of functional abilities, recent losses of family member, property, housing, material goods, family support, etc.)
   - changes in behavior, interpersonal relationships, mood, memory, level of orientation, attention span, thought process
   - recent crises
   - sudden change in lifestyle
   - drug and alcohol abuse

IV. Strong Preoccupations or Altered Thought/Processes
   - fears

- phobias
- hypochondriasis
- feelings of worthlessness
- feelings of hopelessness
- low self-esteem
- self-image
- life satisfaction and concerns
- delusions
- obsessions
- speech (rapid, blocking, stuttering, coherent, incoherent, etc.)
- doubting and indecisiveness
- flight of ideas
- impaired insight
- ideas of reference

V. Cognitive Functioning (Coates 1963; Folstein 1975)
- level of orientation (time, place)
- cognitive impairment
- attention span and concentration
- insight into illness
- judgments (social, moral, ethical)
- capacity for abstract thinking
- capacity to understand abstract thinking or statements
- attitude toward old age
- attitude toward frail health
- diminished memory, orientation and judgment
- memory: recent and remote, recall and retention

VI. Family
- how the family members interact
- relationship with caregiver(s)
- attitude toward frail elderly
- insight into the patient's illness
- family strength and coping capabilities
- kinds of behavior which "upset" the family and primary caregiver
- what is the patient's and family's perceived ability to cope with the scope of care required?
- how does the family perceive the patient's behavior (de-

pressed, agitated, cooperative, acting out, wandering, suspicious, hostile, overly critical, guilty, etc.)?
- are there other stresses on the family?
- has the patient undergone psychological testing? If so, what were the results?
- behaviors which are worrisome to the family
- behaviors and lifestyles in the family which are worrisome to the patient (elderly)

In addition to the interview of the patient and family, there are some standardized tests which can be administered in the home and scored by the nurse who has been properly trained.

Some tests for psychosocial assessment in the home include:

- Mini Mental State (MMS) (Folstein 1975)
  (The Mini Mental Status Scale has eleven [11] questions requiring only 5 to 10 minutes to administer. Validity and reliability have been documented on patients with dementia syndrome delirium, affective disorders, pseudo-dementia, mania, schizophrenia, and personality disorders. It requires no test kit or special training. The last part of the test [reading and writing] is difficult for visually impaired or illiterate elderly.)
- Hamilton Rating Scale for Depression (HAM-D) (Hamilton 1960)
- Zung Self-Rating Depression Scale (SDS) (Zung 1973)
- Older American Resources and Services Multi-Dimensional Functional Assessment Questionnaire (OARS) (Duke University 1978)
- Instrumental Activities of Daily Living (IADL) (Lawton 1969)
- Katz Adjustment Scale (KAS) (Katz 1963)
- Mental Status Questionnaire (MSQ) (Kahn & Goldfarb 1979)
  (The MSQ consists of 10 questions covering orientation, memory and general information which have been found to be valid and reliable indicators of mental status. No partial score for nearly correct answer.)
- FROMAJE (Libow 1981)
  F—Function is self-care ability
  R—Reasoning is measured by proverb interpretation

O—Orientation
M—Memory (remote and recent)
A—Arithmetic (counting and serial subtraction)
J—Judgment (patient is asked to solve a hypothetical problem)
E—Emotions are assessed by patient's behavior during the interview

Note: Errors are scored: 13 or more signals severe dementia; 11-12 moderate; 9-10 mild. This is not a useful test for aphasic patients.

Set Test (Hays 1983)

The client is asked to list 10 items from each of four groups:
fruits
animals
towns/cities
colors

(The maximum score is 40. Scores under 15 are correlated with a clinical diagnosis of dementia. Scores between 15 and 24 show less association with dementia. The developers feel that categorizing, counting, naming and reimbursing items demonstrate motivation, altertness, concentration, short-term memory, and problem solving.)

- Global Deterioration Scale (GDS) (Reisberg 1982)
  (Seven clinically distinguishable stages of normal aging and progressive Alzheimer's disease are described and used—7 stages of cognitive decline are assessed.)
- Functional Assessment Status Test (FAST) (Reisberg 1985)
- Brief Cognitive Rating Scale (BCRS) (Reisberg 1985)
- Sandoz Clinical Assessment Geriatric Scale (SCAGS) (Shader 1974)
- Index of Independence in activities of daily living (Katz, Ford & Moskowitz 1963)
- Physical and Mental Impairment of Function Evaluation (Gurd, Lenn & Lenn 1972)
- Global Deterioration Scale (GDS) (Reisburg 1984; Reisberg 1982)
- Functional Assessment Stages Test (FAST) (Reisberg 1985)
  (Provides information about the general onset, course-diag-

nosing of staging with respect to severity of uncomplicated dementia of the Alzheimer's type.)

- The Mental Status Examination (MSE) (Mueller 1984)
  (MSE assesses a patient's orientation, attention, feeling states, thought patterns and specific cognitive skills. The instrument has 9 items and is easy to score.)
- The Psychological Mental Health Index (PMHI) (Ulin 1981)
  (The PMHI is a 10 item subscale of the general well-being and distress of noninstitutionalized adult population.)
- Mental Status Questionnaire (MSQ) (Goldfarb 1974)
  (The MSQ consists of 10 items to assess orientation, memory, and general information and it has been found to be a reliable indicator of mental status.)

Scoring of MSQ:

Number of errors	Presumed Mental Status
0-2	Organic mental syndrome, absent or mild
3-5	Organic mental syndrome, mild to moderate
6-8	Organic mental syndrome, moderate to severe
9-10	Organic mental syndrome, severe
Non-testables	Organic mental, severe

- Community Assessment Guide
  (CAG) (1975)
- Home Assessment Guide (HAG) (Remnet 1976)
  (Guide for the assessment of the comfort, safety, family relationship and convenience for A.D.L. [activities of daily living].)
- Comprehensive Assessment and Referral Evaluation (CARE) (Sharpe, Kuriansky & Gurland 1977)
  (CARE is a lengthy multi-dimensional instrument developed to compare health and social problems of the community dwelling elderly.)
- SHORT/CARE (Gurland, Golden & Teresi 1984)
  (Short CARE is an abbreviated version of CARE with 143 items to assess dementia, depression, subjective memory im-

pairment, sleep disorders, somatic symptoms and overall disability.)

- The Burden Interview (BI) (Zarit, Reiner & Bach-Peterson, 1980)
  (A guide to interview for an assessment of feelings of burden of the caregivers.)
- Memory Training and Memory Loss: Effects on Senile Dementia Patients and their Families (Zarit, Reever 1982)
- Assessing the Caregiver Information Needs: A Brief Questionnaire (Simonton 1987)

CHECKLIST/GUIDE FOR CONTINUING CAPABILITY TO KEEP THE ELDERLY AT HOME

The decision whether to keep the patient at home should be based not only on loyalty and commitment but also on the physical and emotional resources of the primary caregiver(s). The following list of general questions will guide or help to evaluate the continuity capability to keep the patient at home:

- Home environment—what can you do to make the home safe and comfortable?
- Is the home large enough, can you rearrange the furniture, are there stairs outside and inside the house? Can you hire help, is outside help available?
- Medical accessibility
- What about ambulance, will the physician make home calls?
- Finances. Can you afford to pay for attendants, nurses, physical therapists and are they available? Will Medicare/Medicaid cover some of the expenses or all?
- Transportation: Can you drive or do you have transportation for daily needs?
- Your health: Are you realistic about your ability to care for the patient at home? Can you put in a 36-hour day without jeopardizing your health?
- Equipment: What do you need to care for someone in your home?
- Family and personal services: Do you have family members

who can share the burden or can you afford to hire trained reliable help?
- General: Are you prepared to care for a relative at home even through the final state of the dementia, when she or he becomes very sick and bedridden? Have you investigated the value, availability, quality, cost/location and staffing of nursing homes?

Several studies have sought to measure and describe the impact on family caring for an Alzheimer's disease person. Researchers unanimously report enormous and prolonged demands. Caring for a person who has Alzheimer's disease/dementia often has an adverse effect on:

- The caregiver's physical and mental health
- The caregiver's participation in recreation and social activities (Robin 1982)
- The family arrangements (George 1984)
- The caregiver's employment status (Ota 1985)
- The caregiver's financial security
- The caregiver's retirement plans

Symptoms of mental impairment, disruptive or "acting out" behaviors, extent of need for personal care, and a number of disruptive behaviors; all increase the caregiver's stress (Poulschock 1982).

- One-third of the caregivers in a National survey of people caring for the disabled or frail elderly rated their health as fair or poor (Stone 1986).
- The Ota study found that 12 percent of the caregivers who were living with the person with dementia reported becoming physically ill or being injured as a result of caring for the person. Thirty-five percent of caregivers who were living with the patient reported becoming very stressed and 11 percent sought the help of a psychiatrist (Ota 1985).

Studies report high levels of depression among caregivers (George 1986; Ota 1985; Wilder 1983). These studies also find that

many caregivers feel angry and guilty and are grieving. They report an increased level of family conflict. People caring for someone with dementia have three times as many stress symptoms as people of the same age who are not caregivers and they report lower life satisfaction. Caregivers used more psychotropic drugs (sleeping medications, tranquilizers, and antidepressants) and more alcohol than comparison groups (Ota 1987).

In the area of assessment, one must be mindful that the elderly may not present their illness the same as a younger patient (Henderson 1985) (see Table 1).

Some of the test and/or assessment guidelines have been described above. In the selection of an assessment test, use caution in determining that the test is valid and reliable for the elderly; in addition, note when it is valid and reliable for a noninstitutional elderly population. Very few tests assess the elderly in the home (noninstitutional setting).

Consent for assessment must be sought, in writing, after fully explaining the nature and purpose of the test and how the results will be used on behalf of the elderly. Indicate who will have access to the scores/results of the test. It may be necessary to let a member of the family participate in the orientation to the assessment procedure(s). Generally, a multidisciplinary and multidimensional approach to assessment is best.

The home health care provider may observe for Social Breakdown Syndromes (SBS). The SBS is a syndrome of social and personal care failure which is thought to occur independently of specific psychiatric diagnosis. The SBS is compared on two dimensions: (A) Functional Level (FL)—usually described as low, minimal, almost adequate and adequate. (B) Troublesome Behavior (TB)—usually described as a very troublesome, moderately troublesome, and not troublesome (Gruenberg 1966). It is very important that the health provider know how the elderly person and the family perceived the behavior. In a study at Johns Hopkins University, it was found that most of the functional limitations and troublesome behaviors occurring in the elderly are unrelated to the presence of a mental disorder in the elderly person. For example, Mr. C., a 72-year-old, has no mental disorder. He is arthritic, almost blind, and has an amputation above the left knee. He must be helped in and out of bed, fed,

TABLE 1

How Illness Changes With Age

Problem	Classic Presentation in Young Patient	Presentation in Elderly
urinary tract infection	Dysuria, frequency, urgency, nocturia	Dysuria often absent, frequency, urgency, nocturia sometimes present. Incontinence, confusion, anorexia are other signs.
myocardial infarction	Severe substernal chest pain, diaphoresis, nausea, shortness of breath.	Sometimes no chest pain, or atypical pain location such as in jaw, neck, shoulder. Shortness of breath may be present. Other signs are tachypnea, arrhythmia, hypotension, restlessness, syncope

pneumonia (bacterial)	Cough productive of prurulent sputum, chills and fever, pleuritic chest pain, elevated white blood count	Cough may be productive, dry or absent; chills and fever and/or elevated white count also may be absent. Tachypnea, slight cyanosis, confusion, anorexia, nausea and vomiting, tachycardia may be present.
congestive heart failure	increased dyspnea (orthopnea, paroxysmal nocturnal dyspnea), fatigue, weight gain, pedal edema, night cough and nocturia, bibasilar rales.	All of the manifestations of young adult and/or anorexia, restlessness, confusion, cyanosis, falls.
hyperthyroidism	Heat intolerance, fast pace, exophthalmos, increased pulse, hyperreflexia, tremor.	Slowing down (apathetic hyperthyroidism), lethargy, weakness, depression, atrial fibrillation and congestive heart failure
depression	Sad mood and thoughts, withdrawal, crying, weight loss, constipation, insomina	Any of classic, plus memory and concentration problems, weight gain, increased sleep.

and usually requires a bed pan twice during the night. Mr. C. was perceived by his family as *very troublesome*. They sought the help of a Psychiatric Mental Health Nurse Specialist after two traditional home health care agencies had terminated his services on two separate occasions because he and the family were "uncooperative" and "troublesome." Therefore, the nurse must know how to assist the family in handling "troublesome" behavior.

The Management of "Troublesome" and "Challenging" Behaviors in the Home

In my survey and in the literature, the conditions, behaviors and illnesses which the home health care providers (including the family) find "troublesome" and "challenging" include:

- Delirium (confusional states)
- Suicidal ideation and attempts
- Wandering and pacing
- Dementia: Alzheimer's type
- Hostile behavior
- Agitation, restlessness
- Depression
- Expressions of wish to die
- Post-hip fracture surgery (disorientation, confusion, agitation)
- Psychotropic Drug Interaction resulting in confusion delirium.

I shall make some comments on each of those behavioral areas which are "troublesome" and "challenging" to home health care providers.

Polypharmacy/Drug Interaction: patients over 65 years of age use more drugs than any other group. Although the elderly constitute 11.9 percent of the general population, they consume about one third (33 percent to 40 percent) of the 1.5 billion prescriptions written annually. By the year 2000, it is estimated that the elderly will consume 50 percent of all prescriptions written annually in the nation (Lamy 1982; Special Committee on Aging 1983).

The World Health Organization (WHO) estimates that 50 percent of all drugs are presently consumed by the elderly (WHO Confer-

ence 1981). Persons over 65 years of age, on an average, use over 14 prescriptions and 3.2 to 5 over-the-counter drugs (OTC) in one year, which is nearly three times the average amount used by persons between the ages of 25 and 54. The older Americans who are hospitalized are given an average of 10 different drugs during each stay in the hospital (Osborn 1985; Craig 1987).

With the simultaneous use of multiple drugs, the incidence of adverse drug reaction (ADR) is likely to increase with the number of drugs used. Between 12 percent and 17 percent of hospital admissions—that is, one out of every six hospital admissions—for persons over the age of 70 are due entirely to ADR. That is compared with only three percent of hospital admissions, or one in 30 or 35, for the entire population.

Drugs are a 25 billion dollar industry and account for the fourth largest health care expenditure. Because Medicare does not cover drug cost, the bulk of this cost comes out of the pocket of the elderly consumer. About 300,000 people are hospitalized each year because of ADR. The estimated national cost of drug-induced hospitalization is nearly 3 billion dollars per year (Lang 1982).

One study found that each patient consumes 4.5 drugs per month; furthermore, the study found 1.3 ADRs per 100 prescriptions filled. By extrapolation, one can calculate at least 30 ADRs per month for 375 subjects when OTC drugs are included (Christensen 1981; Kirking 1986). For example, there is an estimated 27-33 percent chance of adverse drug interaction among persons who consume two or more drugs (Barton 1985). The term drug interaction not only refers to drug-drug reactions, but also to interaction with nutrients and sociologic, psychologic and disease factors. My focus in this paper will be on the psychopharmacologic drugs.

Psychopharmacological drugs are frequently used, overused and misused, possibly because of a lack of knowledge of the pharmodynamics, pharmacokinetics and toxicology of psychotropic drugs (Gottlieb 1978; Lennard 1970).

Psychopharmacologic drugs alter mood, perception, intellectual functions, behavior and consciousness. Unquestionably, the use of psychoactive drugs to regulate personal and interpersonal processes is increasing (Yanchick 1985). While these drugs are powerful in their outcome, they should be accompanied by some form of psy-

chotherapy (milieu therapy, reality orientation, family/patient counseling) as well as a written plan of care used by all health providers including members of the family. One hundred eighty million doses of mood-elevator drugs are prescribed each year (Select Committee on Aging 1985). Most of the people receiving them do not have a psychiatric diagnosis.

In several studies of the noninstitutionalized elderly, the most common drug categories noted were psychotropic drugs, analgesics, cardiovascular medications and diuretics (Kiernan 1981; German 1985; Ray 1986). Therefore home health care providers can expect a high percentage of their patients to be on psychopharmacologic drugs without a pychiatric diagnosis. The principal provider of mental health services to the elderly is the general practitioner (Waxman 1984; Nickens 1986).

Some Geropsychiatric Drugs

Antipsychotic Agents	Antianxiety Agents	Antidepressant Agents
Phenothiazines	Barbiturates	Tricyclic
• Chlorpromazine	• Phenobarbital	• Derivatives
• Promazine	• Diazepam	• Amitripteine
• Haloperidal	• Meprobamate	• Doxepin
• Reserpine	• Chlordiazepoxide	• Impromine
• Thioridazine	• Hydroxyzine	• Nortriptyline
• Loxapine		

Drug-drug interactions involving these drugs are common, as may be drug-disease interactions. For example, caution is indicated when psychotropic drugs are used in dementia, as these drugs may worsen the patient's mental disturbance. Their use can also lead to chronic oversedation which, in turn, can be responsible for such complications as pneumonia, bedsores or dehydration.

Possible adverse effects of psychopharmacologic drugs in the elderly include (Kirking 1986; Lamy 1981):

- Expect therapeutic effect at lower dose.
- Expect toxic side effects even at lower dose, particularly neurological and cardiovascular effects; watch for severe jaundice, anemia, dermatologic reactions.
- Watch for long-term side effects; psychotropic agents may cause changes in pigmentation and tardive dyskinesia.
- Central Nervous System (CNS) side effects are not uncommon, such as dyskinesia and parkinsonism-like effects.
- There may be hypotension, arrhythmias, and congestive heart failure.
- Agitation, insomnia, and excitement (paradoxical reaction) often occur following the administration of phenobarbital and chloral hydrate.
- Expect severe adverse reactions at night; drugs that increase confusion or decrease cognitive control may heighten symptoms that the patient experiences at night, such as hallucinations or delusional behavior.
- Frequent Adverse Effects of Antidepressants

Drug	Adverse Side Effects
Tricyclics	Atropine-like effects (dryness of mouth). Tachycardia, urinary retention, decreased mobility, delirium, psychotic states with high doses, hypotension, drowsiness, dizziness, blurred vision, constipation and diaphoresis.

Anti-anxiety agents are generally used for restlessness, irritability, hyperexcitability and fatigue. Anti-anxiety drugs are effective in the elderly, except that the old, old show a lessened response. Highly anxious patients may suffer from a decrease in speed and accuracy in carrying out self-care activities.

The benzodiazepines (diazepam, flurazepam, oxazepam, serax) halcion, centrax, etc. are relatively safe for use with the elderly if given low doses. Benzodiazepones are CNS depressants. In the elderly they may cause dizziness, drowsiness, light-headedness and gait disturbance (Blackwell 1975; Hecht 1985).

A problem may exist for patients on various anti-hypertensive drugs which act on the central nervous system and further depress

the ability of the body's baroreceptors to respond to change in posture. The problems are widespread and serious in their consequences, as demonstrated by Jackson (1976) who described "six symptomless patients, aged 64-84, who, within a week of starting therapy with antihypertensive drugs, were admitted as emergencies with episodes of unconsciousness, one patient suffering a major stroke." This is an example of how physiologic changes that occur with aging can predispose the elderly to adverse drug reactions (Goaff 1987).

Selected Drugs Reported to Cause Psychiatric Symptoms

Drug	Reactions
Antihistamines	—Anxiety, hallucinations, delirium
Anticonvulsants	—Tactile, visual and auditory hallucinations; agitation; depression; paranoia; confusion and aggression
Phenobarbital	—Excitement, hyperactivity, depression, visual hallucination, delirium tremens-like syndrome
Diazepam (valium)	—Rage, excitement, depression, confusion, disorientation, suicidal ideation
Propranolol (inderal)	—Depression, confusion, nightmares, visual hallucinations
Zomrpirac (zomax)	—Depression, anxiety and stupor
Indomethacin (indocin)	—Depression, confusion, anxiety, hostility, paranoia and depersonalization.

Because the elderly are heavy consumers of psychopharmacologic agents, it is important that home health care providers be aware of the pharmacokinetics (drug absorption, distribution, metabolism, and excretion) of these drugs. They must always be alert for drug-drug interaction because of the elderly "heavy bent" toward polypharmacy.

Each home health care provider should be aware of the necessary laboratory tests that are essential for selected drugs. Long-term use of psychotropic drugs can cause physiologic problems that are best

detected by laboratory test. Recent issues of *Nursing 87* and *Geriatric Medicine* have printed a chart and an outline showing which drugs require what test and why (Goaff 1987 and McDue 1987).

We must be aware of the drugs which require patient and/or family consent.

According to Yesavage (1987) some of the drugs which affect attention and retention include:

Effect on Attention	Effect on Retention
Neurotransmitter effects: levo-dopa	Choline
Vasodilators: Nylidrin, Papaverine, Cyclandelate	Tetrahydroamino Acridine (THA)
Metabolic Active Drugs: Ergot Alkaloids Venca Alkaloids pervaceton	Oxotremorine Seratonin
Phosphodieslerase inhibitors: Flavonoids, Phalazine Pentifylline	Antagonists
Neuropeptides: Acth 4-10 Vasopressin, Enkephalins	
Nonspecific agents: CNS stimulants	
Antidepressants, antipsychotics Beta blockers	
Calcium channel inhibitors	

DEPRESSION

The most common psychopathologic syndrome in the elderly is depression (Finalyson 1982; Ouslander 1982). Depression among elderly patients is a clinical problem of great significance that has received far too little attention. Nearly 20 percent of all elderly adults suffer from significant symptoms of depression (Solomon 1981; Abrahams 1978-79). Unlike most conditions, depression is

more common in elderly men than elderly women. Depression is often misdiagnosed and inadequately treated (Goldstein 1979; Solomon 1981; Laurent 1986).

For a diagnosis of depression to be made, the Diagnostic and Statistical Manual of Mental Disorders (DSM III) requires that four of the following eight symptoms be present for at least two weeks (APA-DSM III 1980).

- recurrent thoughts of death, or wishes to be dead
- feelings of a worthlessness or excessive guilt
- impaired thinking or concentration
- loss of energy or fatigue
- reduced appetite and weight loss not due to dieting
- loss of libido
- sleep disturbance, whether insomnia or hypersomnia
- change in psychomotor activity, whether agitation or the generalized slowing known as psychomotor retardation

It has been estimated that 30 percent to 50 percent of persons over the age of 65 will undergo an episode of depression severe enough to interfere with daily functioning (Redick & Kramer 1973; Blazer 1979; Ouslander 1982). Depression is the chief cause of psychiatric institutionalization among the elderly (Goldfarb 1974).

Goldfarb elucidated a particular psychodynamic sequence of events to explain depression. He says that the aged person senses a decrease in his or her ability to master either the internal or external environment. This difficulty in mastery is due to any of the numerous biological, psychologic or social stressors. With this loss of mastery, the elderly person feels increasingly dependent on the vicissitudes of the environment and therefore feels, and frequently becomes, progressively more helpless. Helplessness then engenders feelings of fear and/or anger. In depression, we must be aware of the interplay between helplessness, rolelessness, low self-esteem and psychopathologic disorders (Goldfarb 1974; Levinson 1986).

Depression is among those psychiatric disorders that are responsive to treatment. Major treatments for depression include:

- Psychotherapy as a major treatment modality or in combination with other treatment, particularly pharmacotherapy (tricyclic antidepressants, monoamine oxidase inhibitors [MAO], lithium, phenothiazenes, and minor tranquilizers). Note: Psychomotor stimulants, barbiturates, and sedative/hypnotics have little value in treating depression.
- Doxepin is particularly recommended for treating depression because it has fewer side effects.
- Lithium (sodium-depleting diuretics, such as chlorothiazide [diuril], are contraindicated with lithium therapy because such diuretics lead to hysonatremia, which causes reabsorption of lithium by the kidneys. This can lead to toxic levels of lithium.)
- Electric convulsive therapy (ECT)
- Insulin therapy

Commonly used drugs which will produce depression include:

- reserpine
- ethanol
- propranolol
- digitalis (intoxication)
- anticancer drugs
- sulfonamides
- antidepressants (toxicity)
- barbiturates
- phenothiazines

Symptoms of Depression/ Pseudodementia	Dementia
• Onset quite abrupt; changes in mood and behavior apparent within 2 to 8 weeks.	Onset insidious and ill-defined; cognitive deficits not apparent until months later.
• Mood depressed; patient is often withdrawn & apathetic.	Patient is typically happy and not depressed.

• History of psychiatric disturbance common	Not common
• Suicide risk considerable	Suicide risk much lower
• Complains of memory loss	Patient tries to hide loss (confabulates and denies)
• Impairment not usually worse at night	Usually worse at night
• Duration: generally self-limited if prolonged; reversible with medicating, ECT or psychotherapy.	Chronic with progressive deterioration

The similarities of pseudodementia and dementia include (Levinson 1986; Goldstein 1979; Gordon 1981):

- Lack of self-care
- Restlessness
- Loss of creativity
- Somatic complaints
- Disorientation
- Memory and concentration difficulties

Depression that is secondary to drugs or organic diseases is much more likely in the elderly. Therefore, careful physical and laboratory evaluation, and psychological assessments are essential. In a study of 74 depressed elderly in St. Louis, 86 percent of the depressed patients had an accompanying physical disorder (Nillner 1978; Weissman 1978).

Depression is higher in the 70 plus age group (Brown 1983). Psychotherapy is very helpful and effective in treating noninstitutionalized depressed elderly (Ban 1978; Brown 1983). Depression may mimic and/or coexist with dementia (Pfeiffer, Larson & Hanley 1982; Wells 1980; Goldstein 1979; Gruenhaus 1983).

The following attitudes are essential in care/treatment of the depressed elderly (Minot 1986; Brinks 1977):

- Unqualified acceptance of the patient as a valuable human being;
- openness and honesty about the provider's own feelings; and
- accurate, empathic understanding of the patient's problems, situation and feelings.

Suicidal ideation and suicidal attempts are common behaviors for the depressed patient.

SUICIDE IN THE ELDERLY

Suicide is indeed more prevalent among the elderly. The white male is most vulnerable. White males over 65 have a suicide rate four times the national average; whereas, white females over 65 have a rate twice the national average. In the United States of America (U.S.A.), white males over 65 commit suicide three times more often than white males aged 20-24. In 1978, the elderly white male suicide rate in this country was 26.5 per 100,000 people, a dramatically high rate relative to the suicide rate for the U.S.A. as a whole which has remained between nine and 13 per 100,000 people since World War II (Osgood 1985).

Elderly suicide rates among non-whites are considerably lower than those of whites. The ratio of elderly white to elderly non-white is 3:1. In 1982, the suicide rate for all white males was 20.0. The suicide rate for white males 65 plus was 39.2 (Miller 1976; Osgood 1985; McIntosh 1985). The suicide rate for all black males in 1982 was 11.6. The suicide rate for black males 65 plus was 12.9 (Scheldman 1987). White suicide peaks in the last stages of life; by contrast, the minority suicide rate peaks between 25-30 years of age and then declines through the later years of the life cycle (Manton 1987; Schneidman 1987).

Osgood (1987) reported that 294 residents (one percent of the total) sample studied in long-term care facilities engaged in some type of suicidal behavior. Over 80 percent of those who were suicidal engaged in international life threatening behavior (ILTB). Less than 20 percent engaged in overt suicidal behavior. More than 75 percent of all those engaged in some type of suicidal behavior (overt and ILTB) lived; only 22 percent died. ILTB include: non-

adherence to important and specific medical regimes, refusal to eat and/or drink, eating foreign objects, head banging, scratching or biting one's self, refusal of medications, serious accidents. McIntosh often points out that the elderly compose 11.9 percent of the population; however they commit 25 percent of all of the suicides. The National Center for Health Statistics noted that more than 100,000 persons 60 plus kill themselves each year (NCHS 1985).

Depression is frequently cited as the primary cause of those people who commit suicide (Murphy 1975). Fifty to seventy-five percent of successful suicides have a depressive illness (Temples 1986; Murphy 1975). Many have alcohol or drug abuse problems. In addition, as many as 25 percent may have schizophrenia. The future suicide victim typically presents to a general physician rather than a psychiatrist, with complaints of physical symptoms. In retrospect those complaints are seen as aspects of a depressive illness for which the patient receives a potentially lethal prescription that is likely to be used in the suicide. Therefore, the keys to prevention of suicide are: recognition of depression, schizophrenia, substance abuse, low self-esteem and feelings of helplessness; explorations of suicidal ideation; avoidance of large sedative prescriptions; and referral to appropriate treatment.

Risk Factors for Suicide (Osgood 1984; Miller 1976)

- Old Age
- Living alone, no children
- Depressive illness
- Substance abuse
- White male
- Financial difficulty
- Attitude of hopelessness and helplessness
- Specific suicidal plan
- Possession of a lethal weapon
- Lack of social support/network
- History of potentially lethal attempt
- Unmarried
- Involuntary retirement
- Accumulation of negative events and circumstances
- Unendurable psychological pain/stress

The home health care provider must be alert to signs, symptoms and plans for suicide. Suicidal ideation as well as attempts must be reported and recorded. It is important to recognize the risk factors associated with suicide and prevent it from taking place.

DELIRIUM/CONFUSION

Delirium/confusion/transient cognitive disorders are highly prevalent among the elderly. Delirium is a common feature of physical illness or drug intoxication in the elderly and requires prompt medical and nursing attention. It has been found that five percent to 20 percent of the elderly admissions to general hospital medical-surgical units are for confusion (Lipowski 1983, 1985) especially difficult to manage at home.

Lipowski has described a semantic muddle around the words "delirium" and "confusion." Currently "acute confusional states" and "delirium" are the most often used designations. The World Health Organization (WHO) uses the term "acute confusional states" and defines it as a syndrome characterized by "features of delirium" (World Health Organization 1972). "Acute confusional states" is a designation favored by geriatricians and neurologists. It refers to some combination of spatio-temporal disorientation, difficulty in thinking coherently, memory impairment and bewilderment (Berrios 1981; Lipowski 1980).

In psychiatry, the terms "confusion" and "acute confusional states" have no established meaning; they may be used in reference to a person of any age and they lack a clear etiological connotation of either organicity or psychogenicity (Hoskinson 1976; Gallant 1985). In the DSM III "delirium" has replaced "acute confusional states" and is listed among organic brain syndromes.

Delirium is defined as an organic brain syndrome that is characterized by global cognitive impairment of abrupt onset and relatively brief duration (usually less than one month) and by concurrent disturbances of attention, sleep-wake cycle and psychomotor behavior.

Confusion is a more-or-less lay term—it is described as the manifestation of disordered thought processes with an inability to respond coherently to environmental stimuli. These symptoms may

be transient and sporadic or permanent and, thus, present in both delirium and dementia.

In this paper, I shall refer to the disorder as delirium, although in the nursing literature and discussions with home health care providers (including the members of the family) it is referred to as confusion.

Nearly every physical illness may give rise to delirium in an elderly person. As one geriatrician puts it, "acute confusion is a far more common herald of the onset of physical illness in an old person than are, for example, fever, pain, or tachycardia" (Solomon 1981).

Failure to diagnose, recognize and treat delirium may have lethal consequences for the patient, since it may constitute the most prominent presenting feature of myocardial infarction, pneumonia, or some other life threatening disease. The elderly often present the onset of their disease in an atypical manner. Confusion, dizziness, disturbance of gait, feelings of lightheadedness, feeling bad all over, fatigue, insomnia, poor appetite are some of the atypical behaviors signalling the onset of illness in the elderly.

Few epidemiological studies have been done on delirium in the elderly. The incidence of delirium is four times higher in persons more than 40 years of age and highest in persons older than 10 years of age. One out of four elderly, delirious patients in a British and a San Francisco General Hospital study died within one year. The mortality rate for delirium ranges from 18 percent to 30 percent (Rebok 1977).

The health care features delirium in the elderly include (Lipowski 1983; Lipowski 1985):

1. *Disorders of Cognition*. Perception, thinking and memory are the three main aspects of cognition.

   Cognitive processes, whereby the individual acquires knowledge and guides his or her behavior, and is disorganized, rendering him or her helpless to some degree. Acquisition, processing, retention, retrieval, and utilization of information are impaired, resulting in what the home health care providers and family frequently refer to as confusion.

   Perception in delirium is marked by reduced ability to dis-

criminate and integrate percepts and to distinguish them clearly from imagery, dreams and hallucinations.

Thinking is disorganized and fragmented. The elderly, delirious patient may have incoherent thought processes and his/her ability to reason, use abstract concepts, judge, solve problems and plan action is reduced.

Memory in the elderly, delirious patient is impaired in all its aspects: registration, retention and retrieval.

2. *Disorders of Attention and Wakefulness*. In delirium, attention is disordered in all of its main aspects: alertness, readiness to respond to stimuli and ability to respond to stimuli selectively, to mobilize, sustain and shift attention at will.
3. *Disorder of Psychomotor Behavior*. A delirious patient may be predominantly hyperactive or hypoactive. Speech may be slurred, hesitating, disjointed, repetitious, circumlocutory and paraphasic.

In general, confusion clears up in one to four weeks with adequate treatment:

- Treatment includes adequate diagnosis.
- Assessment of drug-drug interaction.
- Laboratory work and electroencephalogram (EEG).
- Good nursing, consistent supportives and orienting environment are essential (Foreman 1984).
- Provide a proper sensory environment for the patient to feel secure, and one that guards against both extremes of sensory input. A quiet, well-lighted room, a clock, a calendar and a few significant personal items (Wolanin 1981; Sullivan 1986).
- Fluid and electrolyte balance and nutrition must be maintained.
- Haloperidol is usually the drug of choice (Rebok 1977).
- Prevention of confusion (Remaker 1981).

Delirium frequently masquerades as violent behavior in a head-injured patient; as factitious illness—in a 65-year-old widow with a "pulling sensation" in the left side of her head; as suicidal ideation—following gastric surgery in an 80-year-old man; as a phantom limb—in a 72-year-old woman after hip surgery; as agitated

and impulsive behavior after carotid surgery (Campbell 1986; Sullivan 1986; Surgeon General Conference on Hip Fracture Prevention 1983; Tinetti 1986; Furstenberg 1986).

Delirium and dementia are frequently confused. Some of the differences include (Seynidur 1986):

Feature	Delirium	Dementia
Onset	Rapid	Usually insidious
Duration	Hours to week	Months to years
Course	Fluctuates over 24 hours: worse at night and somewhat lucid at intervals.	Relatively stable
Physical illness or drug toxicity	Usually present	Often absent
Sleep-wake cycle	Always disrupted; frequently drowsiness during the day, insomnia at night.	Fragmented sleep
Memory	Recent & immediate impaired. Fund of knowledge intact if dementia is absent.	Recent and remote impaired. Some loss of common knowledge.

Drug-Induced Delirium

Drug-induced delirium is very common in the elderly because of their consumption of numerous drugs. Some drugs which account for a large number of delirium cases include:

- anticholinergic antidepressants
- benzodiazepines
- flurazepam
- diuretics
- antihistamines

- digitalis glycosides
- cumetidine

Home health care providers must be aware of the half-life of drugs; they need to be knowledgeable about drug interaction and they should be sure that dosage is adjusted to blood-level measurement. Remind the physician to get routine laboratory work. Members of the family should ask questions of their physician and nurse about the effects and cautions pertaining to adverse drug reactions.

Physiological causes and some physical conditions associated with delirium in the elderly include (Seynidur 1986; Lipowski 1985):

- congestive heart failure
- cerebrovascular accident
- pneumonia
- genitourinary infections
- uremia
- cancer
- hyponatremia
- malnutrition

An algorithm to guide the home health nurse in assessing and intervening in the care of the delirious patient includes (Foreman 1984; Sullivan 1986):

1. Assess patient (restlessness, agitation, incoherent speech, disorientation, etc.).
2. Obtain vital signs and compare to previous recordings (blood pressure, T.P.R., urinary output).
   - review current medications.
   - laboratory work, Blood Urea Nitrogen (BUN), glucose, electrolyte, etc.
   - assess (neurological status, psychological status, etc.).
3. Avoid fluid volume deficit. Dehydration, water and sodium depletion frequently precipitates delirium (Seynidru 1986).
4. Assess water and sodium deficit.
5. Prevent respiratory insufficiency (assess and observe dryness, periods of apnea, cyanosis, breathing sounds, etc.).

6. Position patient to improve respiration.
7. Assess alterations in temperature.
8. Prevent hyperglycemia.
   • observe for nausea, vomiting, weight loss, irritability, etc.
9. Avoid hypoglycemia.
   • observe for diabetes mellitus, tachycardia, weakness, fatigue, etc.
10. Consider drug toxicity—review drugs such as tranquilizers, antidepressants, thiazide diuretics, antihypertensives, etc.
11. Increase orientation by providing a stimulating environment.
12. Hostility and uncooperativeness are frequent symptoms in the delirious patient. The elderly person may become hostile because of his/her powerless position.

There are over three million delirious/confused people in the U.S.A. These behaviors increase with age. These behaviors are frequently the first manifestation of the onset of a major illness in the elderly; the onset of illness in the elderly is generally atypical.

DEMENTIA

Dementia is a degenerative condition which affects more than 2.5 million Americans. Dementia affects 10 percent of the elders in the community and 30 percent-50 percent of the nursing home population (Ota 1987).

The DSM III criteria for dementia include (APA-DSM III 1980):

A. Loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.
B. Memory impairment.
C. At least one of the following:
   1. impairment of abstract thinking
   2. impairment of judgment
   3. other disturbance of higher cortical function
   4. personality change
D. State of consciousness not clouded.
E. Either 1 or 2:

1. Evidence of specific organic factor of etiologic significance.
2. In the absence of such evidence, nonorganic etiologic factors must be reasonably excluded and the behavioral change must represent cognitive impairment in a variety of areas.

There are several forms of dementia including:

- Alzheimer's disease 70 percent
- Multi-infarct dementia 20 percent
- Infections
- Pick's disease
- Traumatic
- Creutzfeldt-Jakob disease, etc.
- Huntington's disease, etc.

There are several degenerative diseases/disorders. However, in this paper, I shall concentrate on Alzheimer's disease—because this is the condition which the home health care providers and member of the family find "most challenging."

Alzheimer's disease is the leading cause of dementia in the elderly affecting approximately five percent to six percent of persons 65 years of age and older and accounting for the majority of all cases of dementia. Alzheimer's disease currently affects at least three million Americans and it is the fourth leading cause of death in this country. It account for 51 percent of the dementia cases (Larton 1986). Alzheimer's disease may affect any age, beginning in the late 30s.

Cause of Alzheimer's Disease

The exact cause of Alzheimer's disease is not known. There are several theories and hypotheses—but no proof. Some of the theories include:

- the acetylcholine hypothesis
- the genetic hypothesis
- the aluminum hypothesis
- the infectious agent hypothesis
- the abnormal protein/autoimmune hypothesis

Conditions which produce Alzheimer's-like symptoms include (Barnes 1981; Veterans Administration Guidelines):

- drug intoxication
- depression
- head injuries
- brain tumor
- sensory-deprivation
- nutritional deficiencies such as pernicious anemia
- psychiatric disorders and anxiety

Some of the early changes in Alzheimer's patients, which the family, friends and home health care providers will notice, are (Beam 1984; Teysink 1984):

- deterioration in personal appearance (family and friends may perceive this as carelessness)
- an inability to concentrate on such things as reading, watching television, writing or balancing the checkbook
- lack of interest in household, job and/or hobbies
- apathy
- depression
- despair (knows things are not right—but does not know why)
- tasks that require abstract thinking (mathematical calculations and reasoning) gradually become difficult.

Depression and delirium may mimic Alzheimer's disease. Ways to differentiate the two have been pointed out elsewhere in this paper.

Some of the behaviors which the home health care providers and members of the family find challenging include:

- wandering
- outbursts of anger
- demanding behavior
- irritability
- agitation
- hostile behavior
- calling out and screaming
- personally assaultive/combative
- packing and unpacking clothes, suitcases and drawers
- leaving the stove on and burning food
- refusing to bathe
- setting fires

Some of the devices which can be used in the home to prevent wandering and to protect the patient include (Snyder 1978):

- body holders
- pharmaceutical restraints
- door locks and alarms
- halfdoor
- rocking chairs
- bean bags
- tracking devices as in department stores
- reality therapy (brief session)
- memory training
- avoid restraining (physical) if possible
- long walks and/or exercise prior to meals and naps if health permits
- assigned meaningful, noncompetitive tasks in the home
- a stimulating environment
- encourage some kind of group activity outside the house with other people.

There seem to be three psychosocial factors which influence the tendency to wander (Snyder 1978):

- life-long pattern of coping with stress
- previous work roles
- search for security (i.e., calling out, asking where is my wife or daughter).

It is essential that the home health care provider assist the members of the family in planning and evaluating their days and activities. Assist the family in using community resources (Teysink 1984; Larson 1986; Beam 1984; Robertson 1982).

Some of the approaches, strategies, tips and procedures for the home health care provider should include:

- Avoid hurried approaches. Talk slow, use simple words, and short sentences.
- A planned approach to keep self-esteem and feelings of worth high.
- Plan with patient and family "meaningful" family and household activities. Write weekly plans with proposed goals and evaluate them weekly.
- Try to use the same nurse or home health aide, so that the patient and health worker can develop a relationship.
- Maintain optimal nutrition.
- Maintain bowel and bladder regularity.
- Provide cognitive stimulation in the patient's environment.
- Establish a schedule of care and be consistent in the implementation of it.
- Provide a safe and structured environment.
- Maintain scheduled health care visits.
- Utilize respite and community resources to lessen the strain on the family caregiver.
- Solicit training in cognitive therapy, reality therapy and socialization techniques and use them with patient and family.
- Assist the patient/family in safely using some of the 165 new home test procedures (i.e., titret sulfite test, uritest for excess sugar and ketones, colorectal cancer test, etc.). The annual sales of home tests have grown from $200 million in 1981 to $384 million in 1985 (Barnhill 1985).

Some tips and strategies, approaches and procedures in the care and management of patients with Alzheimer's disease:

- You will recall that dementia occurs in a clear sensorium, with alteration in:
  - judgment
  - affect
  - memory
  - cognition
  - orientation

In one longitudinal study of personality changes in senile dementia of the Alzheimer's type (SDAT), it was found that 63 percent of the patients were passive, agitated and self-centered upon their initial evaluation. In the 50-month followup evaluation, the percentage of patients who exhibited agitated and self-centered behaviors doubled (Rubin, Morris, & Berg 1987).

There are numerous behavioral problems which the caregivers will need to be aware of; some tips on care and management include (Guide to Care of Alzheimer's Disease Patients 1985; Harper 1987):

In the fourth stage of Alzheimer's disease (late confusional phase) (Reisberg 1986) the dominant moods and personality changes of the patient include: withdrawal, flattening of affect, crying spells, and denial. Denial generally protects the patient from the emotional impact of the diagnosis and its consequences. The patient withdrawal is an adequate response to his or her decreased cognitive capacity; pushing the patient to perform activities upon demand will only provoke anxiety.

Continuous correcting of the patient's mistakes or the things he or she is denying will only serve to embarrass the patient and provoke shame, anger, hostility and possible assaultiveness. Some of the modified activities which the patient in stages 4, 5 and 6 may participate in may include:

- playing of cards, chess and checkers with subtle reminders, drawing concrete objects, making simple clay shapes, letters, doing structured/supervised exercises, helping maintain plants, etc.

Covering Up Memory Loss

Rather than admit their losses, many people with Alzheimer's and other dementing illnesses deny that there is a problem. This is quite effective in the beginning. However, when coping and covering up become more difficult, they may withdraw into their homes or apartments, stop going out or doing things they used to enjoy, blame others for their mistakes, make extensive lists, and generally narrow their lives. Because signs of the illness cannot be seen, they may be able to hide their illnesses for a long time. Suggestions:

- Obtain a neuropsychological assessment to help the family and victim understand what he or she can or cannot do.
- Offer the person positive reinforcement to encourage him or her to continue previous activities as long as possible. It is important to monitor abilities and recognize when the person has lost a function skill.

Wandering

Wandering is frightening for the caregiver and a problem which requires either constant supervision or a secure environment. A person may become separated from a friend or family member while in a strange place and become lost trying to find the person. Alzheimer's patients may become lost in formerly familiar environments or may be searching for something or someone previously known. They may wander or pace because of being overstimulated, anxious, or uncomfortable. Aimless wandering may be a way of expressing that they feel lost, bored, restless or in need of exercise. Agitated pacing may be a catastrophic reaction to not being able to make sense out of the surroundings. Wandering may even be the result of continued life-style patterns of dealing with stress though physical activity.

An analysis of wandering behavior may help determine if there are prompting events. However, there are times it may occur when there may be no apparent stimulation from the environment. Caregivers may not always be able to prevent this problem. Suggestions:

- Provide a secure place for wandering activities.
- Purchase an identification (I.D.) bracelet engraved with "memory-impaired," name, address and telephone number.
- Write instructions for the mildly impaired.
- Reassure the person frequently about where he or she is and why.
- Use restraints or geri-chairs for brief periods only.
- Evaluate the episodes of wandering for "triggers," such as: time of occurrence, frequency, route. Also check for responses to environmental clues, for example, the presence of coats, shoes, suitcases.
- Observe the feet and legs for signs of problems, such as blisters, bruises, or swelling.

Sundowning

Behavior problems may worsen in the late afternoon and evening, possibly because after a day's activities, everyone is tired and less able to handle stress. This symptom is evidenced by increased confusion, agitation and anxiety, along with pacing, wandering, wringing hands, and intensification of any behavior problem. Suggestions:

- Rearrange the person's daily schedule so that fewer major activities take place in the evening (i.e., have bath and main family meal during the day).
- Reduce hustle-bustle in the evening, such as television and family or other social activities.
- Observe situation to determine if there is a specific cause for the behavior.
- Allow the person to pace in a visible, secure area. Do not restrain. Take for a walk, if possible.
- Offer companionship.
- Use bean-bag chairs when pacing is not feasible. These chairs are difficult for the person to get out of and are more humane than using restraints.

Hiding Things and Suspiciousness

The general insecurity caused by Alzheimer's, coupled with a sense of loss of control and memory, contributes to certain behaviors described as follows: taking another person's possessions and going through another's belongings; accusing family of taking or misappropriating money or other possessions. Other behaviors include clinging to purses, coats, or other objects; thinking others are talking about them; becoming very suspicious when questioned, especially about past interests; going through drawers over and over or taking flatware or food from the dining room and hoarding them. Suggestions:

- Reduce hiding places by locking closets, cupboards, unused rooms, etc.
- Look in wastebaskets before emptying.
- Do not argue or rationally explain disappearances.
- Agree item is missing and help look for it.
- Do not whisper to others around the patient.
- Distract with other activities.
- Never confront or try to teach a lesson.

Repetitive Behaviors

A person with Alzheimer's forgets what has been done or asked from one minute to the next. In some cases, repetitive acts may be reassuring to the person and can be worthwhile activities. Suggestions:

- Put on the right track by helping to go to the next step.
- Give the person something else to do that is simple, like holding an object or folding something.
- Reassure with warmth.
- Write answers to most commonly repeated questions in visible places (if person can still read with comprehension).

Offensive Behavior

The person who is a victim of Alzheimer's disease does not have a total grasp of reality. He or she may misinterpret many things, including the efforts of those who are trying to help him or her. The person may be critical, insulting, or use abusive or offensive language. Anger and hostility are sometimes ways of expressing the fear and anxiety experienced by the Alzheimer's victim. Suggestions:

- Do not try to reason with the person or contradict.
- Ignore the comments or distract the person.
- Respond to the feeling you think is being expressed; i.e., when an impaired person says, "you stole my glasses," your response might be, "I know you're upset because you can't find your glasses."
- Do not take the comments or criticisms personally.

Delusions and Hallucinations

Delusions are defined as fixed or persistent incorrect beliefs that explanations or reality will not change. These are not uncommon experiences for an Alzheimer's victim. Neither are hallucinations which are the experience of hearing or seeing things that cannot be verified. Visual or auditory sensations may be distorted in the brain, causing distorted perceptions. Suggestions:

- Do not argue or try to convince the person that the belief is incorrect.
- Reassure and distract when a hallucination or delusion is frightening.
- Help the person to see and hear as clearly as possible.
- Reduce clutter and shadows in room of patient.

Catastrophic Reactions

When a person appears to be extremely upset over a minor problem, he or she may be having what is referred to as a "catastrophic reaction." The person seems to be making a mountain out of a

molehill. However, the problem is not minor to the person who is experiencing it.

Alzheimer's patients may have these strong emotional reactions to simple routine experiences; i.e., someone who screams and refuses a bath. The person may appear stubborn, inflexible, or extremely sensitive. The reason that the person appears overcome by a simple problem is that Alzheimer's disease has taken from the person the ability to think about more than one thing at a time. Also the mechanism in the brain which regulates emotional expression may not be functioning adequately. For example, the patient may cry excessively, but the degree of distress may not be as severe as the behavior suggests.

Any of the following might cause a catastrophic reaction: feeling overwhelmed, lost, abandoned, or frightened by strange people; being overstimulated by noises or activities; having an argument or being scolded; being unable to complete a simple task; being asked too many questions; responding to internal discomfort; and misperceiving the environment or an experience. Behaviors associated with catastrophic reactions can include crying inconsolably; wandering; shouting and swearing; striking out at another person; becoming suddenly withdrawn; refusing to take a bath, undress, or participate in activities; or pacing in an agitated manner. Suggestions:

- Accept that the person is not reacting "on purpose" and that he or she cannot help the responses.
- Simplify the environment by breaking all activities into small steps, such as in taking a bath or in going to the toilet.
- Take one step at a time, reassuring the person after each step.
- Reduce the confusion by turning off the television, eliminating other distracting noises.
- Plan things that the person is realistically able to do; i.e., if he or she cannot tie shoelaces, buy slip-on shoes.
- Be calm and gentle with the person.
- Remove the person from the distressing situation if appropriate and possible.
- Assess reasons for refusals. If fearful, reassure, etc.
- Limit question-asking and decision making.

- Distract with favorite activity or treat.
- Do something familiar with person.
- Use rocking, holding hands, patting, or soothing music to calm.
- Avoid restraining, arguing, or explaining.
- Remember that the feeling may last longer than the memory of the event.
- Leave, if safety is in jeopardy, and call for help.
- Try to respond to the feelings being expressed rather than the specific behavior.

RURAL ELDERLY

Seven million elderly (31 percent) live in rural, nonmetropolitan areas. There are fewer formal resources and services in the rural areas. However, there are more access informal/family/community resources. Transportation is a problem in the rural areas.

Organizations which may be helpful regarding resources and alternative care resources include:

- State Mental Health Office
- State or district health association
- Local churches and synagogues
- Help for Incontinent People, P.O. Box 554, Union, South Carolina 29379
- Community mental health centers

One recently organized source of help is the National Association for Families Caring for their Elders, Inc. (NAFCE), P.O. Box 3441, Silver Spring, Maryland 20901, Phone (301) 593-1621.

ELDERLY ABUSE

It is estimated that 500,000 to 2.5 million elderly people are abused each year (Pendrick-Cornell & Gelles 1981). Forms of abuse include neglect, violation of the elder's rights, physical abuse, psychological and verbal abuse.

Under Title XX mandates, virtually all states have enacted Adult

Protective Service Legislation to assist adults who are unable to protect their own interest and are therefore in danger of abuse, neglect, or exploitation (USDHHS 1978). But before the protective services will intervene in many cities and states, the elderly person must generally be legally incompetent, leaving the majority of elderly still unprotected.

The most prevalent form of elderly maltreatment is neglect. Black (1983) suggests that approximately 66 percent of maltreated elders are deprived of adequate food, medication, clothing, or shelter as well as such essential corrective and remedial devices as eyeglasses, hearing aids, dentures, canes, walkers and wheelchairs. Elder neglect is characterized by the following criteria:

1. Act of omission or withholding of necessary care; the inability to provide or the deprivation of adequate care.
2. demonstration of potential physical or psychological harm to the elder; and
3. determination that the neglect is sufficiently severe to warrant intervention.

Neglect refers to a situation in which the caretaker/caregiver deliberately impinges on the elder's well-being by limiting or denying access to basic needs (Bock 1983; O'Rourke 1981).

Elderly abuse or maltreatment is defined differently in each state, however, it is a required reportable acton in every state.

If a health/social services provider sees symptoms of abuse, he/she is required to report it to the adult protective services or the appropriate legal office in his/her district/state or county.

It must be remembered that nine million of the elderly live alone and one-half of them are below the poverty line (Alone 1987). The health care provider will need to rely heavily on community resources.

FALLS/HIP FRACTURES AMONG THE ELDERLY

There are 620,000 elderly people who suffer household injuries each year which cost $3 billion dollars a year according to the Consumer Product Safety Commission (*The N.Y. Times* 1985). There

are 200,000 persons who fracture their hips in the U.S.A. every year, costing $1 billion dollars excluding the surgeon's fee and nursing home cost (Surgeon General's Report 1983).

It has been estimated that a white woman, 35 years old, has an eight percent chance of having one hip fracture in her life; a white man has a three percent chance. Mortality one year after fracture ranges from 12-67 percent. This diagnosis now ranks tenth in terms of total patient-days in general hospitals (Surgeon General's Report 1983).

Some of the causes of falls/hip fractures include:

- fragility of bone
- osteoporosis
- confusion from toxicity due to drug interaction
- unsteady gait due to drug interaction
- physical and perceptual disorders
- imprudent or hazardous activity
- frayed, torn rugs
- use of escalators by the elderly with glaucoma or cataracts
- excessive disability, drug side effects, chronic illness

Predictors of outcome following hip fracture include (Brody 1984):

- age
- mental status
- functional status
- health condition

In an effort to identify chronic characteristics associated with falls among elderly persons, Mary E. Tinetti found nine risk factors (Tinetti 1986):

- mobility score
- morale score
- mental status score
- distant vision
- hearing condition
- blood pressure (high or low)

- result of back examination
- postadmission medication (polypharmacy)
- activity of daily living score at the time of admission

The subject's fall risk score was equal to the total number of factors present. The proportion of recurrent fallers increased (0 percent to 30 percent) for those with 0 to 3 risk factors. Falling seems to be a result of multiple disabilities. The mobility test seems to be the best predictor of recurrent falling.

The duty of the home health provider is to educate the patient/family in the prevention of falls and injuries and to make informal safety inspections in the home. Try to prevent postoperative confusion and agitation; actively participate in the patient's rehabilitation in the home. Collaborate with the physical therapist, occupational therapist, family and physician in planning and evaluating patient care and rehabilitation.

SUMMARY

Ninety-five percent (95 percent) of the elderly live in the community. At least five million of them need help with activities of daily living. Eighty percent have one or more chronic illness. Eighteen to 25 percent of the elderly have significant mental symptomatology. Only four percent of the elderly visit the community mental health centers (Ernst 1977; Talbott 1985). The primary providers of mental health services to the elderly are the general practitioners, the primary health care nurse, the home health aide psychiatric social workers, members of the family, and a few clinical geropsychologists (German 1987). Over half of the home health care clients are elderly. The primary home health care providers are "challenged" in providing comprehensive health services to the elderly in their homes—often because of a lack of training of the primary home health care provider or because of lack of access because of agencies' policies regarding the acceptance of patients with behavioral, social and mental disorders, including Alzheimer's disease.

In this paper, I have profiled the behavioral, social and mental health needs of the elderly with physical illnesses as well as those with behavioral, social and mental disorders.

I have dealt with those specific conditions which home health care providers and families find specifically challenging and worrisome, namely:

- Delirium (confusional states)
- Suicidal ideation and attempts
- Psychological assessment
- Dementia of Alzheimer's type
- Depression
- Delirium: (confusion and other behavioral problems associated with hip fractures)
- Psychotropic drug interaction
- Wandering

Every effort must be made to respect the privacy of the elderly, protect the elderly from research risk, get informed consent when indicated, provide counseling and always assure a high quality of care and supervision.

There must be a current plan of care in which both the patient and family participate when feasible.

Every effort and plan of care must focus on the maintenance of independence and self-care capabilities and prevention of excessive disabilities.

REFERENCES

American Association of Retired Persons. *A profile of older Americans*, Washington, DC, 1986, pp. 1-3.

American Bar Association Report. *The black box of home care quality*. Washington, DC, 1986.

Abrams, R.B., & Patterson, R.D. Psychological distress among the community elderly: Prevalence, characteristics and implications for service. *International Journal of Aging & Human Development*, 1978, 9(1), 79-85.

American Psychiatric Association. *Diagnostic and statistical manual for mental disorders* (3rd Edition, pp. 213-214). Washington, DC: The Association, 1980.

Alone, old and poor, Report of the Commonwealth Fund Commission on Elderly People Living Alone, Johns Hopkins University Press, 1987.

Blackwell, B. Rational drug use in the management of anxiety. *Rational Drug Therapy*, 1975, 9(6), 1-8.

Brown, R.G. Age as predictor of treatment response in endogeneous depression. *Journal of Clinical Psychopharmacology*, June 1983, *3*(3), 176-178.

Ban, T.A. The treatment of depressed geriatric patients. *American Journal of Psychotherapy*, 1978, *32*, pp. 3-96.

Brink, T.L. Depression in the aged: Dynamics and treatment. *Journal of the National Medical Association*, *69*(12), 891-893.

Blazer, D.G. et al. Depression in later life. *American Journal of Psychiatry*, November 1979, *20*(5), 91-96.

Berrios, G.E. Delirium and confusion in the 19th century: A conceptual history. *British Journal of Psychiatry*, 1981, *139*, 439-449.

Barnes, R.G. DSM III and the clinical diagnosis of dementia: A nursing home study. *Journal of Gerontology*, 1981, *36*(1).

Beam, I.M. Alzheimer's disease: Helping families survive. *American Journal of Nursing*, February 1984, *84*(2), 229-232.

Barnhill, W. Testing yourself at home. *Washington Post*, August 28, 1985, (Health Section, pp. 6-8).

Brody, E.M. Predictors of falls among institutionalized women with Alzheimer's disease. *Journal of the American Geriatric Society*, December 1984, *32*(12), 877-882.

The black box of home care quality. Washington, DC: The American Bar Association, August 1986.

Block, M.D. Abuse of the elderly, In S.H. Kadish, *Encyclopedia of Crime and Justice*, New York: Free Press, 1635-1637.

Brody, E.M., Stanley, J., & Ruff, G.E. *Aging and rehabilitation: Advance in the state of the art*, New York: Springer Publishing Co., 1986, p. xvi.

Blazer, D.G., & Maddox, G.L. The use of epidemiologic survey data in planning for geriatric mental health services. In A.D. Whanger & A.C. Myers (Eds.), *Mental health assessment and therapeutic intervention with older adults* (pp. 215-285). Rockville, MD: Aspen Publication, 1984.

Blazer, D.G., & Hoyt, J. Perceptions of poor health in the healthy older adult. *Journal of the American Geriatric Society*, 1979. *27*(7), 33-38.

Branch, L.G. et al. The Framingham disability study: Social disability among the aging. *American Journal of Public Health*, 1981, *71*(11), 1202-1210.

Burns, B., Lardon, D., Muller, N., & Goldstron, I. Mental disorders among nursing home patients: Preliminary findings from the national nursing home survey pretest, paper presented at the World Psychiatric Association, Section on Epidemiology and Community Psychiatry, Edinburgh, Scotland, Sept. 23-26, 1985.

Brody, E.M., Kleban, M.H., & Molese, E. What older people do about their day to day mental and physical health symptoms. *Journal of the American Geriatric Society*, 1983 *31*(8), 489-498.

Besdine, R. The educational value of assessment. In *Evaluating the elderly patient: The case for assessment technology* (pg. 6), paper presented at the NIH Technology Assessment Conference, Bethesda, MD, June 29-30, 1983.

Barton, R., & Hurst, L. Unnecessary use of tranquilizers in the elderly patient. *British Journal of Psychiatry*, 1985, *112*, 989-994.

Census Bureau, Aging America: Trends and projections, Washington, DC, U.S. Government Printing Office, 1986, pp. 1-10.

Cruz, F.A. The educational needs of home health nurses. *Home Health Care Nurse*, March 1986, *4*(3), 11-17.

Coates, D.B. Evaluating hospital and home treatment for psychiatric patients. *Canadian Psychiatric Association Journal*, 1967, *12*, 387-401.

Craig, J., & Eves, G.B. Minimizing drug misuse among the elders: A proposal. *Public Health Reports*, January-February 1987, *102*(1), 86-89.

Christensen, D.B. Documenting outpatient problem intervention activities of pharmacist in an HMO. *Medical Care*, January 1981, *19*, 104-119.

Campbell, E.B., Williams, M.A., & Mlybarczyk, S.M. After the fall: Confusion. *American Journal of Nursing*, February 1986, *86*(2), 151-154.

Community Assessment Guide, New York, Lehman College, Department of Nursing, Cuny, Bronx, 1975.

Doty, P. An overview of long term care. *Health Care Financing Review*, Winter 1985, 7(2), 73.

Dye, C. Laboratory values. In C.A. Dye (Ed.) *Assessment and interaction in geropsychiatric nursing* (pp. 183-194). New York: Grune & Stratton Inc., 1985.

Dye, C. Assessment of mental process. In C. A. Dye (Ed.), *Assessment and intervention in geropsychiatric nursing*. New York: Grune & Stratton, Inc., 1985.

Dorpatt, T.L. et al. The relationship of physical illness to suicide. In H. Resnick (Ed.), *Suicidal behavior* (pp. 78-90). Little, Brown & Co., 1968.

Duke University Center for the Study of Aging. *Multidimensional functional assessment*. The OARS methodology (2nd ed.). Durham, NC: Duke University Press, 1978.

Eisenberg, F., & Rodney, B. *Who are the elderly living alone?* Baltimore, MD: Johns Hopkins University, Commission on Elderly People Living Along, 1986.

Ernst, P. et al. Incidence of mental illness in the aged: Unmasking the effects of a diagnosis of chronic brain syndrome. *Journal of the American Geriatric Society*, August 1977 XXV (8), 371-375.

Ehrlick, P. Informal support networks meet health needs of rural elderly, *Journal of Gerontological Social Work*, 9(11), 85-97.

Foreman, M.D. Acute confusional states in the elderly: An algorithm. *Dimension of Critical Care Nursing*, July-August 1984, 3(4), 207-215.

Finestone, D.H., & Larson, D. Hyperactivity in senile dementia. *Journal of American Geriatric Society*, August 1982 *30*(8), 521-523.

Furstenberg, A.L. Expectations about outcome following hip fracture among older people. *Social Work in Health Care*, Summer 1986, *11*(4), 33-47.

Friedman, R.S. Profile of psychiatric emergency patients. In G.M. Barton, (Ed.) (pp. 25-35). New York: The Haworth Press, Inc., 1986.

Folstein, M. Mini-mental states: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 1975, *12*, 189-198.

Finalyson, R.E., & Martin, L.M. Recognition and management of depression in the elderly. *Mayo Clinic Proceedings*, 1982, *57*, 115-120.

Foreman, M.D. Acute confusional states in the elderly: An algorithm. *Dimensions of Critical Care Nursing*, July-August 1984, *3*(4), 207-215.

Furstenberg, A.L. Expectations about outcomes following hip fractures among older people, *Social Work in Health Care*, 11(4) Summer 1986, pp. 33-57.

Goaff, H. Laboratory tests you can't overlook. *Nursing 87*, February 1987, *17*(2), 56-59.

Goldstein, S.E. Depression in the elderly. *Journal of the American Geriatric Society*, January 1979, XXVII (1), 38-42.

Goldfarb, A.I. Minor adjustments of the aged. In S. Arieti et al. (Eds.), *American handbook of psychiatry* (pp. 820-860). New York: Basic Books, 1974.

Grunhaus, L. et al. Depressive pseudodementia: A suggestive diagnostic profile. *Journal of Biological Psychiatry*, 1983, *18*(2), 215-225.

Gordon, W.F. Elderly depressive: Treatment and follow-up *Canadian Journal of Psychiatry*, March 1981, *26*, 110-113.

Gallant, D.M. Differential diagnosis of confusion in geriatric patients. *Geriatric Medicine Today*, April 1985, *4*(4), 73-81.

German, P., Shapiro, S., Skinner, E.A., Van Korff, M., Klein, L.E., Turner, R.W., Tietelbaum, M.L., Burke, J., & Burns, B.J. Detecting and management of mental health problems of older patients by primary care providers. *Journal of American Medical Association*, *257*, (4) 489-493.

Gurel, L., Lenn, M.W., & Lenn, B.S. Physical and mental impairment of functions evaluation in the aged: The PAMIE scale, *Journal of Gerontology*, 1972, *1* 83-90.

Goldfarb, A. Aging and organic brain syndrome, Washington, PA., McNeil Laboratories, 11-13, 1984.

Gurland, B., Golden, R.R., & Teresi, J.A. The shortcare: An efficient instrument for the assessment of depression, dementia, and disability, *Journal of Gerontology*, *39* 166-169.

Gurland, B., Kuriansky, J., & Sharpe, L. The comprehensive assessment and referral evaluation (CARE) rational, development and reliability, *International Journal of Aging & Human Development*, *8*, 9-42.

George, L.K. The dynamics of caregivers burden. Report submitted to American Association of Retired Persons, Andrus Foundation, 1984.

George, L.K., & Gwyther, L.P. Caregivers well-being: A multidimensional examination of family caregivers of demented adults. *The Gerontologist*, *26*, 253-259, 1986.

Guide for understanding & care of persons with Alzheimer's disease, Atlanta, Georgia, Alzheimer's Disease & Related Disorder Chapter, 2nd Edition, 1985.

Gattozzi, A. *Prospective payment of mental health care: The impact of medicare's prospective payment system on psychiatric facilities and patients*. Rock-

ville, MD: National Institute of Mental Health, Intergovernmental Affairs and Public Liaison Branch, 1986.

German, P.S., Shapiro, S., Skinner, E.A., Von Karoff, M., Klein, K.E., Turber, R., Tietelbaum, M.L., Burk, J., & Burn, B. Detection and management of mental health problems of older patients by primary care providers. *Journal of American Medical Association*, January 1987, *257*(4), 489-493.

Goodstein, R.K. Grief reactions in the elderly: An acute care issue. In E.S. O'Neill, *The psychiatric emergency: Its recognition and management* (pp. 77-95). New York: The Haworth Press, Inc., 1986.

Gupta, R.L., & Patanwala, S.K. Geriatric endocrinology: The value of routine thyroid function test in elderly patients. *Geriatric Medicine Today*, August 1986, *5*(8), 59-64.

Gurland, B.J. Epidemiology of psychopathology in old age: Some implications for clinical services. *Psychiatric Clinics of North America*, April 1982, *5*(1), 11-26.

Gruenberg, E.M. et al. Identifying cases of the social breakdown syndrome. In E.M. Gutenberg, *Evaluating the effectiveness of community mental health services*. New York: Milbank Memorial Fund, 1966.

Gottlieb, K.M. et al. The physician's knowledge of psychotropic drugs: Preliminary results. *American Journal of Psychiatry*, 1978, *135*, 29-33.

German, P.S. Adverse drug experience among the elderly (pp. 40-48). Paper presented at the Medical Concerns of Drug Use by the Elderly Conference, Washington, DC, November 1985.

Hecht, A. A guide to the proper use of tranquilizers, *F.D.A. Consumer*, December 1985/Jauary 1986.

Hodkinson, H.M. Common symptoms of disease in the elderly (p. 24). Oxford, England: Blackwell, 1976.

Harper, M.S. Alzheimer's disease: Challenges of providing care. Paper presented at the National Gerontological Nursing Convention, Chicago, IL, September 19, 1987.

Health Care Financing Administration. Health Care Financing Notes, (HCFA Publication #03232, No. 6, Baltimore, MD, Health Case Financing Administration, September, 1986.

Harlow, K.S., & Wilson, L.B. *DRGs and the community based long term care system testimony*. Paper presented to the U.S. House of Representatives, Committee on Education & Labor, Subcommittee on Human Resources, Washington, DC, July 30, 1985.

Health Care Financing Administration, Federal Law & Regulation 42USC, Section 1396d (a) (b).

Health Care Financing Administration. State Medicaid Manual, Part 4, Section 4390, Services to individuals age 65 or older in institutions for mental diseases, Transmittal No. 3, December 1982.

Henderson, M.L. Assessing the elderly. *American Journal of Nursing*, October 1985, *85*(10), 1103-1106.

Hays, A.M., & Borger, F. A test in time. *American Journal of Nursing*, October 1985, *85*(10), 1107-1109.

Hamilton, M.A. Rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry*, 1960, *23*, 56-62.

Hays, H. The set test to screen mental status quickly. *Geriatric Nursing*, March-April 1983, *6*, 96-97.

Jazwiecki, T., & Press, S. Federal reimbursement for long term care of the mentally ill. In M. Harper & B. Lebowitz (Eds.), *Mental illness in nursing homes: An agenda for research* (DHHS Publication No. (ADM) 86-1459 and G.P.O. #163-313;QL.3). Washington, DC: U.S. Government Printing Office, 1986.

Jackson, G. et al. Inappropriate antihypertensive therapy in the elderly. *Lancet*, 1976, *2*, 1317-1318.

Kovar, M.G. Expenditures for medical care of elderly people living in the community in 1980. *Milbank Memorial Fund Quarterly*, 1986, *64*(1), 100-131.

Kutner, B. et al. *Five hundred over sixty: A community survey of aging*. New York: Russel Sage Foundation, 1956.

Kessel, W., & Shepherd, M. Neurosis in the hospital and general practice. *Journal of Mental Science*, 1962, *108*, 159-163.

Katz, M.M., & Lyerly, L.B. Methods for measuring adjustment and social behavior in the community: 1. Rational, description, discriminative validity and scale development. *Psychological Reports*, *13* (Monograph Suppl. 4), 593-535.

Kahn, R.L. & Goldfarb, A. Brief objective measures for determination of mental status in the aged: *American Journal of Psychiatry*, *117*, 326-328.

Kirking, D.M. et al. Detecting and preventing adverse drug interactions: The potential contributions of computers in pharmacies, *Social Science Medicine*, 1986, *22*, 1-8.

Kiernan, P.J. et al. Use of drugs by the elderly. *Journal of the Society of Medicine*, 1981, *74*, 196-200.

Katz, S., Ford, R.W., & Maskowitz, R.W. Studies of illness in the aged. The Index of ADL; a standardized measure of biological and psychological function, *Journal of the American Medical Association*, 1963, *185*, 914-919.

Kinderknecht, C.H. In home social with abused or neglected elderly: An experimental guide to assessment and treatment. *Journal of Gerontological Social Work*, 1986, *9*(3), 29-42.

Libow, L.L. A rapidly administered, easily remembered, status evaluation: FROMAJE. In L.L. Libow et al. (Eds.), *The care of geriatric medicine: A guide for students and practitioners* (pp. 85-91). St. Louis, MI: The C.V. Mosby Co., 1981.

Lamy, P. Psychopharmacologic drugs in the elderly. In P. Lamy (Ed.), *Prescribing for the elderly* (pp. 501-591). Boston: John Wright. P.S.G. Inc., 1982.

Lennard, H.L. et al. Hazards implicit in prescribing psychoactive drugs. *Science*, 1970, *169*, 438-442.

Levinson, D.G., & Simpson, G. The emergency treatment of affective disorders.

In E.S. O'Neill (Ed.), *The psychiatric emergency: Its recognition and management* (pp. 45-54). New York: The Haworth Press, Inc., 1986.

Lipowski, Z.J. Transient cognitive disorders (delirium acute confusional states) in the elderly. *American Journal of Psychiatry*, November 1983, *40*(11), 1426-1436.

Lipowski, Z.J. Delirium (acute confusional state). In P.J. Vinken, G.W. Bruyn, & H.L. Klawans (Eds.), *Handbook of clinical neurology* (pp. 523-559). New York: Elsevier Science Publishing Co., Inc., 1985.

Lipowski, Z.J. *Delirium (1980): Acute brain failure in man*. Springfield, IL: Charles C Thomas, p. 26.

Larson, E.B. et al. Evaluating elderly outpatients with symptoms of dementia. *Hospital and Community Psychiatry*, May 1986, *35*(5), 425-428.

Lezak, M.D. Living with characterologically altered brain injured patients. *Journal of Clinical Psychiatry*, 39:592-598, 1978.

Libow, L.S. *Overview: New pills for old ills*. Paper presented at National Conference, New Research & New Concern: Pharmaceuticals for the Elderly, Pharmaceutical Manufacturers Association, Washington, DC, November 1986, pp. 2-5.

Levit, K. National health expenditures. *Health Care Financing Review*, Fall 1985, (1) 5.

Lowenthal, M.F., & Berkman, P.S. *Aging and mental disorders in San Francisco*, San Francisco: Jossey Bass, 1967.

Luke, E. Prevalence of psychological impairment in an advanced-age population. *Journal of the American Geriatric Society*, February 1982, *30*(2), 114-122.

Leeper, J.D. et al. Mental disorders among physical disability determination patients. *American Journal of Public Health*, January 1985, *75*(1) 78-92.

Lipowski, Z.J. Transient cognitive disorders (delirium, acute confusional states) in the elderly. *American Journal of Psychiatry*, November 1983, *104*(11), 1426-1436.

Ludwick, R. Assessing confusion: A tool to improve nursing care. *Journal of Gerontological Nursing*, August 1981, *7*(1), 474-477.

Laurent, C.L. Hidden depression. *American Journal of Nursing*, May 1985, *85*(5), 543-548.

Larson, E.B. Evaluating elderly outpatients with symptoms of dementia. *Hospital and Community Psychiatry*, May 1984, *35*(5), 425-428.

Lawton, P., & Brody, E. Assessment of older people: Self maintaining and instrumental activities of daily living. *Gerontologist*, 1969, *9*, 179-186.

Manton, K.G., Blazer, D.G., & Woodbury, M.A. Suicide in middle age and later life: Sex and race specific life tables and cohort analysis, *Journal of Gerontology*, 1987, *52*(2), 219-227.

McIntosh, J.L. Suicide among the elderly: Levels and trends, *American Journal of Orthopsychiatry*, 1985, *55*: 288-293.

Murphy, G.E. The physician's responsibility for suicide, II errors of omission. *Annals of Internal Medicine*, 1975, *82*, 305-309.

Mueller, J. The mental status examination. In H.H. Gildman (Ed.), *Review of General Psychiatry*, 1984 New York: Lange Medical Publishers, pp. 123-130.

Morris, E.M. Home care today: An interview: *American Journal of Nursing*, March 1984, pp. 340-345.

Menolascino, F.J. The nature and types of mental illness in the mentally retarded. *Psychopharmacological Bulletin*, 1986, *22*(4), 1060-1071.

Mimot, S.K. Depression: What does it mean? *American Journal of Nursing*, 1987, *86*(3), 283-298.

McIntosh, J.L. Suicide among the elderly: Levels and trends. *American Journal of Orthopsychiatry*, April 1985, *55*(2), 288-293.

Mezy, M. Assessment of mental-emotional and neurological functioning. In M.D.Mezeey, Rauckhorst, L.H., and Stokes, S.A. (Eds.), *Health assessment of the older individual* (pp. 101-118). New York: Springer Publishing Co., 1980.

McIntosh, J.L. et al. Suicide among the elderly: A review of issues with case studies. *Journal of Gerontology*, 1981, *4*, 31-74.

McCue, J.D. Routine medical screening of the relatively asymptomatic elderly patient, *Geriatric Medicine Today*, 1987, *6*(2), pp. 23-45.

Minot, S.R. Depression: What does it mean? *American Journal of Nursing*, March 1986, *86*(3)m 285-298.

Miller, M. Suicide among older men. In unpublished doctoral dissertation, University of Michigan, Ann Arbor, 1976.

Nickens, H.W. Psychotropic drugs. *Generations*, Spring 1986, 33-37.

National Center for Health Statistics (1985), Vital Statistics of the United States, 1980, Vol. 11—Mortality, Part B, USDHHS, PHS, Hyattsville, MD.

The New York Times, Helping elderly avoid injury. *The New York Times*, March 3, 1985, p. 22.

Osgood, N.J. The case of the elderly suicide: Contributing factors, theoretical explanations and conceptual models. In N.J. Osgood (Ed.), *Suicide in the elderly* (pp. xix-klix). Rockville, MD: Aspen 1985.

Ouslander, J.G. Illness and psychopathology in the elderly. *Psychiatric Clinic of North America*, April 1982, *5*(1), 145-158.

Osgood, N.J. *Suicide in the elderly*, (pp. x-xxi). MD: Rockville Aspen Publication, 1985.

Osgood, N.J. Suicides. In E. Palmer (Ed.), *Handbook of the aged in the United States* (pp. 371-390). Westport, CN: Greenwood Press, 1984.

Osborn, J.R. et al. Medication usage in an elderly population. *Medical Care*, February 1985, *23*, 157-164.

Ouslander, J.G. Physical illness and depression in the elderly. *Journal of the American Geriatric Society*, September 1982, *30*(9), 592-599.

Osgood, N.J. Patterns of suicidal behavior in long-term care facilities: A preliminary report of an ongoing study, Final Report for grant funded by the Virginia Commonwealth University Faculty Grant-in Aid Program, Richmond, VA. 1987.

Office of Technology Assessment, *Losing a million minds: Confronting the trag-*

edy of Alzheimer's disease and other dementias, Washington, DC, Congress of the United States, Office of Technology Assessment, 1987, OTA-BA-264, pp. 3-42.

O'Rourke, M. The State of Art. Paper presented for the National Conference on the Abuse of Older Persons, Boston, MA, unpublished manuscript, Boston, MA, 1981, 23-25.

Palley, H.A., & Oktay, J.S. The chronically limited elderly. *Home Health Care Services Quarterly*, 1983, *4*(2), 141.

Pfeiffer, E., & Busse, E.W. Affective disorders. In E.W. Busse & E. Pfeiffer (Eds.), *Mental illness in later life* (pp. 86-92). Washington, DC: American Psychiatric Association, 1973.

Poulschock, S.W. The Affects on Families Caring for Elders in Resistance, Cleveland, OH, Benjamin Rose Institute, 1982.

Pedrick-Cornell, G. & Gelles, R.J. Elderly abuse: The status and current knowledge, *Family Relations*, 31, 457-465.

Reifler, B.V., Larson, E., & Hanley, R. Coexistence of cognitive impairment and depression in geriatric outpatients, *American Journal of Psychiatry*, 139: 623-628.

Rebok, G.W. et al. The functional context of the elderly behaviors. *The Gerontologist*, 1977, *17*(1), 27-34.

Remakers, B.L. et al. How to prevent confusion in hospitalized elderly. *Geriatrics*, June 1981, *36*(6), 121-124.

Robertson, D., & Reisner, D. (1982). Management of dementia in the elderly at home: Stress & supporter. *Canada's Mental Health*, 9: 36-38.

Reisberg, Barry. (1984) Stages of cognitive decline, *American Journal of Nursing* 47: 225-228.

Reisberg, B., Ferris, S.H., DeLeon, M.J., & Crook, T. (1982) The Global deterioration scale for assessment of primary degenerative dementia, *American Journal Psychiatry*, 139:9, 1136-1139.

Reisburg, B., Shulman, E., Steinberg, G., Rabinowitz, E., Khan, R., & Ferris, S.H., (1986) Patient and caregiver management. *Drug Therapy*, 65-93.

Reisberg, B., Ferris, S.H., & Franssen, E. (1985) An ordinal functional assessment tool for Alzheimer's type dementia, *Hospital and Community Psychiatry*, 36: (6) 593-595.

Remnet, V.L. The home assessment: A therapeutic toll to assess the needs of the elderly. In I.M. Burnside (Ed.) (1976), *Nursing and the Aged*, New York, McGraw-Hill, p. 490.

Robin, P.V., Mace, N.L., & Lucas, M.J. The impact of dementia on the family, *Journal of American Medical Association*, 1982, 848: 333-335.

Rubin, E.H., Morris, J.C., & Berg, L. (1987) The progression of personality changes in senile dementia of the Alzheimer's type, *Journal of the American Geriatric Society*, 35: 721-725.

Saldo, B.J., & Manton, K.G. Changes in health status and service needs of the oldest old: Current patterns and future trends. *Milbank Memorial Fund Quarterly*, Spring, 1985, *63*(2), 286-290.

Select Committee on Aging, U.S. House of Representatives, (1984) Building a long term care policy: Home care data and implications. Cmte Pub. No. 98-484, Washington, DC, US Government Printing Office.

Seymour, D.G. Acute confusional states and dementia in the elderly: The role of dehydration/volume depletion, and physical illness. *Age and Aging*, August 1980, *9*(3), 137-146.

Snyder, L.H. et al. Wandering. *The Gerontologist*, 1979, *18*(3), 272-279.

Shylman, K. Suicide and para-suicide in old age: A review. *Age and Ageing*, 1978, *7*(3), 201-209.

Solomon, K. The depressed patient: Social antecedents of psychopathologic changes in the elderly. *Journal of the American Geriatric Society*, January 1981, *29*(1), 14-18.

The Surgeon General's conference on hip fracture prevention proceedings. Washington, DC: U.S. Department of Health & Human Services, September 1983, pp. 19-20.

Shapleigh, J. Hematologic values in the aged. *Journal of Gerontology*, 1952, *7*, 155-163.

Salzman, C. Depression in the elderly: Relationship between depression, psychologic defense mechanisms and physical illness. *Journal of American Geriatric Society*, 1978, *26*, 253-260.

Schwab, J.J. et al. Sociocultural aspects of depression in medical patients. *Archives General Psychiatry*, 1967, *17*, 533.

Slaby, A.E. Definitions and conceptual framework of psychiatric emergencies. In G.M. Barton & R.S. Friedman (Eds.), *Handbook of emergency psychiatry for clinical administrators* (pp. 9-23). New York: The Haworth Press, Inc., 1986.

Shader, R. The new scale for clinical assessment in geriatric population: Sandoz clinic assessment-geriatric (SCAG). *Journal of the American Geriatric Society* 1974, *22*, 107-113.

Select Committee on Aging: Drug use and misuse: A growing concern for older Americans. A joint hearing before the Special Committee on Aging—U.S. Senate and the Subcommittee on Health & Long Term Care of the Select Committee on Aging—U.S. House of Representatives, 98th Congress. Washington, DC: U.S. Government Printing Office (#24-8610), June 28, 1983, pp. 2-25.

Solomon, K. The depressed patient: Social antecedents of psychopathologic changes in the elderly. *Journal of the American Geriatric Society*, January 1981, xxix (1), 14-18.

Shneidman, E. At the point of no return. *Psychology Today*, March 1987, *21*(3), 54-58.

Sullivan, N., & Fogel, B.S. Could this be delirium? *American Journal of Nursing*, December 1986, *86*(12), 1359-1363.

The Surgeon General's Conference on Hip Fracture Prevention Proceedings, Washington, DC: U.S. Dept., HHS, September 19-20, 1983.

Seynidur, D.G. et al. Acute confusional states and dementia in the elderly: The

role of dehydration/volume depletion, physical illness and age. *Age and Ageing*, August 1986, *9*(3), 137-146.

Snyder, L.H. (1978). Wandering. *The Gerontologist*, 18:(3), 272-279.

Stone, R., Caffarata, G., & Sangl, J. Caregivers of the frail elderly: A national profile. U.S. Department of Health & Human Services, National Center for Health Service Research, 1986.

Simonton, L.J. Assessing caregiver information needs: A brief questionnaire, *Journal of Gerotological Social Work*, 10(1&2): 177-179.

Redick, R.W., Taube, C. Demography and mental health care of the aged: In J.E. Birren (Eds.), *Handbook of mental health and aging* (pp. 57-71). Englewood Cliffs, NJ: Prentice-Hall, 1980.

Talbott, J.A. Mental health needs of the elderly: Clinical and policy issues. Paper presented at the Maryland Office on Aging Regional Workshop, Baltimore, Maryland, December 12-13, 1985.

Taube, C.A., & Barrett, S.A. *Mental health, United States*, (DHHS Publication No. (ADM) 85-1378, Rockville, MD: National Institute of Mental Health, 1985.

Thompson, L.W. et al. Cognitive therapy with older adults. *Clinical Gerontologist*, August 1986, *5*(3/4), 245-279.

Temples, D.I. et al. Suicide in the elderly: Assessment and intervention. *Clinical Gerontologist*, August 1986, *5*(3/4), 475-487.

Tinetti, M.E. et al. Fall risk index for elderly patients based on number of chronic disabilities. *The American Journal of Medicine*, March 1986, *80*, 429-434.

Teysink, J.P. Helping families cope with Alzheimer's disease. *Hospital & Community Psychiatry*, February 1984 *35*(2), 152-156.

Talbott, J.A. (1985) Clinical and policy issues, *Bulletin of New York Academy of Medicine*, 61: (5) 445-464.

Ulin, Priscilla R. (1981) Measuring adjustment in chronically ill clients in community mental health care, *Nursing Research* 30 (4) 229-235.

United States Department of Health Education & Welfare. Public policy and the frail elderly, Washington, DC: U.S. Government Printing Office, December 1978.

United States Congress, Office of Technology Assessment and Aging in America, OTA-BA-264m Washington, DC: U.S. Government Printing Office, June 1985.

Veterans Administration. *Dementia guidelines for diagnosis and treatment*. (Pub. #1B-18-3). Washington, DC: Veterans Administration Central Office, October 10, 1985.

Valentine, D., & Cash, T., (1986). A definitional discussion of elder maltreatment, *Journal of Gerontological Social Work*, *9*(3), 17-27.

Weiss, R.S. (1982). Loneliness: What we know about it and what we might do about it. In L.A. Peplau (Ed.), *Preventing the harmful consequences of severe & persistent loneliness* (pp. 3-12). Washington, DC: U.S. Government Printing Office.

Williams, T.F. (1986). The aging process: Biological and psychological. In S.J.

Brody and G.E. Ruff (Eds.), *Aging and rehabilitation: Advance in the state of art* (pp. 13-18). New York: Springer Publishing Co.

Wood, J.B., & Ester, C.L. Home health care under the policies of nee federalism. *Caring*, June 1984, pp. 58-61.

Wasylenski, D. The psychogeric problem. *Canada's Mental Health*, September 1982 *30*(3), 16-19.

Williams, T.F. Assessment as a useful tool. In *Evaluating the elderly patient*: The case for assessment technology (pp. 2-3). Paper presented at the NIH Technology Assessment Conference, Bethesda, MD, June 29-30, 1983.

World Health Organization. *The control of drugs for the elderly*. Report on the Ninth European Symposium on Clinical Pharmacological Evaluation of Drug Control—Schlangenbad November 18-21, 1980. Copenhagen: Regional Office for Europe—World Health Organizations, 1981.

Waxman, H. et al. Physician's recognition, diagnosis, and treatment of mental disorders in elderly medical patients. *Gerontologist*, 1984, *24*, 593-597.

Walls, C.E. (1980). Pseudomentia, *American Journal of Psychiatry* 136. 895-900.

Wilner, M. Individual psychotherapy with depressed elderly outpatients: An overview. *Journal of the American Geriatric Society*, May 1978 XXVI (5), 231-235.

Weissman, M.M., & Myers, J.K. Affective disorders in a U.S. community: The use of research diagnostic criteria in an epidemiologic survey. *Archives General Psychiatry*, 1978, *35*, 1304-1311.

World Health Organization (1972), *Psychogeriatrics*, Technical Report #507, (p. 15). Geneva, Switzerland, WHO Press.

Wolanin, M.O. et al. *Confusion*. St. Louis, MO: C.G. Mosby Co., 1981. p. 62.

Wilder, D.E., Teresi, J.A., & Bennett, R. Family burden and dementia. In *The Dementias*, R. Mayenth & W.G. Rosed (Eds.), New York: Raven Press, 1983.

Yanchick, V.A. Drug therapy. In C.A. Dye (Ed.), *Assessment and intervention in geropsychiatric nursing* (pp. 137-169). New York: Grune & Stratton, Inc., 1985.

Yesavage, Jerome. Memory and cognitive decline. Paper presented at the International Congress of Psychogeriatrics, Chicago, IL, August 31, 1987.

Zarit, S.H., Reeves, K.E., & Back-Peterson, J.M. (1980). Relatives of impaired elderly: correlates of feelings of burden, *The Gerontologist*, 29: 649-655.

Zarit, S.H., Reever, K.E., & Zarit, J.M. (1982). Memory training and memory loss: Effects in senile dementia patients and their families, *The Gerontologist*, 22: 272-377.

Zung, W.N., & Green, R.L., Jr. Detection of affective disorders in the aged. In C. Eusdorfer & W.E. Fann (Eds.), *Psychopharmacology and aging* (pp. 63-70). New York: Plenum Press, 1973.