

PSYCHOSOMATIC MEDICINE IN GERIATRIC PRACTICE

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The rapidly increasing number of publications, grants, committees, projects, and symposia is striking evidence that there is no easy short-cut to the solution of the ever-increasing problems created by the ever-growing number of senior citizens. The problems lie not only in the vast number that make up the "three-score-plus" age group of our population but also in the rapid evolution of the socio-economic structure of our culture and the "revolutionized" spirit of the general quest for human rights. Besides the paramount importance of the socio-economic predicament of our geriatric patients, the state of their physical and mental health and functional efficiency in many cases continues to present difficult problems despite progress in the medical sciences and despite greater availability of medical services.

The purpose of this paper is to discuss some essential points in the holistic management of non-institutionalized geriatric patients in private, clinical, and group practice where ideal, multidisciplinary teamwork is only rarely, if ever, available. The basic principle of holistic management is the essential recognition of human beings as indivisible psycho-physical units inseparably interrelated with their field of existence. It cannot be denied that the aging ("degenerative") changes in the anatomical-morphological, histological, biochemical, enzymatic systems may adversely affect the entire psycho-physical unit. However, it has also been shown that psychogenic factors may significantly affect the functional efficiency—even in the somatic and mental intellectual spheres—of patients with or without actual organic findings, including the "chronic brain syndrome." The changes may take place so slowly and the patient may "fight and hide" them so successfully that the aging person and/or his environment may not become aware of the true significance of the changes for a rather long period of time. However, the physician and the psychotherapist should be well prepared to recognize, to evaluate, and to correlate the psychic as well as the somatic manifestations.

Generally speaking, by *geriatric psychosomatosis* we mean the especially close interrelation between the actual organismic and the behavioral manifestations in all aspects of the elderly patient's existence.

In virtually all elderly patients we usually deal simultaneously with both somatic and behavioral changes—though possibly not in the same degree. Not infrequently the significance of one or the other aspect of the patient's symptoms is either over- or under-estimated, often resulting in serious consequences to the patient. It is well known that many elderly patients have been treated for minor "somatic" ailments for long periods of time while the underlying serious depression or anxiety was neglected. However, it is also known that serious organic diseases, including malignancies (especially of the brain, pancreas, and prostate), minor strokes, cerebral lesions, hematological disorders, etc., have been overlooked because the patient's presenting symptoms were primarily emotional and were treated as such. Some organic diseases in their early stages are oftentimes not accompanied by significant somatic symptoms but rather by some intellectual or emotional manifestations (as in cerebral arteriosclerosis, cerebral tumor, chronic prostatism, uremia, cancer of the pancreas, etc.). Thus, aging patients may be unaware of their actual organic diseases for a rather long period of time.

The significance of geriatric psychosomatosis lies in our growing recognition of the fact that certain patients tend to deal with their somatic symptoms in line

with their "private logic" and unduly exaggerate their somatic symptoms or their importance while others assume an attitude of "fighting and hiding" their symptoms and thus minimize their physical decline. Of course, in all cases the diagnostician's primary task is to recognize not only the cause and significance of the symptoms but the patient's way of dealing with and using his symptoms.

For example, a 68-year-old widower who lived on his social security allotments, augmented by a part-time job, sustained a relatively minor accident. His complaints, however, were so severe in comparison with his actual injury that he was totally unable to perform his job for almost six months. The rationale of such disability may be found in the desire to have a short "paid" vacation; in dissatisfaction with one's work; in the unconscious wish to have some benefit from the disability which is not reportable lest his part-time income compromise his social security checks, especially if the "take-home pay" is not substantially higher than the disability benefit, and any number of other reasons growing out of the "private logic" of the aging individual.

The other extreme—the "fighting and hiding of symptoms," as it were—is illustrated by a woman one of whose breasts was already deformed by cancer but who successfully hid the fact from her own family until bony metastasis had occurred. Here also belong those patients who intentionally or unintentionally disregard prescribed therapeutic regimen—oftentimes being fully aware of the serious consequences of such "sabotage" (cf. "chronic suicide" and "pseudo-physiologic" or disguised suicide, described elsewhere).

One of the most frequent manifestations of geriatric psychosomatosis occurs in the musculoskeletal system. The usual wear-and-tear manifestations in the locomotor system—such as arthritis, arthrosis, osteoarthritis, fibrositis, etc.—are actually present and demonstrable in the vast majority of aging people. However, it is known that the actual symptomatology caused by such diseases may vary from insignificant symptoms to rather severe and more or less disabling symptoms. Muscular rheumatism and fibrositis have been declared by some physicians to be the prototypes of "psychogenic rheumatism." It is known that many elderly women with "rheumatic" symptoms which did not respond to medication have been successfully treated by massage—probably not so much by the physical massage itself as by the sympathetic dialogue and "psychic catharsis" accompanying the massage sessions.

The clinical picture may be made more complicated by so-called "reflectory pain," which may mimic disease symptoms in what is actually a healthy organ in which the patient feels more or less severe pain, while the actual pathological process is taking place in a distant, often symptom-free organ. Among the numerous clinically important "reflectory" or "referred" manifestations are apparent cardiac pain in gall bladder disease and spinal arthritis; pain in the left upper-limb in heart disease; pain in the right shoulder in diseases of the gall bladder, liver, or diaphragm; upper back pain in peptic ulcer; lower back pain in diseases of the prostate or female reproductive organs; and in many other instances. Examination of the symptomatic "target" organ in patients reporting such pain usually yields negative results and thus not infrequently leads to the improper diagnosis of "psychogenic pain."

It has often been stated that physicians who employ extensive diagnostic methods are guilty of causing "iatrogenic" symptoms in their patients by fixing the patient's attention on their somatic symptoms. This concept must be modified somewhat in dealing with geriatric patients because the majority of elderly patients are likely to have some "positive" organic as well as psychiatric find-

ings. It is extremely important—and at times crucial—to properly recognize the actual significance of such “positive” findings. Some such patients are just too glad to neglect their actual organic symptoms for an unduly long period of time. They may even consider the “psychiatric” diagnosis as a legitimate excuse to expect special privileges or to shed unwelcome responsibilities. They believe that the psychiatric diagnosis fully justifies their neurotic behavior. Some obese patients, for instance, refuse to go on a medically indicated diet. “I am in a depression. I cannot go on a diet,” they may well insist. Others refuse helpful orthopedic appliances by saying, “I cannot wear this heavy support because of my anxiety neurosis.”

A concerted multidisciplinary approach is especially important for those patients who unduly attribute their somatic symptoms to emotional factors (the “battle for psychogenesis”), as important as it is for those who deny or unduly minimize their emotional instability and dramatize their somatic symptoms (the “battle for somatogenesis”). It is well to remember that the occurrence of “masked depression”—even “masked suicide”—in elderly patients is a widely known phenomenon. However, the occurrence of “masked degeneration” (organismic) deterioration in elderly patients is a much less recognized though nevertheless rather frequently encountered phenomenon in geriatric practices. One should also bear in mind that geriatric patients may not only “mask” but may also “mimic” certain diseases. A truly and consistently applied holistic approach may early enough “unmask” the real state of affairs. An exceedingly helpful tool in the holistic management of geriatric problems is what we may term the *geriatric profile*.

The Geriatric Profile

The concept of *geriatric profile* not only implies that a truly holistic approach in the diagnosis and management of elderly patients is even more important than in other patients, but also offers a valuable tool toward that goal. As important as the actual medical problem may be, it often does not represent the only—and frequently not even the most important—aspect of the successful management of geriatric patients. Based on sound medical principles and on the holistic Adlerian concept of human life, such an operational profile should in principle include any given patient’s past, present, and anticipated status and functioning in the three main aspects of human existence: namely a) work, b) sex, and c) society.

Translating this basic principle into practice, the geriatric profile should include:

a) the patient’s work history, work experience, economic status, and available or expected future sources of livelihood;

b) for obvious reasons, the sex aspect of the patient in this context must be extended to include his entire organismic status or, in other words, a complete medical anamnesis and a thorough medical “work-up”;

c) the patient’s family and community relationships and functions, his interpersonal relationships, his formal and informal affiliations (activities in clubs, societies, groups, etc.) and any recent or contemplated changes in all his interpersonal relationships. It should also be mentioned that in many instances recognition of the patient’s cultural, ideological, philosophical, spiritual, and religious

background and affiliations may prove to be very helpful.

Patients should be asked explicitly if they have belonged or now belong to any clubs, groups, or organizations. Frequently, it will be found that they did belong to various groups and organizations but that they have gradually dissociated themselves for various reasons. These reasons and their significance can often be most profitably discussed with patients. Patients may also be asked how they managed the loss (by death, sickness, moving away, or otherwise) of their close contemporaries, whether relatives, friends, business associates, or fellow workers. Do they miss (some of) them, or have they found replacements?

The most time-consuming part of such a profile is frequently the organismic aspect, because the usual "routine" physical examination is rather inadequate—and sometimes even misleading—in the determination of an aging person's organismic status.

Such a basic profile—to which later changes are to be added as they occur—proves to be extremely helpful in the management of geriatric patients. It may reveal not only the patient's probable life expectancy but also his functional expectancy. It may reveal that not only his "social security" but also his "biological security" and "interpersonal security" are far from being secure. They often prove to be discouragingly insecure and may in fact represent the real pathogenic agents. The profile will also show in which area(s) the therapeutic management is most important or most urgent. It often reveals that the patient is not, or at least *not only* "a sick old man" but also, or even mainly, an "angry old man" or "a bitter and sad old man," a "revenge-seeking old man," and most frequently a "discouraged old man" with little incentive or motivation and almost always with a great deal of decompensated inferiority feelings. It will also often be found that the frequently assumed "unconscious fear of death" is really a "fear of life," a "fear of slow dying," or in many cases a "fear of social death"—rather than the fear of biological death.

Another important factor toward helping any given aging patient is the physician's or the therapist's readiness to recognize, evaluate, and beneficially influence what one might call the "*geriatric (or gerontal) protest*" which one might find—in a more or less hidden form—in a surprisingly large number of elderly patients.

The "*Geriatric Protest*"

In the various manifestations of the behavior of many elderly patients there seems to be a common denominator pointing to the purposive function of their often misinterpreted behavior. Generally speaking, this common psychodynamic denominator, which might appropriately be termed the *geriatric (or gerontal) protest*, represents an aging individual's own way of counter-rejecting his being socially rejected.

By analogy with Adler's concept of "masculine protest," it could be termed "juvenile protest," being a protest against the glorification of youthfulness, just as masculine protest is directed against the unwarranted glorification of masculinity. Both represent protest against certain prejudiced misconceptions prevailing in our society.

Psycho-dynamically, "geriatric protest" represents an aging person's attempts to (over)compensate for his bio-socially centered specific inferiority feelings by using compensatory methods in line with his lifelong unique life-style. The "specificity" of these inferiority feelings lies in the fact that a person's previous inferiority feelings may well have been changed or augmented by an increasingly oppressive age-consciousness in which the prevailing (mis)concept of "age" amounts to a painful inferiority feeling—if not to a paralyzing inferiority complex. The "geriatric protest" may also be present in apparently "well adjusted" individuals in whom the compensation takes place in a (relatively) constructive way.

It is known that the more difficult a stress or shock situation is, the more *undistorted* will one's genuine life-style appear and that it is only one's life-style which any human being carries essentially intact into his old age. The multitude of shocks and stresses which occur at the threshold of aging generally exceed in kind and intensity most of the previous stresses and strains which had been more or less successfully overcome by an individual's available social feeling. Some aging individuals become more extravagant in order to impress other people. Some become more thrifty, justifying "building up their future security." Some cling to their duties in order not to lose status and not to "give in." Some relinquish a part or all of their duties in order to avoid possible mistakes, failures, defeats. Some male patients may get divorced and re-marry (usually much younger women). Some may become depressed, others agitated, others anxious, or they may overemphasize somatic symptoms, etc., as I have indicated earlier.

Occasionally, it has also been observed that the decreasing responsibilities accompanying aging may exert a "softening and compensatory effect" on previously neurotic behavior. At any rate, "geriatric protest" should not be looked upon as a simple reaction to external stimuli, but as an aging individual's unique way of dealing with the new problems imposed upon him by the new configuration of the "three main tasks of life," as described above.

Whether, by what means, and how successfully any given individual tries to compensate for his age-centered inferiority feelings or hide his perceived inferiority will depend largely upon the ratio between the demanded and available social feeling, on the one hand, and on the type and intensity of the shocks and stresses experienced, on the other.

The awareness and display of somatic symptoms—exploited by some patient's "private logic" as an excuse for avoiding certain unwanted responsibilities, as an alibi against external or internal pressures, as a justification for demanding or seeking certain tangible or subtle benefits (for example, housing, pension, sympathy, preference, etc.)—may become a rather conspicuous form of the "geriatric protest," as if the patient were saying: "You dumped me because I am old, so now you must help me and should not expect anything of me because I am sick." Such a twist or trick seems to be rather appropriate and it is not infrequently quite successful, for the life-style of our generation has more consideration for *sick* people than it has for *old* people. The elderly patient may therefore tolerate with much less inferiority feeling some physical imperfection than the awareness of his senescence. As Swift put it: "Every man desires to live long, but no man wants to be old."

Another form of "geriatric protest" may be observed in connection with one of the most important changes which occurs in the aging period and which is rather euphemistically termed "retirement by choice" or "retirement by force."

Sometimes retirement actually means "retreat"; at other times it means to be "repulsed," to be "ostracized." Some people want to retire but cannot. Others do not want to retire but are forced to. Not too infrequently, retirement means a welcome and approved escape from an undesirable, tiresome, poorly rewarded, humiliating, stereotyped, machine-like existence.

A great number of "ready-to-retire" people seek medical help for a variety of somatic complaints for various, often hidden reasons; for instance, to retire before their retirement age, to justify retirement, to be in "good shape" when they retire, etc. In such patients typically, various complaints have already started during the late pre-retirement years. They complain of various symptoms which they may have had for a long time, such as backaches, pain in the shoulder, chest, or neck, etc. Significantly some of them may not have any significant complaints *after* their retirement although (or because) they actually become more active after their retirement than they had been prior to it. Some, however, continue to complain out of proportion to the manifest pathological findings. In these geriatric patients a thorough search for possibly undetected diseases as well as for a possibly serious disappointment with their new situation is indicated.

Generally, in overall management it proves very helpful to investigate the circumstances of a patient's retirement ("disengagement") or contemplated retirement in order to discover the meaning of his "geriatric protest," mainly:

- a) whether his retirement was in fact forced against his will;
- b) whether he really wants to retire but for certain reasons—mostly economic—he is unable to do so.

a) In certain situations, retirement becomes mandatory at a certain age. However, patients may resent such retirement for various reasons: their present job gives them satisfaction, status, and (self)respect; they refuse to take cognizance of their calendar age; or their socio-economic status may be seriously imperiled by the loss of their position and they realize the sometimes insurmountable difficulties of relocation.

Besides economic reasons, there are a variety of other reasons why older persons may want to continue functioning: the death of a mate and its following painful loneliness; too much "leisure" time to think about oneself; disturbing environmental or family circumstances; fear of the loss of prestige, which to them threatens "social death" before biologic death; and sometimes even apparently genuine social interest. A properly constructed and properly interpreted "geriatric profile," as discussed above, often helps greatly toward the successful management of apparently complicated cases. In these patients the "geriatric protest" as an expression of their counter-rejection of being rejected is usually rather easily detected.

b) Some older persons may want to retire for other than health reasons: because of certain antagonisms toward the working environment or their inadequate remuneration; because they may want and with the help of their pension, social security, or annuities, etc., they can afford to turn to some new but long desired activities (for instance, hobbies, studies, writing, painting, traveling, work on their inventions, etc.). They may even want to change their living as well as their working environment, their apartment, their home, or even the community in which they live.

A special category comprises those geriatric patients who would like to retire but who for some economic reasons cannot—or feel that they cannot—retire. Many of these patients are in failing health—physically and emotionally. In people who refuse to retire or to "slow down" despite evident biologic impair-

ment, one very frequently finds more or less complicating economic responsibilities, real or assumed. Not infrequently, one may recognize the phenomenon of the "chronic suicide," the "pseudo-physiological" or "masked suicide," mentioned earlier.

Although some aging patients may become aware of gradual mental deterioration before being aware of any significant somatic symptoms, they still continue to function until the inevitable complete break-down. As a typical example, a well-known writer admitted after his hospitalization: "I knew that I was mentally sick, but I have been fighting and hiding it as long as I could." His protest against aging—in reality, against his younger and more efficient colleagues—consisted of his trying to "fool everybody" by keeping up the "as if," which he admitted he had done "all the time, anyway."

Geriatric protest may be more easily recognized and understood—just as it may more likely be present—in people who in their younger years themselves felt prejudice against old people. If a patient's parents or other close relatives grow old and become dependent on them, such a pre-existent negative attitude toward aging may oftentimes be recognized most readily.

On an appropriate occasion, one might paraphrase this question to his patient: "Do you ever think of how you felt toward your parents, grandparents, teachers, or other elderly people when you were young?" Of course, one must avoid implanting false, complicating "guilt" feelings, feelings of being punished, or any other complicating neurotic constructs. It is more helpful to use this concept to encourage patients to prove to themselves and to others that such an attitude was unjustified.

Needless to say, "geriatric (or gerontal) protest" may take on many forms and may use various methods for apparently various purposes. However, it is always guided by and reflects the patient's unique—basically unchanged—life-style, and it always has a direction, a "line of movement." The determination of the significance of the "geriatric protest" and the alleviation of its potentially disruptive effects may best be accomplished by trying to determine the "target" of the protest: against whom or what is it directed? Oftentimes it is directed against family, against associates, institutions, society at large, not infrequently against oneself, and though rather infrequently, even against "God."

In the following, the case history of a patient ready for total "retirement," that is, "total retreat," is briefly presented.

A 64-year-old married clerk sought treatment for various recurrent musculoskeletal disabilities, including bursitis of both shoulders, cervical sprain, low-back pain, hamstring tendonitis, varices, etc. He admitted that he had had recurrent "rheumatic" aches and pains of various intensity at various localizations virtually all his adult life but that he had had no medical treatment for the last twenty years. Various other physical complaints necessitating a number of tests and consultations—mainly cardiological, laryngological, ophthalmological and genitourinary—were undertaken with invariably negative organic findings. The musculoskeletal findings, though present, were not adequate to explain the apparently severe symptoms which were interpreted by the patient as warning signs of his "falling apart" as the result of "old age." His entire behavior, once observed and evaluated, justified the clinical diagnosis of a "masked depression."

The significance of psychosomatic manifestations as indication of dissatisfaction with working conditions should always be kept in mind as a possible frame of reference from which the meaningful function of somatic symptoms

may be recognized, understood, or eliminated. It has been statistically shown in large industrial plants that the majority of developing psychoneuroses begin with various somatic complaints. This observation is especially true for the older age group.

In this patient's "geriatric profile" it was found that some of his younger colleagues made his life on the job a continuously depressing experience with daily frictions, intrigues and frequent derogatory remarks. Despite the fact that he was fully aware of the great difficulties in securing another satisfactory job at his age, he decided to retire in six months, at age 65. Out of a lack of courage to fight back and possibly suffer defeat, he saw his only "safeguard" in his retreat from an "inferiorizing" situation.

The function of his intense pre-occupation with his organic symptoms (the "battle for somatogenesis") served as justification for his decision to "retire," that is, to "retreat." His "geriatric protest" manifested itself as a face-saving attempt to prevent his young co-workers from triumphing over him and, at the same time, his revenge-seeking attitude against the organization which he had served well for a quarter of a century but which did not now protect him against the unjustified assault of his younger competitors who admittedly had more formal training but far less practical experience.

A frequent "side function" of elderly people's seeking medical help for their somatic symptoms is the desire to assure themselves the best of health for carrying out activities which as voluntary retirees they usually plan for their retirement.

At any rate, after his retirement, despite all his continuing musculoskeletal and other symptoms, our patient "threw himself" into intensive reading, music appreciation, the study of geography and of history—as a full-time hobby. Significantly, all his activities were evidently those of a self-designated and self-styled young student, as if it had been one part of his "geriatric protest with juvenile means" to demonstrate that his mental capacities were still "young"—despite the contrary opinion of his younger colleagues.

"Despite" his rejuvenating attempts and "despite" the overemphasized somatic nature of his presenting symptoms, the working diagnosis of "masked depression" had to be maintained, supported as it was by sleeplessness, headaches, progressive, unplanned social disengagements, etc.

It was also found that his own previous attitude toward old people was a rather hostile one. In his previous opinion, "those old people always thought they knew everything better." He was gently reminded of the possibility that now he might be assuming that the "young people thought that they knew everything better" and that he, now being one of "those old people" himself, might also possibly be behaving in a way that might be making young people think exactly the same of him as he used to think of old people. This explanation was offered as one of many possibilities rather than as an interpretation. At any rate, he recognized the nature of the eternal "battle of the generations" creating the phenomenon of "anti-gerontism."

After a while he started making occasional visits to his old working place. He found that the atmosphere was not as inimical as he had thought when he had been working there. Soon he was invited to return to his job, an invitation to which he "consented." After his return to his job on a full-time basis once again, he had no time to take care of his old "rheumatic diseases" or to indulge in his "rejuvenating" cultural hobbies. Nor was there any need for them. By useful activity, he successfully compensated his gerontal inferiority feelings. There was no

longer any need for the various useless manifestations of his geriatric protest.

Alfred Adler has rightly taught that the best way to prevent and to treat geriatric problems is to keep aging people active in their own lines and callings as long as possible. In the present hypertechnological era, in which even young people have to undergo retraining(s), re-orientation(s), and re-location(s), one should endeavor to keep aging people active biologically, economically, and socially so that they can achieve the best possible "social security"—which in its real meaning must also include "biological" and "economic" security.

The therapist's task in such cases is to "rejuvenate" the patient's degenerating social interest which is usually "demoralized" by his ill-directed compensation of his age-centered inferiority feelings. This is not an easy task, but it is not a hopeless one either.

The carefully drawn geriatric profile can point out clearly the area(s) which should receive the most attention or adjustment—if necessary with the help of environmental manipulation—in order to decrease an otherwise hopeless discrepancy between the demanded and the available social interest. Furthermore, the recognition of the content, means, and target of the patient's "geriatric protest" may very well reveal his faulty and oftentimes self-defeating compensatory mechanism.

Thus, by means of an effective holistic management of the geriatric patient, an unhealthy attitude of a "protest against" may be changed into a more healthy attitude of "striving for" a relatively useful way of life, or at least a satisfying and worthwhile human way of life until the time of the final retirement comes along.

CONTACT!

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She was 86 years old. In this home there are many older than she, but she was completely senile.

I discovered her at lunch when two nurses were caring for her. One put food into her mouth; the other pushed her hand so that she could swallow.

She slept all the time. She didn't react to anything. Incidentally, I found out that years ago she had been a dancer—an amateur, I believe.

We know that the habits, hobbies, or the profession that people live with for years remains a part of their memories. One day I came into the infirmary with a record player and set it up near her on the table. She was German and this was a German waltz. When the music started, she opened her eyes but closed them immediately. Then I took a red scarf in my right hand and a green one in my left. I started to dance very fast. She opened her eyes and started to smile and articulate her voice.

After two days, I came again and said, in German, "Hello! How are you?" She didn't close her eyes for fully the ten minutes that I was there.

When I returned again with the record player, I took her hands and did movements with them to the sounds of the same waltz.

Thus I continued many days, and then I took her feet in my hands and moved them. She started to move her hands—without any assistance from me.

She was paralyzed and remained in the wheelchair. But she had good hearing. I took her to my office many times and played the piano for her. After each