GATEKEEPER TRAINING MANUAL
ELDERLY OUTREACH SERVICES
ABBE CENTER FOR COMMUNITY MENTAL HEALTH

Part II
Specific Disorders, Signs and Symptoms
GATEKEEPER TRAINING MANUAL
Part II

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Enid Light, Head, Geriatric Mental Health Services Research, Mental Disorders of the Aging Branch, NIMH

Brenda Thompson, Typist, Community Health Center of Linn County
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PREFACE

This is the second manual in the two-part Gatekeeper Training Program. It highlights specific disorders commonly found among the elderly, focusing on signs and symptoms. A glossary of psychiatric terms is also included. The purpose of this manual and the second part of the Gatekeeper training program is to enhance the basic knowledge and skills introduced in Part I.
DEMENTIA

Although dementia strikes only about 4% of all persons over 65 years of age, demented individuals take up somewhere between 50 and 75% of all nursing home beds. Early identification and referral of demented elderly in the community by gatekeepers will facilitate accurate diagnosis and treatment that may slow the progression of this deteriorating illness, and delay nursing home placement. Early detection of demented individuals is also important in providing much needed help to their family members such as support groups, respite care, legal and financial counseling, and in protecting both the demented person and the community from potentially hazardous situations, such as driving vehicles with impaired judgment.

Dementia is defined as a loss of mental abilities caused by damage to brain cells that is not a normal part of the aging process. Demented persons appear confused and may have problems with their thinking, severe enough to interfere with social relationships in work, home, and community life. Dementia includes the loss of:

1. memory, especially recent memory,
2. judgment and impulse control,
3. abstract thinking, and
4. language ability.

These symptoms are observed as changes in personality and behavior. Onset is usually gradual, and symptoms get worse over time, leading eventually to total dependency and ultimately death. The course of dementia is varied and unpredictable and may last months to many years. Dementia has also been called “senility” or “hardening of the arteries”.
Types of Dementia

There are many types of dementia. Alzheimer's disease is the most common type followed by multi-infarct dementia. These two are discussed briefly because the course of these dementing illnesses may be different.

Alzheimer's Disease. Alzheimer's disease is a progressive deteriorating dementia of unknown cause that damages the cells of the brain. Commonly this incurable disease is categorized in three stages:

1. **First Stage** — (2 to 4 years) characterized by memory loss, disorientation to time, and lack of spontaneity
2. **Second Stage** — (5 to 10 years) characterized by difficulty communicating, wandering, repetitive movements, agitation, confusion, and changes in appetite. Early in the second stage appetite may be voracious, while later on a marked disinterest in food may develop
3. **Third Stage** — (1 to 2 years) the person becomes emaciated, incontinent, and unable to communicate, may suffer from seizures, and exhibit outbursts of temper

Multi-Infarct Dementia. Another type of dementia is caused by multiple small strokes, which leads to decreased blood supply to the brain. This type of dementing illness is known as multi-infarct dementia (MID). The course of multi-infarct dementia is somewhat different from Alzheimer's disease and may include:

1. stepwise deterioration of intellectual function that, early in the disease, leaves some intellectual functions relatively intact
2. specific nervous system signs and symptoms depending on area of brain injury
3. speech difficulties, changeable moods or emotions, shaking or trembling of various body parts, and convulsions
4. weakness, slowness, and increased reaction of reflexes
5. fluctuations in mental abilities and thinking with short episodes of confusion (delirium) which presumably follow small strokes
6. a history of high blood pressure or strokes

---

DELERIUM

- Acute deregulation of brain function
- Acute confusional state
Symptoms of Dementia

The loss of mental abilities, whether due to Alzheimer's Disease or some other type of dementia, produces a variety of signs and symptoms. Gatekeepers may observe these changes over a period of time, and be alerted to the possibility of a dementing illness.

Memory Loss. Memory loss is usually the first sign of dementia noticed by both the affected person and others. Some behavioral signs of memory loss include:

1. forgetting names, phone numbers, directions, conversations, events of the day
2. needing to have statements repeated several times in order to remember
3. writing many notes in order to remember
4. hesitancy in responding to questions
5. forgetting to return to a task if interrupted, or forgetting to complete a task, such as turning off a stove or water faucet
6. making up stories to cover memory gaps
7. difficulty learning new information (short-term memory) or in recalling past events (long-term memory)

Judgment and Impulse Control. Changes in judgment and impulse control associated with dementia are indicated by the following signs:

1. spending large amounts of money or buying unusual or inappropriate items
2. neglect of personal appearance and hygiene; this includes inappropriate clothing, pajamas or underwear over outer clothing, dirty clothing or body odors
3. ignoring common rules of social conduct
4. using coarse language or making inappropriate jokes or sexual comments
5. exhibiting angry or irritable outbursts or inappropriate sexual behavior
6. impaired ability to recognize and accept limitations
7. decreased concern for others and increased self-centeredness

Abstract Thought. Problems with abstract thought may be observed as:

1. difficulty coping with new or unusual tasks, especially if in a hurry
2. trying to avoid situations and tasks that require using new and complex information
3. difficulty sorting out important from unimportant details
4. impaired ability to generalize, form new concepts and reason logically
Language. The following language changes may be heard:

1. words or phrases may be vague, stereotyped or responses may not match the questions
2. phrases may be long with little meaning in an attempt to cover memory loss (known as confabulation)
3. difficulty naming objects or recalling names and places

Personality Changes. The various symptoms that accompany loss of mental abilities may combine with one another to produce changes in personality, behavior, and emotional responses. Signs of personality changes include the following:

1. the person is described by others as “not him/herself”
2. the client may appear apathetic, withdrawn, listless, fearful, or dependent
3. social contacts are decreased
4. personality traits may be accentuated
5. the person may be suspicious or paranoid, blaming others for their own inability to find things because of memory loss
6. a previously neat or meticulous person becomes untidy or unconcerned about appearance

Behavioral Changes. Signs indicating a change in “normal” behavior are:

1. confusion and disorientation — to time, place, and person
2. failure to recognize or identify objects in spite of good function of the senses (vision, hearing, touch, smell, taste)
3. inability to perform or carry out activities in spite of adequate understanding and physical ability
4. difficulty understanding written information even though the person can still read letters or words
5. difficulty writing, working with hands, walking due to poor coordination
6. delusions and/or hallucinations (see Glossary of Terms)
7. disturbed sleep patterns and wandering, especially at night
8. inability to control urine and/or bowel (incontinence)
**Emotional Changes** include:

1. irritability, stubbornness and refusal to cooperate
2. anxiety
3. depression
4. increased jealousy, possibly including delusions of unfaithfulness, partner infidelity, or even physical abuse of partner
5. excessive reactions to stressors, such as retirement or death of a friend
6. rapid emotional changes

The table on the following page summarizes the symptoms and behavioral signs of dementia in the elderly.
<table>
<thead>
<tr>
<th>DISORDER: DEMENTIA</th>
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</thead>
<tbody>
<tr>
<td><strong>SYMPTOMS</strong></td>
</tr>
</tbody>
</table>
| Memory Loss (recent) | 1. forget names, phone numbers, directions, conversations, events of the day  
                           2. need statements repeated  
                           3. write many notes  
                           4. hesitancy in responding  
                           5. forget to return to or complete a task  
                           6. make up stories  
                           7. difficulty learning new information |
| Loss of Judgment and Impulse Control | 1. spend large amounts of money  
                                   2. buy unusual or inappropriate items  
                                   3. inappropriate clothing, dirty clothing, body odors  
                                   4. ignore rules of conduct  
                                   5. coarse language, inappropriate jokes (sexual comments or behaviors)  
                                   6. angry or irritable outbursts  
                                   7. lack of concern for others  
                                   8. self-centered |
| Loss of Abstract Thought | 1. difficulty with new or unusual tasks  
                               2. avoidance of complex tasks and situations  
                               3. can't sort out important and unimportant details  
                               4. difficulty generalizing, reasoning logically, or forming new concepts |
| Loss of Language | 1. uses vague words or phrases  
                          2. uses long phrases with little meaning  
                          3. difficulty naming objects, recalling names and places  
                          4. unable to communicate |
| Personality Changes | 1. apathetic  
                                  2. withdrawn  
                                  3. listless  
                                  4. fearful  
                                  5. dependent on others  
                                  6. decreased social life  
                                  7. suspicious or paranoid of others  
                                  8. neat or meticulous person becomes untidy  
                                  9. outbursts of temper |
| Behavioral Changes | 1. confused about time, place, persons  
                                  2. can't identify objects in spite of good senses  
                                  3. can't perform or carry out physical activities in spite of adequate ability  
                                  4. difficulty understanding written information, yet can read it  
                                  5. difficulty writing, working with hands, walking  
                                  6. delusions or hallucinations  
                                  7. disturbed sleep patterns and wandering  
                                  8. incontinence  
                                  9. repetitive movements  
                                  10. changes in appetite  
                                  11. seizures or convulsions  
                                  12. shaking, trembling |
| Emotional Changes | 1. irritability, stubbornness  
                          2. anxiety  
                          3. depression  
                          4. jealousy  
                          5. excessive reactions to stressors  
                          6. rapid emotional changes  
                          7. lack of spontaneity  
                          8. delirium |
AFFECTIVE (MOOD) DISORDERS: DEPRESSION AND MANIA

Depression

Depression is the most common psychotic disorder found among community-dwelling elderly. Somewhere between 10 and 15 percent of all non-institutionalized persons over age 65 are thought to be depressed and may benefit from treatment. Unfortunately, depression is frequently overlooked among the elderly because being "old and sad" are often falsely considered part of the aging process by both elderly and health professionals. Also, many elderly wrongly believe that nothing can be done to improve their mood. However, careful use of medications and many types of talking therapies have been shown to be very effective in reducing depression among the elderly. Depression can color every aspect of an elderly person's life. Most commonly it is observed as changes in: (1) mood, (2) perceptions of the self, the environment and the future, and (3) vegetative or physical and behavioral signs. These three categories of disturbances are often referred to as "the depressive triad". The following are some of the many signs and symptoms frequently observed within these three categories (the depressive triad) in depressed elderly persons.
Pervasive disturbance of mood:

1. sadness, discouragement, crying
2. anxiety, irritability, panic attacks, brooding
3. person may state that they feel sad, blue, depressed, low, hopeless, discouraged, down in the dumps, not caring any more, nothing is fun anymore

Disturbance in perception of the self, the environment, and the future:

1. loss of interest in and withdrawal from usual activities, even those that previously were sources of pleasure
2. decreased sex drive or lack of interest in sex
3. loss of ability to experience pleasure
4. feelings of worthlessness which range from feelings of inadequacy to unrealistic evaluations of one's worth
5. unreasonable fears
6. feelings of guilt, including self reproach for minor failings
7. delusions of poverty
8. hallucinations (usually don't last long and may involve voices nagging the person for his/her shortcomings or "sins")

Vegetative (physical and behavioral) signs:

1. increased or decreased body movements
2. pacing, wringing hands, pulling or rubbing hair, body, clothing
3. sleep disturbance — difficulty getting to sleep, staying asleep or especially waking early
4. appetite decreased, sometimes increased
5. weight loss or occasional weight gain
6. fatigue, decreased energy
7. preoccupation with physical health, especially cancer or other serious illness
8. difficulty concentrating, thinking, or making decisions
9. slowed speech, pauses before answering, decreased amounts of speech; low or monotonous tone of voice
10. thoughts of death or suicide or suicide attempts
11. constipation
12. unusually fast heart rate (tachycardia)
Risk Factors for Depression

Certain personality types are more likely to become depressed or suicidal. These people are very critical of themselves and others. They are passive, expecting others to read their minds and do what they want.

Likewise, there are many situational changes, including many forms of loss, that can put a person at risk for developing depression. Death, financial changes, retirement, moving, or changes in health can all create situational distress. In the absence of adequate support and coping, the person may be more prone to becoming depressed.

Suicide in the Depressed Elderly

One of the most important reasons for early detection and treatment of depression in the elderly is suicidal risk. The elderly have the highest rate of committing suicide of any age group, with over 80 year old white males having the greatest incidence. It is more difficult to predict suicide in depressed elderly because they may not give warning signals or dramatically change their behavior before a suicide attempt. Also, the elderly tend to use more lethal methods in their suicide attempts and are therefore, more likely to actually kill themselves than younger people.

Another situation for gatekeepers to be aware of is indirect or “passive” suicide among the elderly, who may slowly kill themselves by a variety of means such as:

1. starvation
2. alcohol abuse
3. mixing or overdosing on medications, or
4. discontinuing needed medications.

Some elderly may simply seem to give up the will to live.
Risk Factors for Suicide in the Elderly

1. depression (see signs and symptoms list)
2. suicide statements or threats
3. have definite plan
4. have means of suicide readily available
5. previous suicide attempt(s)
6. hopelessness/helplessness/feelings of emptiness and dejection/self-accusation
7. sudden marked changes in behavior or personality
8. neglect of responsibilities
9. selection of reading material about death
10. making final arrangements
11. requests for sleeping pills
12. divorced, separated or widowed status
13. socially isolated
14. drug and alcohol use
15. chronically or terminally ill

What To Do If You Suspect an Elderly Person is Suicidal

As a gatekeeper, there are several things you can do if you see one or more signs of suicidal thinking in an elderly person and think that he/she may be suicidal. The key thing to do before making a referral to get more information about how the elderly person is feeling and thinking. In other words, is he/she really suicidal? Remember, if you suspect the potential for suicide, make a referral to the Outreach Team, or to the Community Mental Health Center (398-3562). The referral process is in the Introduction to the Gatekeeper Role Training Manual.

Depression or Dementia

While many of the symptoms of depression and dementia are similar, important differences do exist. The following table compares these two illnesses and highlights characteristics that are common to each.
<table>
<thead>
<tr>
<th></th>
<th>DEMENTIA</th>
<th>DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Insidious, indeterminate</td>
<td>Rapid</td>
</tr>
<tr>
<td>Duration</td>
<td>Long</td>
<td>Short</td>
</tr>
<tr>
<td>Mood/Behavior</td>
<td>Fluctuates</td>
<td>Consistently depressed</td>
</tr>
<tr>
<td>Response</td>
<td>Provides a close, but usually incorrect answer to questions</td>
<td>“Do not know”</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Concealed</td>
<td>Highlight</td>
</tr>
<tr>
<td>Cognition</td>
<td>Relatively stable</td>
<td>Fluctuates greatly</td>
</tr>
<tr>
<td>SYMPTOMS</td>
<td>BEHAVIORAL SIGNS</td>
<td></td>
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<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Pervasive Disturbance of Mood</td>
<td>1. sadness, discouragement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. crying</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. anxiety, panic attacks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. brooding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. irritability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. states they feel sad, blue, depressed, low, nothing is fun, down in the dumps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. paranoid</td>
<td></td>
</tr>
<tr>
<td>Disturbances in Perception of Self, Environment, Future</td>
<td>1. withdrawal from usual activities</td>
<td></td>
</tr>
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<td></td>
<td>2. decreased sex drive</td>
<td></td>
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<tr>
<td></td>
<td>3. inability to express pleasure</td>
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<td></td>
<td>4. feelings of worthlessness</td>
<td></td>
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<tr>
<td></td>
<td>5. unreasonable fears</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. self reproach for minor failings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. delusions of poverty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. hallucinations (short duration)</td>
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</tr>
<tr>
<td></td>
<td>9. critical of self and others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. passive</td>
<td></td>
</tr>
<tr>
<td>Vegetative</td>
<td>1. increased or decreased body movements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. pacing, wringing hands, pulling or rubbing hair, body, clothing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. difficulty getting to sleep, staying awake, waking early</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. decreased or sometimes increased appetite</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. weight loss or sometimes gain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. fatigue</td>
<td></td>
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<tr>
<td></td>
<td>7. preoccupation with physical health, especially fear of cancer</td>
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<td></td>
<td>8. can't concentrate, think or make decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. slowed speech, pauses before answering, decreased amount of speech, low or monotonous speech</td>
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<td></td>
<td>10. thoughts of death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. suicide or suicide attempts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. constipation</td>
<td></td>
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<td></td>
<td>13. tachycardia</td>
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</tbody>
</table>
Mania

Another less common type of affective (mood) illness found in the elderly is mania, which is almost the exact opposite of depression in its symptoms. Manic individuals feel elated or euphoric (emotionally high). They appear to have excess energy and enthusiasm and may talk in a pressured manner "a mile a minute". Often their ideas are grandiose and unrealistic and when questioned about them, they may react aggressively. Manic persons may endanger their physical health by being too busy to eat or sleep properly. Sometimes the behavior of manic persons centers on religious or sexual themes. Gatekeepers should be alert to symptoms of mania in the elderly. It is also important to note that moods can swing (cycle) back and forth between mania and depression in some individuals, and that these mood changes can occur quite suddenly.

The table on the following page summarizes the common signs and symptoms observed in a manic individual.
<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>BEHAVIORAL SIGNS</th>
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</thead>
<tbody>
<tr>
<td>Elation and Euphoria,</td>
<td>1. increase in activity</td>
</tr>
<tr>
<td>Mood Swings</td>
<td>2. physical restlessness — pacing, fidgeting</td>
</tr>
<tr>
<td></td>
<td>3. talk more, talk more loudly</td>
</tr>
<tr>
<td></td>
<td>4. ideas don't make sense or fit with conversation</td>
</tr>
<tr>
<td></td>
<td>5. delusions of grandeur, special relationships with God or mission</td>
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<td></td>
<td>for CIA</td>
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<td></td>
<td>6. sleep less, but still seem alert</td>
</tr>
<tr>
<td></td>
<td>7. when talking, jump from topic to topic, talk a mile a minute</td>
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<tr>
<td></td>
<td>8. buying sprees</td>
</tr>
<tr>
<td></td>
<td>9. gambling</td>
</tr>
<tr>
<td></td>
<td>10. sexually active</td>
</tr>
<tr>
<td></td>
<td>11. may harm self</td>
</tr>
<tr>
<td></td>
<td>12. irritable, angry</td>
</tr>
<tr>
<td></td>
<td>13. too busy to eat</td>
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<tr>
<td></td>
<td>14. aggressive reactions when questioned about grandiose and unrealistic ideas</td>
</tr>
</tbody>
</table>

**GRANDIOSE DELUSIONS**

Exaggerated sense of importance, power, knowledge, identity,...
SCHIZOPHRENIC DISORDERS

Schizophrenia is usually identified early in the person's life. The onset is often in the late teens or early twenties although the illness is commonly chronic and continues throughout the person's lifetime. The primary areas of disruption are in the person's ability to think clearly, perceive things accurately, and interact with others in a meaningful way. Their disrupted thinking is accompanied by changes in behavior. Unusual body movements, mannerisms and ways of dressing may call attention to their problems. Most often, however, their ability to talk logically and sensibly decreases and communicates to others that something is "just not right".

This illness has both an active phase when psychotic symptoms are most intense and easily seen, and a residual phase, when the symptoms aren't as strong. The person usually has repeated episodes of acute or intense symptoms followed by periods of less obvious disturbance. Overall, schizophrenia involves deterioration from a previous level of functioning which may be seen in work, social relations, and self-care.

A wide variety of symptoms may be seen in schizophrenia. Many are due to disturbances in thinking (loose associations, ideas of reference) while others are caused by changes in perception (hallucinations). In addition, changes in affect and behavior are commonly observed.
Although it is rare for an older person to develop this illness, some elderly individuals with chronic schizophrenia now live in the community rather than in institutions. Although most experience less intense symptoms with age, some periodically have active phases which may require mental health interventions. The table on the following page summarizes the symptoms and associated behavioral signs that may indicate schizophrenia.

- Ideas shift from subject to subject
- Not aware topics are unconnected

LOOSE ASSOCIATIONS
<table>
<thead>
<tr>
<th>DIAGNOSES: SCHIZOPHRENIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYMPTOMS</td>
</tr>
<tr>
<td>Disturbances in thought</td>
</tr>
<tr>
<td>Disturbances in perception</td>
</tr>
<tr>
<td>Disturbances in affect</td>
</tr>
<tr>
<td>Disturbances in motor behavior</td>
</tr>
<tr>
<td>Disturbances in activity</td>
</tr>
</tbody>
</table>

*Please refer to the Glossary of Terms for definitions.
PARANOID DISORDERS

There are three basic causes of paranoid behavior in the elderly: (1) chronic schizophrenic (onset in early twenties), (2) paranoid delusions accompanying dementia, and (3) late life onset paranoia (paraphrenia).

Many chronic schizophrenics now live until old age. Although most experience less intense symptoms with age, some elderly schizophrenics become periodically confused and delusional. Their delusions are often of a paranoid nature. They often believe that someone or something is “out to get them”. Likewise, demented persons frequently exhibit paranoid behaviors. Their own forgetfulness contributes to the false belief that people are stealing things from them or doing things behind their back. In both chronic schizophrenia and dementia, the paranoid behaviors are only one part of a larger illness that effects the person in many ways.

In contrast, the person with paraphrenia does not exhibit the overall decline in function that is so common in schizophrenia and dementia. Persons with paraphrenia usually become paranoid for the first time in later life (onset late fifties or sixties). Many paraphrenics are socially isolated and have hearing losses. However, the person's ability to perform work, physical activities and other mental functions is usually normal. Thinking is clear and orderly in spite of delusional ideas or hallucinations. Emotion and behavior are appropriate to the content of the delusional ideas. Delusions of persecution usually concerning one topic or a series of connected topics are often present. These delusions are usually about conspiracy, being cheated, spied upon, followed, poisoned or drugged, lies that injure one's reputation, harassment, or interference with obtaining long-term goals.

There are many levels of severity associated with paranoia ranging from mild suspiciousness to psychotic behavior. Persons who suffer from paranoid disorders may have delusions and/or hallucinations about being persecuted or notions of exaggerated self-importance.
The following signs and symptoms may be present:

1. suspiciousness, lack of trust
2. exaggerated jealousy
3. anger, argumentativeness and sometimes violence
4. anxiety with no known object or cause
5. social isolation or seclusiveness
6. eccentric (odd or unusual) behavior
7. social interactions may be stilted and formal or extremely intense
8. letter writing complaining about various injustices
9. orientation and memory are typically unimpaired in the uncomplicated case
10. fears about being considered homosexual, doubts about sexual preferences and being approached by homosexuals
11. severe problems in partner relationships, including marriage, and other social relationships are also possible
12. starting legal action against others

Risk Factors for Paranoid Disorders

In addition to sensory changes and social isolation mentioned earlier, other losses may precipitate paranoid feelings and ideas in the elderly. Many of the losses associated with the aging process are not under the control of the individual. The changes may be so subtle in onset that they are not recognized by the person at first. These losses create a sense of decreased control over the environment which may lead to a search for some explanation to account for them. A paranoid interpretation of the changes may thus occur. The table on the following page summarizes the symptoms and behavioral signs of paranoia.
<table>
<thead>
<tr>
<th>DISORDER: PARANOIA</th>
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<tbody>
<tr>
<td>Delusions of Persecution</td>
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<tr>
<td>1. suspiciousness, lack of trust</td>
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<td>2. exaggerated jealousy</td>
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<td>3. anger, agrumentativeness, sometimes violence</td>
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<tr>
<td>4. anxiety</td>
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<tr>
<td>5. social isolation</td>
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<td>6. eccentricity</td>
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<tr>
<td>7. stilted, formal, or extremely intense social interactions</td>
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<td>8. letter writing complaining about various injustices</td>
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<tr>
<td>9. legal actions against others</td>
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<tr>
<td>10. severe problems in partnership relations</td>
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<tr>
<td>11. auditory hallucinations</td>
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<tr>
<td>12. fear of homosexuality</td>
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</tbody>
</table>

Person/Group being attacked, harassed, cheated,...
ALCOHOLISM

Alcohol effects about 11% of the elderly (over 65) population or somewhere around 3 million persons. Of those affected, 1/3 are “reactive drinkers”, that is, persons who have had no drinking problem until later life. In response to severe losses that may accompany aging, such as death of a spouse, forced retirement and poor health, these elderly persons may become alcoholic over a relatively short period of time. “Reactive drinkers” can almost always benefit from identification and treatment.

The other major category of elderly alcoholics are known as “survivors”, that is, chronic (long-term) drinkers who have managed to survive into old age. “Survivors” usually have many more physical, social, psychological and economic problems than reactive drinkers, and are less likely to benefit from therapy.

Sometimes friends and family help the elderly alcoholic to continue drinking because they feel sorry for them or believe that alcohol is one of the few pleasures they have left in life. These “enablers” become part of the problem and need to understand that alcoholism is a serious problem especially among the socially isolated elderly.

Drinking patterns may vary and commonly include drinking every day or drinking heavily on weekends only (binge drinking). People who abuse alcohol frequently abuse other drugs, especially drugs to calm or quiet the nerves and sleeping medications.
They may also have physical conditions which look like alcohol withdrawal or drunkenness such as low blood sugar (hypoglycemia) which may be a result of excess alcohol intake and/or decreased food intake.

Alcohol abuse is measured three ways: (1) unhealthy patterns of use, 2) problems caused at work, in the family or other social relationships, and (3) duration of use, (reactors versus survivors).

**Symptoms of Alcohol Abuse**

- Hangovers that interfere with activities
- Incoherent speech
- Aggressive behavior
- Agitation
- Tremors and "shakes"
- Convulsions
- Impaired coordination and reflexes
- Lethargy
- Restlessness
- Blackouts
- Bruises/burns in unusual places
- Health problems, especially liver disease
- Sleep disturbances
- Incontinence
- Malnutrition and vitamin deficiencies
- Impaired judgment
- Fear/paranoia
- Manic behavior
- Delirium
- Memory loss/confusion
- Self-neglect
- Daily drinking
- Accidents related to alcohol
- Financial problems related to alcohol use
- Problems with relatives, partners, friends, or neighbors related to alcohol use
- Problems on the job
- Problems with the law

**Korsakoff's psychosis** is associated with excessive drinking and produces massive loss of recent memory, confabulation (making up facts), poor insight and poor motivation. It often occurs in conjunction with Wernicke's disease in which drowsiness and disorientation are accompanied by a variety of physical disturbances, such as difficulties with balance, walking, and eye movement and control. Both are related to thiamine and other vitamin deficiencies. The symptoms and behavioral signs of alcoholism in the elderly are presented in the following table.
<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>BEHAVIORAL SIGNS</th>
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<tbody>
<tr>
<td>Memory loss</td>
<td>1. incoherent speech</td>
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<td>Language loss</td>
<td>2. aggressive behavior</td>
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<tr>
<td>Personality changes</td>
<td>3. agitation</td>
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<tr>
<td>Mental changes</td>
<td>4. tremors, shakes</td>
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<tr>
<td>Physical changes</td>
<td>5. convulsions</td>
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<td></td>
<td>6. impaired coordination and reflex-action</td>
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<td></td>
<td>7. hangover</td>
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<td>8. lethargy</td>
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<td>9. restlessness</td>
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<td>10. blackouts</td>
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<td></td>
<td>11. bruises or burns in unusual places</td>
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<td>12. sleep disturbance</td>
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<td>13. incontinence</td>
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<td>14. malnutrition</td>
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<td></td>
<td>15. impaired judgment</td>
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<td>16. fear, paranoia</td>
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<td>17. mania</td>
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<td>18. delirium</td>
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<td>19. memory loss, confusion</td>
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<td>20. self-neglect</td>
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<td>21. daily drinking</td>
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<td>22. accidents</td>
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<td>23. financial problems</td>
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<td></td>
<td>24. interpersonal relationship problems</td>
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<td></td>
<td>25. problems on the job</td>
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<td></td>
<td>26. problems with the law</td>
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</tbody>
</table>
ELDER ABUSE

Elder abuse affects more than 1 million victims annually. The typical victim is elderly (over 70), female, white, and has moderate to severe physical or mental impairment(s). The typical abuser (81%) is a relative (often a daughter, son or spouse) who lives with the elderly victim. There are 5 main types of abuse that gatekeepers should be aware of, including:

1. physical (battering)
2. emotional (psychological)
3. financial (material)
4. sexual (rape)
5. neglect (failure to provide necessary care, food, medicine, etc.)

What to look for if you suspect abuse in the elderly victim

1. bruises or broken bones
2. malnourished condition
3. confusion
4. fear
5. reluctance to discuss situation

Clues to an abuser

1. hostility
2. alcohol abuse
3. indifference
4. caught in a stressful situation
OTHER DISORDERS

There are a number of other emotional conditions that affect the well-being of the elderly. Among the most common are anxiety disorders, adjustment disorders, personality disorders, and sleep disturbances. Stress is often a contributing factor to the development of these problems, which are briefly described in the final section of this manual.

Anxiety Disorders

Anxiety disorders occur more frequently in women than men, affecting somewhere between 10-15% of women over age 65. Elderly persons with anxiety disorders often complain only of physical symptoms that may mask their anxiety. Elderly persons with anxiety disorders may appear worried, nervous or fearful. Phobias (irrational fears) are a very common type of anxiety disorder among the elderly. Panic disorders or attacks (intense anxiety with physical symptoms) and obsessive-compulsive disorders (recurring thoughts and behaviors) are also seen. The neurologic, gastrointestinal, cardiovascular/respiratory and miscellaneous symptoms frequently associated with anxiety in the elderly follow.

Neurologic
- Tremor
- Tic
- Dizziness
- Headache
- Blurred vision
- Tingling

Gastrointestinal
- Difficulty swallowing
- Indigestion
- Nausea and vomiting
- Abdominal bloating
- Hiccups

Cardiovascular/respiratory
- Difficulty breathing
- Chest pain
- Fast heart rate/pounding

Miscellaneous
- Weight gain
- Weakness and fatigue
- Neck and back pain
- Sleep disturbance
- Dry mouth
- Jaw aching and cracking
Adjustment Disorders

In adjustment disorders, some “stressor” sets off the emotional disturbance. Unlike many other illnesses, this stressor can be clearly identified by the person. The source of stress varies from person to person but often involves one or more of the many losses that elderly face.

Elderly who have had many losses may have less strength to handle another loss. Also, physical illness often interferes with the elder’s ability to “get back on their feet”. Thus, the person’s usual ability to cope is lessened and the stressful event is even more upsetting than would be expected under the circumstances.

In adjustment disorders, the person experiences difficulty in their usual social or work roles. Likewise, the symptoms are stronger and last longer than would be expected for the situation. The symptoms vary but often include emotions of anxiety or depression. Some common clues include:

1. depressed mood, sadness
2. tearfulness
3. hopelessness
4. nervousness
5. worry
6. jitteriness
7. difficulties making decisions
8. anger
9. increased dependency
10. withdrawal

Personality Disorders

Personality disorders do not begin in later life. Rather, these problems of poor relationships and behavior usually begin by the teenage years and continue throughout life. They may even become less obvious and less severe (burn-out) with increasing age. Some people have called elder individuals with personality disorders “late life losers” — they have achieved little by way of work, educational, family and social relationships. Some common traits or patterns among these “late life losers” are:

- blaming others,
- constant complaining, and
- bitterness.
These people seem unable to learn from past experiences. There are many different types of personality disorders that have been identified by mental health professionals. These include:

1. paranoid (suspicious)
2. schizoid (eccentric and/or seclusive)
3. histrionic (attention seeking)
4. narcissistic (self-centered)
5. antisocial (hurts others)
6. borderline (unstable)
7. avoidant (withdrawn)
8. dependent (relies on others)
9. compulsive (perfectionist)
10. passive-aggressive (gets back at others through indirect means)

A common characteristic of all these various types of personality disorders is a poor relationship with people.

**Sleep Disorders**

Physical symptoms are often the major complaint of elderly persons with mental illness. Sleep disturbance is one such symptom often seen in physically healthy but emotionally disturbed older individuals. Sometimes emotional conflicts get expressed as sleep disorders. Most elderly persons require 6 to 7 hours of sleep per night. They sleep more lightly and awaken during the night more than younger persons, often to go to the bathroom. Insomnia can be related to a variety of factors including:

- move to a new environment (such as a nursing home or apartment)
- anxiety (worry)
- drug withdrawal (alcohol and sedatives)
- dementia
- depression
- physical illness (especially difficulty breathing)
- pain, such as from arthritis or heart pain (angina)

Some elderly persons may complain of sleeping too much (hypersomnia) or short uncontrollable sleeping episodes (narcolepsy). Elderly persons who sleep too much may awaken with difficulty and often appear confused or disoriented. Sometimes sleep medications or drugs to calm the nerves create more harmful effects than benefits for the elderly person’s sleep cycle. This is true for drugs purchased over the counter as well as those prescribed by a doctor. The elderly person who has been taking sleep medications over a long period of time is at especially high risk for sleep problems both on the drugs and during withdrawal. Gatekeepers should be aware that even normal changes in sleep associated with aging can be very upsetting to elderly persons. Sleep disturbances should be evaluated by trained professionals to determine if they are normal or caused by any one of the problems listed earlier. The following table summarizes the symptoms and behavioral signs of anxiety, adjustment, personality and sleep disorders.
## DISORDER: ANXIETY

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>BEHAVIORAL SIGNS</th>
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</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td>1. tremors</td>
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<td></td>
<td>2. tics</td>
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<tr>
<td></td>
<td>3. dizziness</td>
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<tr>
<td></td>
<td>4. headache</td>
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<tr>
<td></td>
<td>5. blurred vision</td>
</tr>
<tr>
<td></td>
<td>6. tingling of the skin</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>1. difficulty swallowing</td>
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<tr>
<td></td>
<td>2. indigestion</td>
</tr>
<tr>
<td></td>
<td>3. nausea</td>
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<td></td>
<td>4. abdominal bloating</td>
</tr>
<tr>
<td></td>
<td>5. hiccups</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1. difficulty breathing</td>
</tr>
<tr>
<td>Respiratory</td>
<td>2. chest pain</td>
</tr>
<tr>
<td></td>
<td>3. fast heart rate, pounding</td>
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<tr>
<td>Other</td>
<td>1. weight gain</td>
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<tr>
<td></td>
<td>2. weakness, fatigue</td>
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<td></td>
<td>3. neck, back pain</td>
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<td></td>
<td>4. sleep disturbances</td>
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<tr>
<td></td>
<td>5. dry mouth</td>
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<tr>
<td></td>
<td>6. jaw aching, cracking</td>
</tr>
</tbody>
</table>

## DISORDER: ADJUSTMENT

1. depressed mood, sadness
2. tearfulness
3. nervousness
4. jittery
5. anger
6. withdrawal
7. dependency
8. can't make decisions

## DISORDER: PERSONALITY

1. blame others
2. constant complaining, bitterness
3. poor relationships with others

## DISORDER: SLEEP

1. sleep too much
2. sleep too little
SUMMARY

A number of specific mental disorders that may affect the elderly have been described to further enhance gatekeeper's knowledge and skill. While gatekeepers are not expected to diagnose illness, awareness of the various signs and symptoms may facilitate recognition of important clues to emotional distress. As outlined in Part I, identification is the critical first step to providing essential services that may alleviate needless suffering. Gatekeepers provide the vital link between elderly community members in need of services and sources of mental health, social and medical treatment.
GLOSSARY OF TERMS

This glossary is designed to help gatekeepers and health professionals to better communicate with each other when discussing elderly community members who may need professional help.

**Affect** — The word “affect” refers to how a person feels and how they show that feeling through facial expressions, pitch of the voice, and the use of hand and body movements. This outward expression of mood or emotion may vary considerably. Some common descriptors for affect are:

- **Broad or normal** — facial expressions, tone of voice and gestures “fit” with the content of what the person is saying
- **Restricted or blunted** — little change in facial expression or voice
- **Flat** — no expression on the face and speaks in a monotone with no change in voice pitch
- **Inappropriate** — expression does not match what the person is saying; for example, laughing or giggling while describing a painful or scary experience
- **Labile** — repeated, rapid, and sudden changes in expressions; for example, an older person may be very sad and depressed one moment and aggressive the next

**Agitation** — Excessive motor activity that usually has no purpose and is related to internal tension. For example, inability to sit still, pacing, fidgeting, wringing of hands or pulling at clothes or hair.

**Anxiety** — Apprehension, tension, or uneasiness resulting from some threat or danger which is not recognized by the person. Feelings of helplessness or uncertainty often accompany anxiety. (Different from **fear**, which is the emotional response to a recognized danger.)

**Blocking** — When a person is talking and stops in the middle of a sentence for a few seconds and then cannot remember what he has been saying or meant to say, he is “blocking”. Unlike the demented patient, the person who is blocking will know that he has lost his thought and can state the reason for pausing.

**Compulsion** — A compulsion is an anxiety-driven, excessive and repetitive behavior designed to decrease tension. For example, an individual feels a compulsion to wash his hands every time he shakes hands because of a fear of contamination, even though the individual may recognize that the hand washing is excessive.

**Delerium** — Decreased functioning of memory and other mental abilities because of temporary damage to the brain such as from trauma, infections, drug side effects, or nutritional deficiencies. In contrast to dementia, there may be more fluctuation in the person's clouded consciousness and they will improve over time with treatment.
Delusion — False ideas or beliefs which are maintained in spite of obvious proof of their inaccuracies. Delusions are the most serious and most common disturbance in thinking. Some examples of delusions in the elderly are:

- delusions of persecution — the person believes they are being spied upon, singled out for harassment, or plotted against
- delusions of reference — events, objects, or other people are given special meaning or unusual significance, often exaggerating their negative aspects
- bodily delusions — pertain to body functions or image and are often of a morbid nature (e.g. insides rotting out, cancer, death scenes)
- delusions of poverty — the belief that one is poor even though the person has more than adequate means of support
- delusions of grandeur — an exaggerated sense of importance, power, knowledge or identity, such as believing that they are the President or God
- delusions of being controlled — the person’s feelings, thoughts, impulses, or actions are felt to be imposed by some external force

Dementia — Decreased functioning of memory and other mental abilities because of permanent damage to the brain. The onset and progression are usually gradual except in multi-infarct dementia (caused by repeated small strokes) where change can be sudden and remain at a plateau until the next sudden change. Unlike delirium, there is no improvement in mental abilities.

Distractibility — The inability to maintain attention on one topic; shifting from one area to another with little provocation. May be due to an organic impairment (dementia) or other disorders such as anxiety, mania, or schizophrenia.

Flight of Ideas — Verbal skipping from one idea to another. The ideas appear to be continuous but are fragmentary and determined by chance associations. Often found in manic individuals.

Hallucination — Seeing, hearing, smelling, tasting, feeling things that are not really there. Auditory hallucinations, hearing voices outside the head, are most common.

Ideas of Reference — An idea (less firmly held than a delusion) that events, objects or persons in the environment have a special and unusual meaning specifically for her or him.

Illusion — A misinterpretation of a real environmental stimulus. An example of a common illusion is hearing the wind rustle the leaves of a tree and believing there is someone talking.

Loose Associations — Ideas shift from one subject to another in an unrelated manner though the speaker is unaware that topics are unconnected. Speech may appear incoherent.
Magical Thinking — The belief that “thinking” equals “doing”; the lack of a realistic relationship between cause and effect. This type of thinking is common in children and dreams. Superstitiousness is one type of magical thinking.

Mood — A prolonged and far-reaching emotional state that colors the person’s perception of the world and influences both personality and ability to function in life. Common examples of mood include depression, elation, and anger.

Nervous Breakdown — A nonmedical and nonspecific description commonly used for any type of mental distress or disorder.

Paranoid Ideation — The suspicion or belief that one is being harmed or mistreated. An individual may believe that someone is out to get him when this is not in fact the case. Persecutory delusions center around the belief that a person or group is being attacked, harassed, cheated, etc.

Phobia — An irrational fear with a persistent, compelling desire to avoid the dreaded object, e.g. spiders, snakes, etc.

Poverty of thought — An adequate amount of speech is present but little information is conveyed because the speech is vague, too abstract or concrete, repetitive, or stereotyped. Poverty of thought is a common symptom of a thought disorder.

Psychosis — A major mental disorder of organic or emotional origin in which a person’s ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is grossly impaired and interferes with their capacity to meet the ordinary demands of life. It is often characterized by regressive behavior, inappropriate mood, lowered impulse control, and such abnormal mental content as delusions and hallucinations. The term applies to many conditions and has a wide range of severity and duration.

Regression — The partial return to earlier patterns of acting or thinking. For example, a person who is extremely anxious (or psychotic) may regress to behaviors that are common in childhood or infancy.

Sensory Deprivation — The experience of being cut off from usual sources of stimulation. For example, the loss of hearing or eyesight, physical isolation, or some type of confinement like hospitalization. Disorganized thinking, delirium, depression, delusions or hallucinations may occur.

Stressors — Threatening, challenging or harmful stimuli that create tension for the individual and require extra energy to cope.

Thought Disorder — A disruption in the person’s ability to think clearly, both in terms of what they think about (the content of their thinking) as well as how they think about it (the form of their thinking). Delusions, ideas of reference, poverty of thought, flight of ideas and loose associations are examples of disturbed thinking. A thought disorder can be caused by either a functional emotional disturbance (schizophrenia) or by an organic condition (dementia).