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The elderly in crisis: Identifying crisis situations in an emergency room setting. A definitional study

Chatham, Gail N., Ph.D.

The Union Institute, 1991

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The Elderly In Crisis: Identifying Crisis Situations In An Emergency Room Setting.

A Definitional Study

Gail N. Chatham

In Fulfillment For A Ph.D. In Counseling Psychology

The Union Institute

October 5, 1991

Running Head: Elderly Crisis

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ACKNOWLEDGEMENTS

My personal interest in studying psychogeriatrics and counseling gerontology originated with my relationship with my grandparents. Along with Norma, Rocky, Emma, Frank, Nancy, Arthur, Isabelle, and Oscar were a positive influence in my development. Their guidance, love, support, and discipline [or lack of it] helped shape my world and my desire to help others. As a result of my experiences with them, I want to give something back to a group of individuals that are very special to me.

In addition, I would like to take this opportunity to thank my doctoral committee Marilyn, Marvin, Larry, Jay, and Carl and my husband, Peter, who helped make this profound journey and learning experience possible.

Do not go gentle into that good night
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.
Though wise men at their end know dark is right,
Because their words had forked no lightning they
Do not go gentle into that good night.
Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay,
Rage, rage against the dying of the light.
Wild men who caught and sung the sun in flight,
And learn, too late, they grieved on its way,
Do not go gentle into that good night.
Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light.
And you, my father, there on the sad height,
Curse, bless, me now with your fierce tears, I pray.
Do not go gentle into that good night.
Rage, rage against the dying of the light.

---Dylan Thomas, 1952

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Abstract

The purpose of this Project Demonstrating Excellence [PDE] is to identify the medical, psychosocial, and psychiatric crises associated with elderly patients utilizing the services of an urban emergency care unit, and to examine their diagnoses and dispositions to determine what types of hospital and community programs are being utilized to meet their growing needs.

In this study, a crisis situation is defined as changes in the patient's cultural/social milieu, personal or environmental conditions, social status, or life cycle that produces an acute emotional upset or homeostatic imbalance. A crisis occurs when the patient's interpretation of the event, temporary inability to cope by his/her usual problem-solving devices, and the limitation of his/her social resources lead to stress so severe that the individual can not find relief [Hoff, 1984].

During a one-year period, the Crisis Stabilization Unit log book at Raritan Bay Medical Center- Perth Amboy Division, in central New Jersey, was reviewed to identify elderly patients, ranging in age from 59 years ["young-old" age] to 84 + years ["old-old" age]. Subjects were divided into six age groups based upon modifications to Schaie's [1988] definitions of the elderly and categorized on a data tally sheet that focused on

age, sex, diagnosis[es], disposition, and race for statistical analyses. A total of 290 patients, 145 males and 145 females, were identified from the crisis stabilization unit's archival data.

The most significant finding is the majority of patients seen by crisis intervention counselors had medical dispositions with a non-DSM-III-R classification. Interventions involved issues of loneliness and physical isolation, fear of the hospital, denial of a medical condition, and/or resistance/refusal of treatment. Additional areas noted as precipitating crises among elderly patients included death of a spouse or loved one, substance abuse, acute and chronic psychiatric problems, and a lack of transportation or housing.

Tabulations between sexes indicated that 47 percent of the females and 35.5 percent of the males were seen by crisis counselors for problems related to their medical conditions. Thirty-eight percent of the males received assistance for substance abuse problems whereas only 5.5 percent of the females were associated with the disease. 38.5 percent of the females were in need of acute psychiatric intervention whereas only 21 percent of the males required intervention. In addition, 9 percent of the females versus 5.5 percent of the males were seen for psychosocial stressors. Intervention programs included immediate hospitalization, out-patient treatment, mental health and self-help group referrals, and transportation and housing assistance.

These data suggest there is a relationship between sex, age, and the reasons elderly seek assistance in an emergency care unit. However, these data are limited to this

sample and are not generalizable to larger populations. Therefore, further research is needed to reduce the dichotomy in geriatric research and identify variables that impact upon the entire elderly population rather than one specific group of elderly or geriatric patients.

In addition, continuing studies utilizing emergency care units a the "portal of entry" are essential in defining elderly related problems as well as specific hospital and community based programs to meet their needs.

The Elderly In Crisis: Identifying Crisis Situations In An Emergency Room Setting. A Definitional Study

Americans are living longer. This comes as no surprise as improvements in diet, nutrition, exercise, and medical care[1] abound and education about the physiological and psychological risks associated with stress[2], alcohol[3], tobacco[4], and substance abuse[5] assist people in making healthy lifestyle changes. Even such terms as "Graying Americans", "Senior Citizens", and "Well-Elderly" have become synonymous with living longer, healthier, and more productive lives.

"Successful aging", as defined by the American College of Physicians [1988], is a process in which individuals exhibit "modest age-determined changes" caused by the effects of intrinsic factors with minimal exposure to environmental determinants such as toxins [including cigarettes and alcohol], medications with deleterious effects, insufficient nutrition and low levels of physical activity[7]. In contrast, the American College of Physicians [1988], following a medical model, defines geriatric adults are defined as "persons harboring diseases"[8] and the understanding of bodily systems. Geriatric patients are in need of long- term care and follow-up treatment because of chronic

physical and psychiatric illnesses[9].

Jenick [1990], in a study with over 200 elderly patients admitted to the hospital, notes that 78 percent had at least four major diseases, 38 percent had six or more, and 13 percent had more than 8 diseases. In terms of medications, the elderly consume 25 percent of all medications prescribed. Less than 5 percent use no medication. The most frequently prescribed pharmaceuticals include cardiovascular drugs, psychotropics, analgesics, and laxatives[10].

Cassidy [1990] and Santrock [1986] suggest differences between successful and geriatric aging may be due to variations in chronological age [the number of years lived] and biological age [the age level at which the body functions]. In terms of health and longevity, the biological age seems to be more important[11]. Goleman [1991] cites research data suggesting that not all memory deteriorates with chronological age. Rather, there are at least three major memory systems, episodic, semantic, and implicit memory stores, and only episodic memory worsens with age[12]. However in both areas of research further investigation is warranted.

Nationally, more than 25 million Americans are over 65. This figure represents 12 percent of the total population. According to the American Association of Retired Persons, by 2030, there will be about 66 million older persons. If current fertility and immigration levels remain stable, the only age group to increase in numbers in the next century will be individuals over age 55 In addition, by the year 2000, persons aged 65+ are expected to represent 13.0% of the population, and this percentage may climb to 21.8% by 2030[13].

These statistics reflect an aging Baby Boom generation with women living approximately 7.8 years longer than men[14]. In 1988, there were 18 million older women and 12.4 million older men, or a sex ratio of 146 women for every 100 men. Currently, women are living 20 to 25 years past retirement which by the year 2000 will be more than 30 years[15].

For New Jersey, the estimated population for individuals 60 years and older are staggering. Second only to Florida in the number of retired persons, New Jersey will increase from an estimated 7,814,00 million in 1990 to 8,500,00 by 2000 and 9,307,70 by 2020. Individuals 75 years and older, the 29% estimate for 1990 will increase in 2000 and 2010 as the Baby Boomers become sentigenarians and will drop back to 29% by 2020 as those born in the 1960s reach this age bracket. For minorities, the growth with double from an estimated 9% in 1990 to 19% by 2020.

Table 1 illustrates the population projection estimates for New Jersey. However, the author notes that in New Jersey, there is no set age when an individual becomes a "senior citizen". Rather, the age requirements for federal and state programs have been established by legislative action. The term age is relative to the individual and level of functioning[16].

Table 1: New Jersey Population Projections

Total	60 Plus	Percent of Population
7,814,300	1,458,000	18.7%
8,157,000	1,507,000	18.5%
8,500,200	1,515,400	18.3%
8,996,000	1,901,200	21.0%
9,307,700	2,379,300	26.0%

Minority As Percent of 60 Plus Population

1990: 09%

2000: 13%

2010: 17%

2020: 19%

75 Plus As Percentage of 60 Plus Population

1990: 29%

2000: 35%

2010: 32%

2020: 29%

Within the next decade, this growing elderly population will need additional financial, psychological, medical, social, and educational support to cope with physical deterioration, psychological dysfunction, and social discrimination and isolation. However in order to understand the current and future crises experienced by the elderly, the author thinks clarification of elderly needs is essential. Kaplan [1960] reiterates the "needs and drives" of older persons as listed by The Institute of Gerontology of the State University of Iowa. Since the 1960's, the elderly's basic needs have not changed, and the author views these needs and drives as inalienable rights that ought to be afforded to all elderly individuals. There are nine needs listed by Kaplan[17]:

1. Need to render some socially useful service
2. Need to be considered a part of the community
3. Need to occupy their increased leisure time in satisfying ways
4. Need to enjoy normal companionship
5. Need for recognition as an individual
6. Need for opportunity for self-expression and a sense of achievement
7. Need for suitable mental stimulation
8. Need for suitable living arrangements and family relationships
9. Need for spiritual satisfaction

The elderly "need" to feel useful, part of a community, and recognized as individuals with wants, needs, desires, and drives to live satisfactory lives. Crises develop

when a homeostatic imbalance is generated by internal and/or external stressors. When this occurs, they turn to their families, friends, community organizations, and local, state, and federal governments for assistance but they are ill-equipped to help.

Problems Facing The Elderly

America's elderly have not been spared from the destructive forces of mental illness. Currently, between 15 and 25 percent of the 28 million Americans over 65 years old suffer from a wide range of mental disorders and are in need of mental health services[18]. Included in this figure are an estimated 2 to 4 million Americans who suffer from dementia, including Alzheimer's disease[19]. Dementia has become so widespread that half of all nursing home beds care for demented patients with a present cost of 12 billion dollars. Of this population, 5 to 7 percent are over age 65 and 20 percent are 80+ years old. Current projections estimate that by 2030, the cost for caring for demented patients will exceed 30 billion dollars[20].

With few social supports, limited financial resources, and a variety of societal barriers and stereotypes that prevent the availability of adequate care and treatment, America's elderly are attempting to cope on their own, but not without a price. With an increasingly high incidence of depression and suicide, anxiety, substance abuse, and family problems, the aged are forcing change within organizations that are supposed to be designed to meet the needs.

Depression and Suicide

Approximately 10 to 15 percent of the elderly suffer from significant and persistent depressive symptoms, with estimates as high as 50 percent for individuals residing in long term care facilities[21]. Depressive symptoms range from depressed mood with fatigue, diminished interest, concentration difficulties, and sleep problems to appetite/weight changes, psychomotor retardation/agitation, and suicidal thoughts or attempts[22].Frequently, these symptoms are associated with clinical and "holiday" depression, loneliness and physical isolation, death of a spouse or pet, loss of identity [i.e.: decreased independence with job loss, deteriorating health, or re-location to unfamiliary surroundings], and physical/emotional elder abuse or neglect inflicted by relatives usually residing with the client[23].

In addition, higher suicide and parasuicide rates have been linked with affective illnesses such as depression due to diminished socialization, decreased communication with family and friends, and increased feelings of helplessness, hopelessness, and pessimism about the future[24].

Clients at highest risk of suicide are elderly men, ranging in age from 80 to 90 years, living alone, with no previous history of depression but who have significant vegetative signs and moderate dysphoric symptoms[25]. Along with elderly men, the suicide rate among nursing home residents appears to be four times that of non-institutionalized senior citizens. Clearly, the psychological needs of nursing home patients are not being met and increases in psychological interventions are warranted[28].

Anxiety Disorders

Anxiety disorders are starting to be recognized, diagnosed, and treated by the medical community[27] as well as by mental health professionals. Roughly 12 percent of this population is over age 65 and they use approximately 25 percent of all prescription and over-the-counter medications to alleviate anxiety[28].

Classification of anxiety disorders should first include a medical examination to rule out diseases such as hyperthyroidism, hypertension, hypoglycemia, alcoholism, and caffeinism because their etiology can mimic anxiety symptoms. Once medically cleared, the counselor must interview the client in order to diagnose his/her anxiety disorder. The DSM-III-R [1987] lists five anxiety classifications for anxiety with subcategories. The five types include phobias [simple, social, and agoraphobia with/without panic], panic disorders, generalized anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. However, an anxiety disorder diagnosis is not given if the anxiety is due to an organic syndrome such as Parkinson's Syndrome, Alzheimer's Disease, or AIDS dementia[29]. Once anxiety is properly diagnosed, psychological and pharmacological treatment can be initiated. Usually, treatment incorporates behavioral therapy, individual counseling, and anxiolytic medications such as benzodiazepines to quell the physical symptoms[30].

However, research concerning the etiology, symptomotology, and treatment of anxiety disorders is limited and as a result the severity of these syndromes are not fully understood.

Alcohol and Substance Abuse

Alcohol, prescription and over-the-counter [OTC] drug abuse studies and programs are starting to permeate medical and psychological literature as professionals begin to recognize the deleterious effects [i.e. physical addiction and side-effects such as depression] these substances are having on the elderly. These studies include assessment of seniors abusing alcohol and drugs, short- and long-term treatment approaches, community intervention with outreach, self-help, and peer support groups, and educational programs designed to develop awareness and insight into the problems of alcohol and drug abuse[31]. However, this is only the beginning. Additional research is needed in order to fully understand the impact alcohol and drug addiction is having on America's elderly population.

Elder Abuse

Elder abuse is the most recent and most neglected form of family violence in American today. Family members have been found to be the major perpetrators of abusive behavior toward the elderly. However, there is conflicting evidence regarding who is the primary assailant. For example, Pillemer and Finkelhor [1988] noted that 58% of elder abuse was committed by the victims spouse while 24% of the abusers were the victims children[38]. Some researcher studies support the popular stereotype that the elderly are abused by a resentful son or daughter and they silently cope with the physical and emotional abuse for fear of retaliation by relatives that could result in removal from their only know residence and lead to institutionalization[38A].

Elder abuse will continue as long as ageism and violence endure. Aguilera [1990] has compiled the following characteristics that seem to increase the potential for elderly abuse and neglect:

1. Female. Elderly women are less likely to resist abusive behavior and more prone to sexual molestation.
2. Advanced Age. Advanced age is associated with physical and mental impairments that leads to an inability to resist adversities.
3. Dependency. Older individuals who depend on others for care are more vulnerable. Economic dependency can lead to hostility and abuse by the caretaker.
4. Internalizing Blame. Elderly who are prone to self-depreciating behavior and self-blaming may fail to acknowledge the abuser as the source of the problem.
5. Excessive Loyalty. If the abused elder has a strong sense of loyalty towards the care giver s/he is less likely to report the abuse.
6. Past Abuse. An elder abused by a family member in the past are likely to be abused again in the future when s/he displays impairments and dependency.
7. Isolation. An isolated older person is vulnerable to abusive behavior because of the lack of detection and intervention by neighbors, friends, other relatives, and service providers.[36B]

In order to combat and prevent elderly abuse, individuals who provide services to the aged need to be educated about the problems related to spousal and family abuse and be able to recognize the physical, psychological, and social signs and symptoms associated with battering, abuse and neglect.

Development of Problems

According to the available research literature concerning psychogeriatrics, the problems facing the elderly are developing for a number of reasons:

1. Increasing psychological concerns and physical limitations associated with growing older[32];
2. Living alone or in a nursing home with increased physical isolation and loneliness[33];
3. Having decreased financial security and fewer social networks to resolve problems[34];
4. Dealing with physical/physiological changes and increased medical problems[35];
5. A reluctance to seek out mental health services for "fear of being regarded as mental or crazy because they were raised in an era when psychiatric knowledge was in its infancy, and a person was supposed to handle his/her problems by him/herself"[37]. Individuals born prior to 1955 did not have the same exposure to psychology as those born after and therefore, usually view their symptoms as a physical malady or moral malaise[38]; and

7. A lack of "caring" or nurturance exhibited towards the elderly because they are assumed to be non-productive, dependent, and useless.

Societal Barriers

In addition, there are a number of societal barriers that prevent the elderly from receiving adequate mental health treatment. These barriers include ageism, discriminatory and exclusionary public policies[39], a lack of legislative lobbying and advocacy organizations[40], and insufficient financial resource programs. All of these obstacles impede elderly clients from obtaining the assistance they require[41].

Ageism, like sexism and racism, occurs daily in our society, has stereotypes, and negatively effects the treatment the elderly receive by mental health professionals[42]. This concept is based on the erroneous and cynical assumption that working with elderly clients is futile and doomed to fail because they are difficult, unproductive, and have an increasingly long life span characterized by a decline in cognitive functioning, ego strength, learning ability[43], and skills retention.

According to Knight [1990], a geropsychologist and professor at the University of Southern California, psychologists must "learn about aging, overcome assumptions and misconceptions about aging, and learn to confront their own problems with aging and death [because working with older patients][44] can make therapy feel different, whether or not it is in terms of content, process, and technique[45].

Ageism is prejudicial and discriminatory and in our society, socioeconomic status, sex, and ethnic background influence an individual's chances of living a long life[46]. Frequently, ageism leads to inadequate services because of discriminatory public policy. Incorporated in this realm are age discrimination, mandatory retirement, entitlement programs based on age rather than need, and a lack of geropsychological professionals with sufficient non-biased education and training[47]. These problems, coupled with an increased financial burden caused by a lack of federal and state funding and stringent insurance guidelines, make it increasingly difficult for the elderly to receive care[48]. Among racial and ethnic minorities, these problems are further compounded by cultural and language barriers and a lack of minority mental health professionals with practical knowledge and training[49].

Too often, the combination of societal barriers, personal problems, and psychiatric illnesses prevent the elderly from obtaining mental health services which results in a crisis where the "patient is the sickest, the support systems most strained, and the nature of the problem most complicated"[50].

The Elderly In Crisis

In medicine, a "crisis" refers to the "turning point in the course of a disease, when it becomes fairly clear whether a patient will recover or die"[51]. Psychologically, a crisis situation is defined as a time-limited event [as short as six weeks] that threatens the physical and psychological well-being of an individual by creating cognitive

disorganization and emotional disturbances[52]. This occurs as a result of changes in the client's cultural/social milieu, personal or environmental conditions, social status, or life cycle that produces an acute emotional upset or homeostatic imbalance. A crisis occurs when the client's interpretation of the event, temporary inability to cope with his/her usual problem-solving devices, and the limitations of his/her resources lead to stress so severe the individual can not find relief[53].

Usually, a crisis originates from either a situational, transitional, or cultural/social homeostatic imbalance. In situational crises, endogenous events such as a physical illness or exogenous [environmental] factors such as a fire, flood, or earthquake cause the individual to experience a crisis because the situation was unanticipated and unforeseen.

In a study by Phifer [1990], the author examined the vulnerability of older adults to psychological distress and somatic symptoms following exposure to a natural disaster [i.e.: severe flood]. By examining the data collected from 200 older adults, ranging in age from 55 to 75+ years, in pre- and post-flood interviews, Phifer concluded that "men, with lower occupational status, and persons aged 55-64 were at significantly greater risk for increased psychological symptoms such as depression, anxiety, and somatic complaints" than the older old. Phifer reported two major factors as possibly contributing to the resiliency of the older old. These factors included "rich histories of coping with prior crises . . . which reduced the impact of the disaster experienced in later life", and "lower level of ongoing stress . . . may facilitate adaptation to natural disasters". In

addition, the author noted that older adults approaching retirement age [55-64 years] were more susceptible to adverse psychological effects because they were in the midst of a life transition in which they were trying to develop new coping strategies. As a result of the disaster being concurrent with retirement, the stress was overwhelming and psychological sequelae developed[54].

Another type of situational crisis may occur because of a loss of environmental support which was crucial to the individual's functioning. This can range from the death of a spouse to the closing of a grocery store that was within walking distance of the person's residence.

With a transitional crisis, the individual usually experiences severe stress as a result universal lifecycle changes or non-universal alterations that signify a shift in social status. These transitions can range from adolescence [universal] to retirement [non-universal]. Crises developing from cultural/social-structure changes are usually the most difficult to understand and treat successfully because they reflect changes in the individual's cultural values and social milieu. For example, these crises include job discrimination, physical and emotional abuse, rape, incest, and marital infidelity. When a crisis occurs and the individual is unable to return to homeostasis, s/he frequently utilizes the emergency room services of a general hospital because s/he unable to reach a solution to the escalating problem and reduce the associated pathological sequalae[55].

Also, research studies suggests the availability of interpersonal and emotional support from family, friends, and community members are important determinants in the

"evolution and resolution" of the emergency stage of a crisis because they contribute to the personal, affective, and social components of the individual[56]. However, family members are frequently reluctant to intervene and care for an elderly family member [particularly if the individual has a preexisting psychiatric illness such as Alzheimer's Disease] and report their initial reaction as "stunned" when faced with the prospect. Three major areas were cited by family members as being responsible for their hesitation. They include inappropriate patient behavior [i.e.: physical violence, inappropriate sexual behavior, incontinence, catastrophic reactions, accusations, and suspiciousness]; care giver problems [i.e.: chronic fatigue/anger/depression, family conflict, loss of friends and hobbies, no time for self, worry about personal illness, difficulty assuming new roles/responsibilities, and guilt]; and the reversal of parent/child roles [i.e.: environmental modifications and bathing][57].

For elderly clients experiencing a crisis, the characteristics of the situation and the techniques used for intervention have received little attention in the literature[58]. However, researchers agree the majority of elderly clients have been left without adequate care and do not enter the medical/social system "until the situation deteriorates so that both the client and his/her environment are in a state of crisis"[59].

When the elderly enter the emergency room, they usually define their problem in terms of somatic complaints such as loss of appetite, constipation, hypersomnia, or heart

palpitations rather than viewing the problem "psychologically, interpersonally, or situationally"[60] because they grew up in an era where such concepts were unknown[61].

During a crisis, elderly clients in distress usually convey their feelings through body language [i.e.: tense body posture, hand-wringing, repeated sighing, facial wrinkling resembling an omega symbol just above the bridge of the nose or a furrowed brow, slumped posture with drooped shoulders, and a lack of eye contact] and are reluctant to share the circumstances of the crisis or their feelings related to those events with "strangers"[62].

As a result, the emergency room triage nurse usually refers the client to the emergency room physician for examination, diagnosis, and treatment because the presenting problem is a somatic complaint.

However, Steinhauer [1984] suggests there are fourteen methods to effectively communicate with elderly patients:

1. Keep the visual aids simple in design.
2. Use large printed materials.
3. Red is the color best seen.
4. Advise the patient of your movements in advance.
5. Place only one or two objects at a time in their field of visions.
6. Use vocabulary that is neither technical or specific to a younger age group.
7. Speak slower and a little louder than you usually do.
8. Touch a person to make sure of their attention. [optional]
9. Eliminate background music or noise before you begin.
10. Use gestures with your verbal descriptions.
11. Encourage patient participation and allow plenty of time for your response.
12. If objects are demonstrated, such as brushes, include some with special adjustments or grips for those with dexterity problems.
13. Refer to individuals by their proper names such as "Mr.," "Mrs., and not "Granny" or "Gramps".
14. Face your patient directly and establish eye contact to secure feedback for yourself.

If the client is "medically cleared" by the physician [which implies that all necessary diagnostic testing are completed and the results followed- up], s/he may be referred to the psychiatric emergency service for evaluation, disposition, and follow-up treatment[63]. However, most gerontologic research and literature in this area present the elderly population as a dichotomy.

Either researchers examine the problems associated with geriatric clients OR they focus on elderly issues. Rarely do they describe the total population. In addition, researchers tend to dissect the elderly by classifying or labeling them as either medical OR psychiatric OR social emergencies OR non-emergencies rather than providing a "continuum of care" that looks at the totality of the individual regardless of the level of crisis when they enter the emergency room[64].

For example in a study by Waxman, et al. [1984], researchers questioned whether clients were labeled medical or psychiatric based on an initial impression of the triage nurse or emergency physician stemming from a "single piece of data, a single symptom, a single item of past history, or a previous diagnosis". Based on a comparison of records between elderly patients with psychiatric disorders and elderly patients from the medical emergency department, the authors concluded physicians are often mislead by behavioral disturbances [i.e. aggression, belligerence, disorganized thought, hallucinations, and delusions] and overlook a medical diagnosis for the psychiatric symptoms. Therefore, they recommend that all patients with behavioral disturbances

undergo "adequate medical evaluations" to differentiate physical disorders [such as organic brain syndromes] from functional psychiatric disorders [such as depression] before being referred for a psychiatric evaluation[65].

Overview of Psychogeriatric Literature

Most psychogeriatric research studies do not focus on elderly crises in emergency room settings. Rather, researchers tend to focus their attention in the following areas:

1. Geriatric Mobile Outreach and 24-hour crisis hotlines that provide comprehensive medical, psychological, social, and nursing interventions[66];
2. The evaluation of elderly patients utilizing psychiatric emergency services in general hospitals[67];
3. The role of psychiatric emergency services in meeting the mental health needs of the elderly {i.e.: emergencies versus non-emergencies}[68];
4. Characteristics of elderly patients admitted to psychiatric units of a general or psychiatric hospital[69];
5. Characteristics of geriatric patients utilizing emergency room services[70];
6. Evaluations of intervention programs that delivered mental health services in senior citizen or community mental health centers[71];

7. Spiritual crises in which the individual feels or perceives that significant meanings or values are threatened or being taken away[72];
8. Types of intervention programs for hospitalized geriatric patients[73];
9. Types of physical, psychological, cognitive, and social problems and changes associated with the elderly[74];
10. Evaluations of Medicare, Medicaid, HMOs, and catastrophic health care programs for the payment of short and long-term health care services[75]; AND
11. Investigations and proposals for federal, state, and local policies/guidelines for the care and treatment of elderly and geriatric patients[76].

As a result, there appears to be research data on the types of crises elderly clients bring to emergency room settings or the types of crisis intervention services offered either to geriatric OR elderly individuals [other than medical treatment] prior to being referred to a psychiatric emergency service or crisis stabilization unit. However, researchers do not seem to present detailed, integrated information that illustrates the needs, problems, and concerns of both geriatric and elderly clients in emergency rooms and the crisis stabilization interventions utilized to assist this population.

Purpose of the Project Demonstrating Excellence

A Gap In The Literature

The literature presented in this chapter is divided into the areas of research currently investigated by researchers and scientists in the psychogerontological community. The available information in these areas is extensive, descriptive, and is presented in a way as to acquaint the reader with the many facets of geriatric research.

However, the available literature seems to lack integrated information that illustrates the crisis stressors elderly patients and clients demonstrate in emergency care units and the types of community programs used by crisis professionals in assisting this population. In addition, the research data described in this section is the culmination of many dichotomous studies that attempt to define a single problem, age group, or community/hospital treatment program.

Research Statement

The purpose of the Project Demonstrating Excellence is to identify crisis situations in emergency room settings that are associated with elderly and geriatric patients. This will be accomplished through a retrospective descriptive study utilizing archival data from a crisis stabilization unit which is affiliated with the emergency medical department of a general hospital and who's crisis intervention counselors are an integral component of the emergency care unit triage team.

By examining the records of the crisis stabilization unit, the author will identify specific psychological, social, and medical stressors that are precipitating crises among this population and clarify the types of hospital and community based programs that are being utilized to de-escalate the crises.

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Chapter 2: Design Of The Study

Overview Of Project Demonstrating Excellence

Introduction and Research Methods

In 1989, Raritan Bay Medical Center-Perth Amboy Division [RBMC-PAD] was a 522-bed public, non-profit, teaching hospital serving Middlesex County with a regional population of 656,737[1]. Located in central New Jersey, Raritan Bay Medical Center provided assessment, treatment, and prevention programs for medical, substance abuse, and mental health problems.

From January 1, 1989 through December 31, 1989, the Crisis Stabilization Unit [CSU], staffed 24-hours a day by crisis intervention counselors [i.e. Counseling Psychologists and Social Workers], evaluated 5,015 patients or 15.8 percent of the total emergency care unit population. 5.8 percent or 290 subjects were selected from this population for inclusion into the project demonstrating excellence.

As a crisis intervention unit and psychiatric emergency service, the crisis department served a specific "catchment" area or region specified by the Department of Human Services-Division of Mental Health and Hospitals that included Perth Amboy City, Carteret, and Woodbridge Township [i.e. Avenel, Colonia, Fords, Hopelawn, Keasbey, Port Reading, Sewaren, and Woodbridge]. Total population of Raritan Bay Medical Center's catchment area was 150,130 based on a 1978 federal government census[2].

In 1989, Raritan Bay Medical Center was not affiliated with a designated psychiatric screening center. As a result, involuntary psychiatric commitments were completed with "alternate route" commitment papers consisting of an applicant, two physicians, and a judge[3]. Admissions to Raritan Bay Medical Center's psychiatric unit were for voluntary patients only [refer to Appendix 1]. Also, an in-house or on-call psychiatrist was available 24-hours a day for psychiatric assessments, commitments, and referrals of patients. In cases of commitment, PL 1987 C. 116, legal definitions for mental illness and dangerousness were utilized to assess dangerousness to self, others, and/or property[3A] [refer to Appendix 1A].

While in the emergency care unit, each patient was examined by a multidisciplinary triage team that consisted of a physician, registered nurse, psychiatrist, and crisis intervention counselor. The crisis counselor completed a psychosocial assessment of the patient's present mental status and history of decompensation as well as gathered information in the following areas [refer to Appendix 2]:

1. Relevant History: Included physical, mental, social, emotional, environmental, and medical information which might have precipitated the patient's present condition. Also, obtained information about the patient's home and family as well as their strengths and weaknesses to cope and work with the patient toward his/her recovery.

2. Psychiatric/Alcohol/Substance Abuse History: Indicated previous treatment, dates, names of facilities, treatment provided, and relevant outcomes. In addition, previous Crisis Stabilization and Emergency Care Unit charts were utilized to ascertain an accurate services utilization history.

3. Collaboration with Other Health Professionals: Showed consultation with the psychiatrist, emergency care personnel, mental health professionals, and family members. This entry also included notations for past history and medications as well as level of functioning and signs of decompensation.

4. Diagnostic Impression: Included a Diagnostic and Statistical Manual of Mental Disorders [DSM-III-R {American Psychiatric Association, 1987}][6] diagnosis. Impressions of the patient were based on individual interviews, collaborations with the emergency care unit staff, and consultations with the psychiatrist.

5. Proposed Action: A brief description of treatment plans for each problem which have been compiled from pertinent patient history information and from discussions with the patient, family, friends, and other professionals.

6. Disposition: Entries are made when action is completed even though proposed actions have been listed. If proposed action is undertaken, modified, or abandoned, the reason was noted on the intake record. Follow-ups on patient referrals were not completed by the Crisis Stabilization Unit.

Following the examination, the patient was either admitted to the hospital or referred to another facility for in-patient or out-patient treatment based on the investigation of the patient's status. All pertinent information [i.e.: name, diagnosis, disposition, race, age, time-in and -out of the emergency care unit, and time seen by the crisis counselor] were recorded in the crisis stabilization unit log book [refer to Appendix 3]. Then, at the end of the crisis counselor's shift, s/he would record the types of patients assessed and disposition as well as collateral contacts on a daily stat sheet [refer to Appendix 4].

Subjects

First, written permission was obtained from Raritan Bay Medical Center-Perth Amboy Division to utilize archival data in the Project Demonstrating Excellence [refer to Appendix 5].

Sample Selection

The Crisis Stabilization Unit log book was reviewed for the period of January 1, 1989 to December 31, 1989. Based on patient records, two-hundred and ninety [290] elderly and geriatric patients aged 59 years to 84 + years of age were identified for inclusion into the heterogeneous sample. All elderly patients seen during this calendar year were included in this study with the exception of chronic or recidivist patients who were counted only one time per day. Subjects were either self-referred, brought by family members, or sent by nursing homes, community mental health centers, police and fire departments, or other psychiatric emergency services for evaluation and treatment.

The sample divided equally into two groups: one-hundred and forty-five [145] were male and one-hundred and forty-five [145] were female. Then, the subjects were divided into six age groups based on modifications to Schaie's [1988] definitions of the elderly. These groups, divided by five year increments, ranged from 59 years to 63 years [late middle age to "young-old" age]; 64 to 68 years [middle young-old age]; 69 to 73 years [late young-old age]; 74 to 78 years [young to middle "old-old" age]; 79 to 83 years [late old-old age]; and 84 + years ["very-old" age][4].

The author reviewed the Crisis Stabilization Unit log book, the unit intake records, prior Crisis Stabilization Unit charts, and the psychiatric consultation sheets, if available, for additional information. Data concerning medical and/or psychiatric diagnoses, dispositions, psychosocial stressors, age, and race were recorded on a data sheet for tabulation.

Implementation of Research Methods

Overview of Data Collection

After the subjects were identified in the log book [refer to Appendix 3], the information was recorded on a statistical data sheet that tallied diagnosis and disposition and documented patients according to such demographic control variables as age, sex, and race. Subjects were counted only one time per day to avoid multiple entries of chronic and recidivist patients seen by the crisis stabilization unit staff. However, the sample was not restricted to first time admissions.

Data analyses were tabulated from the data sheet information. Descriptive statistics including means, standard deviations, variance, percentages, and histograms were applied to the data[5] for examination, discussion, and conclusions.

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Chapter 3: Results

Total Sample Results

Characteristics of 290 Subjects

The total sample of 290 persons was composed of 145 men [50 percent] and 145 females [50 percent]. Medically, 41 percent [119 of 290; m= 51/f= 68] received crisis intervention assistance. 30 percent [87 of 290; m= 31/f= 56] received help for psychiatric problems. 22 percent [63 of 290; m= 55/f= 8] were treated for substance abuse and 7 percent [21 of 290; m=8/f= 13] were given psychosocial assistance for transportation and shelter.

Categorically, forty-seven percent of the females [68 of 145] and 35.5 percent of the males [51 of 145] were seen by crisis counselors for problems associated with their medical condition. 38.5 percent of the females [56 of 145] and 21 percent of the males [31 of 145] received intervention for acute or chronic psychiatric conditions. Thirty-eight percent of the males [55 of 145] were treated for substance abuse problems whereas 5.5 percent of the females [8 of 145] were associated with the disease[s]. An additional 9 percent of the females [13 of 145] and 5.5 percent of the males [8 of 145] needed psychosocial assistance.

In the sample, 73 percent [211 of 290; m= 108/f= 103] were caucasian, 19 percent [56 of 290; m= 27/f= 29] were hispanic, 6 percent [19 of 290; m= 6/f= 13]

were black, and 2 percent [4 of 290; m= 4] were asian. Ethnicity, marital status, and educational data were not incorporated due to incomplete charts.

On the next page, Table 2 contains the basic demographic characteristics collected on all 290 elderly subjects from either crisis stabilization unit log sheets, unit intake records, or emergency care unit medical charts.

Of the sample, 32.5 percent [94 of 290; m= 53/f= 41] were between the ages of 59 and 63 years. Twenty-eight percent of the sample [81 of 290; m= 43/f= 38] were between 64 and 68; 18.5 percent [54 of 290; m= 21/f= 33] were between 69 and 73; 9.5 percent [27 of 290; m= 15/f= 12] were 74 to 78; 7.5 [22 of 290; m= 11/f= 11] were 79 to 83; and 4 percent [12 of 290; m=2; f=10] were 84+ years old [refer to Graph 1].

Table 2

CHARACTERISTICS OF 290 ELDERLY CRISIS INTERVENTIONS

		n/290	%
SEX			
Males		145	50.0
Females		145	50.0
RACE:	Males vs. Females		
Caucasian	108 vs. 103	211	73.0
Hispanic	027 vs. 029	56	19.0
Black	006 vs. 013	19	06.0
Asian	004 vs. 000	04	02.0
AGES:			
59 to 63	053 vs. 041	94	32.5
64 to 68	043 vs. 038	81	28.0
69 to 73	021 vs. 033	54	18.5
74 to 78	015 vs. 012	27	09.5
79 to 83	011 vs. 011	22	07.5
84 +	002 vs. 010	12	04.0
DISPOSITION:			
Medical	051 vs. 068	119	41.0
Psychiatric	021 vs. 056	87	30.0
Substance	055 vs. 008	63	22.0
Psychosocial	008 vs. 013	21	07.0

Medical Treatment: Disposition By Diagnosis

Forty-one percent of the total sample [119 of 290] were seen by crisis stabilization counselors in either the emergency care or crisis stabilization unit. Forty-seven percent [56 of 119] were admitted to the hospital with medical dispositions and interventions dealt with such non-DSM-III-R problems as loneliness and/or physical isolation, generalized fear of the hospital, and denial of medical problems and/or treatment. Thirty-one were female, and 25 were male. Twenty-six percent [31 of 119] were medically treated and released with dispositions to follow up with their personal physician or at the local medical clinic. Of this group, 23 were female and 8 were male. An additional 7 percent [8 of 119] were referred to such organizations as the Multi-Service Program on Aging, Women's Abuse Services, the Counsel on Ageing, and the local Senior Citizens Center for follow-up. Six were female, and two were male.

Twenty percent of the sample [24 of 119] either expired in route to the hospital or in the emergency care unit. Sixteen were male, 8 were female. Crisis counselors intervened with spouses and family members to help cope with the grief reactions. However, no data were available on family assistance [refer to Graph 2].

Comparatively, more females than males were assisted by the crisis intervention counselors for medical admissions, social service referrals, and follow-ups with their personal physician or medical clinic. However, the males outnumbered the females in DOAs and expirations en route to the hospital with crisis interventions focusing on stabilization surviving family members [i.e.: namely, spouse and children].

Psychiatric Treatment: Disposition By Diagnosis

Of the total sample, 30 percent [87 of 290] received psychosocial assessments for psychiatric disorders ranging from organic brain syndromes, acute decompensating schizophrenia, and reactive depression to generalized anxiety, phobias, and adjustment disorders. Fifty-six were female and 31 were male.

In this group, 53 percent [46 of 87; 32 females and 14 males] were admitted to the hospital's psychiatric unit for treatment. Twenty percent [17 of 87; 12 females and 5 males] were referred to the local community mental health center for follow-up care, and 23 percent [20 of 87; 11 males and 9 females] were involuntarily committed to either public or private psychiatric facilities that included Marlboro Psychiatric Hospital, Lyons Veterans Hospital, Fair Oaks Hospital, and the Carrier Foundation.

The remaining four percent [4 of 87; 1 male and 3 females] were assessed, treated, and released from the emergency care unit without a follow-up disposition [Refer to Graph 3].

Substance Abuse/Dependence Treatment: Disposition By Diagnosis

In this sample, 22 percent [63 of 290] were evaluated by the crisis intervention counselors for alcohol and/or substance abuse problems. Fifty-five were male and 8 were female. Of this group, 67 percent [42 of 63] were admitted to the alcohol/substance abuse detoxification unit at the hospital for addiction problems. Thirty-eight were male; 4 were female. Twenty-nine percent [18 of 63] of those with alcohol problems were referred either to Alcoholics Anonymous [AA] or the hospital's 28-day, in-patient rehabilitation program for follow-up care. Seventeen were male; one was female.

In addition, four [3 of 63] percent were admitted to the detoxification unit for drug abuse/dependency problems to such prescription medications as benzodiazepanes [i.e.: Valium and Xanax] or analgesics [i.e.: Percocet and Tylenol with codeine]. All 3 admissions were female.

In this sample, no one was referred to an outpatient drug treatment program such as Narcotics Anonymous [NA], and no one was admitted to the detoxification unit for a cross-addiction. [Refer to Graph 4].

Overall, males outnumbered females in alcohol detoxification admissions and outpatient referrals by 87 percent whereas females only made up 13 percent of this group.

Psychosocial Stressors: Disposition by Diagnosis

Two psychosocial stressors were identified from the crisis stabilization unit log book: transportation [i.e.: via public or private ambulance and taxicab] and housing [i.e.: shelter]. Seven percent [20 of 290] were in need of transportational assistance to return to the nursing home, personal residence, or other facility. Of those requiring assistance, 13 were female and 7 were male.

In terms of housing, less than one percent needed assistance in locating housing [1 male of 290]. This participant was referred to the local shelter for follow-up outreach and placement [refer to Graph 5].

Table 3

Characteristics Of Sample By Disposition

Medical Treatment [n= 119]:	*Percentage*
Admission To Hospital	47%
Medically Treated and Released	26%
Expiration and DOA	20%
Social Service Referral	7%
Psychiatric Treatment [n= 87]:	
Admission To Hospital	53%
Involuntary Commitment	23%
Mental Health Center Referral	20%
Psychiatrically Treated and Released	4%
Substance Abuse/Dependence Treatment [n= 63]:	
Admission To Hospital {for alcohol}	67%
Admission To Hospital {for drugs}	4%
Self-Help or Rehabilitation Referral	29%
Cross-Addiction Admissions	0%
Psychosocial Stressors [n= 21]:	
Transportation	7%
Housing	Less than 1%
	Total n= 290

Table 4

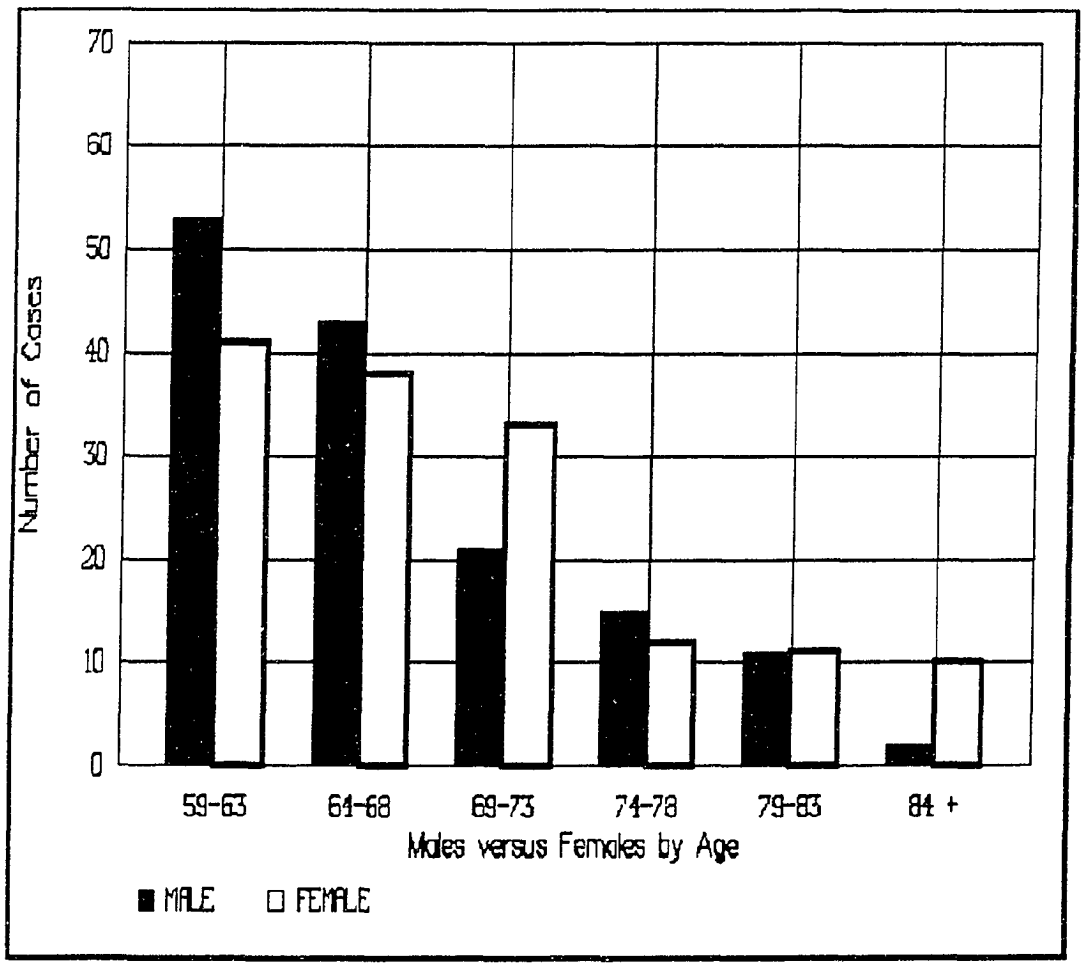
Number Of Males and Females Per Disposition

	Males vs. Females
Medical Treatment [n= 119]:	
Admission To Hospital	25 vs. 31
Medically Treated and Released	8 vs. 23
Expiration and DOA	16 vs. 8
Social Service Referral	2 vs. 6
Psychiatric Treatment [n= 87]:	
Admission To Hospital	14 vs. 32
Involuntary Commitment	11 vs. 9
Mental Health Center Referral	5 vs. 12
Psychiatrically Treated and Released	1 vs. 3
Substance Abuse/Dependence Treatment [n= 63]:	
Admission To Hospital {for alcohol}	38 vs. 4
Admission To Hospital {for drugs}	0 vs. 3
Self-Help or Rehabilitation Referral	17 vs. 1
Cross-Addiction Admission	0%
Psychosocial Stressors [n= 21]:	
Transportation	7 vs. 13
Housing	1 vs. 0
	Total n= 290

Graph 1

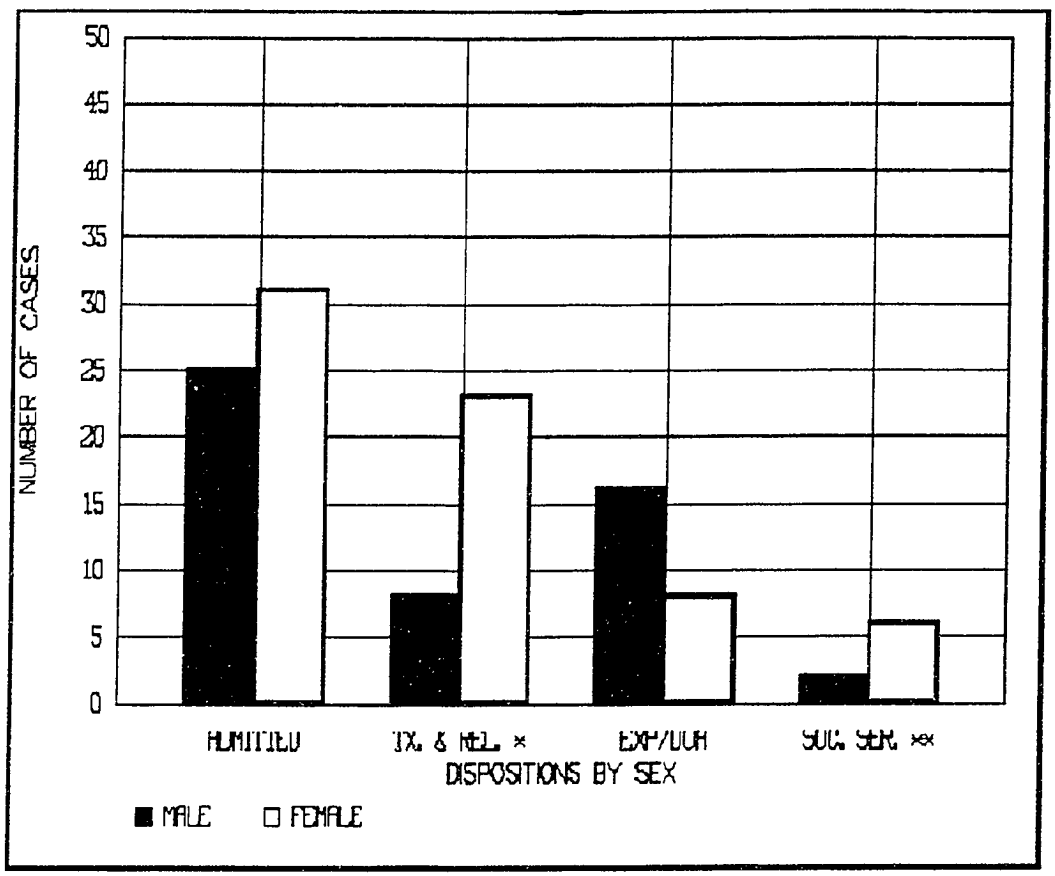
NUMBER OF CASES SEEN BY THE CRISIS STABILIZATION UNIT

MALES VERSUS FEMALES BY AGE



Graph 2

A COMPARISON OF MEDICAL DISPOSITIONS BY SEX

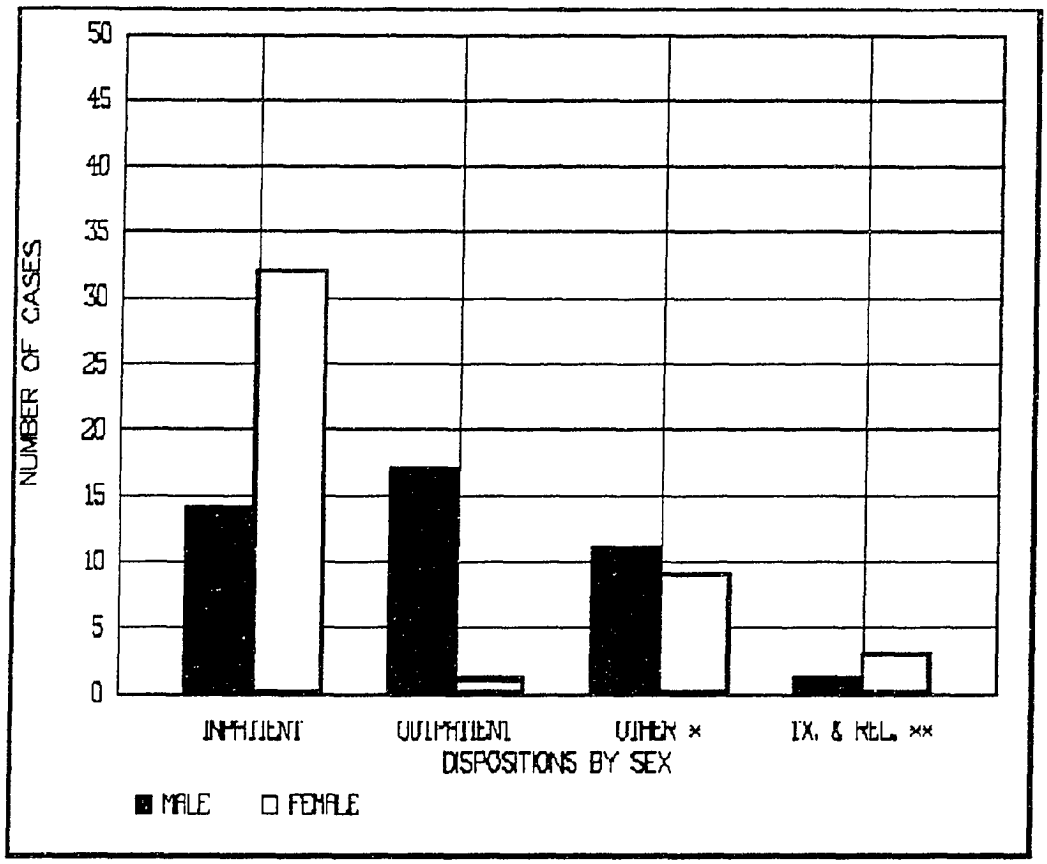


*Treated and Released

**Social Service Referral

Graph 3

A COMPARISON OF PSYCHIATRIC DISPOSITIONS BY SEX

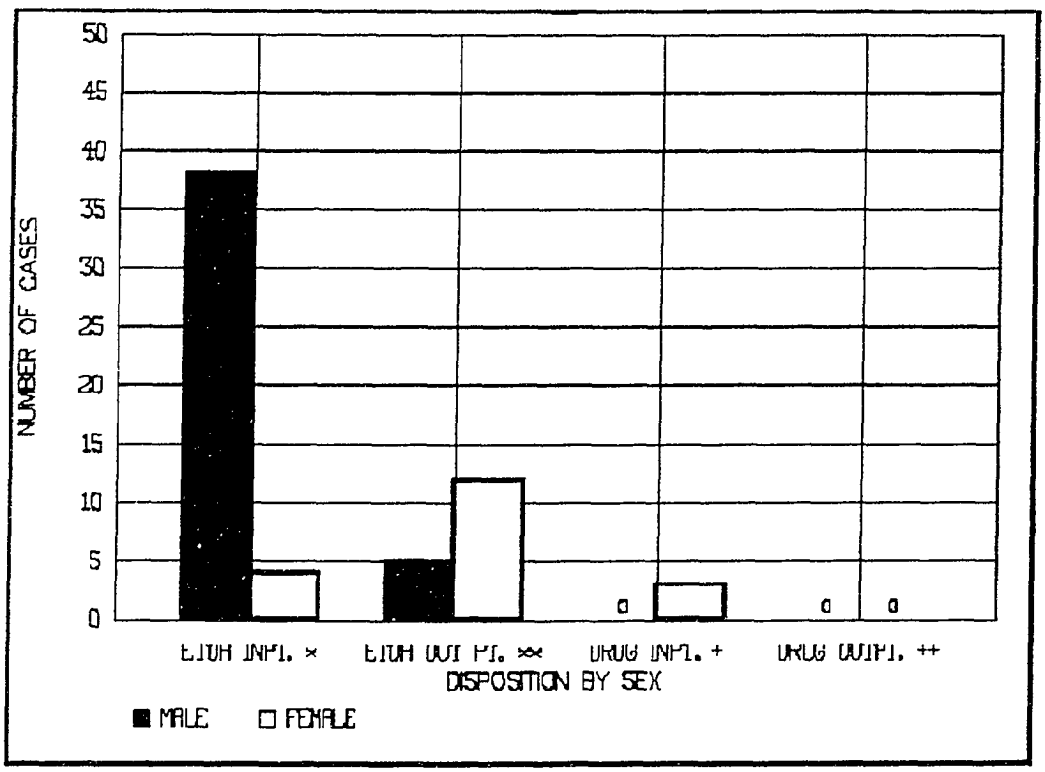


*Other Psychiatric Facility

**Psychiatrically Treated and Released

Graph 4

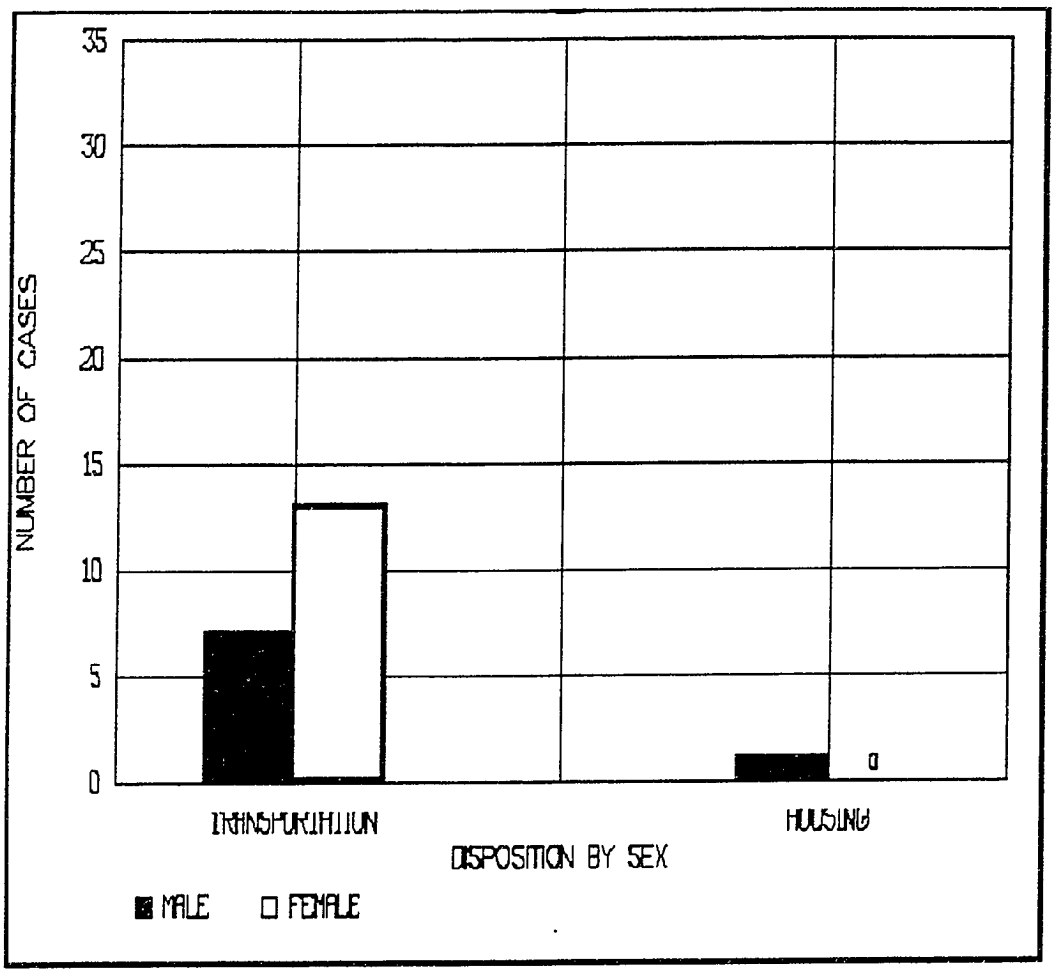
A COMPARISON OF SUBSTANCE ABUSE/DEPENDENCE DISPOSITIONS BY SEX



*Alcohol Inpatient
**Alcohol Outpatient
+Drug Inpatient
++Drug Outpatient

Graph 5

A COMPARISON OF PSYCHOSOCIAL STRESSORS BY SEX



Chapter 4:

Conclusions And Implications For Future Applications and Research

Discussion

These findings indicate that elderly and geriatric patients sought assistance in an urban emergency care unit to help resolve specific psychological, social, and medical crises. Based upon examinations of archival data [i.e. diagnoses and dispositions] from the crisis stabilization unit log book, their crises ranged from assistance during emergency medical treatment, loneliness and physical isolation, and the death of a spouse or loved one to substance abuse, acute and chronic psychiatric illnesses, and a lack of transportation or housing. In addition, crisis intervention counselors played a distinct role in responding to the needs of this population through identification, de-escalation, and assessment of the immediate problem and through the utilization of hospital and community based programs in order to facilitate a continuum of care.

Although the majority [41 percent; n = 119] of the patients seen by crisis intervention counselors were diagnosed medical conditions and intercession dealt with a non-DSM-III diagnosis [i.e.: loneliness; fear of the hospital; and denial of medical problems], significant differences existed between males and females in terms of disposition and age.

For example, more females [n = 60] than males [n = 35] were assisted by crisis counselors with medical treatment and admissions, social service referrals, and follow-ups with their physician or medical clinic. Males [n = 16] only outnumbered females [n = 8] in expirations and DOAs.

Other areas showing differences between the sexes were the substance abuse and psychiatric illness categories. For example, among those seeking assistance for acute or chronic psychiatric conditions, females [n = 44] outnumbered males [n = 19] in voluntary hospitalizations and referrals to social service agencies and the mental health center. However, more males [n = 11] than females [n = 9] were involuntarily committed to either a public or private psychiatric facility for intensive treatment due to decompensating functional psychiatric disorders such as paranoid schizophrenia and manic/depression. In this group, no statistical significance existed between the groups based on sex and disposition.

In contrast, among those evaluated for alcohol and/or substance abuse, the males [n = 55] sharply outnumbered females [n = 8] in hospitalizations for alcohol detoxification and referrals to in-patient rehabilitation programs and outpatient self-help groups such as Alcoholics Anonymous. However, only females [n = 3] were admitted to the hospital for prescription drug abuse/dependence. No one was admitted or referred with a cross-addiction to drugs and alcohol.

Referral and disposition patterns covered a variety of areas. The main source of dispositional referrals for medical, psychological, and substance abuse problems were

either voluntary or involuntary hospitalization [57.5 percent; n= 167]. Social service referrals ranked second with 22 percent [n= 64] being directed toward outpatient treatment. The remaining 20.5 percent [n= 59 including expirations] were medically treated and released either to self, relative, or friend.

These findings support the notion that focusing on the "portal of entry" in an emergency room setting [i.e.: Psychiatric Emergency Service {PES}], as suggested by Baker et. al. [1988], would be an appropriate avenue for researching the problems connected with the elderly psychiatric patients. However in addition to researching this population, the author integrated well- elderly and geriatric patients as well as focused on crisis stabilization methods **[prior to]** the utilization of psychiatric emergency services] in an effort to obtain comprehensive picture of the problems facing the elderly. The justification for investigating both elderly and geriatric patients of all ages was to minimize the dichotomy that exists in psychogeriatric research which tends to focus on a single problem, a single age group, or a single category of people rather examining the entire population.

Another area elucidated by these findings was the role of crisis intervention counselors play as coordinators and primary guides for the elderly in establishing access to mental health, health, and social service systems. As with the study by Simson and Wilson [1982] which noted that emergency mental health services are a "critical triage point" for making decisions about the types of services available to the elderly, these findings suggest that crisis counselors play an essential role in establishing the diagnosis

findings suggest that crisis counselors play an essential role in establishing the diagnosis and disposition of the patient as well as providing treatment and access into the mental health and health care systems.

Finally, these findings indicate the delimitations and limitations of the Project Demonstrating Excellence contribute to future areas of investigation in psychogeriatric research. For example, this study was delimited to an examination of archival data consisting of non-recidivist elderly and geriatric patients ranging in age from 59 to 84 + years who utilized the services of a urban emergency care unit to resolve crises. However, by focusing on all aspects of the geropsychiatric genre and by eliminating the dichotomy between elderly and geriatric patients, researchers, educators, and clinical practitioners will develop a clear and accurate picture of the social, emotional, medical, and psychological problems older individuals are facing today as well as in the future. Therefore, future studies are imperative that focus on psychogeriatric crisis intervention.

The following are a few examples of these types of studies:

1. Identification of specific counseling techniques that are effective in the de- escalation of elderly crises;
2. Comparisons between socioeconomic status of elderly patients and their use of public, non-profit hospitals for emergency crisis intervention;
3. Comparisons between socioeconomic status of elderly patients and personal resources with their use of private, non-profit hospitals for crisis intervention;

4. Investigation of perceptions between the elderly and other crisis interventionists such as physicians, nurses, and ministers in emergency room settings;
5. A cross-cultural comparison of elderly patients utilizing emergency room services;
6. Enhancement of educational training programs in psychogeriatrics with an emphasis on developing syllabi for minority programs;
7. Analysis and evaluation of the role of crisis intervention counselors play in establishing elderly patients' diagnoses and dispositions in emergency room settings;
8. Comparisons between elderly patients and the types of services offered by urban, suburban, and rural emergency rooms;
9. Longitudinal studies on changing needs of the elderly and their use of emergency services; and
10. Development of research studies that seek to reduce the dichotomy and ageism that exist in the psychogeriatric genre.

Other avenues for research include supplementary documentation on the strategies for the implementation and utilization of mobile outreach and 24-hour hotlines, integration of emergency medical and mental health services, and education in psychogeriatrics, mental health, and crisis intervention.

The limitations of study include the investigation of a single hospital, a representative but non-random sample population because all elderly and geriatric patients utilizing the emergency room services were subjects in the study. In addition,

quantitative statistics were not implemented in relation to ethnicity because of the disparity in subject groups [i.e. caucasians n= 211; 73 percent versus 27 percent; n= 79 hispanic, black, asian, and other} thereby eliminating comparisons or quantifications between the variables sex, age, race, and/or disposition], and an absence of such demographics as marital status, employment, socioeconomic status, education, ethnicity, and insurance coverage. Therefore, although inferences have been made regarding the reasons why elderly and geriatric patients seek assistance in emergency room settings, replication studies are warranted with qualitative and quantitative statistics such as proportional calculations. Included in these replications should be additional demographic variables and a proportionate representation of racial groups to ensure the results are generalizable to larger elderly populations.

Conclusions

A retrospective, descriptive study of elderly and geriatric patients utilizing the services of an urban emergency care unit was conducted for the 1989 calendar year. Using a modified version of Schaie's [1988] definitions of the elderly, this sample demonstrated that elderly patients sought assistance to resolve specific psychological, social, and medical crises.

In this sample, fewer patients were diagnosed with psychiatric disorders and substance abuse problems. The majority of patients seen by crisis intervention counselors had an ICM medical diagnosis [including organic brain syndromes] and intercession dealt with a non-DSM-III-R classification [i.e.: fear, denial, and loneliness]. Of this group, 56 patients were hospitalized, 31 were treated and released either to self, relative, or friend, 24 expired enroute to the hospital or in the emergency care unit, and 8 were referred to social service agencies for follow- up treatment.

Overall, these data suggest there is a relationship between sex, age, and the reasons elderly individuals seek help in an emergency care unit. However, these data are limited to this sample and are not generalizable to larger populations. Therefore, replication studies are warranted and further research is indicated with this growing segment of our population {which is estimated to exceed 34 million by the year 2000 [United States Bureau of the Census, 1990}] in order to develop financial, psychological, medical, social, and educational systems to help them cope with the daily stressors in their lives.

Glossary

Definition of Terms

AGEISM: prejudicial and discriminatory practices based on sex, age, race, socioeconomic status or ethnic background.

ALTERNATIVE ROUTE COMMITMENT: involuntary psychiatric admission to a psychiatric unit consisting of an applicant, two physicians, and a judge's signature.

BIOLOGICAL AGE: the age level at which the body functions.

CATCHMENT AREA: a psychiatric emergency service area or region that is defined by the Department of Human Services-Division of Mental Health and Hospitals.

CHRONOLOGICAL AGE: the actual number of years lived.

CRISIS: the turning point in the course of a disease when it becomes fairly clear whether a patient will recover or die. [Medical Model]

CRISIS SITUATION: a state of acute emotional upset that includes the temporary inability to cope by means of one's usual problem-solving devices. A crisis occurs when the individual's interpretation of the event, the coping ability, and the limitation of the individual's social resources lead to stress so severe that the individual cannot find relief. [Psychological Model]

CULTURAL/SOCIAL-STRUCTURAL ORIGIN-CRISIS SITUATIONS: that reflect changes in the cultural values and social milieu.

EFFICIENT PERCEPTION OF REALITY: individuals with fairly realistic appraisals of their reactions and abilities as well as interpretations of what is going on in the world around them.

EMERGENCY ROOM SETTINGS: Emergency care units that are part of a general hospital or emergency care facility and employ triage teams that provide emergency medical services and crisis intervention to community members.

GERIATRIC ADULTS: "persons harboring diseases" and the understanding of bodily systems. Elderly in need of long-term care and follow-up treatment because of chronic physical and psychiatric illnesses.

LITERATURE REVIEW: The purpose of the literature review was to acquaint myself with the research studies that have been completed in the area of Gerontology. The major emphasis of the literature review concentrated on primary sources such as journal articles, monographs, and dissertations from computer data banks. Information was compiled from such disciplines as Psychology, Psychiatry, Medicine, Psychopharmacology, Nursing, Social Work, and Crisis Intervention. Secondary sources such as books will be used to augment the literature review and help clarify theories and concepts.

MEDICALLY CLEARED: patient is seen by a physician and all the necessary diagnostic tests are completed and the results followed-up.

PERCEPTION: process of becoming aware of objects, qualities, or relations by way of the sense organs. While sensory content is always present in perception, what is perceived is influenced by set and prior experiences, so that perception is more than a passive registration of stimuli.

SELF-KNOWLEDGE: individuals with an awareness of their own motives and feelings.

SENIOR CITIZEN: relative age requirement pertaining to an individual's level of functioning for federal and state programs established by legislative action.

SITUATIONAL ORIGIN-CRISIS SITUATIONS: originate from either material or environmental sources, personal or physical sources [excluding organic brain syndromes and emergency medical treatments], and interpersonal or social sources.

SUCCESSFUL AGING: a process in which individuals exhibit modest age-determined changes caused by the effects of intrinsic factors with minimal exposure to environmental determinants such as toxins.

TRANSITIONAL ORIGIN-CRISIS SITUATIONS: are either universal and a product of the life cycle or non-universal such as changes that signify a shift in social status.

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APPENDIX 1:

VOLUNTARY APPLICATION FOR ADMISSION AND TREATMENT

RARITAN BAY MEDICAL CENTER
Perth Amboy Division

VOLUNTARY APPLICATION FOR ADMISSION AND TREATMENT

I desire to be admitted to Perth Amboy Division as a voluntary patient for care and treatment in its _____ unit. Before signing this application, I have been informed of and understand the rules and regulations of the unit and I agree, if admitted, to obey them.

I further voluntarily consent to such treatment, medication, diagnostic procedures, and hospital care, as may be given by Dr. _____ his assistants or designees, interns, nurses, counsellors, technicians, and other personnel as may be necessary in his or their judgement, from time to time in connection with such care and treatment, whether such care and treatment be at the hospital, at one of its associated units or at any treatment unit sponsored by the hospital, whether held within or outside the hospital. I agree to give my physician, 72 hours in advance, written notice of my intention should I decide to leave against medical advice.

I am aware that no guarantees have been or can be made as to the results of such care and treatment. I understand that the hospital may deem it necessary to inspect my person, my possessions and my hospital room and remove such items as are considered dangerous to my safety and welfare or to the safety and welfare of other patients and hospital employees. I hereby CONSENT to any such inspection of, and removal of such items from my person, my possessions and my hospital room and RELEASE the attending physician and the hospital and its employees from any and all liability whatsoever or other responsibility of the consequences of such an inspection and removal.

I have been informed that a certain amount of personal freedom of action, such as a leave of absence from the hospital or attendance at any of its associated units or sponsored meetings, may be indicated by my attending physician as part of my treatment. I also understand that I may not leave my treatment unit without specific clearance by the hospital staff. I further understand that such freedom of action may lead to self-injury or other serious consequences and I hereby RELEASE the attending physician, the hospital and its employees from any and all liability whatsoever and from any ill effects which may result from this action.

I understand further that this release shall be binding upon _____ (his) (her) heirs, executors, administrators and assigns.
name of patient

_____ Witness

_____ Signature of Patient

_____ Date

(If patient is unable to consent or is a minor, complete the following:)

Patient (is a minor _____ of age) (is unable to consent because):

_____

_____

Hence, the consent is hereby given by the undersigned:

_____ Date

_____ Closest Relative or Guardian

_____ Witness

_____ Relationship to Patient

801-025-2

APPENDIX 1A:

LEGAL DEFINITIONS OF MENTAL ILLNESS AND DANGEROUSNESS

LEGAL DEFINITIONS OF MENTAL ILLNESS AND DANGEROUSNESS:
PL 1987 c. 116

1. Mental Illness [Section 2.r]:

"Mental illness" means a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgement, behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability unless it results in the severity of impairment described herein.

2. Dangerous to self [Section 2.h]:

"Dangerous 'to self'" means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical debilitation or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care or shelter if s/he is able to satisfy such needs with supervision and assistance of others who are willing and available.

3. Dangerous to others or property [Section 2.i]:

"Dangerous to others or property" means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior, and any recent act or threat [Division of Mental Health and Hospitals {Handout 3}, 1990].

APPENDIX 2:

CRISIS STABILIZATION INTAKE RECORD

distribution - white-medical records; yellow-crisis stabilization

RARITAN BAY MEDICAL CENTER
PERTH AMBOY DIVISION

CRISIS STABILIZATION UNIT
INTAKE RECORD

tient's Name _____ DOB & Age _____ Phone _____

Address _____ Date & Time _____

City State _____ Who Brought Person In _____

Presenting Problem _____

_____

_____

_____

Status (Circle Yes/No) If yes - Explain

Disoriented	Y	N	Loss of Appetite	Y	N	Addiction Drug	Y	N
Intoxicated	Y	N	Somatic Complaints	Y	N	Addiction Alcohol	Y	N
Depressed	Y	N	Inappropriate Affect	Y	N	Blackouts	Y	N
ıxious	Y	N	Inappropriate Behavior	Y	N	Seizures	Y	N
..somia	Y	N	Out of Contact	Y	N	Tremors	Y	N
Assaultive	Y	N	Family Disruption	Y	N	Hallucinations	Y	N
Homicidal	Y	N	Cooperative	Y	N	Delusions	Y	N
Suicidal	Y	N				Paranoid Ideations	Y	N

Other-- _____ BAL _____

_____ Length of Abuse _____

_____ Age of 1st Drink _____

_____ Age of 1st Drug _____

(1) Relevant History; (2) Prior Psych/Alcohol/Drug History; (3) Professionals Consulted;
(4) Diagnostic Impression; (5) Recommendations; (6) Disposition

_____

_____

_____

_____

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_____

_____

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_____

_____

_____

_____

_____

_____

_____

808-007-1A (rev.1/88)

_____ Signature

_____ Date

APPENDIX 3:

SAMPLE OF CRISIS STABILIZATION LOG BOOK

RARITAN BAY MEDICAL CENTER • PERTH AMBOY DIVISION • **CRISIS STABILIZATION UNIT**

Diagnosis:	P - Psych	M - Medical	Race:	C - Caucasian	A - Asian
	D - Drug	C - Child		B - Black	O - Other
	A - Alcohol	Exp. - Expiration		H - Hispanic	

DATE	NAME	TIME IN	TIME SEEN	AGE	RACE	DX.	TIME OUT	DISPOSITION

808-006-2

APPENDIX 4:

SAMPLE OF CRISIS STABILIZATION DAILY STAT SHEET

CRISIS STABILIZATION UNIT

DAILY Stat Sheets

Name_____

Date_____

Shift_____

	Alc./Drug	Alcohol	Psych	Drug	Medical	Social	Psych/ Drg/Alc	Ass't	±Oth. *Spec Spkg
SSS									
MIU									
CFL									
MEDICAL									
BAY HARBOR									
RBMHC									
MARLBORO									
OTHER STATE FACILITY									
UMDNJ/CMHC									
S.A.M.H.									
OTHER FACILITY									
:-ADMIT									
PEDIATRICS									
AA/NA									
CHILDREN									
TRANSFERS									
HANDICAPPED									

PHONE CALLS

	Alcohol	Psychiatric	Drugs	Other	Total
HOT LINE					
DIRECT SERVICE					
TOTAL					

Telephone Contact with Psychiatrist
Number Contacts with Psychiatrist
Pts. Discharged from State Hospital w/n 30 days
s. Discharged from other facility w/n 30 days
Prison/Jail inmate seen
Emergency Bed Used
Referred from RBMHC

PSYCH	ALCOHOL	TOTALS

±Other Foreign Language
*Duplication

APPENDIX 5:

PERMISSION LETTER FOR ARCHIVAL RESEARCH STUDY

PERMISSION TO UTILIZE ARCHIVAL INFORMATION IN RESEARCH

Appendix VI: Project Director's Statement Explaining Permission Form

You are being asked to allow Crisis Stabilization Unit information to be utilized in a research study. This form is designed to provide you with information about this study which you should know and to answer any of your questions.

PROJECT DIRECTOR: Gail N. Chatham, M.A.

TITLE OF DISSERTATION PROJECT:

The Elderly in Crisis: Identifying Crisis Situations in Emergency Room Settings. A Definitional Study.

PURPOSE OF THE RESEARCH:

To identify and clarify the specific crises associated with the elderly when they seek assistance in an emergency room setting as well as identify community resources and programs utilized by the emergency room to meet their needs.

THE FOLLOWING PROCEDURES WILL BE INVOLVED:

1. Only archival data from April 2, 1987 to December 31, 1989 will be collected from the Crisis Stabilization Unit [red] log book for the purpose of statistical analyses associated with identifying elderly crises.
2. Only the patient's age, race, gender, diagnosis[es], and disposition will be recorded on the data tally sheet. AT NO TIME WILL PATIENTS NAMES BE RECORDED AS PART OF THIS RESEARCH PROJECT. Individual patient names and associated diagnoses will be anonymous and confidential.
3. Data collected will be for research purposes only.
4. As part of the written dissertation, Raritan Bay Medical Center will be credited with providing the archival data generated as part of this research study.
5. The Coordinator of the Crisis Stabilization Unit will retain the right to review all my materials and notes associated with this research study while I am at Raritan Bay Medical Center to ensure that confidential information is not utilized or removed from the premises.

THE POTENTIAL RISKS OR DISCOMFORTS TO YOU, STAFF MEMBERS, OR PATIENTS:

There are no risks.

THE POTENTIAL BENEFITS TO YOU, STAFF MEMBERS, OR PATIENTS:

There are no benefits to you, staff members, or patients. The data to be collected will benefit others.

PERMISSION TO UTILIZE ARCHIVAL INFORMATION IN RESEARCH

I have read the above description of the research study and general conditions. Anything I did not understand was explained to me and any questions I had were answered by Gail N. Chatham. In consideration of this understanding, I voluntarily agree to allow Gail N. Chatham to utilize archival data from the Crisis Stabilization Unit at Raritan Bay Medical Center at 530 New Brunswick Avenue, Perth Amboy, New Jersey for the purpose of this research.

RARITAN BAY MEDICAL CENTER

Keith H. McLaughlin
Keith H. McLaughlin
President

Signature of Project Director/Date

Gail N. Chatham M.A.
6-19-90

Signature of Witness/Date

Diane E. Manoman
Coordinator
Crisis Stabilization Unit.