UNIT 2   OLD AGE AND MENTAL HEALTH

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2.1 INTRODUCTION

Old age is a phase of the life cycle associated with loss of physical functions, and problems in mental faculties. Advancement in medical technology has further contributed to rapid growth in the population of ‘Senior Citizens’ throughout the world. With this, a host of related issues have come to the fore ranging from the physical care, security, engagement, social relations to the mental health concerns in the elderly. In this Unit, you will learn about various mental health problems and disorders affecting our elderly population.
2.2 OBJECTIVES

After studying this Unit, you will be able to:

- identify mental disorders in elderly;
- describe the clinical presentation of mental disorders;
- know the assessment procedure for the mental disorders; and
- discuss the psychological and pharmacological interventions for these disorders.

2.3 INDIA IS GREYING

India is in a process of demographic transition. With the advent of better health facilities, there is a downward shift from a high mortality/high fertility scenario to a low mortality/low fertility scenario. The expectancy of life at birth has increased to 66.21 years in 2012. Life expectancy for women was 68.00 years and for men 64.51 years. The elderly population accounted for 7.1% of total population in 2001 and it is projected to rise to more than 10% by the year 2021. This has resulted in an increased proportion of older people in the total population, termed as the “greying of population”. The elderly population is facing a huge burden of communicable and non-communicable diseases. With ageing comes changes in our brain. Ageing causes changes in brain size, vasculature and cognition. As we age, our brain shrinks in volume and size. As our vasculature ages, the pressure of blood in the vasculature (blood vessels) rises, which further leads to the chances of stroke and ischemic changes in brain. Memory decline is also associated with ageing. There is a role of neurotransmitters (i.e. brain chemicals), genes, hormones and of course, experience involved in ageing. A healthy life, both physically and mentally, may be protective factor for ageing brain.

However, rapid changes in the family systems in India have made the elderly people more prone to psychological problems.

2.4 MENTAL HEALTH PROBLEMS IN THE ELDERLY

Burden of mental health disorders is increasing in elderly due to ageing of the brain, problems associated with medical diseases and social issues such as breakdown of the family support systems, social isolation and decrease in economic independence. The reported prevalence of geriatric psychiatric morbidity in the Indian community is ranging from roughly 10 to 60 percentages. The mental disorders frequently encountered in Indian elderly include dementia and depression. Other disorders include anxiety disorders, drug and alcohol abuse, delirium and psychosis. Female sex, low education, single status, medical co-morbidities, poor socio-economic status and disability are all well-established factors playing significant role in mental disorders among elderly.

Studies from hospital clinic, community as well as old age homes found depression as the most common mental health problem in geriatric population with prevalence ranging from 20 to 60 percentages of gero-psychiatric patients. Suicide especially due to depression occurs more frequently in the elderly which adds to this problem. Depression is an often-missed diagnosis especially in the medical elderly patients. Dementia seems to be the next silent epidemic in the country. The prevalence of dementia in Indian studies has been shown to vary from 0.84 to 6.7 percentages. Diabetes, depression, hyperlipidaemia, urban living and lack of exercise are independent risk factors for
LIVING IN JOINT FAMILIES AND INCREASED INTAKE OF POLYUNSATURATED FATS CONFERRED PROTECTION AGAINST DEMENTIA. THE PREVALENCE OF ANXIETY DISORDERS HAS BEEN REPORTED TO BE UP TO 20 PERCENTAGES AMONG GERO-Psychiatric PATIENTS.

LET US NOW DISCUSS IN DETAIL SOME OF THE MAJOR MENTAL HEALTH PROBLEMS IN THE ELDERLY.

### 2.5 DEMENTIA AND OTHER COGNITIVE DISORDERS

Cognitive disorders are characterized by a limitation of cognitive functioning as the main feature. These disorders involve impairment in areas of memory, attention, perception, and thinking. Most common mental disorders affect cognitive functions, mainly memory processing, perception and problem solving. These cognitive disorders are **dementia, delirium and amnesia**.

Dementia syndrome, an important diagnosis in elderly is characterized by impairment in memory, judgment and other cognitive functions. The prevalence of dementia is 2 to 5% in the general population older than 65 years of age and reportedly doubles every 5 years. Of all patients of dementia, 50 to 60% have dementia of the Alzheimer’s type followed by 15 to 30% of vascular subtype. Other common causes of dementia i.e. head trauma, alcohol related dementia and movement related dementia represent 1 to 5% of all cases of dementia.

Another cognitive disorder, delirium is characterized by short-term confusional state and changes in cognitive functions. The prevalence of delirium reported between 10-14% in patients admitted in emergency departments. Patients having age of more than 60 years, having diagnosed with dementia, cerebro-vascular accidents, burns, infections, alcohol withdrawal state are more prone to delirium. Depending on etiology, delirium is further classified into:

1) Delirium due to general medical condition like infection, tumor etc.
2) Delirium due to drugs like cannabis, alcohol etc.
3) Delirium due to multiple causes.
4) Delirium due to other causes like lack of sleep

Amnestic disorder is defined by memory impairment and forgetfulness. Depending on etiology, amnestic disorder is also classified into three sub-categories:

1) Amnestic disorders caused by medical condition like hypoxia
2) Amnesia disorders caused by toxin or medication like cannabis, benzodiazepines.
3) Cause not known

#### 2.5.1 Clinical Presentation of Dementia

Dementia is defined as a progressive impairment of cognitive functions that occurs in clear consciousness. It denotes a decrement of two or more intellectual functions, in contrast to focal or specific impairments such as amnestic disorder or aphasia. The persistent and stable nature of impairment also differentiates dementia from the fluctuating short term cognitive deficits of delirium. Dementia should be distinguished from mental retardation as the former represents an acquired loss of or declining prior intellectual and functional capacities. The diagnosis of dementia is based on the clinical examination and on information provided by patient’s family, friends and employers. Clinically,
dementia diagnosis is entertained with following criteria:

1) Memory dysfunction (especially new learning)
2) At least one additional cognitive deficit (aphasia, apraxia, agnosia, or executive dysfunction)
3) Sufficiently severe to cause impairment of occupational or social functioning and must represent a decline from a previous level of functioning

Memory impairment is typically a prominent feature in dementia. The patient finds difficulty in learning new information and to recall previously learned information. The patients in dementia may also suffer from aphasia (problem in language), apraxia (inability to carry out motor activities despite intact motor functions), agnosia (failure to recognize or identify objects despite intact sensory functions) and disturbance in executive functioning (planning, organizing, sequencing, abstracting). These cognitive deficits cause significant decline in social or occupational functioning from previous level. Important features differentiating types of dementia are:

a) **Dementia of the Alzheimer’s Type:** The patients with this subtype had course of illness characterized by gradual onset and continuing cognitive decline without the evidence of other causes of dementia.

b) **Vascular dementia:** In addition to general symptoms of dementia the diagnosis of vascular dementia requires definite clinical or laboratory evidence in support of vascular cause. The patient of this subtype usually show a decremental and stepwise deterioration than Alzheimer’s dementia.

c) **Dementia due to other general medical condition:** This category includes dementias related to HIV disease, head trauma, Parkinson’s disease, Huntington’s disease, Pick’s disease and Creutzfeldt-Jacob disease.

d) **Substance induced persistent dementia:** The specific substances that may induce dementia are alcohol, inhalant, sedative, hypnotic or anxiolytics.

We can identify case with dementia by observing the following ten warning signs:

1) Recent memory loss affecting job
2) Difficulty performing familiar tasks
3) Problems with language
4) Disorientation to time or place
5) Poor or decreased judgment
6) Problems with abstract thinking
7) Misplacing things
8) Changes in mood or behavior
9) Changes in personality
10) Loss of initiative
Case Vignette of Dementia

Mr. R, a 65-year-old, illiterate farmer had been performing his usual work of farming. Initially he had some difficulty in performing usual farm activities and made gross errors in home financial management. Gradually, he lost his way to home from fields on several occasions. His intellectual deterioration started interfering in his work. He committed mistakes while sowing seeds in rainy season. Due to this, his sons stopped him to go to fields. He spent most of the time in searching farming equipments at his house. He became quarrelsome and irritable. Eventually, he required assistance in bathing and dressing. When examined 3 years after the first symptoms developed, the patient could not recall correct place and time. He could not recall his home address. He could not remember the age of his two children. He could not recall about the last breakfast he had. His speech was fluent and well-articulated but he finds difficulty in finding words for common objects. He could not perform simple calculations correctly. His interpretation of local proverbs was concrete. He had no insight into the nature of his problems.

2.5.2 Clinical Presentation of Delirium

Delirium is defined by the acute onset of fluctuating cognitive impairment and other behavioral phenomenon. It is frequently missed or misdiagnosed resulting into substantial morbidity and mortality. Hence it is crucial to be aware of the clinical features, diagnose and apply appropriate intervention strategies to deal with it. The clinical features of delirium are as follows:

a) Disturbance of consciousness and attention

The most important feature of delirium is difficulty in sustaining attention, leading to distractibility. The patients having delirium have problem in focusing, sustaining their attention on one topic.

b) Acute change in cognitive functioning

The delirious patient reports problem in learning new information. He may also report disorientation to time, place and rarely to person. Associated clinical features include illusions, hallucinations and delusions.

c) Fluctuating course of symptoms over time

The above mentioned symptoms may develop abruptly and fluctuate rapidly throughout the day. The presence of lucid intervals (normal periods between episodes of delirium) may also be present in delirium.

d) Disturbance of arousal, psychomotor state and sleep

Disturbance of psychomotor activity in delirium include hypoactive, hyperactive and mixed behavioral states. Hypoactive patients may appear apathetic, withdrawn and confused, while hyperactive patients remain overactive and at times aggressive.

e) Other mood and anxiety symptoms

Emotional reactions in delirious patients include mood changes, depression, anxiety, fear, anger, apathy and euphoria.
2.6 GERIATRIC DEPRESSION

Depression is considered to be ‘Disorder of losses’ - loss of mood (sadness of mood); loss of interest in pleasurable activities (anhedonia); and loss of energy (easy fatigability). However, disturbed sleep has also been shown to be the most common complaint. Depression may be associated with medical conditions. Short duration of episode and living in joint family has been associated with better outcome.

2.6.1 Clinical Presentation of Geriatric Depression

Depressed mood remains the hallmark for diagnosis of geriatric depression. Elderly patients often report bodily symptoms (aches & pains, gastro-intestinal disturbances) rather than sadness of mood. They also report subjective experience of forgetfulness or memory loss and slow thinking (Pseudo-dementia; ‘dementia of depression’) which should be differentiated from dementia. They may also present with anxiety symptoms, agitation and psychotic symptoms. There is always a high risk of suicide associated with depression in late life. The patient with clinical diagnosis of geriatric depression may present with:

a) Classical depression: The patient may present as the classic variant with features of depressed mood, crying spells, easy fatigability, impaired concentration, loss of appetite, insomnia, ideas of helplessness/ worthlessness and death wishes.

b) Somatisation: There are usually high rates of somatisation (bodily symptoms), weight loss and hypochondriasis (concern for serious disease).

c) Psychotic symptoms: Among psychotic symptomatology, delusions are more common than hallucinations and the usual content is depressive aggressive (nilhistic, somatic or poverty).
d) **Death wishes and suicide:** Suicidal ideations are well hidden and less commonly reported in the elderly. However, more lethal means are used for committing suicide in elderly.

e) **Masked depression:** The entity of “masked depression” means depression in the elderly can be replaced or masked by multiple somatic complaints.

f) **Behavioural regression:** The patient usually becomes less physically and socially active, neglects personal hygiene and necessary medical treatment, loses contact with friends and family and allow the home environment to become disordered.

g) **Vascular depression:** Vascular depression hypothesis states that, especially in the elderly, a subtype of depressive disorder exists that is caused by vascular brain disease. A substantial portion of elderly individual with depression presents with cognitive impairment particularly in visuospatial ability, psychomotor speed and executive functioning.

### 2.7 Late-Onset Anxiety Disorders

Anxiety disorders are thought to be among the most prevalent disorders in older age, with higher rates in older patients with medical co-morbidities. Generalized anxiety disorder (GAD) is the most frequently diagnosed followed by specific phobias. Social phobias, panic disorder are less common. Anxiety disorders in elderly may be associated with medical disorders or exist as independent disorders.

#### 2.7.1 Clinical Presentation of Late-life Anxiety Disorders

Patients with anxiety disorders may be presented with physical symptoms like palpitation, chest pain, choking, giddiness, and tingling numbness; and psychological symptoms like worrying, nervousness, tension, apprehension, anticipatory fear & lack of concentration.

Some unique features in the manifestation of anxiety disorders in older adults include the minimization of psychological complaints, an increase in somatic complaints, and an amplification of external obstacles (i.e., difficulty with transportation, concerns about finances, and fears for the health of family members). GAD often presents as restlessness, irritability, fatigue, insomnia, and muscle tension. The more common phobias of late life include fears of driving, travelling, and falling. Late-onset panic disorder appears to be associated with lower levels of cognitive and somatic distress during panic attacks. In Obsessive Compulsive Disorders, older persons report more contamination and religious obsessions but few rituals involving symmetry or counting. Older adults experience bereavement at much higher rates (up to 20%) than do younger adults.

### 2.8 Late-Onset Psychotic Disorders

Elderly are also prone to psychosis like young adults. In late-onset psychosis (also called ‘Paraphrenia’), delusions of persecution and reference and, auditory and visual hallucinations are usually present.

Most common symptoms in late-onset schizophrenia are non-bizarre delusions. Lower levels of negative symptoms, thought disorder, affective blunting and less severity of cognitive deficits are seen in cases of late-onset schizophrenia. Patients with very late-onset schizophrenia have more brain abnormalities, more persecutory delusions and higher rates of visual, tactile & olfactory hallucinations.
2.9 ASSESSMENT OF THE MENTAL DISORDERS IN THE ELDERLY

Evaluating history and clinical interview remain cornerstones of assessment of geriatric patient with mental health problem. Clinician/therapist must determine whether a patient understands the nature and purpose of the clinical assessment. When a patient is cognitively impaired, an independent history should be obtained from a family member or caretaker. A complete history includes identification details (name, age, sex, and marital status), chief complaint, history of the present illness, history of previous illnesses, personal history, and family history. The mental status examination offers a cross-sectional view of how a patient thinks, feels, and behaves during the examination. Symptoms elicited during history need to be thoroughly checked with mental status examination.

2.9.1 General Description

A general description of the patient includes appearance, speech, motor activity, and attitude towards the clinician. Change in motor activity (bodily movements) should be recorded. Many patients with cognitive problems seem to be slow in speech and movement. The patient’s speech may be pressured in cognitive dysfunctions. Tearfulness and overt crying may also occur in depressive and cognitive disorders, especially if the patient feels frustrated about being unable to answer any question.

2.9.2 Functional Assessment

The mental health professional/therapist must evaluate patients for their capacity to maintain independence and to perform the activities of daily life, which include self care, toileting, preparing meals, dressing, grooming, and eating. The degree of functional competence in their routine behaviors is an important consideration in formulating a treatment plan for these patients.

2.9.3 Mood, Feelings and Affect

The therapist should specifically ask the patient about any thoughts of self harm, loneliness, worthlessness. Low mood and anxiety can also interfere with memory functioning. An expansive or euphoric mood may signal a dementia disorder. Frontal lobe dysfunction of brain often produces witzelsucht syndrome, which is the tendency to make puns and jokes and then laugh aloud at them.

The patient’s affect may be flat, blunted, constricted, shallow, or inappropriate, all of which can indicate a depressive disorder, schizophrenia, or cognitive dysfunction. Dominant lobe dysfunction causes dysprosody, an inability to express emotional feelings through speech intonation.

2.9.4 Perceptual Disturbances

Hallucinations (perception without a sensory stimulus in the environment) and illusions (misinterpretation of sensory stimulus) by patients with cognitive dysfunction can be transitory phenomena resulting from decreased sensory acuity. The therapist must note whether the patient is confused about time or place. Cognitive disorders may cause perceptive impairments like agnosia characterized by the inability to recognize and interpret the significance of sensory impressions.

2.9.5 Language Output

The therapist must assess language output. The aphasias, which are disorders of language
output are related to organic lesions of the brain. Broca’s aphasia is among the common types of aphasia in which the patient’s understanding remains intact, but the ability to speak is impaired.

2.9.6 Visuo-spatial Functioning

The therapist may ask a patient to copy figures or a drawing in assessing the visuo-spatial function. A detailed neuropsychological assessment need to be performed when visuo-spatial functioning is obviously impaired.

2.9.7 Thinking

The therapist should evaluate any disturbances in thinking. The loss of the abstract thinking (ability to appreciate nuances of meaning) may be an early sign of dementia. Thought content should be examined for phobias, obsessions, somatic preoccupations, and compulsions. Ideas about suicide or homicide should be discussed. The examiner should examine delusions (fixed false beliefs) and evaluate how such delusions affect the patient’s life.

2.9.8 Sensorium and Cognition

Sensorium concerns the functioning of the special senses; cognition concerns information processing and intellect.

1) Consciousness

Altered consciousness is a sensitive indicator of brain dysfunction in which the patient does not seem to be alert, shows fluctuations in levels of awareness, or seems to be lethargic.

2) Orientation

Problem in orientation to time, place, and person is associated with cognitive disorders. The examiner should test for orientation to place by asking the patient to describe his or her present location. Orientation to person may be checked by asking his or her own name. Time is tested by asking the patient the date, the year, the month, and the day of the week.

3) Memory

Memory usually is assessed in terms of immediate, recent, and remote memory. Immediate retention and recall are tested by giving the patient six digits or giving days of week to repeat forward and backward. The examiner should record the result of the patient’s capacity to remember. Persons with unimpaired memory usually can recall six digits forward and five or six digits backward. Remote memory can be tested by asking for the patient’s age of marriage, age of eldest child and names of the patient’s parents and children.

Recent memory can be assessed by giving the patient the names of three items early in the interview and ask for recall later. Memory of the recent past also can be tested by asking for the patient’s place of residence, including the street number; the method of transportation to the hospital; and some current events. Retention and recall also can be tested by having the patient retell a simple story or names of three items told earlier.

4) Intellectual Tasks, Information, and Intelligence

Various intellectual tasks estimate the patient’s fund of general knowledge and intellectual
functioning. Counting and calculation can be tested by asking the patient to subtract 7 from 100 and to continue subtracting 7 from the result until the number 2 is reached. The patient’s fund of general knowledge is related to intelligence. The patient can be asked to name the local elected leader both at village or sub-district or district levels, to name the three adjoining villages or cities near his village, and to give the distance from his village to clinic. The examiner must take into account the patient’s educational level, socioeconomic status, and general life experience in assessing the results of some of these tests.

5) Reading and Writing

The therapist may ask the patient read a simple story aloud or write a short sentence to test for a reading or writing disorder.

6) Judgment

Judgment is the capacity to act appropriately in various situations. Does the patient show impaired judgment? What would the patient do on finding a stamped, sealed, addressed envelope in the street? What would the patient do if he or she smelled smoke in a theater? Can the patient discriminate? What is the difference between a dwarf and a boy? Why are couples required to get a marriage license?

2.9.9 Neuropsychological Evaluation

A thorough neuropsychological examination includes a comprehensive battery of tests that can be replicated by various examiners and can be repeated over time to assess the course of a specific illness. The most widely used test of current cognitive functioning is the Mini-Mental State Examination (MMSE). HMSE is the Hindi adaptation (Ganguli et al., 1995), which assesses orientation, attention, calculation, immediate and short-term recall, language, and the ability to follow simple commands. The MMSE is used to detect impairments, follow the course of an illness, and monitor the patient’s treatment responses. It is not used to make a formal diagnosis. The maximal MMSE score is 30 (31 by HMSE). Age and educational level influence cognitive performance as measured by the MMSE.

Table 1: Hindi Mental Status Examination (HMSE)
(Ganguli et al., 1995)

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct</th>
<th>Wrong</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is it morning or afternoon or evening?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. What day of the week is it today?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. What date is it today?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Which month is it today?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. What season of the year is this?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6. Under which post office does your village come?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Which district does your village fall under?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Which village are you from?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Which block or numbered area is this?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Which place is this?</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
11. I went to Delhi and brought three things - mango, chair and coin. Can you tell me what are the three things I brought from Delhi? 
1 2 3

12. (a) Now can you tell me the names of the days of the week starting from Sunday? 
(b) Now can you tell me the names of the days backwards? 
1 2 3 4 5

13-15. What are the names of the three things, which I told you I have brought back from Delhi? 
1 2 3

16. (Show the Subject the wrist watch and pen) Can you see these objects? 
(If yes, items 17 & 18 apply)[If no, items 17 (a), 18(a)]

17-18. Show him the wristwatch and say, what is this? OR,17(a) (If necessary, identification of watch by touching) What is this? 
1 0

18. Show him the pen and say-what is this? OR,18 (a) (If necessary identification of pen by touching) What is this? 
1 0

19. Now I am going to say something, listen carefully and repeat it exactly as I say after I finish Phrase: “NEITHER THIS NOR THAT” 
1 0

20. Now look at my face and do exactly what I do. 
(Close your eyes for 2 seconds) 
1 0

21. First you take the paper in your right hand, then with your both hands, fold it into half once, and then give the paper back to me. 
1 2 3

22. Now say a line about your house? (something specifically about your house) 
NOT INCLUDED IN HMSE TOTAL, If given-1, not given-0

23. Here is a drawing. You must copy this drawing exactly as shown in the space provided here.

Score:
Must draw 2 four sided figure = 1
1 figure should be inside the other = 2
Orientation of the figures should be obviously appropriate = 3

Total score = /31

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Self Assessment Questions 2
1) Name the three ‘losses’ present in depression.

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2) What are the unique features of anxiety disorders in the elderly?
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3) What is agnosia?
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4) Late onset psychosis is also called ___________.

2.10 MANAGEMENT OF MENTAL DISORDERS

2.10.1 Management of Dementia and other Cognitive Disorders

Dementia

The first step in the treatment of dementia is verification of the diagnosis. Diagnostic exercise of patient with memory problem starts with a good history from both family members and the patient regarding chronological presentation of symptoms and problem behaviours. Evaluation includes questions related to memory loss like becoming lost in a familiar place, asking food again and again, and losing objects. A thorough evaluation of medical history and examination of bodily systems, including neurological examination is must for patient with memory loss. The nature and degree of the cognitive function and activities of daily living should be assessed with Hindi adaptation of Mini-Mental State Examination (HMSE) and Everyday Abilities Scale for India (EASI). The laboratory tests to rule out reversible causes for dementia are: thyroid stimulating hormone, vitamin B12 & folate levels, electrocardiogram, blood sugar & creatinine. Computed tomography of brain is required for patients with memory loss.

Pharmacological Approach

The general treatment approach to patients with dementia is to provide supportive medical care, emotional support for the patient and their families, and pharmacological treatments for specific symptoms. Preventive measures are important particularly vascular dementia which includes changes in diet, exercise and control of diabetes and hypertension (anti-hypertensives or anticoagulants or anti-platelet agents).

Most of the current approved pharmacotherapy of dementia is directed at reversing the known deficient cholinergic transmission. The drugs used for arresting or delaying the progression of dementia are acetyl cholinesterase inhibitors (donepezil, galantamine and rivastigmine) and memantine. Disruptive behavior and aggression can be managed with low dose antipsychotics like quetiapine and risperidone.
Non-pharmacological Interventions

1) Behavioral therapy

Behavioral therapy has been based on principles of conditioning and learning theory using strategies aimed at suppressing or eliminating the undesirable behaviors in dementia and anxiety disorders in elderly. Behavioral therapy requires a period of detailed assessment in which the triggers, behaviors and reinforcers (also known as the ABC: antecedents, behaviors and consequences) are identified and their relationships made clear to the patient. The therapist will often use some kind of chart or diary to gather information about the manifestations of a behavior and the sequence of actions leading up to it. Interventions are then based on an analysis of these findings. Behavioral interventions must be tailored to individual cases.

2) Reality orientation

Reality orientation aims to help people with memory loss and disorientation by reminding them of facts about themselves and their environment. It can be used both with individuals and with groups. In this therapy, people with memory loss are oriented to their environment using a range of materials and activities. This involves consistent use of orientation devices such as signposts, notices and other memory aids.

3) Reminiscence therapy

Reminiscence therapy involves helping a person with dementia to relive past experiences, especially those that might be positive and personally significant, for example, family holidays and weddings. This therapy can be used with groups or with individuals.

4) Alternative therapies

As in other areas of health care, alternative therapies are gaining currently in the treatment of people with dementia like art therapy, music therapy, activity therapy, complementary therapy, aromatherapy, bright-light therapy and multisensory approaches. All of these have received some research attention but efficacy is yet to be established.

5) Brief psychotherapies

There has been an increasing interest in applying some of the brief therapeutic frameworks such as cognitive–behavioral therapy (CBT) and interpersonal therapy to dementia. Interpersonal therapy, as the name suggests, examines the individual's distress within an interpersonal context. It uses a specific framework in which the individual's distress is conceptualized through one of four domains: interpersonal disputes; interpersonal/personality difficulties; bereavement; and transitions/life events. Both CBT and interpersonal therapy have limitations, particularly with severe dementia.

In short, patients often benefit from a supporting and educational psychotherapy. They may also benefit from assistance in grieving and accepting the extent of their disability. Patient should be encouraged to focus on the activities in which successful function is possible. Patient should be asked to keep calendars for orientation problem, making schedules to help structure activities and taking notes for memory problems. Emotional problems in family members of patients with dementia should be adequately dealt.

Delirium

For patients with delirium, initial treatment includes medical support, i.e., maintenance of vital parameters (adequate airway, blood pressure, pulse and temperature). The cause of delirium is established through history, physical examination, and laboratory
tests. Specific therapy/intervention is started after identification of precipitant of confusional state. Clinicians also look after and manage excess and confused environmental stimuli present in the vicinity of patient. Patient should be kept in quiet, well-lighted and simply furnished room. Family members and hospital staff should regularly acquaint the patient regarding time, place and person. Restraints should be avoided. For agitated behaviour, low dose antipsychotics (Haloperidol or Risperidone, either oral or intramuscular) may be prescribed. The management of delirium involves the following steps:

1) **Reverse medical problems and provide supportive care:** The primary treatment of delirium is to identify and treat the underlying cause or contributing medical conditions which have a direct bearing on the survival of the patient. For example, in hepatic failure, medication is given to reduce serum ammonium levels. In addition to reversing medical problems, delirious patients may need extra supportive medical care and maintenance of vital parameters for rapid recovery.

2) **Prevent further medical complications:** Benzodiazepines, opiates, anticholinergic agents and other non-essential medications should be avoided.

3) **Use environmental intervention to facilitate reality:** Keeping the patient in quiet environment free of unnecessary stimulation may help in reducing agitation. Frequent familiar clues (clock, calendar) to orientation may also be helpful. Supportive contacts with the patients, family and sometimes staff member are necessary to reassure the patient. The patient can be oriented to staff, surroundings and situations repeatedly, particularly before any hospital procedures. Sensory devices (eyeglasses, hearing aid) also help the patient to get rid of sensory deficits.

4) **Facilitate sleep, cognition and healthy functioning:** Personalized interventions like antipsychotics may be helpful in promoting restful sleep and controlling anxiety. Sleep hygiene must be explained to care givers.

5) **Prevent and manage disruptive behavior:** Control of agitation in delirious patients is essential to prevent self-damage and allowing appropriate examination and treatment. Physical restraint or chemical restraint should be avoided as much as possible. Patient’s bed can be maintained in low position with brakes locked and position the side rails up. Hazard free environment can be maintained by removing unnecessary equipment or furniture. The commonly used antipsychotics are haloperidol, risperidone, in addition to benzodiazepines. The dosage should be low and titration should be slow. Family members can be encouraged to be with patients.

### 2.10.2 Management of Depression

**Assessment**

Older persons may not reveal depressive symptoms so easily, hence needs good observation and clinical skills. More focus of interview is towards motor activity, hopelessness, worthlessness, hallucinations, suicidal ideations and memory problems. The laboratory tests to rule out co-morbid medical conditions are: complete blood counts, thyroid stimulating hormone, vitamin B12 and folate levels (vegetarians), electrocardiogram, fasting blood sugar, serum electrolytes, blood urea and creatinine. Computed tomography of brain is optional for suspected cases of cerebro-vascular lesions.
Treatment

Antidepressants remain mainstay for treatment of geriatric depression. Newer antidepressants, Specific Serotonin Reuptake Inhibitors (SSRIs) like fluoxetine, sertraline, citalopram and escitalopram can be initiated at lower doses (preferably half of young adult dosage). Gastrointestinal disturbances, weight loss and agitation are commonly reported side effects with SSRIs. Tricyclic antidepressants may be avoided due to postural hypotension and anticholinergic side effects. Families should be involved for support building and motivating patient in activities.

2.10.3 Management of Late-onset Anxiety Disorders

Assessment

Anxiety symptom may be part of medical and mental disorders like hypoglycaemia, hyperthyroidism, cardiac arrhythmias, pulmonary emboli, delirium, depression, dementia and psychotic disorder. It could be related to medications like ephedrine, anticholinergic drugs and benzodiazepine withdrawal.

Both pharmacological treatment and behavioural interventions can be given.

2.10.4 Management of Late-onset Psychotic Disorders

Psychotic symptoms in the form of suspiciousness, delusions, hallucinations and agitation are present in schizophrenia and delusional disorders. Family members should be interviewed to explore behavioural disturbances. Patient with psychosis requires a safe environment. Agitated and suspicious elderly needs inpatient hospitalization. Antipsychotic medications may be given.

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<th>Self Assessment Questions 3</th>
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<td>1) Describe the assessment of depression in older persons.</td>
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<td>2) Explain interpersonal therapy.</td>
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<td>3) Name the alternative therapies.</td>
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2.11 LET US SUM UP
Geriatric mental health is a neglected issue with poor sensitivity among health professionals. Staunch efforts should be made for understanding mental disorders in the elderly. In the present Unit you learned how these disorders affect various domains ranging from memory, attention, perception to thinking. You also studied about the common mental disorders such as cognitive disorders, depression and anxiety disorders affecting the elderly population. These disorders are associated with significant disability, poor quality of life, and burden on families. There are various methods of treatment modalities available from medication to supportive management. Early detection and intervention can make a major impact on the outcome of these mental disorders.

2.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1
1) Cognitive Disorders are characterized by a limitation of cognitive functioning as the main feature. These disorders involve impairment in areas of memory, attention, perception, and thinking.
2) The types of cognitive disorders in the old age are dementia, delirium and amnesia.
3) Dementia is defined as a progressive impairment of cognitive functions. The impairment is persistent and stable whereas delirium is marked by fluctuating short term cognitive deficits.

Self Assessment Questions 2
1) The three ‘losses’ present in depression are ‘loss of interest’, ‘loss of energy’, and ‘loss of mood’.
2) The unique features in anxiety disorders in the elderly include the minimization of psychological complaints, an increase in somatic complaints, and an amplification of external obstacles.
3) Agnosia refers to the inability to recognize and interpret the significance of sensory impressions.
4) Paraphrenia

Self Assessment Questions 3
1) The focus in assessment of depression in the older persons is on motor activity, hopelessness, worthlessness, hallucinations, suicidal ideations and memory problems. Laboratory tests are also done to rule out co-morbid medical conditions.
2) Interpersonal therapy examines the individual’s distress within an interpersonal context. It uses a specific framework in which the individual’s distress is conceptualized through one of four domains: interpersonal disputes; interpersonal/personality difficulties; bereavement; and transitions/life events.
3) The alternative therapies are art therapy, music therapy, activity therapy, complementary therapy, aromatherapy, bright-light therapy etc.
2.13 UNIT END QUESTIONS

1) Describe the clinical features of delirium.

2) Discuss the late-life anxiety disorder.

3) Discuss the management of delirium.

4) Explain behavior therapies.

2.14 REFERENCES AND SUGGESTED READINGS


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Sons.