

Cambridge University Press

978-0-521-68191-9 - Guide to the Psychiatry of Old Age

David Ames, Edmond Chiu, James Lindesay and Kenneth I. Shulman

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# Guide to the Psychiatry of Old Age

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# Foreword

By the time I launched the first dementia programme at Johns Hopkins in 1979, the psychiatry of old age was well established in the UK. Two small gems from those early days of geriatric psychiatry in the UK – the sections on old age psychiatry in *Clinical Psychiatry* by Mayer-Gross, Slater and Roth and the monograph by Felix Post, *Clinical Psychiatry of Late Life* – influenced my decision to pursue a career in the psychiatry of old age.

This new, brief guide makes geriatric psychiatry accessible to generalists, clinicians not medically trained, and even patients and families. Such efforts are needed in these days of ageing populations and shrinking resources to persuade doctors and the public to reject the prejudice of ageism, and to teach that clinical signs and symptoms of elderly patients are the products of diseases and vulnerabilities, just as they are in younger people, and not the inevitable consequences of ageing which require the discovery of the fountain of youth before the ills of the elderly can be prevented and cured.

In addition to the recognition and explanation of pathological processes causing signs and symptoms, this book promotes the narrative, or meaningful, approach, which illuminates the dignity and right to life of the elderly. The privilege of sharing the stories of almost completed lives is one of the rewards of geriatric practice. In an attempt to demonstrate this to a class of medical students, I interviewed a distinguished 90-year-old American psychiatrist, Mandel Cohen. I expected him to describe the changes he experienced as he grew older. I asked, ‘Doctor, what is it like to be old?’ He replied, ‘I don’t feel old in my mind’, and he wasn’t. Another story that illustrates the dignity of old people and their right to life emerged on an Alzheimer’s disease (AD) unit in a nursing home. The question arose as to the validity of documents signed by family members requesting that patients not be resuscitated. In order to answer this question, I gathered a group of 10 severely impaired residents, none of whom had a Mini-mental State Examination (MMSE) score greater than 10 out of 30, and asked them if they wanted to be resuscitated. When one said, ‘what does “resuscitated” mean’, another member of the group said, ‘you know, brought back to life’. The first person responded ‘well, you have to make allowances for people with memory trouble.’ Seven of 10 said they wanted resuscitation. The ones who didn’t appeared to be depressed. Too often, we fail to honour the dignity of cognitively impaired elderly by asking them if they want to live, and if they don’t want to live by giving them the benefit of an examination to determine if their decision was the product of a pathological process causing dementia or depression.

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I would highlight a few aspects of the contemporary assessment, diagnosis and treatment of psychiatric disorders of the elderly surveyed by this book. The first is the importance of using a quantitative cognitive examination for clinical decision-making and for educating patients and families. Although cognitive examinations can be performed by specialists such as neuropsychologists, the treating clinician should examine the patient and be able to explain the results in appropriate terms to the patient and family. The important point here is not which of the several available tests is used, but that clinicians should use some quantitative method suitable for the clinical situation and purpose. Just as medicine was advanced by the introduction of the thermometer, psychiatry has been advanced by the introduction of quantitative methods of assessment. Before the modern thermometer was introduced 150 years ago, physicians felt the skin temperature and judged whether it was too warm. This method was good enough to appreciate the importance of fever, but it was not good enough to measure reliably whether the temperature was rising or falling. Today, it is not enough for the clinician to say that a patient is confused when it is possible to describe quantitatively the severity of the various impairments and to determine by serial measurement whether impairments are improving or worsening.

The second issue I would like to emphasize is the authors' discussion of that murky diagnostic category, pseudodementia. This term was usually intended to mean that a patient's cognitive impairment was not due to a neuropathological abnormality, and it implied that all true dementias were irreversible. Pseudodementia was usually applied to elderly persons with depression and cognitive impairment. Follow-up studies indicate that many of the patients so labelled do deteriorate and some have AD. This kind of evidence has been influential in returning the term dementia to its intended usage: deterioration of multiple cognitive functions in clear consciousness, without specifying either aetiology or reversibility. Instead of pseudodementia, designations such as 'depression with cognitive impairment' or 'dementia of depression' are better descriptors of the condition. This usage also encourages the point of view that depression in the elderly, both in the presence and absence of AD, should be a focus of treatment.

Finally, I would like to draw attention to the authors' discussion of currently used medications and their side effects. In some circumstances, 'reverse pharmacology' – stopping many if not all medications – leads to cognitive improvement. In other circumstances, doctors recommend medications even though treatment options are limited, because there are no curative drugs and the available symptomatic remedies carry substantial risk. In this unhappy situation, the doctors must explain the options to the patient and family and encourage them to collaborate in the decision as to whether the benefits are greater than the risks. This discussion is useful because it offers hope that something can be done or at least that no harm will be done, and it conveys to the patient and family the physicians' respect for cognitively impaired people, who often perceive that their clinicians do not consider them worthy of their efforts.

This brief guide is a welcome addition to the distinguished publications about geriatric psychiatry from the UK and more recently from many

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other countries. In addition to introducing the field to students and generalists, this brief book might even persuade some young student to join the field, just as 40 years ago one small book and a small part of a larger book written by their predecessors steered me into a satisfying career which gave me the opportunity to teach, to learn from, and to collaborate with many elderly patients and their families in order to enable them to choose to live as best they could given their individual circumstances.

Marshal Folstein MD,  
Miami Beach, 2009



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# Preface

With rapid ageing of the world population, the psychiatry of old age (POA) has become a crucial discipline, because rates of dementia, delirium and late-life functional psychiatric disorders such as depression are increasing quickly in both the developed and developing world as a consequence of the sustained and unprecedented increase in the number of older people. In many developed countries, the subspecialty of psychiatry of old age (also known as old age psychiatry, psychogeriatrics, geriatric psychiatry and geropsychiatry) is now well established, with over 500 subspecialists in the UK and 200 in Australia. Special training programmes for the discipline have been operating in several countries for some years now, and often completion of these programmes leads to the award of a certificate of competence in the psychiatry of old age. In developing countries, especially those with rising affluence, there is emerging interest in the subspecialty and recognition of the need for service providers to acquire expertise in the area. In addition, most basic training programmes for general psychiatrists now require some exposure to and knowledge of POA, and we hope that this trend will strengthen as old people approach one-quarter of the total population in many places. Despite this need, although there are excellent comprehensive, detailed and expensive texts on POA, there are fewer good, short, inexpensive books on this subject, and those that exist tend to have a national rather than an international focus. For this reason, supported by Cambridge University Press (CUP) and with the endorsement of the International Psychogeriatric Association (IPA), the four of us resolved to write a book on POA that would be short, comprehensive and affordable. In making this decision, we were mindful both of an apparent unmet need and the involvement that all four of us have had with IPA over many years (all of us have been members of IPA's Board of Directors, EC was IPA secretary and then president, and DA has edited IPA's peer-reviewed journal *International Psychogeriatrics* since 2003). This, after a prolonged gestation and writing process, is the result. It is aimed at trainee psychiatrists, higher trainees in the psychiatry of old age, geriatricians and trainee geriatricians, general psychiatrists, neurologists, physicians in training, general practitioners, allied health staff, nurses and medical students. We hope that our audience will be international, so the book's content is not limited solely to the experience of POA in the three countries in which the authors have lived and worked, but is informed by our experience of visiting, teaching and talking to our colleagues in a wide variety of countries around the world. In order to keep the book to a relatively manageable size, the text is not referenced with citations for every statement made, but we hope that

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the suggestions for further reading given at the end of each chapter (many of which are available free of charge to members of IPA) will be found to be up to date and helpful. We trust that health practitioners around the world will find this to be a useful book and that in due course a second edition will be needed. To that end we encourage readers to suggest to us how this edition could be improved (contact David Ames on [dames@unimelb.edu.au](mailto:dames@unimelb.edu.au)). Books like this do not appear without the help and assistance of a large number of people. We are grateful to Richard Marley and his colleagues at CUP (CUP is an IPA corporate partner and has published *International Psychogeriatrics*, IPA's peer-reviewed journal, since 2004) for their encouragement to write the book and their patience when the first author's numerous other responsibilities slowed down its creation. Nisha Doshi worked hard to help us get the book into production, then Jo Endell-Cooper and Sara Brunton refined the copy that was submitted into the elegant text that you now hold. Susan Oster, the executive director of IPA, was consistently enthusiastic about this project, especially the idea of offering copies to IPA members at discounted cost. Leonardo Pantoni (IPA publications committee chair) and Michael Philpot (book review editor of *International Psychogeriatrics*) checked the text rapidly at short notice to ensure that its content was compatible with IPA's mission and values, and we are very grateful to them for doing this so quickly and cheerfully, and for their many useful and thoughtful suggestions which improved the final text. Roz Seath gave tireless and invaluable secretarial support to this project, as she has done for more books than we, or she, would care to count. The book was completed during the last three months of 2009 when DA was on sabbatical leave from his research institute and university – the hospitality and kindness of Craig Ritchie and his Imperial College colleagues at Charing Cross Hospital, London during this time helped to make possible the book's completion. Finally, we would like to thank our patients and their families – from them we have learned most of what little we know about this expanding and intriguing branch of medicine. David Ames, Edmond Chiu, James Lindesay, Ken Shulman

London, Melbourne, Leicester, Toronto

December 2009

# Abbreviations

AAMI	age-associated memory impairment
ACE	angiotensin converting enzyme
Ach	acetylcholine
AD	Alzheimer's disease
ADAS-Cog	Alzheimer's Disease Assessment Scale Cognitive subscale
ADI	Alzheimer's Disease International
ADL	activities of daily living
ApoE	apolipoprotein E
APP	amyloid precursor protein
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CAMCOG	Cambridge Cognitive Examination
CDT	Clock Drawing Test
CERAD	Consortium to Establish a Registry for Alzheimer's Disease
CIND	cognitive impairment not dementia
CMAI	Cohen Mansfield Agitation Inventory
CVAE	cerebrovascular adverse event
DLB	dementia with Lewy bodies,
DRS	Delirium Rating Scale
ECA	Epidemiologic Catchment Area
ECT	electroconvulsive therapy
EOS	early-onset schizophrenia
FAB	frontal assessment battery
FBE	full blood examination
FTD	frontotemporal dementias
GAD	generalized anxiety
HGA	hypothalamus–pituitary–gonadal
HPA	hypothalamus–pituitary–adrenal
HPI	history of present illness
IPA	International Psychogeriatric Association
LOS	late-onset schizophrenia
MAOI	monoamine oxidase inhibitor
MCI	mild cognitive impairment
MEG	magneto-encephalography
MMSE	Mini-mental State Examination
MoCA	Montreal Cognitive Assessment

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NMDA	<i>N</i> -methyl-D-aspartate
NSAID	non-steroidal anti-inflammatory drug
PDD	Parkinson’s Disease Dementia
PET	Positron Emission Tomography
POA	psychiatry of old age
RBF	Regional Blood Flow
RCT	randomized controlled trial
RUDAS	Rowland Universal Dementia Assessment Scale
SPET	Single Photon Emission Tomography
TCA	tricyclic antidepressant
TIA	transient ischaemic attack
VaD	vascular dementia
VBR	Ventricular Brain Ratio
VLOSP	Very-late-onset schizophrenia-like psychosis
WMH	white matter hyperintensity