Caring for the Elderly Female Psychiatric Patient

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• Geriatric psychiatry • Female psychiatric patients
• Dementia • Psychiatric disorders

With the growth of the elderly population, and the female elderly population in particular, health providers will be seeing increasing numbers of elderly women with psychiatric disorders. To properly care for this group of patients, better understanding is needed not only of group differences in this patient population but also to understand the differences in each individual, as they age, given their unique life experiences, cohort effects, medical comorbidity, social situation, and personality traits. Understandably, these characteristics will interact with psychiatric disorders in ways that may increase the challenge to correctly diagnose and treat these patients. In addition, understanding late life changes, the prevalence of various mental disorders, and the sometimes unique presentation of mental disorders in this age group are required to better diagnose and treat this population.

As per the Administration on Aging (2002), the numbers of our elderly population will reach 70 million by the year 2030 and will make up 20% of the population. Women will continue to greatly outnumber men despite the fact that the male death rate from heart disease and other causes continues to decline and thus narrow this ratio. The change in death rate between women and men is one example highlighting that differences between men and women are not necessarily genetic, but may be caused by environmental or cohort effects. The latest report from the 2000 US Bureau of Census showed that in the age group of more than 65years of age, men account for 5.1% of the population, whereas women account for 7.3%.

Thus this growing population of elderly women warrants more attention toward their physical and mental well being. Despite some socioeconomic advances by women in recent years, research shows women continue to be at a disadvantage,[1,2] although they still continue to be the primary caregivers as mothers, spouses, and daughters. And because of the increasing life expectancy of the oldest old, their role as caregivers to aging parents, although at high need to receive care themselves, further increases

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the complexity of their lives. Unfortunately, serious illnesses, such as lung cancer and heart disease, have now reached similar rates for women as men.[3,4] As mental health problems may be intimately linked to physical and socioeconomic health,[5] the previously mentioned problems are indicative of issues facing this growing elderly female population.

Research has revealed that women of older age groups are in a lower socioeconomic status than men.[1] Unfortunately, studies have shown that there are higher rates of most psychiatric disorders among those with lower socioeconomic status.[5] These socioeconomic differences may be in part why women have more anxiety and mood disorders,[5,6] across the life span, whereas men have more substance use.[5,6]

We will now address an approach to the elderly female psychiatric patient and issues specific to psychiatric disorders in this population.

APPROACH TO GERIATRIC FEMALE PSYCHIATRIC PATIENTS

Patients will present for mental health issues to their primary care physician or directly to the psychiatric setting. Frequently, they are brought because of the concerns of others (spouse, children, friends or other physicians) and less frequently because of the legal system or adult protective services, rather than presenting on their own. As such, patients may not want to be evaluated or will deny there are any problems. Thus, in the evaluation of the elderly female patient, outside informants should always be sought. Certainly anyone accompanying patients should be interviewed. If patients come alone, calling relevant outside informants is often the only way to get an accurate history.

Because of the prevalence of cognitive disorders (dementia, mild cognitive impairment, delirium) in the elderly age group, a cognitive assessment should always be done. This assessment is done not only for accurate diagnosis of cognitive disorders but also to assess the potential accuracy of patients' history and the ability of patients to follow through on the treatment plan, be it medication or otherwise. Simple assessments, such as the Folstein Mini Mental State Exam,[7] are adequate for this purpose.

In addition to a routine psychiatric history and examination, special information should be sought for elderly patients. For example, any family history of cognitive impairment or dementia should be sought. A social history should also be sought. Information needed for obtaining a social history includes the current living situation, including any aides or family members who are nearby or help out; current driving status (if still driving, any accidents?); who does the patients' bills/finances; who gets groceries and does the cooking; whether patients are independent regarding bathing, dressing, feeding, and toileting, and gait status (use of a cane/walker/wheelchair). Any care-giving responsibilities of patients should be recorded, because one may be surprised to find patients with dementia still watching grandchildren because the daughter is working, or other such situations. If a spouse or other family is in the home, the relationships of such individuals should be evaluated because abuse may begin for the first time in late life. A simple question regarding how others treat them is often a good starting point in asking about potential abuse.

History of gait instability, or any falls and the circumstances of such falls, should be documented. A detailed medical history, including conditions common in the female elderly population, such as recurrent urinary tract infection (UTI), should be done. History of hormonal therapies and emotional response/side effects to them should be recorded. Any changes of appetite, sleep, and weight loss or gain should be obtained. All patients should have a primary care physician and those that do not