Clinical assessment in old age psychiatry

David Okai

Abstract

Assessment in the elderly psychiatric population requires a particular focus on cognition and co-morbid physical illness. Although there can be differences in the way that psychiatric illnesses manifest in younger and older adults, a structured approach to history-taking with a clear understanding of the diagnostic hierarchy of the psychiatric disorders allows for a clear formulation of psychiatric conditions. For organic conditions, there should be emphasis on correctly identifying cognitive and neurobehavioural deficits, as well as an assessment of the 'real-world' impact of such problems, which will in turn inform management.

Keywords Cognitive assessment; dementia; old age psychiatry; psychiatric history; psychiatric signs

Key points

- Psychiatric illness is often under-recognized in old age
- The hierarchy of psychiatric diagnoses should guide assessment
- Assessment is incomplete until collateral information has been obtained
- Cognitive function can be broadly divided into cortical and subcortical problems
- Neurobehavioural factors are an important additional component of the old age assessment

Introduction

Psychiatric illness is often under-recognized in a medical setting. This is of particular importance in the elderly as a complex interplay of physical illness and psychiatric diagnosis may impact on morbidity and mortality.[1] The onset of physical illness is a major life event and can evoke depressive or adjustment disorders. Additionally, a physical illness can mimic a psychiatric condition and vice versa.[2] Medication associated with physical illness can also contribute to – or perpetuate – a range of diagnoses including organic, depressive and psychotic disorders (Figure 1).

Assessment

The structure of psychiatric assessment in older adults should follow the same format as in the general adult population. However, it requires the need for an additional focus on cognitive factors and on the impact that physical co-morbidity can have on a patient. As patients are more likely to be seen in a medical setting, consideration should be given to an appropriate environment for assessment. Interviewing patients in a medical bed without curtain separation, or writing notes with no eye contact, is not helpful in establishing rapport and facilitating disclosure.

Although a single 'presenting complaint' may be stated, a range of connected issues is perhaps more typical. A consideration of the full range of possible differential diagnoses, including both mental and physical diagnoses, should guide the structure of questions asked (Figure 1).

David Okai ***MD(Res) MRCPsych MB BS BMedSci PGDip(CBT)*** *is a Consultant Liaison/Neuropsychiatrist in the Department of Psychological Medicine, Oxford University NHS Foundation Trust, UK. Competing interests: none declared.*

Be careful in assuming a 'comprehensive and complete' assessment until all information has been sought. Patients may present with a convincing social facade. Collateral information is often provided by family members who may also have adopted a carer role. Ask about evidence of deterioration of the symptoms and an appropriate timescale, especially for dementia. Disparity between patients' and carer's accounts should be noted, and is often found in individuals with dysexecutive problems (see below) or more advanced stages of dementia. The clinician should also be wary of a natural tendency to 'normalize' the symptoms, attributing them to the natural ageing process. For instance, where there are changes in behaviour, the informant should be encouraged to think back several years to see if the patient was functioning in much the same fashion then as now.

Mental state examination

Appearance and behaviour: determine whether the patient attended the appointment by themselves or required the assistance of family or friend. Levels of self-care can also be a useful indicator of how the patient is functioning from day to day.

Speech: make a note of whether the patient's speech is coherent, continuous and relevant.

Mood: in the elderly, depressive disorders often present with a significant anxiety component. Increased irritability can be found in individuals with early signs of cognitive impairment or in those with elevated mood. Lability of mood (with exaggerated crying or laughing) can be found with subcortical deficits such as a pseudobulbar palsy associated with stroke disease.

Thought content: look for evidence of strange thoughts or beliefs. An organic cause of psychosis should be considered. This, or a psychosis associated with delirium, is more likely to be fleeting, inconsistent and vague. Alternatively, a chronic psychotic disorder is more likely to manifest as a sustained system of plots, predictions and arguments. In such circumstances, misidentification delusions; paranoid delusions of theft; or morbid jealousy are common. These may also arise in people with cognitive impairment.

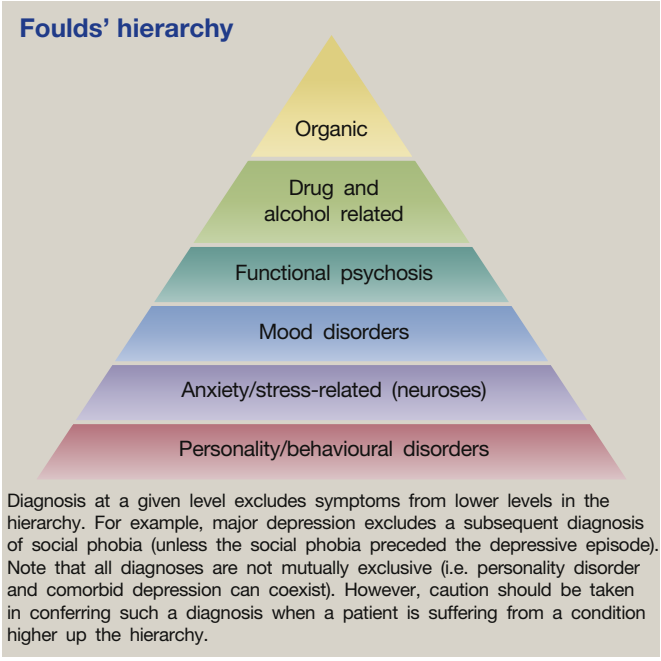

Figure 1

Perception: hallucinations in sensory modalities other than auditory can result from physical illness. For example, complex visual hallucinations can indicate a diagnosis of dementia with Lewy bodies or occur with visual impairment. Tactile and visual hallucinations are more commonly found in delirium.

Cognitive examination

Evidence for cognitive impairment or dementia requires both a detailed history and collateral information. This can be helped by using screening tools such as the Abbreviated Mental Test,[2] the Montreal Cognitive Assessment and the Folstein Mini-Mental State Examination (see Table 5 of *Clinical assessment and investigation in psychiatry on* page 630–637 of this issue).[3] The latter two have an advantage of indicating the areas of potential cognitive deficit and can be used to monitor future cognitive decline.

A large number of assessment scales exist for patients with dementia. For instance, the Addenbrooke's Cognitive Examination – version III has greater sensitivity and specificity for impairment in various cognitive domains than any of the aforementioned tests. For further discussion in this area, see the further reading.

Tests of orientation and attention are described elsewhere (see *Clinical assessment and investigation in psychiatry* on pp. 630–637 of this issue), but if a patient has too great an impairment to undertake any of the above tests, it can be helpful to perform basic orientation to time, place and person (e.g. year, day, city, name of the current building/ward). Bedside tests to aid assessment of each of the cognitive domains are outlined in Table 1.

Functional and social care assessment

It is important to bear in mind that no neuropsychological test can confirm a diagnosis of dementia. This needs to be based on evidence of impairment of the various domains of cognitive function and resultant impact on activities of daily living (ADLs; Table 2). In other words, there needs to be a 'real-world' impact of any identified cognitive impairment.

Careful enquiry regarding personal circumstances should include the patient's ability to attend to personal care, continence and mobility. There should also be an assessment of family and social support systems alongside a sensitive enquiry into the level and nature of the carers' burden or strain.[4]

Risk assessment

Risk assessment is important, particularly as suicidal ideation ordinarily decreases with age.[5] Thus, an expression of ideation should be taken seriously. Any history of actions or behaviours that have put patients at risk (e.g. leaving the cooker on or the front door open) should be explored. Furthermore, elderly individuals can be at risk of self-neglect or increasingly vulnerable to exploitation by others.

Cognitive and neurobehavioural disorders

This should broadly be divided into problems that occur as a result of cortical damage (e.g. Alzheimer's dementia) and those affecting subcortical structures such as the brainstem, internal capsule and thalamus (e.g. Parkinson's disease).

Cortical disorders

These usually manifest as problems with amnesia (memory difficulties), aphasia (word-finding difficulties, problems understanding others), apraxia (difficulty with the coordination of movements in order to perform tasks or movements), and agnosia (impaired awareness or recognition of objects, people and their own condition).

The early stages often result in word-finding difficulty with a reduction in vocabulary from the patient's premorbid level. At this stage, the patient may be able to perform most ADLs, warranting a diagnosis of mild cognitive impairment. More advanced stages lead to a retrograde amnesia with difficulties in retrieving and summoning personal (autobiographical) and public (e.g. current news, names of previous prime ministers) events. Deficits tend to follow a temporal gradient.

Subcortical ('dysexecutive') disorders

Executive (previously referred to as frontal lobe) dysfunction often manifests with increasing disorganization due to problems in planning, prioritizing and selecting appropriate actions. Neurobehavioural features are often prominent, with relative preservation of cognitive function or intelligence. This means that patients may perform relatively well in structured clinical tests but present with profound personality and behavioural problems that consist of two main types – disinhibition and apathy. The two problems commonly overlap. The former can present with uncharacteristic rudeness, impulsivity, eating and sexual changes. The latter is differentiated from depression by absence of subjective low mood, continuing engagement in conversation when prompted and subjective accounts of enjoyment of visits from friends. Altered sense of humour has been highlighted as a sensitive early marker of impaired social cognition.