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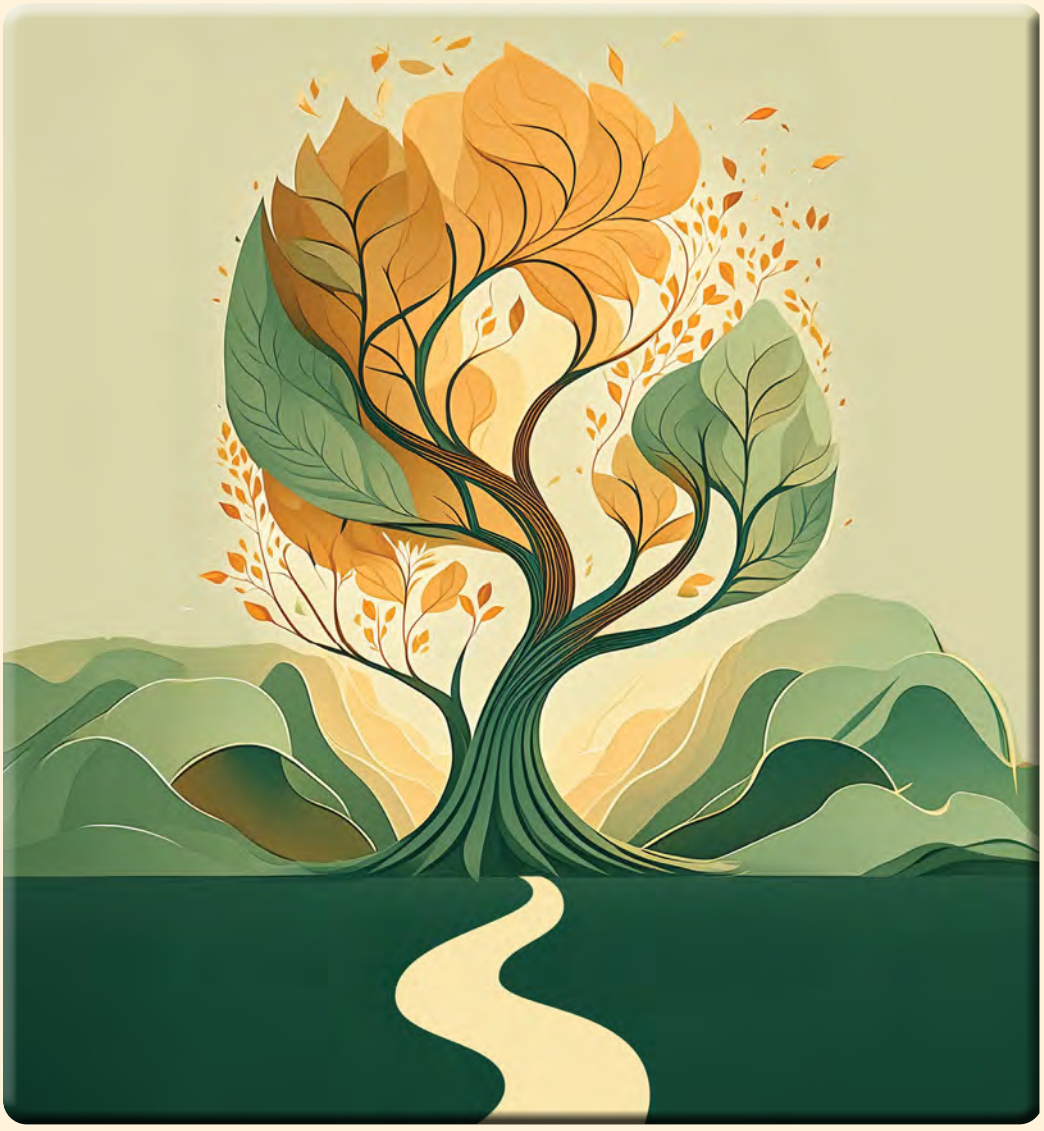
Geriatric Psychiatry Fact Book



"An essential, quick yet thorough, reference for any clinician working with older adults."

—Louis Trevisan, MD, MEd

Clinical Professor of Psychiatry, Creighton School of Medicine,
Associate Professor of Psychiatry, Adjunct, Yale School of Medicine

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GERIATRIC PSYCHIATRY FACT BOOK

FIRST EDITION

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Introduction to Geriatric Psychiatry

Over the course of my career, I've had the privilege of working with countless older adults and their families. These experiences have profoundly shaped my understanding of mental health and the aging process. What I've learned is that treating older patients requires honoring their resilience, listening to their stories, collaborating with their families, and appreciating the wisdom they've accumulated through decades of lived experience.

Effective clinical practice in geriatric psychiatry demands a sophisticated understanding of the complex interplay between the biological vulnerabilities, psychological stressors, and sociocultural contexts that uniquely influence mental health in later life. Older adults also navigate significant life transitions like retirement, bereavement, chronic illness, and cognitive changes, while often depending on support networks. The geriatrician must consider all these factors to deliver truly exceptional care.

As our population ages, the need for specialized expertise in geriatric psychiatry has never been greater. Yet, we face a critical shortage of practitioners equipped with the necessary skills and knowledge in this field. This book addresses this gap by offering evidence-based, high-yield clinical insights accessible at the point of care. My goal is to empower a broad range of health care professionals with the tools to provide competent, compassionate care to older adults that takes

Psychiatric Assessment of Older Adults

The psychiatric assessment of older adults builds upon standard adult evaluation practices but includes special attention to age-related factors. In this section, I'll walk you through key modifications and additional elements to consider when evaluating older patients.

CLINICAL PEARL: *Always involve a family member or caregiver in the assessment when possible. They often provide crucial information about functional changes that the patient may not recognize or report.*

Style and Technique

Many older adults experience hearing loss. This can cause them to feel left out of appointments or have difficulty understanding questions. I've found these techniques particularly helpful:

- Face the patient and talk clearly and slowly.
- Speak a little louder than usual without shouting.
- Repeat yourself as needed.
- Direct your voice to the ear with better hearing.
- Use gestures or facial expressions to get your points across.
- Provide written materials that the patient can refer to later.
- Consider the room setup—minimize background noise and ensure good lighting.

PRACTICE POINT: *If you suspect hearing difficulties, ask "With which ear do you hear better?" at the start of the session. This simple question can dramatically improve communication.*

Chief Complaint

Begin by recording the patient's main concern in their own words. This provides valuable insight into the patient's perspective and helps prioritize their needs.

History of Presenting Illness (HPI)

In addition to the standard HPI questions, when conducting psychiatric evaluations in older adults, it is essential to assess functional and cognitive status. This practice ensures a comprehensive evaluation, enabling accurate diagnosis and management plans tailored to the unique needs of older patients. (See "Functional Assessment in Older Adults" [page 12] and "Neurocognitive Testing for Dementia" [page 101] fact sheets in the "Geriatric Assessment" and "Assessment and Treatment of Neurocognitive Disorders" sections of this book.)

Here are some pointers on cognitive domains to assess in older adults and how responses may guide clinical interpretation:

Memory changes

Short-term memory typically declines before long-term memory in conditions like Alzheimer's dementia (AD). Ask:

- "Have you noticed any changes in your memory or have you become more forgetful?"
- "How is your memory for recent events?"
- "Have you been forgetting appointments, birthdays, or anniversaries?
- "Have you lost or misplaced items like your keys, purse, or wallet?"
- "How is your memory for things that happened a long time ago?"

CLINICAL PEARL: *Pay attention to how patients answer these questions. Do they turn to their family member to confirm details? Do they seem embarrassed or frustrated? These observations can be very telling.*

Anxiety in the Older Adult

Anxiety disorders occur in 8% of older adults and are more common than late-life mood disorders, yet they are often underdiagnosed and undertreated (Aggarwal R et al, *Focus* 2017;15(2):157–161).

CASE VIGNETTE: *Mrs. Chen, 82, presents with stomach problems and withdrawal from activities. While denying anxiety, she shows constant health worries, frequent medical appointments, and repeated calls to her children "to make sure they're okay." Diagnosed with generalized anxiety disorder (GAD), she improves with sertraline 50 mg daily and deep breathing techniques, resuming her social activities after eight weeks.*

Recognizing Anxiety in Older Adults

Verbal cues

- *Expressions of worry or fear*
  - Listen for repeated expressions of worry about health, safety, finances, or family. Older adults might express concerns about becoming a burden or express fear of future events.
- *Change in language*
  - Note any increase in conversations about feeling overwhelmed, stressed, or unable to cope with daily routines or changing circumstances.
  - Older adults may describe anxiety differently than younger people, using terms like "nervousness" or "worry" rather than "anxiety" (Lutz J et al, *Med Clin North Am* 2020;104(5):843-854).

Complaints of physical symptoms

- Pay attention to complaints that might be due to underlying anxiety, such as unexplained aches, increased fatigue, headaches, or gastrointestinal issues without a clear medical cause.
- Physical symptoms of anxiety (eg, heart palpitations, dizziness) may be misattributed to medical conditions, leading to under recognition of anxiety.

Behavioral signs

- *Avoidance behavior:* Observe if the individual starts to avoid social interactions, activities they once enjoyed, or specific situations, like going outside or attending appointments.
- *Changes in sleep patterns:* Difficulty falling asleep, staying asleep, or excessive sleep can be signs of anxiety. Older adults might mention having racing thoughts at night or fearing the dark.
- *Increased irritability or restlessness:* Older adults with anxiety may exhibit restlessness, have difficulty sitting still, or become more easily irritated by minor issues.

Physical symptoms/reactions

Look for signs of restlessness, trembling, muscle tension, or being easily startled. Some older adults have physical reactions to anxiety, such as sweating, rapid heartbeat, or breathing difficulties.

Common Late-Life Anxiety Disorders

GAD

- Ask: "Are you a worrier?"
- GAD is characterized by excessive, uncontrollable worry about different topics

Depression in Older Adults: Diagnosis

Late-life depression (LLD) is defined as a depressive episode occurring in an individual aged 60 or older. It impacts about 2%–5% of older adults in the community (Steffens DC et al, *Arch Gen Psychiatry* 2000;57(6):601-607). In medical and skilled nursing settings, LLD occurs in up to 25% of older adults. While the clinical interview remains the gold standard for diagnosis, LLD is frequently overlooked or misattributed to normal aging or anxiety. It is important to note that even subthreshold depressive symptoms can lead to significant disability and may warrant treatment.

Clinical Presentation

In younger adults, depression is diagnosed by the presence of low mood or loss of interest or pleasure plus four out of eight of the classic SIGECAPS symptoms occurring over a two-week span. While these criteria are also applicable in older adults, there are some variations and special considerations.

- ***M****ood*
  - "How have your spirits been over the last two weeks?"
  - "Have you felt so down that your entire life has been affected?"
  - Some older adults will not endorse feeling "depressed," but will admit to:
    - Having low spirits
    - Feeling sad
    - Increased irritability
    - Being discouraged
    - Never feeling happy
    - Becoming desperate
  - Other patients will feel a constant sense of "nervousness" or "anxiety" but on further assessment, they will have LLD rather than an anxiety disorder.
- ***S****leep*
  - "How have you slept over the last two weeks?"
  - The most common complaints are difficulty falling asleep and frequent nighttime awakenings. Patients may have early-morning awakenings but as a result of age-related changes in sleeping patterns, instead of depression.
- ***I****nterest decrease*
  - "Have you found any activities enjoyable lately?"
  - Look for signs like social withdrawal, neglecting hobbies/friends, or a lack of enthusiasm for activities formerly enjoyed.
- ***G****uilt*
  - "Do you feel that you are a good person?"
  - "Have you felt guilty about things you've done or haven't done?"
- ***E****nergy decrease*
  - "How has your energy level been over the last couple of weeks?"
  - "Is it taking longer than usual for you to get things done?"
  - Rather than decreased energy, older adults with depression frequently report weariness.
- **C**oncentration
  - **"**Do you forget names, addresses, or birthdays?"

Personality Disorders in Older Adults

Personality disorders (PDs) in older adults are understudied and underdiagnosed. The most common PDs in older adults, in order of prevalence, are obsessive-compulsive, paranoid, narcissistic, and avoidant.

CASE VIGNETTE: *Mr. Ewing, an 82-year-old retired accountant, is brought to the clinic by his son for conflicts at home. He insists every household item must be kept in a precise location, checks locks repeatedly, and berates his son for minor deviations in daily routines. These behaviors have intensified since his wife passed away six months ago. The clinical picture is suggestive of OCPD exacerbated by bereavement, now causing significant caregiver strain.*

Clinical Features in Older Adults

- *Age-related changes:* Life transitions (retirement, bereavement, health decline) can exacerbate maladaptive personality traits as older adults lose independence and rely more on others.
- *Cognitive vs. personality changes:* Older adults with PDs may develop increased suspiciousness or rigidity, which can mask underlying cognitive decline.
- *Decline in impulsivity*: People with borderline PD show fewer self-harming acts and less impulsivity in later life but fear of abandonment and poor interpersonal functioning persist. Antisocial behavior including impulsive actions and legal trouble decreases in older age.
- *Increased interpersonal strain*: Family or caregiver relationships can become tense, especially if the older adult requires more assistance but resists due to untrusting or obsessive traits.

Table 11: **Personality Disorders in Older vs Younger Adults**

Aspect	Older Adults	Younger Adults
Prevalence	11%–15% in the community; 58% in nursing homes	9%–13% in the general population
Onset	Longstanding patterns become more apparent under stress (eg, bereavement, retirement)	Typically identified in late adolescence or early adulthood
Common Types	Obsessive-compulsive, paranoid, narcissistic, avoidant	Borderline, antisocial, narcissistic
Clinical Features	More likely to be: male, married, have mixed PDs, high polypharmacy	More frequent: impulsivity, self-harm, chronic unstable relationships
Impulsivity	Tends to decrease with age, though core emotional dysregulation (eg, fear of abandonment) may persist	Often high (eg, reckless behavior, self-injury)
Interpersonal Conflicts	May shift to strained caregiver/family relationships, sometimes leading to isolation	Usually with peers or significant others
Rigidity/Suspiciousness	Can intensify due to medical issues	May be present but less tied to health

Frontotemporal Dementia: Treatment

Frontotemporal dementia (FTD) encompasses a group of neurodegenerative disorders that primarily affect the frontal and temporal lobes of the brain, leading to progressive changes in behavior, personality, and language. Treatment strategies for FTD focus on managing symptoms, as no FDA-approved therapies exist. The best evidence for neuropsychiatric symptoms (NPS) due to FTD is for citalopram and trazodone. See the fact sheet "Frontotemporal Dementia: Diagnosis" [page 115] for tips on identifying FTD in older adults.

Nonpharmacological Treatments

Implement legal and safety measures

- ***Establish power of attorney:*** Ensure a power of attorney for health care and finances is in place to manage risks related to poor judgment, impulsive behavior, and spending. Since people with FTD are mostly younger, this is a critical step to protect the patient's assets and interests.
- ***Assess driving safety:*** Evaluate the patient's driving abilities with an on-the-road driving evaluation. Patients with FTD struggle with attention, complex road conditions, and impulsivity, increasing the risk of accidents.
- ***Advice regarding firearm safety:*** Recommend that caregivers remove firearms from the home or securely store them in a gun safe that the patient cannot access to prevent accidents.

CASE VIGNETTE 1: *Mr. Patrick, a 63-year-old man with behavioral variant frontotemporal dementia (bvFTD), displays impulsive and disinhibited behavior, including verbal aggression toward family members. Mr. Patrick has always been an avid gun owner, and his wife is concerned about the presence of firearms in the home. Due to the risk of impulsivity and potential harm, his family is advised to remove firearms from the home or lock them securely in a safe to which Mr. Patrick has no access. With the implementation of this last safety measure, his family begins to feel more secure.*

Enhance communication

Use speech therapy to help maintain language skills or facilitate communication through alternative methods such as communication books or assistive technology. This is especially crucial for patients with semantic dementia and nonfluent primary progressive aphasia (nfPPA).

Promote physical and cognitive activities

- ***Encourage regular exercise:*** Promote regular aerobic exercise to improve strength and balance, reduce fall risk, and slow disease progression.
- ***Stimulate cognition:*** Engage patients in regular cognitive activities to slow the rate of cognitive decline and reduce disease severity.

Use occupational therapy strategies

Optimize daily function: Occupational therapists can assess cognitive and physical status and provide strategies like step-by-step activity guides with pictures for tasks like computer or cell phone logins to support patients with executive dysfunction.

Prevent choking

Monitor eating habits: Have caregivers supervise patients during meals to prevent choking, particularly if the patient

Capacity and Competency Evaluations

You may be asked to determine decision-making capacity (DMC) in various situations, such as consent for medical procedures, for leaving the hospital against medical advice, or for other major decisions. In this fact sheet, I suggest an approach to evaluating DMC and what to do if you conclude that DMC is impaired.

Method for Evaluating Capacity in Older Adults

Assess cognitive function

- The Mini-Mental Status Exam or Montreal Cognitive Assessment are useful for a general assessment, but these tests are not specific for determining DMC.
- The aid to capacity evaluation is a standardized tool for DMC. It can be found at the University of Toronto Joint Centre for Bioethics (https://tinyurl.com/4bznbpp5). It takes 10–15 minutes to administer.

Respect the patient's autonomy

Involve patients in the decision-making process by using clear, simple explanations.

Evaluate a specific decision

Utilizing the four criteria for DMC as a framework, evaluate one specific decision (see table below).

Include patient and family

Family can provide insight into the patient's baseline decision-making abilities and preferences.

Engage a multidisciplinary team (if needed)

It can include neurologists, geriatricians, bioethicists, social workers, and legal experts.

Reevaluate frequently

Capacity may change over time, such as in people with delirium, so regular evaluation is essential.

Table 44: Criteria for Decision-Making Capacity

1. ***Communicate a choice***
• The patient must be able to communicate their decision. This can be verbal or nonverbal, but it must be clear that the patient has made a choice. • Ask: "What have you decided?"
2. ***Understand the relevant information***
• The patient should be able to understand the information provided by their team. This can be tested by asking the patient to summarize what they know about the situation and their options. • Ask: "Tell me what's happening." "What are your clinician's recommendations?"
3. ***Appreciate the situation and its consequences***
• The patient must have an appreciation of the nature and consequences of their decision. This involves knowing the options available; the risks and benefits of each option; the potential outcomes of each choice; and the alternatives to each option. • Ask: "What are the pros and cons of your decision?" "Are there any alternatives?" "What could happen if you do or don't follow your clinician's recommendations?"
4. ***Reasoning about options***
• The patient should be able to reason and use logic in making their decision. This includes being able to evaluate different options and to make a decision based on logical reasoning. The decision should be consistent with the patient's cultural, religious, and personal values.

Geriatric Psychiatry Fact Book

"This book has become invaluable to me in my daily practice, covering everything from anxiety to substance use in the geriatric population."

—James Sherer, MD
Deputy Chief Medical Officer, Carrier Clinic, Hackensack Meridian Health Network

"A valuable resource and learning tool for a deeper dive into geriatric Psychiatry. It highlights key differences in clinical presentation and offers practical guidelines to provide care for older adults."

—Mary-Ann Abraham, MD
Geriatric Psychiatrist Assistant Professor of Psychiatry University of California, Davis

YOUR GO-TO GUIDE for geriatric psychiatry—clear, concise, and packed with practical tools to help you deliver exceptional mental health care to older adults.

INSIDE YOU'LL FIND:

- ✔ **Essential Clinical Knowledge at Your Fingertips:** High-yield, evidence-based information designed for busy clinicians working with older adults.
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- ✔ **Behavioral and Psychological Symptoms of Dementia:** Learn strategies for recognizing and managing agitation, psychosis, depression, and apathy in people with neurocognitive disorders.

Designed for real-world use, this fact book puts expert geriatric psychiatry knowledge at your fingertips, so you can make confident decisions, even in complex situations.

AUTHOR

Dr. Rehan Aziz was born and raised in NJ. He graduated from Rutgers New Jersey Medical School in Newark, NJ. He completed internship and residency training in psychiatry at Yale School of Medicine in New Haven, CT and fellowship training in geriatric psychiatry at Yale-New Haven Hospital. He is board-certified in psychiatry, geriatric psychiatry, and behavioral neurology/neuropsychiatry. Dr. Aziz is currently Associate Professor of Psychiatry and Neurology at Hackensack Meridian School of Medicine in Nutley, NJ. He is the Program Director for the Psychiatry Residency Program and Associate Program Director for the Geriatric Psychiatry Fellowship Program at Jersey Shore University Medical Center in Neptune, NJ. He has presented at several organizations' national meetings, including the American Psychiatric Association (APA) and the American Association of Geriatric Psychiatry (AAGP). He has been published in several academic medical journals and quoted by Forbes, Fox News, Medical News Today, Medscape, TIME Magazine, US News and World Report, and WebMD. He is a member of the editorial board for The Carlat Geriatric Psychiatry Report. Dr. Aziz has been inducted into the Alpha Omega Alpha Honor Medical Society, was nominated to the Gold Humanism Honor Society, and has won three teaching awards.

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