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Mental Health in the Elderly: Key Conditions, Assessment, and Management

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Intended Learning Outcomes

By the end of this session, participants will be able to:

- Define common mental health conditions affecting the elderly.
- Differentiate between normal ageing and pathological cognitive changes.
- Identify key features of dementia, Alzheimer's disease, depression with hallucinations, and schizophrenia.
- Recognize the clinical presentation of delirium and anxiety disorders in older adults.
- Understand the impact of mental health issues on functional ability and physiotherapy outcomes.
- Discuss interdisciplinary strategies for managing geriatric mental health.

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Mental health in the Older Adults: An Urgent Concern

- Mental health disorders affect 15–20% of older adults globally.
- Often underdiagnosed due to overlapping physical and cognitive symptoms.
- Affects independence, quality of life, and treatment adherence.
- Physiological, psychological, and social factors contribute to vulnerability.
- Requires a multidisciplinary approach in care, especially in geriatrics.

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Understanding Cognitive and Emotional Changes with Age

Normal Aging	Pathological Changes
Mild forgetfulness (e.g., misplacing keys)	Memory loss affecting daily functioning
Slower processing speed	Disorientation to time/place
Occasional difficulty finding words	Frequent word-finding pauses or repetition
Preserved insight and judgment	Impaired judgment, poor decision-making
Stable personality	Marked personality or behavioral changes
Mood varies with circumstances	Persistent sadness, anxiety, and hallucinations

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Dementia: An overview

- **Definition:** A chronic, progressive syndrome marked by deterioration in memory, thinking, behaviour, and ability to perform everyday activities.
- **Global Prevalence:** Over 55 million people living with dementia (WHO, 2023).
- **Common Types:**
  - Alzheimer's Disease (60–70% of cases)
  - Vascular Dementia
  - Lewy Body Dementia
  - Frontotemporal Dementia

Key Symptoms

- Memory impairment
- Language difficulties
- Impaired reasoning and executive function
- Personality and behavioural changes

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Alzheimer's Disease: The Most Common Cause of Dementia

- **Onset:** Gradual; typically, after age 65

Core Features

- Short-term memory loss
- Difficulty with language (aphasia)
- Impaired visuospatial skills
- Poor judgment and insight
- Personality changes in later stages

Pathophysiology:

- Amyloid plaques and neurofibrillary tangles
- Progressive neuronal loss (esp. hippocampus and cortex)

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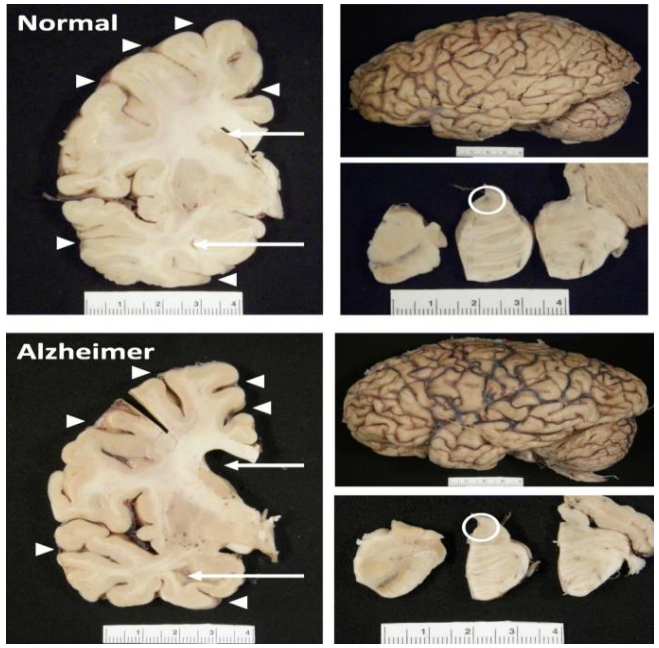
Amyloid Plaques and Neurofibrillary angles



Gross Anatomy of Alzheimer's Brain. Lateral view of an Alzheimer's brain can show widening of sulcal spaces and narrowing of gyri compared to a normal brain. This may be more readily observed in coronal sections as indicated by the arrowheads, and this atrophy is often accompanied by enlargement of the frontal and temporal horns of the lateral ventricles as highlighted by the arrows. Additionally, loss of pigmented neurons in the locus coeruleus is commonly observed in the pontine tegmentum as shown with the open circle. None of these features is exclusive to Alzheimer's disease.

(DeTure, M.A., Dickson, D.W. The neuropathological diagnosis of Alzheimer's disease. *Mol Neurodegeneration* **14**, 32 (2019). https://doi.org/10.1186/s13024-019-0333-5)

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Alzheimer's Disease: The Most Common Cause of Dementia

Diagnosis:

- Clinical history + MMSE or MoCA
- Neuroimaging (MRI shows cortical atrophy)
- Rule out reversible causes (e.g., B12 deficiency, hypothyroidism)

Management:

- Medications: Donepezil, Rivastigmine, Memantine
- Supportive care: Orientation aids, caregiver education
- Role of Physiotherapy: Promote mobility, fall prevention, structured routines

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Other Dementias: Key Clinical Features

1. Vascular Dementia

- Cause: Ischemic or hemorrhagic cerebrovascular disease
- Onset: Sudden or stepwise decline
- Features:
  - Impaired attention and executive function
  - Memory may be relatively preserved early
  - Associated with hypertension, diabetes, and strokes
  - MRI: Multiple infarcts or white matter changes

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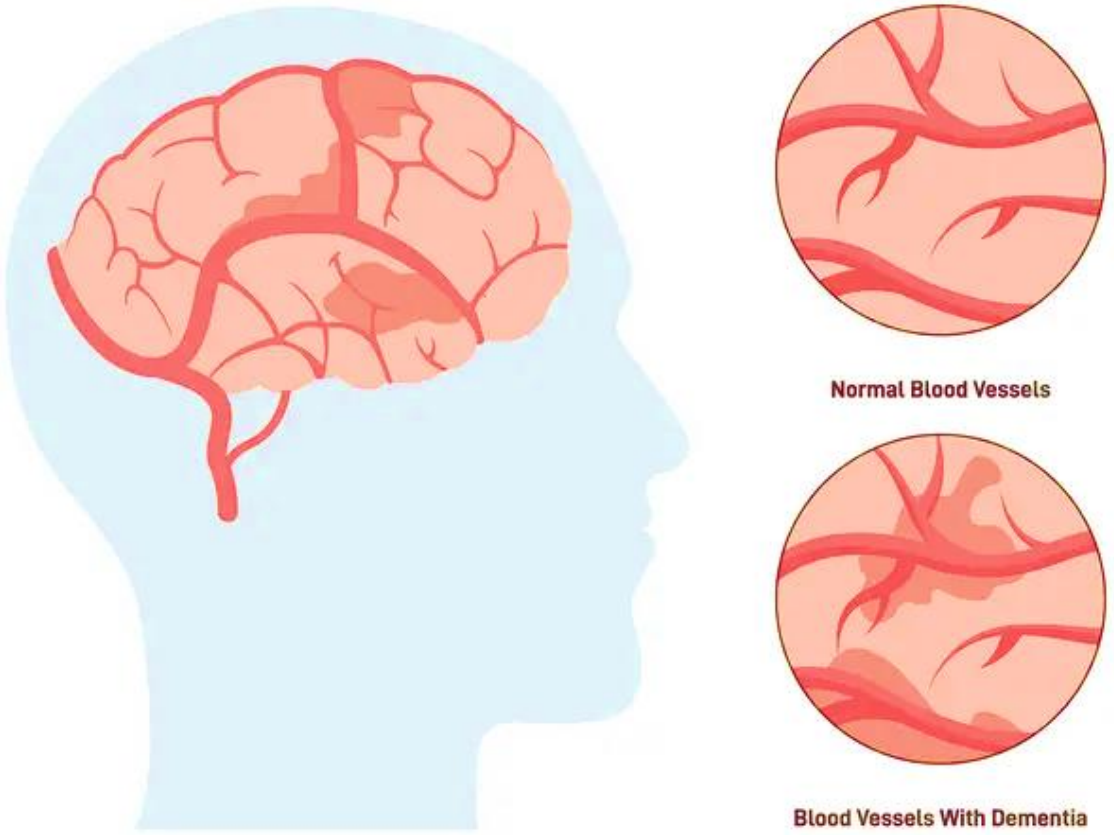
Vascular Dementia



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Other Dementias: Key Clinical Features

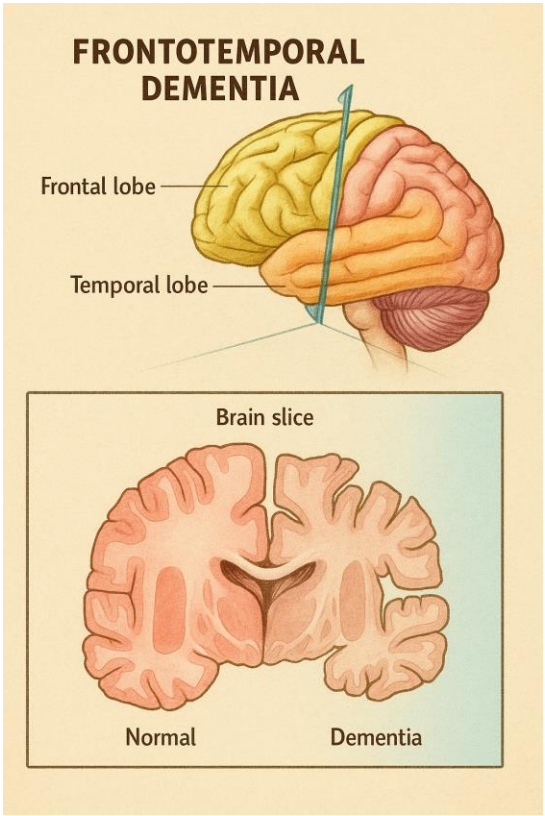
2. Lewy Body Dementia (LBD)

- Lewy body protein deposits in the brain
- Key Features:
  - Visual hallucinations (early and vivid)
  - Parkinsonism (rigidity, bradykinesia)
  - Fluctuating cognition and alertness
  - REM sleep behaviour disorder
  - Note: Very sensitive to antipsychotics

Other Dementias: Key Clinical Features

3. Frontotemporal Dementia (FTD)

- **Onset:** Younger age (45–65 years)
- **Key Features:**
  - Early personality and behaviour changes
  - Disinhibition, apathy, loss of empathy
  - Language problems are more prominent than memory
- **Subtypes:** Behavioural variant, Semantic variant, Non-fluent variant



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Other Neurodegenerative Disorders in the Older Adults

1. Parkinson's Disease (PD)

- The second most common neurodegenerative disorder
- Motor symptoms: bradykinesia, rigidity, resting tremor, postural instability
- Non-motor symptoms: depression, cognitive impairment, REM sleep disorder
- Dementia develops in 30–40% of patients (Parkinson's disease dementia)

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Other Neurodegenerative Disorders in the Older Adults

2. Huntington's Disease (HD)

- Rare, inherited disorder (onset typically earlier but may present in elderly)
- Chorea (involuntary movements), mood disturbances, and progressive dementia
- Psychosis or severe depression may occur in later stages

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Other Neurodegenerative Disorders in the Older Adults

3. Amyotrophic Lateral Sclerosis (ALS)

- Progressive motor neuron disease
- Muscle wasting, fasciculations, respiratory decline
- Cognition is typically preserved early, but up to 50% develop cognitive/behavioural changes
- ALS-FTD variant overlaps with frontotemporal dementia

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Other Neurodegenerative Disorders in the Older Adults

4. Multiple System Atrophy (MSA)

- Parkinsonism + autonomic dysfunction (e.g., orthostatic hypotension)
- May cause executive dysfunction, apathy, and mood changes

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Late-Life Depression

- A Silent Burden
- Prevalence: Affects ~15% of elderly; often underdiagnosed
- **Clinical Features**:
  - Persistent sadness, low energy
  - Somatic complaints (e.g., pain, fatigue, sleep disturbance)
  - Anhedonia (loss of interest), apathy
  - Cognitive slowing—may mimic dementia ("pseudodementia")
  - Psychotic features: Hallucinations or delusions (e.g., guilt, poverty)

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Late-Life Depression

- **Risk Factors:**
  - Bereavement, chronic illness, social isolation
  - Functional disability, pain, sensory loss
- **Assessment Tools:**
  - Geriatric Depression Scale (GDS)
  - PHQ-9 adapted for older adults
- **Management:**
  - Antidepressants (SSRIs preferred; monitor for side effects)
  - Psychotherapy: CBT, interpersonal therapy
  - Social activation and exercise (key physiotherapy roles)

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Schizophrenia in the Older Adults

- **Types in older adults:**
  - Early-onset schizophrenia (EOS): Continuing into old age
  - Late-onset schizophrenia (LOS): Onset after age 40
  - Very-late-onset schizophrenia-like psychosis: After age 60
- **Core Features:**
  - Paranoia and auditory hallucinations
  - Social withdrawal and self-neglect
  - Less disorganized speech compared to younger patients
  - Cognitive impairment is common

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Schizophrenia in the Older Adults

- **Challenges in the Elderly:**
  - Higher sensitivity to antipsychotic side effects
  - Coexisting dementia, physical illness
  - Medication non-adherence
- **Management:**
  - Low-dose antipsychotics (e.g., Risperidone, Olanzapine)
  - Psychosocial support, family involvement
  - Role of physiotherapy: promote routine, reduce agitation through physical activity

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Delirium in the Older Adults: A Medical Emergency

- **Definition:**
  - Acute, fluctuating disturbance in attention, awareness, and cognition
  - Rapid onset, often reversible if promptly treated
- **Common Causes** (Mnemonic: “I WATCH DEATH”):
  - Infections (e.g., UTI, pneumonia)
  - Withdrawal (alcohol, medications)
  - Acute metabolic issues (e.g., hypoglycaemia)
  - Trauma (e.g., falls, head injury)
  - CNS pathology (e.g., stroke, tumour)
  - Hypoxia, electrolyte imbalance, medications

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Delirium in the Older Adults: A Medical Emergency

- **Types of Delirium:**
  - Hyperactive: Agitation, hallucinations
  - Hypoactive: Lethargy, confusion (often missed)
  - Mixed: Fluctuating between both
- **Assessment Tools:**
  - Confusion Assessment Method (CAM)
  - Mini-Cog, Delirium Observation Screening Scale (DOSS)

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Delirium in the Older Adults: A Medical Emergency

- **Management:**
  - Treat the underlying cause
  - Ensure hydration, nutrition, and pain control
  - Orienting environment, minimise restraints
  - Avoid antipsychotics unless the patient is severely agitated

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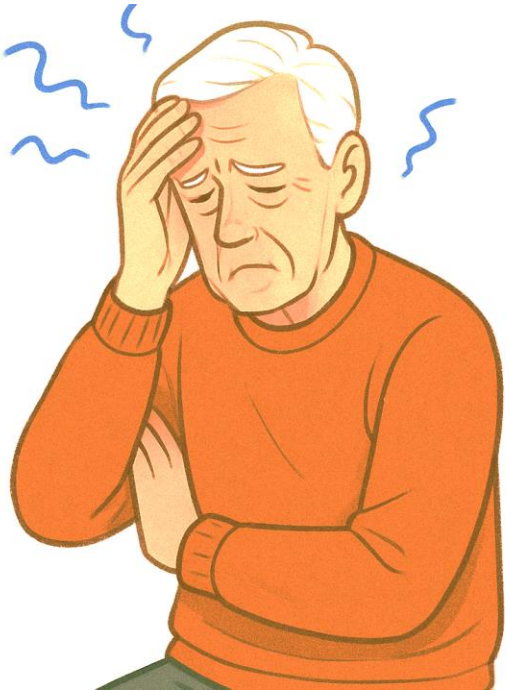
Anxiety in the Older Adults

- **Prevalence:** 10–20% in older adults; often coexists with depression or physical illness
- **Common Types:**
  - Generalized Anxiety Disorder (GAD): Chronic worry, muscle tension
  - Panic Disorder: Sudden intense fear, palpitations
  - Phobias: Including fear of falling or being alone
  - Obsessive-Compulsive Symptoms (less common in late life)



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Anxiety in the Older Adults

- **Clinical Features:**
  - Excessive worrying, restlessness, fatigue
  - Poor sleep, palpitations, dizziness
  - May present as vague somatic symptoms
  - Often exacerbated by cognitive decline or chronic illness
- **Assessment:**
  - Geriatric Anxiety Inventory (GAI)
  - Hamilton Anxiety Rating Scale (HAM-A)
- **Management:**
  - Non-pharmacological: CBT, relaxation therapy, breathing exercises
  - Pharmacological: Low-dose SSRIs (caution with benzodiazepines)
  - Physiotherapy Role: Guided breathing, progressive muscle relaxation, physical activity

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Sleep Disturbances in Older Adults

- **Common Types of Sleep Disorders:**
  - Insomnia – difficulty initiating or maintaining sleep
  - Sleep Apnoea – disrupted breathing during sleep
  - REM Sleep Behaviour Disorder – acting out dreams, vivid movements
  - Restless Legs Syndrome – discomfort in legs relieved by movement

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Sleep Disturbances in Older Adults

- **Contributing Factors:**
  - Age-related circadian rhythm changes
  - Polypharmacy and side effects
  - Chronic pain, depression, anxiety
  - Poor sleep hygiene and inactivity
- **Consequences of Poor Sleep:**
  - Daytime fatigue and falls
  - Cognitive decline and mood disturbance
  - Increased risk of cardiovascular and metabolic diseases

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Sleep Disturbances in Older Adults

- **Management Strategies:**

  - Sleep hygiene education (fixed routine, light exposure)
  - Treat underlying conditions (e.g., sleep apnoea with CPAP)
  - Encourage physical activity and daytime engagement
  - Avoid sedatives; consider melatonin where appropriate

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Elder Abuse

- A Hidden but Critical Determinant of Mental Health
- Definition: Any act of commission or omission that causes harm or distress to an older person
- **Types of Abuse:**
  - Physical abuse – hitting, restraining
  - Psychological/emotional abuse – threats, humiliation
  - Financial exploitation – misuse of assets
  - Neglect – failure to meet basic needs
  - Sexual abuse – non-consensual sexual contact

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Elder Abuse

- **Risk Factors:**
  - Cognitive impairment (e.g., dementia)
  - Physical dependence
  - Social isolation
  - Caregiver stress or substance abuse
- **Consequences:**
  - Depression, anxiety, PTSD
  - Functional decline, increased hospitalization
  - Premature death

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Elder Abuse

- **What You Can Do**

  - Be observant for unexplained injuries, withdrawal, poor hygiene
  - Know local reporting mechanisms and legal obligations
  - Multidisciplinary approach: medical, social work, legal
  - Empowerment through education and support

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Managing Mental Health in the Older Adults

- **Biopsychosocial Model**
  - Integrates biological, psychological, and social factors
  - Prioritizes patient-centred, individualized care
- **Multidisciplinary Team Involvement:**
  - Physicians & Psychiatrists – diagnosis, pharmacological management
  - Nurses – monitoring, emotional support, medication adherence
  - Physiotherapists – mobility, exercise, relaxation techniques
  - Occupational Therapists – ADL training, home adaptations
  - Social Workers – support services, legal protection, caregiver support
  - Caregivers & Family – continuity of care, communication

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Managing Mental Health in the Older Adults

- **Physiotherapy-Specific Contributions:**

  - Encourage physical activity to improve mood and cognition
  - Structured routines to reduce agitation and anxiety
  - Fall prevention and functional independence
  - Empower patients through movement and engagement

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Key Takeaways: Mental Health in the Older Adults

- Mental health issues in older adults are common, often underrecognized, and significantly impact quality of life.
- Dementia and Alzheimer's disease are leading causes of cognitive decline; early identification and support are essential.
- Depression, sometimes with hallucinations, is a major contributor to disability and is often misinterpreted as physical illness.
- Schizophrenia, delirium, anxiety, and sleep disorders also present unique challenges in late life.
- Elder abuse must be screened for vigilantly—it worsens psychological outcomes and physical morbidity.
- A holistic, multidisciplinary approach is the gold standard, with physiotherapists playing a vital role in mental health promotion and rehabilitation.

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