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Commentary

Psychological Status of Elderly

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DESCRIPTION

The mental status examination of the older psychiatric patients is central to the diagnostic work up. Many aspects of this examination can be assessed during the history taking interview.

Appearance may be affected by the older patients psychiatric symptoms, cognitive status, patient with dementia may not be able to match clothes or even put on clothes and environment.

Affect and mood usually can be assessed by observing the patient during the interview. Affect is the feeling tone that accompanies the Patients cognitive output. Affect may fluctuate during the interview; however, the older person is more likely to have a constriction of affect. Mood, the state that underlies overt affect and is sustained over time, is usually apparent by the end of the interview. For example the effect of a depressed older adult may not reach the degree of dysphoria seen in younger persons, yet the depressed mood is usually sustained and discernible from beginning to end.

Psychomotor activity may be agitated or retarded. Psychomotor retardation or underactivity is characteristic of major depression and severe schizophrenic form symptoms, as well as of some variants of primary degenerative dementia. Psychiatrically impaired older persons except some who advanced dementia are more likely to show hyperactivity or agitation. Those who are depressed will appear uneasy move their hands frequently, and have difficulty remaining seated through the interview. Patients with mild to moderate dementia, especially those with vascular dementia, will be easily distracted, rise from a seated position and or walk around the room or even out of the room. Pacing is often observed when the older adults is admitted to a hospital ward. Agitation usually can be distinguished from anxiety the agitated individual does not complain of a sense of impending doom or dread. In patients with psychomotor dysfunction, movement generally relives the immediate discomfort, although it does not correct the underlying disturbance. Occasionally, the older adult with motor retardation may actually be experiencing a disturbance in consciousness and may even reach an almost stupors state. The patient may not be easily aroused but when aroused he or she will respond by grimacing or withdrawal.

Perception is the awareness of objects in relation to each other and follows stimulation of peripheral sense organs. Disturbances of perception include hallucinations that is false sensory perceptions not associated with real or external stimuli. Hallucinations often take the form of false auditory perceptions, false perceptions of smell, taste and touch. The older patient who is severely depressed may have frank auditory hallucinations that condemn or encourage self-destructive behaviour.

Disturbances in thought content are the most common disturbances of cognition noted in older patients with psychosis. The depressed patient often develops beliefs that are inconsistent with objective information obtained from family members about the patients abilities and social resources. Older patients appear less likely to expertise delusional remorse, guilt or persecution. Even if delusions are not obvious, preoccupation is closely associated with obsessional thinking or irresistible intrusion of thoughts into the conscious mind. Although the older adult rarely acts on these thoughts into the conscious mind. Although the older adult rarely acts on these thoughts compulsively, the guilt provoking or self-accusing thoughts may occasionally become so difficult to bear that the person considers, attempts or succeeds in committing suicide.

Disturbances in thought process accompany disturbances of content. There may be problems with the structure of associations, the speed of associations and the content of thought. The older adults who is compulsive or has schizophrenia may pathologically repeat the same word or idea in response to a variety of probes as may the patient who has primary degenerative dementia. Some older adults with dementia have circumstantially that is the introduction of many apparently irrelevant details to cover a lack of clarity and memory problems. On other occasions, elderly patients may appear incoherent with no logical connection of their thoughts, or they may produce irrelevant answers. The intrusion of thoughts from previous conversations into a current conversation is a prime example of the disturbance in association found in patients with primary degenerative dementia, such as dementia of Huntington's disease. However in the absence of dementia even paranoid older adults do not

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generally show a significant disturbance in the structure of associations.