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Editorial

Meet Our Challenge: Why a Broadly Encompassing Paradigm in Psychogeriatrics Is Essential

Mental disorders and illnesses in old age are not an inescapable fate, particularly if physicians can look beyond the medical aspects of an illness to the potential interpersonal, familial, and social influences. Indeed, the different factors involved in the genesis of mental disorder intertwine to form an intricate network, from which it is very difficult to isolate single components. Moreover, the importance of the components that trigger an acute mental disorder and shape the course and diversity of the symptomatology can continue to change. The interweaving of different pathogenic factors contributes further to the diversity and ambiguity of the clinical symptomatology.

Given the multifactorial genesis of mental disorder, a multidimensional diagnosis is then required. Early recognition is essential, and the search continues concerning the appropriate diagnostic instruments to facilitate the diagnostic process.

A clinically recognizable pattern of disorder characterizes mental breakdown in the elderly. Where a disorder is complicated by disability, some assessment of the severity of this disability, its progression over time, and its response to treatment may then overlap the clinical presentations from a different illness. To add to the complexity, the presentation of symptoms of one disease may be modified by the presence of another disease. In fact, geriatric symptoms may be overdiagnosed, because it is not always possible to relate symptoms to one diagnosis in the presence of coexisting illness and multiple treatments.

Consider the chronically ill patient who is unable to walk, is plagued by pain, and is dependent on social assistance, walking aids, and architectural changes to his home. He can be helped to walk again by a prosthesis. Without the prosthesis he will continue to be unable to walk, to be dependent on help from others, to have limited social contacts, and, possibly, to remain isolated at home. A long-term inability to walk could then lead, via a chronic pain syndrome, to dependence on painkillers, which in turn can lead to other much greater dangers for the patient. Certainly, a carefully planned strategy for intervention is necessary.

Thus, prior to defining any rational therapeutic approach for the elderly patient, identification of all factors that may compromise function and adaptation is required. This involves the traditional process of diagnostic evaluation within the somatic and psychopathological dimensions, as well as recognition of the poten-

tial role of psychological factors in modifying the presentation of symptoms. The objective of this kind of assessment is to differentiate nonspecific and overdiagnosed symptoms from specified target symptoms and to formulate an individualized multidimensional treatment plan.

In the last decade, physicians—especially geropsychiatrists and psychologists—have approached the problems of measuring cognitive decline in a number of ways, with varying success. One such attempt has been to devise a definitive test for dementia that will assist the clinician in the differential diagnosis of, for example, depression complicated by cognitive impairment. A second approach has been to examine individual symptoms of dementia using either psychometric techniques or contemporary theories of information processing in an attempt to extend knowledge of the nature of these symptoms. The final approach has been to study patients' functional capacities. It has been suggested that the search for clinically useful tests has led to a concentration on relatively crude measures of dysfunction, which might be insufficiently sensitive to detect important changes in function. It is clear that further research is needed to understand the whole process in more detail. This kind of extended investigation should encompass abnormal and pathological changes, but should tap all available sources of information to give the most comprehensive picture of the patient's abilities as possible. Of course, we are interested first in areas of deficiency, but information and understanding of intact function and potential resources and skills are also relevant. Data concerning the progress of deficits over time and the development of new resources and capacities for patients undergoing treatment are important and worthy benefits derived from the application of these tests of activities of daily living.

Yet, there remains an obvious need for standardization of methods measurement; it seems unreasonable that there should be dozens of rating scales and psychological tests that differ only in minor details. How, then, is standardization to be realized? The problems and difficulties involved in achieving common measurement methods are much more complex than first believed. In fact, it has been suggested that this search is akin to the medieval alchemist's search for the philosopher's stone, with little likelihood of success. Let us hope that our efforts will prove to be more fruitful.

Still, there is a need for more specific and more comprehensive multidimensional research in psychogeriatrics, in clinical gerontopharmacology, and in gerontopharmacotherapy. Specifically, in the cognitive aging literature it is clear that a number of processes and affective, environmental, and individual difference variables could profoundly influence cognitive and memory performance. Neuropsychological and cognitive assessment designed to evaluate subtle changes must take into account these variables in a multivariate approach. In addition, assessment of the efficacy of pharmacological agents that purport to exert facilitative effects on cognitive functioning in the elderly could improve the sensitivity of cognitive assessment pertaining to drugs or other types of intervention.

Many of the psychometric tests available today have the disadvantage that their validity is still disputed, that they lack sensitivity when it comes to detecting milder forms of organic brain syndromes, and that they are of very limited use in

the advanced stages of dementia. Another disadvantage is that they never portray the organic deficits to their full extent, either measuring only individual functions, or presenting the qualitative structure of intellectual degeneration, as far as the given composition of the battery of tests allows. Reliable results can come only from a multidimensional analysis of cognitive and functional performance and behavior that uses psychometric methods to arrive at a uniform record of as many disturbances as possible. This analysis must fulfill the conditions for the application of correlative statistical methods.

Suitable therapeutic strategies rely on a holistic concept, however. The genuine communication that is critical to a truly successful treatment may be overlooked in the atmosphere of the physician's sterile examining room, in the depersonalized hospital, and among abundant, ubiquitous technical devices.

A holistic view of the patient must rediscover the dimension of communication, without which the therapy remains only fragmentary. We still have no paradigm that points the way to the future, yet we continue to develop ever better and more expensive forms of first aid against disease. This is, in effect, firefighting medicine—the damage caused by the water can be far worse than the original sources of fire.

In the next 20 years the drastic increase in mental and physical diseases of the elderly will underscore all over the world the need to adjust our present health system and services. Diagnosis, treatment, and rehabilitation must be seen ever more cogently as a multidisciplinary task, whose strategies are based in a new theoretical framework. Their standards will be derived from a theory of social action, without which they could not measure up to the challenges of tomorrow's world.

It is an old maxim that the whole of something cannot be understood if the parts are not understood, and vice versa. How many of us are contributing to the knowledge of the parts and how many to the knowledge of the whole? How can we understand our own scientific work concerning the parts if we are not contributing toward, or even interested in, the whole? Finally, how much can we change both diagnostic and therapeutic possibilities for the better if we ourselves try to find a multidimensional vision—in which the pieces of our knowledge are integrated elements of a unit?

We believe that a multidimensional vision comprising integrated elements is the expression of a new theoretical framework in the concept of medicine. It is the beginning of a new paradigm in clinical and scientific psychogeriatrics.

Prof. Dr. med. Manfred Bergener, Editor

Erratum

In the report *Aging-Associated Cognitive Decline* by Raymond Levy, MD, PhD, FRCPsych (Vol. 6, No. 1, 1994, pp. 63-68), on p. 63, we regret that the name of Dr. Tim Corn (Glaxo, U.K.) was omitted from the list of members of the International Psychogeriatrics Association Working Party in association with the World Health Organization. Dr. Corn contributed fully in the discussions leading up to the report and his role was greatly appreciated.

—Raymond Levy