LETTERS TO THE EDITOR

Psychiatric Disorders in Patients Attending an Outpatient Memory Clinic

Dear Editor

Deficits of memory and other cognitive functions in the elderly patient may indicate a variety of internal somatic, neurological or psychiatric disorders. Numerous organic disorders are known to cause cognitive deficits. In contrast, most studies mention only major depression as the single functional cause. We examined the psychiatric diagnoses of 430 consecutive outpatients attending the memory clinic (MC) of Maastricht (average age 61.7 ± 15.8 years). Every patient underwent a structured neuropsychiatric and neuropsychological examination according to the standardized diagnostic procedure described elsewhere (Verhey et al., 1993). Psychiatric conditions, including dementia, were diagnosed according to the criteria of the DSM-III-R (American Psychiatric Association, 1987). Hundred-fifty-two patients (35%) fulfilled the DSM-III-R criteria for dementia, whereas 175 (41%) patients had cognitive deficits but no dementia. Seventy-seven patients (18%) had mere subjective complaints about memory, not objectifiable by the neuropsychological test battery. Distribution among the diagnostic categories on axis III of the DSM-III-R was as follows: 1) primary degenerative (Alzheimer’s disease); n = 91; 2) cerebrovascular disorder; n = 60; 3) other neurological causes (e.g. epilepsy, head trauma, Parkinson’s disease, Huntington’s disease); n = 93; 4) internal-somatic (e.g. drug side-effects, alcohol abuse); n = 24; 5) no diagnosis on Axis 3: n = 132; 6) diagnosis unknown: n = 27.

Table 1 shows a matrix of the psychiatric diagnoses on axes I and II (rows) and the different axis III categories (columns). An organic mental syndrome was diagnosed in 189 (44%) of the patients, whereas a non-organic diagnosis by DSM-III-R was made in 152 patients (35%). The remaining 89 patients did not have a psychiatric diagnosis.

Psychopathology in patients with organic mental syndromes

152 patients had dementia; in 53 of them the dementia was complicated by additional psychopathology; 34 of these patients had depressive symptomatology, whereas 19 had various other psychiatric disorders. In 37 patients, an organic mental syndrome other than dementia was diagnosed; 16 of them suffered from an organic mood syndrome, while 21 patients had another organic behavioural syndrome.

Psychopathology in patients with non-organic mental syndromes

152 patients received together 159 non-organic DSM-diagnoses. This involved depression and dysthymia in 38% and 25% of the patients respectively. Various other diagnoses were made in 59 patients (38%). This especially involved adjustment disorders, personality disorders and anxiety disorders.

Thus, although depression formed the greater part of the psychiatric diagnoses of the group that was studied, memory complaints also occurred together with many other psychiatric conditions. On the whole, affective disorders, including dysthymia, formed not more than 60% of all psychiatric conditions.

In several reports on the causes of memory disorders, depression is mentioned as the single psychiatric cause. However, MC’s differ among themselves in the reference pattern, specific goals and diagnostic approach, which influences the diagnostic outcome. The Maastricht MC partly functions as a tertiary reference centre; about half of the patients had been referred by medical specialists. There are no self-referrals. Some MC’s show quite a few self-referrals (Philpot and Levy, 1987; Almeida et al., 1993), whereas the majority of patients from other MC’s had usually been referred by general practitioners (Cammen et al., 1987; Erkinjuntti et al., 1987), or by medical specialists (Larson et al., 1984). Moreover, studies differ substantially with regard to the mean age of the patients (varying from 57.7 years (Larson et al.,
Table 1. Relationship between psychiatric diagnoses (on axes I and II of the DSM-III-R) (American Psychiatric Association, 1987) and physical disorders (axis III), N = 430

<table>
<thead>
<tr>
<th>Diagnosis on axes I and II</th>
<th>Primary degenerative (n = 91)</th>
<th>Cerebrovascular (n = 60)</th>
<th>Aetiological category of axis III</th>
<th>Internal- somatic (n = 24)</th>
<th>No diagnosis* (n = 132)</th>
<th>Unknown (n = 27)</th>
<th>Total (n = 430)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No diagnosis on axis I or II</td>
<td>1</td>
<td>12</td>
<td>34</td>
<td>7</td>
<td>15</td>
<td>20</td>
<td>89</td>
</tr>
</tbody>
</table>

*No diagnosis on axis III specified.

Organic mental disorders

Dementia,
— uncomplicated
— with depression
— with delusions
— with delirium
— with anxiety
— with behavior, disord.
— with obsessions
Org personality syndr.
Org mood syndr.
Org delusional syndr.
Delirium

Functional mental disorders

Depression
Dysthymia
Adjustment disorder
Personality disorder
Anxiety disorder
Phobia/OCD
Dyslexia
Mental retardation
Somatoform disorder
Psychosis

1984) to 75 years (Bayer et al., 1987) and the proportion of patients with dementia (varying from 51% (Philpot et al. Levy, 1987) to 94% (Larson et al., 1984)). In the Maastricht MC, the average age was 61.7 years, and only 35% of the patients fulfilled the criteria of dementia, reflecting that the MMC is a memory clinic, not a dementia clinic.

Additionally, variation between MC’s could be explained by differences in the way the assessment was carried out. The psychiatric evaluation in some MC’s is restricted to checking whether symptoms of depression are present or not (Cammen et al., 1987), or psychiatric evaluation only takes place when other specialists suspect depression to be present (Erkinjuntti et al., 1987). In other MC’s including the Maastricht MC, assessment is carried out by an Old Age-psychiatrist (Philpot and Levy, 1987; Verhey et al., 1993).

Thus, it is plausible that the relatively high number of patients with depression and the low number of patients with non-affective psychiatric disorders could result from an incomplete psychiatric examination. This would probably lead to an underestimation of the prevalence of non-affective psychiatric disorders and, as a consequence, potential possibilities for treatment will be used inappropriately. Therefore, psychiatric assessment of patients with memory disorders should not be restricted merely to looking for depressive symptoms.

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REFERENCES

Dear Editor

Professor Mann’s suggestions (Int. J. Geriatr. Psychiat. 10, 87–91) deserve a serious debate. Old age psychiatry is coming through its ‘pioneering’ stage and the time is ripe to consider where we are going next.

There is nothing biologically special about the age of 65. Nevertheless, it represents a convenient social divide and has clinical utility for three main reasons: the increasing prevalence of dementia, the changing social circumstances of those beyond retirement age and the increasing frequency of concurrent physical and mental illness. All of these have organizational and training implications. Professor Mann’s points about the needs of younger people with dementia and the need for flexibility in handing over patients with functional mental illness are well made but do not detract from the fundamental utility of having an age cutoff at or around 65 years.

Old age psychiatrists have been praised for their community and catchment area orientation and Professor Mann’s suggestion that we should pay even more attention to the community is welcome. Getting research money to study whether by reducing the general burden of depression in the community we can reduce the number of people with more severe depression is indeed worthwhile. However, the interventions may have to be more complicated than simply providing befrienders! A major problem here is the continuing dearth of academic sessions in old age psychiatry. In my own university, for example, there are no full-time academic posts in old age psychiatry and the amount of work that can be done by two ‘NHS’ senior lecturers with only three academic sessions each is strictly limited.

‘Integrated’ is a nice word, but ‘exclusive’ has negative connotations. In old age psychiatry, ‘integrated’ is often used to denote the way in which services provide a ‘seamless’ continuity between hospital and community care with close networking with social services, geriatric medicine and general practice. This kind of service probably works best on an age-related basis and is in no sense ‘exclusive’ since the needs of younger carers are often an important focus for concern and action. Outcome studies are indeed rare, but a special problem in old age is relating outcome to particular service interventions. Again, we desperately need more research and development work—but to get the funding for that we need more academics in the field.

Thank you for printing this stimulating paper. The British management ‘guru’ Sir John Harvey Jones reminds us that without change nothing is possible and not to change is to face extinction. I hope that there will be a real debate about the direction old age psychiatry should be taking and that the money to enable research for change will be found.

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Psychotic Symptoms After Benzodiazepine Withdrawal

Dear Editor

The use of benzodiazepines in the elderly is known to be widespread (Closser, 1991). All problems associated with benzodiazepines and their withdrawal are proportionally greater among the elderly, although most literature on the subject is based on an adult population. Thomas (Thomas et