CHAPTER 15
THE COGNITIVELY IMPAIRED PATIENT

Cognitive impairment affects millions of people, and this number continues to rise as people live longer and survive increasingly severe illnesses. Sophisticated imaging and laboratory evaluations have allowed for a deeper understanding of such syndromes as dementia and delirium, but these remain clinical diagnoses that are made on the basis of the interview. Although the diagnosis may be obvious, many cases are subtle enough to be missed by the family and clinician. Furthermore, few patients spontaneously complain about either the gradual cognitive decline of dementia or the acute confusion of delirium. These factors contribute to a 3-year diagnostic delay in the typical patient with Alzheimer's disease and to the reality that most cases of hospital-based delirium are never recognized by the treating staff.

Cognitive impairment strikes at the core of how we define ourselves. Memory loss, inattention, disorientation, environmental misperceptions, behavioral dyscontrol, and mood lability tend to accompany cognitive impairment, and this constellation of symptoms induces powerful feelings of being overwhelmed. These same symptoms undermine the patient's ability to participate effectively in social and health-related situations, leading to a psychological and financial drain on all who care for the patient. Effective interventions with the cognitively impaired patient require not only the ability to diagnose and treat but also facility with interview techniques that differ from those used with most other patients. Such interventions can be singularly useful not only to the patient but also to the family and medical staff. In this chapter, two prominent types of cognitive impairment are explored: delirium and dementia.
PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Delirium

Delirium is an acute confusional state that can present with any level of activity, from severely agitated to quietly mute. Careful assessment of the delirious patient will detect problems with arousal, attention, orientation, perception, cognitive function, and mood, but most cases of delirium will be suspected by a confused look in the patient’s eyes or by speech that is uncharacteristically garbled. Clouding of consciousness tends to fluctuate throughout the day, frequently worsening at night. Although uncommon in a typical outpatient psychiatric practice, delirium is found in 15% of hospitalized adults.

Some delirious patients present with increased activity. Such activity is often related to substance withdrawal or intoxication, and these hyperactive patients tend to be quickly recognized. Many others present with either a hypoactive delirium or a mixed state in which the activity level fluctuates over the course of the delirium. Quiet confusion is often seen in patients who have recently had surgery or who are in the intensive care unit, have a terminal illness, or are battling illnesses of any severity within the context of a dementia. Under these circumstances, hypoactive delirium is usually unrecognized. When the medical staff and relatives do notice that the patient appears “out of it,” there is a tendency to “psychologize” this neurological dysfunction as a response to a serious biopsychosocial stressor. In such cases, the patient often receives diagnoses such as depression, apathy, or a catastrophic reaction to bad news. At other times, the patient receives no formal diagnosis but instead prompts the casual use of euphemisms. For example, the term sundowning stems from the frequent finding that the behavioral dyscontrol of delirium and dementia tends to worsen at night. Similarly, the term ICU psychosis is used because delirium occurs frequently among the very ill in intensive care units. By normalizing delirium, both terms diminish the motivation to search for etiology.

The search for etiology is important because the onset of delirium is frequently the first sign of a serious medical condition. Delirium can be precipitated, for example, by infection, medications, cancer, trauma, or metabolic abnormalities. Drug and alcohol intoxication and withdrawal frequently cause delirium. In the patient with dementia, a superimposed delirium can be induced by something as simple as a fever, anemia, or prolonged confinement to bed. Within a psychiatric population, antipsychotic medications can cause a delirium called neuroleptic malignant syndrome, whereas selective serotonin reuptake inhibitor...
antidepressants can cause a serotonin syndrome. The single best treatment for these iatrogenic disorders is prompt discontinuation of the offending psychiatric medication. Although delirium is generally considered to be acute and self-limited, all such confusional states are likely to continue as long as the underlying cause remains untreated. Underdiagnosis can lead to complications such as aspiration pneumonia, falls, and bedsores and can also exacerbate emotional distress in the patient and his family.

There are a number of difficulties in the diagnosis of delirium. Although classically of acute onset, the history may be difficult to elicit, especially if the patient is not accompanied by an observant caretaker. Delirium is generally time limited, but it can last indefinitely, especially in terminal illness, coexisting dementia, and complicated drug and alcohol withdrawal. Because fluctuating symptomatology is a core aspect of delirium, and symptoms tend to worsen at night, the daytime interviewer may underestimate the patient's problems. The underdiagnosis of delirium frequently stems from the reality that quiet confusion does not generally warrant a thorough interview until either the family becomes worried or the patient is unable to sign an informed consent form.

Although it has a medical cause, delirium is also a psychological disorder. Social isolation and sensory deprivation increase the risk for delirium in at-risk patients, and hospital-based psychosocial interventions have been shown to reduce the incidence of delirium in the elderly. Interventions can, therefore, reduce diagnostic and treatment delays, medical complications, and hospitalization lengths of stay.

Equally as important, the experience of delirium is upsetting to the patient and everyone involved in his care, including relatives and medical staff. When the delirium is recalled weeks later, the patient is often haunted by memories. In addition to possible medical interventions, the identification and explanation of delirium can significantly reduce the anxiety surrounding the experience.

Clinical Presentation

A delirium prodrome is often recognized first by the nurse or family member who appreciates subtle personality change and sleep problems well before the development of overt cognitive deficits. For example, it is common for family members to notice that their loved one “just doesn’t look right” a day or two before the patient becomes more obviously delirious. Similarly, family members will often notice that even though the patient has improved enough to be discharged from the hos-
Hospital, it may take several weeks or months before he fully recovers.

Once the delirium has developed, the patient may appear quite normal for periods of time only to relapse recurrently to states of agitation, confusion, or stupor. This is not necessarily accompanied by drowsiness, and in fact the delirious patient is frequently hypersensitive to environmental stimuli. The speed with which he recognizes others may be slowed, and he tends to appear perplexed or confused. When the interviewer looks at a delirious patient, it often appears that “no one is at home.” Affective changes are often prominent, and irritable dysphoria is common. These personality changes often elicit the greatest concern in the family.

The loss of cognitive powers is reflected by the heightened effort required to perform routine intellectual chores. The patient has particular difficulty with abstract thought, performing better with concrete problems. Mild degrees of perseveration are reflected in slowness and an inability to shift easily from one topic to another. Inattentive and disoriented, the patient first loses awareness of the date and may also fail to recognize the place or the situation. It is fairly common to meet with a quietly delirious patient who appears bewildered and who, despite the presence of white-coated doctors and beeping ventilators, believes he is at home and that it is 1996.

Many delirious patients have perceptual abnormalities. These may begin with the complaint that noises seem too loud or that other sensory stimuli are annoying. Many delirious patients prefer to speak with their eyes shut or in a darkened room. This reflects their difficulty with editing out extraneous environmental cues, as though the world is too much with them. This leads to misperceptions of noise, conversations, or shadows. It is common for delirious patients to see bugs crawling on their turned-off television and to wonder about the people who are hanging from the hospital drapes. At times, this can have a distinctly paranoid flavor, but many delirious patients will calmly describe events that would generally be perceived as scary. For example, one patient described being kidnapped by neighbors after having been restrained by nursing staff, but he did so with equanimity. Some clinicians offer the distinction that the delirious patient usually misperceives by making the unfamiliar more familiar, whereas schizophrenic hallucinations worsen the feeling of alienation. The delirious patient often sees hospital personnel as relatives, for example, whereas the schizophrenic patient is more likely to see them as terrorists. Again in contrast to the schizophrenic person, the delirious patient is much more likely to experience visual and tactile hallucinations. Auditory hallucinations can occur and may be accompanied by poorly organized delu-
sions. It is often difficult to tease apart a hallucination in a confused, medically ill patient from an illusory misperception of a real experience. Such a distinction is far less important, however, than the recognition that the patient is delirious in the first place.

Dementia

As the population has aged, dementia has become increasingly important to the family members and health care professionals who care for dementia patients every day.

Dementia is a chronic syndrome of global intellectual deterioration, often accompanied by affective and personality changes. Dementia interferes with activities of daily living and is accompanied by a clear consciousness. There are dozens of underlying etiologies for dementia, and almost all of these are brain disorders that are irreversible and progressive. This chapter focuses on the most common dementia, Alzheimer’s disease, although the underlying principles are broadly applicable.

The brain has a remarkable ability to develop compensatory mechanisms, and the typical early Alzheimer’s patient functions well enough to avoid a dementia diagnosis for several years. Instead, the patient and his loved ones assume that the deficits are consistent with the mild cognitive impairment of normal aging. Despite months or years of warning signals, many families feel the dementia diagnosis as a sudden, severe blow. Most patients with dementia, meanwhile, bear the diagnosis with equanimity or even apathy.

Dementia is usually defined in contrast to other conditions. For example, in delirium, consciousness is clouded, whereas dementia patients are usually alert. The cognitive deficits in both mental retardation and traumatic brain injury tend to be stable, whereas dementia tends to progress inexorably. In practice, these contrasts are often obscure. Cognitive and behavioral problems may abruptly worsen during periods of stress and at night so that the dementia may not appear “stable” to caretakers. Furthermore, dementia patients are highly vulnerable to the metabolic and psychological stressors that can induce a delirium. When the delirium clears, the dementia patient may return to his previous level of functioning or may fall to a lower baseline level of functioning. These speak to the frequent confusion in differentiating acute from chronic brain syndromes.

Clinical Presentation

Cognitive impairments in dementia are wide-ranging and include the learning of new information, the naming of objects, and the ability to do
calculations. Abstraction, calculation, and visuospatial construction progressively decline and interfere with the patient's ability to function independently.

The patient with dementia often attempts to compensate for memory deficits by using descriptive phrases as substitutes for forgotten names. This might lead to circumstantiality in which the patient describes the hospital rather than naming it. A different patient might look around the hospital room and confabulate that he is in a hotel. It is not uncommon for patients to insist that staff members are relatives or that relatives are staff members. Patients often try to shut down the interview by claiming fatigue. They may truly be tired, but such insistence is often an attempt to dodge the embarrassment of having one's declining abilities exposed.

Although cognitive decline is central to the diagnosis of dementia, other neuropsychiatric symptoms often pose a greater threat to the dementia patient's autonomy and well-being. Poor insight and apathy are frequent, as is a passive disregard for himself and his loved ones. Although some dementia patients may become transiently hypersexual, most lose interest in sex as well as in sleep and food. Speech becomes impoverished, and the patient tends to rely on stereotyped phrases rather than spontaneous interchange. It may appear that all unique vitality has drained out of the person. This apathy should be differentiated from depression, which is also common in the dementia patient. The depression may seem to result from awareness of decline—especially early in the course—but most dementia patients are strikingly unworried about their situation. Instead, many dementia-related depressions seem related to neurological changes that are part of the underlying disease process.

Up to half of patients with dementia become delusional, focusing on such things as theft, persecution, and spousal infidelity. Hypochondriasis is frequent. Wandering, restlessness, hoarding, and even assaultiveness are not uncommon. Visual hallucinations and illusions occur, although auditory hallucinations are unusual. Many dementia patients become disinhibited and resistive. Dementia may appear to change personality so that a previously pleasant and refined elderly person may become verbally coarse, unreasonable, and labile. At other times, normal personality traits may become exaggerated. In one case, a mildly obsessive woman became relentlessly rigid and orderly as her dementia progressed. In another, an outgoing man became embarrassingly exhibitionistic and rude. Cognitive decline is painful for families, but it is these emotional and behavioral problems that tend to lead to family exhaustion and residential placement.
MANAGEMENT OF THE INTERVIEW

Cognitive decline affects the interview significantly. For example, few people with dementia or delirium complain of intellectual problems. They will rarely have requested to see a psychiatrist. They tend to lack cognitive and emotional flexibility. In the midst of one of life’s tragedies, the cognitively impaired patient tends to discuss not existential loss but the mundane. Although the interviewer should strive to create a predictable and quiet interview setting so as to calm the easily distractible patient, hospital settings can be unpredictably chaotic and public. Although the initial interview is generally intended to be diagnostic, optimal clarity is not achieved unless an alliance is created, and this alliance can be undermined if the interviewer too quickly seeks to formally evaluate cognition. As with other types of interviews, words remain important, but some observation of the patient is required to put the words into perspective.

The effective interview must take into account these inherent obstacles while also making use of this population’s strengths. Usually the patient and his relatives will not have a preexisting psychiatric diagnosis, for example, and so the treatment effort can be applied to the debilitating neurological process as well as to often mild neurotic issues. Conflicts and self-defeating behavior—found in both the patient and relatives—can often be readily and successfully addressed by the alert interviewer.

Finally, the interviewer should remain attentive to the reason for the interview. If another physician would like help with the management of acute agitation and confusion, it would be a mistake to gather only information related to family dynamics. Conversely, if two siblings have brought in a parent known to have dementia-related dyscontrol, it would be unwise to focus only on the exact extent of the patient’s decline. For these reasons, the patient with cognitive impairment warrants a flexible, supportive interview that is modified based on the extent and type of impairment.

The Opening Phase

The initial moments of the interview should be devoted to several overlapping tasks. A friendly attitude is important. Patients and relatives appreciate warm handshakes and brief introductions. While saying hello, the interviewer observes the patient and the surroundings, looking for signs of health and disturbance. Grooming and posture are important keys not only to the patient’s degree of cognitive impairment
but also to the availability and attentiveness of family. In addition, the psychiatrist should look for any signs of personal history that can later be used to gain an alliance or to better understand the patient. Tactful appreciation of photographs of grandchildren or a well-worn baseball cap can be the starting point for an alliance. During these opening moments, the interviewer must make some important decisions that are based on immediately available information. A well-dressed patient with a reportedly mild cognitive decline might want to talk about aging and loss and can best do so in private. The psychiatrist will generally ask relatives or attendants to step outside. A moderately impaired patient with dementia or delirium may profit most from reassurance and explanation that are delivered in front of loved ones. Severely affected people are often unable to communicate verbally with the interviewer, and so the interview is primarily conducted with caretakers. In many cases, the decision about the presence or absence of family members will be made by the family and patient. The risk of compromised confidentiality is often outweighed by the reassurance and clarification that can be provided by a well-meaning friend or relative. Furthermore, it is often useful for family members to witness effective styles of interaction and then to have their own concerns directly answered by the interviewer.

Most interviews with delirious patients occur in hospitals at the request of other physicians (see Chapter 17, “The Hospitalized Patient”). After deciding whether the family should be present and while observing the patient and situation, the interviewer identifies himself, carefully sounding out his own name. After reducing distraction and enhancing privacy by drawing curtains and turning off the television, the psychiatrist should try to position himself at eye level with the patient and explore the patient’s understanding of the reason for the consultation. “I am Dr. X. Did your doctor explain that I would be coming?” The physician guides his next response by the patient’s reply to this introduction. If the patient understands that he is being interviewed by a psychiatrist, the interviewer may proceed. If not, the interviewer should tactfully explain why he was consulted. For example, he might say, “I understand that you have been upset” or “Dr. Jones tells me that you have had some periods of confusion” or “Your doctor thought I could help with your nightmares.” The mildly impaired patient will then begin to discuss his problems, and the interviewer will follow the patient’s lead. If physical discomfort is the matter of greatest concern to the patient, the interviewer should spend some time discussing the chief complaint. The severely delirious patient is likely to be diagnosed as soon as the interviewer enters the room. In addition to the pursuit of
diagnosis, the interview with such patients can be therapeutic from the outset by providing structure and a tone of reassurance.

The interview with the dementia patient begins in a similar fashion, except that the patient is not as likely to be seriously medically ill. Again, someone other than the patient has usually requested help. Most often the patient is elderly and has been accompanied by a relative or friend.

Relationship With the Patient

Attitude of the Interviewer

Some interviewers may doubt the therapeutic value of a psychodynamic interview for patients with delirium or dementia. In talking to patients who are "out of it," the interviewer may want to concentrate on formal assessment of cognitive functioning. Even a patient who has significant confusion or dementia can, however, detect the interviewer's level of personal interest and respond to the doctor's respect, as does anyone else, by feeling reassured and becoming more cooperative. Patients with dementia and delirious patients need considerable support and will not react favorably to a physician who is aloof, distant, or overly neutral. Although a generally warm, interested, and friendly attitude is desirable, the interviewer may sometimes need to guide the patient firmly toward more socially acceptable or safe behavior.

Transference

Patients with mild organic impairment develop a transference that is primarily determined by their basic personality type. Patients with more severe disorders may relate to the doctor in ways that have more to do with their neuropsychiatric illness than with their lifelong character traits. The transference attitudes of these patients are not interpreted or worked through in their treatment. Nevertheless, recognition of the patient's attitudes can allow the interviewer to ally himself with the positive aspects of the transference. It might be useful, for example, for an interviewer to act parentally with a patient who is acting dependently, although it may be a challenge for a young interviewer to act parentally toward an elderly patient without sounding uncertain or patronizing. A common example is referring to an elderly patient using his first name. Other delirious patients and patients with dementia are mistrustful and frightened. It is useful to remember that such attitudes are often fed by confusion and that the interviewer should be straightforward, reassuring, and sober-minded.
Specific Techniques

Using Brief Interviews

A shorter interview is helpful if the patient fatigues easily. It may be better to see a patient several times in one day or on several successive days for 15-minute interviews.

Recognizing the Patient as a Person

After the patient’s initial spontaneous remarks, the clinician determines the chief complaint and a brief history of the present illness and then may direct attention to the patient’s personal background and current life situation. The patient with dementia is particularly dependent on recollections of past achievements and capabilities in order to maintain his self-esteem. Therefore, a review of the patient’s earlier life is not only informative for the interviewer but also therapeutic for the patient.

Allowing the Patient Time

Memory loss, circumstantiality, perseveration, and a lack of spontaneity can frustrate the interviewer. The patient should be given the chance to tell his story in his own way. If the patient is too disorganized to provide structure, the interviewer can help by asking direct, concrete questions. Impatience and overly rapid questioning can increase the patient’s disorganization.

Stimulating Memory Chains

The interviewer may be able to improve the patient’s recall by stimulating associative patterns. It is often useful, for example, for the interviewer to concisely summarize what the patient has said and to help him maintain continuity when the patient loses his place. When the patient stops in the middle of a thought and asks, “What was I just talking about?” the interviewer should repeat the patient’s words, thereby helping his concentration and focus. An empathic comment regarding how frustrating it must be to keep losing his place will be appreciated.

Speaking Clearly

The patient’s recollections will be enhanced by simple declarative sentences that focus on one topic at a time. Humor is generally inappropriate as a therapeutic maneuver, although it can help as a diagnostic measure: both delirious patients and dementia patients are likely to respond blankly to any sort of wordplay.
Aiding Reality Testing

Frequently, when a physician discovers that a patient is disoriented or confused, he permits the patient to give wrong answers without any attempt to provide the correct information. Instead, it is helpful to tactfully reorient the patient by providing the date and place and the name of the interviewer.

Taking Interest in Physical Complaints

Alliance is enhanced when the interviewer takes an interest in what most troubles the patient. After discussing these chief complaints, many patients will be more amenable to discussing psychological and cognitive issues.

Assessing for Self-Destructiveness

Delirious patients and dementia patients hurt themselves in several different ways. They are at greatly increased risk for falls and other types of inadvertent injury. Since their ability to perform activities of daily living is impaired, they may become malnourished, dehydrated, and noncompliant with medications. The evaluation for depression and suicidality is complicated by several factors. Depressions in geriatric patients are frequently atypical, and these patients may present primarily with, for example, a disorder of executive functioning or with somatic preoccupation rather than with sadness, diurnal variation, or self-criticism. Furthermore, delirious patients sometimes kill themselves impulsively and without ever having mentioned suicidality or depression.

The Mental Status Examination

The mental status examination is an important tool in the diagnosis of cognitive decline. The write-up of the mental status exam can loom so large to the interviewer that the entire assessment is transformed into a simplistic cognitive exam. Such an examination may yield much data but little information. For example, one interviewer spent the bulk of his interview administering the Mini-Mental State Exam. The 80-year-old patient performed quite well, missing only occasional questions. Since the patient was completely oriented and scored 26 out of 30 on the examination, the interviewer concluded that neither delirium nor dementia was present. In looking down at his form and not looking at the patient, however, the interviewer failed to notice the glazed, perplexed look in the eyes of the patient or the prolonged pauses and the exertion required to answer the questions. In this case, the patient’s very high
baseline cognitive functioning allowed for a reasonably good examination score despite the fact that she had significant delirium. In addition to missing the diagnosis, the interviewer did not recognize that the relentless questioning had led the patient to feel alienated, threatened, bored, and annoyed.

Observation of the patient lies at the core of the mental status examination, and such observation begins immediately upon entering the room. Is the patient awake, sleepy, alert, hostile, stuporous, depressed? The patient's appearance, effort, and level of interaction help to make sense of the rest of the mental status exam. Speech is a particularly revealing window into the patient's cognitive and emotional worlds. Does the patient lack fluency, pace, spontaneity? Are there errors of syntax or word choice? These may be clues to a smoldering delirium or subtle dementia and can be readily assessed during the course of the interview.

The patient with cognitive decline tends to have poor insight into emotional states. Observation of affect is critical, as is acquisition of collateral information from relatives and loved ones. When sadness is accompanied by significant guilt, hopelessness, or suicidality, the patient should be carefully evaluated for a treatable major depression. Hallucinations and delusions may be denied if the patient is asked directly. Instead, the interviewer should pay attention to clues that the patient is experiencing these phenomena during the interview. Is the patient picking at his skin or reaching into the air? Is the patient looking oddly at the television or the curtains? Is the patient unduly wary of the interviewer or of the interviewer's request to contact members of the patient's family? Some patients may respond freely when asked if they are suicidal, and all patients should be asked. The yield is greater, however, when the patient is also asked if life has become not worth living or if he ever gets so frustrated or scared that he feels like he might just have to end it all. Similarly, many patients who deny the desire to hurt someone will admit that there is someone from whom they have to protect themselves. Such questions are intended not simply to identify suicidality and homicidality but to tactfully elicit paranoia and depression.

The most commonly administered "test" within the mental status examination is orientation to time, person, and place. This is often best begun by asking about the situation, the fourth axis in the evaluation of orientation. For example, the interviewer can ask the patient what brought him to the hospital or to the psychiatrist's office. If the patient seems puzzled by that or any other relatively straightforward question, the interviewer might say, "It seems that you might be having trouble remembering things." If the patient responds, "Why do you say that?" the interviewer might say, "Whenever I ask a question that taxes your
memory, you change the subject. It seems that you might be having problems with your memory." Such a comment demonstrates that the interviewer understands the patient's situation, which can both increase the alliance and allow for an assessment of the patient's insight. The interviewer can then say he would like to ask a few questions about memory. Time is a sensitive measure of orientation and can be assessed by asking the date. One patient did not know the date or month, and when asked the season, she looked out the window to look for clues from the weather. The interviewer recognized that the patient was seeking clues from the weather and further clarified the extent of her confusion. The patient may try to deflect the question by saying that he had not been paying attention to such things, but tactful persistence will likely help the interviewer decide whether the patient lacks the knowledge because of cognitive decline or as a result of depression or oppositionalism. Orientation is, however, of limited usefulness. Many people with cognitive decline are fully oriented. Furthermore, disorientation can be caused by a range of difficulties related to inattention, memory, thought content, and language.

Bedside neuropsychiatric testing often focuses on memory, attention span, and concentration. Recall and short-term memory can be efficiently tested by asking the patient to repeat three objects immediately and then after a few minutes. Tests for attention and concentration are heavily affected by levels of education. For example, serial sevens are difficult for many medically ill and elderly people, so the interviewer should be quick to shift to a request for serial threes or repetition of the months backward. The Folstein Mini-Mental State Exam is useful in eliciting a host of such cognitive deficits, whereas the Clock-Drawing Test can provide a rapid estimate of executive functioning and constructional apraxia. If done as part of the routine assessment of at-risk patients, these tests are fairly quick and much more useful than simply inquiring into the level of orientation. They may also be useful in anticipating the potential for recovery and for following the patient's clinical course. The interview and collateral history, especially concerning home functioning, help put these tests into perspective.

Cognitive testing can have psychological significance. For example, when asked to spell "world" backwards, one elderly woman quickly recited "rawdlrow." This particular patient had become paranoid and noncompliant upon entering the hospital, and the medical team had been concerned about delirium or dementia. After hearing this repeated, the interviewer realized that the patient was spelling "World War" backward, which led to an extensive discussion of the patient's Holocaust experience. The patient was not at all cognitively impaired.
but was, instead, frightened by the institutional setting and her own medical illness and loss of control.

Much of the mental status examination can be performed with a patient who says almost nothing. For example, an interviewer approached the hospital bed of an elderly man who was hospitalized for pneumonia. She found him lying at a 45° angle with a sheet over his head. The interviewer began by saying, “It looks like you’re having a hard time. Would you like to tell me about it?” The patient lowered the sheet but remained quiet and fearful and kept his eyes squeezed shut. The interviewer continued by saying, “It looks to me like you may not be feeling safe.” The patient responded, “I’m OK.” The interviewer then said that it seemed like he might be feeling confused. The patient did not move. The interviewer then hypothesized that he was keeping his eyes shut because it was too hard to concentrate with all the lights and movement. The patient nodded. The interviewer asked what he was doing there, and the patient said he did not know. When asked where he thought he was, the patient said at home. The interviewer made a tentative diagnosis of delirium as soon as she saw the elderly patient lying diagonally in bed. This diagnosis was substantiated by the patient’s disorientation, fearfulness, inability to edit external stimuli, and apparent clouding of consciousness. The interviewer concluded the interview by telling the patient that it seemed that he had become confused because of the infection and that the team would work to get him back to his usual self. She continued by saying that she would prescribe medications to help him get to sleep that night and help him get his thoughts straight. These words appeared to comfort the patient. This brief interaction would be incomplete without corroborating personal and medical history, a review of the chart, and a discussion with the primary medical team, but a reasonable working diagnosis can often be rapidly acquired through observation of the patient.

The Physical Evaluation

The diagnosis of either delirium or dementia warrants a thorough medical evaluation that includes a physical and neurological examination, laboratory tests, and neuroimaging. More than perhaps any other psychiatric diagnoses, these syndromes require a search for the underlying etiology.

The Therapeutic Plan

Efforts to gain trust and cooperation may seem futile with patients who may forget you before your next appointment. Nevertheless, patients
and their families do recognize warmth, respect, and attention. Simple explanations and efforts at connection and reassurance can often be immensely therapeutic.

Successful resolution of delirium requires the maintenance of safety and treatment of the underlying medical problem. Low-dose antipsychotic medications are often warranted, especially as a means to ensure nighttime sleep. Clarification is important, both for the patient and for the family. For example, loved ones are often reassured by knowing that delirium has a generally favorable prognosis once the underlying medical problem is corrected. At the same time, delirium is often found in the terminally ill, and the job of the interviewer then includes counseling of both the patient and loved ones. The physician who realizes that his job is to improve, not necessarily cure, the patient's condition will be less likely to feel overwhelmed by the limitations created by the patient's disability or life situation.

People with mild dementia often profit from having a role in the family, such as chores and responsibilities in the home. Creative talents, avocational interests, and hobbies should be explored. The interviewer can demonstrate his interest by asking to see examples of work the patient has produced. Patients may want to discuss feelings of helplessness and vulnerability. Recognition and respect for the patient's pre-morbid accomplishments can have a substantial therapeutic effect. By carefully reflecting on the patient's life story, the therapist offers himself as a substitute or supplement for the patient's internalized lost love objects. This can yield significant benefits to the patient.

An 80-year-old man, who had retired 15 years earlier, moved in with his daughter and son-in-law after his wife died. The daughter noticed periods of confusion, irritability, and memory loss and brought her father in for an evaluation. After a medical workup and a psychiatric evaluation, the patient was diagnosed as having age-related cognitive decline. In addition, it appeared that the patient's main source of self-esteem during his retirement had come from dominating his wife. He attempted this same technique in his new home, but he met constant rebuff and failure. In one session he reported that his daughter had said to him, “Dad, would you please stop telling us what to do all the time?” The interviewer asked, “How did you feel?” The patient replied, “I was only trying to be helpful.” The interviewer continued, “But how did it make you feel?” The patient answered, “A little rejected, I guess. Maybe I'm a burden.” The interviewer reviewed several incidents with the patient in which he was trying to be helpful. It emerged that the patient was reminding his family of chores that needed to be done. The interviewer asked, “Were these chores that were done by your wife when she was alive?” The patient nodded, “Yes, now that you mention it.” The interviewer added, “Perhaps they feel that you are being critical or nagging.”
The patient looked pensive. The clinician asked, "Would you be willing to try an experiment for 2 weeks?" The patient agreed, and the interviewer continued, "Tell your daughter and son-in-law that you would like to make a bigger contribution around the house and do some of the household chores." The patient said that he would think about it and then went on to talk about how much he missed his wife. The therapist asked, "Do you discuss your feelings with your family?" The patient said that he did not. The clinician responded, "You are depriving them of the opportunity to comfort you."

The clinician's intervention stemmed from his view that the patient had regressed in the context of his mild cognitive decline and the loss of his wife. Instead of pitching in, the patient had sat idly by, expecting to be taken care of as he had been by his wife. Although his wife had been willing to accept his irritable domination, his daughter and son-in-law were uninterested in re-creating that particular dynamic. Instead, the three of them had recognized tension but had known no way to identify and address the problem. At the patient's request, the therapist relayed these ideas to the daughter, who picked him up from his weekly sessions. During the ensuing weeks, the patient and the daughter reported significant improvement both in the patient's mood and in the family's level of relaxed intimacy.

The Patient's Family

Cognitively impaired patients prompt more involvement with relatives than is typical for a psychiatrist. Not only is there much greater communication, but family members may end up making significant decisions about the patient, sometimes in conflict with the patient's expressed wishes. It is useful for the interviewer to have contact with these relatives early in the evaluation. Some relatives have difficulty recognizing and accepting the degree of impairment in their loved one and feel guilty about and fearful of institutional care. This guilt is sometimes openly discussed. At other times it is expressed in the form of hostility toward the medical staff. Other families resent the patient and look for any opportunity to get him out of the home. A large percentage of caregivers of Alzheimer's patients become depressed. One psychiatrist found that his most useful intervention with family members was to remind them that they needed to get out and enjoy themselves on a regular basis. In order to allow for such freedom, the psychiatrist may have to focus not just on family guilt but on the many behavioral interventions that can be used with people with dementia.

Countertransference

Patients with cognitive impairment can evoke avoidant, pessimistic attitudes in the interviewer. These stem from several related issues.
First, delirium and dementia affect insight, cognition, and memory, qualities that tend to be highly valued by interviewers. Therapists tend to want their patients to improve, and many of these patients will never recover. Whether subtle or dramatic, personality changes are generally found, and they may bear little relation to historical events or current stressors. This can be disconcerting to interviewers who have been trained to assume that personality is relatively enduring over time and that personality and mood changes tend to have some connection to internal or external events. Finally, the interview with the cognitively impaired patient may require expertise in neurology that is beyond that of the typical clinician. When evaluating a patient with cognitive impairment, the interviewer may experience dread when trying to recall the dozens of dementing illnesses and the hundreds of underlying causes for delirium. This potential complexity may lead many interviewers to avoid this increasingly sizable portion of the population. The attendant anxiety from being confronted by such a patient can de-skill even an experienced interviewer.

Other interviewers react very differently to this population. Often reacting to concerns about the aging of their own parents or of themselves, they may become intensely involved with their patients. This can lead to both professional satisfaction and anxious fatigue.

CONCLUSION

It may be difficult for the young, healthy physician to empathize with the delirious or demented person whose cognition is impaired and who may face a bleak, lonely future. The interviewer’s own uncertainty about treating this patient may be paralleled by that of the patient’s friends and family, who should be encouraged to visit, call, and surround the patient with newspapers, pictures, and other things that remind him that there is continuity to his life. In addition to family involvement, it is often very useful for such a patient to feel that the doctor is paying attention and lending a sympathetic ear. A clear formulation of the patient’s problem and life trajectory can help the patient feel loved and protected, thereby providing gratification for his dependent needs while also providing structure and perspective for his loved ones.
PART III

SPECIAL CLINICAL SITUATIONS