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The journal will accept studies that are usually described as original research, quality assurance, proof-of concept, theoretical reflections arising from meta-analytic reviews and theoretical reflections from case studies.

These could be submitted as regular articles, reviews or brief reports. This journal specifically solicits brief reports, which may involve preliminary results of ongoing research, clinical hypotheses, and front-line perspectives on rehabilitative care and treatment delivery.

Editor: J. D. Mendonça PhD, CPsych

Instructions for Authors

Manuscripts submitted for publication must follow the rules of APA Style® detailed in the *Publication Manual of the American Psychological Association*. For more details visit the [APA website](#).

Regular articles (not to exceed 4000 words) should contain the following sections: 1) Title page 2) Structured Abstract with Clinical Implications and Limitations, and Key Words 3) Body Text with Tables / Figures, References (as per APA style) and 4) Funding Support / Acknowledgements.

Brief reports (not to exceed 1500 words) may be submitted in the usual APA style or in two additional variations given below (while observing the APA citing and referencing style).

1) *Front Line Perspectives*

The submission would consist of a description of actual or prototypical cases ($n < 5$, from hospital or community settings, de-identified, with patient consent placed in the clinical file).

Sections: Abstract, Introduction, Case Review, Commentary, Conclusions.

2) *Clinical Hypotheses*

A hypothesis should include an organized structure of known facts and their real world impacts that are observable.

Sections: Abstract, Introduction, Hypothesis/Theory, Evaluation Pilot Data (if applicable), Clinical and Research Implications, Conclusions.

The editor may be approached for any unique manuscript variations required by the subject matter.

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Paranoid States in the Elderly

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Challenges in Geriatric Forensic Care - From Assessment to Community Reintegration



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Elders whose mental health difficulties put them into conflict with the law face unique challenges. The forensic mental health system, in its current form, primarily provides assessment and rehabilitation services for young adults with major mental illness (generally, schizophrenia or serious mood disorder). It is ill-equipped to provide appropriate services to the geriatric population. We review challenges faced by this population by following a fictional patient through the forensic mental health system. Particular challenges in the correctional system, forensic assessment services, rehabilitation, and eventual community placement are reviewed. More accessible environments, age-appropriate programming, access to specialized assessment services, flexible visitor policies, enhanced staff capacity, and long-term care partnerships are areas identified for further improvement.

A Prototypical Case

Vivian Page is a 92-year-old woman, accused of Second Degree Murder of her husband, Glen. She is an inpatient on the Assessment Unit in a forensic psychiatric hospital, waiting for her trial, where her legal team plans to raise the defence of Not Criminally Responsible on Account of Mental Disorder (NCR).

Vivian had a happy childhood in rural Ontario. She went as far as Grade 8 - typical of her peers in that era. She met Glen at 18 at a church barbeque; they connected in the choir, and married within a year. Glen was a farmer; despite some financial troubles, there were no problems in their relationship. She helped on the farm when she was not taking care of their 6 sons, who all grew up, married, and had children of their own. She was active and well-liked in her community. Despite her advancing age, she still helped organize the town fair every year.

In 2015, after the unexpected miscarriage of a great-granddaughter, Vivian suffered from a "mental breakdown." She told her family that the Devil was talking to her through the computer. She asked her pastor for an exorcism, who counselled her to visit the local hospital. She was admitted for a week; a psychiatrist diagnosed her as having a depression with psychotic features, and she was discharged on a small dose of antidepressant medication. Her symptoms resolved soon after, and her psychiatrist cautiously tapered her off medication before

discharging her back to her family doctor. Aside from some mild forgetfulness, none of her family had any other concerns about her mental health. Most of her children could barely recall the 2015 admission. Although her family doctor described her as unusually healthy for a woman her age, she had some vision and hearing problems, but took no medications. She suffered from osteoarthritis, required a walker to ambulate, and occasionally struggled with incontinence.

On Easter Sunday in 2021, Vivian and Glen visited a sons' family home for dinner. The son noticed "something was off." Vivian looked distraught, tired, and glanced nervously around the room. She had not gone to church that morning, and left the table during grace; she "barely picked at the food" after she returned. She told her daughter-in-law that she had seen Glen with "another woman last night" and made out-of-character remarks about witchcraft. Glen himself minimized the changes and said: "you know how your mother gets, the COVID is really getting to her" when approached by his son. They left shortly after dinner. At some point later that night, Vivian struck Glen in the head at the top of the stairs in their kitchen with a cast iron skillet, before calling 911. On the phone, she told the police between tears that she had been "attacked by a Devil" and that her husband was missing. Glen was dead when the police arrived at the scene.

Vivian was detained in jail for 6 weeks before being transferred to a forensic psychiatric hospital for a

court-ordered NCR assessment. She barely ate and made suicidal statements in jail, leading to her being placed on enhanced observation. When she was admitted to hospital, the forensic assessment team readily identified overt evidence of psychosis, including religious persecutory delusions and auditory hallucinations. She also presented as depressed, with poor sleep, anxiety, and a lack of appetite. Her cognitive assessment revealed some deficits – she scored 21/30 on the Montreal Cognitive Assessment (MoCA), for example. She refused to consent to head imaging. She continued to insist that she had not killed her husband, but that an imposter had entered her house, “some kind of demon,” which took on Glen’s appearance, intent on “destroying my faith.” She was diagnosed with depression with psychosis, and the court was informed that she likely had the defence of NCR available to her, based on her mental status at the material time.

Vivian’s story is a fictional case inspired by geriatric patients assessed in the forensic mental health system. Elders in the forensic system are atypical – the average NCR-accused individual in Ontario is in their mid-30s (Crocker et al, 2015). To our knowledge, no specific data exists regarding the number of geriatric patients supervised by the Ontario Review Board (ORB; the body that oversees NCR-accused individuals in the province). Geriatric forensic psychiatric patients struggle with several unique challenges across the forensic system.

Challenges in the Correctional System

Prior to admission to a forensic hospital for an NCR assessment, patients like Vivian are detained in correctional institutions, which were not designed with elders in mind. A recent investigation (Zinger & Landry, 2019) by the Correctional Investigator of Canada and the Canadian Human Rights Commission found that the health, safety, and dignity, and human rights of this vulnerable population are not adequately protected. The physical infrastructure of our institutions does not adequately meet the needs of incarcerated elders: the investigation found that even in some cells described as “accessible,” wheelchairs, for example, still could not pass through the doors.

Challenges in Forensic Assessment

Unique challenges can arise during the course of forensic assessment of geriatric individuals. Typically, serious charges, such as those Vivian faces, attract understandable scrutiny from the courts. Forensic psychiatrists often order psychological testing in such cases, to help clarify diagnosis or rule out the presence of malingering (deliberate feigning of psychiatric symptoms, for example, to avoid prison). However, such psychological instruments are often not validated in the elderly population. Even results from common cognitive screening tools, such as the Montreal Cognitive Assessment (MoCA) can be difficult to interpret in individuals as advanced in age as Vivian. Clarifying the nature of cognitive problems requires specialized neuropsychological expertise, which is often unavailable in forensic hospitals. Courts tend to want more certainty around diagnoses than we commonly accept as appropriate in medical settings. For example, ambiguity around the specific contribution of a cognitive component to Vivian’s illness presentation would likely be tolerated in the publicly-funded healthcare system, especially if she did not consent to an MRI. However, that may not square with the needs of the courts, which may struggle to accept diagnoses that are “provisional” or “rule-outs.”

It is common for forensic assessment patients to spend significant time waiting for their trial after their NCR assessments are complete (even a year is not uncommon in murder trials). Individuals are traditionally returned to correctional institutions to wait after their 30 or 60-day inpatient assessment. With advocacy (a controversial practice in psycholegal assessment settings itself [Appelbaum, 1997]), Vivian could potentially wait for her trial in hospital – but even then, she would have no privileges to leave the facility, and have to wait amongst much younger, psychiatrically unwell peers on an acute forensic assessment unit. Although forensic psychiatric institutions are hospitals, medical and nursing staff expertise is focused on violence risk assessment and the management of major mental illness. They do not have the level of experience and support typically required for individuals with the medical comorbidities common in the geriatric population.

Challenges in Forensic Rehabilitation

Once found NCR, Vivian would still have to spend significant time as an inpatient on forensic treatment and rehabilitation units. The forensic mental health system focusses on the recovery and rehabilitation of forensic patients by safely re-integrating them into the community. Reintegration is generally done in a graduated manner, commensurate with a given individual's risk for violence. A large part of that risk assessment is informed by evaluating social relationships and occupational engagement. The inpatient milieu is dominated by young men with major psychotic disorders (Crocker et al., 2015). Geriatric patients thus experience a lack of social connection, as there are few, if any, similar-aged peers or accessible activities geared to their interests. The lack of appropriate recreational programming leads predictably to boredom, depression, and subsequent isolative behaviours, making it difficult to make the case that an individual is doing well in their recovery, and thus suitable to receive community access privileges. Insight is another heavily weighted risk factor in forensic care (Douglas et al., 2013), typically addressed through psychoeducational programming. However, forensic in-hospital psychoeducation programs generally target substance use, emotional dyscontrol, or the development of insight into conditions like schizophrenia or bipolar disorder. They are not typically designed with common geriatric conditions (such as neurocognitive disorders) in mind.

Even if Vivian were granted community access privileges, she would face barriers. While forensic staff can support individual community activities, there are other challenges to accessing the community, including inpatient staffing needs and accessible transportation. On top of that, policies around the COVID-19 pandemic resulted (and continue to result) in severe restrictions on both community access and available programming in forensic mental health care, independent of a given patient's risk for violence.

Family relationships are important for all forensic patients, including elderly ones. Supporting Vivian in having family visits, however, would also be complex and impacted by forensic hospital policies and environments. For example, visitors may not be

permitted in personal patient bedrooms. Visits often have to occur in common spaces off-unit, where acoustics are a challenge, or in unit visitors' rooms that require advanced reservation – non-private, sterile, and challenging environments for meaningful engagement. Entering the forensic setting alone can be overwhelming for families - while referred to as a hospital, there are many elements akin to a correctional setting, including security clearance, contraband policies, and a number of secure entrances that must be navigated for families to spend time with their loved one. For long stretches during the pandemic, families may not have been able to visit at all, due to restrictive infection control policies.

Challenges in Finding a Home

If and when Vivian could be considered “well enough” for community living, placement would become a particular challenge. Forensic hospitals have well-developed relationships with local group homes that can support the typical adult population. However, transitioning patients to long-term care (LTC) is another matter. The LTC referral process includes information about patient history, including the index offense – in Vivian's case, murder. Referrals to LTC are often declined, despite our advocacy. The system does little to provide a rationale for declined referrals other than to insinuate or explicitly state that staff skills are inadequate to manage “forensic patients.” Ironically, forensic mental health patients transitioning into the community come with a robust outreach support network attached - often for years following discharge from the inpatient environment. The physical and mental health needs of the geriatric population in the forensic setting are generally the same as the others in LTC, but patients like Vivian may ultimately be rejected due to stigma.

Conclusions

We have presented Vivian's case as a device to explore the barriers faced by elders entangled in the forensic mental health system. Luckily, cases like Vivian's are rare – but they do occur. As our population ages, we are likely to experience more of

them. As it is currently structured, the forensic mental health system – like the correctional system - is poorly suited to managing the unique needs of the geriatric population. We need to do better for our elders who, by the cruelty of illness and circumstance, end up under our care. Accessible environments, age-appropriate programming, access to neuropsychological assessment services, flexible policies, staff capacity, and LTC partnerships are all required to humanely care for this vulnerable population.

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The Treatment and Rehabilitation of Paranoid Elderly Patients

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110 (83%) of 133 paranoid elderly inpatients were successfully returned to their community residence following psychogeriatric hospital care, emphasizing the combined use of neuroleptics, anxiolytics, tricyclic antidepressants, and Lithium Carbonate. Only 44 (33%) patient suffered from organic brain disorder, 52 (39%) were schizophrenic, 26 (20%) affectively ill, and 11 (8%) add a reversible toxic state. As predicted, prolonged hospital stay occurred in only 11 patients (8%), 6 of whom were chronic schizophrenics and 4 organically ill. Especially in the effectively disturbed, but also in schizophrenic and organic states, Lithium Carbonate combined with neuroleptic, tricyclic antidepressant and anxiolytic significantly facilitated discharge from the hospital.

Paranoid states, whether functional or organic, are common in elderly people and often accompany social isolation and sensory impairment (Hamilton, 1978), as in late paraphrenia (Roth, 1955), or persistent persecutory states (Post, 1966). Elderly depressives may also have paranoid delusions and then respond poorly to tricyclic antidepressants alone (Hordern, Holt, Burt, & Gordon, 1963). The addition of neuroleptic to tricyclic antidepressants was found successful in 12 of 13 such patients (Nelson & Bowers, 1978), and in a more recent study 85% were relieved by combining anti-depressant, neuroleptic, and Lithium Carbonate (Gordon, 1981).

The present review of 133 paranoid elderly patients in a psychogeriatric unit hopes to show the relatively high incidence of schizophrenic and affective disorders, along with their good response to combining neuroleptic with anxiolytic, tricyclic antidepressants and Lithium Carbonate. This will enable the return of 80% to their former abode, whether family residence or nursing home.

It is predicted that prolonged psychogeriatric hospital stay is only likely in a small percentage of the schizophrenic or demented patients and that in contrast, the outlook for discharge is excellent in affective, as well as toxic states.

It is hoped to demonstrate the significant effectiveness of Lithium Carbonate in combination with tricyclic antidepressant and neuroleptic in the affective group of the paranoid elderly.

Methods

The study took place in the psychogeriatric unit of St. Thomas, Ontario, Psychiatrist Hospital where all patients, aged 65 years or above, with psychiatric symptoms too severe for outpatient or nursing home care, were assessed and initially treated in a 30-bed ward.

The therapeutic milieu, as described in a previous article (Gordon, 1981) includes a multidisciplinary team approach, with discharge planning at the outset and a continuing aftercare program.

After physical and psychiatric examination and an intake team conference, a definitive diagnosis was made, using the criteria of Feighner et al. (Feighner, Robbins, Guze, et al., 1972) for paranoid symptomology. They were systemically studied as a group, with respect to incidence of functional, versus organic or toxic states, selective responses to combined pharmacotherapy and prognosis for symptom alleviation and hospital discharge.

Detailed tabulations were made of diagnostic groups and subtypes, physical deficits, psychotropic drug combinations, and such data as sex incidents, age of onset of illness and age of admission to the psychogeriatric unit.

The neuroleptics used were Haloperidol, Chlorpromazine, and Trifluoperazine. The tricyclic antidepressants were Imipramine and Amitriptyline, and the anxiolytics were Oxazepam and Diazepam.

Drug dose levels were correspondingly less than in young adults in view of the older age range (Gordon,

1981). Antiparkinsonian drugs (BENZTROPINE and Trihexyphenidyl) were prescribed along with neuroleptics in 27% of the schizophrenics and 23% of the organic states. Anticonvulsants (Phenytoin and Phenobarbitone) were also used in 20% of the organic patients with seizure history.

Results

Admission and Discharge Characteristics

Table 1 gives the frequency with which patients in each of four diagnostic categories were characterized by: first admission, brief hospitalization, family history of illness, admission from family residence or nursing home and discharge status.

Table 1. Admission and Discharge Characteristics of 133 Paranoid Elderly Patients

	Schizophrenic (N=52)	Organic (N=44)	Affective (N=26)	Toxic (N=11)	Chi-Square
1. First admission to a psychiatric hospital	16	22	3	7	14.73(df=3), $p<0.01$
2. Short-stay patients (up to 3 months)	26	19	16	8	3.90, <i>ns</i>
3. Family history of psychiatric illness	14	11	5	4	1.26, <i>ns</i>
4. Prior residence					
(a) Admitted from family residence	24	21	15	8	3.26, <i>ns</i>
(b) Admitted from nursing home	28	23	11	3	
5. Discharge modes					
(a) To family residence	16	8	17	6	22.6(df=9), $p<0.01$
(b) To nursing home	27	26	5	5	
(c) Remaining in hospital	6	4	1	0	
(d) Deaths in hospital	3	6	3	0	

Separate chi-square analyses were performed on each of the five descriptions and found to be significant in two of them. The data suggests that diagnosis is significantly related to the readmission rate and those with affective disorders are more likely to be readmitted. Also, the diagnosis is significantly related to discharge status, especially greater probability that affective patients be discharged home and that organic patients be discharged to a nursing home.

Physical State

Table 2 describe the frequency of major physical disorders. Separate chi-square analyses revealed that, in general, the presence of physical illnesses are not significantly associated with diagnoses, excepting for the frequency of heart disease (in the affective group) and the presence of stroke or Parkinsonism.

Table 2. Physical State

	Schizophrenic (N=52)	Organic (N=44)	Affective (N=26)	Toxic (N=11)	Chi-Square
1. General physical state normal	9	5	5	5	7.40, <i>ns</i>
2. Deafness or partial blindness	16	18	7	1	4.66, <i>ns</i>
3. Stroke history or Parkinsonism	8	18	3	1	12.07(df=3), $p<0.01$
4. History of fracture, pneumonia, or cancer	8	5	5	3	2.40, <i>ns</i>
5. Alcoholism or drug toxicity	7	-	2	9	4.48, <i>ns</i>
6. Heart disease	4	2	7	1	9.77(df=3), $p<0.01$

Diagnostic Subtype

Table 3 gives a breakdown of diagnostic subtypes, average age of onset and average age on admission for four diagnostic categories. The proportion of females in all four categories is statistically significant.

Table 3. Diagnostic Types Among 133 Paranoid Elderly Patients

Diagnostic Type	N	%	# of Females*	Average Age of Onset (Years)	Average Age of Admission to Psychogeriatric Unit (Years)
1. Schizophrenic	52				
(a) Paranoid	24	46	10	37.5	72.2
(b) Late paraphrenia	24	46	19	61.4	74.3
(c) Schizoaffective	4	8	1	33.5	68.0
2. Organic	44				
(a) Progressive dementia	36	81	26	73.6	77.3
(b) Post-anorexic state	3	7	2	65.7	70.3
(c) Epileptic psychosis	3	7	2	37.3	68.0
(d) Psychosis with retardation	2	5	2	51.0	68.0
3. Affective	26				
(a) Delusional depression	13	50	8	62.4	71.9
(b) Neurotic depression	4	15	3	75.5	76.0
(c) Mania (manic-depressive)	7	27	4	43.6	70.7
(d) Depression (manic-depressive)	2	8	1	53.0	69.0
4. Toxic Psychoses	11				
(a) Alcoholic	7	57	4	59.7	71.7
(b) Toxic (drugs)	4	43	2	62.5	68.0

*Binomial probability $8 = 3.03, p<0.005$

a. Schizophrenic group.

Using the criteria of Feighner et al (1972), Roth (1955), and Post (1971), paranoid schizophrenia and late paraphrenia accounted for 92% of the schizophrenic group, with late onset (61 years average) and female preponderance (79%) being more notable in late paraphrenia than the other two.

b. Organic group.

81% of organic illnesses were represented by progressive dementia, with female preponderance and late onset (average 74 years). In this subgroup, Alzheimer-type dementia (senile) predominated

(67%) while dementia accompanying stroke syndrome (multi infarct) applied to 25% of such patients. It has been remarked that the most common cause of senile dementia appears indistinguishable from Alzheimer's disease (Crapper & DeBoni, 1978).

c. Affective group.

Unipolar delusional depression was the diagnosis in 50% of patients and bipolar manic states in 27%. In both subgroups there was moderate female preponderance (62% and 57% respectively) and onset before old age (average 62 years and 44 years respectively).

d. Toxic group.

They represented toxic psychotic states, occurring in elderly patients, due to alcoholism or drug toxicity following misuse. The onset age was under 65 years.

Psychotropic Drug Therapy

Table 4 describes the four categories of psychotropic drugs used. Overall, the association between the type of drug therapy and the diagnosis is highly significant. The association is especially noteworthy with drug combinations using Lithium Carbonate in all categories and drug combinations using neuroleptics and/or anxiolytics in the affective category. It appears that in general drug combinations involving lithium therapy are more frequently useful, even in symptomatic control of schizophrenics and organics, though not at the same high level of statistical significance as the patients in the affective category.

Table 4. Psychotropic Drug Schedule^a

	Schizophrenic (N=52)	Organic (N=44)	Affective Psychosis (N=26)	Toxic (N=11)
1. Neuroleptic alone + neuroleptic combined with anxiolytic	31	27	4	7
2. Neuroleptic(s) plus tricyclic antidepressant + neuroleptic(s) plus tricyclic antidepressant plus anxiolytic + anxiolytic plus tricyclic antidepressant	13	11	9	1
3. Neuroleptic(s) plus lithium carbonate + neuroleptic(s) plus lithium carbonate plus tricyclic antidepressant	4	3	12	1
4. No psychotropic drug given or taken	4	3	1	2

^a $\chi^2=44.49, df=21, p<0.01$

Drug Therapy and Hospital Discharge (Table 5)

These two variables show an association with a high level of significance especially in the case of combinations of neuroleptic, antidepressant and lithium. These combinations were particularly useful in helping patients achieve a level of symptomatic

control such as to permit their discharge and care in the community.

Table 5. Drug Therapy and Hospital Discharge^a

	Number of Patients Discharged	Number of Patients Remaining in Hospital
1. Neuroleptic alone	34	5
2. Neuroleptic combined with tricyclic antidepressant, lithium carbonate and anxiolytic	69	3
3. No psychotropic drug	7	3

^a $\chi^2=8.03, df=2, p<0.025$

Discussion

Based on previous reports (Nelson & Bowers, 1978; Simpson & Varga, 1972) and a recent study of elderly depressives (Gordon, 1981), it was predicted that combining neuroleptic with tricyclic antidepressant, Lithium Carbonate, and anxiolytic would also succeed with paranoid elderly inpatients, especially when affectively disturbed and anxious. The overall results show that neuroleptic alone was effective in 34 patients with 5 failures, whereas 69 patients successfully left the hospital after combined drug therapy, with only 3 non-responders (Table 5).

Diagnosis and Onset

The high incidence of functional illness in the paranoid elderly (59%) is confirmed: 39% were schizophrenic and 20% affectively ill. Only 44 patients (33%) had organic brain disorder, and 24 of these (67%) were diagnosed as Alzheimer-type dementia, with average onset age of 74 years, indistinguishable from the presenile form (Crapper et al., 1978).

24 (46%) of 52 schizophrenic patients were early onset (38 years average) paranoid schizophrenics, 69% of whom had previous hospital care, their admission to the psychogeriatric unit representing acute relapse in old age or a continuum of unrelieved illness.

An equal number, 24 (46%), were late paraphrenics with late onset (61 years average), female preponderance (79%) and strong association with loss of spouse and impaired hearing and vision (Roth, 1955).

There were only 4 schizo-affective patients, with early onset age (34 years average) and previous hospitalization.

In the primary affective group of paranoid elderly, there were 13 delusional depressives (50%) of 62 years average onset age. 9 patients (35%) were manic-depressives of earlier onset (49 years average). There were only 4 non-delusional depressives (15%) of late onset (76 years average). In 11 patients with toxic psychosis, 7 (64%) were first admission to a psychiatric hospital, with average onset age of 61 years.

Diagnosis and Drug Combination

The diagnosis in the individual paranoid patient influence the drug combination choice: 21 schizophrenics responded to neuroleptic alone, while 10 needed the addition of an anxiolytic, 13 a tricyclic antidepressant and 4 also required Lithium Carbonate to deal with affective symptoms, especially in late paraphrenia.

27 organically ill patients did well with neuroleptic alone (17 patients) and with anxiolytic (10 patients). 11 patients, however, required the addition of tricyclic antidepressant and in 3, Lithium Carbonate also. 5 bipolar manics with paranoia symptoms remitted with neuroleptic, combined with Lithium Carbonate. In 16 depressives, neuroleptic-tricyclic antidepressant – anxiolytic was a successful combination, with the addition of Lithium Carbonate in 7 delusional depressives.

7 of 11 toxic states required a neuroleptic, alone or combined with anxiolytic, as well as withdrawn from the responsible agent, whether alcohol, hypnotic or such drugs as Digoxin, L-Dopa and steroids. 10 patients in the study refused medication or were too unwell physically (Tables 4, 5).

Diagnosis and Physical State

The interrelationship of physical and mental illness is well known in the elderly (Ross & Kedward, 1977). In the present study, physical abnormalities, sometimes multiple, were commonest in organic states (41%), especially stroke history or Parkinsonism. However, 30% of the schizophrenics had sensory impairment (hearing or vision) and 27% of those affectively ill suffered from heart disease.

Only 24 patients (18%) were physically intact. 12 patients, 6 with dementia, died while in the hospital.

Diagnosis, Admission, and Discharge

Patients admitted from their own home often exhibited self-neglect, especially when living alone. Those from nursing homes had previously shown lack of social competence. Paranoia illness in the elderly is regularly accompanied by physical illness, social isolation and aggressive behavior (Ross & Kedward, 1977). Only 12% of the affectively ill with paranoid symptoms were first admissions, compared with 50% of the organic disorders and 31% of schizophrenics.

However, by prescribing and maintaining combined psychotropic drugs (neuroleptic, anxiolytic, tricyclic antidepressant and Lithium Carbonate) in all categories, but especially in the affective group, the prognosis for paranoid elderly patients is considerably improved, bearing in mind that the psychogeriatric program includes continuing community aftercare and liaison with the family physician to maintain rehabilitation (Table 5).

All 11 patients with toxic states left the hospital. 85% of the affectively ill, 83% of the schizophrenics and 77% of the organic disorders successfully returned to the community. The organic and schizophrenic patients, however, were less often able to leave the hospital within 3 months and were more frequently admitted from and discharged to a nursing home (in 60% of cases). Also, as one might expect, there was a poorer therapeutic response and an increased mortality (14%) in the progressive dementias (Table 1).

Conclusion

Affective symptoms are common in paranoid elderly patients and are not limited to delusional depressives only. Organic and schizophrenic patients exhibit depressive symptoms and anxiety and respond well to the addition of tricyclic antidepressant, Lithium Carbonate and anxiolytic.

The study describes the successful rehabilitation of paranoid elderly patients into the community by initiating and maintaining tricyclic antidepressant, Lithium Carbonate and anxiolytic, additional to neuroleptic alone. Only 11 patients (8%) failed to leave hospital. lithium carbonate: combined with neuroleptic, tricyclic antidepressant and anxiolytic, significantly facilitated hospital discharge, especially in the affectively ill, but also in organic and schizophrenic elderly paranoid patients.

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Invited Commentary on *Challenges in Geriatric Forensic Care - From Assessment to Community Reintegration*



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The inpatient study on paranoid states in the elderly by Gordon et al published in the Research Bulletin of the St Thomas Psychiatric Hospital in 1982 focused on the treatment and successful rehabilitation of the patients. Management was based on a multi-modal approach consisting of diagnostic clarification, a therapeutic milieu, psychotropic medication, and multidisciplinary discharge planning. Diagnostic subtypes included schizophrenia, organic disorders, affective groups, and toxic states.

Schizophrenia was diagnosed by using the criteria of Feighner, Roth and Post. Organicity was ruled out by history taking and physical examination as well as bloodwork and available technology. The four tables provided details of diagnostic subtypes, admission and discharge characteristics, physical states, and psychotropic drug schedules.

The study concluded that adding different combinations of lithium, tricyclic antidepressants and anxiolytics to a neuroleptic significantly improved the clinical response and facilitated discharge from the hospital. Aftercare included continuing support by the team as well as liaison with family physicians.

Conceptual Framework

In the evolving nosology of the DSM-5 there is broad recognition that an overly rigid categorization system fails to capture clinical experience and scientific observation. As the boundaries between disorders are fluid, symptoms assigned to a single disorder may occur in other disorders as well. Using a dimensional approach with biomarkers permits a more accurate description of patient presentations and increases the validity of diagnosis.

The Feighner criteria of schizophrenia used in the Gordon study was published in 1972. It was the basis

for the development of the DSM-5 research diagnostic system. Late onset schizophrenia is better classified as schizophrenia-like psychosis as it is similar to the early onset psychosis. The study examines paranoid states as the defining symptom of psychosis in the elderly. In the latest DSM-5 diagnostic system however, the term “ Paranoid Disorder” is no longer recognized as a separate entity. Affording it a specific grouping does not appear to add value to clinical utility or scientific validity or reliability. Only paranoid personality disorder is recognized as an entity. This latter diagnosis should not be made if paranoia presents as a symptom in the context of medical, neurologic, psychiatric or medication induced illnesses.

The disorders of dementia and toxic states (referred to in the study), as well as other neurological conditions, are now subsumed under the newly named entity of neurocognitive disorders in the DSM-5 system. These are syndromes for which the underlying cause can potentially be determined. Using this medical term facilitates a common language which has the potential to harmonize the field.

Depressive Disorders is the blanket term that covers the entire spectrum of disruptive dysregulation disorders, major depression (one of the diagnostic entities studied), dysthymia, substance induced, premenstrual, and medically induced depressions. The common feature of all these disorders is the presence of sad or irritable mood accompanied by somatic and cognitive changes.

Modern Trends in Geriatric Psychopharmacology

This has gained importance in the last decade. One must show abundance of caution to age related

changes. Pharmacokinetic and pharmacodynamic factors may profoundly influence the absorption, distribution, metabolism and elimination of drugs. The risks are compounded by the negative effects of polypharmacy and comorbidities. Pharmacokinetic factors refer to the effects of the body on a particular drug. Reduced blood flow and decreased liver mass, reduced body water content, reduced renal clearance, and loss of cell integrity in the blood-brain barrier have the potential to increase sensitivity to drugs and cause adverse and toxic side effects. Pharmacodynamic factors refer to the effects of a drug on the body. Age related changes including a decrease in cholinergic receptors make them susceptible to disabling symptoms of urinary retention, dry mouth, constipation, blurred vision, and increased risk of falls and infections. Cerebral effects may include confusion and cognitive impairment.

A word about modern drugs. Atypical neuroleptics are prone to produce the metabolic syndrome with diabetes and heart disease. These should be addressed with education, lifestyle changes, and regular cardiac and blood monitoring. The incidence of tardive dyskinesia due to older drugs has dropped significantly in recent years due to judicious use and preventative screening measures.

Clozapine with proper monitoring is a relatively safe option worth considering. Atypical neuroleptics have largely replaced typical neuroleptics in the management of psychosis. Some of them also provide mood stabilizing effects precluding the need for additional drugs like lithium. As lithium continues to be used in the elderly one must closely monitor declining renal and thyroid functions throughout the treatment process. Benzodiazepines are generally discouraged in the elderly due to the risks associated with cognitive impairment, dependence, falls, and MVAs. Tricyclic antidepressants are also not recommended for common use due to risk of unexpected cardiac events. SSRIs and tetracyclic antidepressants are safer alternatives.

The clinical aphorism in the treatment of the elderly is to think low. Not to use three drugs if one would do and not use five milligrams if two would suffice!

Collaborating with family physicians, following diagnostic and treatment guidelines, managing risk factors, and choosing and using drugs judiciously are the cornerstones of modern geriatric practice.

Comment

In light of above considerations this clinically relevant study by Gordon et al must be commended. All the core elements of sound methodology based on scientific principles were applied. Diagnostically they were clinically able to separate the organic from the functional by using the prescribed criteria at the time. Despite the limitations and constraints of available medications and imaging technology, they were able to diagnose and treat people optimally with good results. Their main goal was to reduce the duration of hospitalization and return them to the community. This was accomplished. Rehabilitation was based on collaborative care principles. They could not have accomplished so much with so little without their clinical skills and enthusiasm. This they had in spades!

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