RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE OLD AGE PSYCHIATRIST

Issue 94

January 2026

HELLO

Welcome to Issue 94, January 2026, of the RCPsych Old Age Faculty Newsletter

Editorial Team

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Disclaimer:
Please note that ‘The Old Age Psychiatrist’ newsletter is intended for the RCPsych Old Age Faculty membership. The content is provided by contributors and does not necessarily reflect the views, position, or policy of the College. The Royal College of Psychiatrists does not provide any endorsements or assume any responsibility for the accuracy, completeness, or suitability of the content provided. This is not a formal peer reviewed publication and clarifications should be sought from individual authors.

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UPDATE FROM THE EDITORIAL TEAM

Thank you to everyone who put in their valuable time towards making this edition of the Old Age Psychiatrist a varied and interesting one. The editorial team is overwhelmed by the huge number of impressive write ups, articles and reviews, some of which will feature in the next edition. As the year 2025 has some to an end, it is so heart warming and encouraging to see the growing interest in Old Age Psychiatry nationally and globally. The active shift to proactive, integrated, holistic care delivered in the community closer to home on neighbourhood models of care promises to deliver preventive, convenient and coordinated care for Older Adults.

The Chair, Dr Mohan Bhat and co-chair, Dr Ben Underwood's report gives an overall summary on the progress made on two national priorities i.e. national workforce mapping in Old Age Psychiatry and experience of ethnic minorities accessing memory services. Dr Rebecca Glasser, FY2 doctor has written a very impressive reflective review on 'The Joy of Old Age', one amongst many excellent articles we have received for this edition.

Jennie, our higher trainee editor put in her valuable time to make this edition an excellent one, thank you Jennie. I would also like to thank Curtis Osbourne, our other higher trainee editor, who stepped down at the end of 2025 and had been part of the editorial team for the last 2 years with the current editorial team and a couple of years prior to that.

Thank you to our faculty manager, Kitti Kottasz for her diligence and tremendous support. Do consider sharing your interesting pieces of work and articles for the newsletter by emailing kitti.kottasz@rcpsych.ac.uk or oldage@rcpsych.ac.uk for the May 2026 edition, send these in time before or by early April.

Ending the year on a note of gratitude. Wishing all members of the Old Age Faculty, members and fellows of the Royal college of Psychiatrists and all staff a Happy, Peaceful and Prosperous 2026.

I hope you all enjoy this edition.

Best wishes

Dr Shaheen Shora

MBBS, MSc, FRPsych
Lead Editor

VIEW FROM THE CHAIR

Dr Mohan Bhat and
Dr Ben Underwood
Chair & Vice-Chair of the Old Age Faculty

As we begin 2026, We would like to offer my warmest wishes to all members of the Faculty of Old Age Psychiatry. We hope the festive period brought a moment of rest and renewal after an exceptionally busy and challenging year for our specialty.

Stepping into the New Year, we continued to be inspired by the dedication, compassion and innovation shown by colleagues across the country in improving care for older adults and their families. We are also delighted to highlight that our next Faculty of Old Age Psychiatry Annual Conference will take place on 26–27 March 2026 in London. Further details, including programme updates and registration information, can be found on the college website or by clicking here.

In recent months amongst the many projects that the faculty has been involved in, the faculty has made significant progress on two national priorities. Our survey on the experiences of ethnic minority elders accessing memory services has provided valuable insights into cultural barriers, unmet needs and opportunities for more equitable pathways—work that will form a key part of our recommendations later this year. In parallel, our national workforce mapping initiative continues to strengthen our understanding of capacity, distribution and future requirements in old age psychiatry, informing our engagement with NHS England, training bodies and policymakers.

Looking ahead, we will have eight Executive Committee vacancies open for election, and we strongly encourage colleagues to consider standing. This is a pivotal opportunity to shape national policy, influence service improvement and contribute to the long-term direction of our specialty. Full details of the election process, including eligibility and role descriptions, are available at: https://www.rcpsych.ac.uk/about-us/our-people-and-how-we-make-decisions/elections/elections-2026/faculty-elections.
The deadline for applications is 6 February 2026, and We hope to see a wide and diverse range of members putting themselves forward. Please do get in touch with us if you need to discuss about these roles with either of us.

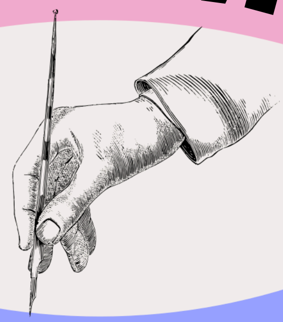
Best wishes,

Dr Mohan Bhat
Chair

Dr Ben Underwood
Vice Chair

THE *OLD AGE PSYCHIATRIST*

CREATIVE WRITING COMPETITION 2026



THIS YEAR'S TITLE IS:

'THE PERFECT JOB IN OLD AGE PSYCHIATRY'

We invite you to imagine your dream job in Old Age Psychiatry.
Is it your current job or something quite different?

We're looking for imaginative and original entries in your preferred creative writing medium- short fiction, poetry, personal essays, comic strips, screenplays, diary entries and more.

1ST PRIZE: £150
2ND PRIZE: £50

Winners will also have their writing published in *The Old Age Psychiatrist* and will receive a day's free registration at the RCPsych Old Age Faculty Conference in March 2026.

CLOSING DATE: MONDAY 26TH JANUARY 2026 AT 5PM

Competition Rules: Entries should be no more than 1000 words long /// This competition is open to doctors of all grades including consultants, SAS and resident doctors, as well as medical students /// Maximum 1 entry per person /// Original work only/// The use of AI is prohibited /// For more information, visit the RCPsych Old Age Faculty prizes webpage

Please submit your entries marked as 'OAP Competition' to oldage@rcpsych.ac.uk
Please remember to include your full name & job role.

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Opportunity for Resident Doctors in the Old Age Faculty(ST4+)

The Old Age Psychiatrist, the official newsletter of RCPsych's Old Age Faculty

TRAINEE EDITOR VACANCY DEADLINE: 2ND FEBRUARY

An exellent oportunity for your special interest time

- We're looking for 2 enthusiastic and creative resident doctors with experience of Old Age Psychiatry to join the team from **May 2026.**
- Being the trainee editor is a great way to develop your leadership, research and publication skills, as well as having opportunities to get involved with the RCPsych Old Age Faculty.
- To apply, please send your CV and a brief description of why you want to apply for the role to our editor, Dr Shaheen Shora via oldage@rcpsych.ac.uk. Please put the subject of your email as 'OAP Trainee Editor'
- Ensure your TPD supports your application

Closing Date for applications: 2 February
Interviews will be held in the Spring

IS CO-PATHOLOGY THE RULE NOT THE EXCEPTION IN DEMENTIA?

Dr Jemma Hazan
UCL Clinical Research Fellow and Honorary Consultant Old Age Psychiatrist at the North London Foundation Trust

Most individuals with dementia exhibit co-pathology, where multiple brain pathologies co-exist. Single pathologies, such as a pure Alzheimer's disease (AD) in Familial AD, are the exception rather than the rule. Although AD pathology is the most common cause of dementia in older adults, mixed pathologies are at least as prevalent, with cohort studies reporting a range between 10 to 74%.[1] A post-mortem cohort study of individuals over 80 years old found that 91% had at least one neuropathology, and 41% had three or more.

Pathologies can be broadly categorised as Alzheimer's disease-related (e.g. Braak neurofibrillary tangle stage, Consortium to Establish a Registry for Alzheimer's disease [CERAD] diffuse and neuritic plaque score), vascular (e.g. arteriolosclerosis, atherosclerosis, macroinfarcts, microinfarcts, lacunes, cerebral amyloid angiopathy), or other (e.g. hippocampal sclerosis, limbic-predominant age-related TDP-43 encephalopathy neuropathologic change [LATE-NC], and Lewy body [LB] pathology).[2]

In a longitudinal cohort study of cognitively unimpaired older adults, multiple pathologies increased the odds of developing a clinical dementia syndrome threefold compared with those with a single pathology, as confirmed by post-mortem analysis.[3] This suggests a cumulative effect that may surpass cognitive reserve and result in a clinical dementia syndrome[1]. Studies also indicate that co-pathologies influence disease progression. AD and LB pathology increased the speed of cognitive decline, compared to those who had LB pathology alone.[4,5]

These findings suggest a shift away from rigid diagnostic boundaries toward a quantitative approach to co-pathology in those with cognitive symptoms.[5] Biomarkers may play a critical role in this transition. How can we integrate tests which detect co-pathologies into our diagnostic formulations? The future of dementia diagnosis likely involves a panel of plasma biomarkers. Robust and accurate plasma biomarkers for AD pathology, such as phosphorylated tau217 (p-tau217), already exist, and their clinical utility under evaluation in the UCL Alzheimer's Disease Diagnosis and Plasma p-tau217 (ADAPT) clinical trial.

A newer research platform, the Nucleic Acid-Linked Immuno-Sandwich Assay (NULISA), measures over 200 proteins in the plasma, including neuro-specific and inflammatory proteins associated with neurodegenerative disorders.[6] These include glial fibrillary acidic protein (GFAP) and neurofilament light chain (NfL), markers of neuronal injury and axonal damage; alpha-synuclein, which reflects Lewy body pathology and synucleinopathies; and other candidate proteins for vascular dysfunction. Could such a panel one day provide an individualised diagnostic profile? These advancements could have implications for treatment and management, enabling more targeted and individualised therapies based on identified co-pathologies.

As clinicians in memory services, we will likely be tasked with interpreting this information, so-called "precision subtyping" and communicating it to patients and families. Even interpreting a single AD plasma biomarker presents challenges related to cut-off points and intermediate ranges; a multi-biomarker panel is likely to introduce further complexity.

While this vision is not yet realised, assay technology and biomarker innovation are advancing rapidly. In the future, memory clinics may have access to a comprehensive biomarker panels. As old-age psychiatrists, it will be critical to use these tests effectively to provide individualised diagnoses and treatments.

References*:

1. Rahimi J, Kovacs G. Prevalence of mixed pathologies in the aging brain. Alzheimers Res Ther. 2014; 6 (9): 82.
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*Please note, the author is responsible for the accuracy of these references

THE RCPSYCH ARCHIVES AND LIBRARY AND THE HISTORY OF OLD AGE PSYCHIATRY

Dr Claire Hilton
Consultant Old Age Psychiatrist & Honorary archivist, RCPsych

The recent Gilbert and George exhibition at the Hayward Gallery, London, did not provide the traditional interpretation labels alongside each artwork to help the viewer appreciate the exhibits. Instead, viewers had to work out for themselves what the artists were endeavouring to say, about twenty-first century western communities. Much was alien, even offensive, but it certainly provoked reflection about societal norms.

So, what has that got to do with old age, psychiatry and archives?

The old age bit is perhaps the easiest: the artists Gilbert and George are in their 80s and continue to create dramatic and thought-provoking art. Regarding psychiatry, their work resonates with RD Laing's concept of mental illness as a sane response to an insane world. Gilbert and George's 'Dividers' echoes Laing's *The divided self: an existential study in sanity and madness* (1960) not just in name.

Like art, archives are unique and unpredictable, often uncensored responses to circumstances as they unfurl. They may be shocking and humorous, confront our conceptions, and come without explanations or interpretations. Deciphering and contextualising them may be challenging. How, for instance, does one interpret crossings out and insertions, or scribbled notes and expletives in the margins of draft committee minutes? They may indicate what the speaker really wanted to say, rather than what officialdom deemed prudent to include. Recorded in the typescript of verbatim evidence given to the Committee on Administration of Public Mental Hospitals, psychiatrist Frank Perceval called his staff 'flotsam and jetsam and scum of the earth'. (The National Archives, MH 58/219, 24 Feb 1922).. It does not indicate who deleted the last five words, or why, but it conjures up questions about psychiatric leadership, hospital staff, power and influence. Archives rarely provide direct answers to today's pressing issues, but they can bolster your arguments and stimulate questions which may influence decision making. Not everyone has the time, interest or means to go to art or archive collections, so other resources can help fill in the story, albeit through someone else's interpretation, e.g. The development of psychogeriatric services in England c.1940 to 1989.

In the modern world of medicine, evidence is everything. If you want to introduce a new treatment, you refer to the scientific literature, either individual studies or compilations such as from NICE. However, if the government or NHS leadership want to introduce a service ‘improvement’, their proposals are usually devoid. of historical evidence. In this way, information which might improve the project’s design, predict pitfalls and overcome challenges, is ignored. Quality Improvement methodology also generally focusses on the present and future, with little learning from further back beyond personal experience.

Sometimes I hear the argument that since society has changed, studying past models of care is irrelevant. Although precise details may be out-dated, many societal attitudes which influence policy and practice fluctuate and do not disappear. For example, people requiring healthcare who are likely to be unable to repay society for that care, still tend to fare badly. They include older people and others, with learning disabilities, severe mental illness, or requiring palliative care. Hospices are still funded approximately one-third from government and two-thirds from charity. Regarding mental healthcare, the principle of parity of esteem, enshrined in the Health and Social Care Act 2012, has still not materialised. For old age psychiatry, our colleague John Wattis commented in 1987: ‘mentally ill old people need a larger slice of a larger cake not the crumbs left under the table after the other areas of medicine have fought over the dry crusts of present funding’ (RCPsych Archives, ‘Working party on the care of the elderly mentally ill: service recommendations’). It aligns with the RCPsych’s report in 2018.

Mental healthcare archives exist in many repositories, not just at the RCPsych. Local authority archives often hold clinical and administrative documentation back to the founding of the local county asylum. The National Archives can tell us about central government’s decision making on service provision. Other medical Royal Colleges and the British Geriatrics Society have substantial archives. Some collections have been digitised, at least in part, something which the RCPsych is looking into at the moment.

Old age psychiatry resources in the RCPsych Archives include:

- Geriatrics Sub-committee minutes and agenda, 1951–9.
- Agendas, minutes and ephemera of the Faculty (1997–) and its predecessors (Group, 1973–78; Section 1978–97).
- Proposals and correspondence on establishing old age psychiatry as a separate specialty, 1987–8.
- Meeting attendance book, 2000–12.
- College Reports relating to old age psychiatry.
- Material about Felix Post.
- Donated documents from Tom Arie.
- Oral history recordings plus transcripts of old age psychiatrists, including Tom Arie, Klaus Bergmann, Dave Jolley and Brice Pitt.
- Section and Faculty newsletters: 1980–2000 in hardcopy; digital since 2000. They include much about pioneering services (see Fig 1).

If you cannot find what you are looking for in the archives catalogue, please contact archives@rcpsych.ac.uk.

The RCPsych Library

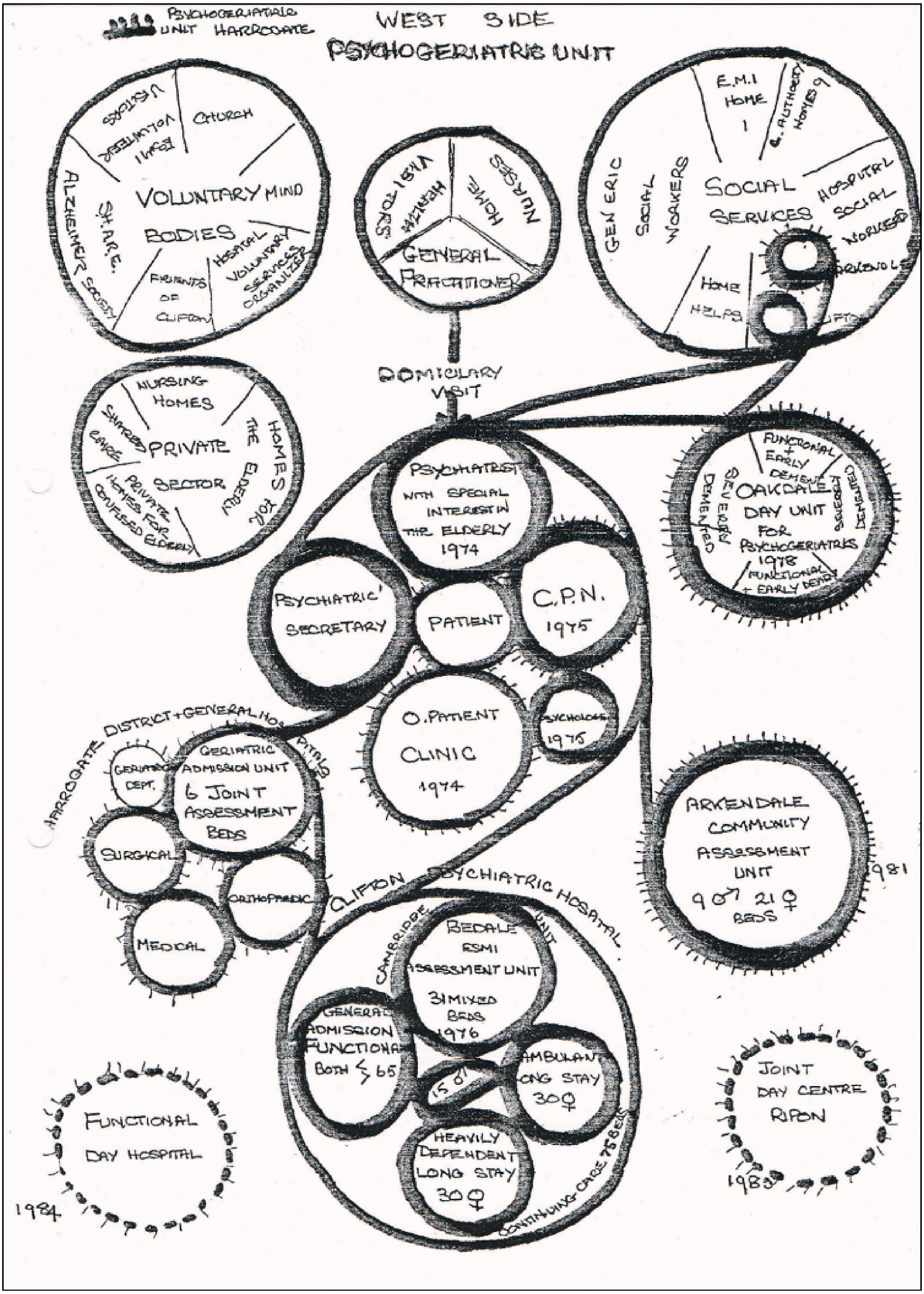
Grey Literature

Pamphlets and newsletters which had limited circulation, and were often binned when considered obsolete, may be found in both archive and library catalogues.

Among those in the RCPsych library catalogue are:-

- RMPA, Report of Geriatric Committee, 1951
- RMPA, The course and outcome of mental disorders in old age, 1957
- RMPA, Memorandum on psycho-geriatric assessment units, 1969

Fig 1.



Source: Beryl Bromham, ‘A psychogeriatric unit in North Yorkshire, Newsletter, 1985, 7: 14–17, 16a.

Books

The library also has textbooks and conference reports back to the 1950s, providing more glimpses into the formative years of old age psychiatry. The library is very grateful to Dr Peter Jeffreys, a retired old age psychiatrist, who has recently donated a substantial number of old age books from his own library, and that of his mother, the late Professor Margot Jefferys.

Here are catalogue links for some of the classics:-

- Old age in the modern world: report of the third congress of the International Association of Gerontology London 1954. Dr Sam Robinson, then a trainee psychiatrist at Crichton Royal Hospital, Scotland, attended the conference. The old age service he established inspired others south of the border.
- JAN Corsellis, Mental illness and the ageing brain, 1962. Corsellis' research at Runwell Hospital, Essex, showed that 'senile' dementia was Alzheimer's disease and not part of normal ageing.
- Felix Post, The clinical psychiatry of late life, 1965; the first UK text book on the subject.
- Psychiatric disorders in the elderly: report on the symposium held by the World Psychiatric Association, London, 1965. Meeting some of the pioneers of old age psychiatry and hearing their presentations, inspired trainee psychiatrists into the field.
- Barbara Robb, Sans everything: a case to answer, 1967; for more information see https://en.wikipedia.org/wiki/Barbara_Robb.
- David Enoch and John Howells, The organisation of psychogeriatrics, 1971, a joint geriatrician and psychiatrist inspired plan for future services.
- DWK Kay and A Walk, Recent developments in psychogeriatrics: a symposium, 1971
- JA Whitehead, Psychiatric disorders in old age: a handbook for the clinical team, 1974

On the RCPsych website

The development of old age psychiatry from the 1960s until 1989, 2008 (transcript).

This was a 'witness seminar'—an oral history project where those who experienced happenings first-hand shared their memories of shaping our specialty. Speakers included Brice Pitt, Dave Jolley, Tom Arie, Klaus Bergmann, Colin Godber.

Also, if you are thinking of delving more into the history of psychiatry, look at the History of Psychiatry Special Interest Group resource page.

Conclusions

Although some of psychiatry's past was the 'bad old days', much was not. Like today, our predecessors had to jump many hurdles to create the best possible services for their patients. Researching the past will not give answers for today, but will help us ask questions outside the box, and hopefully help us leap the hurdles. If not, in the words of Brice Pitt, they may inspire us into 'occasional militancy...to gain a fair share of scant resources, to put them to best use, to make do with too little while wheeling, dealing, and fighting for more.' (RCPsych Archives, Group into Section, 1980–81).

NABILONE FOR SEVERE AGITATION IN EARLY-ONSET ALZHEIMER'S DISEASE: WHAT WE LEARNED FROM ONE CASE

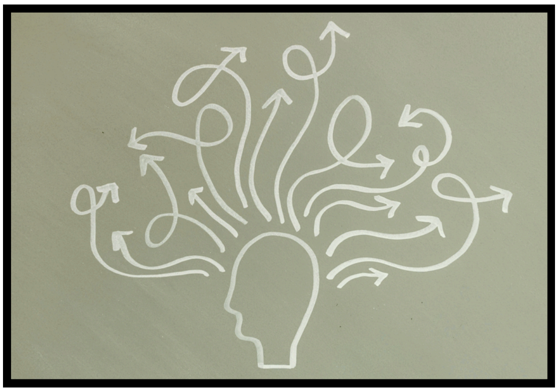
Dr Tharun Zacharia, Dr Jiedi Lei, Dr Charvi Saraswat and **Dr Anne M. Bonnici-Mallia**
South London and Maudsley NHS Foundation Trust, London

Severe behavioural and psychological symptoms of dementia (BPSD) can become the dominant driver of risk, carer breakdown and hospital admission, particularly in early-onset Alzheimer's disease, where younger patients retain the physical strength to cause serious harm during aggression. This article describes an inpatient case in which careful measurement of outcomes and a structured multidisciplinary approach helped a specialist team safely trial an off-label medication and achieve meaningful reduction in distress and risk.

Why this case felt different

The patient was a 61-year-old Polish woman with early-onset Alzheimer's disease, diagnosed in 2019 after several years of progressive cognitive decline. She developed paranoia, anxiety, sleep disruption and severe aggression. Community services managed her with cognitive enhancers and psychotropics, but her behaviour escalated to intense agitation, repeated aggression towards carers, and frequent "controlled falls" (purposeful floor contact, possibly linked to anxiety). By early 2022, she needed admission to a specialist dementia ward under the Mental Health Act.

What stood out was the severity and persistence of risk behaviours despite multiple standard medication strategies. The inpatient team undertook a biopsychosocial formulation using the Newcastle Model, addressing potential drivers such as pain (regular paracetamol) and attempting rationalisation of her complex medication regimen. A major challenge was communication. The patient had severe expressive English language loss despite being a Polish native, so the team used visual communication aids and culturally attuned approaches to reduce her distress.



The medication journey (briefly)

Prior to the nabilone trial, the patient had received antipsychotics (risperidone in the community, then olanzapine on the ward), antidepressant changes, and regular benzodiazepines. During admission she experienced two seizures; encephalopathic EEG changes prompted discontinuation of olanzapine (a known seizure threshold-lowering agent) and initiation of sodium valproate. Despite these adjustments, aggression and "controlled falls" remained at a very high frequency: around 25–35 incidents per day each.
The ward team's realistic goal was not symptom eradication, but sufficient reduction of high-frequency risk behaviours to enable safer care, reduce distress, and support eventual discharge. At the same time, the team wanted to reduce polypharmacy, particularly regular benzodiazepine use, without compromising safety.

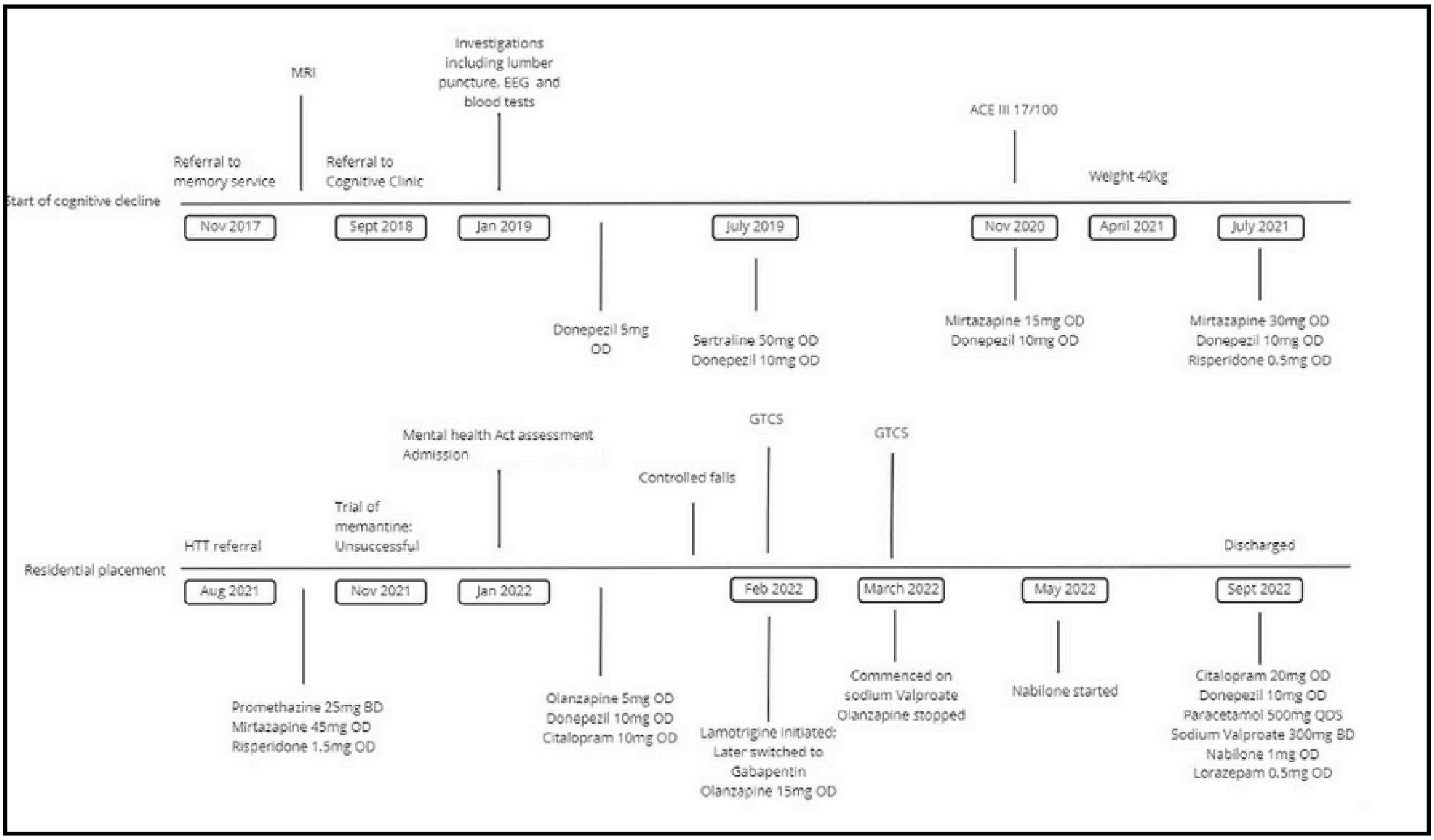


FIGURE 1: TIMELINE

What changed with nabilone

Nabilone (a cannabinoid receptor agonist) is licensed for the treatment of nausea and vomiting caused by cytotoxic chemotherapy, which is unresponsive to conventional antiemetics. It has several off license uses with a more limited evidence base which including in chronic pain relief, appetite stimulation in severe cachexia, reduction of nightmares in PTSD and in severe behavioural problems in intellectual disability or Alzheimer's dementia.

In this case, Nabilone was started off license in April 2022 at 0.25 mg once daily, increasing by 0.25 mg every two weeks to a maximum of 1 mg once daily by June. Crucially, the team did not rely on clinical impression alone. Staff used hourly behavioural charting to track aggression and "controlled falls" objectively, and also administered validated proxy measures—the Cohen–Mansfield Agitation Inventory (CMAI) and the Neuropsychiatric Inventory (NPI), including caregiver distress scoring.

Over the subsequent weeks, the ward documented a marked reduction: aggressive incidents fell from 25–35 per day to around 5–10 per day by July, and "controlled falls" nearly ceased. Standardised measure scores moved in the same direction. CMAI fell from 86 to 64; NPI caregiver distress fell from 21 to 8, with frequency/severity scores declining from 73 to 40. Staff also noticed qualitative changes: the patient showed more warmth towards carers, better engagement with her daughter, and use of single Polish words and phrases—changes that mattered deeply to her family.

An unplanned nabilone supply shortage in late June coincided with behavioural deterioration, which improved again on reinitiation in July. This "on–off–on" pattern strengthened the team's confidence that the change was genuine. During this period, lorazepam was successfully discontinued, reducing sedative burden while behaviour improved. Importantly, no increase in uncontrolled falls was observed, and body weight remained stable.

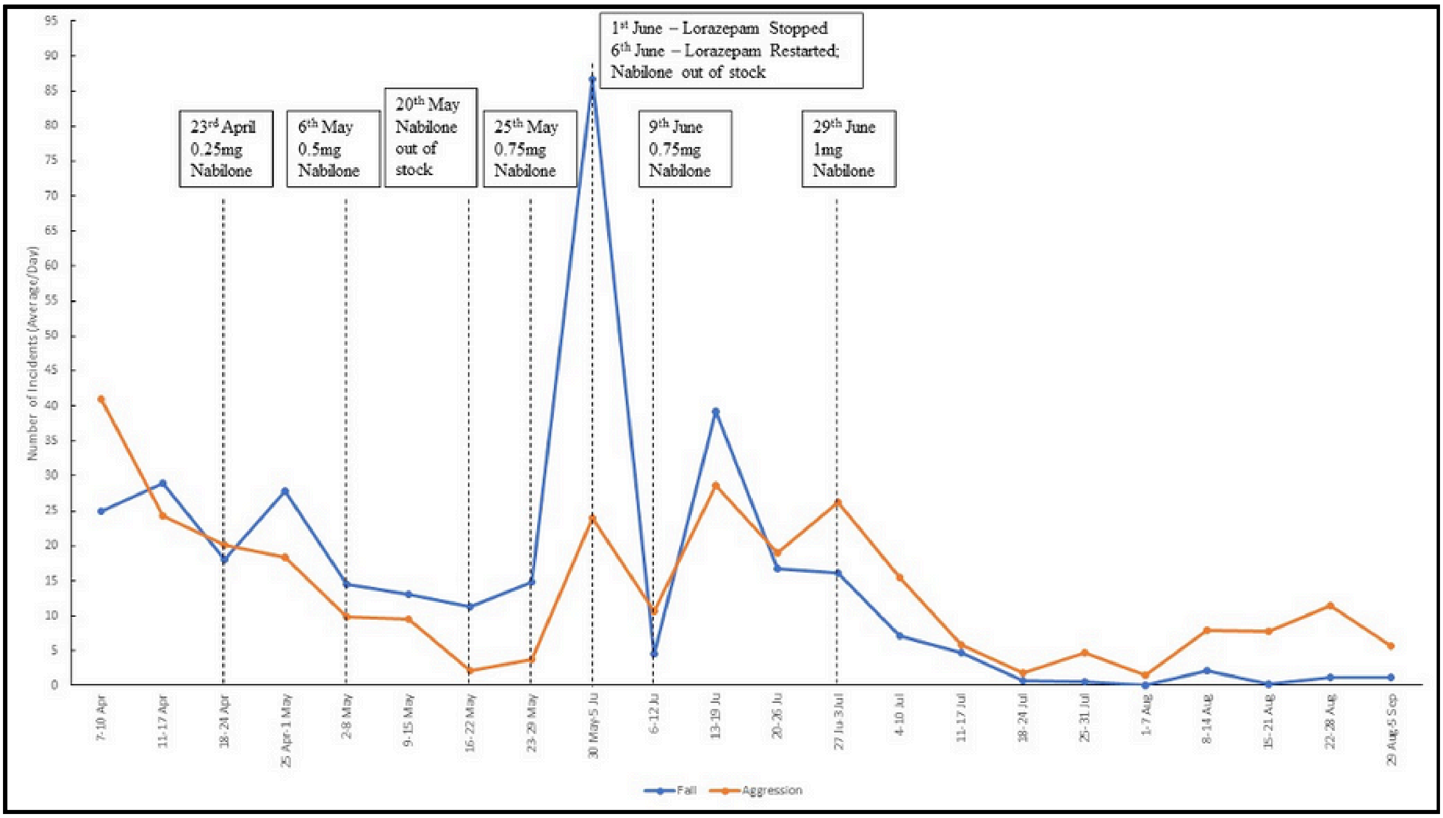


FIGURE 2: AVERAGE DAILY NUMBER OF INCIDENTS FOR FALLS AND AGGRESSION PER WEEK DURING ADMISSION FROM 7TH APRIL TO 5TH SEPTEMBER 2002

The patient was discharged to a specialist care unit without an antipsychotic and prescribed Nabilone 1mg, Donepezil 10mg, Paracetamol 500mg QDS, Sodium Valproate 300mg BD and Lorazepam 0.5mg OD.

Why measurement matters

One key lesson from this case: when someone presents with extreme BPSD, progress becomes visible when the team measures the right behaviour, in a consistent way, at fixed time points. Regular charting, combined with standardised instruments, allowed the multidisciplinary team to distinguish genuine improvement from day-to-day noise and have clearer discussions about benefit, harm and next steps.

Practical reflections for old age psychiatry

First, medication choice cannot be separated from the broader clinical context. Here, the team was balancing severe aggression, a seizure onset period, communication barriers, and cumulative sedation, while still preserving therapeutic relationships and dignity. A biopsychosocial formulation (addressing unmet needs, communication supports and meaningful activity) ran alongside psychopharmacology rather than replacing it, which likely contributed to the overall improvement and ability to reduce overall polypharmacy with some initial improvement noted following the discontinuation of an antipsychotic.

Second, although this case appeared to involve nabilone benefit, it remains a single case and is hypothesis-generating rather than definitive evidence. However, it adds to a small but growing literature suggesting that cannabinoid agonists may have a role in severe BPSD when standard options have been exhausted. The evidence remains inconclusive overall, but cases like this can help us refine patient selection and monitoring protocols for future research.

Third, the supply interruption highlights a practical issue: when a patient finally stabilises on a less commonly stocked medication, services may wish to plan contingency supplies or have clear escalation pathways.

Take-home messages

If you manage severe BPSD in inpatient settings, consider pairing routine incident recording with a validated proxy measure (CMAI or NPI) whenever trialing medication for agitation. Define your "target behaviours" operationally so all staff record consistently. If you consider off-label nabilone, start low, titrate slowly, document response and adverse effects carefully, and keep deprescribing of previous treatments on your agenda. Finally, communication support (language, visual aids, culturally meaningful engagement) is not an optional extra in severe BPSD but remains central to reducing distress and risk.

This is a real case. The authors have sought consent from the patient's next of kin to share her journey here.

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*Please note, the author is responsible for the accuracy of these references

MISSED AND MISUNDERSTOOD: THE CHALLENGE OF DIAGNOSING CATATONIA IN OLDER ADULTS

Dr Shalina Ramsewak, Psychiatry Liaison Service Speciality Doctor and
Dr Shruti Lodhi, Consultant Liaison Psychiatrist in Older People
Frimley Park Hospital, Surrey and Borders Partnership NHS Foundation Trust

Background

Catatonia is a neuropsychiatric syndrome characterised by disturbances in movement, behaviour, and autonomic function. Modern diagnostic criteria describe a recognisable cluster of motor, behavioural, and autonomic abnormalities that can occur across a wide range of psychiatric and medical conditions (1). Catatonia is often perceived as a rare or historical diagnosis, despite being clearly defined in modern psychiatric classification systems. Diagnostic criteria describe a cluster of motor, behavioural, and autonomic abnormalities that can occur across multiple psychiatric and medical conditions (1). Traditionally associated with severe mental illness, catatonia is increasingly recognised in physical conditions in general hospital settings, particularly among older adults (3).

Literature emphasises that catatonia may present more frequently than clinicians often appreciate, especially when patients experience either acute medical or psychosocial stress (2). Recent cases identified through the Psychiatric Liaison Service at Frimley Park Hospital reflect this broader trend, with several presentations occurring in individuals without previous psychiatric histories (3). Long-standing descriptions of catatonia as a 'hidden' syndrome highlight why it continues to be frequently missed in routine practice, contributing to diagnostic delays and suboptimal patient care (2)

Challenges in Older Adults

In older adults, catatonia is particularly vulnerable to misinterpretation because its symptoms can closely resemble other common geriatric syndromes such as delirium, depression, dementia, or frailty syndromes (1). Signs including mutism, withdrawal, psychomotor slowing, or agitation are often attributed to underlying physical illness rather than recognised as part of a distinct neuropsychiatric syndrome (3). Characteristic features such as posturing, negativism, and echopraxia are subtle and can be easily overlooked without a structured and targeted assessment (2). The Bush–Francis Catatonia Rating Scale provides a validated method to systematically identify catatonic features, yet it remains underused in general medical settings (4). The lorazepam challenge has a well-established diagnostic and therapeutic role, frequently producing rapid symptom resolution even when the clinical picture is complex or unclear (4). Contemporary reviews consistently recommend benzodiazepines as the first-line treatment for catatonia, underscoring their safety and efficacy (2).

Case 1

The first case involved an 80-year-old woman recovering from a urinary tract infection, who presented with agitation and confusion initially presumed to be delirium. Over subsequent days, she developed classic catatonic signs including mutism, rigid posturing, and echopraxia—features clearly described in diagnostic criteria. Administration of a lorazepam challenge produced rapid improvement, consistent with evidence demonstrating the efficacy of benzodiazepines in catatonia (4). Regular lorazepam was subsequently commenced, resulting in sustained benefit and allowing the patient to regain functional abilities. This case illustrates how catatonia can closely mimic delirium, potentially leading to diagnostic uncertainty and delayed treatment. It highlights the importance of considering catatonia in older adults who demonstrate abrupt changes in behaviour or cognition, particularly in the context of acute medical illness (2).

Case 2

The second case involved an 84-year-old woman with chronic neuropathic pain and psychosocial stressors, who developed escalating agitation following initiation of duloxetine. The agitation resolved after intramuscular lorazepam in the Emergency Department to ensure compliance with medical care, and after nearly an hour the patient returned to her baseline. She was admitted to the medical ward and then became mute, and her oral intake reduced. A repeat lorazepam challenge test was performed, and she responded positively, which confirmed the diagnosis of catatonia. Regular lorazepam therapy was initiated, and a low-dose antipsychotic was cautiously added to address persistent nihilistic beliefs. The patient's condition subsequently stabilised, and she was transferred to a psychiatric ward for ongoing management. This case demonstrates the reproducibility of lorazepam response and underscores the need for vigilance in detecting catatonia even in individuals without prior psychiatric histories (3).

Discussion

These cases reflect well-established findings that catatonia frequently arises in the context of acute medical or psychosocial stress, can occur in individuals without pre-existing psychiatric illness, and is often misdiagnosed as other geriatric syndromes (3). Rapid and robust response to benzodiazepines remains a hallmark feature of catatonia (4). Misdiagnosis can lead to unnecessary investigations, inappropriate use of antipsychotic medications, worsening of symptoms—including potential medical complications such as dehydration or immobility—and increased length of stay in hospital (1,2). Conversely, timely recognition enables rapid and often dramatic clinical improvement (4). Awareness is especially important in acute hospital settings where overlapping presentations—delirium, depression, or frailty—may obscure the underlying diagnosis (1).

Recommendations

Improving recognition of catatonia in older adults requires enhanced clinician awareness across all general medical services (3). Routine mental state, neurological, and delirium assessments should include evaluation for catatonic features, ideally using structured tools such as the Bush–Francis Catatonia Rating Scale (4). When diagnostic uncertainty persists, a lorazepam challenge offers a safe, informative, and widely supported approach to clarify the diagnosis and initiate prompt treatment (4). Multidisciplinary collaboration between liaison psychiatry, geriatric medicine, nursing staff, and allied health professionals is crucial to ensure accurate diagnosis, timely intervention, and ongoing management of both medical and psychiatric needs (2).

Conclusion

Catatonia in older adults is frequently overlooked due to symptomatic overlap with other medical and psychiatric conditions, yet it remains highly treatable once identified (1). The cases presented highlight the importance of considering catatonia in older adults who demonstrate abrupt behavioural or cognitive changes, regardless of psychiatric history (3). Early administration of a lorazepam challenge can rapidly clarify the diagnosis, relieve symptoms, and prevent unnecessary investigations or inappropriate medication use (4). The key message is that catatonia in older adults is not rare; however, it can be routinely missed, and timely recognition can significantly improve patient outcomes and quality of care.

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WISDOM AND OLDER AGE

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In Erikson's model of psychosocial development, the development of wisdom through the successful resolution of the final psychosocial conflict, integrity versus despair, is considered the key task of successful aging(1). He argued that those who develop wisdom achieve a sense of integrity, allowing them to look back on life with acceptance, coherence, and gratitude, whereas those who fall into despair experience regret, bitterness, and a sense of meaninglessness (1). Empirical research in modern psychology supports this notion, with wisdom being positively associated with mental health, life satisfaction, and eudaimonic well-being, even after controlling for demographic factors (e.g., age, sex, education) and personality traits (e.g., neuroticism, extraversion, openness to experience) (2).Traditionally, wisdom is associated with advancing age, with the archetype of the "wise elder" guiding younger generations through adversity. Yet, while time provides the context for wisdom to develop, it does not guarantee it, as Oscar Wilde pithily observed: 'With age comes wisdom, but sometimes age comes alone'. The question remains: what enables some individuals to age not only well, but wisely?

What Is Wisdom?

Wisdom is a complex concept that transcends time, culture, and academic discipline, it can be simply defined as the ability to make sound judgments based on what someone has learned from their experience (3). The modern psychological study of wisdom began in the early 1970s, when it was first conceptualized as expert knowledge about the fundamental pragmatics of life, that is, a deep understanding of the conditions and processes of human existence (3). More contemporary frameworks, such as the integrative model of wisdom, propose that wisdom is not purely cognitive (2). Rather, it reflects the dynamic interplay of cognitive and non-cognitive factors. Cognitive components such as knowledge, metacognitive awareness, and self-reflection combine with non-cognitive elements like empathy, emotional regulation, humility, and a prosocial orientation to produce wise reasoning and behaviour (2).

Fostering Wisdom

The study of wisdom can inform the development of strategies that cultivate it both in the short term, within specific situations, and over the long term, where it becomes a stable trait rather than a temporary state (3). Short-term interventions are theorized to enhance a person's access to their previously acquired wisdom by encouraging the adoption of alternative perspectives, rather than by generating entirely new insights in the moment (4).

Research has shown several interventions can be useful in the short term such as encouraging a person to:

1. Adopt an external perspective e.g., imagine giving advice to someone else (5)
2. Take a distanced view of their problems (6), such as picturing themselves from a distance, almost like watching a scene from above or across the room;
3. Think about themselves in the third person (7), shifting from “Why am I feeling this way?” to “Why is X feeling this way?”

While short term interventions tend to be effective when the patient creates distance from their current distress longer term interventions appear to require the contrary, becoming intimate with the distressing moments of life (4). As Erikson’s intellectual successor, George Vaillant, observed, this deeper work requires cultivating ‘the capacity to come to terms constructively with our pasts and futures in the face of inevitable death’(8).

Longer-term increases in wisdom can be supported through reflection, that is looking back on one’s personal past to gain insight from it, which can then be applied to future situations. Interestingly, research suggests that wisdom is not correlated with the frequency of such reflection but with the motivation for doing so and the manner in which it is carried out, In terms of motivation, the ancient Greek maxim ‘Know thyself’, inscribed at the Temple of Apollo at Delphi, appears to ring true as being motivated by self-knowledge, rather than simply resolution is associated with greater wisdom (9) (4). This motivation is tied to the manner of reflection, with the two distinct pathways existing, redemptive processing which focuses on transforming negative events into positive outcomes and exploratory processing, which focusing on confronting negative emotions, analysing one’s role, and searching for meaning. Research shows that these pathways have distinct consequences: exploratory processing is associated with wisdom, but not necessarily with immediate well-being, whereas redemptive processingis linked to well-being and adjustment, offering a more direct and psychologically safer route to happiness (4).

Meaning or happiness

This raises a deeper question: Should people prioritize a meaningful but potentially less happy life, or a happy but less meaningful one? Victor Frankl famously argued that ‘Life is not primarily a quest for pleasure, as Freud believed, or a quest for power, as Alfred Adler taught, but a quest for meaning’(10). Happiness tends to be present-focused and grounded in the fulfilment of desires, whereas meaning is more enduring and often involves purpose, responsibility, and contribution. This distinction echoes findings from broader positive psychology research, for example, parents often report lower levels of day-to-day happiness but higher levels of meaning.

Ultimately, this is not a simple dichotomy in which one option is universally better. The choice depends on the individual and what they value: a life of comfort and satisfaction, a life of depth and purpose, or as I would argue a balance of both. It could be that some wounds in life are simply too deep and require complete healing to restore one’s ability to function and move forward. However, other wounds might be allowed to heal with a bit of scar tissue, becoming a bump in the road less travelled.

Conclusion

Wisdom is a complex concept associated with improved mental health outcomes, and in some developmental models it represents the final task of psychological growth. It is composed of both cognitive and non-cognitive components. In the short-term wisdom can be increased by creating emotional distance from a problem, allowing people to access their previously acquired capacities for wise reasoning. In the longer-term wisdom can be fostered through reflection motivated by the desire to 'know thyself', which encourages deeper processing that prioritises meaning over quick resolution.

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MY JOURNEY IN OLD AGE PSYCHIATRY: REFLECTIONS FROM UNIVERSITY HOSPITAL KERRY

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Moving from Malaysia to Ireland two and a half years ago has been one of the most transformative journeys of my life. Cork became my first home here, where I completed my rotations in general adult and perinatal mental health. Six months ago, I began a new chapter in Kerry, joining the Old Age Psychiatry team at University Hospital Kerry. The move not only brought professional growth but also a deeper connection with the people and pace of life in rural Ireland.

I've encountered a wide spectrum of presentations throughout my posting which have strengthened my skills in assessing older patients. Depression and anxiety often appear intertwined with bereavement, loneliness, and physical frailty. Dementia and other cognitive disorders bring challenges around capacity and risk, while psychotic symptoms may be driven by delirium or other neurological causes. These experiences are a reminder of the intricate interplay between physical and mental health in this population, while also reinforcing the importance of a holistic assessment that includes psychological and social factors. Old Age Psychiatry demands not only diagnostic precision, but empathy, patience, and curiosity about the whole person.

One of the most rewarding aspects of this job has been the opportunity to conduct home visits. Travelling with consultants and nurses to see patients in their own environment has offered a perspective that no clinic room could provide. Sitting at a patient's kitchen table, often over tea, revealed subtle details about their lives, routines, and support systems that shaped our clinical understanding in ways no assessment form ever could.

What has struck me most is the distinct character of life for many older people in rural Ireland. In Kerry, patients are often deeply rooted in small communities, with long-standing ties to family farms and local clubs. I noticed first-hand the strong culture of neighbourliness and looking out for one another. At the same time, I have seen how geographic isolation, limited public transport and the loss of local services can magnify loneliness, carer burden and barriers to accessing mental health care. Having previously worked mainly in larger urban centres, the contrast has been striking.

I had an opportunity to lead an interactive educational session at the local day centre. A day centre is a community-based facility where elderly individuals attend during daytime hours for social interaction, activities, and support services. These centres offer structured programs like meals, exercise, and therapeutic activities to promote independence and reduce isolation. They enable participants to return home in the evenings while providing caregivers respite. I gave informal talks on depression and mental health in older adults, touching on physical contributors such as polypharmacy, hyponatraemia, and the pitfalls of benzodiazepine use. I emphasised practical, non-pharmacological strategies — behavioural activation, social connection, and meaningful activity which empowers older adults to maintain well-being. The lively question and answer sessions that followed became the most valuable part. They revealed how eager people were to understand their mental health and how much misinformation still lingers. Witnessing that engagement reminded me how education and conversation can be as therapeutic as medication.

In a nutshell, Old Age Psychiatry is not just about managing illness ,it is about honouring each person's history, values, and hopes for dignity and quality of life. This rotation has deepened my respect for the resilience of older adults and for the subtle balance between independence and support that defines later life. The mentorship and camaraderie of my colleagues at University Hospital Kerry have made this journey both enriching and deeply personal. As I look ahead, I carry forward a genuine appreciation for the lessons rural psychiatry can teach about humanity and community that extends far beyond the clinic walls. I hope sharing my story encourages and motivates others to discover the profound rewards of working in Old Age Psychiatry.

STILL ALICE: REFLECTIONS ON MEMORY, AUTONOMY AND DYING

Dr Karishma Hurry,
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Lisa Genova's 2007 novel, Still Alice, and its 2014 film adaptation, starring Julianne Moore, offer a poignant exploration of identity's unraveling through early-onset Alzheimer's. This compelling work serves as a profound meditation on the fragile interplay of memory, selfhood, and love's enduring nature, inviting critical reflection on autonomy and human dignity. This narrative is particularly pertinent amidst Scotland's renewed debate on assisted dying, powerfully illustrating that autonomy and compassion are not abstract concepts, but lived realities for patients and their families.

A Quiet Unravelling of the Mind

The first time I watched Still Alice, I found myself listening for the silence that descends as words begin to escape. It is the same silence I have heard in clinic rooms: that fragile space - between knowing and forgetting, between self and shadow. The film adaptation of Still Alice asks for witness. Julianne Moore’s portrayal of Dr. Alice Howland, the brilliant linguistics professor slowly losing her language to early-onset Alzheimer’s, is profoundly resonant. We watch her consciousness fray at the edges even as the person - the mother, the wife, the scholar - clings to meaning, to memory, to the very structure of who she once was. Some films entertain; others alter how we see the world. This one reminds us that identity is not a fixed construct but a living dialogue: between memory and love, intellect and presence.

The Professional Gaze: Watching and Remembering

In old age psychiatry, we often navigate the thresholds between clarity and confusion, independence and reliance, loss and adaptation. Still Alice exquisitely captures these thresholds. Watching Alice’s quiet descent, I found myself recalling patients I have encountered: the ones who pause mid-sentence, their thoughts stranded mid-bridge; the ones who smile through bewilderment, painfully aware of what is slipping away. To practise in this field is to learn that memory is both biology and biography. It is a neurochemical sequence, yes, but equally, a narrative. When neurons fail, stories falter. That is where we, as clinicians, step in. Not to cure but to bear witness to the rewriting of a life.

A Life That Echoed Alice

During my old age psychiatry placement, I encountered a patient whose story eerily mirrored Alice’s. Julia, a 56-year-old solicitor specialising in Oil & Gas, and mother to an 18-year-old son, sought clinical assessment after what she described as “a few silly mistakes”: missed deadlines, misplaced files, and forgotten appointments. Her scans and tests told us what she already feared: early-onset Alzheimer’s disease. For a while, she managed with remarkable discipline and grace. But slowly, inevitably, her mind began to blur at the edges.

Words she once wielded like instruments of justice began to betray her. At home, her son became both her anchor and her caretaker. Their bond was marked by fierce, unspoken love, yet also by exhaustion and the ache of anticipatory grief. Julia dreaded becoming a stranger in her own home, fearing the moment when her son would look into her eyes and find not recognition, but vacancy. As her illness advanced, Julia chose to take leave while she still recognised herself. It was not despair but authorship. She oscillated between resolve and guilt, between the rationality of a lawyer and the tenderness of a mother. “Surely I should have a choice”, she stated to her old age psychiatrist, Dr. RA. That conflict - between autonomy and love - remains the most profound tension I have ever witnessed. In Julia’s story, I saw both courage and agony, both the will to protect her dignity and the longing to stay for her son’s future. Yet, her peaceful passing occurred in Switzerland, at Dignitas.

Autonomy, Dignity and the Poetics of Care

One of Still Alice's most haunting moments features Alice recording a message to her future self: a plea to retain autonomy in the face of oblivion. This act is both disturbing and profoundly tender. Julia’s choice, like Alice's, underscored the profound theme of authorship—the imperative to define one's final chapters before they are written by others. In medicine, autonomy is often discussed in clinical terms, yet its reality is profoundly poetic. To possess autonomy is to wield a voice; to possess dignity is to have that voice truly heard. As Scotland re-examines its stance on assisted dying, individuals like Julia emerge not as mere arguments in a policy debate, but as poignant reminders that compassion inherently resides in complexity. Still Alice offers no definitive answers, nor does it need to. Instead, it compels us to continue asking—gently, humbly, humanly.

Old Age Psychiatry: Bearing Witness

Our field often operates in the shadow of sadness, yet it is equally illuminated by moments of quiet grace. We do not merely assess cognitive decline; rather, we diligently guard the fragments of identity that persist. We preserve narratives, holding them steady when their narrators can no longer do so themselves. As the film's credits rolled, I found myself not grieving Alice's decline but rather marveling at the enduring essence that remained: the tenderness of touch, the resonant echo of language, and the profound persistence of love. I thought of Julia and of all the patients who live between remembering and forgetting. Still Alice transcends being merely a film about memory. It serves as a powerful reminder that love, compassion, and meaning persist beyond the reach of pathology. Even as memory fades, these elements remain immeasurable, inexplicable, profoundly, and enduringly real. Love endures.

This reflection is based on a real case. The author has sought permission from the patient’s next of kin to share her story here.

DEVELOPMENT OF AN OLDER ADULTS MENTAL HEALTH LIAISON TEAM PATIENT AND CARER BOOKLET AT GUYS & ST. THOMAS' HOSPITAL

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I developed The Older Adults Mental Health Liaison Team – Patient and Carer Information Booklet as a patient resource to enhance the experience, understanding, and engagement of older adults and their carers during hospital admissions at Guy's and St Thomas' Hospital. This project is intended to offer accessible and clinically accurate information to support individuals navigating mental health challenges alongside physical health needs.

Development of the OA MHLT patient and carer booklet provided an opportunity to critically examine the processes through which mental-health information is communicated to older adults within acute hospital settings. The primary aim of the booklet was to enhance patient understanding of liaison psychiatry, particularly the service provided by the OA MHLT, the rationale for psychiatric involvement, and the nature of the assessments and interventions offered. In producing this resource, for my development, I have reflected on several themes as follows: communication, accessibility, learning, and the challenges presented in synthesising complex information for patients.

Communication

A central consideration in the creation of the booklet was the need for high-quality patient communication. Liaison psychiatry is often introduced during periods of physical illness, cognitive vulnerability, or heightened distress, which can limit patients' ability to process and retain verbal information. This necessitated a written resource that conveyed essential concepts with clarity and sensitivity.

Translating clinical terminology into accessible language without compromising accuracy required careful reflection. For example, sections on the Mental State Examination, capacity assessment, and risk assessment were reframed to emphasise their supportive function. Similarly, descriptions of multidisciplinary roles were constructed to indicate psychiatric input consistent with patient-centred communication frameworks. This process reinforced the broader professional obligation to ensure that information provision promotes understanding, reduces anxiety, and facilitates collaborative engagement in care.

Accessibility

Accessibility served as the key principle underpinning the booklet's layout and tone.
The target population includes older adults who may present with sensory impairments, delirium, dementia, or emotional distress and therefore information needs to be concise, legible, and logically organised.
The booklet has short paragraphs, clear headings, and simple explanations. Complex legal concepts, such as the Mental Health Act and Deprivation of Liberty Safeguards, were distilled into succinct descriptions focused on patient rights and safeguards. Including sections on coping strategies, wellbeing, and carer guidance ensured the content was holistic

and addressed the psychosocial dimensions of hospitalisation. This process highlighted the role of written information as an accessibility tool that can supplement and reinforce verbal explanations, thereby supporting informed decision-making and autonomy.

Learning

Engaging in the content development process facilitated deeper reflection on the typical gaps in patient knowledge regarding liaison psychiatry. Patients frequently encounter psychiatric terminology and assessments such as risk assessment or capacity evaluation without adequate contextual explanation. This experience highlighted the importance of proactively addressing these gaps in a structured, patient-friendly manner.

Furthermore, drafting the sections on psychological therapy, medication, and discharge planning prompted reflection on the broader care pathways experienced by older adults in acute settings. It became evident that patient education must extend beyond immediate assessment to include preparation for ongoing community support, crisis services, and the role of carers. This broader learning reinforced the interconnected nature of psychiatric, medical, and social care in older adult mental health.

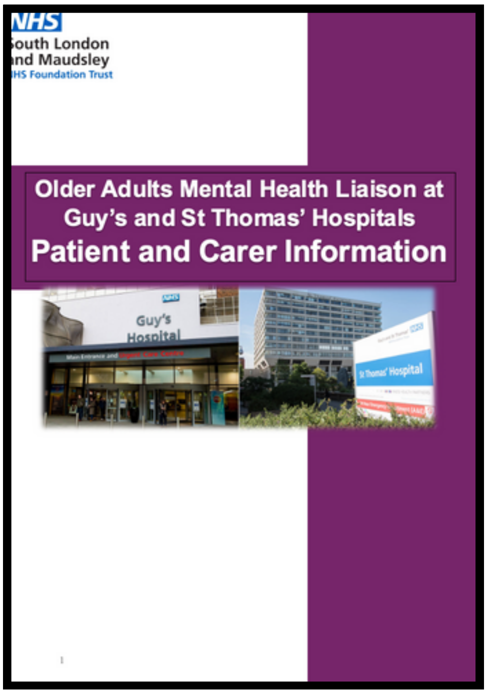
Challenges in the Creation Process

The creation of the booklet presented some challenges. A significant difficulty lay in balancing brevity with comprehensive coverage. The breadth of topics including multidisciplinary roles, legal frameworks, treatment options, and crisis pathways risked overwhelming the reader if presented in excessive detail. Conversely, oversimplification would have undermined the educational value of the resource. Achieving this balance required extensive editing.

A further challenge involved presenting sensitive clinical concepts in a manner that was non-alarming yet transparent. Discussions of risk, legal detention, or crisis management required careful framing to avoid provoking anxiety while still providing accurate and meaningful information. Additionally, ensuring internal consistency across sections written from different disciplinary perspectives medical, psychological, nursing, and occupational therapy necessitated coordination.

Conclusion

Overall, the development of an OA MHLT patient and carer booklet served as a valuable academic and clinical exercise in the dissemination of complex mental health information for an older adult population. The process highlighted the challenges inherent in translating specialist knowledge into a format that is cognitively, emotionally, and contextually accessible. Producing the booklet has strengthened my appreciation for the critical role that well-designed educational materials play in supporting informed, compassionate, and patient-centred care within mental-health liaison services.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If you would like to see a full copy of the booklet, you can email *LiaisonPsychOAGSTT@slam.nhs.uk*

GRATITUDE(2015) BY OLIVER SACKS; THE JOY OF OLD AGE

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It was during medical school that my attention was drawn towards the author, Dr Oliver Sacks; a British neurologist and profound thinker who was admired by many philosophers. He is best known for The Man Who Mistook His Wife for a Hat, case stories of patients living with the peculiarities of neurological disorders. Sacks studied Medicine at Oxford before moving to America where he remained until his death at the age of 82.

Published in 2015, Gratitude is a short collection of reflective essays:- Mercury, My own life, My periodic table and Sabbath. Written in chronological order from his 80th birthday to his final weeks, the essays encapsulate the reflections of a man looking back over his life nearing to the end. It is aAn inspiring, meaningful read that challenges our prejudices of aging, and invites us to consider what truly makes life worthwhile.

Each essay marks a significant occasion in the last few years of Sacks' life. He begins with his reflections on reaching eighty, namely Mercury - originally titled "the Joy of old age". As readers we are invited to question the concept of age and what it means to 'complete a life'. Sacks describes no attachment towards the word 'old', reportedly full of energy in a life that is seemingly just beginning. In particular, he frames his aging as an accumulation of knowledge and perspective rather than a decline. His reflections invite us to re-examine our own assumptions about later life and recognise its potential for increased wisdom rand enjoyment. He resonates with Freud's belief that "'love and work are the cornerstones of our humanness', " suggesting that our sense of fulfilment in old age is a measure of how individually or, equally, we have succeeded in these both. Are we motivated by our careers, in finding a sense of purpose? Or connection and love? For some who are fortunate to find purpose in both, as Sacks proclaims, age is boundless.

In My Own Life written after his diagnosis of terminal cancer he confronts the reality of dying. Here, we explore the importance of connection. Following his diagnosis, his intensity and eagerness for life deepens and he reflects on the friends that he has lost already. Loneliness is prevalent in older age however we know that positive social connections predict increased longevity and a lower risk of mortality. In Sacks' writing, his relationships appear to dominate many of his reflections, alongside his love for writing, with his priority to deepen friendships even in the face of death. My periodic table follows on from this with the under-current of connectivity being the root of healthy aging.

Sabbath, published just two weeks before his death, reflects on his challenges exploring sexuality and religion. He discusses his amphetamine addiction that stemmed from a craving of deeper connection and meaning. He emphasises the importance of reconciliation and the well-being of later life being sustained by belonging.

Living a good and worthwhile life is about achieving inner peace, which he connects to feeling a sense of gratitude and a life with a clear, essential focus. Through Oliver Sacks we are reminded that aging well is not merely the absence of disease, but the preservation of identity, meaning and connection. When we cultivate meaningful relationships and pursue work we love, we build a life shaped by gratitude—one in which, even in old age, we do not feel 'old' at all.

THE EMPEROR OF GLADNESS (2025) BY OCEAN VUONG

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Poet turned author Ocean Vuong's second book 'The Emperor of Gladness' is set in an opioid-plagued American town called East Gladness. The book begins dramatically with Hai, a nineteen-year-old boy struggling with addiction, standing on the edge of a bridge contemplating suicide. Grazina, an eighty-two-year-old woman with Frontal Lobe Dementia, interrupts this scene from the doorway of her crumbling house and invites Hai in for tea. Having run away from home Hai gladly accepts Grazina's offer to do simple care tasks in exchange for accommodation. I found the cross-generational friendship between Hai and Grazina the most compelling aspect of the novel, especially in contrast to the relationship between Grazina and her villainous son. Other storylines such as Hai's part-time work in an American fast-food restaurant bored me slightly and elongated the novel to a tiresome length, especially given Vuong's poetic writing style that often wanders from the plot. Overall it was a thought-provoking read but I wish it had been more condensed.

One of my favourite elements of the novel was the exploration of mutual benefit from caring roles when it comes to supporting those with dementia. At night Grazina's cognition deteriorates transporting her back to personal experiences of Lithuanian wartime. During these delusions Hai embodies Sergeant Pepper, a soldier who guides Grazina through her psyche . He believes that 'If she was that deep in the past, maybe he could reach her by going back there himself, something he did once or twice with his grandmother when she had one of her schizophrenic breaks' which suggests that Hai has a holistic approach to care in past and present[1]. For Hai these episodes act as a way to escape reality providing a therapeutic distraction from his desire for opioids. Therefore, Grazina's dementia becomes a liberation rather than burden and both characters form an interdependence on each other. By suggesting that the role of the care-giver can be therapeutic Vuong advocates for a more symbiotic relationship between care-giver and care-receiver. Whilst this is quite an an idealistic idea Vuong also emphasises the more practical side of caring for people with dementia. For example, Hai begins his care role by organizing Grazina's medications which she refers to as 'vitamins'. Grazina takes 13 pills a day ('three gabapentin for nerve pain [. . .] and a calcium tablet with breakfast') for various medical conditions[1]. The length and depth of this list, which resembles a geriatric medicine clerking note, weighs on the reader highlighting the burdens of polypharmacy on the elderly population. I enjoyed how Vuong incorporated these easily overlooked aspects of care into his novel as it gave the story a more balanced feel.

In contrast to Hai and Grazina's relationship, the more conventional relationship between Grazina and her son Lucas is very oppressive. Lucas appears abruptly in the middle of the novel flashing his Power of Attorney. He insists that Grazina needs to be placed in care against her wishes. At one point he defends his oppressive yet distant role saying 'Six months after that she'll be dead weight in a wheelchair. I'm trying to keep my distance to protect myself,'. Whilst Hai and Grazina escape together, Lucas escapes from Grazina to 'protect' himself against her cognitive decline, believing that his mum will become a burdensome 'dead weight' due to her dementia. I felt Vuong explored this viewpoint in a nuanced way by locating the origin of his character's ideas. In this case Lucas believes he is acting in Grazina's best interests, 'You're safe now' he says when she is eventually brought into a care home against her wishes[1]. As a reader it's clear that Lucas does not have Grazina's best interests at heart but you are powerless over the situation unfolding which made me more invested in the plot. I think anyone involved in making decisions surrounding capacity and consent would find this aspect of the story interesting and at times infuriating.

In conclusion, Ocean Vuong's new book has led to me reflect on how best to care for those with dementia. In particular, this fictional work presents opposing paternalistic and patient-centred approaches to care and offers an insight into the benefits of the latter. I think anyone involved in caring for those with dementia would enjoy this story and feel seen by the complex dilemmas explored.

What's on your reading list this Winter? If you'd like to write a book, film or other cultural review for The Old Psychiatrist then please email us: oldage@rcpsych.ac.uk

ECHOES OF LOVE

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We often come across older patients with varied presentations and this particular patient left a deep mark on me. I did take a bit of creative liberty to write this. However, it is based on one such interaction during my domiciliary visits.

It was a regular community visit at a care home for a routine cognitive assessment, but one that made me ponder over the mysteries of the human mind yet again.

I had come for a routine domiciliary visit to assess Mrs X, a 90-year patient with visual and hearing impairment whose world had shrunk to the sensations she could still grasp- warmth, touch and the faint murmur of voices.

Even though Mrs X wore hearing aids and glasses, she could not hear me properly, nor see me very well, so I leaned in close as was advised by Ms Y, a carer, who was in attendance. My voice loud enough, yet gentle, as I asked her how she was feeling. Before my words could settle, she pressed a warm kiss to my cheek, soft and deliberate.

I smiled, surprised, but touched by her affection. Perhaps she mistook me for someone familiar.

I introduced myself and again, I leaned in to ask another question, and she reached out to hold my hand and kissed it gently- this time with a small, contented sigh. A ghost of something flitted across her face, something deeper than recognition. Something fleeting, yet impactful.

Feeling a little unsure, I politely signalled to Ms Y, the carer, ‘Maybe you could ask Mrs X the questions instead?’ I definitely could do with a little help here.

The carer, perhaps accustomed to such mysteries kindly obliged. But when the carer leaned in to repeat my question, Mrs X kissed her too, with the same warmth, the same quiet joy. Each question was rewarded with the same warm affection. No words said- just a gentle smile and a kiss!

There was no mistaking it, this wasn’t confusion, nor a mere habit. It was something deeper, perhaps something intricately woven into the entire fabric of her being.

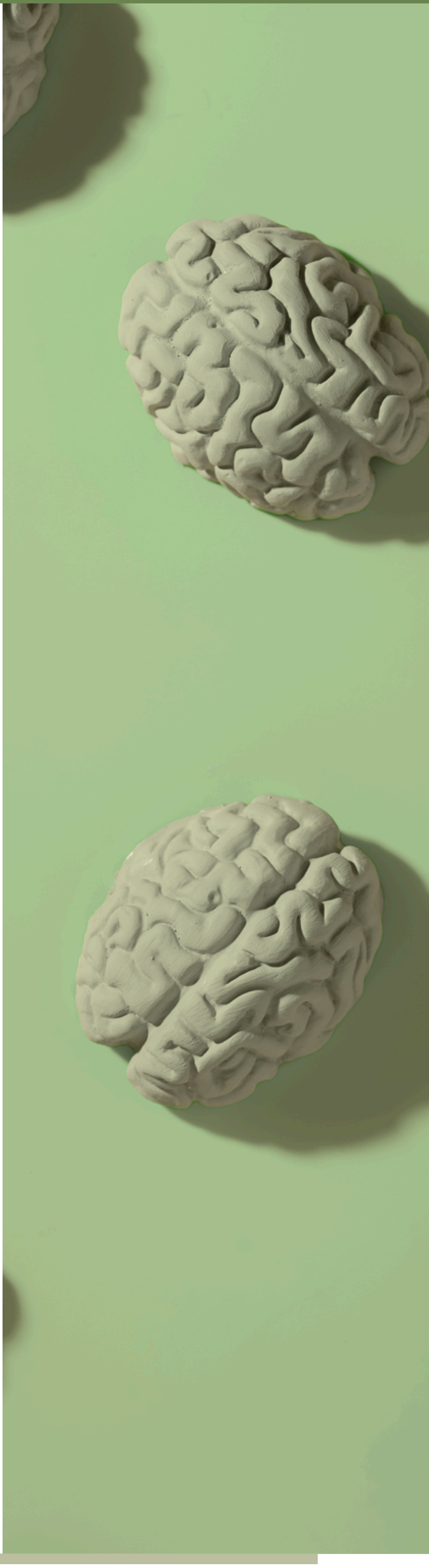
Perhaps, in the fog of her mind, love was the last thing that remained. A gesture long repeated, a memory that outlived names and faces. Was she thinking of a husband long gone? A child she once cradled and comforted? Someone who had leaned in close, once upon a time, and spoken words she no longer remembered, but whose presence she had never truly lost?

A place in her mind where faces blurred, time unravelled but the affection endured...

CPD CORNER

In this section, we offer you some ideas about upcoming conferences and courses related to Old Age Psychiatry. The list is directed towards trainees, but of course these courses may be of interest across various career stages.

Please send any course recommendations and reviews you think should be included to oldage@rcpsych.ac.uk



26-27 March 2026
Faculty of Old Age Psychiatry Annual Conference 2026
Hybrid In-person/ Livestream event, RCPsych, London

24- 26 September 2026
European Association of Geriatric Society: Intensive Refresher Course in Old Age Psychiatry
In-person, Leuven, Belgium

Flexible dates - <April-Oct 2026
The Oxford Clinical Neuroimaging Course
Online, self-paced

11 February 2026
Impact of Loneliness on Mental Health
Online, RCPsych

WINNERS OF THE NATIONAL OLD AGE PSYCHIATRY RESIDENT DOCTOR ESSAY PRIZE 2024

This prize is awarded annually by the Old Age Faculty for an original and inspiring essay of between 4,000 and 6,000 words on a broadly based clinical topic directly relating to the care of mentally ill older adults.
There are two prizes; one for a Foundation Doctor/ Core Trainee (£150) and one for a Specialty Trainee (£150).
The closing date is 1st November each year.

Information about the various available prizes can be found on the Faculty's prize page.

This year's winners are...

Dr Miriam Alwerdani (CT category) - for an essay entitled *'Culture, Cognition, and the Meaning of Care in Old Age Psychiatry'*

and

Dr Muthumathi Swamenathan (ST category) for an essay entitled *'Healthy Aging and Successful Aging- The Amalgamation on Dementia Landscape; from Prevention to Dying Well'*

Read their winning essays below!

CULTURE, COGNITION, AND THE MEANING OF CARE IN OLD AGE PSYCHIATRY

Dr Miriam Alwerdani
Core Psychiatry Trainee (CT2)

Abstract:

Old age psychiatry sits at the intersection of medicine, memory, and meaning. This essay explores how cultural narratives shape the understanding and experience of ageing and dementia. Drawing on my journey from practising medicine in Egypt to psychiatry training in the NHS, I reflect on the importance of recognising and integrating cultural context to meet the mental health needs of older adults. Through my work with the Dementia Support Initiative in Egypt (DSIE), I illustrate how community-based projects can bridge medical knowledge with local culture and lived experience. A culturally informed, community-centred approach does more than improve clinical outcomes, it reshapes how compassionate care is understood in later life. By placing empathy, dignity, and human connection at the centre, old age psychiatry can move beyond diagnosis to support meaning, identity, and personhood. This essay argues that effective psychiatric care for older adults must be rooted in community dialogue and cultural awareness.

Origins of a Question

I have often reflected on a question that lies at the heart of both medicine and life: what makes a life worth living? This question feels especially poignant in the care of older adults, where illness, frailty, and cognitive decline can begin to blur the boundaries of identity and purpose. My search for answers did not begin in lecture halls or textbooks, but in the quiet human moments I witnessed as a young doctor in Egypt. On the wards of geriatric medicine, I met patients whose memories had faded and whose sense of self diminished in the eyes of those around them. Dementia revealed itself not only as a biological illness but as a deeply social one - marked by stigma, misunderstanding, and profound loss. Families often felt helpless and alone, unsure how to respond to the changes they were witnessing. Too often, patients were dismissed as simply “getting old,” losing their social roles and sense of belonging while still alive.

It became clear that dementia existed in a double shadow: biological decline intertwined with social neglect. This realisation left me convinced that the stories and struggles of people living with dementia needed to be brought into public view. Patients and carers needed to be seen and supported; communities needed to understand the difference between ageing and dementia. This conviction inspired me to begin volunteering in community outreach projects in Egypt, working to raise awareness and foster understanding.

Working across two worlds —Egypt and the UK —has taught me that dementia care is inseparable from culture. In Egypt, the challenge lies in building awareness and access; in the UK, it lies in making care inclusive and culturally responsive. These early encounters continue to shape my practice and my thinking, prompting a question that continues to guide my practice: *how can healthcare systems respond compassionately and effectively to the mental health needs of older adults, while honouring the cultural meanings through which illness is experienced?*

“Marad Al-Kharaf”: Dementia and the Fear of Alienation

One experience that stands out from my early years is an elderly man who could no longer recognise his daughter, though she visited him every day. She held his hand and softly repeated her name, as if anchoring him to the present. In her other hand, she carried a bag of medications prescribed by different doctors—each one aimed at a symptom, yet none touching her father’s loss or her own confusion and guilt. That moment captured how dementia care sits at the crossroads of medicine, family, and culture.

The Arabic term for dementia, **Marad Al-Kharaf**, literally means “the disease of confusion.” The phrase carries an implicit message of decline and hopelessness, reinforcing the perception that dementia is just a normal part of ageing rather than a medical condition that requires care. Stigma deeply shapes how the illness is experienced and understood. Many families, worried about judgment, delay seeking medical help until the condition has advanced, often resulting in late diagnoses and unnecessary suffering.

For many patients, stigma becomes a very personal struggle. Some respond to the first signs of cognitive change with denial, unsure what a diagnosis might mean for their independence or sense of self. Others experience a quiet sense of disconnection—wondering if a phone they can no longer use is broken, or if they still “fit” in a world that suddenly feels unfamiliar. These small, confusing moments show just how real the fear of losing one’s place in life and in the eyes of others can be.

Cultural Silence and the Stories We Tell About Dementia

In many Middle Eastern cultures, memory loss is interpreted through moral or spiritual lenses. Families may view it as a test of faith, a sign of divine will, or simply an inevitable part of ageing. While such beliefs can offer comfort, they can also obscure opportunities for early intervention and support.

The fear of being labelled as mad or lost adds another layer of silence. Popular media often portrays people with dementia as completely disoriented or incapable, shaping public attitudes and even influencing how families perceive the illness. These portrayals reinforce shame and denial, making it harder for individuals to seek help and maintain dignity.

Caregiving carries a profound emotional and practical weight. In Egypt, this responsibility often falls on daughters and wives, who balance long hours of care with employment and social duties without formal training or respite. Institutional care remains culturally stigmatised and is often perceived as an act of ingratitude or betrayal (1).

Public awareness is still limited. In a cross-sectional study I participated in and published in July 2024, nearly one-third (33.4%) of participants demonstrated poor knowledge about dementia, and 37.1% believed it was simply a normal part of ageing (2).

Confronted with these challenges, I felt compelled to act. In 2022, I co-founded the Dementia Support Initiative in Egypt (DSIE) with senior colleagues who shared these concerns (3). Our aim was to create a platform for open dialogue about dementia, provide families with reliable information, and promote a view of people living with dementia as individuals deserving understanding and dignity.

DSIE evolved into several community-based activities. We organised awareness campaigns in hospitals, universities, and community centres using accessible language to explain what dementia is and how it progresses. We held interactive workshops for caregivers, offering both practical strategies and emotional support, and engaged nurses, junior doctors, and allied health professionals who are often underprepared for the complex realities of dementia care.

With support from the International Brain Research Organization (IBRO), we expanded our activities, produced educational materials, and engaged local communities to spark conversations about dementia. Collaboration was a cornerstone of DSIE's success, with partnerships formed between IBRO, the American University in Cairo, and the Egyptian Red Crescent. Our work was recognised internationally through conference posters presented at the IBRO Annual Congress (Spain, 2023) and the RCPsych Old Age Psychiatry Faculty Conference (UK, 2023) (4).

Through this work, I learned that effective dementia care must address both medical and cultural realities. In Egypt, where family bonds are deep but formal support is limited, understanding cultural context is not optional—it is essential. I also realised that community engagement is not a one-way process; listening to caregivers and patients revealed unmet needs, misconceptions, and practical challenges that guided the evolution of DSIE's programs. These lessons reinforced a broader principle: sustainable impact in dementia care requires collaboration, humility, and continuous dialogue with the communities we aim to serve.

Bridging Worlds: Practising Psychiatry in the NHS

When I moved to the UK and started the psychiatry training, I carried with me the memories of the patients and families I had met in Egypt - their confusion, courage, and hope. Entering the NHS was both inspiring and humbling. Mental health services were more structured and multidisciplinary. Yet as I began working with older adults, I realised that even in such a welldeveloped system, the challenges were not entirely different from those I had seen before.

In my first placement in general adult psychiatry, I met older patients with complex presentations: depression masking cognitive decline, late-onset psychosis complicated by frailty, and dementia accompanied by behavioural disturbance. What struck me most was not only the clinical complexity but also the quiet grief that surrounded it. In Egypt, families grieved the gradual loss of loved ones amid stigma and silence. In the UK, that grief was often more contained, expressed through quiet withdrawal as relatives faded behind illness, even when care and support were available.

My subsequent placement in older adult psychiatry services deepened this reflection. I observed thorough cognitive assessments, collaborative team meetings, and thoughtful communication with families. Yet, beneath the surface, subtle cultural barriers persisted. I remember one older South Asian man with advanced dementia whose family hesitated to seek help, fearing judgment and misunderstanding. They described feeling "lost between two systems": their own traditions of family care and a healthcare system that seemed to speak a different language.

These experiences echo a broader reality across the UK. An estimated 25,000 people currently living with dementia are from Black, Asian, and minority ethnic (BAME) backgrounds; this figure is projected to rise to 50,000 by 2026 and over 170,000 by 2051, given the ageing BAME population (5&6). Despite this growing need, these groups remain underrepresented in dementia services and often present later in the course of illness.

Several qualitative studies have examined why people from BAME backgrounds may be hesitant to seek professional help for dementia symptoms. The barriers are complex, spanning factors related to patients, caregivers, communities, and healthcare professionals, as well as structural aspects of services. Among South Asian communities in particular, help-seeking is often influenced by cultural beliefs, stigma, and limited understanding of dementia as a medical condition. On the professional side, challenges such as language barriers, limited cultural awareness, diagnostic uncertainty, and time pressures can further impede timely assessment and support (7-10).

I came to realise that, despite differences in healthcare infrastructure, dementia care shares a similar emotional landscape: love intertwined with loss, resilience alongside helplessness, and the universal struggle to find meaning as memory fades.

Culture, Care, and Connection in Later Life

Working across two healthcare systems, from the crowded geriatric wards of Egypt to the structured, multidisciplinary pathways of the NHS, has reshaped my understanding of ageing, mental illness, and what it means to provide care. I have come to see psychiatry as a practice of meaning-making.

Older adults with mental illness often face multiple vulnerabilities, including physical frailty, cognitive decline, bereavement, and social isolation. Yet they also show remarkable resilience, insight, and depth of emotion. I have met patients who, despite significant memory loss, retain emotional clarity in love or faith. These encounters have reminded me that clinicians are called not just to treat symptoms, but to sustain personhood and preserve what endures as memory fades.

Culture shapes nearly every aspect of mental health care. In Egypt, explanations for dementia often blend medical, moral, and spiritual perspectives, while in the UK, similar patterns emerge within minority communities. Recognising these beliefs does not undermine scientific practice; rather, it enriches clinical understanding. Engaging with patients and families within their cultural frameworks fosters trust and allows care to be relevant, meaningful, and personcentred.

The Cultural Lens in Old Age Psychiatry

This perspective has led me to cultural psychiatry, a discipline that frames mental illness as an experience profoundly shaped by social context, personal beliefs, and collective meaningmaking. Cultural frameworks influence not only how psychological distress is expressed and when help is sought, but also how individuals and families sustain hope in the face of illness.

Culture encompasses shared traditions, beliefs, values, and lifestyle practices. It is central to an individual’s identity and shapes how people perceive and respond to the world. It informs language, religion, gender roles, education, and migration history, all of which influence behaviour, cognition, and emotion (11,12).

Culture also informs how individuals interpret health and illness, including dementia. These influences shape not only how symptoms are expressed and understood, but also whether and when individuals decide to seek help, shaping their interactions with health care services. Moreover, cultural values may influence resilience to cognitive decline, as well as the lived experience of dementia within families and communities (13).

For instance, in my work with older adults in Egypt, I observed families interpreting memory loss as a test of faith or as part of divine will. At first glance, such beliefs might appear to contradict medical models of dementia, yet they often serve an important social and emotional function: helping families navigate fear, uncertainty, and grief in a culturally intelligible way. Far from rejecting medical care, these interpretations coexist with efforts to seek treatment, balance caregiving responsibilities, and maintain a sense of dignity for the affected individual.

Differences in expectations around autonomy, responsibility, and caregiving can also create tension. In some cultures, decisions about treatment or care may be made collectively, whereas Western biomedical practice often emphasizes individual consent and autonomy. Navigating these differences demands sensitivity, negotiation, and clear communication to ensure ethical care that respects both the patient's rights and their cultural framework.

In reflecting on my work in both Egypt and the UK, I am struck by the universality of human experience: the fear of losing oneself, the grief of watching a loved one fade, and the small victories of connection and understanding. Yet, the context —the cultural, social, and familial environment— shapes how these experiences are lived and interpreted.

The psychiatrist's role, therefore, extends beyond simply combining cultural and biomedical perspectives; it involves facilitating an open, respectful discussions that identifies potential tensions, and acknowledges cultural boundaries It also requires reflection on one's own assumptions and cultural lens, ensuring that the process of negotiation is mutual and grounded in respect rather than paternalism. In this way, cultural psychiatry becomes both a clinical and ethical practice, aiming not only to treat illness but to honour the stories and identities of the individuals and families we serve.

Policy Frameworks: Embedding Culture in Psychiatric Practice

In the UK, several national frameworks underscore the importance of culturally appropriate care within psychiatry services. The Care Quality Commission (CQC) defines culturally appropriate care as being responsive to people's cultural identity, beliefs, and heritage, and encourages care providers to understand and respect individuals' preferences and backgrounds when planning and delivering (14).

The Royal College of Psychiatrists (RCPsych) highlights in its Standards for Older Adult Mental Health Services that services should be person-centred, accessible, and culturally appropriate, ensuring that patients' spiritual and cultural needs are met in both community and inpatient settings (15). Similarly, the GMC-approved Old Age Psychiatry Curriculum requires psychiatrists to demonstrate an understanding of how cultural, spiritual, and religious factors influence clinical presentation and patient experience (16).

Culture and Cognition: The Limits of Standardised Cognitive Tests

During my work in both Egypt and the UK, I became increasingly aware that cognition cannot be understood in isolation from culture. Standardised cognitive assessments, while valuable, often fail to capture the nuances of an individual's abilities when applied across diverse cultural and linguistic contexts.

Previous reviews in cultural psychiatry have highlighted the importance of adopting a cultural approach when assessing dementia patients, particularly among individuals from BAME backgrounds (17-19). Cognitive testing should move beyond a one-size-fits-all model to consider the sociocultural and linguistic realities that shape how people think, communicate, and perform.

Cultural background shapes not only what is assessed in a cognitive test but also how the process and its results are interpreted. Most cognitive tests were developed in Western populations, reflecting specific education systems, languages, and social expectations. Because of this, they may not always represent the abilities of individuals from other cultural or linguistic groups. When these tests are applied to individuals from different backgrounds, they can measure familiarity with the test context rather than cognitive ability itself. For example, tasks requiring abstraction or verbal fluency may be influenced not only by cognitive decline but also by literacy, educational opportunity, or primary language.

Even small details, such as how instructions are given, how comfortable someone feels during testing, or how they interpret a task, can be shaped by cultural expectations about authority, communication, and performance (17,19). Using culturally relevant normative data is essential. Normative data establish the typical range of cognitive performance and the cut-offs for identifying impairment within a specific cultural or linguistic group. Without this, clinicians risk over- or under-diagnosing cognitive problems, as test scores may be compared against inappropriate benchmarks. Some international projects have begun developing adapted tools and culture-specific datasets to improve accuracy, but progress has been slow, and coverage remains limited (17).

Language and Bilingualism in Cognitive Assessment

Assessing cognition across different languages and literacy levels presents unique challenges, as standard tests may not fairly reflect an individual's true abilities (17). Tools such as the Multilingual Naming Test, the Bilingual Verbal Abilities Test, the Receptive and Expressive OneWord Picture Vocabulary Tests – Bilingual Edition, and the Rowland Universal Dementia Assessment Scale (RUDAS) have been developed to address these challenges by providing better assessments across cultural and linguistic backgrounds (20–24). However, limited training opportunities and the absence of locally validated normative data can still make interpretation difficult, sometimes leading to diagnostic uncertainty, delayed intervention, or misjudged abilities.

In practice, I have seen how these limitations play out. For instance, a bilingual patient I assessed in the UK performed poorly on a verbal memory task in English but demonstrated much better recall when tested in their first language. The initial results could have suggested a memory impairment, but the discrepancy reflected language proficiency rather than cognitive decline. This experience highlighted how easily cultural and linguistic factors can confound cognitive testing and how vital it is to interpret results within the context of an individual's background, education, and lived experience

Acculturation and adaptation

Acculturation is the process of adapting to a new cultural environment. It adds another layer of complexity to cognitive assessment. For many older adults who have migrated later in life, adapting to a new language, health system, and set of social norms can be both enriching and disorienting. Factors such as age at migration, language proficiency, and the strength of connection to one's original cultural identity all influence cognitive test performance and even how symptoms are described or perceived (17, 25).

Open conversations with patients about their migration story, preferred language, and the ways they navigate between cultures can transform a routine cognitive assessment into a more collaborative and meaningful encounter. These discussions often reveal important details, such as which language feels most natural for recalling memories or performing everyday tasks. These details can significantly affect cognitive test outcomes. Taking time to understand how a person's cultural background shapes their sense of self and communication style helps ensure that assessments are not only technically accurate but also compassionate and respectful.

Structured tools like the Abbreviated Multidimensional Acculturation Scale can support this process by providing a framework to understand how individuals adapt to and integrate aspects of their heritage and host cultures (26).

Such measures remind us that cognition exists within language, identity, and the wider landscape of lived experience. In this way, cognitive assessment becomes more than a test of memory or attention, it becomes a window into how people live, adapt, and sustain meaning across cultural contexts.

Bridging Research Gaps: Toward Inclusive Evidence

Despite growing recognition of cultural diversity in clinical practice, research in dementia and cognitive ageing continues to reflect significant ethnic and racial disparities. Minority groups remain underrepresented, and there is still limited understanding of how sociocultural experiences shape cognition, ageing, and symptom presentation (27).

These gaps have real clinical consequences. When research samples lack diversity, the assessment tools, and reference norms built from them may fail to capture the true abilities or needs of individuals from different cultural and linguistic backgrounds.

Bridging this gap requires more than simply adding diverse participants to existing studies; it calls for research designed with cultural context in mind. Studies that explore the influence of bilingualism, education, migration, and lived experience can offer more accurate insights into what “normal” cognitive ageing looks like across populations. Community-led and crossnational collaborations are especially valuable, as they generate data that are both scientifically valid and socially relevant (17).

Toward Culturally Informed Assessment

Taking cultural and linguistic factors into account can greatly enhance the accuracy and meaningfulness of cognitive assessments. These factors include such as acculturation, education, literacy, and bilingualism. Such considerations allow clinicians to interpret test results within the context of a person’s lived experience, rather than relying solely on standardized cut-off values that may not reflect their background.

Beyond accuracy, culturally informed assessment ensures that any recommendations or interventions are relevant, respectful, and aligned with the individual’s values and daily life. Cognition is not separate from culture; it is shaped by the social, linguistic, and cultural environment in which a person lives. By approaching assessment with this understanding, clinicians can preserve dignity, recognise the individuality of each person, and support their personhood, even in the face of cognitive decline.

The Art of Old Age Psychiatry

Old age psychiatry is as much about understanding life as it is about understanding illness. Each patient and caregiver I meet offers a window into how meaning is maintained despite vulnerability, loss, and change. Life retains significance not solely through memory, but through connection to others, to purpose, and to self.

As psychiatrists, we are privileged to witness this truth. We meet individuals at their most vulnerable, yet also at their most resilient. Our role extends beyond alleviating suffering to helping patients and families rediscover meaning, even when it feels out of reach.

Culture is not a mere backdrop to this work; it actively shapes how illness is experienced, interpreted, and healed. Recognising the influence of beliefs, traditions, and social expectations allows us to meet patients where they are and to see them not only through the lens of medicine but within the context of their humanity. The art of old age psychiatry lies in this dual awareness: applying scientific understanding while remaining open to the personal and cultural narratives that give illness its human texture.

Closing Reflection: Culture, Connection, and the Meaning of Care

My experiences across two cultures have shown me that the essence of old age psychiatry lies in understanding people within the worlds they inhabit. The elderly woman in Cairo praying for clarity and the South Asian man in Southampton hesitant to speak of his confusion were not merely patients with cognitive decline, but individuals negotiating identity, belonging, and hope within their own cultural frameworks. These encounters reminded me that medicine cannot be detached from meaning.

Dementia, in particular, blurs the boundary between memory and identity. As the illness progresses, language and recognition may fade, but emotional understanding often remains. A culturally sensitive approach allows clinicians to recognise these enduring forms of selfhood. Being aware of gestures, faith practices, and family customs can help maintain connection even when verbal communication is limited. For multilingual individuals, the return of a first language in later stages of dementia is a poignant reminder that language and memory are deeply intertwined; acknowledging this is an act of preserving dignity rather than merely a linguistic adjustment.

Culture also shapes the collective response to illness. In some communities, caring for an older relative at home is viewed as a moral duty; in others, seeking professional or residential care represents love and protection. Neither view is inherently superior. What matters is that psychiatrists explore what care means to each family and work collaboratively to align support with their values. This requires humility, patience, and genuine curiosity.

Community engagement offers a powerful way to bridge cultural divides. Through my work with the Dementia Support Initiative in Egypt, I learned that awareness grows not from information alone, but from dialogue. When patients, carers, and professionals share their stories, stigma softens, and empathy deepens. Advancing research is essential to ensure that cognitive assessment and diagnosis reflect the diversity of those we serve. One important step is developing normative data that identify the typical range of cognitive performance and test cut-offs within specific cultural and language groups. Without such data, clinicians risk comparing patients to inappropriate benchmarks, which can lead to misinterpretation or misdiagnosis. By including diverse participants and validating tools across settings, research can make cognitive assessment more accurate and meaningful for everyone.

Looking ahead, I hope to contribute to psychiatry practice that is grounded in cultural humility, one that recognises difference while holding on to what we share as human beings. My experiences across Egypt and the UK have taught me that global mental health should not seek to smooth out cultural distinctions, but to listen to them and learn from them. The aim is not to make care the same everywhere, but to make it meaningful for each person, within the world they call their own.

Culture is not a barrier to care but the context that gives it meaning. To engage with culture is to recognise the full depth of human experience. In this way, old age psychiatry becomes more than a medical specialty - it becomes an act of respect, a way of affirming that even as memory fades, personhood endures through relationships, traditions, and shared stories. In that space between medicine and meaning, culture does not divide us; it connects us.

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HEALTHY AGING AND SUCCESSFUL AGING- THE AMALGAMATION ON DEMENTIA LANDSCAPE; FROM PREVENTION TO DYING WELL.

Dr Muthumathi Swamenathan
Specislty Trainee (ST4)

The aging earth and its greying people- both wise, weathered and wrapped in the quiet grace of time. This is the epitome and reality of today’s global scenario. With over 55 million people currently living with dementia worldwide, this number is projected to triple by 2050; the urgency to rethink on aging is undeniable. As the elderly demographic continues to expand worldwide it s an unquestionable fact that dementia prevalence and its economic and healthcare costs are ever rising. A cure for dementia seems distant in the timeline of progress. Hence, prevention of dementia is an urgent and evolving frontier in public health. Understanding how to enhance cognitive reserve and prevent dementia has become a pressing issue. The 2024 update of the Lancet Commission on dementia prevention, intervention, and care offers a compelling and hopeful perspective on reducing the global burden of dementia. As life expectancy increases, so does the number of individuals affected by this condition, particularly in low- and middle-income countries. Yet, the Commission highlights that up to 40% of dementia cases could be prevented or delayed by addressing 14 modifiable risk factors across the lifespan, including low education and learning, hearing loss, vision loss, midlife hypertension, diabetes, dyslipidemia, smoking, physical inactivity, social isolation, obesity, excessive alcohol consumption, traumatic brain injury, depression and air pollution. This evidence-based approach underscores the importance of proactive public health strategies and lifestyle changes to preserve cognitive health and improve quality of life worldwide.

As everyone ages and goes through the process of aging, there arises deep reflection on the foundation and connection between the aging and dementia spectrum. Can healthy aging prevent dementia? Is the diagnosis of dementia indicative of unsuccessful aging? Is an exclusive focus on healthy aging sufficient for a comprehensive understanding of the dementia journey? The aging process has fascinated scientists for centuries, and while no single theory fully explains it, several major frameworks offer compelling insights. The most extensively studied theory of aging in relation to dementia is the cognitive reserve theory. This theory posits that individuals with higher levels of mental stimulation through education, occupation, and engaging activities develop a "reserve" that helps them better cope with age-related brain changes and neuropathology, such as those seen in Alzheimer's disease. Sources of resilience against neurodegenerative diseases, such as the cognitive reserve, have been identified as modifiable factors that can prevent the manifestation of clinical dementia. The concepts that often surface in discussions surrounding aging are healthy aging and successful aging. These two concepts are well-known, thoroughly studied, and widely accepted worldwide. While they share certain similarities, they underscore different facets of the aging process. What is the basis of these concepts that could enhance one’s life journey in relation to dementia? This essay delves into the interaction between healthy and successful agings across the dementia continuum from prevention to a dignified end of life with focus on illuminating their philosophical foundations, practical applications, and implications for caregiving. Both concepts have been meticulously scrutinized in relation to dementia, and this discourse endeavors to illuminate how they can be seamlessly integrated at every tier of care, from day to day clinical practices to the formulation of national policies.

The concept of healthy aging was formally introduced by the World Health Organization (WHO) in 2015 as a shift from its earlier framework of active aging, which had been established in 2002. This transition marked a significant evolution in global public health thinking, moving from a focus on participation and activity to a broader understanding of aging that emphasizes functional ability, intrinsic capacity, and the environmental factors that support wellbeing in older age. WHO defines healthy aging as the process of maintaining good physical, mental, and social health and well-being as we grow older. Guided by the concept, National Institute for Health and Care Excellence (NICE UK) focuses on enabling older adults to live well for longer by promoting good physical and mental wellbeing through regular activity, balanced nutrition, and emotional support. Prevention and early intervention are pivotal to reduce the risk of long term health conditions like hypertension, diabetes, heart diseases and dementia. It ensures older people have choice and control over their daily lives by fostering independent living and dignity. It further cultivates supportive environments that encourage social connection, safety, and accessibility in homes and communities. The existing integrated healthcare system further deepens this concept by treating individuals holistically, coordinating health, social, and community services. These principles aim to shift the focus from reactive treatment to proactive, person-centred care that enhances quality of life as people age.

Healthy aging becomes the core for the development of WHO's Global Action Plan on the Public Health Response to Dementia (2017–2025). The plan sets out seven strategic areas, including raising awareness, reducing risk, improving diagnosis and care, supporting caregivers, strengthening data systems, and promoting research. Many countries have launched national dementia strategies aligned with WHO's Global Action Plan framework, helping to destigmatize dementia and promote early intervention. Over 40 countries have developed or are implementing dementia plans, with growing emphasis on risk reduction and community-based care. WHO has supported member states in strengthening surveillance systems and integrating dementia into broader health information platforms.

Healthy aging concept undoubtedly recognizes all of the risk factors laid out as per The Lancet Commission for dementia prevention. It beautifully covers the bio-psycho-social aspects of preventing dementia. While NICE UK primarily focuses on physical, mental, and social health in its practical guidelines, many broader frameworks of aging process recognize that spiritual health plays a vital role in aging with dignity, purpose, and peace.

Successful aging, on the other hand, is a more challenging concept to define. The concept of successful aging emerged in the mid 20th century as a response to shifting societal views on older adulthood. Traditionally, aging was associated with inevitable decline and dependency, but post-World War II, optimism and advances in public health began to challenge this narrative. In 1961, American psychiatrist Robert J. Havighurst introduced the term "successful aging," emphasizing active engagement, life satisfaction, and adaptation to age-related changes. The idea gained momentum in the 1980s and 1990s through the influential work of Rowe and Kahn, both from United States, who defined successful aging as low disease risk, high cognitive and physical function, and active social participation. This paradigm shift reframed aging as a dynamic, multifaceted process that could be shaped by lifestyle, environment, and personal agency. Not only it encompasses an individual's subjective experience of life in their later years, it also emphasizes the ability to maintain physical health, mental sharpness, emotional resilience, and social engagement well into older age. As people grow older, the goal shifts from avoiding illness to embracing vitality, independence, and purpose. It shifts the narrative from aging as decline to aging as continued growth and contribution. By fostering healthy habits, nurturing relationships, and adapting to life's changes with grace, individuals can experience aging as a fulfilling and empowering chapter. Successful aging involves adapting to age-related changes, coping with loss, acceptance and maintaining a sense of purpose and engagement in life. It values resilience, social networks, and the capacity to find joy despite the inevitable challenges of aging.

The global response to Rowe and Kahn's model of successful aging has been both influential and critically reflective. It was widely embraced in Western countries. The model has guided aging related interventions in the U.S, Canada, and parts of Europe, influencing programmes that promote physical activity, cognitive health, and social participation among older adults. It laid the foundation for initiatives like the WHO's healthy aging framework and national aging strategies that prioritize autonomy and engagement. However, it has its limitations when applying the concept to diverse population worldwide especially to low and middle income countries as there are socioeconomic constraints with limited resources and funding for healthcare systems. Many nations still lack the infrastructure or funding to implement comprehensive dementia strategies. Thus, the concept was not universally accepted when it was first introduced by Rowe and Kahn. In short, Rowe and Kahn's 1997 model has been a catalyst for global dialogue on aging, prompting both admiration and adaptation to meet the needs of diverse populations.

While successful aging prioritizes emotional and psychological well-being, it does not specifically target the mechanisms or risk factors that might lead to dementia. For example, individuals may report feeling satisfied with their lives despite having chronic health issues or even dementia. Thus, successful aging may encourage a positive mindset, but it does not necessarily guarantee the absence of dementia or unavoidable health conditions.

When comparing the two approaches, healthy aging focuses on years before dementia develops, thus it targets all the people across the lifespan who are potentially at risk of developing dementia in future, thus it emphasizes more on the disease prevention through objective health indicators backed by evidence-based researches and implementations of this concept by WHO and NICE UK. This mirrors that healthy aging actually starts from childhood. The inclusion of diverse aging experiences which emphasizes equity and global applicability adds tremendous strength to the healthy aging concept. While successful aging includes many of the same elements, it adds layers of subjective well-being, purpose, and emotional resilience. These are important for coping with aging and living well, but they are less focused on prevention and more on quality of life after aging-related changes occur. It does little to mitigate the biological risks associated with dementia. The principles of successful aging mirrors its point of attention to people with the diagnosis of dementia.

It becomes evident that healthy aging is more directly linked to addressing the dementia risk factors objectively. People who prioritize healthy aging are generally more proactive about their physical health, which translates into better cognitive outcomes. Additionally, the trajectory of cognitive functions tends to be more favorable among those who adhere to healthy aging principles. However, it is essential to recognize that both approaches can be complementary. An individual can pursue a healthy lifestyle while also fostering a sense of purpose and social connectivity, embodying the principles of both healthy and successful aging. This holistic view may provide the most substantial protective effects against dementia, merging the benefits of physical health with emotional well-being. Embedding both concepts into public health sectors and healthcare are equally important.

So why does it matters that healthy aging and successful aging should go hand-in -hand in dementia journey? Healthy and successful aging play a vital role in shaping effective dementia care and prevention strategies. By enabling early identification of frailty, cognitive decline, and mental health concerns such as depression, clinicians can intervene before these issues escalate. This proactive approach allows for the development of personalized care plans that align with each older adult's unique goals, preferences, and lifestyle. As a result, positive outcomes are reflected on decrease in hospital admissions for dementia patients, medication use becomes more precise, and overall quality of life is enhanced. Moreover, these aging frameworks support dementia prevention by targeting modifiable risk factors and fostering cognitive resilience throughout the aging process.

In clinical settings, the principles of healthy and successful aging are applicable through tools like the Comprehensive Geriatric Assessment (CGA). CGA is a multidimensional, interdisciplinary diagnostic process that evaluates an older adult's medical, psychological, functional, and social capabilities. It enables early detection of frailty, cognitive decline, and depression, and supports the development of individualized care plans that reflect the older adult's aims and values. This approach improves outcomes, including reduced hospital admissions, better medication management, and enhanced quality of life. Dementia-friendly services also reflect the values of both aging models. In the UK, initiatives such as Integrated Care Systems (ICS), Dementia Friends and Dementia cafes promote early diagnosis, caregiver support, and community engagement. Healthy aging principles are evident in efforts to create age-friendly environments, while successful aging contributes by encouraging older adults to remain active participants in their care.

Sensory health is another critical area. Hearing and vision loss are key risk factors for dementia. Healthy aging promotes regular screening and access to aids, while successful aging encourages adaptation and continued engagement despite sensory decline. Together, these approaches help maintain communication, autonomy, and social inclusion. Importance of sensory organs are checked and corrected are crucial before dementia diagnosis is made or misdiagnosis of dementia is given. Cognitive assessments are difficult if hearing and vision impairments are not corrected prior. Primary care physicians hold important role in identifying this significant risk factor.

Carer education and heightened awareness regarding the risk factors associated with dementia, as outlined in the Lancet's Commission report on dementia prevention, should be prioritized at the primary care level by general practitioners. Primary healthcare services represent a crucial avenue for the prevention of non-communicable diseases by fostering modifications in individual behaviors and lifestyles. In England, a prime illustration of this is the NHS Health Checks programme. This initiative has the potential to serve as a platform for the integration of a personalized dementia risk assessment, a possibility that has been recognized in both dementia-related and public health policies.

Every referral to a memory clinic for dementia evaluation must emphasize the significance of preventive education, particularly for family members. Elevating the awareness of families and caregivers regarding dementia prevention could potentially mitigate the prevalence of dementia in the long term. Even though the informations on risk factors and prevention are readily available, not many attending the memory services are aware that dementia is actually a preventable disease. Informational leaflets on dementia prevention should be readily accessible in general practitioner clinics as well as in memory clinics. This initiative clearly illustrates the concept of healthy aging. The doctors in training and community psychiatry nurses of the older adult community mental health team who will engage with patients and their families on regular basis must be equipped with comprehensive knowledge of prevention strategies and aging principles. The implementation of psychoeducation to family should be rendered obligatory during home visits, should it not already be an effective standard practice within primary care settings or memory services.

Another positive move within memory services is to designate a specific day each month that is exclusively devoted to the prevention of dementia. On this occasion, the elderly care team could focus on organizing succinct educational programmes for caregivers regarding modifiable risk factors associated with dementia. This step could be executed in collaboration with dementia day care centers or dementia cafes. Such efforts would facilitate networking among caregivers and foster the formation of carer support and caregiver groups. The organizers ought to promote active engagement from families and caregivers, providing ample opportunities for inquiry and discussion.

World Alzheimer's Day 2025 embraces the theme "Ask About Dementia. Ask About Alzheimer's," a compelling call to action that fosters open dialogue, promotes early diagnosis, and mitigates stigma. Additionally, World Alzheimer's Day 2024 centered around the theme "Time to Act on Dementia, Time to Act on Alzheimer's." It is increasingly evident that these themes underscore the significance of healthy aging within the framework of prevention. In everyday clinic practice, these themes can be woven into patient interactions by fostering a culture of curiosity and compassion. Healthcare professionals can initiate conversations with older adults and their families about memory changes, cognitive health, and preventive strategies. normalizing these discussions as part of routine care. Clinics can display educational materials with prompts like "Have you asked about dementia today?" "What is your risk?" "Do you know dementia is preventable?" to encourage patients and carers to voice out concerns early, making cognitive health a shared responsibility.

Healthcare professionals should increasingly make use of AI and digital tools to educate families on dementia prevention in more personalized and accessible ways. Through smart apps, virtual coaching platforms, and wearable devices, carers can receive tailored insights on lifestyle changes that reduce dementia risk such as improving sleep, diet, and cognitive engagement. AI-driven chatbots and virtual assistants offer around the clock support, answering questions and guiding families through evidence-based strategies. Digital dashboards in memory clinics could help doctor to track progress and share visual feedback with families, making prevention efforts more transparent and collaborative. This tech-enabled approach empowers families to take proactive steps, transforming dementia care from reactive to preventive.

Suggestion is that a comprehensive and standardized referral letter from general practitioners to memory clinics be instituted. This referral form should encompass all pertinent risk factors relevant to the patient. These risk factors must be addressed and managed expeditiously. Conditions that mimic dementia, such as depression and delirium, should be systematically excluded. Therefore, the referral should incorporate assessments for depression and delirium, if deemed necessary based on the patient's history, prior to their referral to memory services. The form should emphasize on medical comorbidities, completed investigations, risk assessments, and the social dimensions of care. This standardized referral process could streamline the workflow of services within memory clinics and diminish the rejection rate. From the perspectives of both patients and caregivers, it could conserve valuable time and energy that would otherwise be spent visiting memory clinics only to encounter unwarranted rejections.

In order to effectively implement national policies at the level of local populations and individuals, there is a need for a transparent, stable, and well-structured healthcare system allowing for identification and sharing of good practice both nationally and internationally. A separate, specific national dementia prevention policy may provide consistency in delivery throughout the country as this would separate prevention from other dementia-related issues such as diagnosis. This could provide a coherent governance structure within the public health domain, similar to the way in which prevention of other non-communicable diseases is handled. Policies and strategies need to focus on the full range of dementia specific factors including social isolation and lack of cognitive stimulation. Specific, key messages would be preferable to broad and vague statements about “improving lifestyle” or “changing behavior”.

Regular assessment of national policies concerning dementia prevention is imperative for comprehending the ramifications of policy outcomes on populations, communities, and individuals, particularly in relation to behavioral modification. Such evaluations also facilitate the identification of deficiencies and potential causes of ineffectiveness, thereby aiding in the formulation of future policy initiatives. It is crucial that these evaluations are conducted with clearly articulated, quantitatively defined expected outcomes, such as a reduction in the incidence of dementia, objectively measured enhancements in behavior, and a decline in dementia risk scores over time.

Even with a dementia diagnosis, individuals can experience joy, creativity, and connection. This challenges the binary view of aging as either successful or failed. Healthy aging supports this by focusing on what people can do, not what they’ve lost. Successful aging evolves here to include emotional resilience, spiritual growth, and relational depth. Programmes that promote intergenerational interaction, active family participation in the dementia care, creative expression, and community participation help people with dementia maintain identity and integrity. These reflect the shared values of both aging models been highlighted namely engagement, autonomy, and meaning. Living well with dementia requires a shift from deficit-based thinking to strength-based care, where the focus is on enhancing quality of life rather than merely managing symptoms. Successful aging is achieved when consultants and psychiatrists offer guidance on effective coping strategies and lifestyle adaptations following a dementia diagnosis. We frequently advocate for active social engagement, the pursuit of hobbies, participation in day care centers, involvement in group activities, and the continuation of cognitive stimulation through endeavors such as board games, crossword puzzles, and music appreciation. Additionally, ensuring adequate sleep, engaging in pet therapy, orientation therapy and partaking in reminiscence therapy are all indicative of successful aging and flourishing while living with dementia.

Dying well is an often-overlooked aspect of aging, yet it is an integral aspect to both healthy and successful aging. It is the sixth pillar of the Dementia 100: Pathway Assessment Tool. Healthy aging recognizes dying as part of the life course, advocating for compassionate, person-centered care. Successful aging, when expanded, includes acceptance, wisdom, and legacy-building. Advance care planning is a key component. Encouraging conversations about end-of-life preferences ensures that care reflects the individual's values and supports families in making informed decisions. This aligns with both models, emphasizing autonomy, respect and relational continuity. Spiritual and emotional dimensions are also critical. Dying well involves more than symptom management. It includes emotional closure and spiritual wellbeing. These aspects are often overlooked in clinical settings but are central to aging well. Integrating palliative care with dementia services ensures that individuals can die with dignity, surrounded by support and understanding. Trained nurses within community mental health teams who manage patients with advanced dementia are indeed capable of providing care in a community setting through a well-integrated approach to care planning.

The pinnacle of nursing in the geriatric realm resides in its compassionate embrace of holistic care, wherein dignity, autonomy, and emotional well-being are esteemed alongside physical health. This practice is deeply rooted in empathy and sagacity, acknowledging the principles of successful aging. Nurses emerge as advocates, companions, and healers in navigating older adults through the intricate labyrinth of aging with grace and fortitude. By cultivating environments that nurture independence, celebrate life narratives, and honor the uniqueness of each elder person with dementia, nursing holds the power to transform successful aging into a journey of perpetual growth and fulfillment.

In short healthcare professionals play a pivotal role in shaping the dementia landscape through advocacy, interdisciplinary collaboration, and workforce training. Advocacy involves championing age-inclusive policies, raising awareness about dementia prevention, and ensuring equitable access to care for older adults. Interdisciplinary collaboration is essential for delivering holistic, person-centred care services bringing together geriatricians, nurses, therapists, psychologists, social workers, and community partners to address the complex needs of aging individuals. Medical workforce training must ensures that clinicians are equipped with the latest knowledge and skills in gerontology and dementia care, fostering a culture of empathy, competence, and continuous improvement across healthcare settings. This encompasses fundamental insights into the principles of healthy and successful aging, elucidating their similarities and distinctions, as well as their applicability within clinical practices.

Challenges persist concerning accepted policy implications and global perspectives, encompassing cultural sensitivity, resource allocation, and research deficiencies. One model and one policy to fit all globally is glaringly impossible especially in relation to dementia realm. Aging models must evolve to accommodate a spectrum of beliefs and values, and further research is imperative on aging with dementia, particularly within underrepresented populations. Striking a balance between prevention and care necessitates strategic investment and cross-sector collaboration.

To summarize the ongoing quest to prevent dementia, healthy aging emerges as the more effective approach due to its direct emphasis on risk factors and preventive measures. It aligns with research findings that connect lifestyle choices with cognitive health. However, the role of emotional wellbeing and fulfillment in the successful aging paradigm should not be overlooked, as they contribute significantly to an an individual's overall quality of life. To optimize dementia prevention, a dual approach that incorporates both healthy and successful aging principles may provide the most comprehensive strategy, ultimately enhancing the quality of life in our later years while mitigating the risks associated with cognitive decline.

Therefore, healthy aging and successful aging are not competing paradigms, they are complementary lenses that enrich our understanding of the dementia landscape. Healthy aging provides the scaffolding for equitable, inclusive, and systemic change. Successful aging offers the motivational blueprint for personal growth, resilience, and engagement. Together, they guide us from prevention to dying well, ensuring that aging is not merely about surviving longer, but living meaningfully. In a world where dementia threatens to overshadow the promise of longevity, embracing both models is not just wise but it is also essential. By integrating these frameworks into clinical practice, public health policy, and community life, we can build a future where aging is celebrated, supported, and empowered at every stage.

So, to address the initial conundrum, healthy aging indeed serves as a preventive measure against dementia. Successful aging, in turn, fosters a profound acceptance of dementia. While healthy aging emphasizes preventive measures, successful aging is primarily concerned with post diagnosis strategies. The synthesis of these two concepts is essential for navigating the trajectory of dementia, from its prevention to living well and the experience of dying with dignity. It encourages families, carers, and healthcare professionals to shift from fear based narratives to ones rooted in empathy, open-mindedness and resilience. It calls for memory clinics, care systems and policy makers to evolve beyond diagnosis, embracing a model that supports lifelong wellness, emotional preparedness, and lifelong connection. In doing so, we not only mitigate the burden of dementia but also elevate the experience of aging itself.

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