

Editorial

Normal Aging and Cognitive Impairment Revisited

In psychogeriatrics, clinicians are often confronted with the problem of whether a patient's clinical disorder is associated with an organic brain syndrome. Such pathological cerebral changes and the associated impairments are often very difficult to distinguish from "normal," nonpathological changes. Everyone has to cope with some limitations in old age. Having to cope with changes in social position and social environment and with the loss of certain abilities is part of the aging process, but in psychogeriatrics, attention must go beyond the assessment of how a person deals with loss. A so-called normal aging person can overcome such losses, compensating for deficits in a particular area by drawing on skills acquired through a lifetime of experience.

Practitioners must determine which abilities and capacities are intact and what little-used or unused resources may be able to compensate for illness-related deficits. The assessment is by nature an interdisciplinary diagnostic process involving physicians, psychologists, social workers, nurses, and others. A final diagnosis should be made only after integrating findings from all disciplines. The evaluation should provide extensive description and analysis of the patient's condition, identifying areas in which interventions could be effective.

In the realm of cognition itself, mild dementia and normal aging may be difficult to differentiate, particularly in the old-old:

1. Few large empirical studies have been conducted on older persons. Older people are harder to reach and to recruit for research projects and may have somatic or mental impairments that limit their performance, thus confounding the results. Tests standardized for geriatric populations should be applied. Particularly welcome are tests that have been developed especially for older persons, and so have points of emphasis particularly relevant to aging. Apart from conventional norm-oriented methods, consideration should be given to criterion-oriented methods, which do not assess patients' performances in comparison with their age group, but use a ranked order of abilities needed to cope with particular demands. Such methods investigate only whether these abilities are present or absent.

Unfortunately, there are currently few of these techniques, and more research is needed in this area, drawing on the combined talents of theorists and clinicians. Most commonly used assessment methods do not have adequate age norms and may not use tests developed specifically for the elderly. The elderly may be lumped together as those over 60 or over 65. Yet the performance of a 66-year-old person cannot easily be compared to that of an 86-year-old; in a study of very old patients, this must be considered when the results are interpreted. Additionally, most assessment methods are oriented to the performance spectrum of younger adults. Skills are often tested that are relevant to a young person's life, not to an older person's. For instance, speedy performance of monotonous concentration tasks indicates nothing about the skills older people need to cope by themselves in their apartments.

2. Currently available empirical findings are based mainly on data from cross-sectional studies. Yet this approach compares not just different age categories but different generations, thus comparing people who have developed in disparate historical and cultural circumstances. The results of longitudinal studies differ strikingly from those of cross-sectional studies. Whereas the latter show a continual decrease of mental performance with age, which is in line with the common stereotype of aging, longitudinal studies show that certain mental functions not only remain stable into later life, but can continue to develop. Longitudinal studies thus appear much more suitable for describing and assessing the cognitive performance of elderly people. Unfortunately, there have been only a few large-scale longitudinal studies (only one, excluding studies with just two assessment points, was carried out in the specific cultural environment of Germany). The main reason for this scarcity is the high cost of such studies.
3. Analyses of longitudinal studies have shown that intraindividual fluctuations of performance increase with age and often are more marked than interindividual differences. These fluctuations make it even more difficult to define standards of "normal aging." Considering the theoretical properties of the available tests and measurements for use in making cognitive assessments of elderly patients, it is not surprising that a patient's performance could be found to be impaired in one study and improved in a follow-up study. Such differing results can be much more closely related to circadian fluctuation, the weather, or other situational factors than is true with younger persons; and this variation, clearly, can reduce the reliability of a single test. Thus, repeated testing is needed to allow a more accurate assessment than a single result, which could represent a performance peak or trough.

What are required are tests that objectively and subjectively assess age-relevant aspects of performance and whose results bear on an older person's ability to cope with his or her situation. To this end, methods should be used that are not designed simply to target deficits or impairments of particular functions but also to provide information about the quality of unimpaired capacities.

Furthermore, there is clearly a need to standardize methods of measurement. Currently, dozens of rating scales and psychological tests exist that differ from each other only in minor details. Standardizing them could, among other advantages, further communication between research groups and contribute to making assessment more effective and comprehensive. In dealing with performance changes that are much more complex than previously thought, stronger efforts are needed to comprehensively address patients' needs and abilities. Doing so will be difficult; one hopes, however, that it will not be akin to the medieval alchemist's fruitless search for the philosopher's stone.

Some limitations of assessments are more concrete and involve the patients themselves. Elderly persons cannot be recruited for investigations in the same way as younger subjects. In most cases, they cannot tolerate as much strain and discomfort, and they often have a physical handicap that can affect performance. Visual or motor disturbances can slow down or prevent the understanding of verbal or written instructions. Further, medical treatment during the diagnostic phase or the effects of psychoactive drugs may influence test results.

An elderly person may be less motivated than a younger person to perform as well as possible on a test. The elderly patient may not understand the purpose of the investigation, may understand it but disagree with its usefulness, or may feel overtaxed and hard-pressed—particularly shortly after hospitalization. Often, a patient performs well at least in part because of a good relationship with the investigator. This indicates the importance of a familiar and sympathetic atmosphere, which includes a comfortable physical setting, an absence of time pressure, and an empathic interviewer.

To conclude, inaccurate assessments and interventions occur too often because of a deficit-oriented focus, unreliable or invalid tests, poor settings, poor rapport, and the lack of multidisciplinary input. In psychogeriatrics, the focus is on whether patients can be treated so that they can once more cope with their familiar surroundings. If a particular impairment cannot be reversed, then areas unaffected by pathological changes must be strengthened through training and practice.

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