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# Geriatric Psychiatry in Palliative Care: Addressing Mental Health Disorders in Older Adults with Advanced Illnesses

**Nia Okonkwo***

*Department of End-of-Life Care, University of Nairobi, Kenya*

**Abstract**

Geriatric psychiatry plays a pivotal role in palliative care by addressing the complex mental health needs of older adults with advanced illnesses. Conditions such as depression, anxiety, delirium, and dementia frequently complicate the palliative phase, exacerbating suffering and reducing quality of life. This article explores how integrating geriatric psychiatric expertise into palliative care enhances symptom management, supports decision-making capacity, and improves patient and family outcomes. Through a review of current approaches and evidence, it demonstrates the value of tailored interventions in this population. The findings advocate for a multidisciplinary framework to bridge mental health and end-of-life care, ensuring holistic support for aging patients facing terminal conditions.

**Keywords:** Geriatric psychiatry; Palliative care; Mental health; Older adults; Advanced illness; Depression; Anxiety; Delirium; Dementia; Multidisciplinary care

## Introduction

Older adults with advanced illnesses, such as cancer, heart failure, or chronic obstructive pulmonary disease, often experience a high burden of mental health disorders. These conditions—ranging from depression and anxiety to delirium and dementia—can intensify physical symptoms, impair communication, and complicate palliative care goals. Geriatric psychiatry, with its focus on the psychological and neurological challenges of aging, offers specialized tools to address these issues within the palliative context. Unlike general psychiatry, it accounts for age-related factors like polypharmacy, cognitive decline, and frailty, which are prevalent in this population [1,2].

Palliative care aims to alleviate suffering and enhance quality of life, yet mental health is frequently under-addressed, overshadowed by physical symptom management. The integration of geriatric psychiatry seeks to close this gap, providing targeted interventions to improve emotional well-being and support patients and families through the end-of-life journey. This article examines the methods, outcomes, and implications of embedding geriatric psychiatric care into palliative settings, highlighting its potential to transform care for older adults with life-limiting illnesses [3].

## Methods

The integration of geriatric psychiatry into palliative care involves a combination of assessment tools, therapeutic interventions, and interdisciplinary collaboration. Data for this article were synthesized from studies and clinical reports published between 2020 and 2025, focusing on older adults (aged 65+) with advanced illnesses receiving palliative care. Mental health assessments utilized validated scales, such as the Geriatric Depression Scale (GDS), Hospital Anxiety and Depression Scale (HADS), and Confusion Assessment Method (CAM) for delirium. Diagnoses were confirmed by geriatric psychiatrists or trained palliative care providers [4,5].

Interventions included pharmacotherapy (e.g., selective serotonin reuptake inhibitors for depression, antipsychotics for delirium), psychotherapy (e.g., cognitive-behavioral therapy adapted for frailty), and non-pharmacological approaches (e.g., music therapy, reminiscence therapy). Multidisciplinary teams—comprising psychiatrists, palliative physicians, nurses, social workers, and chaplains—collaborated to tailor care plans. Settings ranged from inpatient hospices to home-based palliative programs. Outcomes were measured via symptom severity scores, patient-reported quality of life (QoL), caregiver burden indices, and rates of psychiatric consultation. Qualitative data from patient and family interviews provided additional context on care experiences [6].

## Results

Evidence reveals that geriatric psychiatry significantly enhances palliative care for older adults with advanced illnesses. In a 2023 study of 300 hospice patients, 62% screened positive for at least one mental health disorder depression (45%), anxiety (30%), and delirium (25%)—with 15% exhibiting comorbid dementia. Psychiatric intervention reduced depression severity (GDS scores) by 35% within two weeks, compared to 10% with standard care. Anxiety symptoms (HADS scores) decreased by 28% with combined pharmacotherapy and psychotherapy, versus 12% in controls [7].

Delirium management improved markedly: a 2024 trial showed that early psychiatric consultation resolved symptoms in 70% of cases within 48 hours, compared to 45% with palliative care alone, reducing agitation and distress. Patients with dementia benefited from non-pharmacological interventions, with QoL scores rising 20% in those receiving music therapy versus 5% in standard care groups. Caregiver burden scores dropped by 18% when psychiatric support was included, linked to better patient symptom control and family counseling [8].

Psychiatric consultation rates rose from 20% to 55% in palliative settings adopting integrated models, reflecting increased recognition of mental health needs. Qualitative feedback underscored emotional

***Corresponding author:** Nia Okonkwo, Department of End-of-Life Care, University of Nairobi, Kenya, E-mail: OkonkwoN@unairobi.ac.ke

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relief: patients described feeling "heard," while families valued clearer communication about prognosis and treatment options. However, rural programs reported lower consultation rates (30%), citing limited access to specialists [9,10].

## Discussion

The results affirm that geriatric psychiatry addresses a critical gap in palliative care for older adults with advanced illnesses. High prevalence of mental health disorders—often underdiagnosed—underscores the need for routine screening and intervention. Depression and anxiety, if untreated, amplify pain and fatigue, while delirium can mimic terminal restlessness, leading to inappropriate management. Psychiatric expertise ensures accurate diagnosis and treatment, distinguishing reversible conditions (e.g., medication-induced delirium) from irreversible decline.

Pharmacotherapy and psychotherapy, tailored to geriatric physiology (e.g., lower doses to avoid toxicity), effectively reduce symptom burden, enhancing QoL. Non-pharmacological approaches, particularly for dementia, offer low-risk alternatives that align with palliative goals of comfort over cure. The reduction in caregiver burden highlights a ripple effect: supporting patients' mental health eases family stress, fostering resilience during loss.

Challenges include workforce shortages geriatric psychiatrists are scarce, especially in rural areas—necessitating training for palliative teams in basic psychiatric skills. Stigma around mental health in older adults persists, with some providers viewing depression as "normal" in terminal illness, delaying referrals. Polypharmacy risks, common in this population, require careful coordination to avoid adverse interactions. Ethically, capacity assessments by psychiatrists aid decisions about treatment withdrawal, but cultural differences in mental health perceptions can complicate family discussions.

The broader implication is a call for systemic change: mental health must be a core pillar of palliative care, not an afterthought. Telepsychiatry could expand access, while integrated care models embedding psychiatrists in palliative teams could standardize practice. Future research might explore AI-driven screening tools or biomarkers to predict psychiatric risk, refining interventions further.

## Conclusion

Geriatric psychiatry in palliative care bridges a vital gap, addressing mental health disorders that profoundly affect older adults with advanced illnesses. By reducing symptom severity, improving quality of life, and supporting caregivers, it enhances the palliative experience, ensuring that psychological well-being is not sidelined. Despite barriers like specialist shortages and stigma, the evidence supports its integration as a standard of care. As the aging population grows, embedding geriatric psychiatric expertise into palliative frameworks will be essential to deliver compassionate, comprehensive support, honoring the dignity of patients in their final stages of life.

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## Conflict of Interest

None

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