THE PSYCHIATRY OF OLD AGE - A REVIEW

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ABSTRACT:

The absolute number of older adults is increasing throughout the world. Furthermore the proportion of the population which they make up is increasing. This is most evident in developing countries. At the same time traditional culture is giving way to urbanisation resulting in less support for the elderly. The delivery of health care to the elderly has extensive economic, social and political implications. Additional resources will be required to meet this demand. This review highlights the demographic changes throughout the world and specifically in Nepal. The psychiatric illnesses of the older adult and the special aspects of their management are discussed. In the conclusion there are guidelines for the way forward as suggested by international health organisations.

Key Words: Aged, psychiatric, dementia, psychological, Nepal, resources

INTRODUCTION:

Psychiatry of Old Age is a relatively new discipline in developed countries and in its infancy in developing countries. In the past the mental health problems of older people were neglected in preference to the more visible and demanding problems of younger adults with severe psychotic and affective disorders. The elderly, particularly with dementia, were seen as a burden. Psychotic and affective disorders in the elderly were largely left untreated. Resources and research were directed towards the care of younger adults. Families were left unsupported. Geriatricians, general psychiatrists and private institutions had to respond to the increasing demands of caring for the elderly with mental health problems and this was often done

reluctantly. About 30 years ago in Britain the Royal College of Psychiatrists and the government responded to this crisis by demonstrating a commitment to prioritising and resourcing a service specifically for the care of the elderly with mental health problems.

POPULATIONS TRENDS:

The World

In Mid-1993 the world population was estimated at 5,544 million, almost three quarters, 4,240 million, living in the less developed countries¹. On average 6% of the total world population is over 65 years, this varies according to region: 14% in Europe, 13% in the United States, 5% in Asia and Latin America and only 3% in Africa. The world

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population is estimated to grow at a rate of 1.7% annually, the rate in developed countries is expected to be 0.5% and 2.1% in developing countries. Furthermore the number of aged in the world will more than double from 500 million in 1990 to over 1 billion by 2025². This increase being more dramatic in developing countries - the population aged 60 years and over will multiply more than nine times from 171 million in 1998 to 1.594 million in 2050³. The variation in population growth is largely due to regional variations in birth rate and life expectancy⁴.

Nepal

In 1998 the population of Nepal was recorded as 23.7 million, an increase 5.2 million (28%) from 1991. The increase between 1981 and 1991 was approximately 3.5 million (increase of 23%). The projected population of Nepal for 2010 is 31 million and for 2025 is 39.5 million⁵. In 1991, the absolute number of people over 60 years and over 75 years, respectively, was 1,070,874 (5.8% of the total population) and 185,165 (1.7%). The average life expectancy in Nepal is now 57 years, having increased by approximately 10 years in the last generation. The age for life expectancy varies from region to region within Nepal and is slightly lower for women⁶.

PSYCHIATRIC ILLNESS IN THE ELDERLY:

The common psychiatric illnesses of the elderly include dementia, depression, psychotic illnesses, neurotic disorders, adjustment disorders and to a lesser extent the addictions.

Dementia

Dementia is a chronic and progressive brain disease. It is characterised by memory difficulties, personality changes, central disturbance of speech, loss of routine skills and impaired judgement. The commoner causes are Alzheimer's disease (AD), vascular dementia (VaD), Lewy Body dementia (LBD) and alcohol dementia. The prevalence of dementia in those over 65 years ranges from 2-7% for moderate and severe dementia⁷. Irrespective of the specific prevalence found in a particular coun-

try it is found to double every 5 years after the age of 60 years⁸. Alzheimer's Disease is more common than vascular dementia in western Europe and the United States, the converse is the case in China, Japan and the Soviet Union⁹.

The search for aetiological factors of Alzheimer's disease continues. Risk factors for Alzheimer's disease include a positive family history of Alzheimer's disease and Parkinson's disease, increasing age, a history of hypothyroidism, female gender, a history of head injury, a history of depression, and possibly exposure to aluminium.

The aim of assessment should be to identify reversible cause of dementia (found in up to 10% of cases), identify coexisting physical illness and functional psychiatric illness. Relatives should receive full information and support, and patients and their families should be introduced to available services and support. It is worthwhile distinguishing AD from VaD as the latter may be due to underlying causes which are remedial. It is also important to distinguish dementia from delirium, pseudodementia (perhaps due to depression) and focal brain disorders, as the management of these disorders is substantially different to that of dementia.

Management of dementia requires a full psychiatric and physical history and examination. Investigations should include serology for syphilis and the human immunodeficiency virus (HIV), vitamin B12 and folate estimations (if available) and thyroid function tests. Routine ECG and CXR should be done to exclude concurrent physical illness. Where there is a clear clinical history of Alzheimer's Disease a CT Scan of the brain is unlikely to help management. The CT Scan of the brain is normal in a sizable minority of patients with AD and can show cortical atrophy and ventricular enlargement in older adults with apparent normal cognitive functioning. It should perhaps be reserved for those patients with an acute onset, focal neurological or psychological signs, and those younger patients where other disorders may be responsible for the cognitive decline.

Recently anticholinesterase inhibitor drugs have become available for the symptomatic treatment of patients with Alzheimer's disease. There is evidence that vitamin E, selegiline and ginkgo bilbo may offer benefit. People with early dementia can often manage at home with a little help, but in the later stages they require 24 hours supervision.

Affective Disorders in the Elderly

Depression in the elderly can be missed¹⁰ or identified but left untreated¹¹ - perhaps due to therapeutic nihilism. But depression is not inevitable in old age, it is common and an eminently treatable disorder. Depression presents with feelings of sadness, loss of energy and drive, reduced interest in previously enjoyed activities, disturbed sleep and poor appetite. Cognitive impairment may be the presenting clinical picture (depressive pseudodementia). Somatic symptoms may be more common in elderly depressive than their younger counterparts¹². Diagnostic difficulties arise when there is co-existing physical illness, the biological or somatic symptoms of depression, such as weight loss or fatigue, being attributed to that physical illness. Obsessive-compulsive, hypochondriacal, hysterical and anxiety symptoms in the elderly may be the result of an underlying depression. Suicide is common in the elderly and attempted suicide, even if the method appears innocuous, should never be ignored in this group.

Mania in old age can be the relapse of an illness that had its onset at a younger age or can occur for the first time in late life. A significant number with first episode mania in old age have an underlying organic brain disorder. Assessment and investigation of this latter group should include a search for such a lesion.

Paranoid Illness

Paranoid illness can occur for the first time in old age or can be a relapse of illness that started in earlier life. The first presentation of paranoid symptoms at this age can herald the onset of dementia or depression, thus accompanying cognitive impairment and depressive symptoms should be

searched for, respectively. Particular attention should be taken to address deafness, impaired sight or social isolation, if present, as they can predispose to a paranoid illness.

Adjustment Disorders

Old age is a time of change and the elderly person can have many life events to deal with. Retirement, the death of a spouse or friends, change of role within the family, emigration of offspring and deteriorating physical health all require adjustment. The majority of older adults cope well with these changes or experience minor but transient psychological symptoms. But others may develop psychiatric illnesses such as depression or anxiety disorders. Professional help can reduce the suffering caused by these illnesses.

Addictions in the Elderly

Alcohol is probably the most commonly abused drug by the elderly. The onset of alcohol abuse in old age can be the presentation of a depression. It is often missed or left untreated by the physician. Some clinicians lack the motivation to address alcohol problems in this group on the basis that the person is of advanced age and that alcohol is one of his few comforts. Relatives may collude with the patient. There may be treatment nihilism. We must question this ageist attitude - the elderly are particularly sensitive to the effects of excess alcohol and can respond to treatment measures.

MANAGEMENT OF PSYCHIATRIC ILLNESSES IN THE ELDERLY:

Particular consideration should be given to the choice and dosage of psychotropic medication in view of the altered pharmacokinetics and pharmacodynamics in the elderly, interaction with other drugs, and contraindications to their use due to co-existing physical illness. Often very small doses of antipsychotic drugs are sufficient, doses which would be considered to have no or a placebo effect if given to a younger adult. On the other hand elderly patients generally require adult doses of an antidepressant for therapeutic effect. ECT is effective

tive in the elderly, the contraindications to its use are the same as in younger adults. The mood stabilizers have been found to be useful in the elderly, though research in this area is limited and careful monitoring is required. In general the number of drugs and drug dosage should be kept to a minimum and dosage schedules should be simple. Patients should be started on a small dose which is increased slowly, while observing for side-effects. Drugs should not be stopped abruptly but tapered off. Medication should be supervised if there is a question of cognitive impairment.

Contrary to the now famous statement made by Sigmund Freud that older people are not amenable to psychoanalysis due to the lack of "elasticity of the mental processes on which treatment depends old people are uneducatable"¹³, psychological treatments are helpful in the elderly, though may need adapting. Family therapy can be useful - the elderly person may be the identified patient but his problems may reflect pathology.

CARERS:

Carers of people with dementia can suffer from depression¹⁴, isolation, loss of social contacts and of earning capacity. There is a substantial literature on the burden of care, psychological distress and psychiatric illness in the carers of older people with other mental illnesses¹⁵. The clinician must look for such problems - addressing them will enable the carer to continue in their caring role for longer and improve their quality of life. They should receive information about the specific mental illness of their relative, coping strategies and be linked to local support groups. Such support groups are being developed in Nepal. Regular respite care and sharing the care among family members can relieve the situation.

ELDER ABUSE:

Elder Abuse is defined as "a repeated act against, or failure to act for, an elderly person, which causes distress or damage, and so prevents the living of a

full life"¹⁶. It can take the form of physical violence, verbal abuse, neglect, financial exploitation or sexual abuse. There are certain factors of the carer, the patient and the caring situation which help identify high situations. Professionals must have a high level of suspicion. The need for compassion is paramount.

THE OLD PSYCHIATRIC SERVICE IN THE UNITED KINGDOM:

The Old Age psychiatric team is multidisciplinary and consists of a range of professionals: consultant psychiatrist, psychologist, community psychiatric nurse, occupational therapist, speech therapist and physiotherapist. The corner stone of the community-orientated service is the domiciliary visit. A member of the team can quickly respond to a crisis situation with a home visit - the benefit of the latter is that the patient is seen in their own environment (allowing the collection of additional information) and hospital admission can be avoided. Additional service facilities include a day hospital (for assessment and treatment) and in-patient beds for assessment and respite. There is an ever-decreasing number of long-stay hospital beds for the care of patients with complex mental health problems. The Old Age Psychiatric team links with social services, other medical disciplines and voluntary organisations involved in the care of the elderly. A key aim is to maintain the independence of the patient ideally in their own home as long as this remains feasible and tolerably safe.

FUTURE:

Recently the World Health Organisation (WHO) has endeavoured to highlight the needs of the elderly in general and in particular those with mental health problems. The WHO and other organisations have addressed these challenges at international forums where experts have been consulted. In collaboration with the United Nations "International Year of Older Persons", the World Federation for Mental Health chose Mental Health and Ageing as the theme for 1999. The World Health Organisation and World Psychiatric Association

have recently published three consensus statements - on the scope of old age psychiatry¹⁷, organisation of services of the elderly¹⁸ and educational issues for professionals and carers¹⁹.

There are other international organisations which raise the awareness of the needs of the elderly, such as Age Concern or the Alzheimers Disease Society. These groups provide expert advice, advocate on behalf of the elderly persons and promote research. Many countries are using links with these organisations to base the development and initiation of Old Age Psychiatric services. Professionals, politicians and the public at large need to come together to decide the way forward. Developments in particular countries need to be culturally appropriate, feasible and tailored for the needs of that country.

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