INVITED ARTICLE

PSYCHIATRIC PROBLEMS IN THE ELDERLY

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ABSTRACT

Psychosocial changes and physical disabilities that occur in the elderly contribute to an increase in the prevalence of psychiatric disorders in the elderly. A comprehensive approach to diagnosis is required. Depression, dementia, delirium and paranoid disorders are common psychiatric disorders seen in the elderly. Underlying treatable causes must be excluded. Treatment requires special considerations such as adverse drug reactions, drug interactions, side effects and concomitant physical illnesses. Management of the elderly should involve the family as well as the patient.

Keywords: Increased Prevalence, Depression, Dementia, Treatable Causes, Involve the family

SINGAPORE MED J 1991; Vol 32: 361-362

INTRODUCTION

In Singapore, there will be a four-fold increase in the number of people above the age of 60 years by the year 2030. The figure of 199,000 in 1985 is expected to rise to 835,000 in 2030[1]. This group of elderly, requires special consideration because of their special needs and vulnerabilities. Many elderly have physical disabilities[2]. In addition the elderly suffer many losses. The elderly lose their health, mobility and independence when their hearing and eyesight deteriorate or when they develop a physical illness. Bereavement leads to further isolation when their spouse or close friends pass away or when their children leave home. All these factors contribute to an increase in the prevalence of psychiatric problems in the elderly[3].

The range of psychiatric disorders seen in the elderly is similar to that seen in adulthood. However, certain disorders are more common, for example dementia and depression; or they may differ in presentation eg. depressive pseudodementia. In treating the elderly, special considerations are required because many have concomitant physical illnesses. Drug interactions must also be considered.

Evaluation and assessment of an elderly patient with a suspected psychiatric disorder is a challenge. An informant, usually a key relative should be interviewed to collaborate the history. Assessment comprises a detailed clinical history including social assessment, mental state examination. Appropriate investigations to exclude any underlying treatable causes should be done.

COMMON PSYCHIATRIC PROBLEMS IN THE ELDERLY

Depression

Depression is a significant cause of morbidity in the elderly. If untreated, the risk of suicide is increased[4]. Kua E H found the prevalence of depressive disorder in elderly Chinese in the community to be 4.6%[5]. However, depressive symptoms are more common[6]. The elderly depressed patient may present with a dysphoric mood, loss of appetite and weight, sleep disturbances especially early morning awakening, psychomotor retardation and decreased interest in activities. However, compared to depression in the younger population, the elderly with depression are more likely to agitation rather than retardation. They have more somatic complaints. Some may present with cognitive impairment (depressive pseudodementia) and may be inadvertently diagnosed as suffering from dementia. Delusions and hallucinations may be present. About 50% of patients who had their first major depressive episode after the age of 60 experienced delusions[7]. Delusions are usually persecutory or somatic in nature. Less commonly, delusions of guilt, poverty or jealousy may occur. Depression that arises after a stroke is often overlooked and if undetected increases the morbidity of the stroke[8].

After a diagnosis of depression is made, any underlying cause of depression should be excluded eg. hypothyroidism, drugs especially anti-hypertensives, metabolic disorders and neurological diseases such as Parkinson's disease. It is also important to assess the risk of suicide. If the risk is high, admission to hospital may be necessary.

The elderly with depression should be referred early for specialist care if the diagnosis is unclear. When there is poor response to treatment or when the risk of suicide is high.

Treatment of depression can be difficult as the elderly exhibit increased sensitivity to the anti-cholinergic and cardiovascular side-effects of the tricyclic anti-depressants especially amitriptyline. The newer anti-depressants like maprotiline, mianserin or dothiepin are useful. Dosage of medication in the elderly is usually 1/2 to 1/3 of the normal adult dose. The desired effects of anti-depressants are also delayed and it may take as long as 2-3 weeks before an improvement in mood occurs. In severe cases, ECT may be necessary.

Dementia

Dementia is a devastating disease that affects not only the sufferer but also his family and society. Dementia, although age-related, is not part of normal ageing.

Kua E H found that the prevalence of dementia in elderly Chinese in Singapore was 1.8%. In those between 80-85 years, the rate increased to 4.8% and in those above 85 years 12.0[9].

The most common type of dementia is that due to Alzheimer's Disease (AD). In AD, the deterioration of the memory, intellect and personality is insidious in onset and progresses gradually. However, multi-infarct dementia (MID) is more acute in onset with episodes of confusion and progresses

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in a "step-wise" manner. The intervals between episodes may be marked by improvement and stability. MID is due to a series of small strokes and is associated with hypertension and atherosclerosis. Empirically, out of every 10 cases of dementia, 6 may be suffering from a primary degenerative dementia, one a multi-infarct state, another alcohol-induced disorder or toxic encephalopathy and one from a potentially reversible cause[10]. The mean survival time from diagnosis to death is usually between 5-8 years.

The aetiology of AD is still unknown. However, there appears to be a genetic link with chromosome 21. It has been documented that relatives of patients with early onset AD appear to have an increased risk of the disease but the risk of AD among relatives of late-onset AD may not differ from that in the general population[11].

An accurate assessment of a patient with dementia requires an exclusion of potentially treatable or reversible causes. In addition, delirium or acute confusional states must be excluded and treated. Depressive pseudodementia can be mistaken for dementia. In pseudodementia, there may be a past or family history of depression; associated depressive symptoms that preceded those of dementia. The onset of symptoms is short in duration and progresses rapidly; and the patient is often distressed and complains vocally about his cognitive deficits. On examination, the patient makes little effort in cognitive testing and often answers "I don't know"; the memory deficit is variable and inconsistent. In some cases, it may be difficult to differentiate the two and a therapeutic trial of anti-depressants may be required.

Other treatable causes of dementia include intracranial tumours, vitamin deficiencies, hypothyroidism and normal pressure hydrocephalus. (Table I).

Table I
Some Common Causes of Dementia

Degenerative	Alzheimer's disease, Huntington's chorea, Parkinson's disease, Pick's disease, normal pressure hydrocephalus
Vascular	Multi-infarct dementia
Deficiencies	Hypothyroidism, sustained lack of B12, thiamine, folic acid
Metabolic	Uraemia, liver failure
Trauma	Head injuries
Intra-cranial lesions	Tumour, subdural haematoma
Infections	Encephalitis, neurosyphilis
Anoxia	Anaemia, cardiac arrest post-anaesthesia, chronic respiratory failure
Toxic	Alcohol, heavy metal poisoning

In the management of a patient with dementia there is much that can be done to alleviate the suffering caused by this illness.

There are no drugs specific for the treatment of dementia. However, anti-psychotic drugs can be used to treat the psychotic symptoms, restlessness or agitation. They should be used cautiously as the elderly are more prone to the extra-pyramidal and hypotensive side-effects of the drugs. Non-drug treatment such as Reality Orientation[12] is useful in maintaining the level of function of a patient suffering from dementia and to retard the intellectual deterioration.

The burden of care is tremendous and caregivers of patients with dementia have increased psychiatric morbidity[13]. Caregivers should be educated about dementia and be aware of their own needs so as to maintain a healthy physical and emotional state[14]. Self-help groups offer mutual encouragement and support. Appropriate use of social and health services such as day centres, home help and respite care, is invaluable in easing the burden on the caregivers and help maintain patients at home, thus avoiding premature institutionalisation.

Paranoid Disorders

Paranoid disorders can present for the first time in the elderly (Paraphrenia) or can be part of schizophrenia. Persecutory delusions are the most common type of delusion. However, delusions of infidelity, love or litigation can also occur. In general, the personality remains intact and auditory and visual hallucinations may be present. In the elderly, there is an association between paraphrenia and hearing and visual defects[15]. Depression and organic states must be excluded.

Patients respond fairly well to anti-psychotic drugs. However, non-compliance is common and depot injections may be required. The dosage used should be titrated according to the clinical response.

CONCLUSION

An awareness of the special needs of the elderly is essential in assessing and managing an elderly person with psychiatric problems. Early diagnosis, appropriate investigations, adequate treatment and psychosocial interventions all form part of a holistic and comprehensive management plan.

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