

PSYCHOGERIATRIC PATIENTS - A SOCIODEMOGRAPHIC AND CLINICAL PROFILE

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SUMMARY

This retrospective study aimed to explore the sociodemographic and clinical profile of patients aged 60 years and above attending the psychiatric services of NIMHANS. Two hundred and sixty-five such patients utilized the services during one year. Preliminary analysis of the data revealed that nearly three-fourths of the patients were between 60 and 69 years of age. The family support was adequate for most of the patients. Psychoses made up two-thirds of the sample (nonorganic psychoses = 43% and organic psychoses = 22%). The difference in the distribution of organic and nonorganic psychoses between the two sexes was significant ($p=0.01485$); men had significantly more organic psychoses than women and the latter had more nonorganic psychoses than the former. It was found that about 70% of the sample had associated physical disorders. The implications are discussed.

Key Words : Geriatric Psychiatry ; Mental Illnesses in the Elderly.

INTRODUCTION

With greater longevity, there is a progressive increase in the elderly psychiatric patients. The VII Five-Year Plan of India estimates that about 6.49% of the population (the VII Five-Year Plan, 1985-1990, cited in India, 1993), i.e., nearly 60 million, are aged 60 years and above. It is likely to go up to 15% by 2025 A.D. Despite this, there is an alarming paucity of literature on psychiatric morbidity in this group worldwide (Jeste & Caligiuri, 1991) and also in India. A few studies have been done in India, e.g., Venkoba Rao et al (1972), Ramachandran (1980), Venkoba Rao and Madhavan (1981 & 1982), and, Ramachandran et al (1981 & 1982). This study was taken up to explore the profile of sociodemographic and clinical characteristics of psychogeriatric patients attending the psychiatric services of the National Institute of Mental Health and Neurosciences, Bangalore.

SUBJECTS AND METHODS

Consecutive patients who were aged 60 years and above registered for detailed evaluation under psychiatry services between January 1, 1991 and December 31, 1991 were selected for the study.

The general duty medical officers examined the patients at the first contact. If any psychiatric disorder was detected or suspected, they were referred to the psychiatrist for further management. These patients were registered for detailed evaluation. The clinical case charts of such patients contained exhaustive notes of clinical evaluation, discussion notes of senior clinicians, physical examination and investigation reports. This data was systematically screened and extracted on a semistructured proforma developed specially for the purpose of this study. This contained the sociodemographic variables, clinical summary, diagnoses along the ICD-9 (World Health organization, 1978), investigations done, associated physical disorders, treatment given and the details of the follow-up. The preliminary analysis of the data will be presented in this report.

RESULTS

During the study period, 6360 patients were registered for detailed evaluation under psychiatry services. Two hundred and sixty-five patients were 60 years and above, forming 4.17% of total psychiatry outpatient. Of them, the charts of 248 patients provided adequate information forming the sample for this study. There were 132 (53.23%) men and 116(46.77%) women.

Nearly 74% of the sample was between 60 and 69 years. In this age group, both the sexes were equally represented. Among those aged 70 years and above, there were more men (17%) than women (9.5%).

All but four patients were married. Sixty-nine (28.3%) patients had their spouses dead; of them 56 (81%) were widows (22.6% of the total sample) and 13 (19%) were widowers (5.24% of the total sample). The family support was graded as I where the patients were married and living with their spouses and their children; grade II where they were either married and living with their spouses as a nuclear unit or a spouse was dead but living with the families of their children, and, grade III where the patients' spouses were dead and were living alone or with other relatives/social organizations. These patients were brought for consultation by the persons with whom they were staying. There were 162 (67.5%) subjects with grade I support, 71 (19.6%) with grade II and only seven (3%) with grade III support. A significant majority had good family support and only a minority had poor family support. This method of assessing the family support had to be used because the charts did not provide us with the necessary information required to score any standard social support scales.

TABLE 1: Psychiatric diagnoses according to ICD-9.

Diagnose	Male	Female	Total	Percentage
Organic Psychoses	35	20	55	22
Nonorganic Psychoses	46	60	106	43
Neuroses	16	26	42	17
Alcohol related disorders	17	0	17	7
Others*	7	8	15	6

* Include Diagnoses such as adjustment disorders, sleep disorders etc.

Note: Thirteen patients (5%) in 'not yet diagnosed' category are not included.

Table 1 shows the psychiatric diagnoses according to the ICD-9 (WHO, 1978). Psychoses

formed about 66% of the sample. Within this group, nonorganic psychoses comprised about two-thirds, i.e., about one-half of the total sample. The differential occurrence of organic and nonorganic psychoses between the sexes was significant ($X^2=5.934$, d.f 1, $p=0.01485$). Neuroses were commoner in women but the difference was not significant. Alcohol-related psychiatric disorders were found exclusively in men.

The associated physical disorders were present in nearly 70% of the sample. The commonest being essential hypertension (35.5%) followed by deficiency related anemia (22.6%), cataract (6.7%), diabetes mellitus (6.6%), ischemic heart disease (3.2%) and other sensory impairment (3.6%). There was no significant difference in the sexwise distribution of the associated physical disorder. Ninety-six subjects (38%) had multiple physical illnesses.

DISCUSSION

This retrospective chart-based study attempts to explore the pattern of mental illnesses and their sociodemographic profile in a clinic population. The adequacy and reliability of the data is reflected by the fact that 93.6% of the case charts could provide us with the necessary data for the study.

The proportion of the geriatric patients in this sample (4.17%) compares well with the finding of Venkoba Rao et al (1972) who reported 5% from a general hospital survey in those who had their first onset of mental illness at the age of 50 years or above. However, community-based studies have shown higher prevalence of psychiatric disorders in the elderly compared to the hospital based studies, e.g., Ramachandran (1980) reported about 35% from a survey conducted in a suburban area near Madras. Venkoba Rao and Madhavan (1982) reported about 8.9% from the Thiruppuvanam survey. The possible reason could be because community-based studies circumvent the factors determining treatment seeking and the patients are seen in the community itself.

A STUDY OF PSYCHOGERIATRIC PATIENTS

The frequency of psychotic disorders reported in our study is lower than that reported in the hospital and community based studies. Venkoba Rao et al (1972) reported 87.63% and Draper (1994) reported 84% from a clinic based study whereas Harrison et al (1988) reported 95% and Snowden (1991) reported 90% from inpatient population. Community based studies by Ramachandran (1982) found 6.83%, and, by Venkoba Rao and Madhavan (1982) reported 2.2%. However, 67% of the subjects in the latter study had depression. It is not clear as to how many had major depression. In our study, subjects with organic psychoses were less compared to 39.17% reported by Venkoba Rao et al (1972) and 30% by Draper (1994). Harrison et al (1988) reported 48% and Snowden (1991) reported 36% from inpatient populations. This may be because patients with dementia, who form sizable portion of organic psychoses, are seen both by the neurologists and the psychiatrists leading to the distribution of these patients between the two departments. We have not included patients with dementia managed under neurology.

The differential distribution of organic and nonorganic psychoses between the two sexes cannot be adequately explained. The world literature or the Indian studies do not report this finding. Men having greater life expectancies at birth than women cannot fully explain this. The risk for the development of nonorganic psychoses, specially schizophrenia, increases in postmenopausal women. Certain biological 'protective factors' against nonorganic psychoses, such as the lowering of estrogen in the postmenopausal age (Hafner et al., 1991) and relatively slower disappearance of dopamine D₂ receptors in women (Wong et al., 1984), are removed in women at this age. The risk enhancement for nonorganic psychoses in women may be responsible for the finding. This finding needs confirmation by further prospective studies, both clinic based and community based.

There are two important findings regarding the family support of the elderly in this study, viz., (i) the study sample had strikingly better

support system, and, (ii) the proportion of the elderly seeking the tertiary support was very small. A similar finding has been reported by Venkoba Rao (1987a & b) in which there was no significant difference in the family jointness between the study and the control groups. The place for strengthening the family ties for the elderly in their psychosocial management is supported by these findings. The family support and the attitude of the family members were not measured in this study. Due to the lack of information in the case charts, it is presumed that the jointness assessed here would reflect the support. However, it is emphasized that the family jointness alone does not satisfactorily reflect the family support and the attitudes of the family members.

The fact that 70% had physical illnesses and 38% had multiple physical disorders warrants greater care in assessing the physical conditions of these patients. Besides, it also issues a note of caution that a diagnosis of "functional" illness in these individuals has to be done carefully. The involvement of other medical disciplines is necessary to offer comprehensive approach to management for these patients. In this light, the model proposed by Schulman et al (1986), for the integration of services and training in geriatric psychiatry is worth adapting.

In conclusion, we report that psychoses (both organic and nonorganic) form the single largest group of mental disorders in this age group indicating the need for more work on late-onset psychoses. Greater emphasis is required in the early detection and long-term management of organic psychoses that forms a sizable portion in this population. The significant difference in the prevalence of organic and nonorganic psychoses between the sexes in different age groups needs further exploration.

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