AN INPATIENT STUDY OF PSYCHIATRIC ILLNESSES IN LATER LIFE

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INTRODUCTION:

Aging involves a pluralistic spectrum of changes - sociological, psychological and biological. At the same time, the aging population is faced with many life-style transitions which are sources of stress. Emotional disturbances or functional mental disorder are the results of the interaction between the individual, whose behaviour is influenced by social and psychological events in his past and present life, and his environment. The aspects of illness in the elderly are therefore many and complex and consist of a mixture of social, medical and psychological factors. With this formidable arry of possible causal factors, it would imply extreme naivete to attempt to implicate any single factor responsible for illness in this group. This paper is not therefor an attempt at identifying causal factors for mental illnesses of the older population, but rather a preliminary study of manifest psychiatric illnesses necessitating hospital admission in this group.

METHOD:

As this was a retrospective study, the patients in this age group of 45 and above were identified by the admission register which lists all the patients in chronological order according to date of admission. The registration numbers were then used to trace the case records from which the reported data were obtained. Only patients who had first illnesses were used in this study. As the diagnoses on the case records followed the diagnostic criteria of the ICD, no cases had to be excluded from the study.

The clinical material consisted of 177 patients (60 men and 177 women) who were admitted to the Psychiatric Unit in University Hospital, Petaling Jaya between October 1975 and October 1978.

RESULTS:

As seen in Table 1, effective illnesses were found in 87 patients, and non-affective illnesses in 90. Schizophrenia, organic brain syndromes and alcoholic psychosis accounted for most of the admissions (74) in the latter group. (The terns A group and NA group refer to affective illnesses group, and non-affective illnesses group respectively, hereafter in this paper.

As seen in Table II in the group of patients with affective illnesses, the percentage of admissions in the age group 45-49, 50-54, 55-59 and was 24.1%, 32.2% and 27.6% respectively which together accounted for 83.9% of the total admissions for the entire group. Thereafter, there was a gradual decline in admissions. In the group of patients with non-affective illnesses, the age group 45-49 accounted for 58.9% of total admissions, whereas the age groups 50-54, and 55-59 showed a sharp decline and only accounted for 15.6% and 11.1% respectively of the admissions.

The percentage admissions for the three age

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groups 65-69, 70-74 and 75-79 showed progressive decline in both the A and NA groups.

Sex

There were 21 males and 66 females in the A group and 39 males and 51 females in the NA group.

Female admissions predominate in both groups. The sex ratio (male : female) in affective and non-affective illnesses was 1:3:14 and 1:1:31 respectively.

Occupation

An almost equal percentage of housewives of 46% and 46.7% were admitted in the A and NA groups respectively. 31.1% were unemployed and 4.4% held professional post in the NA group as opposed to 11.5% and 22.9% respectively in the A group.

Marital Status

As seen in Table IV, 92.3% of the NA group were married while the remaining 7.7% were either single, divorced or widowed.

Sixty-nine per cent of the A group were married and 31.0% single, divorced or widowed.

TABLE 1

DIAGNOSIS

Diagnosis	No. of Cases
Endogenous/psychotic depression	50
Reactive depression	24
Reactive depressive psychosis (including grief reactions)	13
Schizophrenia	53
Organic psychosis (unspecified)	12
Alcoholism	8
Neurosis	6
Alcoholic psychosis	5
Dementia	4
Opium addiction	2

TABLE II

ADMISSIONS BY AGE

Age	Affective Illnesses		Non-Affective Illnesses	
	No.	%	No.	%
45-49	21	24.1	53	58.9
50-54	28	32.2	14	15.6
55-59	24	27.6	10	11.1
60-64	9	10.3	6	6.7
65-69	3	3.4	4	4.4
70-74	1	1.2	2	2.2
75-79	1	1.2	1	1.1

TABLE III

OCCUPATION

Occupation	Affective Illnesses		Non-Affective Illnesses	
	No. of pts.	%	No. of pts.	%
Professional	20	22.9	4	4.4
Skilled	15	17.3	10	11.1
Unskilled	2	2.3	6	6.7
Unemployed	10	11.5	28	31.1
Housewives	40	46.0	42	46.7
Total	87	100.0%	90	100.0%

TABLE IV

MARITAL STATUS

Marital Status	Affective Illnesses		Non-Affective Illnesses	
	Total No.	%	Total No.	%
Single	7	8.0	3	3.3
Married	60	69.0	83	92.3
Divorced	10	11.5	2	2.2
Widowed	10	11.5	2	2.2
Total	87	100.0%	90	100.0%

Major Precipitating Events

Where recorded, these occurred within the six months preceding the admission. We had specifically looked for death in the immediate family, loss of job, financial losses, divorce, separation or previous illnesses of a non-psychiatric nature in the case records. As seen in Table V, precipitating losses were present in 35.7% of the A group and 22.2% of the NA group.

Ethnic Group

The ethnic group distribution of patients in the two groups is shown in Table VI. The racial distribution for the state of Selangor 35.33%, Indians 17.91% and others 8.33%. In this study, the percentages of the admited patients in the three ethnic groups are similar in the A and NA illness groups. However, when compared to the ethnic group distribution for Selangor, the

TABLE V

MAJOR PRECIPITATING EVENTS

Events	Affective Illnesses		Non-Affective Illnesses	
	Total No.	%	Total No.	%
None elicited	56	64.3	70	77.9
Financial losses	9	10.4	8	8.9
Death in Family	9	10.4	2	2.2
Previous illnesses	8	9.2	4	4.4
Divorce or separation	5	5.7	2	2.2
Loss of job	0	0.0	4	4.4
Total	87	100.0%	90	100.0%

TABLE VI

ETHNIC GROUP

Ethnic Group	Affective Illnesses		Non-Affective Illnesses	
	Total No.	%	Total No.	%
Chinese	52	59.8	53	58.9
Indians	25	28.7	25	27.8
Malays	8	9.2	10	11.1
Others	2	2.3	2	2.2
Total	87	100.0%	90	100.0 %

percentage of admitted Malays is under-represented, and that of Chinese and Indians over-represented.

Synptoms

The ten chosen symtoms were those recorded in all the case files. Their incidence is as shown in Table VII.

Sleep disturbance was reported by most patients in both groups. Lack of appetite was reported by 91.5% in the A group as opposed to 50% in the NA group.

Agitation was reported in 82.2% of the NA group, and in only 57.5% of the A group. The commonest delusion was persecutory in both groups with an incidence of 52.2% in the NA group and 21.8% in the A group.

TABLE VII

SYMPTOMS

Symptoms	Affective Illnesses		Non-Affective Illnesses	
	No.	%	No.	%
Sleep disturbance	81	93.0	80	88.9
Lack of appetite	80	91.5	45	50.0
Depressed mood	70	80.5	0	0.0
Agiatation	50	57.5	74	82.2
Thought retardation	48	55.2	20	22.2
Suicidal thoughts	45	51.7	30	33.3
Motor retardation	37	42.5	9.	10.0
Somatic complaints	25	28.7	20	22.2
Delusions:-				
persecutory	19	21.8	47	52.2
guilt	13	14.9	6	6.7
somatic	9	10.3	5	5.5
grandiose	8	9.2	9	6.7
attempted suicide	5	5.7	2	2.2

Depressed mood was present in 80.5% of the A group.

DISCUSSION:

Diagnosis and Age

Of the 177 patients studied, 50 had endogenous (psychotic) depression, 24(13.6%] had neurotic or reactive depression and 13 had reactive depressive psychosis. Of the 90 who had various other non-affective illnesses, 53 had schizophrenia and 21 had organic brain syndromes (this includes organic psychosis) (unspecified), alcoholic psychosis and dementia). Reactive depression is usually distinguished from endogenous depression by its being causally related to external factors, together with anxiety and lack of concentration in the absence of psychomotor retardation. In psychotic depression, the affective variation usually related to nor altered by external environmental circumstances. In this study, the three age groups 45-49, 50-54, 55-59 together accounted for 83.9% of admissions in tha A group followed by a sharp decline thereafter, whereas for NA group, the peak admission age was in the 45-49 age group followed by a slow decline in the subsequent age groups. Studies by wing and Hailey (1972), Adelstein *et al* (1968) also show this same drop in

affective disorders in later life. This might mean that depressive illness in the elderly is undiagnosed or untreated, or dealt with in some way other than by admission to psychiatric hospitals e.g. some old people with neurotic depression or even psychotic depression may be admitted to non-psychiatric wards because of physical illness. Meyer (1974) has also reported that the incidence of neurotic illnesses is low in the older age groups and suggested that as there is a personality factor in the aetiology of neuroses, patients will usually present at an earlier age, and that new neurotic illnesses are probably psychogenic reactions to acute crises. It has also been shown that the majority of neurotic illnesses in the older age groups have depressive symptoms (McDonald, 1967). This study supports these findings as there were only six patients with neuroses of a non-affective type as opposed to 24 patients with reactive or neurotic depression.

The high incidence of depressive illnesses in the 45-49 age groups might be due to the social disorganization that occurs during this period. Impending life style transitions like retirement, children leaving home (the 'empty nest syndrome'), decrease in finances and probable change of residence with resultant decrease in inter-group and community associations, are some of the stresses of this age group. These stresses cause social deprivation and loneliness which are important factors in the aetiology of depressive illness in the older age groups (Robertson, 1974). Two other factors that determine the onset of depression in the 45-49 age group in this country as opposed to the peak incidence in the slightly older group (55-64) in western countries appear to be the earlier age of retirement and also of marriage.

For schizophrenic patients too, stresses and life events can trigger off illness in those who are genetically and constitutionally predisposed to the illness (Brown *et al,* 1973). Though 75% of schizophrenics develop symptoms between the ages of 15-25. schizophrenia with paranoid symptoms often develops after the age of 40. In this study, 58.9% of patients in the NA illness group were between the ages of 45-49. It may be assumed that most of the illnesses in these 58.9% were probably schizophrenic in nature as schizophrenia is the predominant diagnosis in the NA group (53 patients).

Sex

In the A group, female admissions are three times the number of male admissions. This difference between the sexes has been noted by many others (Marks, 1973; Slater & Cowie, 1971) and has been suggested as being due to the greater frequency of neurotic depression; as having a cultural bias and as being due to the higher level of somatic anxiety in woman (Mowbray, 1972). Winokur (1972) has also suggested a more specific male-female difference in genetic transmission of affective illnesses.

In schizophrenic illnesses, Slater and Cowie (1974) reported that after the age of 35, female admissions exceeded that of males, A similar female preponderance is also reported in senile dementia. Our study shows the same preponderance of female admissions in the NA illness group.

In Asian culture, women are more limited than men in their social interactions but are more cohesively identified with their family and immediate environmental groups. The stress of social changes and the difficulty in making necessary adjustments because of their previous restricted experience may be an important factor in the higher incidence of psychiatric illness in older women. However, in this restricted study, it is not possible to correlate the sex difference with any single factor and it only serves to highlight the need for investigating into sex differences in psychiatric research.

Occupation

The higher percentage of those holdings professional post in the A group may indicate that the stress of holding responsible jobs precipitates effective illnesses but the higher incidence may also be a manifestation of differential use of hospital services by the higher income

groups rather than a basic feature of morbidity. However, other studies (Tietze, Lemkau and Cooper, 1971) have shown that the proportion of affective illnesses relative to schizophrenia is high among professional people, upper income groups and suburban residents, and that the reverse is true for those with occupations of lower social status or lower incomes. However, as housewives constitute almost 50% of both the studied population and their socio-economic status is not mentioned, no significantly useful correlations between income and illness could be made between the two illness groups.

Marital Status

92.3% of the NA group were married. This is in variance with most other studies where a high proportion of patients admitted with schizophrenia, personality disorders and organic brain syndromes lived alone (Gerard & Houston, 1953; Bloom, 1968). A possible explanation for this might be because of the practice of arranged marriages which is still prevalent in the three main ethnic groups. In arranged marriages, personality disorders like the schizoid personality or depressive personality which may predispose to psychotic illnesses in later life are not obstacles to marriage.

In the A group, divorce or death of the spouse had occured in 23% as opposed to 4.4% in the NA group. Marital bereavement with resultant lack of companionship, social isolation and decrease in economic resources has been shown to be correlated with depressive reactions (Berstein *et al,* 1973; Parkes and Brown, 1972). Some of the evidence indicates that much of the excessive morbidity and mortality is concentrated within the first year of bereavement (Parkes, 1964; Stein and Susser, 1969) but in this study, the interval between divorce or death of the spouse and the onset of illness is not known.

Major precipitating events

In the majority of admissions for the NA group (77.9%), no major precipitating events were elicited. In the group, a greater number of patients (26.5%) had experienced death, financial loss, divorce or separation, in the six months preceding admission as compared to 17.7% in the NA group. Brown et al (1973) suggested that in affective illnesses, such events are formative rather than precipitating, whereas in non-affective illnesses especially schiozphrenia, most life events serve to trigger the florid onset of symptoms in those who are predisposed and are experiencing difficulties in interpersonal relationships. It would therefore be of more relevance and use if the social milieu and interpersonal relationships of patients are studied in greater detail in subsequent studies rather than just possible precipitating events.

Symptomatology

Affective illnesses of depressive nature manifest with depressed mood, lessening of activities, lack of interest, slowing in thought processes, suicidal thoughts or behaviour, and vegetative symptoms of poor sleep, decreased appetite and loss of weight. However, not infrequently there is agitation instead of motor retardation, especially in the older population. Delusions are of guilt, self-reproach and hypchondriasis. At times, the paranoid delusions in depression are difficult to differentiate from those that occur in paranoid schizophrenia.

Non-affective illnesses of an organic nature may also manifest with depressive mood but this is not constant. In these illnesses, there is also concomitant cognitive decline, confusion, disorientation and nocturnal restlessness.

In this study, only 80.5% of the affective groups were noted to have depressive moods. In the remaining patients, the diagnosis was probably made because of the presence of other symptoms suggestive of depression ('depressive equivalents').

Agitation which has been typically described with depressive illness in the older ages, and is characterized by repetitive movements denoting anxiety was also present in 82.2% of the non-affective group. In the case records studied,

agitation appears to have been used synonymously with the purposeless hyperactivity generally seen in psychotic illnesses rather than the typical agitation of the depressed. Motor retardation was noted in 42.5% of the affective group as opposed to only 10% in the non-affective group.

Of the symptoms chosen for study, motor retardation, poor appetite, thought retardation and suicidal thoughts were seen in a greater number of the A group as opposed to the NA group. The main criterion on which the diagnosis was made appears to have been the mood state.

Ethnic Group

University Hospital caters mainly for Kuala Lumpur and Petaling Jaya residents. Chinese and Indians families predominate in both these areas, whereas the Malay population mainly comprises the younger migrants from adjoining rural areas. This might therefore have been one factor in the over-representation of the Chinese and Indian population observed in this study. A related factor could be that though all the three major ethnic groups accept behavioural changes in the older population as part of normal aging, a disturbed related in a crowded township is less tolerated by the family and neighbours than a disturbed relative in a rural setting. Thus, the older Malay patient in the rural districts may not be brought to hospital.

SUMMARY

This was a retrospective study of 177 patients above the age of 45 who were admitted to the Psyciatric Unit, University Hospital Petaling Jaya during the period October 1975 to October 1978. The available socio-demographic and clinical data from the case files were studied. The patients were divided into two groups - those with effective illnesses and those with non-affective illnesses. The differences in socio-demographic background and clinical symptomatology between the two groups and how the data compares with that in other studies was reported.

The sick elderly person is an economic and psychological liagility to his family and society. Absence of illness in the elderly not only fosters their continued independence but also improves the quality of their individual life. Though no definite correlations or conclusions could be arrived at, this study has sought to bring into awareness the necessity of delineating possible illness precipitating stress factors in the social and domestic environment of patients in later life.

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