GERIATRIC PATIENTS ATTENDING A GENERAL HOSPITAL PSYCHIATRY CLINIC
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SUMMARY
238 case records of all the patients aged sixty years and above who visited psychiatry departments of two general hospitals during a three year period were retrospectively analyzed. The mean age of sample was 67 years; 43.7% of patients had functional psychosis. 55.8% of the functional cases had paranoid features. 43.28% of the sample had at least one associated physical illness. The majority of the patients had a caring spouse, were from joint or extended families and had some education and at least part time occupation.

INTRODUCTION
The number of elderly patients attending general hospital psychiatry clinics has been increasing in the last few years. Many reports suggest that the average life expectancy of an Indian subject is increasing; in 1991 this was reported to be 62 years (Jain & Menon, 1991). These authors stated that longevity increased from 30 years in 1947 to 54 years in 1980 and to 62 years by 1990 and they concluded that India was greying rapidly. It is hence evident that the problem of treating geriatric patients is going to increase day by day. With this background information in mind, the present study was undertaken to assess psychiatric morbidity occurring in the elderly patients.

AIMS
1) To obtain sociodemographic data of geriatric psychiatric patients.
2) To understand the pattern of associated physical illness.
3) To find out the various types of psychiatric illness occurring in elderly patients visiting psychiatry clinics of general hospitals.

MATERIAL AND METHODS
The Department of Psychiatry, J.N. Medical College, Belgaum has been conducting psychiatry clinics in two general teaching hospitals, viz., District Hospital, Belgaum and K.L.E.S., Hospital and Medical Research Centre, Belgaum since 1974 and 1986 respectively. In India, by tradition 'sixty years' is regarded as the beginning of old age. An I.C.M.R. Bulletin (1991) stated that, in India due to various cultural, social and religious reasons persons have age sixty years and above are referred to as 'old age' or 'elderly people'. Hence, in the present study, all patients having age sixty years and above were regarded as geriatric patients.

All patients in the geriatric age group who visited the above mentioned psychiatry clinics between January 1988 and December 1990 formed the sample of this study. The outpatient as well as indoor case records of such patients were analyzed to collect the required data. The information on age, sex, chief complaints, precipitating stress factors like physical and/or psychosocial stress factors, present and past history, personal history including childhood, educational, occupational and marital history, psychosocial stressors, physical and psychiatric investigations and examinations, diagnoses, treatment and follow-up records etc., were noted for analysis. No tests of significance were applied. ICD-9 criteria were used for diagnosis.

RESULTS & DISCUSSION
In all 238 geriatric age group patients were studied. This number formed 6.6% of the total number of patients attending psychiatry department. There were 149 (62.6%) males and 89 (37.4%) females; male : female ratio was 1.67 : 1.00. In geriatrics, patients with age 60 years to 69 years are referred to as 'young-old' and those above 70 years are termed as 'old-old'. This sample had 161 (67.6%) 'young-old' and 77 (32.4%) 'old-old' patients. Venkoba Rao (1989) and I.C.M.R. Bulletin (1991) mentioned that generally three-fourth of India's geriatric population is 'young-old'. More than two thirds of our sample belonged to the young-old type, a finding in agreement with Venkoba Rao's observation.

Almost three-fourth of the patients i.e. 175 (73.5%) were brought by relatives or friends of the patient to the psychiatric clinic for treatment. Only 46 (19.3%) patients were referred by medical practitioners. Physical and psychosocial stress factors precipitating the present illness were specially noted from case records; 102 (42.9%) patients had some precipitating stress factor for the illness. Physical stress factors were present in the majority of cases 60 (58.8%) as compared to psychosocial stress factors found in 42 (41.2%). Thus physical stress was more important precipitating factor. The most common stress factors precipitating psychiatric illness were history of recent major physical illness, death of or separation from spouse or close relatives and worries regarding children's welfare. Joint family stay was reported by many subjects under study. 157 (66%) were from joint families and 26 (11%) were from extended families, accounting for 77% of patients.

Educational status showed that 82 (34.5%) were not educated whereas 132 (55.5%) had school education and 24 (10%) had college education. Belgaum is a semi-urban big town and is a divisional and district head quarters. Historically, it is known to be an educational centre. This would explain the reasonable educational level of the sample. Occupational status showed that 82 (34.5%) were either part time agriculturists or agriculture related labourers. The catchment area of the sample is a...
predominantly agricultural region, which may be the reason for this finding. Out of 89 females, 70 were housewives.

Marital status revealed that 171 (71.8%) patients were married and 60 (25.2%) were either widow or widower, 4 (1.7%) were unmarried and 3 (1.3%) were separated. Thus, about 28% of the patients did not have the support of their spouse. 158 (66.3%) patients had an accepting and caring spouse with a healthy attitude. Social isolation was reported by 48 (20.2%) patients only. Thus, the status of a widow/widower, neglecting attitude of the spouse or social isolation were not important factors in these geriatric patients. Past history of psychiatric illness was present in only 70 (29.4%) cases, whereas 168 (70.6%) cases had psychiatric complaints for the first time.

Table 1
Associated Physical Illness
Present in 103 (43.28%) cases.

| Associated Physical Illness | No. of Cases |
|-----------------------------|--------------|
| 1. Essential hypertension    | 35 (22.88%)  |
| 2. Other C.V.S. disorders    | 16 (10.46%)  |
| 3. Diabetes mellitus         | 18 (10.46%)  |
| 4. Stroke                    | 13 (8.56%)   |
| 5. Cataract                  | 12 (7.84%)   |
| 6. Diabetes                  | 10 (6.53%)   |
| 7. Other illness             | 51 (33.33%)  |

Table 1 shows that 103 (43.3%) cases had at least one associated physical illness or physical handicap. Common associated physical illnesses were essential hypertension, diabetes mellitus, cardiovascular disorders and stroke followed by visual and auditory loss. Venkoba Rao (1981) reported an even higher association i.e., 54% cases having physical illness and handicap. The same author (Venkoba Rao, 1982) in his geropsychiatric morbidity survey stated that 57% of psychiatric illness group cases also suffered from physical morbidity. In the present study, 103 cases had one or more physical illness and amongst the cases having precipitating stress factors 52.8% had a physical rather than a psychological stress factor. These findings suggest that there is a strong association between geriatric physical illness and psychiatric illness.

Table 2
ICD-9 DIAGNOSIS
n = 238

| ICD-9 DIAGNOSIS                  | n  |
|---------------------------------|----|
| 1. Organic psychotic conditions | 80 (33.61%) |
| 2. Other (functional) psychoses | 104 (43.69%) |
| 3. Neurotic disorders           | 47 (19.76%)  |
| 4. Other Cases                  | 7  (2.94%)   |

Table 2 shows the diagnostic pattern of cases studied as per ICD-9. 80 cases had organic psychotic conditions, 104 had other (functional) psychoses, 47 had neurotic disorders and 7 were other cases which had no psychiatric disorder. These included 3 cases of cerebrovascular accident, 2 cases of complex partial seizure, one case of intracranial space occupying lesion and one opium dependence case. Expecting for the opiate dependence case, all others were primarily neurological cases; the opiate dependence case had no active psychiatric problem.

In total, 231 cases were further studied for diagnosis and duration of illness. Duration of illness was less than one year in 133 (57.6%). Thus, the majority of patients did reach the psychiatry clinic within one year of onset of illness. 57 out of 80 cases (71.3%) of organic psychotic conditions, 52 out of 104 (50%) functional psychoses and 24 out of 47 (51.1%) neurotic illness came to psychiatry department for help in the first year, suggesting poor awareness of psychiatric treatment in the local community. This also indicates that there was practically no difference between organic cases and functional cases in the time taken to reach psychiatry clinic for treatment.

In the present study, 80 (33.6%) cases had organic psychotic condition which tallies with Venkoba Rao's (1981) study, where these cases were 34.3%; ICD was not used for diagnosis in that study. However, overall organic brain syndromes' breakup in his study compares well with the present study. About half (i.e., 39 out of 80 cases (48.8%) belonged to the dementia group of whom the large majority (24) had senile dementia cases. Of these 18 were males and only 6 were females. However, an integrative review study by Yorm et al (1998) stated that prevalence of dementia increased exponentially with age. The present study has similar finding. In the age group 60 years to 69 years (161 cases), there were 19 (11.8%) cases of dementia, whereas in 70 years and above age group patients (77 cases) there were 20 (26%) cases of dementia.

Table 3
Other (functional) Psychoses
(ICD-9; 295 - 299) Present in 104 (43.69%) cases.

| ICD-9 Diagnostic                | n  |
|---------------------------------|----|
| 1. Schizophrenic psychoses      | 15 (14.42%) |
| Schizophrenia 7, Paranoid       |    |
| Schizophrenic 5, Schizo-affective Psychoses 3. |
| 2. Affective psychoses          | 33 (31.73%) |
| M.D.P. Circular currently Depressed 18. |
| M.D.P. Circular currently manic 15. |
| 3. Paranoid states              | 44 (42.31%) |
| Paranoia 3, Paraphobia 22.      |    |
| Paranoid psychoses NOS 19.      |    |
| 4. Other non-organic psychoses  | 12 (11.54%) |
| Psychotic psychoses 3. Psychoses NOS 3. |

Functional psychotic syndromes were present in 104 (43.7%) cases as shown in Table 3. The majority, i.e. 58 (55.8%) out of 104 functional cases had paranoid symptomatology. Kumar (1989) observed that physical illness and psychological set back can often precipitate paranoid illness in the elderly. In our sample, associated physical illness was common which could explain increased paranoid features. In addition, the local culture gives importance to supernatural powers and remedies. These factors and the financial and emotional insecurity usually accompanying old age might be responsible for increased suspiciousness, leading to paranoid symptomatology in this sample.
Neurosis was present in only 47 (19.8%) cases, the majority 38 (80.9%) having neurotic depression. Very few i.e. 7 (14.9%) had anxiety reaction and only 2 (4.3%) had obsessive compulsive neurosis. Kumar (1989) supports the view that next to dementia and psychosis, depression is common in the elderly and the same is found in the present study as well. In this study, 38 cases had neurotic depression and 18 had M.D.P. depression (psychotic depression) totalling 56 (23.5%). Thus, the overall diagnostic break up of patients in this study is similar to earlier research workers.

In view of the predominant paranoid features found in the elderly psychiatric patients, there is a need to study the roles of aging, physical illness, culture, emotional and financial insecurity in increasing suspiciousness. The present study brings out a few more interesting findings. The majority in the sample, i.e. 76.9% cases came from joint and extended families; 71.8% had a living spouse; 66.3% had an understanding and caring spouse; 79.8% did not feel socially isolated; 76.9% were at least having partial occupation and 66.5% had at least some education and still all of them suffered from psychiatric illness. It means that there were some other factors responsible for geriatric psychiatric illness which need to be determined.

REFERENCES

ICMR (1991) Mental Health and aging. ICMR Bulletin, 21, 5, 49-54.

India Today (1991) The greying of India. India Today, Vol. XVI, 18, 47-55. New Delhi: Living Media India Limited.

Jorm, A.F., Korten, A. & Henderson, A.S. (1987) The prevalence of dementia: A quantitative integration of the literature. Acta Psychiatrica Scandinavica, 76, 465-479.

Kumar, K.A. (1989) Non-dementing psychiatric disorders in the elderly. In Proceedings of the First National Seminar on Geriatric Psychiatry, Kottayam, September 1989, 13-17.

Venkoba Rao (1981) Mental health and aging in India. Indian Journal of Psychiatry, 23, 1, 11-20.

Venkoba Rao, A. & Madhavan, T. (1982) Geropsychiatric morbidity survey in a semirural area near Madurai. Indian Journal of Psychiatry, 24, 3, 258-267.

Venkoba Rao, A. (1981) Geropsychiatry in India - an overview. In Proceedings of the First National Seminar on Geriatric Psychiatry. Kottayam, September 1989, 1-6.

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