Psychiatric Problems Among the Elderly in Malaysia

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Introduction

The rate of growth among the world's elderly population is reflected by the fact that while the total world population would have increased by 26% between 1980 and 2000, the rate of population growth over 65 years of age would have increased by more than 35%. While the elderly population of the developed countries would have increased by 29.4% in the 20 years 1980 to 2000, that of the developing countries would have increased by 77%[1]. In 1970, only 3.7% of the population in Malaysia was 60 years and above. In the year 2020, this population would have increased to 7% and would comprise 2.1 million of the estimated population of 29.5 million. Factors contributing to the ageing of the population are the decline in mortality rates, the changes in life expectancy which has increased to 69 years for men and 72 years for women in 1990 and the declining fertility rate due to increased literacy, improvements in quality of life and public health and awareness of family planning methods including abortions and sterilisations. The problems of the ageing population will affect both the developed and developing countries.

Generally the population over 65 has a span of 35 years, in Malaysia the life expectancy for men has increased to 69 years and 72 years for women on the average. In Malaysia 'elderly' or older adults can include anyone over 55 but it may be incorrect to generalize about this group. Functioning and disabilities can vary significantly and this can differ markedly between the 'young old' (55 to 75) and the 'old-old' (75 and above)[2]. The prevalence of most of the severe types of disabilities were 3 per 1000 for those under 50, 16 per 1000 for those in their sixties and 133 per 1000 for those 80 and over[2]. This includes disabilities due to all kinds of factors physical as well as psychological.

In Malaysia a local study[3] in Kampung Bahru, Kuala Lumpur covering the elderly showed that 25% had diabetes, 16% had low levels of serum calcium, 24% had low levels of serum albumin and 51% had low haemoglobin levels. The prevalence of psychiatric disorders in those above 65 is reported as 5% with dementia, 13% with depression (4% major depression) and 12% with anxiety states (7% phobic)[4]. Other psychiatric disorders that can occur include delirium usually secondary to physical conditions, memory disorders due to amnesic syndromes, substance abuse related disorders, schizophrenia and personality and behavioral disorders.

Dementia

Dementia is defined as the 'global deterioration of the patients intellectual, emotional and motivational behavior in a state of unimpaired consciousness' over a period of at least 6 months with progressive failure in performance at work and in the common activities of everyday life not due to impairment in health or physical handicap. An earlier study[5] investigated 522 elderly in purely Malay suburban settlements using observer rated screening questionnaires and identified 24% with disturbances of cognitive function. This would include those with dementia, age associated memory decline, depressive and anxiety disorders. In the follow-up of those who were screened, a prevalence of 6% of dementia for the age group 65 and above and a prevalence of 14% for those 75 and above was found. In this group of demented 60% had associated hypertension including other cardiovascular conditions which is implicated in the aetiology of dementia. This slightly raised prevalence rate is due to the presence of multi-infarct dementia and mixed cases as in this study it was not possible clinically to discriminate between the two main types of dementia i.e. Alzheimer's and the multi-infarct type.

A study by Lazli[6] looking at the elderly in an institution in the Klang Valley, supports evidence from elsewhere[7,8] that homes not meant for the demented have a high proportion of elderly with dementia. Lazli[6] showed that 14.7% of the elderly in this institution which is meant for the homeless and destitute were demented. Mann[7] found that two-thirds of the residents in institutions were demented while Kay found that 20% of all demented would be in an institution at any time. The elderly do stay longer in hospitals as compared to the younger patients and one of the main reasons for this not withstanding their illness is the difficulty for carers to take them home. This is a common problem in Malaysian hospitals and lack of support and inadequate resources in the community to provide for effective care are reasons.

Ageing is a powerful risk factor for dementia as shown by Kay *et al*[8] who identified a prevalence of 22% in those over 80. It has also been reported by Jorm et al[9] that it doubles every 5 years after the age of 65. There was a female preponderance in the presence of dementia by 4 times in our local study, but this is likely to be due to the excess of women in this sample (58%) to men 42% because women live longer than men. Although there have been some reports that the prevalence of dementia is higher in women, there is no convincing evidence to show that the incidence rates for dementia is higher in women[10]. Various reports have shown associations between dementia and lower levels of education which is often secondary to lower social class. The hypothesis here that education increases brain cognitive reserve while pathology in the brain tends to reduce it, and the bigger the reserve the more protection there is from dementia is not supported by evidence. In this local study, no association was found between years of education and development of dementia. However, there is some evidence that mental stimulation and physical activity can delay the onset of cognitive decline-the maxim being 'if you don't use it, you will lose it!'

Depressive illness

Depressive illness is the commonest psychiatric disorder in old age, and has been reported to have a prevalence of 11 to 16% in the population over 65 years in the United Kingdom, and getting lower with increasing age. The prevalence is much lower than that for the younger age group although one would expect more depression in the elderly because of more losses e.g. loss of employment, bereavement, isolation, ill-health and so on. However, the onset of depression in the elderly is often preceded by severe life events for example bereavement, loss of income, moving house, physical illness and so on. A good quality of relationships with others and positive life events tend to improve the outcome for depression. Symptoms of depression are very common among the elderly who often complain of feeling sad and lonely and being isolated from others. Social contacts also tend to decrease with the deaths of close friends and relatives while physical ill-health cuts down their outings and visits. Complaints of sleep disturbances are common as the elderly generally require less sleep and this can be worse with superimposed depression. Besides that loss of weight due to problems with dentition can occur again complicating loss of weight due to depression. Other common symptoms that can occur are memory disturbances often resembling early symptoms of dementia. Sometimes these symptoms may not fulfill strict diagnostic criteria for a depressive illness and can be considered to be subsyndromal. However, the elderly are more distressed and disabled by these symptoms as compared to the young. Social support can do a lot to improve the mood of the elderly while physical treatments are also indicated if and when necessary. Pharmocotherapy and other physical treatments like electroconvulsive therapy should not be denied to the elderly on any grounds for example poor physical health, other concurrent medications and fear of untoward side effects.

Other psychiatric problems

Other conditions that can occur in the elderly are anxiety states manifesting as worries about health (hypochondriasis), feelings of tension, irritability, phobias, panic and palpitations. 24% of the elderly in this local study were identified by a screening instrument as having some cognitive deficit and 6% were identified as having dementia. 18% would therefore be manifesting any of the range of other psychological problems the commonest being depression. In another ongoing study by Suzy[11] on elderly general practice attendees, using standardized

psychiatric interviews called the GMS-AGECAT[12], 20% were found to have depressive illnesses. In another study by Fadillah[13], on elderly above the age of 60 in the community in Cheras, Kuala Lumpur, Fadillah showed that out of the 226 he had interviewed, 31% had been physically ill in the last one month and 16% had psychiatric illnesses. Out of this 16%, 7% had depressive illness, 6% had dementia and while anxiety disorders, alcoholism and schizophrenia were much rarer. 50% of those with dementia had physical illnesses including hypertension, diabetes mellitus and one patient had carcinoma with secondaries.

The elderly generally lead more protected lives as compared to others primarily because of infirmity, physical illnesses like strokes, myocardial infarction and arthritis. Sometimes even symptoms like pain, dizziness and fear can incapacitate them. The incapacities can further produce more disabilities resulting in a house-bound invalid even though no physical illness could be attributable. This dependency on carers is a big burden and can cause psychiatric illnesses in carers. The average age of the carer of the elderly demented is about 60 to 61[12] with two-thirds of them having physical health problems and about 50% have disabilities that reduce their activities. At least two thirds have symptoms of distress related to the problems exhibited by the elderly ill. In the West, community care e.g. day care has not helped the carers of the demented elderly in terms of reduction of psychiatric symptoms and full time admission in special nursing homes seems to have better results. In Malaysia elderly living in village-like environments have good support in the community and those with poorer cognitive status are in fact better supported than those with better cognitive status. Neighbours and relatives make an effort to visit the disabled elderly at least daily to look after their needs. However, with urbanisation and redevelopment of villages, the village home with no formal borders and boundaries may no longer exist. Community services will need to be formalized by the social and health services and specialized nursing homes will become necessary for the demented as the carers themselves age.

Deterioration of memory, intellect and behaviour are often the earliest presentation of psychiatric problems in the elderly. The general practitioner often only sees the patient when there is a complicating physical illness and the psychiatric problems then tend to be masked by the physical symptoms. Most of the psychiatric and some of the physical symptoms are attributed to old age and accepted by patient, relatives and sometimes even the doctor as part of the ageing process. This 'ageism' in fact hinders the development, use of services and effective therapeutic measures that could help some of the elderly who are ill. In Britain, the primary care team is required to assess all above the age of 75 annually. This would help in early identification and assessments, appropriate and timely referrals to other services, follow-ups, treatments, advice and support for carers. Such comprehensive services are lacking in Malaysia although there are attempts now to develop such services. Under the auspices of the Ministry of Health, a National Council for the elderly comprising members from non-governmental and governmental organisations has been set up. Under the 7th Malaysia Plan, concerted efforts have been planned to integrate and strengthen services for the elderly with the vision of "Optimal Health and Quality Living throughout Old Age". In the sunset of their lifes, the elderly can have a future to look forward to.

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