Psychopathology Elements of Elderly Population

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Abstract

The frequency of mental illnesses increases proportionally with aging. Mental illnesses in the elderly are ranked second place after cardiovascular diseases, reaching up to 16% of the population over 70 years. In elderly, mental illnesses can be classified into two categories: 1) diseases that have a debut before aging, but not characteristic for old age; and 2) diseases that begin in old age with some specific issues - this category include regressive psychosis and late dementia. Dementia is a disease caused by the degeneration of the neuronal cell. Senile dementia occurs after age of 85-90 years. The long-term memory is frequently functional and the short-term memory is affected. Among the signs of dementia are mentioned: slow thinking and cognitive disturbances, irritability and nervousness, balance and coordination disorders, swallowing disorders, refusal to eat. Treatment is either medical (vitamines) or kinetic: reeducation of walking, recovery of balance and coordination, therapeutic walking, ergotherapy (Brouillet, 1997).

Keywords: *older age, mental illnesses, senile dementia, acute confusional states, sleep disorders*

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I. INTRODUCTION

Mental illnesses in old age may occur as a result of changes in family status as well as changes in professional status. Changes in family status include: children leaving their parental home, restricted living conditions, the abandonment of one's home in order to live with one of the children, sometimes conflicting relationships between generations (misunderstandings with their own children or grandchildren), conflict states between conjugal partners, death of one's partner and implicit loneliness, decrease of material income, sometimes the obligation to accept relocating to a care institution for the elderly (Gubrium, 1973). Changes in professional status include first of all retirement - withdrawal from professional activity (harder for men than for women), loss of social position in terms of financial status or prestige, or change of residence - most often for economic reasons (Guillemard, 1972).

The frequency of mental illnesses increases proportionally with aging. Mental illnesses in the elderly are ranked second place after cardiovascular diseases, reaching up to 16% of the population over 70 years. In elderly, mental illnesses can be classified into two categories: 1) diseases that have a debut before aging, but not characteristic for old age; and 2) diseases that begin in old age with some specific issues - this category include regressive psychosis and late dementia.

One of Freud's professors, the famous neurologist Charcot, stated in the last century that there are no differences between normal and pathological aging, but intermediate states may exist between the two. A multidimensional definition of a pathological process inspired by Birren and Renner (1980) includes six characteristics: "degradation of self-esteem, the decline of adapting to reality of its own representation, diminishing environmental control (the internalization degree of locus of control decreases while the sense of outsourcing increases), loss of autonomy (that tends to increase with age), the immergence of imbalances in personality and the decline in the ability to change" (Birren, & Renner, 1980).

Some of the common mental disorders in the elderly are sleep disorders and dementia. Below some significant features encountered will be briefly presented.

II. SLEEP DISORDERS

Sleep is one of the physiological functions most modified in the elderly relative to the adult. If the adult normal duration of sleep is 7-8 hours per day, the elderly normal duration is about 6 hours per day (Broughton, 1982). There may be a subjective impression on the duration either because the elders are sleeping during the day or the night wakes are longer or more frequent. Proper sleep hygiene practices include: regular bedtime hours, if possible after walking

shortly outdoors or after practicing physical exercises (Ellis, Hampson, & Cropley, 2002); having dinner at least two hours before bedtime; evening meal will not contain hard-digestible foods, irritating or exciting drinks, substances or medication that can cause insomnia (Friedman, Benson, Noda, Zarcone, Wicks, O'Connell, ... & Yesavage, 2000); there will be no smoking before bedtime (because smoking stimulates adrenaline secretion); strong emotions or conflicting states before sleeping will be avoided; proper ventilation in the bedroom; shower or hot bath with soothing effects; milk, linden tea or even wine intake, if there are no contraindications; creating optimum rest conditions on quietness, brightness and bed comfort; use of relaxing techniques such as hypnosis or relaxing massage (Vickers, Zollman, & Payne, 2001; Barnes, Powell-Griner, McFann, & Nahin, 2004).

The placebo effect is very important among the elderly. It has been found that about 60% of the elderly fall asleep using a placebo product, compared to 70% of the elderly who are using products with active ingredients on sleep (Kupfer, & Reynolds, 1997).

III. CONFUSIONAL STATES

Acute confusional states are more or less brutal and they widely alter consciousness as well as mental and relationship behavior (Saxena, & Lawley, 2009). It is an acute reaction that lasts for hours or days, with potential reversibility activated spontaneously or therapeutically. Time of debut is usually in the evening or at night. Triggering factors that cause its appearance are: cardiovascular diseases, metabolic disorders (uremia, hyperglycemia etc.), infectious, respiratory or urinary diseases, brain diseases, vascular accidents, injuries, tumors (Oishi, 1997).

Drug-related (iatrogenic) causes also occur, such as the administration of antidepressants, antiparkinsonians, neuroleptics, sedatives, tranquilizers, hypnotics, corticoids, aminophylline, etc. The sudden change in behavior, occurring for hours or days, represents the alarm signal. It takes the shape of consciousness confusion (related to displacement, concentration, and attention), illusions, hallucinations, disorientation, etc. In terms of therapeutic attitude towards confusional states, the evolution and vital risk issues need to be clarified with calm and patience to the family. Dialogue with the patient is maintained permanently. Treatment primarily targets causes and secondary symptoms. The patient's digression is accepted, he is neither contradicted nor immobilized, and the room is not lit up. If he is highly agitated and if we are convinced that the trigger is not a medicine then an anxiolytic tranquilizer (oral or injectable Haloperidol) or Benzadiazepine (diazepam) is administrated (Lindesay, Katona, Prettyman, & Warner, 2002).

Dementia is a disease caused by the degeneration of the neuronal cell. One of its forms is Alzhaimer. Senile dementia occurs after age of 85-90 years. The long-term memory is frequently functional and the short-term memory is affected. Among the signs of dementia are mentioned:

slow thinking and cognitive disturbances, irritability and nervousness, balance and coordination disorders, swallowing disorders, refusal to eat. Treatment is either medical (vitamines) or kinetic: reeducation of walking, recovery of balance and coordination, therapeutic walking, ergotherapy (Montagnier, Hanon, & Glénisson, 2012).

IV. CONCLUSIONS

The elderly age is followed by a series of psychological and adaptation issues that affects the individual personally and socially. Thus, there is a need for an appropriate understanding of all characteristics and mechanisms specific to this age, in order to identify the most effective solutions for preventing, improving and eventually combating these difficulties (World Health Organization, 2008).

Individual aging is not a state, but a differential process of degradation, and individuals are aging in very different ways (Lamberts, van den Beld, & Van Der Lely, 1997). Due to pharmacological discoveries, improving living conditions and higher level of culture, there has been a very large increase in the number of elderly, active, healthy population with desire to live.

On the other hand, as we all know, not all people are equal in the face of aging; therefore the rhythm of aging of organs and psychological functions is not the same for everyone.

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