Depression in the Elderly "Clinical and Psychosocial Study"

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Depressive illness is common in the elderly and has recently become the focus of much research. The number of elderly poulation is now increasing as compared to children and young adults and has led to an interest in the characteristcs of this group of population specially their mental health problems which are considered a manin cause of disability in old age. In addition to the mental suffering, depression is a risk factor for subsequent morbidity, excessive health care costs and in some instances actual mortality. The prognosis of late-onset depression is relatively poor, and is characterized by frequent and prolonged relapses. So studying the problem of depression in the elderly is important in psychiatric health care. Sociodemographic, clinical, and psychometric assessment of 30 elderly patients with late onset depression and 30 patients with early onset depression demonstrated that elderly persons were more likely to suffer from a single episode of depression of longer duration often precipitated by stressful life events. early onset depressives were more likely to suffer recent episodes of depresson. Few differences in symptoms emerged between geriatric depressives and their younger counterparts. These involved greater self blame, suicidal ideation, psychic anxiety in early onset depresive patients, and greater hypochondriasis, somatic preoccupation, psychomotor retardation and late-insomnia in the elderly depressed patients in this study. Also, geriatric depression was characterized by cognitive impairment and functional disability, in comparison to the early-onset depressives.

(Egypt.J.Psychiat., 2000, 23: 29-36).

INTRODUCTION

The cognitive imparirment that often occur with ddpression may be so marked in elderly person that he or she may actualy seem demented (Alexopulos, 1995 & Anthony, 1996).

Many clinicians assume that depression in late life presents differently form depression at other ages of the life cycle (Elzer, 1997).

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Blzer (1997) reported that late life depression has been thought to be associated with more frequent physical symptoms, fewere emotional symptoms (specially guilt) and more frequent complaints of cognitive impairment.

The elderly may be more likely to mask their depression than individuals at earlier stages in their life cycle (Dewey et al. 1993). Instead, the dysphoric affect is masked by prominent somatic complaints (Alexopulos, 1995).

In Egypt, Shaheen & Rakhawy (1971) stated that depression in elderly is not usually associated with guilt and suicide.

Although symptoms of depression in younger and older people are similar,

complicating factors in the elderly patient contribute to a clinical picture considerably different from that seen in those who are younger (Anthony, 1996).

SUBJECTS AND METHOD

A sample of 60 patients with major depressive illness was selected from outpatient clinic and the inpatient psychiatric depatment of Tanta University Hospital. Diagnosis was done according to The criteria described by DSM - IV. The subjects of this study were grouped into:

Group I:

Early onset depressive group: includes 30 depressed patients with age at onset of first depressive episode above 60 years.

Patients with pre-existing manic or hypomanic symptoms, established neurological disease or serious physical disabilities were excluded.

Guoup II:

A control group of 30 normal individuals matched by age and sex from any clinical neuropsychiatric problems and have no past history of neurologic or psychiatric disorders.

All subjects of study were subjected To:

Clinical study:

a. Clinical psychiatric examination.

b. Physical examination including thorough neurological examination.

c. Routine laboratory investigations including complete blood picture, blood urea and creatinine, liver functions, E.S.R. blood sugar and brain C.T. scan when needed.

1- Hamilton Rating Scale for depression (HDRS) (Hamiltion, 1969).

2- Life Events Qustionnaire (L.E.Q) (Horowitz et al. 1977).

3- Global assessment of functioning scale (G.A.F) (American Psychiatric Association,1994).

4- Bender Gestalt test (BG) (Bender, 1938).

Aime of the work: The aim of this work is to study late-onset depression to determine its characteristics, effect of psychological stressors, the impact of depression in the global functioning and cognitive impairment in elderly depressed patients. It is a trial to answer the question, is there any clinical justification to distinguish late-onset depression. This may help in improving the quality of care in this age group.

RESULTS

The early-onset group has highly significant difference regarding number of

Table 1
Features of Depression in the Early and Late-Onset Patients

characteristics	Early-onset		Late Onset		X2	Sig
	No	%	No	%		
Number of previous depressive episodes						
One episode.	9	30	23	76.67	13.125	P<0.001
More than one episode	21	70	7	23.33		
Duration of illness (months)	3.633 ±1.965		6.717 ±1.7		6.501	P<0.001
Psychotic symptoms	5	16.67	7	23.33	0.24	P<0.05
Congruent to mood	4	80	4	57.1		
Incongruent to mood	1	20	3	42.9	0.8	P<0.05

Table 2
Mean Score of Different Items of HDRS in Early-Onset and Late - Onset Group

Item	Early-onset(30)		Late -onset(30)		t	p
	Mean	S.D	Mean	S.D		
1- Depressed Mood	3.1	0.403	3.066	0.44	0.309	>0.05
2- Guilt	1.733	0.868	1.233	0.679	2.312	<0.05*
3- Suicide	2.267	0.944	1.5	0.63	3.702	<0.05*
4- Insomnia initial	1.7	0.535	1.76	0.43	0.479	>0.05
5- Insomnia middle	1.7	0.466	1.73	0.449	0.531	>0.05
6- Insomnia delayed	1.1	0.712	1.6	0.498	3.152	<0.05*
7- Work interest	3.233	0.568	3.16	0.698	0.444	>0.05
8- Retardation	1.4	0.77	2.067	0.691	3.51	<0.05*
9- Agitation	0.367	0.615	0.266	0.583	0.653	>0.05
10- Anxiety psychic	1.8	0.847	1.2	0.61	3.149	<0.05*
11- Anxiety somatic	3	0.643	2.867	0.73	0.749	>0.05
12- Somatic symptoms gastro intestinal	1.93	0.25	1.867	0.346	0.080	>0.05
13- Somaticysmptoms general	1.333	0.661	1.7	0.466	2.485	<0.05*
14- Genital symptoms	1.667	0.497	1.7	0.46	0.272	>0.05
15- Hypochondriasis	1.433	0.858	2.003	1.033	2.447	<0.05*
16- Loss of insight	0.96	0.718	1.067	0.74	0.266	>0.05
17- Loss of insight	1.53	0.571	1.567	0.504	0.266	>0.05
18- Diurnal variation	1.333	0.547	1.267	0.74	0.395	>0.05
19- Depersonalization	1.333	0.184	1.2	1.186	0.435	>0.05
20- Paranoid symptoms	1.6	0.77	1.83	0.985	1.007	>0.05
21- Obsessional symptoms	0.6	0.724	0.7	0.702	0.453	>0.05
22- Helplessness	1.8	0.635	1.666	1.093	0.481	>0.05
23- Hopelessness	1.833	0.834	1.7	0.952	0.576	>0.05
24- Worthlessness	1.7	0.022	1.8	1.631	0.264	>0.05

* p Significant

Table 3
Total Score of Life Events Questionnaire (LEQ) in Patient and Control Group

	Early -onset Group I (30)		late-onset GroupII (30)		Young - Control GroupIII (15)		Old - Control Group IV (15)	
	No	%	No	%	No	%	No	%
- No life crisis (0 - 149)	21	70	5	16.67	13	86.67	12	80
- Mild to moderate life crisis (150-299)	7	23.33	16	53.33	2	13.33	3	20
- Major life crisis (300+)	2	6.67	9	30	-	-	-	-
- Total	30	100	30	100	15	100	15	100

Gourp I # Group II X $^2_1$= 17.83 P < 0.001

Gourp II # Group IV X $^2_1$= 17.06 P < 0.001

Gourp I # Group III X $^2_1$= 0.03 P > 0.05

Table 4
Different Items of (LEQ) in Patient and Control Group

Items of (LEQ ///0)	Early -onset Group I (30)		late-onset GroupII (30)		Young - Control GroupIII (15)		Old - Control Group IV (15)	
	No	%	No	%	No	%	No	%
1- Death of a loved one	3	10	12	40	1	6.67	3	20
2- Marital problems	4	13.33	3	10	1	6.67	1	6.67
3- Other changes	1	3.33	1	3.33	0	-	1	6.67
4- Work changes	3	10	4	13.33	2	13.33	2	13.33
5- Financial troubles	5	16.67	11	36.66	2	13.33	4	26.67
6-Major illness of the patient or one his near relatives	4	13.33	11	36.66	1	6.67	3	20
7-Moves	2	6.67	2	6.67	0	-	1	6.67

Group (I) # group (II) * significant in items 1.5.6 (P<0.05) insignificant in items 2.3.4.7 (P>0.05)
Group (II) # group (IV) (P> 0.05) in all items
Group (I) # group (III) (P> 0.05) in all items

Table 5
Comparison between the Mean Score of Global Assessment of Functioning (GAF) Scale in Early in Early-Onset and Late - Onset Groups

GAF Scale	Early-onset Group (30)	Late - onset Group (30)
mean	36.9	30.337

t=2.246

Table 6
Correlation between HDRS and GAF Scale in Late-Onset Group

	R	P
HDRS& GAFscale	- 0.593	<0.001

Table 7
Comparison between Mean Score of B.G. Test in Early-Onset Group and Late-Onset Group

	Early-onset Group (30	Late - onset Group(30)
Mean	19.0	16.933
S.D	±3.363	±3.973

t=2.175 P<0.05

Table 8
Correlation between HDRS B.G. Test in Late-Onset Group

	R	P
HDRS& B.G. test	- 0.497	<0.005

recurrent depressive episodes and charaterised by: higher mean score of suicide, guilt and anxiety psychic. Late-onset group showed a higher percentage of psychotic depression and characterised by: retardation, late insomnia, hypochondriasis and general somatic symptoms. No significant difference regarding mood incongruent psychotic. Symptoms between early and late onset group (Tables 1 & 2).

The total score of life events in late onset group is significantly higher than the early-onset group particularly death of a loved one, finacial troubles or illness of the patient. (Tables 3 &4).

The early-onset group has a significantly higher score on B.G test than late-onset group which showed significant negative correlation between score of HDRS and B.G test (Tables 7 & 8).

DISCUSSION

Depression was reported by several studies to be the most frequent psychiatric problem and the single commonest symptom found in older persons (Keleh et al, 1978).

It was found that 30% of persons over the age of 65 years might be expected to experience an episode of depression severe enough to interfere with daily fuction (Fikry et al, 1982).

Geriatrics are not only prone to depression but also to memory deficits, intellectual deterioration, cognitive impairment and pseudodementia (Rashed et al, 1987).

Late-onset depression has a less risk of recurrence than early-onset depression. This was in agreement with some Egyptian and foreign literatures e.g. EL-Khouly et al, (1998). However, the data of the study of Ashour (1979) and Keeler (1982) reported an increasing probaility of relapse after the first episode.

In this study, the mean duration of illness in late-onset group was longer than that of ealry-onset group. This was in agreement with Musetti et al. (1989) and Wasfy (1993) who found that the late-onset major depressive disorder had longer episodes than the ealry-onset patients. Also, this was wupported by Blazer1997) who reported the late-onset depression has a great tendency for chronicity. on the contrary, Kellr et al (1986) did not demonestracte a significant relationship between duration of episodes and an age of onsed.

This study showed no statistically significant difference in the distribution of psychotic depression and mood incongruent psychotic symptoms between early-onset and late-onset depressive patients. This was in agreement with Abd El-Rahman et al (1996) on the other hand Winokur et al. (1990) reported more prevalence of mood incongruent psychotic features in younger depressives than older depressives.

The early-onset group has a significantly higher mean score of suicide, guilt and anxiety psychic than late-onset group. This was in accordance with the

findings of Rashed et al, (1987), Musetti et al. (1989) and Baldwin & Tomenson (1995). However, Brown et al (1984) reported a higher suicidal intent in his elderly depressive patients (cultural difference). Ranga et al (1995) Failed to find any significant difference regarding guilt between early and alte-onst depressed patients.

The late-onset group has a significantly higher mean score of ratardation, alte insomnia, hypochondriasis and general somatic symptoms than th ealry-onset group. This resutl was contrary to the concept that elderly depressive patients were agitated (Brown et al, 1984).

Also, Alexopoulos et al, (1988) reported early insomnia to be more common in elderly depressive patients. Musetti et al. (1989) Failed to find any difference between young and older depressives regarding hyopchondriasis and general somatic symptoms.

In the present study, the total score of life events in late-onset group is significantly higher than the early-onset group and the old control group. This resutl goes in line with some Egyptian studies e.g. Shaheen et al. (1984) and El-Khouly et al. (1993).

Also, these resutls reported that late-onset group had significantly higher percentage in 3 out of 7 sets of events of L.E.Q. "Death of a loved one" "Financial troubles" and "major illness of the patient or one of his near relatives" than the early-onset group. These resutls go in line with Blazer et al, (1985), who reported that low socioeconomic status have been associated with increased risk of depression in the elderly. Also Kennedy et al. (1989) Reported that the events of loss such as death of a loved one can precipitate depression in late-oife, Murphy (1982) reported that life threatening illness to some-body close is often involvd in late life depression.

GAF scale in early-onset was significantly higher than the late-onset group. Wells et al, (1989) reported that geriatric depression is often associated with functioning disability. on the other hand, Jeffrey et al, (1993) in his comparison between elderly and adult depressed patients using GAF scale, failed to detect any significant difference.

Also, highly significnat correlation between the severity of depression on HDRS and degree of functioning disability on GAF scale was detected. This result was in agreement with Alexopoulos et al. (1996).

In the present study, the mean score of B.G test in late-onset group was significantly lower than the early-onset group and their old control group. This was supported by the concept that depressive disoders in the elderly are frequently associated with cognitive impairemtn (Oxman, 1996 and Blazer, (1997).

Also, our result denoted a significant negative correlation between the severity of depression detected by HDRS and the presence of cognitive impairment in elderly depressed patients. This result was in line with Reynolds et al. (1988).

REFERENCES

Abd El-Rahman S. Zeinab Sarhan, Azza El-Bakry et al (1996) Early Vs late-onset depression: A Clinical study. *Egypt. J. Psychiat.* **19**: 111-19.

Alexopouls G.S. (1995) Mood disorders. In Kaplan H.I. Freedman A.M. Sadock B.J. (eds) Comprehensive Text book of psychiatry (6th ed), Baltimore, Williams and wilkins Co, Pp. 2566-2568.

Alexopoulos G. Gounnie V. Takus K. Barentt S. Majers et al. (1996) Disability in Geriatric Depression. *Am. J. Psychiat.* 153: 855-877.

Alexopoulos, G.S. Robert C.R. Barent S.M. et al. (1988) Late onset depression Psychiat. *Clin North Am.* 11:101-115.

American Psychiatric Association (1994). Diagnostic and Statisteial Manual of Mental Disordeas, Fourth Editim, (DSM IV). Washington: *American Psychitric Association.*

Anthony J. Rothscchild M.D. (1996) Thediagnosis and treatment of late-life depression. *J. Clin. Psychiatry*; 57 (Suppl 5).

Ashour A.M. (1979) Depression in elderly. CIBA symposium on depression. Cairo.

Baldwin R.C. and Tomenson B. (1995) DEPRESSION N LAter life: A comparison of symptoms and risk factors in early and late-onset cases. *Brit. J. Psychiat.* **197:** 649-652.

Bender, L. (1938) Avisual motor Gestalt test and its clinical use. American Orthopychiatric Association, New York.

Blazer D.G. (1997) Depression in elderly: Myths and miscoonceptions. *Psychiat. Clin. North Am.* **20:**111-119.

Blazer D.G. George L.K. Landerman R. Penny backer M. Melwille M.L. et al. (1985) Psychiatric disorders: A rural/urban comparison. *Arch. Gen. Psychiat.* **42:** 651-656.

Brown R.P. Seeeney J. Lousch E. et al (1984) Involutional melancholia revisited. *Am. J. Psychiat.* **141:**24-28.

Dewey M.E, de la-Camara C. Copehanad J.R.M. Lobo A. Saz P. (1993) Croos-cultural comparison of depression and depressive symptoms in older people. *Acta psychiatrid scand.* **87:** 369-363.

El-Khoully M. El-Nagar S. and Hashem A. (1993) Depressive illness in the elderly: Psychosocial and dermographic study. *Egypt. J. Psychiat.* **16:** 68-76.

Fikry E. Rashed S. and El-Gueneidy M. (1982) Depression and anxidty in geriatric population. Paper accepted in J. oj High Institute of Public Health, Alex. Univ.

Hamilton, M. (1969) Standarised assessment and recording of depression Symptoms. *Psychiatry, Neurol. Neurosurg.* **72: 201-205.**

Horowitz, M.; Schoefer, C.; Hiroto, D.; Wiener, N. and levin, B. (1977) Life Events Questionane for Measussing Prepumptive stress. *Psychosm. Med.* Vol. 39,N.6.

Jeffery M. Lyness, Eric D. CAINE et al. (1993) Depressive symptoms. Medical illness and Functional status in depressed psychiatric inpatients. *AM. J. Psychicat.;* **150:**910-915.

Keeler M.B. Lavori P.W. Rice J. et al. (1986) The persistent risk of chronicity in recurrent episodes of non bipolar major depressive disorder: a prospective follow up. *Am. J. Psychiat.*; **143:** 24-28.

Keeler M.B. Shaprio R.W. Lavori P.W. et al. (1982) Relapse in major depressive disorder. Analysis with the life table. *Arch. Gen. Psychiat.*; **39:** 911-915.

Keleh J.I. Longe P. and Karu E. (1978) Differential diagnosis of the distarbed elderly patients. Hosp. *Community Psychiat.*; **29 (11)** 735-8.

Kennely G.J. Howard R. Cynthia T. Wendy W. et al. (1989) Hierarchy of characteristics associated with depressive symptoms in an urban elderly sample. *AM. J. Psychiat.;* **146:** 220-225.

Kessing L.V. (1998) Recurrence in affective disorder. II Effect of age and gender. *Brit. J. Psychiat.*; **172:** 29-43.

Murphy E. (1982) Social orgion of Depression in old Age. *Brit. J. Psychiat.*; **141:**135-142.

Mustti L. Giuliv P. Adalgisa S. Rossi V.M. et al. (1989) Depression before and after age 65. A Reexmiation. *Brit. J. psychiat.*; **155:** 330-336.

Oxman T.E. (1996) Antidepressant and cognitive impairment in the elderly. *J. Clin. Psychiat,.* 57 (Supple) 38-44.

Ranga K.R. Krishnan, Judith C. Hays R.N.

Larry A. Linda K. and Blazer D.G. (1995) Clinical and phenonmenological comporison of late-onset and ealry onset depression *Am. J. Psychiat.*, 152: 785-788.

Rashed S. Refaat Y. Mansour S. El-Din and Fikry E. (1987) Combind presentation of depression and demential Behaviour Among Elderly patients. *Egypt. J. Psychiat.*; 10: 25-40.

Shaheen O. Abd El-Rahman S. Ali S.A. et al. (1984) Mood changes in Egyptian senile depressives. *Egypt. J. Psychiat.*; 7:16-72.

Shaheen O. and Rakhawy Y. (1971) ABC of psychiatry. Ciaro, El-Nasr Modern Bookshop.

Wasfy M. Mobasher (1993) Psychological Aspects in Early and Late-onset Depression. M. D thesis, psychiatry, Cairo University.

Wells KB. Stewart A. Hays RD. Burman M.A. Rogers W. et al. (1989) The functioning and well-being of depressed patients: results from the medical outcomes study. JAMA; 226: 914-919.

Winkour G. Behar D. and schlesser M. (1990) Clinical and biological aspects of depression in the elderly. In J. a cole and J.E. Barrett (eds.) Psychopathology in the aged. New York. Raven Press. P: 133-145.

الاكتئاب فى المسنين (دراسة إكلينيكية ونفسية اجتماعية)

أجرى هذا البحث على ستين مريضا من المصابين بالاكتئاب اختيروا من عيادة الأمراض النفسية والعصبية والقسم الداخلى بمستشفى جامعة طنطا وقد قسمت العينة إلى مجموعتين **الأولى**: تشمل ثلاثين مريضاً أصيبوا بالاكتئاب فى سن مبكرة (كان سن حدوث أول نوبة اكتئابية قبل سن الستين عاماً). **والمجموعة الثانية**: وتشمل على مرضى الاكتئاب المتأخر وتضم ثلاثين مريضاً أصيبوا بالاكتئاب فى سن متأخرة (كان سن حدوث أول نوبة اكتئابية بعد سن الستين عاماً). وقد تم لهم جميعاً إجراء مقارنة من ناحية شدة مرض الاكتئاب باستخدام مقياس هاملتون لقياس شدة الاكتئاب كما أجريت مقارنة بين المجموعات فى تعرضهم مصاعب الحياة باستخدام مقياس أحداث الحياة ومقارنة باستخدام التقييم الشامل للكفاءة الوظيفية وأخرى باستخدام اختبار بندر جيشتالت لقياس الذاكرة البصرية القريبة. وقد توصل البحث إلى أن مرضى الاكتئاب المتأخر أكثر عرضة للإصابة بنوبة واحدة من الاكتئاب تكون ذات فترة أطول وفى الغالب مسبوقة بمصاعب فى الحياة ومرضى الاكتئاب المبكر أكثر عرضة لنوبات عديدة من الاكتئاب وقد أوضح البحث أيضا أن مرضى الاكتئاب المتأخر يعانون أكثر من الأعراض الذهانية والتوهم المرضى وقلة الحركة والأرق المتأخر فى النوم بينما يتعرض مرضى الاكتئاب المبكر أكثر إلى شدة لوم النفس وأفكار الانتحار. كما أن مرض الاكتئاب المتأخر قد يتواجد معه أعراض العته كما أنه قد يترتب عليه حدوث انخفاض فى الكفاءة الوظيفية مقارنة بمرض الاكتئاب المبكر.