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Mood Changes in Egyptian Senile Depressives

By : O. Shaheen, Samia Abd El-Rahman, Sanaa A. Ali and Fatma A. Moussa

ABSTRACT

A sample of 31 senile depressed patients aged 65 years or more was selected. All were subjected to careful physical and psychological examinations including provocation of various forms of emotion, and an inquiry about their predominant emotions 6 months prior to asking psychiatric help. A control group comprised 12 persons of nearly the same socio-biological characters was selected.

The clinical picture of our senile depressives differs from the known picture of "Depression" in the absence of a depressed mood and the over-representation of hypochondriacal symptoms. Other manifestations are : tendency to cry, restlessness, fear, desire for loneliness and marked sensitivity. The emotional state prior to consultation was coloured by a lot of symptoms. These were : sense of hopelessness, self reproach, pessimism, frequent dejected mood and a sense of worthlessness.

Emotional deprivation is postulated as an essential causative factor, while in 19.4% no evident cause was observed.

Difficulties arose in a trial to search for the hereditary load in senile depressives, but it seems that this factor is not so important in predisposition, and that the

environmental stresses appeared to be the major contributory elements in depression of late life.

INTRODUCTION :

Researchers and clinicians generally agree about the core symptoms and signs of depression at all stages of life cycle, except in the senium. Beck (1967) considered the diagnosis of depression in late life to be difficult because of the nearly general absence of depressed mood which is always present in other depressive disorders. That is why Brink (1977) regarded that the diagnosis may be settled by looking at the individual's interaction with the environment prior to and during his illness. He observed that the chief complaint made by the senile depressive most likely will not immediately indicate depression, and the essential complaint is a somatic one; so much so that the picture of depression is totally masked. He suggested that clinicians must unearth the core symptoms by skillful questioning. On the other hand, Goldfarb (1974) described an exaggeration of personal helplessness that is characteristic of the "masked depressions" of late life. For Mayer-Gross et al. (1969), the florid symptoms of depression tend to calm down with age to give way to apathy associated with some grotesque delusions and hypochondriacal ideas. Gurland (1980) and Gillard et al. (1981) agreed that the diagnosis of depression in the elderly, particularly the frail elderly, is difficult. That is because not only the depressed mood is hidden, but also there is some mistrust and fear from psychiatrists, which complicates the picture. On the contrary, Lehmann (1959) considered the diagnosis of most cases of senile depression to be easily reached by mere inspection, through a dejected mood among other symptoms, of which dependency, agitation or retardation, helplessness and hopelessness are prominent.

These observations stimulated us to study senile depressives in an affect loaded culture as our Egyptian culture, to investigate whether the culture can change the affective picture of the senile depressive.

This work is also directed to shed some light on the premorbid emotional state of such persons, and the symptoms which bring the patient to psychiatric help.

MATERIAL AND METHOD :

We submitted to our work all elderly depressives at the age of 65 years or more, who presented to Kasr El-Aini Psychiatric Outpatient Clinic in the period March - July 1981. All our patients fulfilled Feighner's et al. criteria (1972) for diagnosing depression, which are :

A. Dysphoric mood characterized by symptoms such as the following: depressed, sad, blue, despondent, hopeless, "down in the dumps", irritable, fearful, worried or discouraged.

B. At least five of the following criteria are required for "probable" depression :

1. Poor appetite or weight loss (positive if 2 lb a week or 10 lb or more a year when not dieting).
2. Sleep difficulty (include insomnia or hypersomnia).
3. Loss of energy, e.g. fatigability, tiredness.
4. Agitation or retardation.
5. Loss of interest in usual activities, or decrease in sexual drive.
6. Feelings of self-reproach or guilt (either may be delusional).
7. Complaints of or actually diminished ability to think or concentrate, such as slow thinking or mixed up thoughts.
8. Recurrent thoughts of death or suicide, including thoughts of wishing to be dead.

C. A psychiatric illness lasting at least for one month with no pre-existing psychiatric conditions such as schizophrenia, anxiety

neurosis, phobic neurosis, obsessive-compulsive neurosis, hysteria, alcoholism, drug dependency, antisocial personality, homosexuality, and other sexual deviations, mental retardation, or organic brain syndrome.

The number of patients amounted to 31; 19 males and 12 females. The patients were subjected to careful physical and psychological examinations. Provocations of various forms of emotions were stressed during the session, to illustrate hidden forms of emotions. A separate session with the nearest relative was held; to allow him to comment on the emotional state of the patient, about 6 months prior to referral to psychiatric out-patient, and allow inquiry about their symptoms. Special considerations were directed to the possible precipitating factors.

A control group comprising 12 persons of the same age group, who were considered by themselves and their relatives to be psychologically free, was chosen. Special stress was directed to the absence of previous symptoms suggestive of a psychotic illness, dementia or previous intensive psychiatric treatment of whatever quality.

RESULTS :

1. Age and Sex Distribution :

TABLE I

Age and Sex Distribution

	Sex				Age	
	M		F		Mean	S.D.
	No.	%	No.	%		
Sample	19	61.3	12	38.7	69.4	3.2
Control	7	58.3	5	41.7	69.8	5.1

2. Emotional Symptoms Expressed :

TABLE II

Emotional Symptoms

Symptom	Sample		Control		Difference
	No.	%	No.	%	(S-C)
. Severe indifference	26***	83.9	5	41.7	42.2**
. Tendency to cry	21***	67.7	2	16.7	51***
. Irritability	17*	54.8	6	50	4.8
. Worry	14	45.2	3	25	20.2
. Restlessness	12	38.7	1	8.3	30.4*
. Aggression	10	32.3	5	41.7	9.4
. Fear	8	25.8	—	0.0	25.8*
. Expression of sadness	5	16.1	2	16.7	0.6

* P ◁ 0.01

** P ◁ 0.005

*** P ◁ 0.001

In our sample, expression of sadness was only observed in 16.1%, whereas a masked face with an expression of severe indifference was highly prevalent (83.9%; P ◁ 0.001). This is followed by tendency to cry in 67.7%, then irritability, which amounted to 54.8%. Other forms of emotions were represented to a lesser degree.

In the control group, although facial indifference and aggression were represented by 41.7% for each, yet it did not reach statistical significance. Neither did irritability, which represented the highest rate of prevalence (50%); other forms of emotions were represented to a much lesser extent.

Comparing our depressed patients with their controls, the variance in between amounted to a statistical significance in : tendency to cry ($P < 0.001$); severe indifference ($P < 0.005$), then restlessness and fear ($P < 0.01$).

3. Precipitating Factors :

a – Prevalence of probable precipitating factors in patients :

TABLE III A

Precipitating Factors

Factor	Sample		Control	
	No.	%	No.	%
— Normal physical and mental decline	31	100	12	100
— Emotional deprivation	18	58.1	6	50
— Physical illness	17	54.8	7	58.3
— Retirement	12	38.7	4	33.3
— Socio-economic difficulties	6	19.4	2	16.7

b – Patient's own rating of possible precipitating factors :

TABLE III B

Precipitating Factors

Factor	No.	%
— Emotional deprivation	19**	61.3
— Normal physical and mental decline	8	25.8
— Physical illness	5	16.1
— Retirement	3	9.7
— Socio-economic difficulties	3	9.7
— Out of the blue	6	19.4

** $P < 0.005$

Emotional deprivation was noticeable (61.3%, P◄ 0.005) as a precipitating factor in our depressed patients. In 25.8%, normal decline in physical and mental capacities was the factor postulated for precipitating the depressive illness. Whereas in 6 cases (19.4%) no evident precipitating factor can be blamed. In our sample, 17 cases (54.8%) had organic disease, but only in 5 cases (16.1%) their disease was accused of precipitation of psychiatric illness through difficulties in treatment programs, complication arising from the original disease or from therapy, and the realization of the chronic course of most of these illnesses. Also, we observed that the prevalence of all these factors showed slight differences between the sample and the control, not amounting to statistical significance.

TABLE IV

Emotional State 6 Months Prior to Psychiatric Trouble

	Sample		Control		Difference
	No.	%	No.	%	
– Sense of uselessness	28**	90.3	6*	50	40.3*
– Socio-economic & emotional dissatisfaction	26***	83.9	8**	66.6	27.3
– Sense of hopelessness	21**	76.7	2	16.7	60***
– Pessimism	20**	64.5	2	16.7	47.3**
– Frequent dejected mood	19**	61.3	1	8.3	43**
– Weeping at times	17*	54.8	4	33.3	21.5
– Frequent worry	16	51.6	3	25	26.6
– Self-reproach	16	51.6	–	0.0	51.6**
– Agitation	15	48.4	–	0.0	48.4**
– Aggression	12	38.7	1	8.3	30.4*
– Sense of helplessness	11	35.5	3	25	10.5

* P ◄ 0.01.
** P◄ 0.005.
*** P◄ 0.001.

4. Emotional State 6 Months Prior to Psychiatric Trouble :

The emotional state prior to asking psychiatric help (Table IV) was coloured in most patients (90.3%, $P < 0.001$) by a sense of uselessness. In 83.9% ($P < 0.001$) there was a sense of dissatisfaction especially from the changing socio-economic values.

Other emotional states which were represented in high scores were sense of hopelessness (76.7%), pessimism (64.5%), frequent dejected mood (61.3%) and crying at times (54.8%).

In the control group, we observed that a sense of dissatisfaction and uselessness represented the prevailing emotional states prior to our inquiry, for they amounted to 66.6% and 50% respectively.

Comparing the depressed sample and the control, we observed that the difference between them reached statistical significance in: sense of hopelessness, self-reproach, agitation, pessimism, sense of uselessness and aggression, This encourages us to consider the presence of these symptoms as prodromal symptoms of a coming depression if not constituting an early phase of senile depression.

5. Symptoms Which Attracted the Attention of the Patient or His Family to Seek Psychiatric Help :

Among the so many symptoms which attracted the attentions of the patient and his relatives; the vague physical complaints (74.2%, $P < 0.005$) come first. It is followed by an insisting desire for loneliness (61.3%, $P < 0.01$) then marked sensitivity (54.8%, $P < 0.01$).

DISCUSSION :

Many Western authors stressed the observation that in the elderly depressive the mood is masked and needs provocation to manifest.

TABLE V

Symptoms Which Attracted the Attention of the Patient or His Family

Symptom	No.	%
– Vague physical complaint	23**	74.2
– Desire for loneliness	19*	61.3
– Sensitivity	17*	54.8
– Suspicious attitude	15	48.4
– Insomnia	13	41.9
– Loss of appetite	10	32.2
– Preoccupation about simple problems	8	25.8
– Aggression	5	16.1
– Excessive religiosity	4	12.9
– Bizarre behaviour	3	9.7

* $P < 0.001$

** $P < 0.005$

Frequently it may be present in a disguised form as various forms of somatic complaints which act as depressive equivalents (Lesse, 1977). This view is also stressed by Lawrence et al. (1981) and Clayton and Darvisk (1979). The latter added that the current diagnostic system for depressions is not suited to the elderly population in whom depression may express itself differently, where depression is often denied and kept hidden or expressed through equivalents.

In our sample, though expression of sadness was only manifested

in 16.1% yet there was a tendency to cry in 67.7%. At the same time, there was marked facial indifference or a masked face in 83.9%. This means that there was an inner experience of depression, yet its expression was withheld consciously or unconsciously.

Although irritability as an evident emotion is represented in 54.8%, yet it did not reach to statistical significance when compared to the control group.

Other forms of emotions were encountered, but to a lesser extent, e.g. worry, restlessness, aggression and sense of fear.

The symptoms of "Restlessness' and "Fear" amounted to statistical significance when compared to the control group. Perhaps the senile depressive may regard these forms of affect to be socially accepted on one hand and attracting more attention on the other hand, than a depressed sad mode of expression. This point of an absence of sad expression was stressed by so many workers, e.g. Salzman and Shader (1978), Goldfarb (1974) and others.

Beck (1967) considered that even a dejected mood is not a common feature in elderly depressives, but decreased life satisfaction is the pervasive emotional symptom. He reported that 92% of his elderly depressed patients show at least partial loss of life satisfaction, and considered this symptom to be the most common among his depressed group as a whole, and that this symptom can be traced back to that period before seeking medical help. In our patients 83.9% were dissatisfied. Almost all were dissatisfied from the socioeconomic standards in which they live. If we compare this factor of " Dissatisfaction" to the control group, we get no statistical difference.

However other emotional states - statistically significant - were : sense of hopelessness, self-reproach, agitation, pessimism, dejected mood and sense of uselessness. It is astonishing that although they are evident, all these emotional states did not attract the attention of the patient or his relatives in our culture, so much so, that they did not necessitate asking psychiatric help. This leads us to two arguments :

1. If this depression is masked, what are the predominant symptoms which brought the patient for psychiatric help ?

2 If this depression is kept hidden at least for some time, what are the possible factors behind its precipitation ?

To answer the first question, we observed the hypochondriacal symptoms to be the most alarming symptoms which attract the attention in 74.2% ($P < 0.005$) of our sample, leading usually to consultation of general physician. A point which was stressed by Watts (1957) who noted that elderly depressed patients treated in a medical clinic frequently presented symptoms suggestive of a physical illness, but proved later to be only hypochondriasis. Also, Bradely (1963) noted that severe localized or generalized pain may be the focus of an elderly depressed patient's complaint. Older persons are more likely to translate their symptoms into physical complaints; as pointed to by De Alarcon (1964). He considered the self-absorbed hypochondriac patient to irritate physicians, to a point that he warned the physician against underestimating the patient's condition. He found in a good percentage of his sample that there was suicidal pre-occupation behind these hypochondriacal symptoms.

Following this, there was a tendency for loneliness (61.3%, < 0.01). This prehaps can be explained by being equivalent to a sense that death is coming, he has to be near God by some religious rituals, e.g. reading Holy Books or repeating religions verses ... etc. It may be due to the concept that mixing will provoke mistakes which are forbidden by religion. This behaviour (social isolation) can be explained also to be a protest against dissatisfying life events (83.9%, $P < 0.001$) which they can't correct. Social isolation in senile depressives was also stres-

sed by so many workers (e.g. Sainsbury, 1962; Bachelor and Napier. 1953; Dowd and Brooks, 1978; Goodstein, 1981). Dowd and Brooks explain social isolation of senile persons as due to their loss of social ties with their culture. That is based on their being more conscious of recent trends in social policy, that is completely different from traditional social values which they are habituated to. Older persons some times may believe that society is under the control of a group of influential persons who are completely different in their concepts and values in life. To Lin et al. (1979), loneliness is liked by the senile person because he feels a generational gap, and a great discrepancy between what is happening and what ought to be.

Marked sensitivity was observed in 54.8% ($P < 0.01$). It is usually coloured by a suspicious attitude (48.4%) underlying both sensitivity of unexplainable crying episodes or dejected mood. This depressive manifestation can be explained by what is going around in the environment which can't go with the aged "life respectable rules". What adds to the distress of the aged is that they can do nothing to change the accepted prevailing values of life. Marked sensitivity was also observed by Goldfarb (1974) who considered it as exaggeration of personal helplessness. Winokur et al. (1980) regarded it to be due to negative feelings towards the self; as the elderly patient feels a sense of emptiness, that is why he is sensitive to the behaviours of others.

As regards the second question, we observed emotional deprivation in the form of bereavement due to loss or disease of an intimate or loved person to be prevalent (61.3%, $P < 0.005$). This observation was also stressed by Bronstein et al. (1973), Clayton (1974) and Silvermann (1976). They regarded this factor to be associated with prolonged grief. Clayton reported grief to occur one year after bereavement, while Silvermann questions that no one knows how long the grieving process takes, but he considered it to be around 2 years, and may be longer as the patient gets older.

Finally, we had to examine organic illnesses as a possible precipitating factor. We observed these disorders to be represented in 54.8% of the depressive sample and 58.3% of the control group. Only in 16.1% this factor could be blamed.

A trial was made to point the hereditary load in senile depression, but actually we faced a major problem, that in 41.9% of cases we cannot assess this point. We were left with only 18 cases, which is a small subgroup, in which 2 cases (6.5) only showed positive hereditary load and the remaining 16 (15.6%) showed negative history. We had the impression that a hereditary load is not an important factor in predisposition. So, we are left with those environmental stresses to be the major contributing elements to depression of late life.

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AUTHORS

O. Shaheen, Professor & Head of Psychiatric Department, Cairo University.

Samia Abd El-Rahman, Professor of Psychiatry.

Sanaa A. Ali, Lecturer in Psychiatry.

Fatma A. Moussa, Lecturer in Psychiatry.

All from Faculty of Medicine. Cairo University, Cairo.

الموجـــــــــز

تغيرات المزاج فى مرضى الاكتئاب المسنين فى مصر

تم اختيار ٣١ مريضا من المسنين (بلغت أعمارهم ٦٥ سنة أو أكثر) يعانون من مرض الاكتئاب ، كعينة عشوائية ، وتم فحصهم من الناحيـــة النفسية والجسمية ، لمعرفة الأعراض الوجدانية المنتشرة فى هذه الفئة ، وكذلك أثيرت فيهم مختلف أنواع العواطف أثناء الجلسة النفسية ــ وقد تمت دراسة الحالة العاطفية لهؤلاء المرضى قبل المرض النفسى بحوالى ٦ أشهر ، وكذلك حدوث الأعراض النفسية التى أدت الى طلب العـــلاج ، والأسباب التى يحتمل أن تكون قد أدت الى ظهور المرض .

وقد قورنت النتائج بمثيلتها فى عينة ضابطة شملت ١٢ شـــخصا من نفس التقسيم السوسيولوجى ، وقد عرضت النتائج مع مناقشتها .

ABSTRAIT

Les Changements Affectifs chez des Egyptiens Déprimés séniles

Un échantillon de 31 patients séniles et déprimés, âgés de 65 ans ou plus ont été choisis par hasard. Tous ont été sujets à un examen physique et psychologique méticuleux. Ce dernier comprenait diverses provocations émotionelles ainsi qu' une enquête concernant les sentiments qui ont prévalu chez eux pendant les 6 derniers mois précédant la consultation psychiatrique. De même un groupe contrôle comprenant 12 personnes et présentant à peu près les mêmes charactères socio- biologiques ont été examinés.

Le tableau clinique de la dépression chez ces patients a différé de celui qui est habituellement reconnu du point de vue de 1 ' absence du sentiment dépressif et de la plus fréquente présentation des symptômes hypochondriaques. D'autres manifestations qui y figurent sont les tendances à pleurer, la névrosite, la peur, la solitude et la sonsibilité exagérée. De même l' état émotionel précédant la consultation

était coloré par un certain nombre de symptômes. Ceux-ci comprenait la désespoir, le reproche à soi-même, le pessimisme, le découragement et la dévaluation de soi-même.

L'étude suggère la présence d' un facteur causatif essentiel, cependant cette cause n'a pas pu être observée dans 19.4/ des cas.

Des difficultés ont apparu quand on a essayé de trouver une base héréditaire chez ces séniles déprimés, mais ce facteur ne paraît pas être si important dans la prédisposition pour la dépression. Cependant les contraintes du milieu, survenant durant la partie antérieure de la me, semble contribuer des élements majours dans1, apparition de la depression.