Characteristics of Depression in the Elderly

Pages with reference to book, From 155 To 156

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Depression is one of the commonest psychiatric conditions encountered in old age[1,2]. Its recognition is important in clinical practice as most cases are not identified at an early stage[3,4]. Although major depressive illnesses in the elderly are often much the same as in younger patients, there may be features which mask, complicate or give an unusual quality to the underlying mood disorder in this age group[5]. For example, cognitive impairment of a degree to suggest dementia has been estimated to occur in as many as 10-30% of elderly depressed patients[6]. Similarly depressed old people do not complain of sadness and rather present with physic4 and somatic symptoms like constipation, pain, anorexia and loss of energy[7,8]. Keeping in view the different presentations of depression in old age, a study was designed to find out the pattern and extent of depressive symptoms in elderly patients.

Patients, Methods and Results

The information was collected from fifty patients, over 60 years of age, diagnosed as cases of depression as per ICD-9[9]. Patients suffering from physical or neurological illnesses or having depression secondary to another illnesses were excluded from the study. Hamilton Depression Scale was used to rate their symptoms[10]. The data was also collected from fifty young adult depressive patients to make comparison in terms of the pattern and extent of symptomatology in both the groups (Table I).

Table I. Demographic profile of two groups.

	Group I Old age depressives n = 50	Group 2 Young depressives n = 50
Age (years)		
Mean	62.0	35.5
S.D.	± 15.5	±6.8
Sex		
Male	35	35
Female	15	15
Duration of illness (months)		
Mean	10.5	13.5
S.D.	±6.4	±7.5
Number of depressive episodes		
Mean	1.5	3.5
S.D.	±0.5	±1.5

Table I shows the demographic details of the two groups.

Table II. Scores on Hamilton Depression Scale.

	Old age depressives Group I (Mean)		Young age depressives Group II (Mean)	
1. Depressed mood	1.04	±0.6688	2.40**	±0.8571
2. Feelings of guilt	1.28**	±0.4965	0.60	±0.5345
3. Suicide	0.76	±0.7440	0.70	±0.6776
4. Insomnia (early)	0.74	±0.5997	1.04*	±0.6688
5. Insomnia (middle)	0.62	±0.5675	1.04*	±0.6376
6. Insomnia (late)	1.16	±0.7384	1.18	±0.6908
7. Work and activities	1.12	±0.7183	2.46**	±0.9304
8. Retardation	1.38*	±0.9666	0.74	±0.5646
9. Agitation	2.14*	±1.0692	0.70	±0.6468
10. Anxiety psychic	0.86	±0.6704	1.82*	±0.9190
11. Anxiety somatic	1.28*	±0.6402	0.86	±0.6392
12. Somatic symptoms (GIT)	1.24	±0.7160	0.76	±0.5911
13. Somatic symptoms (General)	1.52*	±0.5436	0.72	±0.5729
14. Genital symptoms	0.60	±0.5345	1.20**	±0.5714
15. Hypochondriasis	2.30**	±1.0152	0.98	±0.7951
16. Loss of weight	1.82*	±0.5602	1.00	±0.8081
17. Insight	0.94	±0.5115	0.82	±0.3959

*P < 0.05 **P < 0.01

Table II shows the details of symptomatology as measured by HDS. The depression in elderly was more marked in terms of somatization, hypochondriacal worries, agitation and guilt feelings, whereas, the younger patients reported more depressed mood, greater loss of interest, increased psychic anxiety and more sleep disturbances.

Comments

The clinicians who treat elderly often find an increased incidence of mood disorders in their patients. But these illnesses are frequently overlooked or dismissed because of the difficulties in their recognition. The symptoms are usually confused with organic physical symptoms or regarded as understandable and untreatable responses to the inevitable life stresses of the last part of life. The importance of recognizing the symptoms of depression, however, lies in the fact that the condition is treatable by a variety of medical and social measures and in general, an isolated episode carries a favourable prognosis for recovery[11,12]. Symptoms of depression are different in old age as compared to younger patients. The presentation appeared to be more somatic and physical in nature whereas the classical features of depression like sadness, dejection or low mood were not very common in most of our elderly patients. There was a marked memory impairment although on detailed examination they

did not show deficiency of intellect or memory which could suggest that they may be demented. Hypochondriasis was more common in elderly as they were more likely to somatise their depression, complaining especially of headache, abdominal and back pains. The other depressive manifestations in elderly were gastro-intestinal disturbances, the intensity of which were, however, consistent with the underlying mood. Though extensively investigated these lacked a convincing physical or organic quality and even the disability was usually less than its intensity would appear t9 warrant. The disturbances in the behaviour like agitation and restlessness were also more marked in the elderly group. These findings were clearly in line with the concept of melancholia or late life depressive illness with characteristic features of agitation and restlessness. But the reaction of most of these patients was so severe that they got nervous and disturbed due to these symptoms to the point of no longer willing to live. Another feature of depression in the older group, was the paranoid feelings which was consistent with the prevailing mood but its intensity was so marked in certain cases that it needed detailed evaluations. The findings of this study clearly show that depression in old age differs in symptomatology from the young age. As the management of these patients rests on the classic tools of clinical diagnosis, due attention should be given to the phenomenology of this illness in elderly patients.

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