

Different manifestation of depressive disorder in the elderly

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Abstract

OBJECTIVE: To compare the clinical manifestation of depressive disorder in elderly, and younger adults.

METHODS: To compare the clinical manifestation of depressive disorder, we evaluate 46 elderly (33 female, and 13 male, mean age 71.1) and 60 younger adults (40 female, and 20 male, mean age 44.5 years). All patients suffering from depressive disorders according to ICD-10. For evaluation and comparison of depressive symptomatology we used the HAM-D-17. The results analysed by the SPSS.

RESULTS: The clinical manifestation of depression is different in the elderly. Elderly depressed patients compared with their younger counterparts, scored significantly less in Depressed mood, but significantly higher in Work and activities, Retardation, Somatic symptoms – general, Hypochondriasis, Insomnia – middle, Insomnia-late, Anxiety-somatic, and Somatic symptoms – gastrointestinal. On the other hand, younger patients scored significantly higher in Feelings of guilt, and Genital symptoms.

CONCLUSIONS: Clinical presentation of depressive disorder is different in the elderly, depressed mood is often absent or masked. Anxiety, somatization, and hypochondriasis are more often present in the elderly depressed patients than in younger patients. The elderly people are also more likely than their younger counterparts to complain of insomnia.

Introduction

Major depression is one of the most prevalent of all psychiatric disorders [15], and one of the most disabling of medical disorders [24]. Depression is a widespread disorder, with an overall prevalence of 5 – 8% in the world as a whole [10]. Between 10 and 15% of elderly people in the community have some degree of depressive symptomatology at a given time [17, 30, 6, 19, 8]. but only about 3% have a depressive episode [1]. There is, however, marked variation in the prevalence of depression between certain groups of elderly patients [10]. In elderly

patients who seek out-patient medical care, the prevalence of depression varies from 13 to 40% [27]. Evans and Katona [8] used the Geriatric Depression Scale [31] to investigate a series of elderly people who consulted their primary care physicians. They found that 30% of the men and 40% of the women showed signs of depression. Among hospitalised older patients the prevalence of depression ranges between 10 and 45% [28, 27, 25]. About 20% of geriatric patients in Slovakia suffer from depressive disorder [17]. A study from United States found

that approximately one in four patients who attended a geriatric emergency room had significant depression [23, 14]. In residential and nursing homes the prevalence of depression is between 30 to 45% [12, 26].

In contrast to younger depressed patients, elderly patients often avoid reporting or showing that their mood level is reduced, as they experience guilt associated with this symptom. If they enjoy life less than before, they may think that this is an inevitable consequence of ageing. Reduced mood may thus be less evident in elderly people, while anxiety and somatic symptoms – which are more willingly admitted – are more prominent [29, 5, 20].

Depression in the elderly is often hidden behind somatic symptoms, because of either somatisation of the disorder or accentuation of symptoms of a concomitant physical illness. The most common somatic symptom is asthenia. Pain in different parts of the body is also common. Somatic functions are influenced by depression in elderly as well as younger people, but elderly people communicate these somatic complaints more often. Constipation is often seen in elderly individuals, and reduced appetite with weight loss may be prominent [10]. Katona et al [13] found that somatic symptoms were three times as common in depressed as in non-depressed subjects. There is also a significant association between rates of depression and activity limitation [19, 9]. Magni et al [22] found a strong relationship between depressive symptoms and somatic complaints (in terms of number of pains reported) in cognitively intact patients. No such relationship was found in cognitively impaired patients. Some studies found that subjective measures of physical health were much more strongly associated with depression than objective measures of illness [3].

Older people who are depressed are particularly likely to have comorbid physical pathology and disability, sleep disturbance and somatic symptoms [13]. Kramer-Ginsberg et al [18] found no relationship between physical health and hypochondriacal concerns in elderly depressed patients. They also noted that though hypochondriacal symptoms were reduced after antidepressant treatment, some patients continued to have high hypochondriacal ratings. This suggests that some hypochondriacal symptoms in old age may be a trait characteristic rather than being secondary either to physical illness or to depression [13].

The presence of cognitive impairment as part of the depressive syndrome in the elderly is of special importance, as elderly people may already have cognitive impairment caused by ageing or by degenerative diseases [22].

Materials and Methods

To compare the clinical manifestation of depressive disorder, we evaluate 46 elderly, mean age 71.15 years, age range 65–92, 33 women [mean age 72.06 years, range 65–92], and 13 men [mean age 68.84 years, range 65–79], and 60 younger adults mean age 44.5 years, age range from 20–61 years, 40 women [mean age 42.45 years, range 20–57], and 20 men [mean age 47.1 years, range 23–61] [Table 1]. All patients suffering from depressive disorders

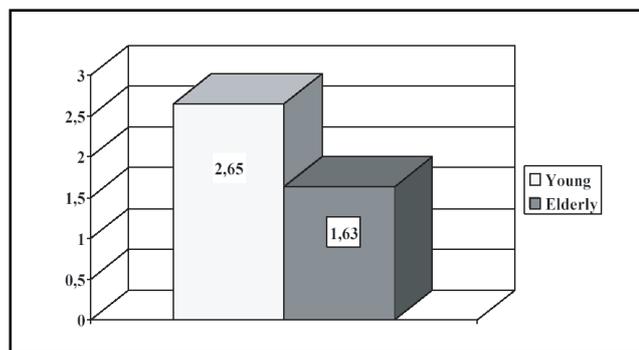


Figure 1. Item 1, Depressed mood – the elderly patients scored highly significantly less compared with younger adults ($z = -4.828$, $p = .000$).

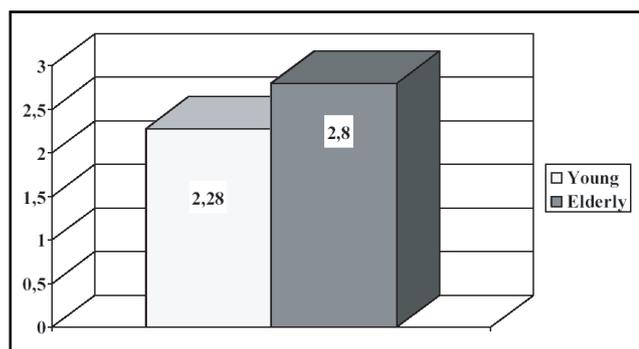


Figure 2. Item 7, Work and Activities, elderly depressed patients scored significantly higher compared with younger patients ($z = -3.156$, $p = .001$).

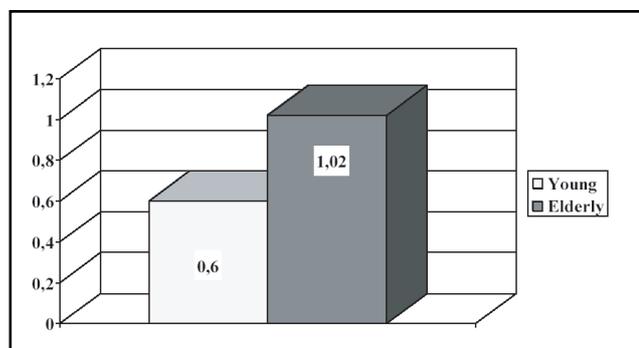


Figure 3. Item 8, Retardation is highly significantly higher in elderly depressed patients ($z = -3.254$, $p = .001$).

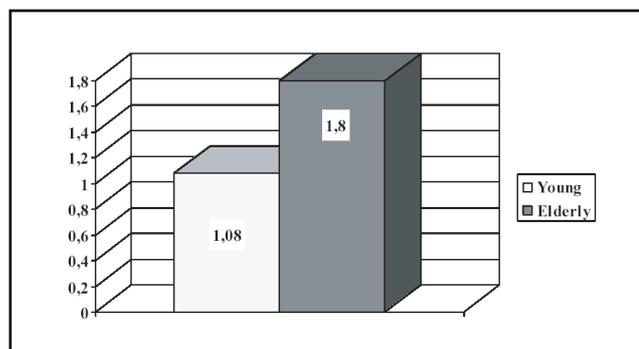


Figure 4. Item 13, Somatic symptoms – general are significantly higher in elderly depressed patients ($z = -6.030$, $p = .000$).

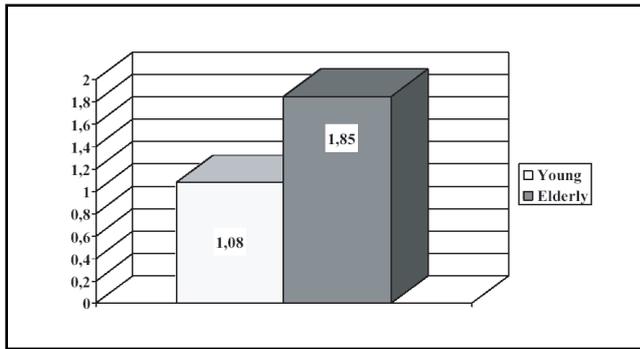


Figure 5. Item 15, Hypochondriasis is also significantly often presented in the elderly depressed patients ($z = -4.328$, $p = .000$).

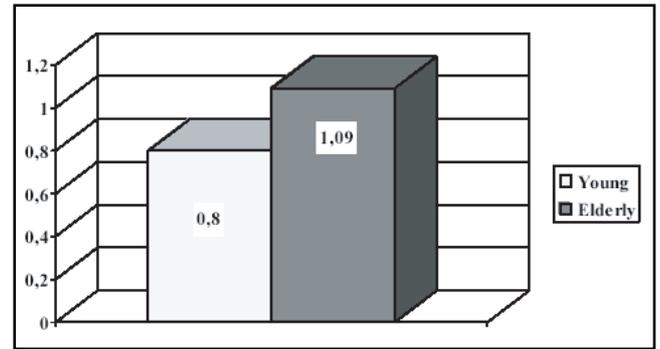


Figure 9. Item 12. Somatic symptoms – gastrointestinal are also significantly more often present in the elderly depressed patients compared to their younger counterparts ($z = -2.511$, $p = .013$).

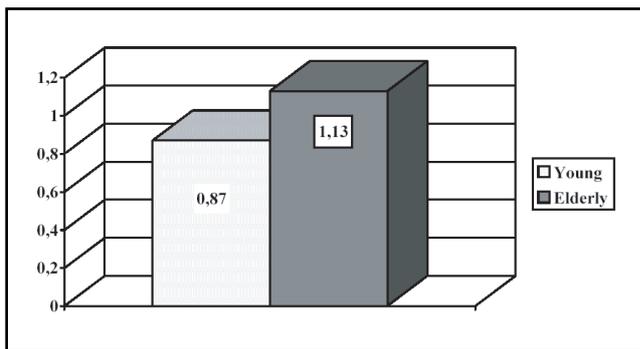


Figure 6. Item 5. Insomnia – middle, elderly patients compared with younger adults more often complained of middle insomnia ($z = -2.215$, $p = .026$).

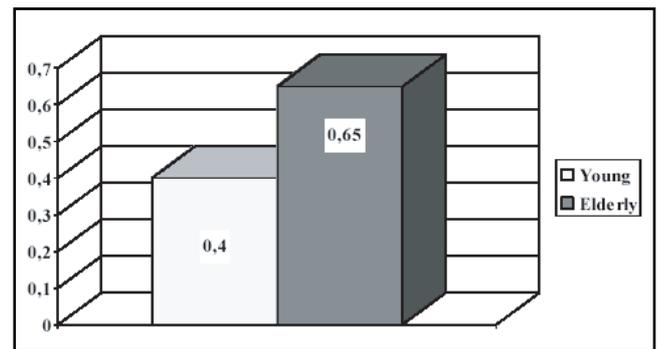


Figure 10. Item 17, Insight is also significantly different, elderly depressed patients often acknowledge illness but attribute the cause to other factors ($z = -2.707$, $p = .006$).

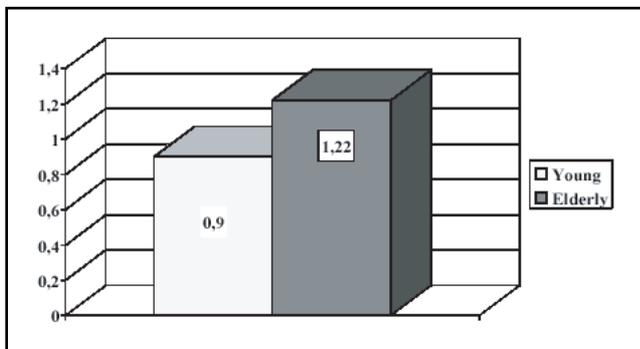


Figure 7. Item 6. Insomnia – late is also significantly common in elderly depressed patients compared with younger adults ($z = -2.235$, $p = .028$).

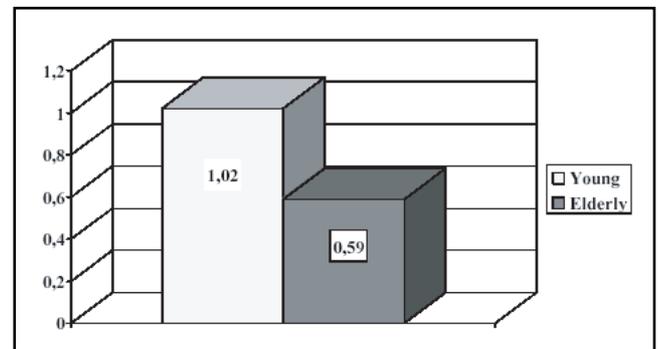


Figure 11. Item 2. Feelings of guilt is significantly more common in younger patients ($z = -2.489$, $p = .012$).

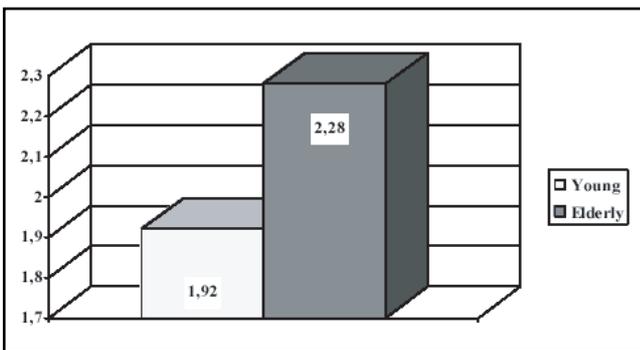


Figure 8. Item 11. Anxiety – somatic, elderly depressed patients present significantly more somatic symptoms ($z = -2.168$, $p = .031$).

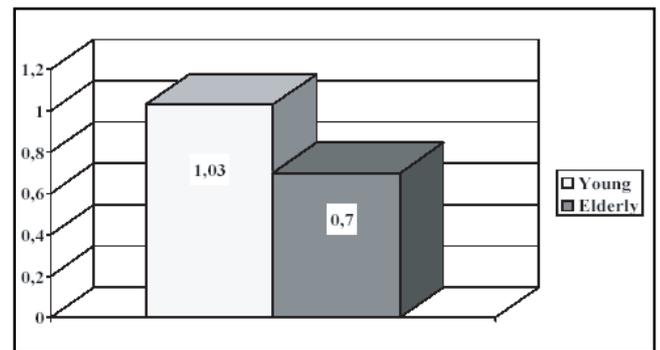


Figure 12. Item 14. Genital symptoms are also more often in younger patients than in elderly depressed ones ($z = -2.102$, $p = .036$).

Table 1. Patients

	Female	Male	Total	Mean age
Elderly	33	13	46	71.15 (65-92)
Young	40	20	60	44.5 (20-61)
Total	73	33	106	

according to ICD-10. For evaluation and comparison of depressive symptomatology we used the HAM-D-17. All results were analysed by the Statistical Package for Social Science [SPSS, version 11]. Mann-Whitney test with Bonferroni correction was applied to compare old age group with young age group for the symptom profile [HAM-D-17].

Results

Out of 17 items, we have found that 5 items [1, 7, 8, 13, and 15] are highly statistically significant [$p=.000-.001$], and 7 items [2, 5, 6, 11, 12, 14, and 17] are statistically less significant [$p=.006-.036$] different.

Item 1. Depressed mood – elderly patients scored highly significantly less than young patients in this item [$p=.000$]. They did not complain of having reduced mood, or had difficulties with admitting that they were sad. In the majority of elderly depressed patients depressed feelings were indicated only when being questioned. On the other hand, almost all young depressed patients present their low mood, and feelings of hopelessness spontaneously [Fig. 1].

Item 7. Work and activities – elderly patients scored highly significantly more compare to young patients [$p=.001$]. Almost all elderly patients scored 3 in this item, which means they have not spent at least three hours a day in activities [Fig. 2].

The item 8. Retardations – was also highly significantly different [$p=.001$], the elderly scored significantly more compared with younger patients, which means elderly depressed patients had more slower speech, impaired ability to concentrate, and decreased motor activity [Fig. 3].

Item 13. Somatic symptoms – General – Again, the elderly patients scored highly significantly more in this item than their younger counterparts [$p=.000$]. Occurrence of backaches, headache, loss of energy, and fatigue is more often in this group [Fig. 4]. The most presented somatic symptoms we found in our elderly patients were headache [28%], abdominal pains [23.9%], pains of different parts of the body [21.7%], pains of hands and feet [19.5%], and backaches [17.39%].

Item 15. Hypochondriasis – The elderly patients scored highly significantly more [$p=.000$], they were more often preoccupied with their health, had frequent complaints, and requested for help [Fig. 5].

Elderly patients also more often complained of middle insomnia [$p=.026$], late insomnia [$p=0.028$], anxiety – somatic [$p=0.031$], and somatic symptoms – gastrointestinal [$p=0.013$] [Fig. 6–10]. These items are however statistically significant, but their significance is lower than one of items 1, 8, 13, and 15.

Item 17. Insights – The elderly patients often acknowledge illness but they attribute the cause to other reasons and factors like somatic illness, overwork, need for rest, etc. This difference is also very significant [$p=.006$] compared with younger adults, the majority of whom acknowledge being depressed [Fig. 10].

But on the other hand, younger patients compared with elderly patients, more often had feelings of guilt [$p=0.012$], and genital symptoms [$p=0.036$] [Fig. 11, and 12].

Discussion

Our results confirm some previous works which state that depression in the elderly has atypical symptomatology [30], elderly patients have problem to report they have sad mood [21, 25], depressed mood is often absent or masked [29], somatic functions are influenced by depression in elderly as well as younger people, but elderly people communicate these somatic complaints more often [7]. Our results also confirm the previous findings that hypochondriasis is consistently report as a symptom more common in later-life depression [11], and elderly patients preferentially seek a somatic explanation of their complaints [10]. Our results also confirmed the other previous finding that older people are more likely than their younger counterparts to complain of insomnia which is often with early waking [16, 20]. We also found that anxiety is more often present in the elderly depressed patients than in younger patients, which is also in accordance with previous studies which suggest that anxiety is more often in elderly patients [4, 2], and according to some studies, anxiety is 15 to 20 times more common in elderly subjects with depression [20].

Both the attitude to depression of clinical staff caring for older people, and the knowledge of the clinical features of depression, may be important in the detection of depression. To identify the reasons for the poor detection rate of depression in our region, we conclude that patients, and their relatives often regard depression as a symptom of normal ageing. The other reason is of course the atypical features of this disorder (more somatic and hypochondriacal symptoms), and the comorbidity of depression with somatic illnesses, which leads the patients and physicians to search for somatic causes. The problem is also the low optimism about the treatment and prognosis of psychiatric disorders in general, and especially of depression in the elderly. To improve detection rates of depression in the elderly, there should be a high index of suspicion for depression within medicine for the teams treating elderly patients, familiarity with its characteristic clinical features, and good liaison with colleagues experienced in psychiatry.

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