Depression and the Elderly

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Depressions are conditions sometimes difficult to identify and often hard to label. The term "depression" is in fact used to describe very different conditions. It can convey a vast spectrum of mood states from a blue Monday to a major depressive episode, otherwise called an affective disorder (Miller, 1987). Depending on the context, the term might serve to describe a temporary mood swing, normal behavior, a symptom, a syndrome, an illness, or a biochemical disorder (Cappeliez, 1988). This confusion in the terminology of depressive conditions explains, in part, the reasons why the data on the incidence and prevalence of depression can sometimes be misinterpreted.

Depression refers to a set of symptoms, which could represent a syndrome or disorder, that is disabling in the sense that it interferes with a usual state of well being or with social or occupational functioning (Billig, 1986). A broad psychiatric definition of depression is a disorder whose central feature is a "dysphoric mood or loss of interest or pleasure in all or almost all usual activities or pastimes" (Miller, 1987, p. 3).

Difficulties in Determining Prevalence of Depression in the Elderly

According to Nagel, Cimbolic, and Newlin (1988), investigators

agree that, by far, the most common psychiatric conditions encountered in old age are affective disorders, especially depression. However, it is difficult to determine the prevalence of depression in the aged because of difficulties in defining what depression is (Cappeliez, 1988).

Misdiagnosis of Depression

The determination of the prevalence of depression is also complicated by the use of different methods of assessment. The assessment of depression is complex and difficult because its manifestations may mimic those of physical illness and dementia while, at the same time, it may co-exist with these disorders (Grau, 1988). Differentiating among dementia, depression, and neurological disorders is especially difficult in the elderly (Yost, Beutler, Corbishley, & Allender, 1986). Fry (1986) stated that perhaps the most difficult task in the differential diagnoses of depression in old age is the distinction from senile dementia.

According to Pitt (1986), the greatest contribution to the misdiagnosis of depression in old age as dementia appears to be the doctors. Psychiatrists, physicians, and family practitioners who know little about the manifestations of depression in late life but are aware of how common dementia becomes with aging may ascribe the abnormal mental state of the depressed to the latter. Rozzini (1988) reported that numerous studies have established that non-psychiatric physicians frequently fail to diagnose clinically significant

depression.

Among elderly people, mental and physical problems are highly correlated and may interact. In fact, often symptoms of impairment in one sphere may mask those in another (Rozzini, 1988). Billig (1986) stated that depression in older adults is a great masquerader. It frequently shows itself as a physical problem such as headaches, low back pain, chest symptoms, and bowel disturbances. He further elaborated that the depressed are often brought to medical attention with complaints of memory failure, disorientation, and confusion. Further, depression can appear as a result or symptom of a primary medical problem or can be the consequence of medications, a medical illness, or a combination of these.

Interaction of Problems in Diagnosis of Depression

Crucial for the proper assessment and determination of the prevalence of depression is the recognition of the potential for the coexistence of and interaction between social, physical, psychological, and organic brain problems (Grau, 1988). Fry (1986) stated that depression in the elderly could be one of several disorders requiring a further clarification of the relative roles of brain disease and organic and biological correlates. Philpot (1986) reported that many changes in brain structure and function accompany aging, and some of these may predispose individuals, perhaps particularly males to depression.

When depression is present, it is difficult to differentiate between somatic and psychological complaints. In a population of 1201

elderly persons living at home, depression was found to be the most important factor in the appearance of somatic complaints. Multivariate analysis showed that depression is the strongest predictor in the appearance of somatic complaints, and increased somatic complaints in depressed elderly people do not simply result from poorer health status (Rozzini, 1988). Rozzini (1988) found further that the degree of social support influences somatization among elderly people regardless of health status. McNeil and Harsany (1989) examined age differences in the somatic symptoms of depression and found that symptoms are reported more frequently by older adults than by younger adults.

Symptoms of Depression in the Elderly

In contrast to the young, the depressed older person may not have a complaint of sad, blue, or otherwise dysphoric mood. Instead, he or she may complain of physical symptoms, difficulty with memory, and dissatisfaction with his or her economic, social, or family situation (Christison & Blazer, 1988). However, depressive symptomatology found in the elderly may largely resemble that observed in the general adult population. Mild symptoms may include feelings of hopelessness, anxiety, self-deprecation, and hypochondriacal preoccupations. At the other end of the spectrum, more severe symptoms surface such as severe obsessive ideation, feelings of depersonalization, nihilistic delusions, and suicidal ideations.

Physiological concomitants of depression include disturbances in bodily cycles, such as sleep, appetite, bowel functions, and diurnal

mood shifts. Depression may be manifested as such behavioral disturbances as isolation, withdrawal, apathy, or by compulsive or hostile behavior (Nagel, Cimbolic, & Newline, 1988). According to Christison & Blazer (1988), by far the most common cause of depressive symptoms in older adults is adjustment disorders with depressed mood. These disorders can result from a number of stressful events in an older person's environment, such as bereavement.

Prevalence of Depression in the Elderly

Based on a comprehensive review of recent epidemiological studies, it is possible to estimate that between 0.8 and 8% of persons aged 65 and over meet the criteria of major depression as defined in the DSM-III (Cappeliez, 1988). Cappeliez (1988) further reported that some studies indicate up to 27% include clinical depression cases as well as mildly depressed or demoralized cases.

Certain subgroups of the older population appear to be at much higher risk to develop psychiatric disorders. One such subgroup is older adults with acute medical illnesses. Prevalence ranged from 17.2% of outpatients in a geriatric medical practice to 31% of older veteran medical outpatients to 45% of elderly veteran inpatients (Rapp, Parisi, & Walsh, 1988). In a study of 153 randomly selected geriatric medical inpatients who were evaluated for the presence of psychological dysfunction, results indicated that a large portion of the sample (27.3%) had at least one psychological disorder and that 15.3% of the total sample had a depressive disorder (Rapp, Parisi, & Walsh, 1988).

Based on the studies reported by Cappeliez (1988), it would seem reasonable to conclude that depression is not more prevalent in groups of people aged 65 and over than in groups of younger adults. On the contrary, some of the data suggest that depressive conditions are comparatively more pervasive among middle-aged adults. Slack (1989) compared random samples of geriatric and nongeriatric male medical inpatients. Unexpectedly, a significantly lower prevalence rate of Major Depression and Systhymic Disorder was found in geriatric patients (6%) than in nongeriatric patients (22%).

Grau (1988) stated that unfortunately, gender differences in the prevalence and manifestation of depression are only rarely addressed by geropsychiatrists. When they are, it is generally in reference to high rates of suicide among elderly men. However, Krause (1986) reported the results from a random community survey of 351 older adults indicating that women are more depressed than men. The findings from this study revealed that elderly women report more symptoms associated with depressed affect and somatic and retarded activities than do older men.

In a study done by Gardner (1989), a sample of aged black females was drawn from a larger national probability sample of 972 community-resident elderly. Crude prevalence of depressive symptoms for aged black females (21%) was significantly higher than for the sample as a whole (10%).

Correlates and Predictors of Depression in the Elderly

Because of the difficulty in establishing causality, one perhaps

would be more accurate in referring to correlates of depression. Gurland, Wilder, and Berkman (1988) stated that there is sufficient evidence to warrant further testing of the hypothesis that disability is the most important determinant of the rates and outcomes of chronic depression of all types in old age, but the relationship between depression and disability is a reciprocal one in that the causal pathways go in either direction.

Another correlate of depression is financial strain because research indicates that it may have an especially deleterious effect on older people. In a study done by Krause (1987), results revealed that older adults who are suffering from chronic financial stain tend to report more symptoms of depression than do elderly persons with fewer financial problems. Further, his findings suggested that the greater the financial strain the greater the psychological distress among the elderly respondents in his sample.

Phifer and Murrell (1986) examined the additive and interactive roles of sociodemographic factors, resources, and categories of life events in the development of depressive symptoms. In a sample of 1233 persons 55 years of age and older, health and social support played both additive and interactive roles. Life events had weak effects and sociodemographic factors did not contribute to depressive onset. Rozzini (1988) found similar results for depression in both elderly men and women, although demographic variables were not included in this study. Turner and Noh (1988) reported that health is more strongly

related to depression among older adults than social support or demographic variables. McNeil, Stones, and Kozma 91986), in a review of the literature, reported that health is one of the strongest predictors of psychological well-being in the elderly, accounting for 10-16% of the total variance.

An age difference of depression is found in the way that depression is influenced or predicted by poor physical health. McNeil and Harsany (1989) reported that the research generally indicates that poor health among the older exerts a greater influence on depression relative to other predictors. They indicated that for younger adults, however, health is either a weaker predictor or at best is no stronger than other predictors such as social support or stressful life events.

Findings from a study done by Krause, Liang, and Yatomi (1989) indicated that changes in satisfaction with support tend to precede changes in depressive symptoms. Persons who are dissatisfied with the amount of social support that has been provided to them may subsequently suffer from psychological disorder. At the same time, there is evidence that individuals who initially suffer from emotional disorder may consequently be less satisfied with their social support systems than persons who enjoy better mental health.

Treatment of Depression in the Elderly

Chaisson-Stewart 91985) made the following observation:

> Depression is the most prevalent mental disorder of late life. yet, it is the most overlooked, misdiagnosed, and inadequately treated illness. Left untreated, depression

> prevents those over 65 from enjoying the satisfactions and involvements unique to the autumn of life. When neglected and allowed to run its course, depression is an emotional and financial drain, not only for the elderly person but for society as well. In too many cases, its ending is suicide. But perhaps the greatest tragedy is that while depression is generally ignored, it remains the most treatable mental health problem in the elderly (p. 3).

In the late 60's, only 2% of patients attending outpatient psychiatric facilities or treated by psychiatrists in private practice were over age 65. This was despite the fact that as many as 13% of community-dwelling elderly citizens and up to 20-35% with concurrent medical illness suffer from the illness of depression, and this situation changed only slightly over the years (Jenike, 1988). Whether the reasons be resistance of older people to seek help and of therapists to provide it, limitations of trained personnel and available programs, or financial and transportation problems, it is evident that older people receive a disproportionately small share of psychotherapeutic services (Nagel, Cimbolic, & Newlin, 1988).

Jenike (1988) stated that the underutilization of services may be the result of many factors. It may reflect a cultural bias. Professionals might believe that resources should go to younger clients who have more years of life ahead of them and who are more economically productive. Clinicians may view the elderly as inflexible or consider decline inevitable. Nagel, et al. (1988) believed this

to be unfortunate because it has been demonstrated that older individuals can unquestionably benefit from therapeutic encounters that encourage them to mobilize their inner resources and regain a sense of belonging.

Pharmacologic Therapy

According to Payne (1988), in recent years there has been an increase in both the sophistication and utilization of pharmacologic therapies for managing depression. Tricyclic antidepressants are usually the first choice treatment for depression. Jarvik and Mintz (1987) found that the two tricyclic medications of doxepin and imipramine definitely are effective for many older people who are depressed.

Payne (1988) reported that pharmacologic therapies for depression management are fraught with side effects which are often more salient, more intolerable, and more dangerous in elderly persons. Side effects of tricyclic antidepressants which require close monitoring in the elderly include orthostatic hypotension, cardiac conditions, and anticholinergic symptoms. Jarvik and Mintz (1987) stated that the most troubling side effects associated with tricyclic antidepressant treatment of the elderly is blood pressure change, and if no response is seen within one to two weeks, the drug should be changed.

Psychotherapy

Because drug therapy may not be appropriate for some elderly depressed patients, Thompson, Gallagher, and Breckenridge (1987)

conducted a research study designed to evaluate the viability of short-term psychotherapy as an alternative. They compared the effectiveness of three different types of brief psychotherapy for the treatment of elderly patients with a clinically diagnosable major depressive disorder (MDD). They concluded that all three modalities of behavioral, cognitive, and brief psychodynamic psychotherapies were equally effective in obtaining positive results. In addition, the number of elders responding to these treatments compared favorably with younger samples in other studies, indicating the efficacy of psychotherapy for the treatment of depression in the elderly.

Yost, Beutler, Corbishley, and Allender 91986) contend that a philosophy based upon cognitive therapy is comprehensible to the elderly and easily can be taught and explored within the context of a group treatment program. The application of a group model holds the promise of providing the depressed elderly with a social support system and network through which they can establish ongoing relationships with others and develop the skills needed for self-assertion and self-acceptance, which will help them restore interpersonal and social contacts. Others contend that group psychotherapy is preferable to individual therapy for treating depression in older people for two reasons: (a) cost effectiveness of group treatment and (b) group therapy's value in combating loneliness, a factor considered by many to be a primary antecedent to depression in the elderly (Cartensen, 1988).

Despite overall positive outcomes, several studies have found

that older people do not improve as much from traditional psychotherapies as younger people (Lewinsohn, Hoberman, & Rosenbaum, 1988). They found that approximately half of depressed elderly subjects who participate in traditional psychotherapies have been found to remain depressed following treatment, although some of these subjects do show some improvement.

Abrams, Alexopoulos, and Young (1987) suggested that elderly patients with a history of major depression may have more lifetime personality dysfunction than normal elderly people. In Thompson, Gallagher, and Czirr's (1988) study where patients were treated with either cognitive therapy, behavioral therapy, or brief psychodynamic therapy, the data suggested that in older persons experiencing MDD, there is a highly significant increase in symptoms normally associated with a personality disorder. The data also provided support for the suggestion that elderly patients with evidence of a personality disorder, irrespective of their level of depression, are less likely to benefit from short-term psychotherapy than patients who have no clear evidence of a personality disorder when describing their usual self. Fogel and Westlake (1990) found in a study of the prevalence of personality disorder in elderly patients with major depression a suggestion that the diagnoses of personality disorder occurs with sufficient frequency in the elderly depressed inpatients to warrant its careful study as a predictor of treatment outcome.

A study conducted by Hoberman, Lewinsohn, and Tilson (1988) clearly demonstrated that when methodological controls are used,

individual predictors of improvement for cognitive-behavioral treatment for depression can be identified. Pretreatment depression level, perceived mastery, social adjustment, social support, and outcome expectancies appear to be rather robust prognostic variables for treatment success or failure. The implication of this study is that persons with severe depression, little perceived mastery, low expectancies for improvement, poor social adjustment, and resistance to a group treatment setting might do better in another treatment modality. Also, if therapists are aware of the characteristics of participants prior to the beginning of treatment, they may be able to modify features of the treatment to better address some of the identified negative prognostic factors.

Preventive Approaches to Treating Depression

In a review of the literature by Bliwise (1987), one pilot research suggested that educational classes to help community-resident elderly monitor symptoms of depression may eventually prove effective for preventing major depressive illness. Long-term trials, however, are needed to establish true "prevention".

Since social support and physical health are the two most important predictors of depressive conditions, some interesting issues to explore where the depressed elderly are concerned would be the network of social support, as well as the behavioral and cognitive strategies which enable effective management of stress (Cappeliez, 1988). Since behaviors are known to cause certain illnesses and

obstruct healing, it might be wise to concentrate on the types of behavior which would maintain good health or hasten its return, thereby improving health and mood.

McNeil and Harsany (1989) suggested that many depressed elderly, in particular those with poor health, can benefit from a health psychology approach. This approach would be directed at improving health status rather than focusing primarily on improving the psyche through traditional psychotherapies. A health psychology approach could take many forms including increasing exercise, improving nutrition and weight control, reducing cigarette and alcohol consumption, improving sleep habits such as decreasing daytime napping, pain control, and adhering to medication regimens.

Use of Volunteers and Lay Paraprofessionals

Nagel, Cimbolic, and Newline (1988) reported that reliance on the use of volunteers and lay paraprofessionals in human services delivery has increased with the rising demand and shortage of professional providers. They examined the effects of a volunteer program on depression levels of nursing home residents. According to the reporters, one unambiguous conclusion was drawn from this study. Volunteer "counselors", whether elderly or adolescent, are demonstrably effective therapeutic agents in helping to improve depression in the elderly.

McNeil and Harsany (1989) also concluded:

In addition, we do not with (sic) to discount the effectiveness of traditional psychotherapies in the treatment of the depressed

elderly. It may be that future research will show that a combination of a health psychology approach with traditional psychotherapies will be the most effective (p. 614).

Conclusions

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