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Depression in the elderly as a significant clinical problem

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Abstract

Introduction: Depression is a very common mental disorder among older people. It limits life activity and interests. It causes difficulties in making decisions or actions. It introduces somatic and emotional changes, which in older people becomes a problem on a large scale. Diagnosis of depressive disorders has very high clinical value.Depression is often associated with chronic diseases that often accompany the elderly.

Material and Methods: The paper reviews literature using the EBSCO and Google Scholar databases. Articles have been analyzed using the keywords depression, depression of the elderly, care for the elderly, treatment of depression, diagnosis of depression, clinical symptoms. The article presents depression as a problem among older people, its symptoms, treatment and care for such people.

Results: Treatment of depressive disorders is based on pharmacology and psychotherapy. Care and the presence of loved ones are very important. Commitment to physical activity improves emotional balance.

Conclusions: Depression in older people creates a problem in terms of diagnosis and clinical aspect. Depression reduces the quality of life, which means that older people cannot perform basic life activities on their own. Reduces motivation and interest in the environment. Correct diagnosis enables quick implementation of treatment that will allow you to recover.

Key words: depression, treatment, care, old age, diagnosis, epidemiology, SSRI, NSRI, helpline

Introduction

The aging process leads to many changes, both somatic and emotional [1]. Deterioration of physical and physiological functioning in the elderly increases susceptibility to mental disorders [2].

Depression is the most common mental health problem at the end of life [1]. It is associated with functional decline, substantial health costs, increased mortality and reduced quality of life [3]. It is more common in hospitalized patients [3]. Disturbance in cognition, mood and inability to perform mental and physical functions characterize this affective illness [4]. Moreover, depressive symptoms are significantly higher in elderly, with other medical conditions such as diabetes, stroke, dementia, heart disease and osteoporosis, which creates problems in the diagnosis of early depression and which delays rapid implementation of the treatment [3]. In result there is the increase in dependence on others and burden of care [4].

Additionally, consequences arising from disorders related to Activities of Daily Living (ADL) increase incidence of depression among elderly [5]. Difficulties in performing daily activities (such as dressing, bathing, eating, housekeeping, going to the toilet, preparing food) reduces independence, which often contributes to the transfer of elderly people to care centers [5]. The engagement of older people in everyday activities has a positive effect on mental health, interruption of this engagement may result in stress, anxiety or depression [5].

A number of screening tests are available to help physicians diagnose older patients with a predisposition to depression. The most widely used effective and efficient tools are the Patient Health Questionnaire (PHQ-9) and the Geriatric Depression Scale (GDS). Screening for depression improves treatment, recognition and outcomes of depressive disorders [4].

Epidemiology

The most common mental disorder of elderly people is late-life depression, which is most pronounced in Western countries [6]. Depression was classified by WHO in 2012 as the fourth cause of disability in the world. Moreover, it predicts that by 2020 major depressive disorder will be second only to coronary heart disease [8]. The first depressive symptoms can be observed at an early age, which often return [8].

An impressive increase in the elderly is predicted based on aging data [6]. Depending on the population studied, settings and diagnostic tools, the prevalence of this disorder varies [6]. WHO predicts that in 2015-2050 the number of elderly people aged 60 or older will increase sharply, from 900 million to 2 billion [7]. Late life depression has been extended to pay attention to depressive conditions that cannot be diagnosed as depression and cause distress or other negative functional outcome, that is severe enough [6].

In 2001, 30% of the total years of life with a disability were neuropsychic diseases, of which unipolar major depressive disorder accounted for 11%. The increasing number of neuropsychic diseases has a financial impact on health care. In 2010, the cost of mood disorders in Europe was EUR 113.4 billion. These are costs directly related to healthcare costs, non-medical costs (60%) and costs related to economic losses resulting from lower patient productivity (40%) [8]. Depression is still under-detected. 20.9% of patients reporting primary care have clinically significant depressive symptoms, of which only 1.2% of the cases caused depression. The treatment of this mental disorder is often under-used and prematurely discontinued. Such treatment is harmful to the patient, because a sufficiently long and effective treatment reduces the burden of disease.

Major depressive disorder is about 2 times more common in women. Changes in the risk of depression have been proven to result from several hormonal changes. The onset of an increased risk of depression in women is associated with the first stages of puberty. Pregnancy does not increase the risk of depression, while postpartum hormonal changes can be a cause of increased risk. The perimenopausal period is also associated with an increased risk of depression.

Clinical symptoms

The main symptoms of depression which are used as diagnostic criteria are presented in the next paragraph. While dealing with the characteristics of the symptoms of depression among elderly

people, it is worth to notice that the clinical picture of depression among seniors varies from that of younger people. When it comes to the elderly people, the dominant signs of depression are more agitation, general and gastrointestinal somatic symptoms and hypochondriasis, but less guilt and less loss of sexual interest [9].

It happens really often that the depression is not diagnosed properly, and the symptoms of depression are attributed to the character traits of the patient, e.g. gentle disposition, calmness or apathy.

Often, clinical symptoms of depression such as pain of various kinds, weakness or decreased appetite can be attributed as somatic symptoms of accompanying diseases [10].

Pużyński mentions two characteristic forms of depressive syndromes among elderly people. One of them is depression with enormous anxiety, often of varying intensity and psychomotor restlessness with a tendency to hypochondriac complaints, sleep disorders and nihilistic delusions or the sense of poverty, guilt, sinfulness, and condemnation [11]. The second variant is the depressive-asthenic variant, which is dominated by a depressed, indifferent mood, which is accompanied by symptoms such as apathy, abulia, reduced mental and physical fitness or loss of interest.

Depressed patients complain about disorders of their cognitive and executive functions. The research clearly shows a reduced efficiency of executive functions in the form of psychomotor retardation, worse semantic fluency, weaker cognitive flexibility or worse quenching of automatic motor reaction. Approximately 70% of patients in both, the control and study group, reported subjective complaints about cognitive functioning. Elderly people with depression, on the other hand, have more often reported sleep disturbances such as difficulty falling asleep, intermittent sleep and waking up early [12].

Diagnosis

The diagnosis of depression among elderly people often causes many problems to specialists and it often happens that the problem is hidden under the mask of dementia or accompanying somatic diseases.

In Poland, the criteria presented by the 10th edition of the International Classification of Diseases (ICD-10) and the standard criteria for the classification of mental disorders DSM-V and the American Psychiatric Association [13] are used for the diagnosis of depressive disorders. In

accordance with ICD-10, the symptoms of depression are divided into basic and additional subgroups.

The basic symptoms include:

- Mood disorders (depressed mood);
- The loss of interest in everyday life and the loss of the ability to enjoy anything;
- The decrease of energy which leads to increased fatigue.
- The additional symptoms are
- The weakening of concentration and attention;
- Self-esteem and self-confidence on a very low level;
- The feeling of being guilty and the sense low value
- The pessimistic vision of the future
- Suicidal thoughts and acts
- Sleep disorders;
- Decreased appetite.

The assumption of the DSM-V is to observe at least five symptoms for a fortnight. Those symptoms are:

- A significant reduction of the interest of the surrounding world and ability to feel pleasure with all, or almost all, activities;
- A decrease in body weight without limiting food intake, or increase in body weight;
- Sleeplessness or excessive sleepiness almost every day;
- Agitation or retardation;
- Fatigue or the feeling of the lack of energy;
- Low self-esteem, or inadequate and excessive sense of being guilty;
- Decreased ability to think or concentrate and indecisiveness;
- Recurrent thoughts of death.

Another diagnostic challenge is to differentiate depression from dementia. What is more, it is highly possible that those diseases may occur at the same time masking themselves. When it comes to elderly people with memory impairment there are two helpful tools to diagnose them: Cornell's scale for depression in dementia [15] and a scale for the assessment of depressed mood in demented patients [14].

There are also professional tools which are dedicated to the diagnosis of elderly people. The most famous among those tools is the Geriatric Depression Scale(GDS) by Yesavage et al [16]. Such an examination bases on the investigating of the self-assessment of people over 60. There are two versions of that tool; the full one which investigates 30 features and the shortened one which examines only 15 features. The examination lasts less than ten minutes.

Treatment

The increasing population of elderly people from year to year means that number of people with depression is growing rapidly. Therefore the primary task of health service is to start right treatment as soon as possible. There are many physical and mental after-effects of depression that effects on health and quality of life of elderly people. Actually pharmacotherapy is of the basic form of helping patients but in fact, combination of drugs and psychotherapy (like art therapy) is most desirable combination of treatment [17].

Depression can be treated by huge range of antidepressant medications. They are usually recommended for mild, moderate and also heavy episode. In this group we can include Selective serotonin reuptake inhibitors (SSRI), Serotonin Norepinephrine reuptake inhibitors (NSRI), Noradrenaline and specific Serotonin Antidepressants (NaSSA). However, they can causes possible side effects like sedation, insomnia, weight gain or GI distress. Therefore, patients should be observed to modify the treatment as soon as possible if problems will showed [18].

Another method is supplementation of vitamin D. This is group of steroid-soluble organic chemical compounds that got many physiological effects in human body especially in the calcium-phosphate economy and in maintaining the correct structure and function of the skeleton. Moreover calciferol causes decrease symptoms of depression in people aged 60 and over [19].

Also attending Yoga Laughter could helps because through simulated laughter, rhythmic breathing, gentle stretching and meditation patients with diagnosed depression can improve their mental health and increase life satisfaction [20].

Patient care

Care for people with depression is very important and especially important when it comes to elderly people. Older people often cannot assign somatic and mental symptoms to depression. Care for such people is not only pharmacological treatment, but also encouraging physical activity,

social involvement and the greatest possible creativity to stimulate the right cerebral hemisphere [21].

Care of the elderly with depression should start with eliminating or reducing the amount of somatic diseases. Chronic diseases and those that cause long-term discomfort (pain, reduced functioning) contribute to the development of depression. The reduced mood is also the cause of the development of many diseases, which is why the condition of the mental state of patients is so important [22].

The increase in home care over geriatric people with depression does not translate into an increase in the effectiveness of treatment. Individuals who treat episodes of depression in a hospital setting are more likely to be cured than in home care. This is due to the fact that older people often do not follow the doctor's instructions and do not take medicines regularly. The complex structure of home health care poses a high challenge for today's medicine [23].

The world also offers help over the phone, i.e. "Telephone helpless". Such a person is classified by phone on the scale of anxiety and depression. Based on telephone conversations, treatment and counseling is effective in moderate depression, reducing its symptoms and improving the functioning of geriatric patients [24].

Conclusions

An increase in the incidence of depression is associated with aging of the population. Depression is more common in women and depends on hormonal changes. Emotional problems during puberty increase the risk of depressive states in the elderly.Symptoms of depressive disorders are often diverse and masked by additional diseases, e.g. dementia. Depressive symptoms should not be attributed to the patient's character. The problem in correctly diagnosing depression is becoming different symptoms in older people compared to younger people.In the treatment of depression, the most effective method is to combine psychotherapy with pharmacotherapy. We have a wide range of anti-depressant drugs that should be selected according to the patient's clinical condition. We start treatment with first-line drugs (SSRIs) at the lowest effective dose. The problem is the time (about 2-3 weeks) to get the therapeutic effect of the drugs. During this time, benzodiazepine drugs are helpful, which will allow them to function normally until the first-line drugs work. Care for the elderly during depression is particularly important as it increases the chances of full

recovery. Hospitals, psychiatric departments, helplines, family assistance and broadly understood care create conditions for the patient to recover and return to proper functioning.

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