

DEPRESSES IN PARTICULARITIES OF ELDERY

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An increasingly growing number of researches confirm that depression in the elderly is twice as common as compared to the rest of general adult population. As late-life depression frequently coexists with other medical illnesses or physical and psychological deterioration inherent to old age, it does not only put additional burden on the patient, but also interferes with the perception by the individual of his/her own illnesses and more or less affected health condition, knowing that old age comes with certain physical and psychological limitations.

A different issue which leads to the rather low-spread treatment of depression in the elderly is the misconception that such treatment may not be needed or may even be unsuitable, as depression comes as a side effect of other medical illnesses and treating such illnesses would result in the amelioration of depression at the same time as the medical illness is cured.

But psychiatric problems in the elderly are so complex that the scientific community is currently considering the development of specializations in psychogeriatry. Such would be highly opportune as “AMERICAN STATISTICAL OF THEY CENSUS BUREAU” THE OFFICIAL STATISTIC” has shown that in 25 years the number of elderly people will increase by approximately 50% as compared to 1998 (MULSANT and GANGULI, 1999).

Causes of depression in the elderly might be: biological changes, death of a spouse or siblings, smaller material resources, loss of social functions, lack of support, but also latent illnesses now becoming acute. (KAPLAN and SADOCK, 2000; SINCLAIR et al, 2001)

In this context, POST(1962) and in particular POSTEL and QUETEL (2005), characterize emotions in the elderly by:

- Sadness accompanied by apathy and weak reactions to affection stimuli;
- Emotional and affective instability (with slight oscillations from one emotion to the other);
- Affective inertia determined by the difficulty to easily adapt to circumstances or contextual tasks;
- Lower adaptability to the environment;
- Strong globalizations of emotions, much more intense as compared to younger depressive individuals, whose orientation and emotional-affective oscillations are somehow more precise and related to their causes;
- Increased irritability with either explosive or delayed reactions, which is generally characterized as cyclicity or rather interlinking by the exaggeration of depression from the feeling of loss of social, professional and relational ability, which exaggerates the depressive feeling; and
- Larger weight of negative emotions as compared to positive ones, associated with loss of self-esteem.

The wish of death might be explained in two ways: on the one side it might be the blackmail to the environment, which shouldn't be ignored, while on the other side it might be the solitude (isolation) accompanied by the wish to disappear.

In focusing on other medical illnesses, one should not forget that behind an ill body lays, most of the times, a perturbed "soul" which needs help, and a failure to correctly diagnose depression results in inadequate treatment, often resulting in an unwanted and serious ending, such as suicide (BOSTWICK and PANKRATZ, 2000).

KENTUCKY and IOWA (1986), KIELHOLZ (1988), GRECU et al (2000 and 2001) and DEHELEAN (2001), outline that many of these elements are related to facts of life, which very frequently include depressive factors.

Regarding neuro-biologic factors, we also need to take into account that in late life patients often suffer from organic and functional illnesses of the central nervous system, whose volume shrinks by destruction of nervous substances, with amyloid plaques

occurring and neuron fiber deterioration associated with the decline of cognitive functions. Such phenomena, as claimed by: BRILEY (1999) and ASHLEY et al (2000), are usually real traps regarding the diagnose of depression in the elderly.

Currently, besides the need for social involvement, researchers speak more and more often of a multidisciplinary approach of the depressive type disorders, both regarding their diagnosis and their treatment.

The need to classify depression has been obvious in the entire history of medicine, but few agreed on its types and on the optimum criteria for assessment. Numerous trials elaborated during the almost two millenniums are very different from one another either by placing emphasis on phenomenology, or on etiology, evolution or other issues, as defining elements. Some schematic classifications only take into consideration few diagnosis categories (one to nine), while other exceed ten categories. In the United States of America, in the 1880 census, seven categories of mental disorders were delimited, of which a significant position was held by: melancholy and mania.

WEYERER (1984) and SILVERMAN (1986), show that, after the second world war, the prevalence of depression increased by 10 – 20 %; while USTIN and SARTORIUS (1994), noted that the prevalence of depression per month is 5.2%, and such prevalence is somewhat different from one country to the other, for example in England it reaches 7.04%, in Australia 4.8% and in Greece 7.04%. In fact, other epidemiologic studies report average values of 3.7 % and 6.75%, regarding the life prevalence rates, varying between 1.7% - 4.7% in men and between 4.1% - 6.9% in women.

The slowly progressive increase of the weight of elderly people in the general population, now almost 12 %, expected to reach 18- 20 % in 2020, represents, besides the improvement of the general health condition, the occurrence of other gerontological issues, among which depression is rather significant.

This research is based on clinical and therapeutic observation during 6 years (1999 – 2004) on a number of 139 patients who benefited from psychiatric care in inpatient facilities.

The methodology used was the prospective clinical study. The clinical, paraclinical and psychological parameters of depressive patients were monitored based on: hospital admission note, clinical examinations, psychological tests assessments, the depressive

patient's observation sheet, electroencefalograms and other investigations adequate to the health condition of each patient, hospital release notes and other documents from outpatient clinics or private medical practices. The longitudinal analysis is only catamnestic, until admission in hospital, and data included in the observation sheet regarding the current psychological and physical condition were added to such analysis. We used Hamilton, Newcastle I and II, Zung scales, as well as stress and vulnerability scales.

Regarding the assessment of stressful life events, we relied on the theory that stress is an adaptation or problem solving process.

Stress factors we perceive as psychologically traumatic events or circumstances result, sooner or later, in physical, psychological and behavioral reactions among which depression is a major one.

“The Social Readjustment Rating Scale” designed by HOLMES and RAHE in 1967

During 1999 - 2004 we studied a number of 112 patients (80 – 57.5% women and 59 – 42.5% men), aged over 65, who, during this period of time, benefited from psychiatric care for depression-type mood disorders as principal diagnosis, (on the first axis, of “Major depressive episode” or averagely severe episodes (with frequent oscillations to a major episode), with multiple potential causes (loss of a loved one, loss of material resources, loneliness, retirement, medical illnesses etc.); general decline of functional capacity and adaptability (Second Axis); other medical illnesses (Third Axis), but with psychosocial difficulties (Fourth Axis) and persistent functional deterioration (Fifth Axis).

In view of diagnosing and assessing the severity of depression episodes in patients included in the study, we used both the “Global functioning assessment scale” (E G F), and the Hamilton depression scale.

Based on my observations, I am of the opinion that the presence of the following symptoms clearly indicates the severity of the depressive episode. Classical symptoms of depression, with increased apathy and lack of vitality.

Due to a significant improvement of therapies available for psychiatric disorders, the treatment of depression is now regarded as a global treatment, with several points of attack in view of ameliorating and curing depressive patients. This therapeutic combination is new as compared to theories existing during the period of introducing pyreto-therapy, insulin-therapy and convulsive therapy.

For this reason I was in study and the forty patients with each sixty-five years and more from Constanța County.