Psychosocial Factors in Late Life Depression

Ramona Maria Chendereş[1], Delia Marina Podea[1], Pavel Dan Nanu[2], Camelia Mila[1], Ligia Piroş[1], Mahmud Manasr[3]

Rezumat

Cu toate ca depresia la varsta a treia este cea mai frecventa tulburare intalnita la persoanele in etate, de peste 65 de ani, aceasta este frecvent nediagnosticata, lucru care aduce dupa sine netratarea tulburarii depresive, din cauza faptului ca atat pacientul cat si familia acestuia cred ca dispozitia depresiva este o stare normala a individului in etate. Peste acestea, se mai adauga si faptul ca tabloul clinic la pacientii varstnici este diferit de tabloul clinic clasic, care apare la adultii tineri si in plus exista frecvent comorbiditati sau boli asociate, cum ar fi dementa care ingreuneaza mult diagnosticul de tulburare depresiva. (Rodda et al., 2008)

Depresia la varsta a treia poate fi considerata o noua entitate nosologica, cu toate ca manifestarile acesteia sunt foarte diferite de la individ la individ, varsta fiind un factor care poate influenta etiologia, fiziopatologia, manifestarile clinice, raspunsul la tratament si evolutia tulburarii depresive. (Roose et al., 2004)

In etiologia depresiei la varsta a treia sunt mai putin importanti factorii genetici decat cei biologici (comorbiditati somatice) si cei psihosociali. Factorii psihosociali cresc vulnerabilitatea individului varstnic in fata tulburarii depresive, aceasta putand fii determinata de scaderea stimei de sine (sentimente de neajutorare, sentimente de neputinta), pierderea rolului social, scaderea numarului de contacte sociale, diminuarea resurselor financiare.

Rolul lucrarii de fata este de a arata importanta factorilor psihosociali in etiologia depresiei la varsta a treia si in diagnosticul precoce a acestei tulburari, acesti factori psihosociali fiind factorii etiologici asupra carora se poate actiona, evolutia tulburarii depresive avand in aceasta situatie un prognostic mai bun.

Cuvinte cheie: *depresia la varsta a treia, etiologie, factori psihosociali*

Abstract

Late-life depression is one of the most common mental health problems in adults over the age of 65; even so it is often under-recognized and under-treated because many patients and their families believe that depressed mood is a normal state of the growing old adult. Additionally, the clinical picture may be different from the clinical picture in younger adults; frequently there are co-morbid physical illnesses or dementia. (Rodda et al., 2008)

Late life depression should be considered an individual clinical entity, despite the heterogeneity of its clinical manifestation. Age is a factor that can influence and modify the aetiology, physiopathology, clinical manifestations, treatment response and outcome of late life depression. (Roose et al., 2004)

Age related physical and psychosocial factors increase the vulnerability of elderly people to depression. Psychosocial model of mental health finds that late-life depression can be generated by loss of self-esteem (helplessness, powerlessness), loss of meaningful roles (work productivity), declining social contacts, reduced functional status or low financial resources.

Late-life depression has been shown to be influenced, less by genetic factors and more by psychosocial factors and biological factors (somatic diseases). The aim of this paper is to show how important are the psychosocial factors in the aetiology of late life depression and in the early diagnosis of the disorder. Additionally, the targets of intervention are modifiable risk factors and many of them are psychosocial factors.

Keywords: *late life depression, aetiology, psychosocial factors*

There are lots of psychosocial factors that contribute to depression. Off all factors, social stress and life events have always appears to be the most important in causing depression. Life events are defined as recent major changes in the individual's socio-economic situation, such as loss of family (children, spouse or parents), loss of friends (many friends are old persons who can die), bereavement, widowhood or divorce, separation from the children, retirement, long term illness, sudden homelessness or having to move into an institution (they feel that they have been put there to be forgotten – sometimes family members stop visiting which makes the person sad), insecurity (elderly person begins to feel more vulnerable and unable to protect themselves, so they begin to stay

home), dependency, lack of social support, financial worries, socioeconomic decline and social isolation. In particular, the death of a loved one is considered as the most significant loss event that affects elderly adults. (Sadock et al., 2005)

A lot of elderly people are on a limited budget because of the retirement and in this situation appear financial worries, social isolation and socioeconomic decline.

Low socioeconomic status leads to a vicious cycle; it determines poorer detection of depression and poorer access to the appropriate treatments. (Baldwin, 2008)

Being a carer of someone who is chronically ill is an important risk factor leading to depression. (Baldwin et al., 2002) In one study (Ballard et al., 1996) a quarter of carers of dementia patients were depressed and many had persistent symptoms. (Baldwin, 2008)

These social factors are more frequent to the patients with the age over 65 and many of these are common life events that happen every living day.

Table no. 1. Aetiological stressful events in depressive disorder

LIFE EVENTS	SOCIAL STRESS
Bereavement/Widowhood (loss of family – children, spouse, parents) Divorce Separation from the children Loss of friends (including a pet) – at late life many friends are old and can die Acute physical illness Sudden homelessness or having to move into an institution	Long term illness Insecurity Dependency Lack of social support Retirement Social isolation Financial worries Socioeconomic decline Caring for a chronically ill and dependent family member

Source: Robert Baldwin, Mood disorders: depressive dosorders, Oxford Textbook of Old Age Psychiatry, Oxford University Press, 2008, p. 537

Bereavement

In a large epidemiological sample of people over 70 years (Turvey et al, 1999), bereavement by loss of spouse was associated with ninefold increase in depressive disorder compared to those still married. In another study (van Grootheest et al, 1999) men adjusted less well after bereavement. The recently bereaved are at high risk of developing depression and represent a group for whom screening would be worthwhile. (Baldwin et al., 2002)

Bereavement refers to the loss through deaths of a loved person. This is a very commune life event that appears at old age. Bereavement is associated with increased psychiatric and medical morbidity and with increased mortality from all causes in the six months following the bereavement. The understanding of the process of grief is important for all healthcare professionals. (Rodda at el., 2008)

Normal grief reaction is described in several stages. (Table no. 2) This description is only from didactical point of view because in practice the process is continuous. Symptoms do not necessarily occur in a specific order and each individual will respond differently to their loss. (Rodda et al., 2008)

After an initial stage o shock, disbeliefs and denial, which usually last up to several weeks, the clinical presentation evolves with social withdrawal, severe emotional pain and obsessional review of the death. With the beginning of the second year, the grieving process is resolved and a return to pre-loss level of functioning is achieved. (Giannakopoulus et al., 2000) Reactivation of symptoms on anniversaries of the death person is common after Stage 3. (Rodda et al., 2008)

Table no. 2

Stage 1 Days – two weeks	Numbness Denial Disbeliefs
Stage 2 Weeks – six months	Preoccupation with the deceased Yearning, pining and waves of grief with autonomic symptoms Restlessness Guilt, anger Poor sleep and poor appetite Illusions, vivid imagery, transient visual hallucinations of deceased Hallucinations of the voice of the deceased Feeling of the deceased being present
Stage 3 Weeks - months	Resolution of symptoms Acceptance

Source: Joanne Rodda, Niall Boyce and Zuzana Walker, The Old Age Psychiatry Handbook. A practical guide, John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, England, 2008, p. 74.

In abnormal grief the symptoms are severe and meet the criteria for a depressive episode. The features, according to DSM-IV-RT, suggestive of depression rather than normal grief are:

Feelings of guilt not related to events surrounding the death of the loved one

Thoughts of death that are not related to the deceased

Preoccupation with feeling of worthlessness

Psychomotor retardation

Prolonged and marked functional impairment

Hallucinatory experiences (other than image or voice of the deceased)

Table no. 3

Factors predisposing to abnormal grief

Sudden or unexpected death
Suicide or murder
Dependent relationship with deceased
Self-blame
Severe depression
Other concurrent stressful life events
Lower socioeconomic status
Poor social support

Source: Joanne Rodda, Niall Boyce and Zuzana Walker, The Old Age Psychiatry Handbook. A practical guide, John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, England, 2008, p. 75.

There are more clinical manifestations of grief:

– delayed grief – symptoms manifest less than two weeks after the bereavement

– inhibited grief – there is an absence of normal features of the grief reaction and may be associated with feelings of anger or guilt towards the deceased.

– prolonged grief – grief lasting for more than six months. (Rodda et al., 2008)

Another aim of this paper is to discuss the social and financial burden of late life depression to society and to medical system. Two factors combine to make depression in late life a public health problem: the global population is growing older and the underscored of the depression consequences. WHO shows that depression causes a greater burden than cardiovascular disease, alcohol use or traffic accidents and is expected to overtake ischemic heart diseases.

The financial burden of depression across the entire life-course is enormous. The estimated cost in U.S. alone is about 50 billion dollars per year. Depression doubles the number of absentee days for employed individuals. Direct physical and psychiatric care and pharmaceutical costs are estimated to be 12.4 billion dollars. (Roose et al., 2004) (Blazer et al, 2007)

Depressive symptomatology in elderly outpatients is associated with increases in physician visits, medication use, emergency room visits and among medical inpatients, major depression has been associated with increased use of health-care resources, including longer hospital stays and greater mortality.

Depression coexisting with physical illness has been shown to **increase** levels of functional disability, use of health-care resources and **reduce** the effectiveness of rehabilitation in older patients with stroke, Parkinson's disease, heart disease, pulmonary disease, etc.

Protective factors against late-life depression

It is possible that changes of attitude in old age reduce the impact of psychosocial risk factors. The elderly may prioritise "time left" and not previous experiences and thus prioritise positive emotional experiences. (Rodda et al., 2008)

The relationship between social support and depressive disorder is complex. Social support appears to act as a buffer against depression or may ameliorate its impact. (Baldwin et al., 2002)

Just as negative life events may promote depression, positive events, like a grandchild birth may be protective. (Baldwin, 2008)

Religious affiliation has been observed to have a protective effect against depression. (Baldwin et al., 2002)

Social intervention

Optimizing support and social contact at home can help to decrease the impact of social distress. Social support and contact is also provided by day centers or day hospitals which can be helpful in patients recovering from depression. A social network should be helpful in protecting patients against future relapse. (Rodda et al., 2008)

Physical exercises could be of benefit in reducing negative mood symptoms in older patients, including those with medical illness and dementia. (Rodda et al., 2008)

Bereavement counseling may be helpful for some, especially in the context of abnormal grief.

Table no. 4. Summarize of the social management of depression in the elderly (Rodda et al., 2008)

Maximize social support and contact
Appropriate accommodation
Day centers/Day hospitals
Exercise programs
Bereavement counseling

Conclusions

Recognising psychosocial factors is a target in treating depression because many of these factors are modifiable. Suppressing these factors improves the outcome of depression.

Treatment of depression can reduce the level of disability and result in improvement levels of functioning, improving the quality of life.

Treatment of depression would result in reductions in general health-care costs.

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[1]*West „Vasile Goldiş" University of Arad, Psychiatry Department*
[2]*West „Vasile Goldiş" University of Arad, Neurology Department*
[3]*DGASPC Satu Mare*