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Geriatric Depression in Family Medicine

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ABSTRACT

Introduction: Elderly persons often suffer from depression, without anyone around them noticing. Depression is more common at physically ill elderly person then at their physically healthy contemporary. It is important mental health problem of developed society, because it is still faintly revealed thus insufficiently treated. **Objective**: To explore the existence of geriatric depression in elderly persons living on their own and those who live in family environment. **Materials and methods:** The research included 200 elderly respondents, experimental group made of elderly persons (›65 years) living alone. Control group included elderly persons living in a family environment. Universal geriatric questionnaire was made for this research. To assess the presence of depression at respondents we used "The scale of geriatric depression". **Results**: The average age (±SD) was 75,4±6,2 years in the experimental group, while in the control group the average age was 74,9±5,6 years. In the experimental group there is significantly larger number of elderly persons that are neglected (p=0,001). Elderly respondents surrounded by loneliness are more depressive than elderly living in the family environment. Statistically geriatric depression is significantly connected with inability for everyday activities, with decreased result of cognitive abilities and indicated result of dementia (P=0.001). **Conclusion**: Depression is an important mental health problem of the developed society, because it is still faintly discovered and by that insufficiently treated. Organizing approach to different aspects of geriatric health, doctors of the primary protection can improve care of their elderly patients.

Keywords: elderly, geriatric depression, family medicine, loneliness.

1. INTRODUCTION

Elderly persons often suffer from depression, without anyone around them noticing. Depressive symptoms seen in elder age are related to the advancing of age, being a female, living alone, divorcement, low education level, functionality disorder, comorbid physical illness, low level cognitive dysfunction, cigarette and alcohol use (1). Depression is more common at physically ill elderly person then at their physically healthy contemporary. The connection between physical disorders and depression at elderly is well known. It is important mental health problem that developed society has, because it is still faintly revealed thus insufficiently treated (2). Elderly most commonly complain about physical set back such as digestion problem, headache, joint pain, muscles or back. The patients complaints of physical symptoms can be result of a physical disorder, but often they are just a part of patients clinical depression picture. It takes special caution so that a physical problem would not be declared as hypochondriac and inversely at elderly. Although elderly often deny depression, it should be suspected when they complain about anxiety or pain, constipation, exhaustion, interference in concentration, difficulties with memory. It seems that the highest risk factors for the formation of depression at elderly are positive psychiatric anamnesis and seriousness of physical disease. In the meta-analysis, it was discovered that the existence of chronic illness and low health perception increased the risk of depression (3). Depression significantly increases morbidity and mortality of elderly. On contrary to dementia, depression is characterized with relatively sudden appearance, untouched, but possibly slow mental abilities and limited duration period. Elderly have higher number of complications, including inability of caring for themselves and their own health. More common is the development of psychotic symptoms. Around 90% of the suicides are connected with depression at elderly (4). Existence of multiple physical diseases in elderly, use of multiple medicines, occurrence of pharmacokinetics and pharmacodynamics changes depending on the age necessitate to take several factors into account while diagnosing and

using medicines (5). Treating depression at elderly should be approached with caution having in mind physical diseases, their slow metabolism for many medicines and the fact that they are taking more different medicines at the same time. With well chosen antidepressant a positive response to the therapy can be expected in 60-70% of the cases (6). The studies in the elderly have demonstrated an unequivocal benefit of long term treatment with the aim of preventing a recurrence. The treatment should be continued for at least 6-12 months, while psychiatrists specializing in the elderly recommend - a minimum of 12 months of treatment after the first episode, 24 months after the second episode, and at least three years after the third or more episodes (7). The treatment of depression at patients with comorbidity demands skills of treatment out of the framework provided with algorithms for treating depression disorders. That is the skill of making adjustments to overall health condition of a patient (8).

Research objective

To explore the existence of geriatric depression in elderly persons living on their own and those who live in family environment.

2. MATERIALS AND METHODS

The research included 200 elderly respondents, 90/200 (45%) in experimental group and 110/200 (55%) in control group. Experimental group included elderly persons (>65 years) living alone. Control group included elderly persons living in family environment. Provided questionnaires were not filled by respondents because of weakening senses accordant to the age, and they would not be able due to the fact that more than half of them is illiterate. Examination and filling in the questionnaire was done in the family medicine clinic, and one number of the respondents was examined in home environment in suburbs. Universal geriatric questionnaire was created for this research, and it contains questions related with age, gender, general physical examination, living conditions, economic conditions, portability, everyday life activities, home safety, neglect, apparatus, smoking, alcohol, urination disorders, sexuality, information on the use of medicines. The questionnaire is adjusted for evaluation in house conditions. The adjusted questionnaire for our conditions was used for fast orientation: examination in clinics for usual elderly problems "Short list for examination" or "Ten Minutes Screen for Geriatric Conditions" (9). This part of the questionnaire contains eyesight, hearing, mobility examination, questions about urinary incontinence, eating and weight loss, questions about physical restrictions. To assess the presence of depression at respondents we used "The scale of geriatric depression" (10). The scale is designed with elements characteristic for symptoms of depression and for elderly behavior. It contains fifteen questions, and avoids topics related to physical symptoms and demands only yes/no answers, one point for each answer marked with large letters. The normal result is from 0 to 5, and above 5 is considered as depression.

3. RESULTS

In total sample there were 200 respondents, 90/200 (45%) in experimental group and 110/200 (55%) in control group. The average age (±SD) was 75,4±6,2 years in the experimental group, while in the control group the average age was 74,9±5,6 years. There were more female respondents in the examination group and control group (62.2%, vs. 52.7%). The frequency of respondents considering neglect was compared. In the examination group (22/90; 24,4%) There is significantly larger number of elderly that are neglected (p=0,001) in regard to control group of respondents (8/110; 7,3%).

Scale values of geriatric depression are compared between two tested groups. Elderly respondents surrounded by loneliness are more depressive than elderly living in family environment (p=0,006).

According to geriatric depression scale value the respon-

Groups	Health status n (%)			
	No depression	Possible depression	Depression	p
Examination	23 (25)	33 (37)	34 (38)	0.03
Control	46 (42)	38 (34)	26 (24)	

Table 1. Distribution of the respondents according to self-assesment of the geriatric depression quality according to groups

Gender	Health status n (%)			
	No depression	Possible depression	Depression	p
Male (n=86)	41 (48)	27 (31)	18 (21)	0.002
Female (n=114)	28 (25)	44 (39)	42 (36)	

Table 2. Distribution of the respondents according to self-assesment of the geriatric depression quality and gender in overall sample (N=200)

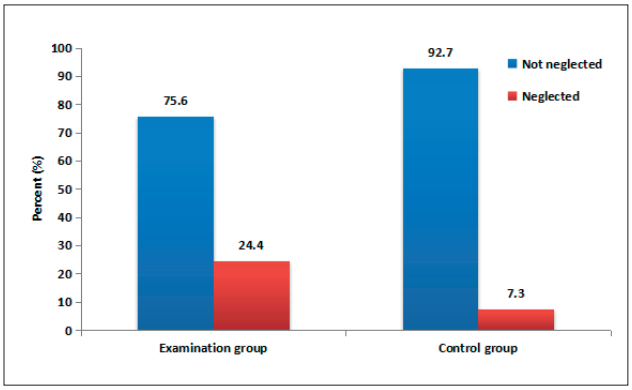

Figure 1. Structure of the respondents according to perception of neglect and groups

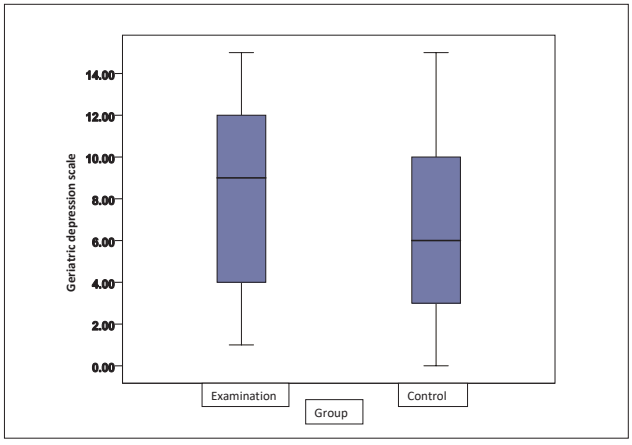

Figure 2. Score median of the geriatric depression scale according to groups

dents are divided into 3 categories (<5-no depression; 5-10-possible depression; >10 depression). Significantly larger number of the control group had the score values <5, while significantly larger number of the examination group members had the score values >10, respectively the respondents living alone are significantly more depressive in regard to control subjects (p=0,03).

Statistically geriatric depression is significantly more represented at female respondents (p=0,002).

Statistically geriatric depression is significantly connected with inability for doing everyday activities, decreased cognitive abilities score and indicated dementia score (P=0.001), and significantly correlates with age and decreased nutritional status. Listed factors are constantly predictors for geriatric depression (P=0.001), and permanently indicated predictors affect the level of geriatric depression (p=0.05).

4. DISCUSSION

Epidemiological researches indicate that 3-4% of the population suffers from severe, while 1,5 to 2% from milder forms of depression. Women more often suffer than men in relation 2:1. Depression is usual at elderly. Studies have shown that 20% elderly living at home have symptoms of depression, and there is only 3-4% of those who satisfy or perform criteria for depression. At nursing homes from severe depression suffers 15-25% of residents. Systematic examination of the population in Central Norway, as well as Alex Corners research from Carlebo, and in Copenhagen has shown that frequency of depression grows with age. Corner has in age group 65-79 years found that 11% had depression, toward 23,3% in group over 79 years (10). Depression in moderate form, as well as serious stage more commonly occurs in late age. Corner research has shown that depression more commonly occurs at women than men. In Sandagers research from 1999, it was a larger number of women between 60 and 79 years and it was 7,9% to 1,2% at men (11). These researches show that women have 1,5-3 times more frequent depression than men. The disease is more common among women in all communities (12). Depressive symptoms have been associated with reduced intellectual capacity, social inhibition and inversive emotional stability (13). Croatian gerontological researches have confirmed that the loneliness is the main problem at elderly. Those elderly are more likely to be permanently immobile, because of the social isolation, which is consequently connected with depression, but also with overweight or malnutrition at elderly age. Our research covered 200 elderly respondents, 45% those who live alone and 55% of respondents living in family or social environment. The age of respondents was moving in range from 65 to 94 years, average age of respondents from the experimental group was 75,4 years, and in the control group 74,9 years. Statistically there was not any significant difference among groups according to age (p=0,05). In total sample there was 57,5% women and 42,5% men older than 65 years. The part of women among elderly residents is larger in all elderly age groups, moving from 56,3% of all residents aged 65-69 years and growing to 77,8% elderly aged from 95 years (14). When the frequency of the respondents was compared considering neglect Odds Ratio for neglect in the examination group was 4,13 (%95CI=1,74-9,80), so the chances for neglect were 4,13 times larger in the examination than in control group. Therefore, in our research we reached the information that the elderly respondents that are surrounded with loneliness are more depressive than elderly living in family environment. Geriatric depression is significantly more represented at female respondents (p=0,002). Statistically geriatric depression is significantly connected with inability for doing everyday activities, decreased cognitive abilities score and indicated dementia score (p=0.001), and it significantly correlates with age and decreased nutritional status.

5. CONCLUSION

Depression is an important mental health problem of the developed society, because it is still faintly discovered and by that insufficiently treated. Due to ignorance and prejudices around 50% depressive persons don`t seek for medical help. Patient complaints about physical symptoms can be the consequence of physical disorders, but often are just part of their clinical picture of depression. Factors that can cause depression in elderly human population are different stressing situations such as retirement, grief, the loss of independence or social support, isolation, higher sensitivity and vulnerability. Organizing approach to different aspects of geriatric health, doctors of the primary protection can promote the care of their elderly patients.

- Conflict of interest: Autors have no conflict of interest to declare.
- Autor's contributions: Study conception and design: Alibasic Esad. Acquisition of data: Alibasic Esad, Ramic Enisa, Bajraktarevic Amila. Statistical analysis and interpretation: Ramic Enisa, Bajraktarevic Amila , Karic Enisa. Drafting of the manuscript: Alibasic Esad, Ramic Irma, Alibasic Emir. Critical revision of the manuscript for important intelectual content: Batic-Mujanovic Olivera. Final approval of the version: Alibasic Esad.

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