

Psychology of Depression in Elderly: A Review

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Abstract

Emotional problems in elderly people are currently one of the major issues in healthcare. In mental health and chronic medical health care, depression has been observed as the most common psychological disorder in older adults. The elderly depression is a global issue in mental healthcare with growing rate of incidence and prevalence. Though several researches have contributed in widening knowledge and understanding of the domain, however, the authors of this article have explored some visible and invisible issues indicating discrepancy in mental healthcare services. These issues are especially related to socio-demographic characteristics, diagnostic understanding, intervention and rehabilitation. This review work is aimed at investigating and compiling findings of major researches pertaining to elderly depression through kingpin internet sources, and projecting light on deficiencies in researches along with future guidelines for diagnostic, interventional and rehabilitational understanding and services in mental healthcare.

Keywords: Depression; Late Adulthood; Mental Health; Behavioural and Psychological Intervention

Introduction

Depression could be normal or abnormal. People with normal depression are characterized by feeling of sadness, disappointment, frustration, distress, cheerfulness, hopelessness etc. But normal depression is always adaptive by inducing alertness for impending danger or loss in individuals. Such alertness prompts people to explore or look for or revive their sources and resources of support, care, protection, success and survival from failure and setbacks. In contrast, abnormal or pathological depression could be detrimental by virtue of intensity, persistence, interference, and pervasiveness with bodily and psychosocial functioning liable to clinical treatment and intervention. The resulted abnormal physiological functions can be clinically investigated in terms of disturbed hunger, thirst, sleep, marital relationships, visceral functioning, reduced desire for normal and expected roles and responsibilities in daily living. In addition, typical psychotic features of hallucination, delusions and lack of reality contact may appear with gradual deterioration. Sometimes, suicidal thoughts or attempted suicide could also be observed.

As per the American Association for Geriatric Psychiatry, common symptoms of depression in elderly include persistent sadness, feeling slowed down, excessive worries about finances and medical health problems, frequent tearfulness, feeling worthless or helpless, change in weight, pacing or fidgeting, difficulties in concentration, sleeping; somatic complaints like unexpected physical pain, gastrointestinal problems, withdrawal from social activities [1-4]. Depression in older adults is different from the same in young adults. Depression in elderly, regardless of its magnitude level, is often associated with medical crises, disabilities, reduced ability to rehabilitation lasting for longer time. It occurs with increased risks of heart-related medical complications, fear and risk of resulted death. It moderately

increases risk for suicide in elderly. The NIMH observed depression in elderly people above the age of 65 as major problem in public healthcare because people don't believe in hope for help in this stage of life. Depression in elderly may interfere with other health problems like substance abuse, as well as, duly affected by incidental and accidental life events, e.g. death of family members and friends, isolation, poverty etc. All these hinder compliance of elderly patients to treatment [5]. Furthermore, elderly people often don't display affective symptoms like dysphoria, worthlessness, and guilt [6], rather more likely to show cognitive changes as well as somatic symptoms of sleep disturbance, general loss of interest in daily living and agitation. These symptoms and their patterns of development could be attributed to other bodily and age-related factors like co-morbid diseases, poor physical status, cognitive impairment and structural changes in brain [7]. Older adults who experienced an episode of depression earlier in life are more likely to have family history of mental illness [8].

Major risk factors

The major risk factors increasing depression in older adults are: being female, single, unmarried, divorced or widowed; lack of social support, stressful or tormenting life events; physical and psychological clinical conditions, e. g., stroke, hypertension, heart disease [9], diabetes [10], cancer, dementia, chronic pain, damage to body image from surgery or amputation, lupus, family history of major depressive disorder, fear of death, living alone, social isolation, history of suicide attempts, previous history of depression, recent loss of loved one, substance abuse, neurotic and ruminative personality traits, grief and loss, change in social status, other illnesses like endocrinal disorders; effects of some medicines like antidepressant and depressant of CNS, opioids for chronic pain syndromes, anti-psychotics for agitation, beta-blockers like propranolol, corticosteroids, anticonvulsants, anti-Parkinson agents etc. These factors can make diagnosis of depression challenging in elderly as likely to be observed as a part of normal aging or confounded by co-morbidity with dementia or delirium. However, depressive features can be conspicuously differentiated by comparing differential features of depression, dementia and delirium Canadian Coalition for Seniors' Mental Health [11] described below:

Features	Depression	Dementia	Delirium
Onset	Mostly abrupt and coinciding with life events	Generally insidious, but chronic ultimately.	Often occurs at twilight, but usually sudden
Duration	Months to years	Months to years	Rarely longer, hourly to less than a month
Thinking	Intact but negative, characterized by theme of helplessness.	Dearth of thoughts, hard to find words, weak judgment.	Disorganized, weak, lacking coherence.
Memory	Either selective or patchy	Impaired	Impaired/sometimes sudden loss of immediate memory
Attention	Least impaired but easily distracted.	Often normal	Often impaired, sometimes fluctuates.
Awareness	Generally normal	Generally normal	Decreased
Alertness	Normal	Often normal	Usually fluctuating, but sometimes hyper-vigilance or lethargic.
Sleep	Waking in early morning	Wandering at night, often disturbed	Confusion at night.
Progression	Variable and uneven	Slow and Even	Abrupt/fluctuating

Prevalence of elderly depression

Brody, *et al.* [12] have reported that there are 6.1% male and 9.6% female elderly people are suffering from depression in the USA with greater societal costs and highest functional impairments and its prevalence rate is higher in the non-Hispanic Asians (13.9%). According to the Center for Disease Control (CDC), depression affects 1% - 5% elderly male and female population out of which 13.5% require

home-based and 11.5% need hospital-based healthcare services (NIMH, 1999). This is also noticeable that older adults are quite risky for misdiagnosis and lack of treatment as some of the depressive symptoms may mimic normal features of aging. Besides, clinical symptoms of depression can mistakenly be accounted for other illnesses, change in life and impact of medication. Sometimes, these patients become reluctant to talk about their emotional feelings and/or may fail to understand and accept their physical signs and symptoms as indicators of depression. Similarly, their isolated living conditions can make difficult to reach sources of help and supports [13].

Nearly 1/6 of elderly Americans (five million of 31 million) are clinically depressed and one million of them having major depression [14]. As per an older report, depression is prevalent in 1% (i.e. 1.4 in women and 0.4 in men) of general population of the USA, and the rate reaches 12% - 30% patients receiving long-term care facilities [15]. The prevalence of depression in primary healthcare is much more as 17% - 37% of elderly patients received treatment for depression; and about 30% of these have been diagnosed with major depression [16]. The physically health elderly people living in community, 3% of them have major depression [14]. Recurrence of depressive episodes could be high up to 40% and rate of suicide is almost double in depressed elderly patients in relation with general population [16]. Nearly 63% depressed elderly and white Americans committed suicide, and approximately 75% of them committing suicide were not recognized as depressed in preceding month of such attempts, at primary healthcare centres [17,18]. In a latest study of the American Foundation for Suicide Prevention [19], older adults above 85 years are at second highest rate of suicide (19.4%) in the USA. The highest rate of suicide among adults is 19.6% among people between 54 - 64 years of age. In European countries, major depression is prevalent in 3.4% men and 6.3% in women, chronic depression in 1.6% men and 2.2% in women, other types of depression in 4.5% men and 8.2% in women in old age [20]. Talala, *et al.* [21] reported that nearly 24% of elderly population was suffering from major depression in comparison with general population in Finland (5%). It is worth mention here that Finland is one of the fastest aging country in the world wherein 18.5% population comprises people over 65 years and it is also assumed to be 27.5% by 2050 [22]. Stuart [23] observed that 50% - 80% of all suicides occurred due to depression, and possibly 75% of them were committed by psychiatric patients. Smeltzer, *et al.* [24] found that approximately 15% elderly adults suffer from depression and 3% - 26% of this population resides in community.

Indian scenario of depression in elderly

India is the second largest country in terms of elderly population likely to be 300 million by 2050 forming 19% of the total population [25]. It has been considered as a home for 57 million people (18% of global estimate) affected by depression [25]. Albeit meager in number but various types of community-based studies found depression in elderly people ranging from 9% to 62.16% as the most common psychological problem [26-29]. The rate of median prevalence of depression in elderly Indians is 18.2% which is higher than rest of the world (5.4%) reported by Barua, *et al* [30]. However, this comparison in India was made on six studies only, covering 0.5% of total study sample in contrast with 99.5% samples of international studies. The largest community-based international research (conducted on elderly sample taken from six countries, i.e. India, China, Ghana, Mexico, South Africa, and Russian Federation) revealed that prevalence of depression among people above 50 years of age was highest in India (27.1%) followed by Mexico (23.7%), Russia (15.6%), Ghana (11%), South Africa (6.4%) and China (2.6%) [31]. All major studies suggested that depression was more prevalent in elderly inmates of old-age homes in comparison with other settings like home, community, hospitals etc [32-35]. Demographically, females were high on depression, and suicidal tendency in elderly patients was associated with hopelessness and impulsivity [36]. Important factors associated with elderly depression in India were single status (due to any reason), residence in rural area, illiteracy, increasing age, low socio-economic status, unemployment, loneliness, poor support system, isolation, dependency, lack of care and affection in family, insufficient time spent with children, stressful life events, perceived poor level of health, lower level of spirituality, high level of applying emotion-focused coping style, lack of hobby and sources of its fulfillment, substance abuse, lack of exercise/sedentary lifestyle, irregular diet etc [26]. Chadha and Bhatia [37] explored that older adults in affluent societies suffer from isolation as they are unable to find psychological support from their grown up children. Similarly, increased rate of depression in elderly women is due to the particular stresses like lack of education, unavoidable dual responsibilities at home and work, caring for children and looking after ageing parents, rather than greater vulnerability. Sinha, Hrivastava and Ramasamy [38] conducted a research on prevalence of elderly depression in rural India in which 70.9% were aged 60 - 69 years comprising 56.3% male. They found that 42.7% individuals were found to be depressed in which 22.3% participants were found with mild depression, 13.6% with moderate depression and 6.8% with severe depression. In important causative factors, female sex and status of widowhood were significantly associated with depression.

Major physical diseases have also contributed to geriatric depression, e.g. undiagnosed and multiple physical illnesses, hypertension, osteoarthritis, cataract [39]. According to Sundru and Goru [40], osteoarthritis (43.9%), cataract (25.2%), hypertension (17.6%), diabetes (7.6%), and heart disease (3.9%) are major physical diseases elevating depression in older adults in India. In addition, past head injury, stroke, transient ischemic heart disease and hypothyroidism are also seen in elderly patients with depression [41,42]. In fact, the Indian society is gradually witnessing globalization, urbanization, migration and modernization [25] accelerating its movement towards urban and metropolitan societal development due to rapid rate of industrialization and socio-demographic transition. All these are influencing psychological well-being of aged women grimly. In effect, women are twice as likely as men suffering from major depression [43].

Major causes of depression in elderly

Health-related Factors: Poor conditions of physical health, specific co-morbidity, previous episode/s or/and family history of depression are major health-related factors triggering depression in elderly. In addition, some specific diseased conditions like stroke, long-term and disabling Parkinson's disease; deadly diseases like cancer, heart disease [9], thyroid diseases, adrenal insufficiency, lupus, diabetes, dementia -especially Alzheimer's type aggravate and complicate depressive symptoms.

Pharmacology-related Factors: Some allopathic medicines usually prescribed for the elderly, can develop clinical depression. For example, anti-depressants like benzodiazepines, zopiclone, opioids being prescribed for chronic pain syndromes, anti-psychotic drugs for agitation, beta-blockers especially lipid soluble agents like propranolol, corticosteroids, anti-convulsants like gabapentin and carbamazepine to be used for pain syndromes, ulcer medicines, non-steroidal anti-inflammatory drugs (NSAIDs), anti-Parkinson agents especially levodopa, histamin-2, receptor antagonists like ranitidine.

Cognitive Impairment in depression: Impaired memory is very common in depression which may be caused by normal aging, mild cognitive impairment or dementia. Since depression is also a common factor in impairment of memory, therefore, it must be differentiated from early stage of dementia. For example, thinking is characterized by scarcity of thoughts, poor judgment and difficulty in word selection in dementia, but it is quite intact in depression and characterized by theme of helplessness and negative contents. Memory is impaired in dementia but selective or patchy in depression. General awareness is unaffected but attention is found to be generally normal in dementia, whereas, easily distractible and minimally impaired in depression. Both depression and dementia in elderly can be differentially examined by various clinical tools. Struggle with short-term memory, speaking, writing is also highly likely but patients don't care about memory problems in dementia [44].

Sleep disturbance and depression in elderly: Though insomnia and sleep disturbance are common symptoms of depression but insomnia has also been explored as a risk factor of onset, persistence and recurrence of depression in elderly. Since insomnia increases with growing age, so, it is essentially treated in depression.

Demographic and psychosocial factors in elderly depression: Being female; single like unmarried, divorced, widowed [1-4]; lack of social supporting network, stressful life events, grief and loss, change in social status, lack of enjoyment, no work after retirement etc. are major determinants in onset and complexity of depression in older adults. In addition, societal modernization has brought about a breakdown in familial integrity, values and framework of family support. The 'empty nest syndrome' [45] is another reason when children move to urban and metropolitan areas for career development and leave parents alone at home. On the other hand, parents don't adjust in new environment when they also move with children to a new place. In addition, change in family structure and resulted financial insecurity appears in older adults as losing significance and relevance in their own home and duly increases feelings of loneliness [46]. It has been found deadly in psychological well-being of older people.

Personality features and depression in elderly: Characteristics of personality has been investigated in influencing health status and longevity in older adults and contributing adaptation with aging processes [47]. It has been explored in several researches that personality features could be one of the important factors triggering depression in older adults [48-51]. The scientists found low level of domi-

nance and high level of neuroticism associated with depression in elderly [51]. However, low level of neuroticism along with high level of extraversion appeared associated with reduced risks for mortality in elderly [52]. On the other hand, Hoyer and Roodin [53] found optimistic and hopeful older adults with better health status, long life and positive mood as compared to pessimistic older adults who were highly risky for depression with worse health status. Irigaray and Schneider [54] conducted a comprehensive investigation on elderly women and found that high level of deference coupled with low level of aggression were associated with depression of old-aged women. Among other personality features, factors of increased level of assistance, decreased intraception, decreased caress, increased affiliation, low dominance, decreased denial, little lower performance, very low exhibition, low change and autonomy were associated with depression in elderly women. Gonzatti, *et al.* [55] confirmed influence of neuroticism and extroversion in inducing depression, as well as, found lower level of openness of experience' associated with depression and poor cognitive functions. Likewise, Martin, *et al.* [48] compared older adults who were centenarians, octogenarians and sexagenarians and observed that lower level of arousal, increased regression, decreased sensitivity and increased radicalism were associated with fatigue and depression in their longitudinal history and assessment.

Type-D personality and depression in elderly: This type of personality is characterized by 'negative affectivity', i.e. negative emotions toward self and others. The individuals with such personality features tend to be afraid of criticisms and rejection of others. This negative feeling causes them to feel difficulty and inappropriateness in expressing themselves in social situations resulting into social inhibition. In recent years, Type-D personality has been found linked with various health problems, e.g. cardiac complications, anxiety, depression, post-traumatic stress disorder and other physical illnesses [56-61]. Kasai, *et al.* [5] conducted similar research investigation in relation to elderly people and concluded that older adults between 65 - 74 years of age with Type-D personality were 4 - 5 times risky for psychological distress and twice risky for poor self-rated health, adverse health status with physical and mental risks in persons as compared to elderly people living over 75 years of age. The findings were likely to be influenced by various psychosocial incidental and accidental changes accompanying early stages of aging (approximately age 65), e.g. declining physiological function, death of near and dears, retirement, loss of professional identity, the independence of one's children, and the loss of previous social status and roles.

Lee and Ryu [6] conducted an interesting cross-cultural research on impact of pride and regret on elderly depression as these two emotions develop later in life and become source of emotional struggle in prospective living. They investigated content and intensity of these two emotions on the Geriatric Depression Scale involving 234 older adults (130 in USA and 104 in South Korea). In findings, though Koreans were high in intensity of regrets, however, a greater amount and variety of regrets were shown also by Americans. For Americans, regrets were related to leisure and addiction, whereas, health and career were associated with Koreans in regrets. It was also found that pride in leisure activities for Americans and altruism for Koreans in the same were linked with alleviating depression. In addition to pride and regret, concurrent stress level of elderly sample contributed a lot in elevating depression.

Treatment of depression in elderly

An adequate and effective treatment of depression in elderly requires more than one approach and line of treatment. Because attitudes and beliefs of clients duly affect approach of treatment is highly affected by National Mental Health Association [62]. For example, more than 68% of older population in USA doesn't know properly about depression above the age of 65 and only 38% accept that this is a health problem. But these people are unwilling to receive treatment from health professionals. Nearly 58% people above 65 years believed that depression is normal with growing age [13]. Within the scope of the article, here prime focus has been given on psychological and behavioural interventions. Currently available techniques of treating depression in elderly are:

- **Antidepressants:** There are several types of antidepressant medicines in mental healthcare it is helpful only up to 50 - 60% for several reasons. One of the major reasons of selective use of psychiatric medicines in depression is their side effects. For example, feeling of sickness or anxiety, sleepiness in initial days of treatment, interference with other medications, lowering of salt level in body and resulted feelings of weakness and unsteadiness, withdrawal symptoms when suddenly stop medicines etc. Therefore, use of antidepressants must be closely monitored.

Psychological and behavioural intervention for depression in elderly

Psychotherapeutic/counselling intervention: These are known as talk treatment wherein the clinicians work as a good listener. Counselling can also be provided by friends, relatives, immediate reliable (to the client) family member. Psychotherapeutically, cognitive-behaviour therapy (CBT) is the most effective professional technique of behavioural and psychological treatment. In addition, supportive therapy and family therapy, bright light therapy etc. could be very much helpful to elderly patients.

Lifestyle modifications: Regular exercise, yoga and meditation, fulfillment of hobbies and interests, sporting activities, healthy eating habits (after every 3 - 4 hours), watchful alcohol intake; increasing social mingling with family, friends and relatives through various ways could be quite useful in alleviating brooding on things and depression in elderly. Mingling with people of choice, family and friends promotes face-to-face connection and productive engagement, minimizes time span of being alone and cooped at home, as well as, quite helpful in cultivating healthy habits and boosting desirable moods. Similarly, volunteering one's own time by helping others to feel better and increasing social connectivity, taking care of a domestic animal/pet for company and physical fitness; learning new skills like foreign language, musical instrument and other creative games; creating and developing humor in life and enjoying opportunities to laugh could be the best ways of beating depression. Spending time for 30 minutes per day in sun light especially in winter/morning sunshine in any season is good for boosting serotonin level in body and improve mood.

Cognitive modifications: The older adults with depression could be supported by developing following modifications in their cognitive style as a 'self-help measure':

- It is sheer myth that older people cannot learn new skills. Rather, since change is the nature of human brain, therefore, new learning and habits could be helpful in monotony and depression.
- It is logical to think that depressed people don't want to do anything but this is also a scientific fact that isolation and lack of social connections can make depression worse.
- They should think that depression is an illness rather than sign of weakness [63,64].
- They must share with someone closest should they feel low in mood and having thoughts of killing self. They shouldn't keep feelings confined to them.
- Be kind to yourself and change your daily living routine if required.
- Always keep in mind that depression doesn't induce dementia.

Methodological Limitations in Researches and Conclusion

Though geriatric depression extensively studied and explored, however, relevant researches have not been found free of some important methodological deficiencies in investigations. Most of the reported researches on depression in older adults have been conducted on the western population which is quite different from the eastern societies in terms of familial and social structures, cultural norms and practices, psychosocial consequences as well as geographical conditions affecting our physical and mental health differentially. Hence, the research findings cannot be generalized beyond a limit of clinical knowledge and understanding without extensive scientific explorations.

In relation to demographic variables affecting depressive status in older people, education and rural habitat have not been studied on large scale in women in the east and west so far. So much so, depression in older adults with various marital statuses has also not been examined extensively, e.g. widowhood, singlehood, unofficial separation, extramarital affairs, multiple marriages in male and female etc. Similarly, older adults staying in different types of families, e. g. nuclear, joint, extended families, refugee and immigrant societies are required to be explored for proper understanding and intervention programmes as well. In relation to personality factors in depression, heterosexuality/homosexuality and cultural differences in personality features are worth to be investigated. The age-group of the clinical population is an important determinant affecting depression. Therefore, nature of depression in various age-groups of late adulthood (e.g. 60s, 70s, 80s and 90s), as well as, older adults with various sensory and physical disability status should be examined. Regarding design of

research, all available studies are single center based and administered rating scales only. Therefore, there is a dire need of multi-centric investigations using diagnostic tools relying on two-stage investigations (i.e. screening and diagnosis of depression in elderly. In same way, all studies have reported prevalence rate of elderly depression only, rather than incidence rate of the same which can be useful in policy-making and rehabilitation. Data on neurobiology of elderly depression, course and outcome, impact of psychological disorders, role of religion and spirituality etc. are seriously lacking [26]. In relation to affective disorders in older adults, depression has only been explored so far in all available researches and spectrum of bipolar affective disorders has not been covered. For behavioural and psychological intervention and rehabilitation, the authors are willing to advise, recommend and earnestly urge the national policy makers and administrators to think, plan, incorporate and promote an adoption of the elderly people as 'parents' for minor orphans and helpless youngsters at large scale in the same way of adopting children by the childless couples. Apparently it may seem to appear as a 'utopian' concept but it does comprise a deep sense of practical implications for welfare of the national and global societies. It would be mutually advantageous for the orphan children and the helpless parents staying and counting their breath in 'old-age homes' or hospices. Alternatively, a family can be developed through conceptualizing idea like 'family for homeless' comprising neglected parents and street or orphan children rather than habilitating or rehabilitating them in 'home for homeless', 'hope for hopeless and hapless' or 'old-age home'. It could be a magnificent source of mutual psycho-social support, quality of life and nurturing healthy personality features in children and thus preparing them as healthy citizens in place of burden on national economy. Of course, the popular saying that Rome was not built in a day, is also applicable here, and somebody, somewhere and at some point of time has to come forward to lead this Herculean campaign for healthy, hopeful and harmonious society.

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