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Characteristic symptoms of elderly depressives on selected measures of depression

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CHARACTERISTIC SYMPTOMS OF ELDERLY DEPRESSIVES ON SELECTED MEASURES OF DEPRESSION

by

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Characteristic Symptoms of Elderly Depressives on Selected Measures of Depression

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GRADUATE COLLEGE
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Sheryl J. Kongstvedt, Ph.D.

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This research investigated depressive symptoms in the elderly in order to improve diagnostic accuracy among these patients. Select self-assessment depression measures were examined for sensitivity and specificity in detecting depression in the elderly. In addition, this research examined whether geriatric depression differs from depression in younger adults, and whether there are subtypes of depression in the elderly, based on age of onset of first depressive episode (early vs. late onset).

Eighty subjects in two age groups (younger-adult aged 20-40 and geriatric aged 60 and older) participated in the study. Depressed subjects were obtained from psychiatric facilities in the Pittsburgh, PA area. Controls were obtained from senior citizens centers and elderly volunteers.

All subjects were given the Schedule for Affective Disorders and Schizophrenia (SADS), a structured diagnostic interview, and received a psychiatric diagnosis based on this interview. They also completed three self-assessment measures. These were the Beck Depression Inventory (BDI), the Geriatric Depression Scale (GDS), and the Symptom Check

List-90-R (SCL-90-R), with specific focus on the somatization subscale.

Results supported the hypothesis that geriatric depressives endorse fewer and milder depressive symptoms than do younger-adult depressives. Results did not support the often discussed phenomena that elderly depressives are more somatic in their presentation of depression. In fact there was a nonsignificant tendency for the younger depressed to endorse more somatic symptoms than the elderly.

Results also supported the hypothesis that late-onset geriatric depression can be distinguished from early-onset geriatric depression, based on self-report depressive symptoms. Late-onset depressives endorsed the fewest and mildest of all the depressive groups. Results did not support the hypothesis that late-onset depressives would endorse more somatic complaints.

Geriatric depressives in general, and late-onset geriatric depressed in particular, fell in the "mildly" depressed range on both depression measures. It is suggested that these measures be used as screening tools in primary care facilities, using lower, rather than more stringent cutoffs.

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CHAPTER 1

Persons over the age of 65 constitute approximately 17% of the population and nearly 1/3 of these 24 million individuals are believed to have psychiatric problems severe enough for professional attention (Fry, 1986; Gerner, 1979). Yet, professional training and understanding of the aged and the aging process continue to lag behind.

Affective disorders are believed to account for nearly 50% of the admissions of older adults to acute psychiatric hospitals in the U.S. (Gurland & Cross, 1982) and a significant proportion of these cases are believed to be first admissions (Fry, 1986). Community surveys have reported depressive symptoms in as many as 27-65% of persons over 60 (Blazer, Hughes & George, 1987; Raymond, Michals & Steer, 1980). Approximately 1-6% of those reporting depressive symptoms were believed to meet the criteria for major depressive disorder, as defined by DSM III.

Age itself may affect both the pattern of depressive symptoms and the elderly's susceptibility to depression (Fry, 1986). Older depressives report feeling "depressed" to a lesser degree than do the younger depressives. They tend to exhibit more physical symptoms and complaints,

express less guilt, are more apathetic, and display more paranoia, suspiciousness, and irritability (Gerner, 1979). Although frequency of depression is generally reported to be higher in women than men in the younger population, this trend may be reversed in persons over 80 (Gurland, Dean, Cross, & Golden, 1980). Depression in the elderly typically does not remit in a spontaneous manner, as is often the case with depressive symptoms in the young, and tends to worsen over time, becoming increasingly resistant to treatment (Hussian, 1981).

Depressive episodes in the elderly may be triggered by social concerns and losses, i.e. decline in health, alteration in cognitive functioning, loss or change in employment, and less mobility and independence. These changes often result in another loss, that of self esteem, with consequent depression becoming severe enough to precipitate suicide (Hussian, 1981; Salzman & Shader, 1978). The number of successful suicide attempts in the elderly greatly outnumbers those for younger adults, and is especially high for elderly white divorced males (Salzman & Shader, 1978). Individuals over 65 account for approximately 25% of all suicides (Goff & Jenike, 1986) and a preoccupation with somatic symptoms has been associated with increased suicide potential in the elderly (DeAlarcon, 1964).

The aging process is often conceptualized as a gradual

downward trend with increasing levels of inadequacy, impairment, and physical and psychological decline. This has led to widespread myths and misconceptions regarding the utility and feasibility of assessing and treating psychiatric problems in the elderly (Fry, 1986).

Although depression is widespread among the elderly, it often goes unrecognized, misdiagnosed, and mistreated. Psychiatric diagnoses are frequently ignored in the clinical assessment of the elderly, with insufficient time spent in differentiating between relatively mild and benign changes of normal aging and the severe disruptions of function (Fry, 1986). Often complaints of increasingly poor health are attributed to "old age" and may therefore be ignored, especially when medical exams turn up negative. The diagnosis of depression in the elderly warrants increased attention and careful consideration.

Purpose

As the life expectancy of the population increases, it can be expected that elderly individuals will utilize an ever larger proportion of health care resources. The accurate assessment of geriatric depression and recognition of subtypes have important implications for all medical and psychiatric practitioners.

The present study will contribute to the understanding of the assessment of geriatric depression, and will provide guidelines based on empirical data for the uses and

limitations of the most commonly administered depression screening tests in practice today. The importance of improving diagnostic accuracy in this population is critical. Failure to recognize early depression in the elderly may lead to prolonged depression, unnecessary medical procedures, and possibly suicide.

The purpose of the present study is to provide additional information about the phenomenon of depression among the elderly as a basis for identification. More specifically, this study will investigate:

(1) whether selected self-report measures of depression, which can be administered and interpreted by minimally trained medical personnel, yield results that agree with results from a longer structured clinical interview requiring trained professionals for administration and interpretation,

(2) whether depression in the elderly can be differentiated from depression in younger adults, based on endorsement of depressive symptoms,

(3) whether examination of responses to self-report instruments will reveal unique aspects of depression in the elderly, and

(4) whether age of onset of first depressive episode can differentiate patterns on the self-report measures.

CHAPTER 2

LITERATURE REVIEW

Theories of Depression

Everyone experiences some degree of sadness, but normal unhappiness is distinguishable from major depression. No single definition of depression could include all the various findings and theoretical frameworks which appear in the literature. However, there does appear to be widespread agreement as to the "classic" symptoms and manifestations of depression.

The following features were abstracted from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-Revised (DSM-III-R) (1987), and from the Research Diagnostic Criteria (RDC) (Spitzer, Endicott, & Robins, 1978), and define an episode of clinical depression for both older and younger persons.

1. Depressive symptoms have been present for two or more weeks and represent a change from earlier functioning. The patient must report feeling either depressed or a loss of interest and pleasure.

2. At least five symptoms from the following must have been present, nearly every day, as indicated by either subjective account or observation by others: depressed mood; diminished interest or pleasure in all or many activities (anhedonia); significant weight loss or gain, when not dieting, including a change in appetite; insomnia

or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness and/or guilt; diminished ability to think or concentrate; and recurrent suicidal ideation, or thoughts of death.

3. No organic factors initiating or maintaining the disturbance were established.

4. The symptoms were not a normal reaction of grief (i.e. loss of a loved one).

5. No delusions or hallucinations were present for 2 weeks or longer, without accompanying mood disturbance.

6. The symptoms were not superimposed on schizophrenia or any other psychotic disorder.

The RDC specifies that the individual also show evidence of functional impairment, or be taking medication or receiving treatment for the depressive symptoms.

The following represents a broad spectrum of theoretical approaches to depressive phenomena.

Cognitive-Behavior Theory of Depression

Cognitive Theory. Theorists such as Aaron Beck (1967) assign primary causal significance to cognitive processes. In this view, depression is often a result of distorted perceptions and faulty cognitive formulations. Beck (1967) views depression as the result of an individual's negative perception of self. Treatment consists of altering these negative/distorted self perceptions with more positive/appropriate ones.

Cognitive theory has given rise to the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). This Inventory is commonly used to screen for depression, with a wide range of individual clients or patients.

Behavioral Theory. For the behavioral theorists, environmental rewards shape both affect and behavior. Depressed feelings are presumed to be the consequence of a low rate of reinforcement, or a loss of potential reinforcers (Lewinsohn, 1986).

Charles Ferster, one of the earliest researchers to apply the behavioral framework to depression, found depressed individuals were passive and uninvolved with their environment (Wetzel, 1984). Depressives experience few daily activities as pleasurable or satisfying.

Behavioral treatment is devoted to increasing the frequency and diversity of positive reinforcers (including social and situational). To help select potential reinforcers, the Pleasant Events Schedule (MacPhillamy & Lewinsohn, 1971) was developed.

Learned Helplessness. Learned helplessness provides a model for understanding reactive depression or depression that is caused by environmental rather than internal events (Miller, Rosellini, & Seligman, 1986). Initially based upon animal research, a learned helplessness framework states that when an organism finds that its responses will not affect outcome (elicit a reinforcer), then the