

## Aspects of depression in old age

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### **Abstract**

*Mental illnesses in old age may occur as a result of changes in family and employment statuses. Changes in family status may include: children leaving the parental home, restricted housing conditions, the abandonment of one's home in order to live with one of the children, conflicted relationships between generations (misunderstandings with their children or grandchildren), conflicted situations between conjugal partners, death of one's partner and the related loneliness, reduction in revenue and sometimes the obligation to accept relocating to a care institution for the elderly people (Gubrium, 1990).*

*Depression in the elderly is manifested through negation and hypochondriac ideas and cenesthopathy sensations: mimicking other illnesses, culpability feelings, excessive lamentations, and the most serious form of manifestation is suicide.*

**Keywords:** *Depression, elderly person, cognitive and behavioral changes, retirement ages*

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## **I. PSYCHOPATHOLOGY ELEMENTS OF ELDERLY PEOPLE**

The aging phenomenon is characterized by numerous changes with an impact on various organs and physical systems of the body on one hand, and on the other hand there are also some events in the life of an elder that can precipitate this process: retirement, different diseases, the departure of the children, loss of old friends, loss of the life partner, etc.

Mental illnesses in old age may occur as a result of changes in family and employment statuses. Changes in family status may include: children leaving the parental home, restricted housing conditions, the abandonment of one's home in order to live with one of the children, conflicted relationships between generations (misunderstandings with their children or grandchildren), conflicted situations between conjugal partners, death of one's partner and the related loneliness, reduction in revenue and sometimes the obligation to accept relocating to a care institution for the elderly people (Gubrium, 1990). Changes in the employment status primarily include retirement from professional life (being harder to bear by men than by women), loss of social position in terms of financial situation or prestige, or change of address - most often for economic reasons (Guillemard, 1985).

The frequency of mental illness increases with age. In the elderly population, mental diseases are situated on the second place, after cardiovascular diseases, reaching 16% of the population over 70 years (World Health Organization, 2001). Mental illnesses in the elderly can be classified into two categories: 1) diseases that have a debut before aging, not being characteristic for old age and 2) diseases that begin in old age with specific issues - this category includes regressive psychosis and late dementia (Copeland, Kelleher, Kellett, Gourlay, Gurland, Fleiss, & Sharpe, 1976).

One of Freud's professors, the well-known neurologist Charcot, stated in the last century that there are not notable differences between normal aging and the pathological process of aging, intermediary states being able to exist between these two (Freud, 1962).

A multidimensional definition of a pathological process, inspired from Birren and Renner (1980), includes six characteristics: "self-esteem degradation, the dysfunctional adaptation of one's representation of reality, diminishing control over the environment (the internalization degree of locus of control decreases while the sense of outsourcing increases), loss of autonomy (that tends to grow with age), the emergence of imbalances in the personality and the decline in the ability to change" (Birren, & Renner, 1980). It is important to assess the psychological state of a person considering his living context and the responses of his entourage. Thus, a depressed mood due to the death of a friend or widowhood - events whose frequency increases with age - is different from a depressive condition unrelated to the identifiable facts of life.

## **II. DEPRESSION IN THE ELDERLY**

Depression is considered the most common mental illness in the elderly. According to some researches (Boland, & Cappeliez, 1997), the percent of population over the age of 65 who shows depressive symptoms reaches 15% and with the global increasing number of elderly population, depression for this age group has become a social problem.

Among the causes of depression are genetic factors (it is considered that the signs of depression might be genetically transmitted) and pathological factors (mainly intoxications). Other factors of developing or maintaining depression would be the awareness of aging process (evidenced by hair loss, loss of dentition, wrinkles, decreased physical and mental capacities) changes in the environment, loss of family members, loss of friends, loss of home), changing social and economic status (increased chronic diseases), concerns about the concept of death (Thomae, 1970; Blazer, Hughes, & George, 1987).

Depressed people manifest specific cognitive and behavioral changes, such as apathy, lack of motivation, sensitivity and responsiveness only to negative facts of their lives (which strengthens their state). Depression occurs most frequently in two clinical pictures: major depressive disorder and manic depressive disorder. According to ICD -10 (1998, p.143-144), in the typical depressive episode (F32) of any type of depression: mild (F32.0), moderate (F32.1) and severe (F32.2 and F32.3), individuals exhibit a depressed mood, loss of interest and pleasure and energy reduction, a combination of symptoms that leads to increased fatigue and decreased activity. Other common symptoms of depression are: accentuated tiredness after a minimum of effort, poor concentration and short attention span, reduced self-esteem and self-confidence, thoughts of guilt and worthlessness, pessimistic view of the future, suicidal thoughts or thoughts of harming oneself, restless sleep and decreased appetite.

Depression in the elderly is manifested through negation and hypochondriac ideas and cenesthopathy sensations: mimicking other illnesses, culpability feelings, excessive lamentations, and the most serious form of manifestation is suicide (Debruyne, & Audenaert, 2012; Livingston, Blizard, & Mann, 1993). The disorder can become major when it lasts more than a few weeks (Lincoln, & Flannaghan, 2003). Women are twice more likely to experience depression than men (Nolen-Hoeksema, 2001). When it comes to the form of manic depression, the person alternates between the "manic" states (during which the person is hyperactive, enthusiastic, making reckless plans or exhibits exaggerated optimism) and depression states, as described in the previous paragraph. In its paroxysmal form, we are talking about a psychotic state of the disorder (manic-depressive psychosis).

Regardless of the form in which depression may occur, in most cases the symptoms last less than three months and are frequently associated with traumatic events of everyday life: accidents, divorce, mourning, widowhood, unemployment or birth (Cole, & Dendukuri, 2003).

### **III. CONCLUSIONS**

The process of assessing the depressive state on an elderly person is made through self-questionnaires or scales for measuring subjective wellbeing (Garrard, Rolnick, Nitz, Luepke, Jackson, Fischer,... & Waller, 1998). One of the determinant factors of subjective wellbeing evidenced by statistical or factorial analysis and frequently cited in the literature are the congruence felt by individuals from between accomplished projects and the ones wished to be accomplished (as the congruency is weaker, the depressive state is stronger). A second factor is vivacity, the enthusiasm, which is very low in the depressive state, and a third frequently reminded factor is the feeling of being socially adapted or, on the contrary, the feeling of rejecting the society of being rejected by it (Cole, & Dendukuri, 2003).

A widespread idea is that the percentage of major depression increases with age, but this statement is unconfirmed by the previous researches. Blazer, Hughes, and George, (1987) in a study reported that only 1% of the people over 60 years suffer from severe depression.

In another investigation (Nolen-Hoeksema, 1988), the results showed that depression, although it is an important phenomenon in the elderly population, it is not at all specific to this age group and does not increase over the age of 60. The increasing number of clinical investigations for depression at elderly people is given by the growing number of elders at a global level (Charney, Reynolds, Lewis, Lebowitz, Sunderland, Alexopoulos,... & Borson, 2003).

The new forms of therapy developed in the past years for treating depression are the cognitive therapies (Steuer, Mintz, Hammen, Hill, Jarvik, McCarley,... & Rosen, 1984). These forms of therapy are based on three assumptions, (Beck et al., 1979; Lynch, Morse, Mendelson, & Robins, 2003) as follows:

- The fact that not events, but the representation that the individuals projects on the events in their lives can lead to physiological difficulties. In other words, psychological disorders are inherent to our way of thinking;

- It is possible to alter one's ways of thinking, which leads to alterations in one's behaviors and emotions;

- The therapist helps the patient to build new and positive representations, acting on his relationships with the people (Dean, Kolody, & Wood, 1990).

There were also developed group cognitive therapy programs for the elderly depressive patients (Cappeliez, 1991), having as final objective a functional activity level for the elderly, identifying negative beliefs and representations, altering them and building a social supportive network. Also the group and the group therapy turned out to be a positive identifier of the cognitive therapy in depression.

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