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Depression of Young and Elderly Patients

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ABSTRACT

Objective: To compare the presentation and outcome of depression between young and elderly patients.

Design: The clinical presentation, treatment and outcome of 47 young patients (21 to 64 years) were compared with 58 elderly (65 years and older) patients admitted to a general hospital psychiatric ward for the treatment of depressive disorders (based on ICD-10).

Subjects: There was no significant difference between the sexes in each age group. The majority of the elderly were either widowed (36%) or married (53%) while 45% of the young were single and 51% married. Seventy per cent of the elderly had retired while 64% of the young were in full-time employment. Most patients lived with their families (87% young and 96% elderly). All but one elderly suffered at least one physical disorder with two-thirds having two or more physical disorders; this contrasts greatly to young patients who were physically healthier ($p<0.001$).

Results: In clinical presentation and symptomatology, the young patients had significantly more suicide ideation ($p<0.003$) and psychomotor retardation ($p<0.001$) but there was no difference in suicidal attempt, delusion, hallucination or agitation. More young patients (36%) had a past psychiatric illness (often depressive disorders) than elderly patients (8%) ($p<0.001$), more elderly patients (88%) were treated with antidepressants than the young patients (62%) ($p<0.002$). At one year follow-up, more elderly patients (46%) recovered compared with the young patients (23%) ($p<0.05$).

Conclusion: There were some differences in the symptomatology of depression between young and elderly patients, but the prognosis was better for elderly patients.

Keywords: depression, young, elderly, outcome

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INTRODUCTION

Depressive disorders are common psychiatric conditions in both out-patients and in-patients as well as among young and elderly patients. In a study of 343 new adult admissions to the psychiatric unit of a general hospital in Singapore, more than a fifth (22.2%) were diagnosed to have Neurotic Depression[1] based on the International Classification of Disease 9th Revision. This excluded another 7.2% with Manic Depressive Psychosis. A retrospective study of 100 consecutive geriatric patients again showed a predominance of depressive disorders (36%)[2]. Similarly, a community study among elderly Chinese in Singapore reported a prevalence of 4.6%[3] which is commoner than dementia (prevalence of 2.6%). Despite their significant prevalence, clinicians in general have a poor knowledge of depression as a disorder, especially among the elderly[4]. This state is made worse when a major cause of suicide is associated with depression. Follow-up studies of adults with depression showed dismal results with only 20% remaining continuously well, while 63% recovered but had subsequent relapses and 17% remained chronically incapacitated or had died by suicide[5,6]. Similarly, a 5-year follow-up of 31 depressed elderly Chinese in the community showed that a third remained depressed, a quarter recovered while the remainder developed an anxiety disorder, dementia, or had died[7].

This retrospective study illustrates the differences in the presentation of depressive disorders among young (21 to 64 years) and elderly adults (65 years and above), as well as the outcome at one year follow-up.

METHODS AND MATERIALS

Consecutive cases of new adult admissions in two different age groups (young - 21 to 65 years old, old - 65 years and above) for the treatment of depressive disorders to the general psychiatric ward in a general hospital were included in this study. Information gathered included diagnosis (based on the International Classification of Diseases 10th Revision[8], sex, living arrangement, symptomatology, marital status, employment, presence of physical disorder (which had active signs or symptoms, or those requiring on-going medical surveillance), predominant area of stress, treatment and outcome at one year follow-up. The criteria for clinical outcome was modelled after E Murphy's[9] and are as follows:

a) Recovered: This group include those with an absence of symptoms or with minor symptoms which were not at all distressing.
b) Relapsed: This was defined as a return of symptoms which fulfilled the ICD-10 criteria following an apparent clinical recovery from the first episode at admission.
c) Continuously ill: These patients retained their

symptoms of depression throughout most part of the study period with only minor fluctuations in severity.

d) Defaulted: These patients were either lost to follow-up and could not be contacted, or else refused to participate in further review for re-assessment.

A year after admission, the patients were reviewed. For those who did not turn up for re-assessment, telephone calls were made to advise their return.

RESULTS

There were 47 young (21 to 64 years) and 58 elderly (65 years and older) patients of whom 44 (42%) were men and 61 (58%) were women. There was no significant difference between the sexes of each age group. The majority of the elderly were either widowed (n=21, 36%) or married (n=31,53%) while 45% (n=21) of the young were unmarried and 51% (n=24) married; 2 elderly and 2 young patients were divorced. Seventy per cent of the elderly had retired while 64% of the young were in full-time employment. Most patients lived with their families (87% among the young and 96% among the elderly). All but one elderly suffered at least one physical disorder with two-thirds having two or more physical disorders; this contrasts greatly to young patients where one in six had co-existing physical disorders ($p<0.001$).

In their clinical presentation and symptomatology, the young patients had significantly more suicide ideation ($p<0.003$) and psychomotor retardation ($p<0.001$) but there was no difference in suicidal attempt, delusion, hallucination or agitation (Table I). Although more elderly (48%) than young (38%) patients experienced family stress, this was not statistically significant. Four out of every 10 young patients had significant work stress (as most were in full-time employment) but working elderly did not complain about work stress. Four times more young patients (n=17, 36%) had a past psychiatric illness (often depressive disorders) than elderly patients (n=5, 8%) ($p<0.001$); more of the latter group (n=50, 88%) were treated with anti-depressants (n=29, 62% for the young patients) ($p<0.002$). Electro-convulsive therapy was administered to 3 young and 5 elderly patients. Although one in five young and one in three elderly patients stayed beyond two weeks, the majority (75%) in both groups were discharged within 2 weeks. At one year follow-up, more elderly patients (n=25, 43%) recovered while more young patients (n=11, 23%) had relapses ($p<0.05$) (Table II).

Table I - Symptomatology of depressive disorders

Symptom	Young n=47	Elderly n=58
Suicidal ideation	27	17 *
Suicidal attempt	14	18
Psychomotor retardation	31	15 **
Agitation	17	17
Delusion	4	4
Hallucination	4	4

* $p<0.003$
** $p<0.001$

Table II - Outcome after one year

Symptom	Young	Elderly
Recovered	15 (31.9%)	25 (43.1%)
Relapsed	11 (23.4%)	7 (12.1%)
Continuously unwell	3 (6.4%)	10 (17.2%)
Defaulted	18 (38.3%)	11 (19.0%)
Death	0	4 (1.7%)
Could not be contacted	0	4 (6.9%)
Total	47 (100%)	58 (100%)

DISCUSSION

In a study of depression in various adult age groups, Gurland[10] found no clear distinction in symptomatology between elderly and younger patients, except for more frequent somatic complaints in the former. In our present study, the young patients seemed to exhibit more severe depression with suicide ideation and psychomotor retardation. It is possible that the younger patients who were mildly depressed and less disturbed could have been managed as out-patients while the mildly to moderately depressed elderly patients could have caused more distress to their care-givers and therefore were referred for admissions. Moreover, most of the young were working (n=30, 64%) compared to the elderly (n=2, 3%), thus admission could have affected their work adversely, especially if more than two weeks of hospitalisation was necessary. In addition, the young were physically healthier, while all but one elderly patient had at least one significant physical disorder and 34 (60%) suffered from at least two. This could have also contributed to greater disability and that necessitated in-patient care. Common physical disorders included visual impairment eg. cataract, musculoskeletal disorders eg. osteoarthritis, diabetes mellitus, hypertension, and chronic obstructive airway diseases. As this was a retrospective study, no rating scale was used to assess the severity of the depressive disorders.

There were 18 (38%) young and 26 (45%) elderly men and 29 (62%) young and 32 (55%) elderly women in the present study. Nineteen (40%) young patients attributed a major cause of their depression to work stress especially among the men, while both groups (38% young and 48% old) had experienced family conflicts as a contributory factor to their mood state. Family conflicts were a commoner reason for seeking help in women and work stress in men. As men retired from their work and spent more time with the family, this could be a double-edged sword in enhancing relationship at home, but there would be more contact opportunities for greater conflicts if they had poor relationships at home even before retirement.

Traditional teaching has often emphasised the relatively good prognosis of mood disorders (especially depressive disorders) compared to schizophrenic ones which often run a chronic course, punctuated in between with frequent relapses. However, depressive disorders in old age are often characterised by frequent and prolonged relapse. An early study by Post[11] reported that after 3 years, only 26% had made a good and sustained recovery, 37% had a recurrence with subsequent recovery, 25% had recurrent attacks in the setting of chronic, mild depression and 12% were continuously ill throughout the follow-up period. Ten years later, Milliard[12], concluded that the rule of thirds applies: no matter what is done, one-third get better, one-third stay the same and one-third get worse. More recent review by Cole[13], using the MacMaster validity criteria with an average follow-up period of 32 months showed that at least 60% of the combined 990 subjects in 10 methodologically adequate studies had remained well or had had relapses with recovery. However, 25% remained continuously ill. Similarly, a 5-year follow-up study of 612 depressed elderly Chinese living in the community in Singapore by Kua[7], reported that 32% were still depressed, 26% had recovered with the most developing anxiety disorders, dementia or categorised as subcases of depression using the GMS-AGECAT package.

It is estimated that more than 60% of older persons with depression are inappropriately or inadequately treated, and once recognised, depression is as treatable in old people as in the young[14]. The present study showed a more favourable response among the old than young patients. Firstly, this could be due to the severity of the depressive disorders mentioned above with the young suffering more severe ones. Almost half (n=25, 43%) of the old patients recovered, a sixth (n=10, 17%) remained continuously unwell, and an eighth (n=7, 12%) had relapses. This contrasts with the young with almost a third (n=15, 32%) recovered, 3 (6%) continuously unwell and 11 (23%) relapsed. Secondly, a history of past psychiatric illnesses was commoner in the young (n=17, 36%) than old (n=5, 9%) ($p<0.001$). This could have contributed adversely to the young patients in coping with the present episode of depression. Thirdly, most elderly reported family conflicts as a major cause of the depression whereas for the young, it was both family and work stress. At a younger age, work is likely to continue to be a persistent source as well as a major one in their lives. Finally, more elderly patients (n=50, 88%) were treated with anti-depressant than the young (n=29, 62%). As this is a retrospective study, it is difficult to postulate why, except that perhaps older patients often expect their clinicians, including psychiatrists, to prescribe them medication after their consultations. Also, the young ones, especially when the depression is a result of psychosocial stress, would prefer non-pharmacological treatment like psychotherapy. Although psychological therapies are definitely efficacious, if the stressors persisted and the patients were unable to continue regular follow-up at frequent intervals, it could lead to persistence of their depressive symptoms as well. As shown on Table II, 18 (38%) of young patients defaulted while only 11 (19%) of the elderly had done so. This is unfortunate, as depressive disorders can impede both personal and social functioning of the sufferers, whether young or old.

REFERENCES

1. Ko SM, Tsoi WF. New admissions to a psychiatric ward in a general hospital. Ann Acad Med Singapore 1991; 20:204-7.
2. Ko SM, Kua EH, Ang A. Chinese psychogeriatric patients in a general hospital. Singapore Med J 1995; 36:647-50.
3. Kua EH. A study of mental disorders in elderly Chinese living in the community in Singapore M.D. Thesis, National University of Singapore, Singapore 1989.
4. Bower J, Jorm AF, Henderson AS. General practitioners' detection of depression and dementia. Med J Australia 1990; 153:192-6.
5. Kiloh LG, Andrews G, Neilson M. The long-term outcome of depressive illness. Br J Psychiatr 1988; 153:752-7.
6. Lee AS, Murray RM. The long-term outcome of Maudsley depressions. Br J Psychiatr 1988; 153:741-51.
7. Kua EH. The depressed elderly Chinese living in the community: a five-year follow-up study. Int J Geriatr Psychiatr 1993; 8:427-30.
8. International Classification of Diseases, 10th ed. Classification of mental and behavioural disorders: clinical description and diagnostic guideline. Geneva: World Health Organisation, 1992.
9. Murphy E. The prognosis of depression in old age. Br J Psychiatr 1983; 142:111-9.
10. Gurland BJ. The comparative frequency of depression in various adult age groups. J Gerontol 1976; 31:283-392.
11. Post F. The management and nature of depressive illnesses in late life: a follow-through study. Br J Psychiatr 1972; 121:393-404.
12. Milliard P. Depression in old age. Br Med J 1983; 267:375-6.
13. Cole MG. The prognosis of depression in the elderly. Can Med Assoc J 1990; 143:633-9.
14. NIH concensus development panel on depression in late life, diagnosis and treatment of depression in late life. JAMA 1992; 40:561-6.