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التوثيق الالكتروني والميكروفيلم

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﴿ قسم ﴾

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها
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15 – 25c and relative humidity 20-40 %

بالرسالة صفحات

لم ترد بالأصـــل

بعض الوثائق الأصلية تالفة

DEPRESSION IN THE ELDERLY

CLINICAL AND PSYCHOSOCIAL STUDY

THESIS

Submitted for the Partial Fulfillment of Master Degree

In

NEURO-PSYCHIATRY

By

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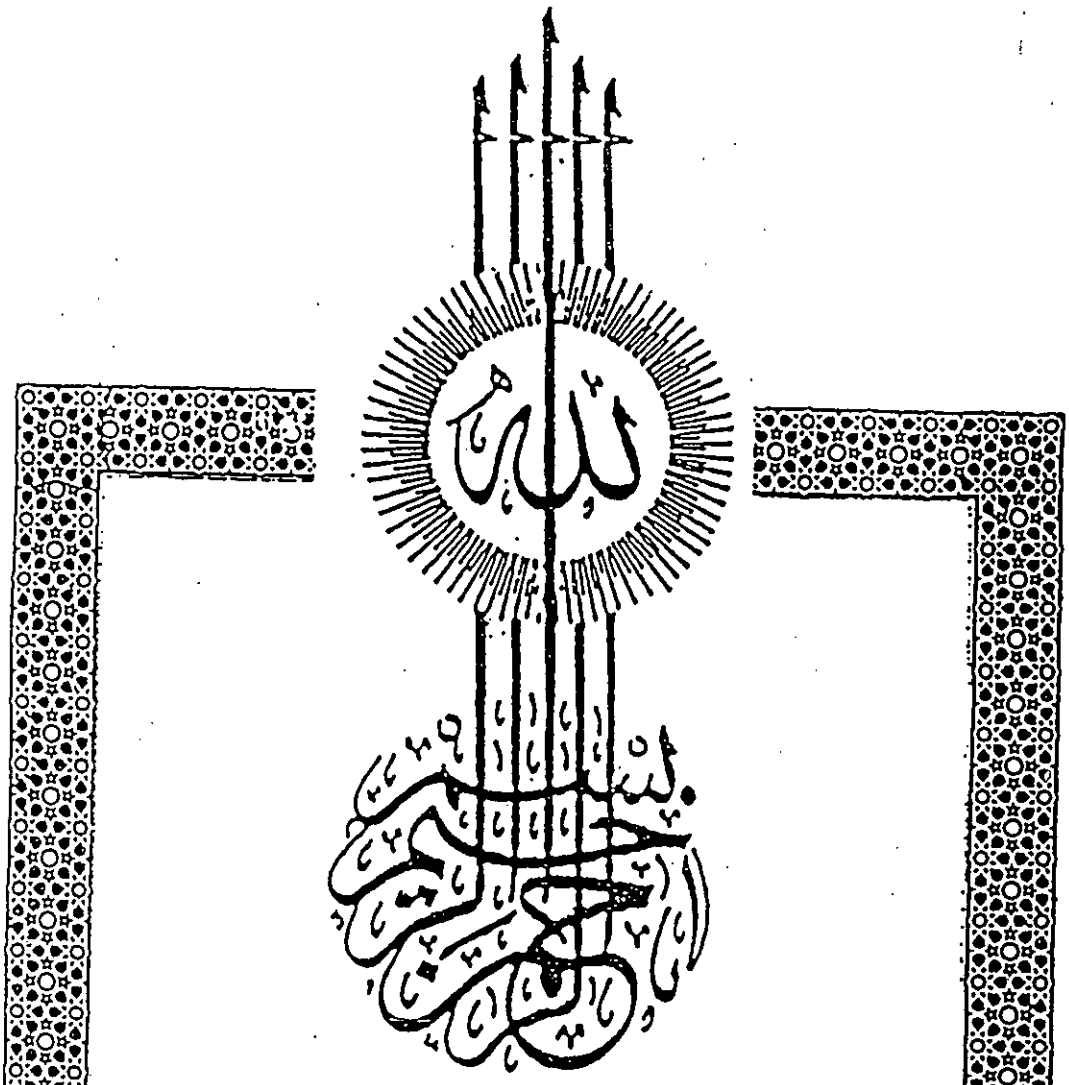

قالوا سبحانك

لا علم لنا إلا ما علمتنا

إنك أنت العليم الحكيم

صدق الله العظيم

(البقرة ٣٢)

To

My Parents

ACKNOWLEDGEMENT

First, I wish to express my deepest gratitude and deepest thanks to **ALLAH** *whose maginificient help is the first factor in everything Ican do in my life.*

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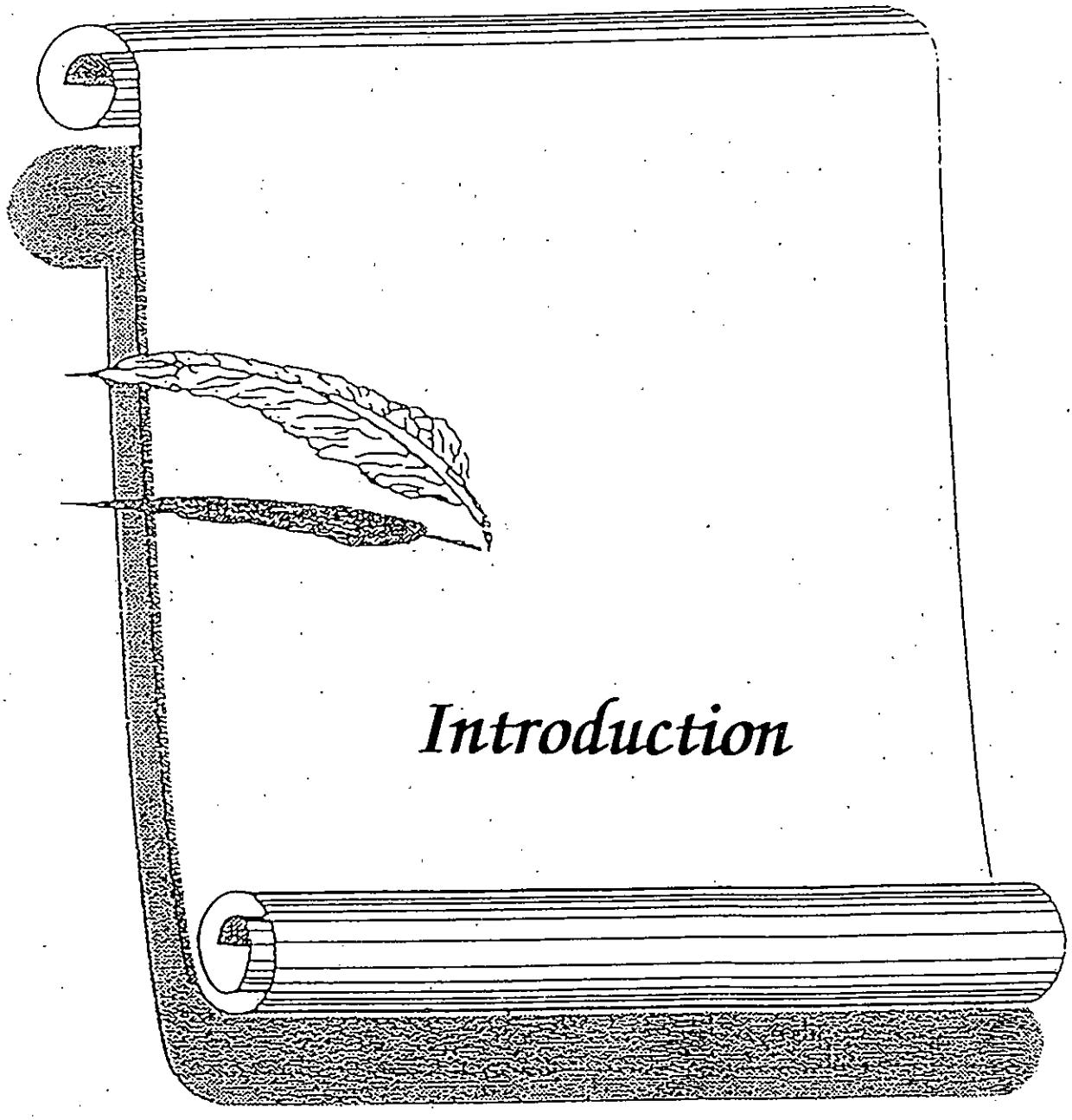
CONTENTS



Introduction

INTRODUCTION

Nowadays people live twice as long as they did at the beginning of this century (Hidayat et al., 1983).

Demographic changes in industrialized countries have produced a steady increase in those aged 65 years and over (Hauser, 1986). They also have led to an interest in the characteristics of that group of population especially their mental health problems which are considered a main cause of disability in old age. Depression was reported by several studies to be the most frequent psychiatric problem and the single commonest symptom found in older people (Rashed et al., 1982, Blazer et al., 1987). Interest in depression stems not only from this prevalence but also from the problems in the treatment and from concern that depressive illness may present as dementia (Dewey et al., 1993). Okasha (1988) attributed the increasing rates of depression all over the world to the following reasons:

1- Life expectancy is increasing.

2- More acute and prolonged psychosocial stresses.

3- Traditional protective mechanisms of families and groups are breaking down.

4- Increased morbidity of medical disorders, associated with depressive symptoms in about 20%.

5- Increased use of variety of medications and alcohol which may predispose to depression.

The age at onset can be defined as the age at which the patient first developed definite major affective symptoms or as the age at first hospitalization (Loranger et al., 1978). Mixed age studies of depression usually consider an onset less than age 30-40 years to be " early"(e.g. Winokur et al., 1979; Price et al., 1987). The data of the study of Weissman et al. (1984) suggested that it may be useful to redefine that early-onset major depression as an onset age of <40 years. Where as most studies of geriatric depression employ age 50-60 years to delineate early-onset from late-onset (e.g. Brown et al., 1984; Meyers et al., 1985).

Cole (1983) found a distinction between early-onset depression, that is the first ever episode occurring before the age of 60 years, and late-onset depression, the first episode occurring after the age of 60 years.

Classic psychiatric teaching have stated that clinical depressions are related to aging in two ways. First the incidence and prevalence of clinical depressive disorders increase with age, and second, the clinical characteristics of depressive disorders vary with age. There are systematic relationships between age and precipitating events, premorbid personality features, and characteristic symptoms, such as appetite changes, sleep disturbance and bodily complaints (Klerman, 1989).

Although figures have varied across different studies, at least 15% of 65 years of age or older probably have some depressive symptoms, while 5% of primary care patients may suffer from a major depressive disorder. Thus, such patients are not uncommon

in the offices of both the primary care physician and the psychiatrist (Jerome, 1996).

In addition to the mental suffering, several studies have shown that depression is a risk factor for subsequent morbidity, excessive health care costs, and in some instances actual mortality. For example, Rovner et al., (1991) reported that major depressive disorder occurred in 12.6% of new admissions to nursing homes. Further more, major depressive disorder was a risk factor for mortality 1 year later. The actual likelihood of death increased by 59% for such patients compared with their non-depressed counterparts in the same kind of setting. Frasure-Smith et al., (1993) reported that survival 6 months after a myocardial infarction differed in patients diagnosed with major depressive disorders compared with those without this comorbid condition and that major depressive disorder is an independent risk factor for mortality at 6 months.

Robinson et al., (1989) conducted a 2-year prospective study of stroke patients and found that the presence or development of depression following stroke interacted with indices of impairment to complicate recovery. Finally, a study of health care utilization among depressed versus non-depressed geriatric medical inpatients found that in the second 6 months of a 1- year follow up, patients with continuing and new episodes of depression spent a greater number of days in the nursing home compared with non-depressed and remitted patients (Rapp et al., 1991).

Although the link between depression and poor medical outcomes are not yet clearly understood, it is never the less important to explain whether treatment of depression improves medical outcomes in geriatric patients. Thus, it is important to diagnose and to treat depression in late life not only because of the mental suffering alleviated but also because of the potential for reducing suffering from medical conditions (Jerome, 1996).

The cognitive impairment that often occur with depression may be so marked in elderly person that he or she may actually seem demented (Anthony, 1996). Untreated or undertreated depression in the elderly enhances the probability of suicide (Fitten et al., 1989). Saltin (1984) stated that although the elderly account for 11% of the population, they account for 25% of the suicide. It was found that 75% of successful suicides have seen a physician within one month of death. It appears that physicians may be sought as potential rescuers. This makes it important that the physician carefully inquire about vague complaints in an elderly patient making an unexpected office visit and consult with a specialist if in doubt over a patient's mood (Fitten et al., 1989, Anthony, 1996). Depression is found to be responsible for the highest suicide rates in the age groups above 55 years rising progressively from 32 per 1000 in the age group between 40-50 to 48 per 1000 in the group above 74 years.

From the above, it is obvious that studying the problem of depression in the elderly is important in psychiatric health care.