Depression in the aged: The importance of external factors

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For many professional workers the term "depression" denotes a psychotic state such as involutional melancholia or manic depressive illness. In the present chapter the term "depression" will be used in a broad sense to refer to the entire range of depressive reactions, most of which fall short of the severe forms of disorder which we refer to as "depressive illness." Since patients with psychotic depressions comprise only a small percentage of cases in which significant depressive feelings occur, it seems reasonable to broaden the use of the term "depression" so as to include the more frequent non-psychotic disturbances. Therefore, if depression is defined as "a painful degree of dejection," one has a more comprehensive definition. One can then think quantitatively, in terms of degrees of depression, as well as qualitatively, in terms of various types of depression.

The existence of a state of depression often goes unrecognized. This is true not only for patients with mild depression but also for patients with severe depressive illness. It is not uncommon for relatives or friends of a severely depressed person who has committed or attempted suicide to remark, "I didn't even know he was depressed." In other words, people as a rule do not exhibit their depressive feelings. Furthermore, they may not only hide these feeling from others; they often hide them from themselves. For the psychiatrist in training, considerable experience is often required before he is able to recognize and to evaluate quantitatively the underlying depressive feelings of his patients. Until he is able to do so, he is apt to deny the existence of these feelings in certain patients. Furthermore, he may become annoyed at those psychiatrists who talk about particular patients as being depressed when he cannot perceive the depressive feelings to which they refer. Similar reactions of annoyance are seen in medical students, social workers, psychologists and other professional workers who collaborate with psychiatrists.

It is well known that the incidence of depressive illness tends to increase with age, and that suicide becomes a progressively more fre-
quent occurrence with advancing age (1). It is less well recognized that the milder forms of depression are also more common in the aged. This lack of recognition is a barrier to understanding old age. One of the main reasons for this lack of recognition is the fact that depression in the aged tends to take a form which is somewhat different from that usually found in younger individuals. The form of depression to which I refer is characterized by a state of "apathy." I do not mean to imply that apathetic features are not present in the depressions of younger individuals. But I do mean to imply that apathy is less characteristic of depressions in earlier years and more characteristic of depressions in the aged. Elderly depressed patients often appear to be disinterested in their surroundings and to lack drive. They are apt to sit idly with a somewhat vacant stare on their faces, appearing pre-occupied. These apathetic states are often not diagnosed as depression and are usually attributed solely to some underlying senile or arteriosclerotic changes. This error in diagnosis may arise not only from lack of recognition of the state of depression itself, but also from the fact that some underlying organic changes are usually present and may contribute to the development of the apathetic features.

A similar error in diagnosis may arise when an elderly depressed patient shows mental confusion. When a patient has some underlying organic brain disease or a reduced cerebral reserve, the development of a state of depression may accentuate the organic manifestations and lead to symptoms such as mental confusion. When this occurs one may incorrectly attribute the patient’s mental state entirely to organic causes and ignore the psychogenic precipitating factors and the state of depression itself. As a consequence, a basic diagnosis of organic brain disease may be made and lead to a degree of therapeutic nihilism. On the other hand, if one does not ignore the depression and is able to take steps to counteract it, the symptoms of mental confusion may diminish or disappear.

In Growing Old, by Cumming and Henry, the phenomenon of "disengagement" on the part of the aged is well documented (2). Disengagement is defined as a "decreased interaction between the aging person and others." These authors also maintain that when disengagement is successful an elderly individual usually lives a reasonably happy life. For example, in referring to the very old, they state: "Given an adequate income, the very old enjoy their disengaged existence. They have reduced their ties to life, have shed their cares and responsibilities, and turn to concern with themselves. They lead static, tranquil, somewhat self-centered lives which suit them very well and appear to provide smooth passage from a long life through an inevitable death." Is it true that such individuals are usually as happy as they appear? I do not believe so, and I would like to suggest that the self-centeredness to which these authors refer is frequently a manifesta-