Depresija u starosti

/ Depression in Old Age

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Učestalost simptoma depresije povećava se sa starošću te pogađa 10-20 % populacije. Depresija često prati tjelesne bolesti, poremećaje sna, bol i druge psihičke poremećaje. Prognoza komorbidnih stanja pogoršava se s komorbiditetom. Prepoznavanje i liječenje depresije relevantno je u do 90 % slučajeva samoubojstava starijih osoba.

Diferencijalna dijagnoza i terapija su složenije te zahtijevaju više strpljenja, kako liječnika tako i pacijenta. Sve metode liječenja su jednako učinkovite kao i kod mlađih odraslih osoba, ali EKT je uspješnija metoda. Postoji velika stopa podcjenjivanja dijagnoze i nedovoljnog liječenja. To se pogotovo odnosi na provođenje psihoterapije. Potrebno je više intervencija u prevenciji iz perspektive zdravstvene ekonomije. Više stigma predstavlja prepreku: starost, psihološki poremećaji, veći broj pacijenata ženskog spola.

***/** An increasing frequency of depressive symptoms with age is found, according to severity 10-20% of the population are affected. Depression frequently occurs with physical disease, sleep disturbances, pain and other mental disorders. The prognosis of comorbid conditions becomes worse with comorbidity. The recognition and treatment of depression is relevant for up to 90% of suicides in the elderly.*

The differential diagnosis and therapy is more complex and needs more patience on both sides, the therapist and the patient. All treatment methods are as efficacious as in younger adults, with ECT being even superior. There is a high rate of underdiagnoses and undertreatment. This applies strongly for the provision of psychotherapy. More interventions into prevention would be beneficial, also from the perspective of health economy. Multiple stigmas are obstacles: age, mental disorders, mostly female patients.

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UVOD

Nakon anksioznih poremećaja, depresija je najčešća psihička bolest u svim životnim razdobljima, uključujući stariju dob. Dugo se pretpostavljalo da se depresivni i drugi afektivni poremećaji smanjuju s godinama (1). Također se pretpostavljalo da depresija postaje učestalija zbog broja problema koji se povezuju sa starijom dobi, a smatralo se i da u starijoj dobi nastupaju jači somatski simptomi. Dijagnostičke kriterije trebalo bi zato posebno definirati za depresiju vezanu za stariju dob, a ona bi trebala uključivati „depresiju bez depresije", tj. bez prevladavajućeg depresivnog raspoloženja ili maskirane depresije.

EPIDEMIOLOGIJA I FAKTORI RIZIKA

No, proučimo li znanstvene dokaze, vidljivo je da su u većini studija stope prevalencije teških depresivnih poremećaja iznosile 2,6 % ili manje. U umirovljeničkim domovima, koje se često ne uključuje u epidemiološka istraživanja, učestalost je značajno veća te varira između 5 i 25 %, s prosjekom od 10 %. Nije bilo značajnih razlika u stopi učestalosti između različitih dobnih skupina. Odgovarajuća istraživanja također nisu pronašla uvjerljive dokaze da su fenomenološke razlike između dobnih skupina relevantne. Premda su stope prevalencije i učestalosti teških depresivnih poremećaja niže u starijoj dobi u usporedbi s mlađim dobnim skupinama, više stope simptoma depresije pronađene su u otprilike 8-16 % slučajeva, dok su simptomi subkliničke depresije pronađeni su 10-50 %, a ustanovljeni su i simptomi drugih tipova depresije, npr. distimije. Moguće je zaključiti kako postoji viša stopa simptoma depresije u starijoj dobi, ali niža stopa teških depresivnih poremećaja (2,3).

Jedno objašnjenje za takvo stanje može biti viša stopa tjelesnih komorbiditeta. S jedne

INTRODUCTION

Depression is - after anxiety disorders - the most common mental illness at all stages of life, including old age. For a long time, it was suspected that depressive and other affective disorders would fade out or chronify with age (1). In addition, depression was expected to become more common given the many problems associated with old age. Last but not least, it was considered that a stronger somatic symptom presentation could occur. For this reason, specific diagnostic criteria were discussed specifically for age-related depression, which should include in particular "depression without depression", i.e. without predominant depressive mood or masked depression.

EPIDEMIOLOGY AND RISK FACTORS

However, if one looks at the scientific evidence, it can be seen that in the majority of the studies prevalence rates of the major depressive disorder were of or less than 2.6%. In nursing homes, which are often not included in epidemiological studies, the frequency is significantly higher and varies between 5 and 25% with a median of 10%. There were no significant differences in incidence rates across age groups. The corresponding studies also did not provide sufficient evidence that the phenomenological differences between the age groups are relevant. Although the prevalence and incidence rates for major depressive disorders are lower in old age compared to younger age groups, comparatively higher rates for depressive symptoms were found in about 8-16% and subclinical depression in 10-50% and also for other types of depression, for example dysthymias. In summary, there is a higher rate of depressive symptoms in old age but a lower rate of major depressive disorders (2,3).

One explanation may be the higher rate of physical comorbidity. On the one hand, this of-

strane, to često vodi do isključenja depresivnih osoba iz epidemioloških istraživanja jer starije osobe u upitnicima navode da su njihove tegobe posljedice tjelesnih uzroka. Moguće je da se teške simptome depresije precjenjuje ili podcjenjuje kod ljudi koji se žale na tjelesne tegobe. Ovo naročito vrijedi u kontekstu depresivnih simptoma slabosti (4).

U starijoj dobi česta je komorbidnost depresije sa somatskim bolestima. Postoje čvrsti dokazi da depresija udvostručuje rizik od kardiovaskularnih bolesti i smrti, a taj se rizik povećava s težinom depresije (npr. 5). Depresija također ima negativan utjecaj na tijek bolesti nakon srčanog ili moždanog udara. Više od 75 % ljudi koji boluju od šećerne bolesti pate od povratnog depresivnog poremećaja. Pokazalo se da i u tom slučaju komorbidna depresija otežava tijek dijabetesa, ali intervencije usmjerene na depresiju mogu ublažiti tijek dijabetesa (6). Depresija također udvostručuje rizik od neurodegenerativnih bolesti, pogotovo Alzheimerove i Parkinsonove bolesti (7,8).

Pretpostavka da normalno starenje može dovesti do depresivnog raspoloženja nije točna. Psihološka su istraživanja pokazala da se zaštitni čimbenici povećavaju s godinama. Subjektivna dobrobit najčešće ima tijek u obliku slova U, pri čemu je najniža točka u srednjim godinama, premda se čini da je napor tada najveći. Ne postoje dokazi da stresori mogu uzrokovati više štete u starijoj dobi nego u mlađoj. Isto vrijedi i obrnuto. Pretpostavka da je gubitak partnera lakše podnijeti u starijoj dobi nije točna. U usporedbi s mlađim odraslim osobama, stariji ljudi imaju jednaku količinu pozitivne afektivnosti, ali manje negativne afektivnosti poput depresije, anksioznosti, sramežljivosti ili čak osjećaja krivnje. Dobra iskustva se također lakše pamte (2,9,10).

Depresija ne utječe jednako na sve ljude. Postoje rizične skupine. Kao i u svim dijelovima života, jače su zahvaćeni ljudi s obiteljskim

ten leads to the exclusion of depressive persons from epidemiological studies because the elderly stated in surveys that physical causes have been found for their complaints. It is possible that severe depressive symptoms are overestimated or underestimated in people with physical complaints. This is particularly true in the context of depressive symptoms of frailty (4).

Especially in old age there is often a comorbidity of depression with somatic diseases. There is very good evidence that depression - increasingly with the severity of depression - doubles the risk of cardiovascular disease and mortality (e.g. 5). Depression also has a negative influence on the course of the disease after a heart attack or stroke. More than 75% of people with diabetes mellitus appear to suffer from a recurrent depressive disorder. Here, too, it was shown that comorbid depression worsened the course of diabetes and interventions aimed at depression can improve the course (6). Depression also doubles the risk of neurodegenerative diseases, especially Alzheimer's dementia and Parkinson's disease (7,8).

The assumption that normal aging could lead to depressive mood is not correct. Rather, psychological studies show that protective factors increase with age. The subjective well-being usually shows a U-shaped course with a low point in middle age, when the biographical strain seems to be the most severe. There is no evidence that stressors cause more damage in old age than in younger years. This applies in both directions. The assumption that a loss of a partner is easier to bear in old age, because one has to reckon with it, is not correct. Compared to younger adults, older people have about the same amount of positive affectivity but less negative affectivity such as depression, anxiety, shyness or even feelings of guilt. Good experiences are also remembered more easily (2, 9, 10).

Depression does not affect all people equally. There are risk groups. As in all stages of life, people with a corresponding family burden or

teretom ili prethodnim periodima bolesti. Također postoje određeni životni događaji u starosti, primjerice gubitak partnera ili nove somatske bolesti. To posebno vrijedi ako su takve tegobe popraćene boli i/ili vode do ovisnosti o drugima. Organske bolesti mozga imaju veću ulogu. Nedostatak ili smanjenje društvenog kruga – usamljenost – povećava rizik od depresije. Kronična oštećenja, a posebno problemi s osjetilima poput vida ili sluha te bol ili kronični problemi sa spavanjem povezuju se s povećanim rizikom (11,12).

Posljednjih se godina raspravlja o fenomenu usamljenosti. Neki tvrde da usamljenost ima negativan utjecaj na tjelesno zdravlje i smrtnost jedino ako se nalazi u kontekstu depresije.

Česti komorbidni anksiozni poremećaji pogoršavaju prognozu u starijoj dobi, a isto vrijedi i za mlađe dobne skupine. Procjenjuje se da je prevalencija anksioznih poremećaja između 3,2 i 14,2 %. Postoje određene fobije i opći anksiozni poremećaji. U starijoj dobi važan je poseban oblik straha od pada. Iz longitudinalne perspektive, u 90 % slučajeva već postoji odgovarajuća simptomatologija do 40. godine. To znači da je prva dijagnoza anksioznog poremećaja rijetka u starijoj dobi. U slučaju prve simptomatologije potrebno je, kao i kod većine psiholoških bolesti, razmisliti o početnom razvoju bolesti mozga, napose demenciji (13).

previous illness episodes are more affected. In addition, there are also life events in old age, e.g. the loss of a partner or new somatic diseases. This is particularly true if they are accompanied by pain and/or lead to dependency. Organic brain diseases play a greater role. A missing or reduced social network - loneliness - increases the risk of depression. In addition, chronic impairments, in particular sensory problems of vision or hearing, pain or chronic sleep disorders, are associated with an increased risk (11, 12).

In recent years, there has been a discussion about the phenomenon of loneliness. Some people argue that loneliness would only have harmful effects on physical health and mortality if loneliness is in the context of depression.

The often comorbid anxiety disorders worsen the prognosis in old age, as they do in younger age groups. The prevalence of anxiety disorders is estimated between 3.2 and 14.2%. There are above all specific phobias and also generalised anxiety disorders. In old age, the special form of fear of falling is important. In the longitudinal view, 90% already show a corresponding symptomatology up to the age of 40. This means that a first diagnosis of an anxiety disorder at an advanced age is rare. In the case of a first symptomatology, one should, incidentally for most mental illnesses, think of an incipient brain disease, in particular dementia (13).

DIJAGNOZA

Iz svega navedenog vidljivo je da se depresija dijagnosticira u starijoj dobi kao i u mlađoj i srednjoj. No, potrebno je više opreza kada postoje popratna tjelesna stanja, a moguće ju je liječiti raznim lijekovima koji utječu na raspoloženje. Neke su diferencijalne dijagnoze posebno važne.

Kada je riječ o njezi, potrebno je obratiti pozornost na depresiju, napose kada dođe do

DIAGNOSIS

From the above it can be seen that depression is diagnosed in old age as in younger and middle life stages. However, greater care must be taken when physical conditions are present at the same time and may be treated with a variety of drugs that can affect mood. Some differential diagnoses are particularly important.

In care, it is crucial to think about depression at all, for example when an unclear weight loss

nerazjašnjenog gubitka na težini. Diferencijalna dijagnoza demencije postaje sve lakša jer se demenciju može sve bolje dijagnosticirati koristeći biološke metode. Kada je riječ o kliničkoj slici, postoji preklapanje simptoma. Povlačenje iz društva, psihomotorno usporavanje i smanjenje interesa simptomi su obje bolesti. No, u depresiji su rijetki vizualno-konstruktivni deficiti i semantički poremećaji, koji su pak česti u ranom stadiju Alzheimerove bolesti. Teška oštećenja samopouzdanja, osjećaji krivnje te čak i snažne suicidalne tendencije prije ukazuju na depresiju nego na demenciju.

Važna je diferencijalna dijagnoza tuge. Tugovanje nije bolest, ali proces tugovanja može biti nedovršen zbog depresije ili kompliciranе krivnje. Prilikom postavljanja diferencijalne dijagnoze važno je prepoznati i poticati proces tugovanja. Postoje različiti modeli stadija. Tuga uvijek ima dva lica u smislu da je, s jedne strane, vezana za prorađivanje gubitka, dok s druge strane ima vezu s okretanjem prema budućnosti i zacjeljivanju rana. Tijekom procesa tugovanja ne nailazimo često na osjećaje krivnje, beznadnosti ili oštećenja emocionalnog odjeka. No, diferencijalna dijagnoza ipak može biti teška (14).

Korištenje instrumenata za pregled može biti korisno u otkrivanju depresije. Postoje različite ljestvice, a napose Ljestvica gerijatrijske depresije (GDS; prema engl. *Geriatric Depression Scale*) i Ljestvica bolničke anksioznosti i depresije (HADS; prema engl. *Hospital Anxiety and Depression Scale*).

SPRJEČAVANJE SAMOUBOJSTVA

Sprječavanje samoubojstva od posebne je važnosti u starijoj dobi. Depresija i samoubojstvo jače su povezani u starijoj dobi nego u drugim dobnim skupinama. Istovremeno je stopa samoubojstva u starijoj dobi najve-

occurs. Differential diagnosis of dementia is becoming increasingly easier because dementia can be diagnosed better and better - also using biological methods. Looking at the clinical presentation, there is an overlap of symptoms. In particular, social retreat, psychomotor slowing or declining interest can be found in both diseases. In depression, however, there are rarely visuoconstructive deficits and semantic disorders, which often occur early in Alzheimer's dementia. Severe impairment of self-esteem, feelings of guilt and even strong suicidal tendencies should make one think of depression rather than dementia.

An important differential diagnosis is that of grief. Mourning is not a disease, but the mourning process may not be completed because of depression or complicated grief. In differential diagnosis, it is important to recognise and promote the process character of mourning. Various stage models are discussed. Grief is always Janus-faced in the sense that on the one hand it is about processing the loss, on the other hand it is about orientation towards the future and healing. In the grieving process one typically finds few feelings of guilt, little hopelessness and few impairments of the emotional resonance. Nevertheless, the differential diagnosis can be difficult (14).

The use of screening instruments can be useful in the detection of depression. Various scales are discussed, especially the Geriatric Depression Scale (GDS) and the Hospital Anxiety and Depression Scale (HADS).

SUICIDE PREVENTION

The prevention of suicide is particularly important in old age. Even more than in other age groups, depression and suicide are linked in old age. At the same time, the rate of suicide in old age is highest in almost all countries of the world, especially among men. It is therefore

ća u gotovo svim zemljama svijeta, a napose među muškarcima. Stoga je važno istražiti i liječiti ljude s depresijom zbog potencijalnih sklonosti samoubojstvu. U isto je vrijeme potrebno proučiti imaju li starije osobe koje žele umrijeti depresiju koja zahtijeva liječenje. Naročito je važno započeti razgovor o želji za samoubojstvom, a ne ga izbjegavati. To uključuje i odluku o tome je li još uvijek moguće liječenje u dnevnoj bolnici ili je potrebna hospitalizacija.

LIJEČENJE

Prilikom liječenja, uvijek je važno provjeriti ne samo deficite nego i dostupne izvore. Pregled aktivnosti svakodnevnog života i društvenog okruženja te, ako je potrebno, razgovor s obitelji ili kućni posjet mogu pritom biti od koristi. Općenito govoreći, liječenje depresije u starijoj dobi nema temeljnih razlika u odnosu na liječenje depresije u srednjoj i mlađoj dobi. U odgovarajućim studijama nisu otkrivene značajne razlike prema dobi, napose kada je riječ o farmakoterapiji. No, u kontekstu polifarmacije i somatskih bolesti, farmakoterapiju je potrebno pažljivije nadzirati. Liječenje je potrebno provoditi u okviru cjelovitog plana liječenja. Pritom je od posebne važnosti da liječnici uključeni u liječenje budu suglasni. Stariji ljudi često u svom okruženju imaju nekoliko stručnjaka od kojih traže podršku. To su najčešće obiteljski liječnik, ljekarnik i drugi njegovatelji. Valja naglasiti da se u farmakoterapiji ne smiju koristiti preparati s dugim vremenom poluraspada i antikolinergičkim djelovanjem. U starijoj dobi litij treba koristiti na jednak način, uz pažljiv nadzor bubrežnih vrijednosti i funkcije štitnjače.

Nažalost, psihoterapija, koja je od velike važnosti u liječenju, često nema uspjeha zbog manja terapeuta i/ili manjka mogućnosti za provođenje terapije u pojedinim okruženjima, primjerice staračkim domovima. Ishodi

important to investigate and treat people with depression for potential suicidal tendencies. At the same time, people who wish to die at an advanced age should be examined for the presence of depression requiring treatment. It is particularly important to begin a conversation about the desire to commit suicide and not to avoid it. This also includes the decision as to whether outpatient treatment is still possible or whether inpatient treatment should already be sought.

TREATMENT

In the treatment, it is always relevant to check not only the deficits but also the available resources. The survey of activities in daily life, the social environment and, if necessary, a family discussion or a home visit can be helpful here. Overall, the treatment of depression in old age is not fundamentally different from that in middle and younger stages of life. Particularly in pharmacotherapy, no relevant difference by age was found in the corresponding studies. Nevertheless, in the context of polypharmacy and somatic diseases, pharmacotherapy should be controlled more carefully. Treatment should be embedded in an overall treatment plan. Here it seems important that a consensus of the therapists involved is reached. Older people usually have several professionals in their environment who ask them for support. This is usually the family doctor, often a pharmacist and other caregivers. In pharmacotherapy, it should be noted that preparations with a long half-life and anticholinergic efficacy are not used. Lithium should be used in the same way in old age with careful control of kidney values and thyroid function.

Unfortunately, the use of psychotherapy, which is of great importance in treatment, often fails because there are too few therapists and/or no possibilities are seen in individual settings, for example in nursing homes. The results of the

psihoterapije su komparativno zadovoljavajući (15). Ispostavlja se da je potrebno nešto manje napora kako bi se postigao jednak psihoterapeutski učinak u usporedbi s mlađim ljudima. Stariji su ljudi često više motivirani i spremniji na suradnju u psihoterapiji, što dijelom pojašnjava taj fenomen. U psihoterapiji postoje posebni oblici terapije za starije ljude. To se odnosi, primjerice, na interpersonalnu terapiju, a vrijedi i za terapiju koja uključuje reviziju života, a koja je posebno uspješna u starijoj dobi.

Novija istraživanja pokazuju da je stimulacijska terapija učinkovitija u starijoj dobi nego u mlađoj. To je jasno vidljivo na primjeru elektrošok terapije. Što se tiče ostalih stimulacijskih pristupa, istraživanja su još u tijeku. U svakom slučaju, time se otvara nove mogućnosti, posebno s obzirom na zanemarive nuspojave (16).

Određene skupine zahtijevaju poseban pristup, primjerice depresija s usporednom demencijom ili Parkinsonovom bolešću. U tim je slučajevima potrebno uključiti stručnjake iz gerijatrijske psihijatrije.

Kao i kod drugih dobnih skupina, uporaba algoritama u terapiji pokazala se uspješnom, a to uključuje i nužnu prilagodbu doziranja i odabir drugačijih lijekova. U svojoj se praksi neprestano susrećem s pretjerano opreznim doziranjem ili nastavkom korištenja određenog lijeka unatoč izostanku učinka.

PROGNOZA

Čini se da je prognoza za depresiju u starijoj dobi gora nego u srednjoj. No, tomu nije tako zbog starosti već zbog čimbenika koji su značajni i u drugim životnim razdobljima. Oni uključuju težinu depresije, broj prethodnih depresivnih epizoda, komordbidnost s kroničnim tjelesnim bolestima te vanjski izvor kontrole (17).

psychotherapy are comparatively pleasing (15). It turns out that slightly less effort is needed to achieve the same psychotherapeutic effect compared to younger people. Older people are usually more motivated and cooperative in psychotherapy, which can partly explain this. In psychotherapies, there are special forms for older people. This applies, for example, to interpersonal therapy. This also applies to the life review therapies, which are particularly successful in old age.

Recent studies show that stimulation therapies are more effective in old age than in younger phases of life. This has been nicely demonstrated for electroconvulsive therapy. For other stimulation procedures, corresponding studies are still pending. In any case, this opens up some good prospects for the future, especially if one looks at the very low side effects (16).

Certain special groups need special therapy considerations, for example depression with simultaneous dementia or Parkinson's disease. Here we refer to the inclusion of special expertise in geriatric psychiatry.

As in other age groups, the use of algorithms in therapy has proven successful. This also includes the necessity of dose adjustment and drug change. In my practice I see again and again that either too carefully is dosed or medicines are not stopped despite missing effectiveness.

PROGNOSIS

The prognosis of depression in old age seems to be worse than in middle age. However, this is not due to age but to factors that are also significant in other stages of life. These are in particular the severity of depression, the number of previous episodes, co-morbidity with chronic physical diseases and an external locus of control (17).

Unfortunately, various obstacles are effective in the treatment of depression in old age. This

Nažalost, različite prepreke otežavaju liječenje depresije u starijoj dobi. One ne uključuju samo starost, već i stigmatizaciju koju se često povezuje s psihičkim bolestima. Psihički bolesne žene često nailaze na trostruku stigmu.

PREVENCIJA

I na kraju, nekoliko riječi o prevenciji. Prevencija je doista moguća. Čini se kako tzv. primarna prevencija ima nisku učinkovitost, no prevencija je učinkovitija kod rizičnih skupina. Različitim pristupima vjerojatnost je umanjena i za 50 %! (18)

is not only the age, but also the stigmatization that is generally associated with mental illness. Mentally ill old women often experience a threefold stigma.

PREVENTION

Finally, a few words should be said about prevention. One could show that the prevention of depression is well possible. Here the so-called primary prevention seems rather little effective, but the prevention is all the more effective with risk groups. With different procedures, a reduction of the probability of occurrence of 50% was achieved! (18).

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