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Prevalence and correlates of depressive symptoms in a catchment-area based cohort of older community-living schizophrenia patients

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ABSTRACT

Background: Depressive symptoms frequently accompany schizophrenia. Older patients constitute the fastest growing segment of the schizophrenia population. With regard to the risk factors associated with depression, it is uncertain to which extent older schizophrenia patients differ from their age peers in the community.

Methods: We assessed self-reported depressive symptoms in an epidemiological sample of older Dutch community-living patients with schizophrenia or schizoaffective disorder ($N = 99$; mean age 67 years). Demographic, clinical and social variables were evaluated for their predictive value on the level of depressive symptoms. A comparison group, proportionally matched for age and gender, was recruited from a community study.

Results: In the schizophrenia group, 47.5% reported depressive symptoms at a level indicating clinically relevant depression, in contrast to 12.1% in their age peers (odds ratio 6.55; 95% CI, 3.19–13.48; $p < 0.001$). This difference could not be explained by differential exposure to the evaluated general risk factors. In both groups, functional limitations were the strongest predictor of depressive symptoms. In the patient group, chronic physical disorders and lack of a confidant were predictors, while a diagnosis of schizoaffective disorder (vs. schizophrenia) was the only disorder-related risk factor that contributed to depressive symptoms, with marginal significance.

Conclusion: The high rate of depressive symptoms in this epidemiological sample of older schizophrenia patients confirms that these symptoms frequently accompany this severe mental illness in late life. With physical and social factors as important predictors of depressive symptoms, risk factors for depression are more comparable between older schizophrenia patients and their age peers than is often assumed.

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1. Introduction

Depressive symptoms are associated with various negative consequences, including reduced quality of life (Spitzer et al., 1995), and worse physical and social functioning (Wells et al., 1989). From a lifespan perspective, the prevalence of major depressive disorder decreases with age (Kessler et al., 2010). In contrast, depressive symptoms, after a midlife decline, increase again in later life (Sutin et al., 2013). This increase is due to age-related risk factors and not to aging itself (Beekman et al., 2011). Late life depression is associated with a range of biological (e.g., chronic diseases, functional disability), psychological (e.g., personality traits, coping strategies) and social (e.g., smaller network size, stressful life events) risk factors (Vink et al., 2008).

In older individuals with schizophrenia, depressive symptoms are more frequent and more severe than in non-schizophrenic elderly

(Zisook et al., 1999), adding a heavy burden to the challenges of living with this serious illness. The rapid increase in the number of older schizophrenia patients (Cohen et al., 2008) underlines the relevance of studying depressive symptoms and their correlates in this vulnerable population. The limited research that has been conducted in this area, largely stems from two North American sites studying convenience samples. Jin et al. (2001), reporting on outpatients with schizophrenia ($N = 202$; mean age 57 years; San Diego, USA), demonstrated that more severe depressive symptoms correlated negatively with several aspects of everyday functioning. In the study by Diwan et al. (2007) of early onset schizophrenia and schizoaffective outpatients in New York City ($N = 198$; mean age 62 years), more positive psychotic symptoms, more physical disorders and a smaller proportion of confidants in their social network, figured among the variables that were associated with a higher level of depressive symptoms. However, risk factors for depression in schizophrenia patients were not compared to those in their age peers.

In the present study, we evaluated self-reported depressive symptoms (SRD) in an epidemiological representative sample of

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Dutch older community-living patients with schizophrenia and schizoaffective disorder. We examined a number of general as well as disorder-related risk factors, identified in the literature for their association with depressive symptoms. In addition, we contrasted the prevalence of SRD and its prediction by general risk factors to a comparison group of community-living elderly, seeking to clarify in which aspects older schizophrenia patients either resemble or differ from their age peers. We hypothesized that (1) the prevalence of SRD in the patients would be higher than in the comparisons, (2) the general risk factors associated with SRD among the patients would at least partly resemble those of the comparisons, and (3) in the patients, disorder-related risk factors would increase the explained variance in SRD severity, over and above the contribution of the general risk factors.

2. Methods

2.1. Participants

Data were derived from an observational, cross-sectional study of an epidemiological sample of older patients with schizophrenia and schizoaffective disorder (DSM-IV-TR; American Psychiatric Association, 2000). Details of the study methods are provided elsewhere (Meesters et al., 2011). Briefly, between March 2006 and September 2008 we recruited 177 patients aged 60 years and over, within the psychiatric catchment area of the southern district of Amsterdam. As the present study focused on community-living patients, patients who were hospitalized at the time of the study ($N = 14$) were excluded. Of the remaining 163 patients, a total of 99 (60.7%) were able and willing to participate (Fig. 1). Basic demographic and clinical characteristics did not differ between participating and non-participating patients, except for female gender ($\chi^2(1) = 4.67$; $p = 0.03$) and compulsory admissions ($\chi^2(1) = 7.13$; $p = 0.008$), that were more frequent among non-participants. In participating patients, diagnosis was confirmed through the Mini-International Neuropsychiatric Interview Plus (MINI-Plus; Sheehan et al., 1998).

A comparison group was recruited from the community-based Longitudinal Aging Study Amsterdam (LASA). LASA studies the determinants, trajectories and consequences of physical, cognitive, emotional and social functioning in relation to aging in a nationally representative random sample of Dutch adults, aged between 55 and 85 years at baseline (Deeg et al., 2003). Details of the sampling and data collection have been described elsewhere (Huisman et al., 2011). For the present study,

we used data of the 282 LASA-participants with a home address in Amsterdam who were interviewed during the 2008/2009 wave. From this sample, 99 individuals were proportionally matched for age and gender.

All respondents provided written informed consent. The study was approved by the Medical Ethical Committee of the VU University Medical Center, Amsterdam, The Netherlands.

2.2. Instruments

SRD was measured using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), a widely used self-report scale that evaluates the presence and duration of depressive symptoms during the previous week. The CES-D was administered orally by the interviewer. Each answer is rated on a 4-point scale ranging from 0 ('rarely or never') to 3 ('mostly or always'). Summation of the 20 items results in scores ranging from 0 to 60. In the general population, CES-D scores ≥ 16 are considered indicative of clinically relevant depression. The CES-D has good psychometric properties in older samples (Hertzog et al., 1990), also in its Dutch version (Beekman et al., 1997). The overlap with symptoms of physical illness has been shown to be minimal (Berkman et al., 1986). In addition, in the patient group the actual presence of a DSM-IV-TR mood disorder diagnosis was evaluated with the MINI-Plus.

We documented independent variables in three domains (demographic, clinical, social). Demographic data were derived from medical records and confirmed in the face-to-face interviews. Age at onset was defined as the earliest age at which in retrospect DSM-IV-TR criteria for the disorder were fulfilled (Meesters et al., 2012). Severity of psychotic and related symptoms was assessed by the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987). The positive and the negative PANSS subscales both comprise 7 items (scoring range 7 to 49). Symptomatic remission status was defined by a score ≤ 3 on eight specific PANSS items (severity criterion of the Remission in Schizophrenia Working Group; Andreasen et al., 2005), with remitted participants in addition having had no psychiatric hospitalization in the previous six months (modified time criterion). Intensity of psychiatric services was measured by the number of face-to-face contacts of patients with mental health staff during the last year, classified as low (less than one contact per month), high (one or more contacts per week), or intermediate.

Global cognitive status was assessed through the Mini Mental State Examination (MMSE; Folstein et al., 1975). Participants were asked if they were taking medication and/or seeing a doctor for seven chronic

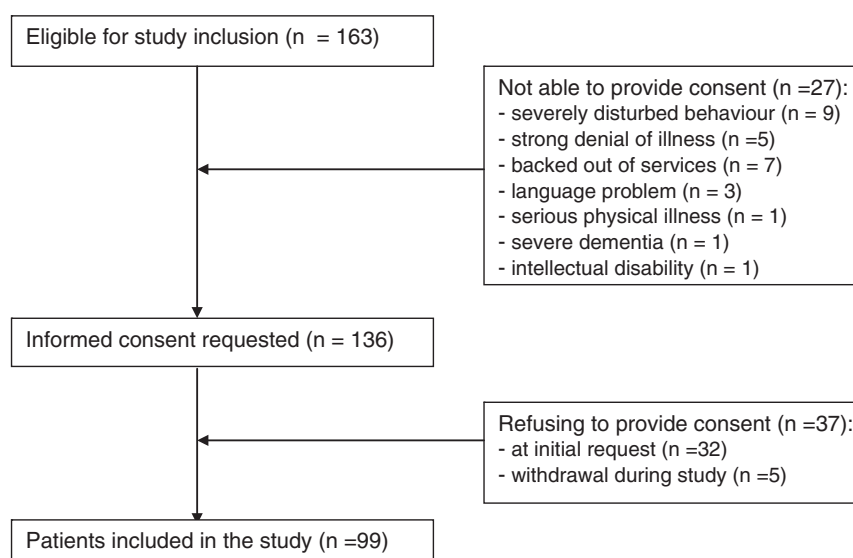


Fig. 1. Flow diagram of the study.

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