บทคัดย่อภาษาอังกฤษ

Background: There is a lack of data regarding prevalence of, clinical characteristics, and clinical manifestations of depressive disorders, anxiety disorders, and suicidal risk in elderly Thais who access health care treatment. Moreover, little is known about outcome of treatment, course and prognosis, and associated factors related to the occurrence and the course of the diseases i.e. perceived stress, attachment, personality, perceived social support, and quality of life.

Objectives: This study aimed to investigate fundamental data regarding the characteristics, features of depressive disorders, anxiety disorders, and suicidality, as well as factors associated with them and the the impact of the factors, such as interpersonal relationships, attachment, personality, social support and quality of life on these disorders.

Method: The study was conducted between October 2012 and March 2015. It was a prospective, multi-centered, 12-month follow-up study among the elderly Thais, those aged 60 years and older. Participants complaining of at least one symptom among the following: sadness, loss of interest, disturbed sleep disturbance, poor appetite, memory problems, lack of energy, and unexplained medical symptoms, were enrolled. At baseline, the participants were interviewed to assess whether they had depressive disorders, anxiety disorders, and suicidality using MINI (excluding Module B for dysthymia) and SCID-I (for dysthymia). An extensive set of scales is being used i.e. 15-item Geriatric Rating Scales (TGDS-15), 7-item Hamilton Rating Scale for Depression (HAMD-7), Mini-Mental State Examination (MMSE Thai 2002), Montreal Cognitive Assessment (MoCA), EQ5D quality of life, Neuroticism Inventory (NI), Core Symptom Index (CSI), (18-item Experience in Close Relationship scale (ECR-R-18), 10-item Perceived Stress Scale (T-PSS-10), and Multidimensional Scale for Perceived Social Support (MSPSS).

Participants who met criteria for depressive disorders were followed-up at 1, 2, 3, 6, 9 and 12 month intervals. At remission and at 12 months, all the tests performed at baseline were repeated. Caregivers were recruited to provide information on burden (MCBI), and attachment (ECR-R-18), at both the baseline and at remission.

Results: In total, 803 elderly people (70% female) were recruited. Mean age was 69.2 years old. Depressive disorders and anxiety disorders were found to be 23.7 and 6.4, respectively. Cognitive impairment and sleep disturbance were the two most common chief complaints while the unexplained somatic symptoms were the least. Even though all complaints were associated with HAMD at baseline, only the chief complaint of boring became the predictor of the HAMD score in longitudinal analysis.

Perceived stress was a predictor of depressive disorder and anxiety disorder as well as suicidal risk. Neuroticism was associated with more depressive disorders and mixed disorders than anxiety disorders. Percieved social support especially from family and friends is associated with both depressive and anxiety disorders. On the other hand, attachment or relationship between the participants and their caregivers were not associated with neither depressive nor anxiety disorders ($p > .05$). However, the caregivers' burden was different in anxiety disorder group but not in depressed group. With regard to quality of life, depressed and anxiety disorder groups reported significantly lower scores than those of non-depressed and anxiety disorders group ($p < .001$). TGDS-15 demonstrated to be a good screening tool for depressive disorders. CSI was also a good screening for participants with either depression or anxiety.

In following-up period, 60 percent of 91 participants diagnosed with any depressive disorders reached remission. Thirty-two percent achieved remission within the first 3 months. Years of education, sleep problems, somatization (somatic symptoms), complaint of bored (instead of sadness), perceived stress, perceived social support, neuroticism, and TGDS-15 all predicted the remission or HAMD score while age and gender did not. These results were mainly consistent with the previous studies with regard to late-life depression. The predicting psychological factors, i.e. perceived stress, perceived social support, and personality trait of neuroticism, had dominant roles in predicting depression more from the self-reporting scale than from clinician-rated measurement. In addition, self-reporting scale of depression was found to be consistent with clinician-rated scale; however, perceived stress came into play

with the agreement (or disagreement) between them. This implied that the patients with less feeling of stress may report fewer symptoms than did the clinicians. Surpringly, attachment style and feeling of burden of the relatives had no impact on recovery from depression.

Perceived stress was the potent predictor of depressive disorder and anxiety disorder as well as suicidal risk at baseline and later time. Neuroticism was associated more with depressive disorders and mixed disorders than with anxiety disorders. In following-up period, neuroticism still had impact on the course of depression, more than with anxiety. Percieved social support especially from family and friends was associated with both depressive and anxiety disorders. In longitudinal study, perceived social support seemed not to have any effect on depression except when it was moderated with neuroticism. On the other hand, attachment or relationship between the participants and their caregivers and the caregivers' burden were not associated with neither depressive nor anxiety disorders both at baseline and follow-up.

The number of patients with anxiety disorders decreased considerably when time passed by. Both anxiety and depression were both related to somatic symptoms which were commonly present in elderly. Anxiety disorders or anxiety symptoms were found to be the independent predictor of the presence of depressive disorder; on the other hand, depression was not a predictor of having anxiety. Also, suicidality score was decreased over time. Depression was the only predictive factor of it. In terms of quality of life, as expected, patients' quality of life improved over the course of treatment. However, the EQ5D utility score tended to bounce back to the baseline at the end of treatment. This cubic trend may be contributed to the fact that the participants endorsed poor quality of life in the the domains of self-care and mobility in later time, making the overall utility score dropped down, contrasting what was found in visual analog scale.

Recommendations: The DAS project sample provides the opportunity to recognize the magnitude of problems with regard to depressive disorders, anxiety disorders, and suicidality among elderly who seek treatment for their suffering at tertiatry care hospitals. The chief complaint and presenting symptoms of late-life depressions are unique, therefore, the valid and sensitive screening tools should be provided. On the other hand, EQ5D index value

should be reevaluated if it is to be used with elderly. The overall results of this study could lead to clinical applications, for example, depressed elderly with sleep problems, somatic symptoms or somatization, and perceived high stress should be paid attention to as they are at risk of developing depression and of being a nonresponder. In addition, some psychosocial factors such as neuroticism, high level of stress, and low level of social support should be screened for in community in order that those who are at risk of developing depression may be identified, and appropriate intervention may be subsequently utilized for them for prevention of depression.

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