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DEPRESSION IN THE GERIATRIC AGE GROUP AND IT'S HOMOEOPATHIC MANAGEMENT

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ABSTRACT-

Depression in older adults is an important public-health concern that can affect mood, sleep, appetite, memory, physical functioning, social relationships and quality of life. It should not be considered a normal part of ageing. Older people at increased risk because of bereavement, loneliness, reduced income, chronic illness, disability, pain, medication effects and limited social support. In India, reported prevalence varies considerably according to the population studied and the screening or diagnostic tool used. Early recognition is important because depression overlooked when symptoms are attributed to physical illness or old age. Assessment should include clinical history, mental-state examination, evaluation of suicide risk, and consideration of medical or medication-related causes. Evidence-based care include psychological interventions, social support, treatment of contributing conditions and antidepressant medication when indicated.

KEYWORDS: Geriatric depression, older adults, elderly, prevalence, mental health, India, quality of life

INTRODUCTION

Depression is a mental health condition marked by persistent low mood or loss of interest or pleasure, usually accompanied by changes in sleep, appetite, energy, concentration, self-worth or daily functioning. In older adults, the presentation include reduced motivation, unexplained physical complaints, irritability, withdrawal from family and social activities, or difficulty managing everyday tasks. Depression is not an inevitable consequence of ageing, and it should be distinguished from short-lived sadness, grief, delirium and dementia. Older adults also experience depression alongside chronic physical illness, which can make recognition and treatment more complex. Early identification and suitable care can improve functioning, wellbeing and quality of life [1,2].

PREVALENCE

Estimates of depression among older adults in India differ across studies because of differences in geography, sampling methods, age groups and assessment tools. A systematic review and meta-analysis of 51 studies from 16 Indian states, covering studies published between 1997 and 2016, estimated a pooled prevalence of 34.4% (95% CI: 29.3–39.7%); the authors cautioned that methodological variation affected the estimate [3]. A 2024 analysis using data from the Longitudinal Ageing Study in India reported depression in 20.1% of older adults, while another government report using probable major depression criteria showed prevalence increasing with age and reaching 9.4% among people aged 75 years and above [4,5]. These estimates measure different outcomes and should not be treated as directly interchangeable. The variation highlights the need for locally appropriate screening and diagnostic assessment.

ETIOLOGY AND RISK FACTORS

Geriatric depression usually develops through the interaction of biological, psychological and social factors. There is no single cause in every patient. Risk increase after the death of a spouse or close relative, retirement, financial insecurity, family conflict, loneliness, social isolation or loss of independence. Chronic conditions such as diabetes, cardiovascular disease, stroke, cancer, chronic pain and neurological disorders increase vulnerability. Sensory impairment, reduced mobility, sleep disturbance, alcohol misuse and a previous history of depression are also relevant. Some medicines and medical conditions can contribute to depressive symptoms, so the clinical assessment should review current medication and consider possible physical causes [1,2].

PATHOGENESIS

The development of depression is multifactorial. Biological factors include changes in stress-response systems, neurotransmitter signalling, inflammatory processes and brain networks involved in mood, motivation and cognition. Vascular changes and neurological illness contribute to depressive symptoms in some older adults. Psychological factors, including persistent grief, negative thinking, reduced sense of purpose and difficulty adapting to life changes, can interact with these biological processes. Social isolation, poverty and limited access to health services further maintain or worsen symptoms. These mechanisms vary between individuals and do not provide a single diagnostic test for depression [1,2].

CLINICAL FEATURES

Common features include depressed mood, loss of interest or pleasure, reduced energy, disturbed sleep, changes in appetite or weight, poor concentration, indecisiveness, feelings of worthlessness or excessive guilt, and recurrent thoughts of death. Older adults report bodily discomfort, fatigue, memory complaints or loss of confidence rather than directly describing sadness. They reduce social contact, neglect self-care or struggle with daily activities. Some symptoms overlap with physical illness or cognitive disorders; therefore, diagnosis should be based on a comprehensive clinical assessment rather than a screening score alone. Any thoughts of suicide or self-harm require prompt assessment and appropriate support [1,2].

DIAGNOSIS

Diagnosis is made through a detailed clinical interview, review of symptom duration and severity, assessment of functional impairment, mental-state examination and evaluation of relevant medical, social and medication history. Symptoms generally need to persist for at least two weeks for a depressive episode, although urgent assessment should not be delayed when risk is present. Screening instruments such as the Geriatric Depression Scale (GDS) or Patient Health Questionnaire-9 (PHQ-9) can support case identification but do not replace clinical diagnosis. Assessment should consider grief, dementia, delirium, bipolar disorder, substance use, thyroid disease, nutritional deficiencies and other conditions when clinically indicated. Suicide risk, self-neglect and the person's ability to remain safe should be reviewed [1,2].

MANAGEMENT

Management should be individualised according to symptom severity, physical health, cognitive status, patient preferences and available support. Helpful measures include explaining the condition, regular follow-up, restoring daily routines, appropriate physical activity, adequate sleep, balanced nutrition, and strengthening social contact. Psychological treatments such as cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation and problem-solving therapy appropriate. Antidepressant medication considered according to severity, history and clinical judgement, with careful review of interactions, adverse effects, falls risk and other age-related factors. Moderate or severe depression, psychotic symptoms, marked functional decline or suicide risk warrants timely specialist assessment. Treatment should be monitored and adjusted when needed [1,2].

HOMOEOPATHIC APPROACH

In homoeopathic practice, remedy selection is based on an individualised history, including emotional symptoms, general characteristics, sleep, appetite, physical complaints and the person's response to stress. Remedies such as Aurum metallicum, Natrum muriaticum, Ignatia amara, Pulsatilla nigricans and Phosphoricum acidum are described in homoeopathic materia medica in relation to different emotional and behavioural presentations. These descriptions represent homoeopathic sources and should not be interpreted as proof.

PREVENTION AND SUPPORT

Supportive measures include maintaining social connections, encouraging safe physical activity, addressing hearing or vision difficulties, managing chronic illness and pain, and helping older adults access community and family support. Regular opportunities for meaningful activity and participation reduce isolation. Caregivers should be aware that persistent low mood, withdrawal, sleep changes or loss of interest indicate depression and should encourage assessment rather than dismissing symptoms as a normal part of ageing [1,2].

CONCLUSION

Depression in the geriatric age group is common, clinically important and often under-recognised. Its presentation influenced by physical illness, bereavement, social isolation, reduced independence and other age-related stressors. Differences in published Indian prevalence estimates reflect variations in study methods and diagnostic criteria. Timely assessment, attention to suicide risk, suitable psychological and medical treatment, and strong social support are essential. Homoeopathic remedies are helpful in treatment of Depression in Geriatrics age group.

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