

# Late-life depression: what can be done?

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## SYNOPSIS

**Depression is commonly unrecognised in the elderly. There is also the problem of defining depression in old age. Severe depression will commonly need to be managed in hospital. Major depression is usually treated in the community setting. Minor depression can be as disabling as major depression. Management of minor depression includes dealing with precipitating factors, helping the patient adapt, and judicious use of medication. If drug treatment is needed the newer antidepressants may be better tolerated by the older person than tricyclic antidepressants.**

**Index words: antidepressants, cognitive behaviour therapy.**

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## Introduction

The presentation of depression in older age is often less obvious than it is in younger people. A majority of people in their seventies and older have at least one physical disability, and depressed elderly patients are likely to focus attention on physical symptoms when they visit their general practitioners. Depression can easily be overlooked.

## Recognition of late-life depression

The cardinal features of depression are lowered mood and loss of interest. However, older people are less likely than younger patients to acknowledge feeling depressed. This is one of the reasons depression may be overlooked in older people. Patients may attribute their symptoms (lack of energy, inability to concentrate, irritability, poor sleep, weight loss and feeling slowed up) to their age, rather than a psychological cause. They may feel less comfortable than younger patients in talking to their doctors about such symptoms.

General practitioners often do not have a lot of time to give to each patient. Commonly there is a queue in the waiting room. Older patients may be anxious not to take more than their share of the doctor's time. Yet people with physical handicaps or disabling medical illnesses are six times more likely than others of their age to have depressive disorders.

Another reason why some studies report that doctors often fail to recognise depression is that experts differ in what they understand by the term 'depression'. Disagreements relate mainly to the non-typical, less obvious, less severe cases, especially those where there is comorbidity with physical disorders, and when anxiety and certain personality traits obscure the presentation. This confusion may be shared by some general practitioners. They are good at recognising

'severe' cases, but are less inclined to record depression in non-melancholic cases, including what used to be called 'neurotic' or 'reactive' depressions.

Epidemiologists have tended to include only cases of major depression (with or without melancholia) and dysthymia when estimating prevalence rates of depression. They say that depression is much less common in older age. However, patients with minor depression (a shorthand term for those with significant depressive symptoms but without fulfilling all DSM-IV<sup>1</sup> criteria for the diagnoses of major depression or dysthymia) may be just as distressed and functionally disabled by their symptoms as those with major depression.

Minor depression is common in older age, with a steep increase in prevalence in people over 80 years of age. This rise is largely attributable to the age-related increase in physical morbidity. Functional decline and symptoms of medical illness may be depressing. In a recent American study of patients over 60 years of age presenting for primary care services, 6.5% had major depression and 15.1% had minor or subsyndromal depression.<sup>2</sup>

Depression itself can lead to a decline in functional ability and well-being as severe as that caused by chronic medical conditions. If this distress can be relieved and the patient's function improved, it is well worth identifying cases of minor depression.

Doctors therefore need to think to themselves, whenever an older patient comes to see them, 'Could this person be depressed?' This particularly needs to be considered in relation to conditions known to have a high correlation with depressive illness, e.g. dementia. If unsure, then explore this possibility with the patient.

## Dementia

Depression and dementia may both present with psychomotor slowing, poor concentration, impaired memory, apathy, fatigue and sleep disturbance. In the absence of tearfulness or depressed mood, comorbid depression may escape notice. A trial of antidepressants may lead to remarkable improvement in mood, although in most cases of dementia there is progressive worsening of the cognitive impairment even if the depression does not recur.

Frontal lobe changes can lead to an apathy syndrome which may be mistaken for a depressive illness, and is unresponsive to antidepressant therapies. Other brain changes may lead to emotional lability, with pathological crying. A trial of antidepressants is worthwhile even in obviously organic mood syndromes.

## Factors related to late-life depression

The first step in effective management of late-life depression is proper assessment. This includes a review of all factors that might be related to the development, persistence or lessening of depressive symptoms. Nature, nurture and life circumstances (including physical changes) may all have relevance when considering the aetiology of depressive disorders. There is a continuum between types of depression which are thought of as primarily biological and primarily psychological in origin, but there may be a secondary organic response overlapping both biological and psychological parts of the continuum. Particular consideration needs to be given to these organic factors when planning interventions for depressed older people.

Personality factors may affect whether someone will respond to certain events or situations by becoming depressed. Personality is partly determined by inherited characteristics and partly by upbringing. The meaning of events or situations to individuals (for example threats or insults) may well be determined by their experience of similar events earlier in life. Some may learn to react by being helpless and submissive, whereas others may learn assertiveness and acquire a need to be in control.

Losses may induce feelings of helplessness or anger. Bereavement may lead to prolonged sadness. Other losses (for example of accommodation, financial security, social network, independence, mobility, source of self-esteem) may also lead to persistent and comparable sorrow, loss of pleasure in life, a sense of emptiness, dwelling on the past, apathy about the future, and maybe frustration, anger and irritability. Loss of health may provoke feelings of insecurity as well as of wretchedness.

Ill health may precipitate depression through physical as well as psychological effects. Endocrine disorders such as hypothyroidism are obvious examples. Other causes include neoplastic disorders, vitamin deficiency and a host of neurological conditions such as stroke, Alzheimer's disease, vascular dementia and Parkinson's disease. Pain has a strong association with depression, but whether this is entirely through psychological processes is debatable.

Stress and emotional reactions provoke neurobiochemical changes, including release of corticosteroids. Thus psychological depressions have biological elements. Stress can lead to atrophy of stress-vulnerable hippocampal neurons by decreasing the availability of protective neurotrophic factors. This may explain why having one depressive episode makes it more likely that a person will have depressive episodes in the future. It may also explain why affective disorders which are believed to be mainly biological in origin (melancholia, bipolar and psychotic depression) are commonly precipitated by psychologically stressful situations.

There is also evidence that late-life depressions may occur in association with age-related (probably vascular) brain changes, in people who have not been diagnosed with dementia or other brain disease.

## Management of late-life depression

If the clinical assessment reveals an obvious and reversible cause of the depression it should be reversed. Relevant physical disorders should be identified and treated. Situations or drugs which are contributing to the depression should be changed if feasible.

As part of the initial examination, the doctor should assess whether the patient is suicidal. If so, or if the patient has severe or psychotic depression, referral to specialist services is advisable and electroconvulsive therapy may be considered. In less urgent cases, inpatient assessment may well be appropriate and an adequate dosage of an antidepressant should be given. In cases of delusional depression a neuroleptic may be added (for example risperidone, olanzapine or quetiapine) although these are only approved on the Pharmaceutical Benefits Scheme for schizophrenia. The newer antidepressants are less likely than tricyclic antidepressants to cause distressing adverse effects and are less toxic in overdose; doctors usually prescribe selective serotonin reuptake inhibitors in therapeutic doses (usually one tablet daily) in contrast to the way tricyclic antidepressants and mianserin are used. However, venlafaxine and tricyclic antidepressants are commonly believed to be more effective in severe and resistant cases. It is always important to be aware of potential drug interactions. For example, moclobemide is preferable to selective serotonin reuptake inhibitors if the patient is taking warfarin.

When patients with severe depression fail to respond to adequate doses of antidepressants, electroconvulsive therapy is the best choice if the patient is willing. Some patients respond to lithium augmentation of antidepressants but it can be very difficult to manage in the elderly and the dose (titrated according to serum levels) is usually less than for younger people.

After recovery, patients who have experienced more than one episode of delusional or melancholic depression should stay on antidepressants (or a mood stabiliser if they have a bipolar disorder) for years. Even after just one episode, antidepressants should be continued for at least a year.

There is evidence that antidepressants can be effective in depressions associated with physical illness.<sup>3</sup> Experts suggest that the more severe depressions, even if precipitated by loss or stress, may respond to antidepressants, but there is only limited evidence for their effectiveness in milder depression.

In all cases of depression, psychotherapeutic support is appropriate. All patients should be enabled to ventilate their feelings and to discuss ways of adapting to their loss or distress. In cases of severe depression this may not be possible until they start to improve.

When depressions are loss-related (including bereavement, demoralisation and those associated with loss of health and functional capacity), the main focus of management will usually be psychosocial. Grief-work, cognitive behaviour therapy, interpersonal therapy, group therapy or counselling may be indicated. Stress and sorrow may be long-lasting, even though initial emotional responses may be regarded as adjustment disorders. Much depends on personality and

whether patients can adapt and move beyond their depressive reactions. Vulnerability and insecurity, which may become more pronounced in some people as they age, interfere with adaptation. This may be especially difficult for elderly migrants. Symptomatic medication (e.g. hypnotics) may be useful for short periods, but prolonged use of anxiolytics is to be avoided. Antidepressants are preferable, and for many patients with persistent depression a combination of psychotherapeutic and pharmacological treatment is appropriate. Given adequate resources, a whole package of interventions aimed at enhancing physical and emotional well-being is desirable. If the doctor lacks skill to provide the appropriate psychotherapy component, a 'shared care' approach (linking with other health professionals) is recommended in these non-melancholic cases.

### Prognosis

Most depressions in old age will respond to treatment, with consequent improvement in function and well-being, improved recovery rate from medical conditions, and reduced mortality rate. The prognosis for patients with severe depression associated with either dementia or deep white matter lesions is poor. Improvement may occur with treatment, but early relapse and treatment resistance are common. Comorbid physical disorders or severe anxiety may also lead to a protracted course.

Overall, the prognosis for late-life depression is no worse than for younger patients. Ageist and nihilistic attitudes to intervention should be abandoned.<sup>4</sup> Patients may take longer to respond, and treatment is often complicated, but there is good reason to be positive. Good liaison between general practitioners and psychiatry services for older people helps promote identification and appropriate treatment of late-life depression. Unfortunately, funding in Australia for such collaborative approaches is limited.

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### Self-test questions

The following statements are either true or false (answers on page 75)

7. The prognosis for uncomplicated depression in old age is worse than for younger patients.
8. Selective serotonin reuptake inhibitors interact with warfarin.

## Facilitators file

The National Prescribing Service (NPS) has provided funds to divisions of general practice to employ facilitators. These facilitators visit general practitioners to discuss common prescribing problems. During their visits the facilitators are finding some interesting issues. *Australian Prescriber* will publish some of these findings from time to time.

### Thiazides and fractures

Some doctors are reluctant to prescribe thiazide diuretics. They fear that these drugs may put their patients at risk of having an osteoporotic fracture.

There has not been a randomised-controlled trial of the effect of thiazides on fractures. Some observational studies show a 60% increase in risk, while others show a 70% reduction in risk. To try to resolve the issue, researchers at the Garvan Institute in Sydney conducted a meta-analysis.<sup>1</sup>

The meta-analysis included 13 studies involving a total of

29 600 patients. It found that patients currently taking thiazides were less likely to have a hip fracture. The odds ratio (OR) was 0.82 with a confidence interval (CI) of 0.73–0.91. There was a trend for a reduction in all types of osteoporotic fracture (OR 0.88, CI 0.77–1.02).

While the odds of hip fracture were reduced with long-term use, short-term use of thiazides appeared to increase the fracture risk. This may be a result of patients having a fall when treatment begins.

Thiazides may influence the risk of fracture by decreasing the excretion of calcium. The authors of the meta-analysis suggest that thiazides should be considered as a method of preventing osteoporotic fractures particularly in patients with hypertension.

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