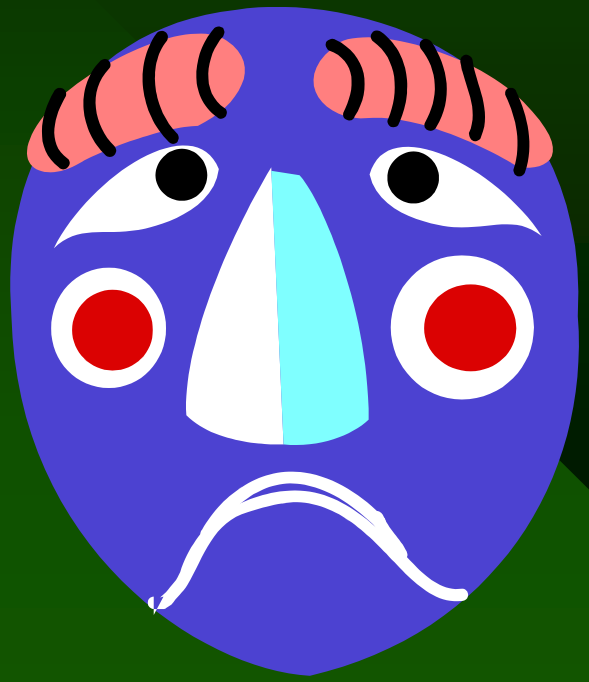
Depressive Disorders in later

Clinical Features

Epidemiology



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DALE CARNEGIE® TRAINING

Case 1: 80 yr old widow

What do you think is wrong & what would you do?

- Son & husband died in road traffic accident two weeks ago
- Thinks a lot about them
- Sometimes tearful
- Able to function independently, though prefers own company

Case 2: 75 yr old man

What do you think is wrong & what would you do?

- Heavy smoker admitted to medical ward after being found collapsed at home three weeks ago
- History of hypertension & transient ischaemic attacks
- Suddenly became labile in mood, often tearful and at times aggressive three weeks ago

Case 3: 80 yrs old married woman

What do you think is wrong and what would you do?

- Sudden onset of memory loss and social withdrawal a month ago
- Gives a lot of ‘I do not know responses’
- Taken to her bed at home, eating and drinking very little

Case 4: 91 yr old widower

- Suffering from tremors, rigidity and slowness of movement for several years.
- Had become increasingly forgetful over past six months
- Became withdrawn, not eating or drinking and made an unsuccessful attempt at suicide.
- Refused all treatment and said he wished to die
- HOW WOULD YOU MANAGE THIS CASE?

CASE 5: 85 yrs old twice married man referred with history of memory loss

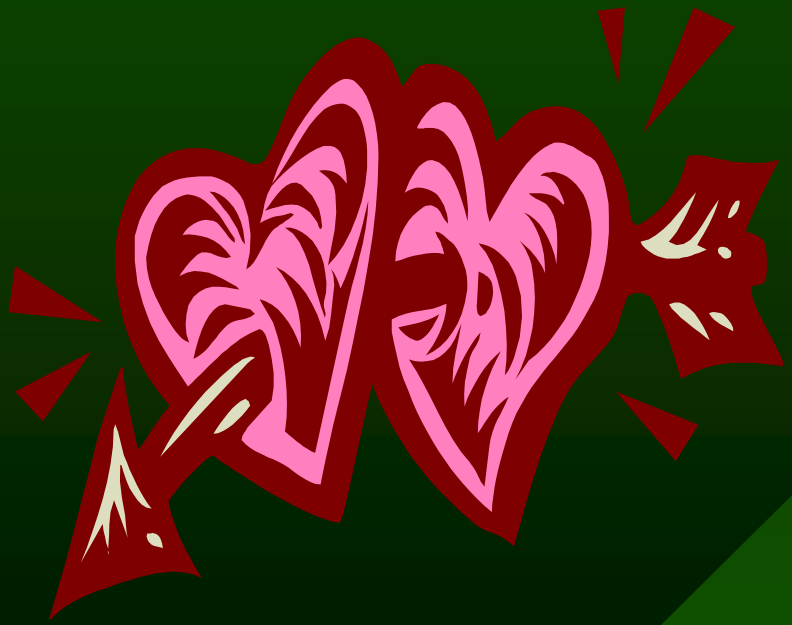
- Reported by 2nd wife to be aggressive, tearful, forgetful and often misidentifying her for his 1st wife for several months
- He said, his wife often shouted at him for being too slow.
- Assessment revealed no memory impairment
- WHAT DO WE THINK IS WRONG AND WOULD DO?

Management of Sample Cases

- CASE 1 Bereavement. Offer counselling
- CASE 2 Hypertensive cerebrovascular disease with possibility of either depression or frontal lobe dysfunction. Investigate fully e.g. CT Brain scan, Neuropsychological testing to confirm frontal lobe dysfunction, screen for depression. Treat possible causes.
- CASE 3: Depressive Pseudo dementia. Treat with antidepressants after ruling out possible alternative causes
- CASE 4: Parkinson's disease with dementia and severe depression. Placed on Mental Health Act Section 3 and treated with ECT, antidepressants and antidementia medication.

Management of Case 5

- Problem was marital disharmony
- Marital therapy was offered and accepted by couple
- **A reminder that not all cases may be depression or require drug treatment**



How common is depression in later life?

- Most common mental health problem amongst older people
- In community **11 –15%** of older people (> 65) suffer from depression
- In residential or nursing homes **22 – 33%** are said to suffer from depression
- In hospital as high as **45% of patients** with physical illness has been reported

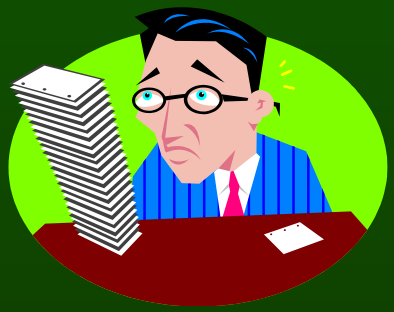
Prevalence of depression in other illnesses

- Peripheral vascular disease 30 -60%
- Post stroke 18 -60%
- Chronic heart failure 13 – 48%
- Parkinson’s disease 50%

Patients most likely to suffer depression

- Frequent attenders
- Have existing mental health problems
- On Benzodiazepenes
- Carer in a difficult caring situation
- Carer whose role has ceased or changed
- Ca lungs or pancreas
- Chronic respiratory disease
- CVA
- Cardiovascular problems

What depression is not?



- Everyone feels sad or blue sometimes, as a natural part of life.
- Sadness associated with normal grief
- In most cases is not associated with the ability to carry on regular activities

Differing depression from grief

- Persisting grief
- Guilt unconnected to loved one's death
- Thoughts of one's own death
- Persistent feelings of worthlessness
- Inability to function at one's usual level
- Difficulty sleeping
- Weight loss

Common symptoms and signs of later life depression

- Persistent sadness (lasting more than two weeks)
- Feeling slowed down
- Excessive worries about finances and health problems
- Frequent tearfulness
- Feeling of worthless or helpless
- Weight changes
- Pacing & fidgety
- Difficult sleeping
- Difficulty concentrating
- Physical symptoms like pain or GIT problems
- Social withdrawal

DSM IV Criteria for depressive episode One of first two symptoms and four or more others over a two week period or longer

- Depressed mood.
- Marked diminished interest or lack of pleasure.
- Significant weight loss.
- Insomnia or hypersomnia.
- Psychomotor agitation or restlessness.
- Fatigue or loss of energy
- Feelings of worthlessness
- Diminished ability to concentrate
- Recurrent thoughts of death or suicidal ideation

ICD 10 depressive episode

Symptoms present for at least two weeks without a history of mania

- Depressed mood
- Loss of interests
- Decreased energy or increased fatigue
- Feelings of inappropriate guilt
- Recurrent thought of death or suicide
- Diminished ability of concentration
- Change in psychomotor
- Sleep disturbance
- Change in appetite

Untreated depression can lead to:

- Disability
- Worsen symptoms of other illnesses
- Premature death
- Suicide

Factors contributing to depression in later life (1)

- Death of partner
- Retirement
- Changes in vision & hearing
- Moving from family home
- Neighbourhood changes
- Other illnesses like cancer, Parkinson's disease, Heart disease, Stroke, Alzheimer's disease

Factors contributing to depression in later life (2)

- Females, widows, widowers & divorcees are more susceptible to depression
- Previous history of depression
- Personality factors (avoidant & dependant types)
- Genetic susceptibility is less important in later life

Other aetiological factors of depression in later life

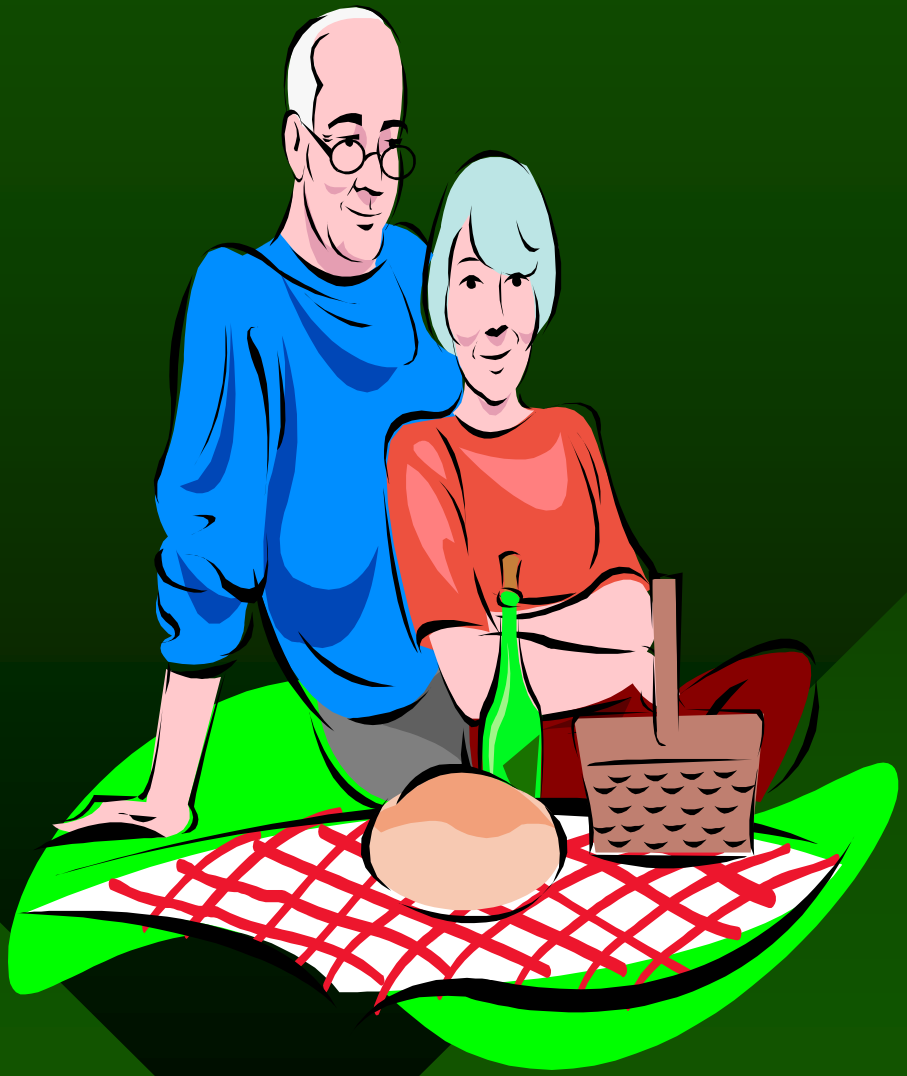
- Decrease in neurotransmitters like acetylcholine, dopamine, noradrenaline and serotonin occur with ageing and these are possibly further decreased in depression
- Deep white matter and subcortical lesions in the brain are commoner in depression
- Studies have shown an association between depression and vascular risk factors like hypertension, smoking and excessive alcohol consumption

Drugs which could cause or aggravate depression

- Beta blockers
- Methyldopa
- Digoxin
- Codeine
- Indomethacin
- Steroids
- Levodopa
- Amantadine
- Tetrabenazine
- Antipsychotics
- Benzodiazepenes

Protective factors from depression

- Good medical care
- Good nutrition
- Physical fitness
- Good coping behaviour
- Adaptive personality
- Capacity for confiding relationships
- Good social support
- Religious and spiritual beliefs



Psychiatric assessments include (1):

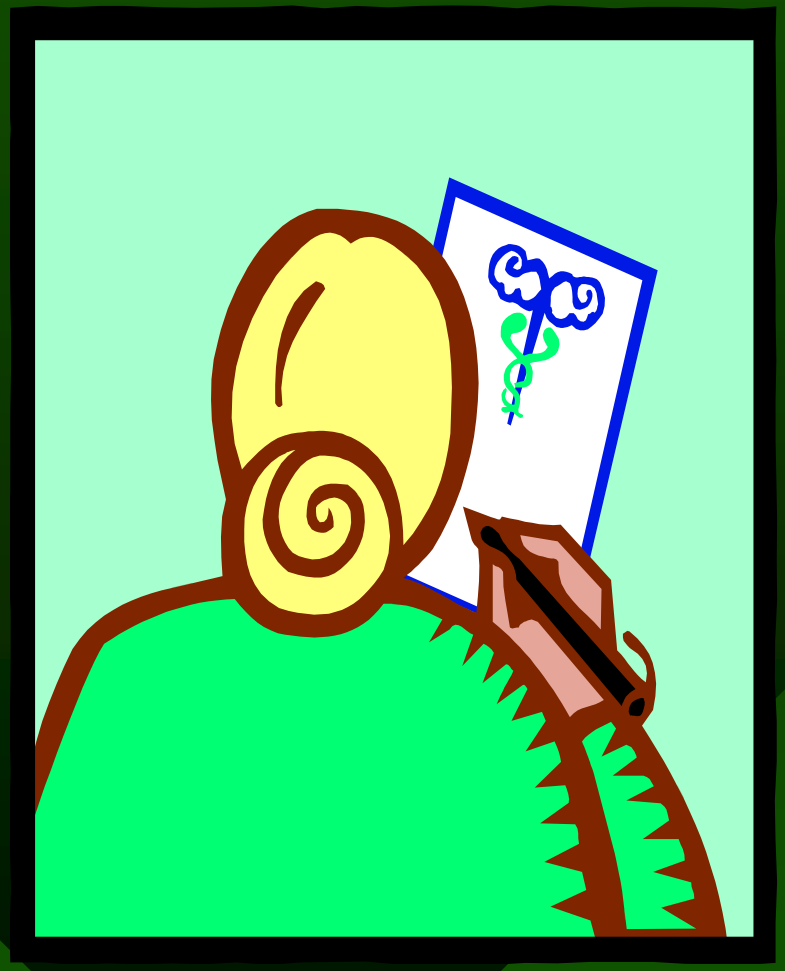
- History of complaints
- Family / Personal History
- Past Medical & Drug History
- Past Psychiatric History
- Alcohol / Psychoactive substance misuse history
- Premorbid personality
- Current social circumstances

Psychiatric assessments include (2): Mental state Examination

- Appearance /Behaviour
- Speech
- Mood
- Suicidal ideation
- Presence of delusions / hallucinations
- Cognitive assessment: test for orientation, recall, …using the Abbreviated Mental test or mini mental state examination to help rule out dementia
- Insight: to help assess likely compliance with treatment

Screening for depression

- **Geriatric depression scale – 30**
  (scores > 11 suggestive of depression)
- **Geriatric depression scale –15**
  (scores greater than 5 suggestive of depression)



Geriatric Depression Scale - 15

Please answer Yes or No

1. Are you basically satisfied with your life? Yes / **No**
2. Have you dropped many of your activities and interests? **Yes** / No
3. Do you feel that your life is empty? **Yes** / No
4. Do you often get bored? **Yes** / No
5. Are you in good spirits most of the time? Yes / **No**
6. Are you afraid that something bad is going to happen to you? **Yes** / No
7. Do you feel happy most of the time? Yes / **No**
8. Do you often feel helpless? **Yes** / No
9. Do you prefer to stay at home rather than going out & doing new things ? **Yes** / No
10. Do you feel you have more problems with memory than most? **Yes** / No
11. Do you think it is wonderful to be alive now? Yes / **No**
12. Do you feel pretty worthless to be alive now? **Yes** / No
13. Do you feel full of energy? Yes / **No**
14. Do you feel that your situation is hopeless? **Yes** / No
15. Do you think that most people are better off than you are? **Yes** / No

TOTAL SCORE =

All responses indicating depression are indicated in **BOLD RED**

A score greater than **5** indicates probably depression

Possible useful investigations

- Obtain a collateral history from relatives or carers
- Blood tests to rule out: anaemia, folate or B12 deficiency, thyroid or renal problems, electrolyte imbalance, folate deficiency
- Brain scans CT or MRI to rule out brain pathologies, tumours, cerebrovascular disease

Possible diagnoses of person presenting with depressive symptoms

- **Depressive episode or recurrent depressive disorder**
- **Bipolar affective disorder (manic depressive illness)**
- **Dementias: Alzheimer's, Vascular, frontotemporal lobe or lewy body dementia**
- **Organic affective disorder e.g. depression secondary to brain tumour, thyroid disorder, cerebrovascular disease, drug induced.**
- **Adjustment disorder**
- **Post traumatic stress disorder**

Treatment Options for Depression

- Psychological Therapies
- Drug Treatments
- Electroconvulsive Therapy
- Alternative therapies

Psychological therapies

- Supportive psychotherapy
- Cognitive therapy
- Interpersonal psychotherapy
- Marital\Family therapy
- Dynamic therapy

Drug treatment of Depression

- Tricyclic antidepressants: Lofepramine up 210 mg daily
- Selective Serotonin re-uptake inhibitors: Citalopram up to 40 mg daily
- Others antidepressants: Mirtazepine, Trazodone
- Mood stabilisers: Lithium, Carbamezepine, valproate & lamotrigine.
- Monoamine oxidase inhibitors useful in atypical depression: Moclobemide

Electroconvulsive Therapy

- Indications: Severe depression with marked weight loss, early morning waking, retardation and delusions.
- Depressive psychosis responds better to ECT than antidepressants or antipsychotics alone.
- Combined antidepressants & antipsychotics may be as effective as ECT.
- Dose of ECT given twice weekly for typically up to a maximum of 12. Response can be immediate or after a few weeks.

Other treatments

- **Sleep deprivation**: specific REM sleep deprivation can alleviate depressed mood (Wu & Bunney 1990)
- **Bright light treatment** (10,000 lux) given for 1 – 2 hours in the mornings. Effective within 2 – 5 days in atypical depression(overeating /sleeping).
- Needs to be maintained to prevent relapse until early spring in case of winter depression.

SUICIDE IN OLDER PERSONS

- Older men are more likely to die from suicide than women
- Marriage is a protective factor with suicide higher in the single & divorced
- Men more frequently use violent methods e.g. hanging rather than drug overdoses

Risk factors in suicide

- 70% of older people who commit suicide are suffering from a psychiatric illness (44 – 88% have depression)
- Up to 15% have Personality disorders
- Physical illness is the most frequent life event (in up to 84% of cases)
- Death of spouse increases the risk of suicide in older men
- 20% of suicides are rational response to insoluble life problems with no underlying psychiatric disorders.

Suicide Prevention

- Risk assessment should be individualised with a thorough interview covering suicidal intent & past history of suicide
- Limit the availability of means of self destruction e.g. stringent gun control (USA), avoid the use of potentially lethal drugs like combination analgesics, cardiotoxic antidepressants like amitryptyline and dosulepin especially in cases where there is no carer to supervise medication.
- Target the high risk groups (socially isolated persons)
- Better training in risk assessment by health workers including GPs & effective exchange of useful information

Summary

- Depression is common in older people
- There are various contributing factors
- It can lead to worsening disabilities, dependency,prolong stay in hospital & suicide.
- It can frequently be missed
- There are various forms of treatments which include psychological, social, pharmacological and electroconvulsive therapies along with treating identified causes