

Depression later in life - an approach for the family practitioner

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Abstract

Depressive disorder is the most common mental health problem in older people. Health professionals mainly come into contact with those who are most susceptible to depression, including older people who live in residential facilities and the frail with acute or chronic physical illness. Quite often, such individuals also exhibit multiple pathology. Under these circumstances, health professionals may have an exaggerated view of the extent of depression among the elderly, causing them to overlook depressive disorders that they may have developed. Organic factors, including alcohol and iatrogenic drugs, must be ruled out in the aetiology. Physical ill health must receive optimum treatment. The choice of antidepressant drug is based on the side-effect profiles and potential drug-drug interactions, rather than on the degree of therapeutic efficacy. Treatment should be multimodal and multidisciplinary, with the aim of complete recovery and not simple improvement. By using a range of treatments, most patients will recover, though keeping patients well is more difficult. Treatment should be continued for at least 12 months. Many patients who could benefit from long-term maintenance therapy do not receive it. With optimum management the prognosis is at least as good as that for any other stage of adult life.

 This article has been peer reviewed. Full text available at www.safpj.co.za

SA Fam Pract 2008;50(4):38-43

Introduction

Doctors view depression and old age as going hand in hand. Chronic ailments, losses in different spheres of life and the deaths of friends in one's own peer group are seen as sufficient reasons to justify such a view.

Furthermore, health professionals mainly come into contact with those among the elderly who are most susceptible to depression, including older people who live in residential facilities and the frail with acute or chronic physical illness. Quite often, such individuals also exhibit multiple pathology. Under these circumstances, health professionals may have an exaggerated view of the extent of depression among older patients, resulting in their overlooking depressive disorders that may have developed.

This article covers classification, epidemiology, clinical presentation, management and prognostic factors of depressive disorders in the elderly.

Classification

The British Association of Psychopharmacology¹ uses a practical classification system that refers to both DSM-IV² and ICD-10 codes.³ (See Table I.)

Any major depressive episode must exhibit sufficient symptoms to reach the syndromal threshold. When patients suffer from relatively mild depression, the symptom count falls just below the threshold, with

Table I: Classification of mood disorders⁴

Classification	DSM-IV Code	ICD-10 Code
Major depression	Major depressive episode, single episode or recurrent episodes (296)	Depressive episode, severe (F32.2); moderate (F32.1) or mild, with at least five symptoms (F32.0); recurrent depressive disorder, current episode severe (F32.2); moderate (F33.1); or mild, with at least five symptoms (F33.0)
Milder depression	Depressive disorder, not otherwise specified (311)	Depressive disorder, mild with four symptoms (F32.0); recurrent depressive disorder, current episode mild, with four symptoms (F33.0); mixed anxiety and depressive disorder (F41.2)
	Adjustment disorder with depressed mood/mixed anxiety and depressed mood (309)	Adjustment disorder: depressive reaction, mixed anxiety and depressive reaction (F43.2); other mood (affective) disorders (F38)
Dysthymia	Dysthymia (300.4)	Dysthymia (F34.1)

For specific criteria for different disorders, see DSM-IV and ICD classification systems.^{2,3}

such patients often showing quite marked anxiety symptoms.⁴ Many patients with psychological reactions to stress fall in this category. In such patients, counselling and psychotherapy are the preferred treatment. Patients with relatively mild forms of depression do not

respond to antidepressant drug treatment as a rule.⁴ Patients should not be squeezed into narrow diagnostic boxes. The clinician must take note of the number and severity of symptoms and the disability resulting from such, in order to see what impact depression has on the patient and what treatment will be best.

Though terms like 'subsyndromal depression' and 'minor depression' have no set meaning, recent naturalistic studies of mixed-aged patients strongly suggest that much subsyndromal depression is a result of incomplete recovery from a major depressive disorder.⁵

Dysthymia, which is a chronic depression of at least two years' duration, often co-occurs with episodes of major depression.

Adjustment disorder (a form of milder depression) usually originates in a major traumatic event. The disorder is self-limiting, usually lasting less than six months.

Epidemiology

Between 10% and 15% of the elderly suffer from some degree of depressive symptomatology at any given time, but only 3% tend to experience a depressive episode.⁴ Although depressive symptoms (subsyndromal depression, minor depression or dysthymia) are more common among the elderly than among younger adults, no evidence suggests that depressive episodes also become more prevalent with advancing age.

Depression was assessed by Robert et al⁶ using DSM-IV criteria in an epidemiologically derived cohort of patients. The researchers came to the conclusion that healthy older people are at no greater risk of depression than is anyone else. Any apparent age effect could be attributed to physical health problems.

Furthermore, prevalence varies by location, with milder depression being found in a third of the elderly patients attending their general practitioner in the United Kingdom.⁷ Of significance is the discovery of a 'significantly depressed mental state' in almost two-fifths of residents in local authority homes.⁸

Depressive disorders in old age often coexist with cerebral disease, with many studies excluding such cases.⁴ Allen and Burns⁹ reviewed published data, calculating a prevalence of moderate to severe disorder in patients with Alzheimer's disease at 20%, higher than in age-matched community residents. Depression is probably more common in vascular, rather than Alzheimer-type, dementia.⁹

Clinical presentation

Previous research emphasised certain aspects of depressive disorder thought to typify old age, including multiple somatic complaints, excessive hypochondriases, greater agitation, more frequent delusions, a more endogenous picture and an increased likelihood of confusion.⁴ A stereotype of depressive disorder in old age has been created. Quite often such studies have been conducted solely on in-patients, which might reflect more severe illness and might not be representative of contemporary geriatric psychiatry. Few of the 'typical' features of late-life depression have withstood the scrutiny of more contemporary research.⁴

More recent research has adopted two main approaches: first, comparing patients with depression in later life with younger adult depressives; second, comparing early-versus-late onset depressions

in later life (60 years of age being the most commonly adopted cut-off point).

In terms of the first approach, the following findings have been reported: Blazer et al¹⁰ found that older community subjects, diagnosed according to DSM criteria, reported more somatic symptoms, had more thoughts about death, and a non-significantly increased preoccupation with the wish to die, compared with depressed younger persons, who tended to report more memory problems. The notion of a special 'masked' depression occurring in old age could not be confirmed by the study.

Musetti¹¹ found no special feature differentiating the older from the younger group, though the older depressives tended to exhibit more retardation than agitation.

While Gurland's study¹² found that hypochondriases was more common in older people, Brodaty¹³ found that the elderly depressives were more agitated, more severe, had more delusions, and were more 'endogenous' than the younger ones. On comparing more homogeneous DSM-IV subgroups (e.g. melancholic subtypes), almost all differences disappeared.

The finding of the presence of more frequently occurring delusions in late-onset depression vary between studies.⁴ Such findings must be interpreted in the context that delusional depressive disorders are rare among elderly people.¹⁴

When early versus late age of onset in older depressed patients is compared, apart from the well-known lower prevalence of a family history of affective disorder among late-onset elderly depressives, few other clinical differences could be found.¹⁵

Lack of motivation and apathy are features of 'vascular depression', which is also characterised by reduced depressive ideation (such as guilt), increased psychomotor retardation and cognitive impairment, especially poor executive function.¹⁶

In terms of its clinical presentation, 'depression is depression at any age'. Several factors influence how depressive disorder presents in old age, including the following:

- an overlap of physical with somatic depressive symptoms (e.g. reduced appetite, fatigue)
- a tendency to minimise feelings of sadness
- somatisation or disproportionate complaints associated with physical disorder
- the sudden emergence of severe anxiety, obsessive-compulsive phenomena, hysteria, or hypochondriases in an elderly person not previously prone to such disorders
- deliberate self-harm (especially medically 'trivial' attempts)
- 'Pseudodementia' (dementia of depression), where patients who appear demented may, in fact, be suffering from severe depression
- depression superimposed upon dementia
- the accentuation of abnormal personality traits
- behavioural disorder such as food refusal, incontinence, screaming and outwardly aggressive behaviour
- late-onset alcohol dependency syndrome

Depression in the elderly is frequently associated with subtle cognitive dysfunction that persists in a minority, and which may reflect disruption of subcortical brain circuits. However, a subgroup which is, as

yet, not readily characterised clinically might serve as a harbinger of irreversible dementia. Practically, patients who present with obvious cognitive impairment when depressed (or with a Mini-Mental State Examination Score of below 24) should be closely followed up after recovery, as such patients appear to have a higher risk of later dementia.⁴

Management

The assessment phase

During the assessment phase, the clinician must realise that checklists of symptoms, as in the DSM or ICD, may be helpful, but, as described earlier, several factors may significantly modify the clinical presentation in the older depressed patient.

The following hints may guide the clinician through pitfalls during the assessment phase⁴:

- A comprehensive history must be obtained from the patient and other informants. Important aspects that should be clarified are: any recent change in behaviour; a family and personal history of depression; a full drug and alcohol history; the treatment and response in previous depressive episodes; any major adverse life events and the previous capacity to cope with such events; personality traits; and the availability and quality of support systems.
- A full mental state examination, a Mini-Mental State Examination (to exclude cognitive impairment) and a physical examination.
- Laboratory investigations including haemoglobin and red blood cell indices (excluding Vitamin B₁₂ deficiency or alcohol excess), folate levels, urea and electrolytes, thyroid function testing, with neuroimaging largely being performed to rule out a space-occupying lesion.
- Screening questionnaires (e.g. the Geriatric Depression Scale "GDS") do not constitute a diagnosis. Non-psychiatrically trained personnel who use scales should be given proper training in their use and adequate support.

What pharmacotherapy must the clinician prescribe?

With a host of newer antidepressants on the market, the perceptive remark of Gerson¹⁷ in 1985 still holds true: "..... the choice of drug is based on the side-effect profiles and potential drug-drug interactions rather than on the degree of therapeutic efficacy".

Alterations in pharmacodynamics and kinetics with age mean that many, though not all, antidepressants should be administered in lower dosages to patients as they grow older, keeping in mind the adage 'start low – go slow'. Older people take longer to respond to treatment, so that an adequate trial of therapy may last up to eight weeks.

The type of depression remains an important factor when deciding what to prescribe:

- For psychotic depression, combine antidepressant and antipsychotic drugs or ECT.¹⁸
- For a more severe type of depression, tricyclic antidepressants are more effective than are selective serotonin-reuptake inhibitors.¹⁹
- For minor depression, current antidepressants may be effective, although they are only indicated for major depressive disorders.

A classification of antidepressants is given in Table II.

Choosing from such a large range of antidepressants should entail matching the antidepressant to the patient, taking account

Table II: Classification of antidepressants

Class	Examples
Older tricyclics	Secondary amines (nortriptyline, desipramine) Tertiary amines (imipramine, amitriptyline, dothiepin, clomipramine)
Newer tricyclics	Lofepramine
Atypical antidepressants	Trazodone, nefazodone, mianserin
Monoamine oxidase inhibitors (non-reversible MAOIs)	Phenelzine
Reversible inhibitors of monoamine oxidase A (RIMAs)	Moclobemide
Selective serotonin-reuptake inhibitors (SSRIs)	Fluvoxamine, fluoxetine, paroxetine, sertraline, citalopram
Noradrenaline and specific serotonin enhancers (NASSs)	Mirtazapine
Noradrenaline reuptake inhibitors (NARI)	Reboxetine
Serotonin/noradrenaline-reuptake inhibitors (SNRI)	Venlafaxine

of tolerability, safety, side effects, drug interactions, and contraindications.

Although newer antidepressants, especially the selective serotonin-reuptake inhibitors (SSRIs), are often recommended as first-line treatment for depressive disorder in the elderly, it is unwise to dismiss the tricyclics out of hand. The well-supervised prescribing of potentially lethal drugs, such as tricyclic drugs, may be indicated in certain clinical conditions, such as for those with a more severe type of depression.⁴

Diagnosing a specific category of depression requires weighing up whether pharmacological treatment is required. Seeing a patient several times over a period of a few weeks or enlisting the help of a mental health care worker with assessing the patient over a period of time might be helpful. An alternative to such a 'wait and see' approach involves conducting a therapeutic trial of an antidepressant.

As certain of the symptoms of bereavement overlap with those of depressive illness, the latter allows one to see which symptoms might require pharmacological treatment. Clayton²⁰ makes some important points. First, the clinician always has a duty to relieve suffering. When such suffering takes the form of severe and enduring affective symptoms arising during bereavement, the short-term relief offered by pharmacotherapy might be justified. Specific symptoms, such as insomnia, can be treated with an hypnotic for a few weeks, with the decision of whether or not to treat being based on particulars of the specific case. Certain features clearly indicate depressive disorder, encouraging recourse to antidepressants. First, the bereaved individual may have begun to make progress over the first few months, only to relapse for no apparent reason. Second, the presence of suicidal thoughts, pervasive guilt, retardation, and 'mummification' – the maintaining of grief by keeping everything unchanged – suggests the presence of depressive disorder.

Building a partnership with the patient is critical, starting with an explanation that the depression warranting treatment with tablets is an illness. Depressive illness is common, treatable, and not a sign of

moral weakness. Many patients require reassurance that the tablets they will be asked to take are not addictive, and that depression is not a sign of 'senility' or a harbinger of dementia. Involve them in their own treatment by telling them, in plain language, why they should not expect immediate results. They should agree on a plan of treatment with their clinician. For example, the bereaved patient might be informed that antidepressants will relieve their depressive symptoms, but that further help to manage anxiety or to address how they deal with their bereavement is also indicated. Doctors who work with the elderly form part of a multidisciplinary team, one of whom should be appointed to co-ordinate the care delivered and to act as a point of contact for the patient and the family. Besides being multimodal, the treatment of later life depression should also be multidisciplinary.⁴

The next question to be asked is whether the numerous antidepressants available are superior to placebo and how their efficacy compares. The drug trials that have so far demonstrated the superiority of antidepressants over placebo have mainly been conducted on relatively young patients.⁴ The published literature suggests that the newer drugs are as effective as the older ones, which is supported by a meta-analysis of antidepressants in older people, which concluded that efficacy was similar across all classes of antidepressants.²¹

One needs to consider how efficacious such antidepressants are for special patient groups.

- **Elderly patients with dementia:**

The practical message seems to be that moderate and severe depressive symptoms should be treated with antidepressants in those with dementia, though, in milder cases, with offering support to the patient and carers, in many cases the symptoms will improve within a month.⁴

- **Depression in those living in residential and nursing homes:**

Given the high prevalence of depressive symptoms in care settings and the high rate of intolerance to older antidepressants, avoiding the older antidepressants is prudent and newer agents, such as the SSRIs, require caution.⁴

- **Depression associated with general systemic disease:**

Although the newer antidepressants appear to have found a niche here, their advantage for physically compromised patients is not all that convincing.⁴

The clinician should be well aware of the different side effect profiles of the different categories of antidepressants. A few pitfalls that may be encountered when prescribing antidepressants to older patients consist of the following:

- The cardiotoxicity of tricyclic drugs has probably been exaggerated.⁴ Nevertheless, a tricyclic should not be administered to patients with a known tendency to either a tachy- or bradyarrhythmia; a bundle-branch block; those with abnormal or interval syndromes; or those whose heart failure is poorly controlled.^{4,22}
- The main problem with administering tricyclics to the elderly is that they often cause postural hypotension, which may lead to unpleasant dizziness or dangerous falls.⁴
- The main metabolite of fluoxetine is clinically active, remaining so for approximately a week, possibly longer for older patients. Therefore, the drug must be discontinued for at least five weeks before an older monoamine oxidase inhibitor can be used.⁴

- Some SSRIs (thus far fluoxetine, fluvoxamine, paroxetine and, to some degree, citalopram) have proved to inhibit the action of hepatic enzymatic oxidation (cytochrome P450 2D6-debrisoquine hydrochloride). About 7% of Caucasians lack P450 2D6, due to a genetic mutation. The combination of a tricyclic with an SSRI has proved quite popular, but is not without risk of elevating tricyclic levels into the toxic range. A particular problem arises from the long half-lives of fluoxetine and its main metabolite.⁴

If the clinician refers the older depressive patient to a psychiatrist, with electroconvulsive therapy (ECT) becoming a treatment option, they must keep the following facts in mind:

- Since ECT was reintroduced in 1938, it has remained the most effective treatment of depression, with a recovery rate of approximately 80% in acute-phase treatment.⁴
- ECT is as effective with older people as it is with any other age group and is effective and well tolerated in the very old.²³
- ECT is the treatment of choice for patients whose lives are threatened by food and/or fluid refusal, profound retardation or suicidal behaviour.⁴
- ECT is highly effective for delusional (psychotic) depression.²⁴
- The contraindications to ECT are relative. If employed as a life-saving procedure, it may be used even in the presence of hazardous physical illness, though the patients' physical condition should first be optimised and the anaesthetist a senior clinician.

Psychological and social approaches to management

The treatment of elderly patients with depressive disorder demands multidisciplinary skills.¹³

Counselling may be appropriate for managing depressive symptoms accompanying change, stress, threat or loss to the individual, such as with bereavement. However, the depressive disorder should first be optimally treated.

Cognitive-behavioural therapy (CBT) and interpersonal psychotherapy are the two most widely advocated forms of psychotherapy in elderly patients with depression, including the use of carers required to look after a person with dementia. Psychotherapy is most effective when combined with antidepressant medication.

The family is, by far, the most important agency supporting the psychogeriatric patient at home.¹⁶ Beginning with the psychiatric history, information must be sought concerning the nature, frequency and quality of family interactions. Interventions with families vary in complexity, with the first step being to provide straightforward information about the nature of the illness. Later, more detailed interviews with members of the family should clarify the key family roles. Formal family therapy can be offered to families with an elderly depressed member if it is thought that family dynamics are a factor in perpetuating the depressive illness.

Social aspects of management, including poor housing, poverty, high local rates of crime and other indices of deprivation, are important prognostic considerations.¹⁴

Prognosis

Poor outcome factors can be grouped in clinical features of the disorder and general factors.⁴

Clinical factors of the disorder include the following: a slower initial recovery; more severe initial depression; a duration of more than

two years; three or more previous episodes; a previous history of dysthymia; psychotic symptoms; extensive deep white matter and basal ganglia grey matter brain disease; and coarse brain disease (e.g. dementia). General factors consist of: chronic stress associated with a poor environment, crime, poverty, a new physical illness, and poorly perceived social support.


The immediate prognosis for an episode of depressive illness in later life is good, though, in the longer term, only about 25% will remain completely well. Such patients seem to be characterised as having responded well and rapidly to conventional treatments, as well as being notable for their physical fitness.¹⁷ For approximately 60% of all patients, the longer term prognosis is quite good, in that they will either remain well or have relapses that can be successfully treated. About 7–10% seem to be resistant to all conventional therapies and up to one-third will improve, but will be left with some disabling symptoms, such as anxiety and hypochondriasis. Little is yet known about the latter group.⁴

Relapses are common and occur relatively early on: two-thirds occurred within the first 18 months of follow-up, according to Godber et al.¹⁸ Careful follow-up, especially during this period, is, therefore, essential. Lastly, such naturalistic studies do not support the view that patients with depression have a higher than expected rate of dementia, which is an important point to emphasise both to patient and carer.⁴

The ultimate tragedy in terms of outcome, suicide, is not covered in this review.

Conclusions

Depressive disorder is the most common mental health problem of the elderly. Diagnosis can be difficult, due to physical comorbidity, which can mask depression and age-associated factors that modify its clinical presentation.⁴ Organic factors, including alcohol and iatrogenic drugs, must be ruled out in the aetiology. Physical ill health must be optimally treated. New research suggests that brain abnormalities, most likely vascular in nature, contribute to the onset of depressive disorder in late-onset depression. Treatment should be multimodal

and multidisciplinary, with the aim of complete recovery and not simply improvement. Persistence pays – using a range of treatments, most patients will recover.⁴ Keeping patients well is more of a challenge. Treatment should be continued for at least 12 months. Many patients who could benefit from long-term maintenance therapy do not receive it. With optimum management, the prognosis is at least as good as that for any other time of adult life.⁴ 

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