

## Lecture Notes: Depression in Later Life

Notes taken by Sandra Hogan

The April lecture in the Aware Monthly Lecture Series looked at *Depression in Later Life* and the speaker was Dr Declan Lyons, Consultant Psychiatrist at St Patrick's Hospital, Dublin.

At the start of the lecture Dr Lyons outlined the questions that he hoped to address during the session:

What is depression, how does it present (differently from younger adults)?

What are the risk factors for depression in older people?

Why is it important to treat?

What are the treatments that work in later life depression?

How can people going through depression help themselves?

What is the take-home message about depression?

### Demographics

- In Ireland and Western Europe most people can expect to live to 80 years of age (30 years more than in 1900)
- People spend an average 20 years in retirement (average retirement lasted one year in 1900)
- 13% of population (520,000 people) are 65 or older in Ireland
- 100,000 older Irish adults have a mental illness of some severity
- We will see greater increases in 'oldest old' (> 85) in the future
- Variability between people increases rather than decreases as we get older: some older people run marathons, some are creative and productive even in advanced old age
- Some elders have wisdom, resilience and ability to compensate in abundance
- For many others we unfortunately see disability, depression, dementia and death

### Depression

- Depression is the commonest mental illness in older people
- Depressive *symptoms* are more prevalent than 'full blown' major depression; 15% in community-dwelling elders but 40% amongst nursing home residents
- Major depression affects: 2-3% of over 65's in community; 15% of hospital inpatients; 15% of nursing home residents
- WHO: depression is second to heart disease as cause of lifelong disability

- Ageist assumptions that old age is fraught and gloomy abound in literature, attitudes and mythology
- Depression seen as justified or understandable due to bereavement, loneliness, ill-health or loss of role. This is a major obstacle to recognising and treating later life depression.

### **Why do we need to recognise depression?**

It is important to recognise depression as it is a very common condition and can cause inherent suffering and reduce quality of life. Depression is the commonest cause of completed suicide in those aged 65+. It is also associated with poorer outcomes for physical illness. Depression can become persistent or progress to an acutely severe stage requiring urgent intervention and treatment may significantly alleviate the distress.

### **Presentation of depression**

The standard definition of major depression is:

- Symptoms persist for two weeks or longer
- Presence of depressed mood/inability to enjoy life
- Any four of the following seven criteria: change in sleeping habits; change in eating habits; low energy/fatigue; trouble concentrating; feeling worthless or excessively guilty; marked restlessness or slowed down movements; thoughts of death or suicide.

### **Differences in late onset depression**

Older people may actively deny depressed mood, perhaps due to an acute sense of shame or the stigma associated with mental health issues. They may have marked anxiety/agitation that actually stems from depression. There is more apathy, impaired motivation and retardation as well as a poor subjective memory. Hypochondriasis and somatic concern can be present instead of sadness. Physical symptoms of depression may be attributed to 'old age' e.g. lethargy. Behavioural changes may also be noted e.g. throwing self on floor, letting go and food/fluid refusal.

### **Diagnosis**

Primary care surveys show that only 50% of people with depression seek help: of those who do, only half had depression diagnosed and adequately treated. Services may be ignorant of depression, apathetic (depression seen as inevitable as one ages) or have a sense of misplaced altruism (wanting to spare older people a psychological inquiry or exposure to medication, fearing side effects). Depression in older people is thus *underreported, underdiagnosed* and *undertreated*.

## Classification of depression

- Major depression - a classical picture similar to younger adults.
- Non-major depression - minor but certainly not trivial. Associated with physical ill health. Similar effects as major depression (features include amotivation, poor concentration and poor cognition)
- Bipolar disorder - rare to start late in life
- Due to physical illness - called organic mood disorder
- Vascular depression - due to mini-strokes which are often asymptomatic.

## Who is vulnerable to depression in later life?

A number of factors increase a person's risk of experiencing later life depression and these include:

- Female gender
- Widow(er), divorced
- Past history of depression
- Poor physical health especially associated with stroke, heart attack, cancer, Parkinson's disease, especially linked with chronic, painful conditions and disability.
- Poor perceived social support
- Institutional residence (poor quality nursing home)
- Alcohol excess
- Medication excess
- Those who are full time carers for a sick spouse or family member
- Personality traits of dependency, excess pessimism, perfectionism
- Recent acute stress e.g. bereavement, divorce, ceasing role as a childminder, retirement, financial loss, and especially change in health
- Brain changes e.g. mini-strokes, brain shrinkage, those who already have been diagnosed with dementia.

## Special presentations of depression

- **Pathological grief -that which is abnormally intense or delayed**  
*Features suggesting depression rather than normal grief:*
  - 1) Guilt feelings not related to events surrounding death of the loved one
  - 2) Thoughts of death not related to the deceased
  - 3) Preoccupation with feelings of worthlessness
  - 4) Psychomotor retardation
  - 5) Prolonged and marked functional impairment
  - 6) Hallucinatory experiences (other than image or voice of the deceased).

- **Psychotic depression - can occur in 25% of all cases**  
Core features are delusions (nihilistic type, failure, extreme guilt, deserving of punishment, hypochondriacal) and hallucinations (especially voices commenting on person's supposed failure, commands to self-harm etc)  
Stupor - person is mute, unresponsive and immobile but awake. This can be associated with risk of death from dehydration.

### **Clinical evaluation of depression**

Involves:

- Screening
- History, mental state examination
- Risk assessment
- Physical examination
- Physical investigations: basic blood tests, exclude thyroid problems, diabetes, anaemia, vitamin deficiencies.
- People at high risk of suicide need urgent specialist referral.

### **Treatment of depression**

The first step is a thorough assessment. A lot of older people receive care for mental illness through primary care. Co-locating mental health and physical care in the same setting with specialist input is ideal.

### **Goals of management**

Approach is multimodal (physical and psychological modalities) and multidisciplinary (input from nursing, social work, psychology, occupational therapy, dieticians, physiotherapy etc).

Aim to reduce risk (suicide and self-neglect), and to restore optimal function, both physical and social.

Aim to treat the whole person, including physical health, nutrition, poor mobility/reduced social supports

Aim to prevent relapse and recurrence

### **Proper management should:**

- Assess and reassess risk
- Educate about depression
- Treat co-existing physical health problems
- Attend to social care needs
- Review medication - stop unnecessary prescriptions
- Intervene with appropriate treatment – often this may be an antidepressant with or without a psychological intervention.

## Choosing an optimal anti-depressant

Which medication will help which person is hard to predict. They don't always work and even when they do, full effect takes 4-6 weeks. Safety is paramount with older patients (not only side effects but also drug-to-drug interactions). Response rates (defined as 50% reduction in symptoms) for most medications is 50-65%. Placebo response is 25-30%.

*Some drawbacks of medication include:*

- As a rule, newer drugs have milder side effects
- Older drugs can be associated with blurred vision, slowed urination, dizziness on standing, sedation, irregular heartbeat, falls and confusion.
- Careful dose adjustment can usually prevent many side effects
- Other side effects: weight gain, constipation, low sodium in blood, bruising/bleeding risk
- Commonest are nausea and stomach upset (transient)

*Increasing response beyond 50-60% may involve:*

Switching to new medication

Raising the dosage

Boosting one antidepressant by combining it with another

Full remission may take months, so it's important not to stop medication too soon.

## Treatment adherence

Non adherence (33-81%) may be brought on by complex tablet regimes, increasing cost, side effects, cognitive problems (forgetting), preference for different treatment, taking the law into own hands (changing doses, sharing tablets). Enlist support from family/friends - anyone who can remind you or help you take the medication. Dosset boxes (usually labelled with days of week) or blister packs are very useful.

## Psychological Therapies in Older People

Psychotherapy can relieve depression by providing safe place to discuss personal thoughts, feelings, wishes and hurts. Therapists are neutral, objective and skilled at helping people make sense of past events or current predicaments. They help to explore the making of appropriate changes in life and relationships. Successful therapy above all needs *rapport, expertise* and *motivation*.

## Models of therapy

- CBT treats depression from the premise that what you think about the world determines how you feel and act. Teaches thought-monitoring and helps you replace depressing assumptions with better ones.

- IPT (interpersonal therapy) educates the person about depression and relationships, aimed at improving communication and expectations within relationships.
- Other therapies include anxiety management (relaxation), bereavement therapy, marital therapy, family therapy, narrative therapy and supportive psychotherapy or counselling.
- A combined approach of medication and therapy can ensure the best outcome.

In general, psychotherapy is underutilised in older people. Therapy should be more active, focusing on short-term goals or behavioural changes. Therapist may need to be more directive, supportive and flexible (with problems of transportation, finance, health, timing of sessions) and the therapy needs to recognise the reality of loss, advanced age and limited time.

## **ECT**

Dr Lyons spoke of ECT as a proven and generally safe treatment for depression in older people. Main indication is severe depression when there may delusional ideation/refusal to eat and drink/severe retardation/acute suicidality, and in emergencies. High remission rates are achieved (75-80%). May be indicated when earlier treatment has failed. ECT has received some bad press in the popular media: some have referred to it as a barbaric treatment. This may perhaps have been the case in the past but not now. Medical supervision, complete anaesthesia and muscle-relaxing drugs ensure it is safe and well-tolerated procedure even among frail older people. Concern and debate over temporary memory loss and mild confusion in some (certainly not all) still goes on. Despite well described accounts, careful studies haven't shown any permanent effects on memory six months after treatment.

## **Support networks**

Many organisations/services exist for older people in the community e.g. active retirement groups, bereavement groups, day centres. They help older people meet key psychological and emotional needs. Practical supports such as home-help services, meals-on-wheels, befriending services can significantly improve quality of life. Campaigning organisations such as Age Action champion needs of and services for older people and try to portray more positive image of aging. Volunteer-based services rely heavily on older people who themselves benefit from being involved.

## **Staying Well**

- Keep as active as possible with gentle exercise
- Build a routine and do something constructive each day

- Keep making new friends
- Make sure your home is bright and safe
- Try and be as accurate as possible about taking all prescribed medication
- Go easy on alcohol; have a varied diet
- Stay enthusiastic; be involved in your community.

### **Summary**

Depression is common: 20-30% of all GP visits may be related to stress and depression. As many as 1 in 2 nursing home residents may have depression. Clues suggesting depression include pain, insomnia, anxiety, frequent calls to GP or family members. Depression is often seen post-surgery (heart), post hip fracture, stroke or in those who refuse medical care. Late life depression magnifies any existing medical/physical disability, pain or dependency. Screening for depression helps identify those who need professional help.

Effective treatments are available: older people may take longer to recover but eventually respond just as well as younger adults. Most late life depression is treated by GP's not psychiatrists. Suicide is still a major problem associated with depression and can be up to 5 times commoner in older people. Maintaining good physical health, keeping your brain stimulated and continuing social and productive activity is the best way to age well.

Resources: *Living Longer Depression Free*; Miller and Reynolds, 2002. Johns Hopkins University Press  
*Mental Health and Well Being in Later Life*; Mima Cattan, 2009. Open University Press  
[www.aware.ie](http://www.aware.ie)  
[www.livinglifetothefull.com](http://www.livinglifetothefull.com)  
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