AFFECTIVE DISORDERS IN LATE LIFE

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Epidemiology of depression in old age:

If strict DSM III R criteria are applied by "trained interviewers" in community surveys, 2-4% of elderly suffer from depressive disorder (major depression 1%; dysthymia 2%; mixed depression and anxiety 1.2% and 'mild dysphoria' 19%). However if clinical interviews by experienced clinicians are conducted and all persons with clinically relevant depressive symptoms are included, the rates of depression rise to 10-15% (Blazer @ Williams, 1980; Gurland et al, 1983).

In elderly, depression is responsible for the majority of psychiatric admissions to psychiatric services of general hospitals or acute psychiatric facilities.

Depression is felt to be the most common psychiatric disorder of old age with an estimated 13-15% of elderly who have significant depressive symptoms. (If strict DSM III criteria are used for major depressive episodes and dementia, then dementia is more common.)

In medical settings, depressive disorders are common and often atypical. 12% of elderly in acute care hospitals suffer from major depression and another 23% has significant depressive symptomatology (Koenig, 1988; Parmelee, 1989).

In nursing homes and other institutions providing long-term care, 12% suffer from major depression and another 31% have depressive symptoms.

Most frequently associated stressor in major depression is an actual or perceived loss, particularly loss of health and resulting disabilities.

Suicide rates in Canada, in 1985:
Highest rate (men and women): 55-59 age group (18.2/100,000)
Highest rates for men: 20-24 age group (30.8) and 70+ age group (30.1/100,000)
Highest rate for women: 45-49 age group (10.4)
Ratio of attempts completed suicide continues to be much lower in elderly (92/1 men; 4/1 women) than that seen in younger women.

Risk factors for suicide in elderly:

- Sex male
- Presence of physical illness (Baraclough '71, Sainsbury '62)
- Previous suicide attempt (Baraclough '71, Bock '72)
- Psychiatric illness (50-70% of suicides had depression)
- Bereavement (Durkheim '51, Sainsbury '62, Paykel '75)
- Organic mental illness (Lesse '67)
- Isolation and loneliness (Sainsbury '62), single, widow(er), living alone, few social contacts

- Alcoholism (Kahne ’73, Gardner ’64)

Depression vs. normal grief reaction:

- In grief reaction, the sx and signs of depression may be present except for morbid preoccupation with worthlessness, marked psychomotor retardation, delusions or active suicidal ideation.
- In normal grief, feelings of guilt are limited to things done or not done in relation to the deceased or his/her fatal illness; thoughts of death are limited to a passive wish that he/she would rather have died before or with the deceased to avoid the pain of grief; depressed mood or reaction is regarded abnormal or proportionate to the loss. . .
- In normal grief, there is no marked functional impairment, at least not beyond the first 2 months after the death: this means that the housewife is able to carry out her normal activities within the house and persons at work have returned to their jobs.
- Occasional tearfulness, ‘anniversary reactions’, and some restriction of social activities may be present for several months or years depending on cultural norms but neurovegetative symptoms have usually cleared within 2 months of the loss.

Masked depression:
More common in the elderly. Depressed mood may be absent but patient presents with somatic complaints, pains, tiredness, fatigue and lack of energy (pseudo-anergic syndrome).

Masked depression may present as a ‘late onset personality disorder’ with alteration of previous usual behaviour (recent alcohol abuse impulsive sexual behaviour, acting out behaviours) or ‘late onset anxiety disorder’ (obsessive-compulsive, somatisation D).

Depression vs. anxiety disorder:

	Anxiety Disorder	*Depression*
Anxiety	future-oriented	past-oriented
Diurnal var	worse in P.M.	worse in A.M.
Feeling	helpless	hopeless
Sleep	initial insomnia	middle/terminal insomnia
Suicidal	afraid of dying	often suicidal
Onset	young adult	later in life
Course	better with anxiolytics	worse with anxiolytics

ORGANIC MOOD SYNDROMES: Most commonly seen in elderly

Strokes: Approx. 25% of stroke victims appear to develop major depression, with pts with left-hemisphere strokes being more vulnerable. 50% of stroke patients have depressive symptoms. This may be related to widespread depletion of NE following stroke. Treatment with Nortriptyline proven effective; other antidepressants with low potential for affective blood pressure and low anticholinergic activity would be reasonable choices.

Parkinson's disease: 30 to 70% of pts with Parkinson's have depressive symptoms. They have lower levels of 5HIAA in their CSF. Drugs without anticholinergic activity (but not MAOI's) are best to treat this condition.

Other common causes of organic mood syndrome, depressed:
Endocrine disorders (thyroid, adrenal), viral illnesses, B12 def. and collagen-vasc. disease as well as medications (resperpine, methyl dopa, steroids) can also cause organic depressive disorders.

Organic manic disorder may also be induced by strokes, right hemisphere cancer, syphilis, encephalitis, hyperthyroidism, hemodialysis, uremia, M.S., post-head injury and drugs such as steroids, thyroxin, levodopa, bromocriptim, sympathomimetics, amphetamines, cimetidine.

Treatment guidelines: correct and/or stabilize underlying problem as much as possible and treat mood dist. With standard treatments as most of the time the mood dist. will continue despite correction of underlying problem. Treatment has to proceed very carefully because these patients will be more susceptible to side effects because of their underlying illness and/or its concurrent treatment.

Pseudo-dementia (depression with cognitive impairment): different from dementia as:
- More acute onset, heralded by changes in sleep, appetite and energy
- Depressed patients communicate their distress non-verbally
- Cognitive loss often 'patchy' or inconsistent
- Patients give 'Don't know' answers on MSE, do not try to hide their deficits
- More frequent personal or family history of affective disorder
- Amytal interview may bring outpouring of depressive affect rather than worsened confusion or disorientation
- Patients improve with ECT or other treatment for depression

Depression with somatic complaints is different from hypochondriasis:
- Patients appear to suffer and communicate their distress
- Anger is internalized rather than directed outwards
- Socially, depressive withdraws or looks dysfunctional while hypochondriac mingles
- When influence of stress on physical sx is suggested, depressive is more receptive to idea
- Somatic difficulties have been episodic (rather than chronic) or onset is late in life; tolerates antidepressants as well as average elderly
- Suicidal thoughts are common in depression and rare in hypochondriasis
- 'Hypochondriasis' (De Alarcon '64) these patients were most likely depressives with somatic complaints: 24% of elderly with hypochondriasis vs. 7% without attempted suicide

Depressions with following sx or signs are accompanied with increased lethality: delusions, agitation, active suicidal ideation, marked retardation (when pt 'activated' but still dysphoric), mixed manic and depressive symptoms.

Common symptoms and signs of late life depression:

- Loss of interest often replaces depressed mood; ‘do not feel like their old selves’
- Feelings of uselessness and decreased life satisfaction but verbalize less guilt
- Irritability, excessive worry, impulses to cry
- Poor concentration/memory: suffer more profound (but probably not more frequent) cognitive dysfunction during depression than younger patients and may be mislabelled demented
- Somatic complaints and tendency to attribute symptoms to medical illnesses (may mimic hypochondriasis)
- Digestive symptoms (poor appetite/digestion, constipation)
- Sleep disturbance (early a.m., frequent awakenings, ‘Have not slept’)
- Unexplainable aches and pains
- Excessive fatigue
- Delusions are more frequent in the elderly (unforgivable behaviour, somatic, nihilistic, ‘paranoid’ revolving around being perceived as a bad person or being tortured)
- Weight loss
- Bowel impaction due to severe constipation
- Agitation and complaints of ‘bad nerves’ (may be mistaken for anxiety disorder)
- Sleep EEG changes with depression include delayed onset of sleep, early morning awakenings, decreased REM latency, increased REM density, and increased sleep discontinuity

Differential diagnosis of major depressive episode:

- Organic mood disorders (see below)
- Dementia with mood disturbance
- Dysthymic disorder
- Normal grief reaction
- Anxiety disorder