Older men and depression

Depression in older men has a number of striking differences from depression in older women. Its presentation and symptoms can be different, more often resulting in death by suicide, indicating a gender-specific management. Though no less common in community populations, it appears to be more prevalent in selected areas. **Professors John Wattis** and **Stephen Curran** review the evidence and the effects management.

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Robust epidemiological studies have shown the overall prevalence of depression in those over 65 is around 12 per cent (14 per cent for women and eight per cent for men)[1]. Interestingly, there was marked geographical variation in Europe – and even within England (eg, London 17 per cent, Liverpool 10 per cent). Prevalence in selected populations is higher. For example, a community study in Perth showed that four months after stroke there was no significant difference between the rates of depression in men and women, but at the 12-month follow-up over three-quarters of the men remained depressed whereas most of the women had recovered[2]. A population-based study of older people with coronary heart disease also showed a relatively higher prevalence in men (29 per cent) compared with women (20 per cent)[3]. Gender-specific data are not available in all areas but, overall, people with dementia and their carers are at increased risk of depression and depressed people with (or without) dementia show a higher rate of impairment in activities of daily living[4,5]. People in residential homes[6] and acute (physical) inpatient settings[7] are more likely to be depressed than those dwelling in the community and recognition of depression in these settings is not good[8]. Perhaps most important of all, is the high rate of suicide in depressed older people – twice that in younger people[8] and highest of all in old men.

Presentation and symptoms

Some think the relatively low prevalence of depression in older men (only two-thirds that of older women) is partly because depression is less likely to be recognised in them. However, breaking research[9] suggests the genetic basis of severe (early onset) depression in men and women may be different. Certainly depressed older men often describe their symptoms differently. In focus groups conducted in the US by the National Institute of Mental Health[10], men described symptoms of depression without realising what they were describing. Many were unaware 'physical' symptoms, such as headaches, digestive disorders and chronic pain, could be associated with depression. In addition, they feared contact with mental health services – or being labelled with a diagnosis of mental illness – would cost them the respect of their family and friends, or their standing in the community.

Suicide and self harm

The profile of older people who deliberately self harm more closely approximates the profile of those who kill themselves than the profile of younger people who deliberately self harm[11]. This implies older people who self harm are more often 'failed' suicides than people making a 'cry for help'.

At all ages, men are more likely to kill themselves than women. Studies have shown that contact with mental health services is lower for males under 65, and for both sexes over 65 years[12]. General practice contact rates were higher but still lower for men than women, with one study finding a higher GP consultation rate in older people (though not necessarily for overt depression)[13].

Detection

When we consider all these facts together, we are drawn to some interesting conclusions about the detection and management of depression in older people. Although some with recurrent depressive disorders may be well known to their GPs with recognisable 'relapse signatures', it is the 'hidden' depressions that cause most concern. They may adversely affect the prognosis of physical conditions and may themselves lead to poor quality of life, self neglect, self harm and suicide. Men seem more likely to have these 'hidden' depressions, with a higher prevalence of depression in men with cardiovascular disease, a stronger tendency to concentrate on physical rather than psychological symptoms and a reluctance to engage with mental health services. They are also at highest risk of suicide.

Detection can be improved by systematically considering the possibility of depression whenever an old person is seen in the clinical context. Where risk factors such as chronic disease, disability and social isolation are present, depression should be carefully sought. People in acute hospital or residential care, people with Alzheimer's disease (and those looking after them) and those recurrently attending surgery with overvalued physical symptoms are other high risk groups. Screening for depression using validated tools such as the Geriatric Depression Scale or one of its shorter versions[14] is justified. The tendency of older people – and men in particular – to de-emphasise psychological and over-emphasise physical symptoms should be remembered.

Management

The first step in managing any condition is making a diagnosis and assessing severity. In guidance issued by the National Institute for Health and Clinical Excellence (NICE)[15], a distinction is made between the following subtypes of depression:

- mild depression;
- moderate depression;
- severe depression;

Table 1. 10 depressive symptoms (modified from ICD-10, 1992)

- Depressed mood that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances and sustained for at least two weeks
- Loss of interest or pleasure in activities that are normally pleasurable
- Decreased energy or increased fatiguability
- Loss of confidence or self esteem
- Unreasonable feelings of self-reproach or excessive and inappropriate guilt
- Recurrent thoughts of death or suicide or any suicidal behaviour
- Complaints or evidence of reduced ability to think or concentrate, such as indecisiveness or vacillation
- Change in psychomotor activity with agitation or retardation
- Sleep disturbance of any type
- Change in appetite (decrease or increase) with corresponding weight change

- severe depression with psychotic symptoms.

These are defined according to the International Classification of Diseases 10th edition (ICD-10, World Health Organisation, 1992)[16]. This uses a list of 10 depressive symptoms (see *Table 1*). Three of these: excessive tiredness, sleep disturbance and disturbances of appetite and weight are commonly considered to be 'somatic symptoms'. A distinction should be made between these core symptoms and the male tendency to concentrate on somatic symptoms (including less specific symptoms such as headaches and general aches and pains). Depressed men are more likely to construe depression in non-psychological terms.

ICD-10 divides the most common form of depression into four groups:

- not depressed (fewer than four symptoms);
- mild depression (four symptoms, including at least two of the first three);
- moderate depression (five to six symptoms); and
- severe depression (seven or more symptoms, with or without psychotic symptoms).

The obvious danger is of relying on this 'symptom count' in men who may deny the core symptoms of depressed mood and persuasively attribute other symptoms to physical illness or circumstances. History of depressive episodes and treatment response, difficulty continuing ordinary activities, the presence of self neglect and ideas of self harm

contribute to the diagnosis and assessment of severity. In moderate depression the patient is likely to have great difficulty in continuing ordinary activities and in severe depression the symptoms are marked and distressing, though sometimes the patient may be unable to communicate them. Many men will conform to the ICD-10 symptom pattern but some – including some who are suicidal and depressed – will not. Sometimes these men present with physical symptoms and anxiety about them; sometimes they may present as apparently 'rational' suicide attempts (eg, choosing suicide as an alternative to a possibly debilitating illness).

NICE guidance advises that where anxiety and depression symptoms co-exist, precedence should be given to treating the depression. On management, NICE is quite specific and detailed, suggesting 'watchful waiting' and 'guided self help' are the best strategies for mild depression. For moderate or severe depression medication, psychological interventions and social support are appropriate. Treatments for mild or moderate depression can be delivered in primary care. Specialist mental health teams should be involved in the following circumstances where the diagnosis is uncertain; depression is treatment resistant, atypical, recurrent or psychotic; and where there is 'significant risk'. Treatment will involve medication, complex psychological interventions and/or combined treatments. Management of physical health is also important as poor physical health is often a cause of depression, making it more difficult to treat. In addition, drugs to treat physical illness can sometimes cause depression. Finally, where there is risk to life or severe self-neglect, crisis intervention and inpatient care with medication, combined treatments and electroconvulsive therapy (ECT) may be needed.

Psychological interventions are beyond the scope of this article. An account of cognitive behavioural therapy (CBT) with older adults can be found in Laidlaw *et al*[17]. A detailed description of the different classes of drugs available and their use can be found elsewhere[18].

Acute and continuation treatment using drugs

Selective serotonin reuptake inhibitors (SSRIs) are recommended as first-line treatments by NICE. Generic citalopram and fluoxetine are cheapest. Sertraline is safest in people with cardiac problems. Venlafaxine should be used with caution in this group and NICE advises it should only be initiated

Key points

> Depression is less commonly diagonsed in old men than old women.

> It is more common in particular sub-populations and in some of these it may be more common in men than women.

> The presentation of depression in older men is sometimes very hard to recognise, being masked by over concern with physical symptoms and denial of depressed mood.

> Suicide rates are high in depressed old men.

by specialists. Venlafaxine and mirtazapine may produce a response where SSRIs fail. Mirtazapine is one of the first choices for combined antidepressant therapy (again, a specialist intervention). Approximately 40–60 per cent of older people respond to antidepressants[19], some doing better on a second choice or combination treatments. There is some emerging evidence drugs that act on the noradrenergic system as well as the serotonergic system (serotonin and noradrenaline reuptake inhibitors (SNRIs)) may be particularly useful in more severe depression and in the presence of somatic symptoms of depression[20]. Given the possible different genetic basis of depression in men and women, it may one day be possible to offer advice on treatment specific to gender but at present this is not the case.

Therapeutic response to antidepressants may occur within two weeks but the onset of therapeutic action may take longer in older people and optimum benefit can take place 8–12 weeks after commencing treatment[21]. When initial treatment with a tricyclic has been ineffective, a second antidepressant may take five to six weeks to have an effect[22]. Adequate doses are essential and easier to achieve without intolerable side effects in some of the newer drugs. The elderly are at high risk of recurrence following a depressive episode, with up to a 70 per cent risk of recurrence within two years of remission[23]. If antidepressant treatment is stopped within six to 12 months and substituted with a placebo, approximately 50 per cent of patients will relapse; but if treatment is continued for 12 months, 90 per cent will continue to respond. The risk of relapse is greater if the patient has had a number of previous episodes[24].

Continuation drug therapy (at the same dose needed for therapeutic effect) reduces the risk of relapse after remission. In older people, a minimum 12-month period of continuation with antidepressants is recommended in contrast to six months for younger patients[25]. Patients with recurrent depression should be treated for at least two years and evidence is accumulating for the benefit of continuing treatment for at least two years even after a single episode of severe depression in old people[26]. Treatment resistant depression, bipolar disorder and the use of lithium, other mood stabilisers and ECT are outside the scope of this article.

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