# Depression

Depression kills people through suicide, self neglect and its negative impact on the outcome of other diseases, especially cardiovascular disease and stroke. It is often not taken seriously enough because it is not recognised. Depression is also a major cause of unnecessary disability.

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There are special considerations in the detection, diagnosis and management of depression in older people, especially those with concurrent physical illness and handicap. Late in 2009 NICE issued revised guidance on the management of depression in adults[1] and on the management of depression in adults with a chronic physical health problem.[2] One of the outstanding features of the guidance is the emphasis it puts on structured psychological therapies. There is still some question as to how far these therapies are available to younger adults and even more question as to whether they are available to older adults. Here we consider issues that are important with older people and then look at how the "stepped care" ideas of the NICE guidance can be applied to them.

## Prevalence

The prevalence of clinically significant depression in over 65s is around 12% (14% for women and 8% for men).[3] In patients with associated physical health problems the gender difference may be reversed.[4] There is geographical variation in prevalence (eg. London 17%, Liverpool 10%),[3] perhaps reflecting social deprivation in the London study population. In residential homes[5] and general hospitals[6] depression is two or three times more common than in the community. Physical disability, handicap and social isolation are also associated with increased prevalence.[7] Patients who repeatedly consult with their GPs are more likely to be depressed and there are causal associations (possibly in both directions) with dementia, cardiovascular disease and stroke. Those who care for people with dementia are also at increased risk of depression. Major life events, especially bereavement, may precipitate depression. The associations are many and are summarised in "Practical Management of Affective Disorders in Old Age".[8] The association between depression and poverty suggests that with the recent recession we will see the prevalence of depression and the associated suicide rate rising.

Some of the factors which should alert the practitioner to a higher risk of depression are summarised in Box 1.

## Presentation and symptoms

Depression in old age does not always present in a straightforward way. Men are particularly likely to present with physical rather than psychological symptoms. Older men may describe symptoms of depression without realising that they are depressed. They may be unaware that "physical" symptoms, such as headaches, digestive disorders, and chronic pain, could be associated with depression. In addition, they may fear the stigma of mental illness. Older people with depression sometimes present with concerns about memory problems, though the full blown picture of "depressive pseudodementia" is rare. Of course, the classical signs and symptoms of depression are often present in older people with depression but physical illness may be used as a "smokescreen" to hide underlying feelings of depression and as a (maladaptive) way of seeking medical attention and reassurance. Such a (fictionalised) case is described in the case study.

Ideas of self harm should always be actively sought in a patient who appears to be depressed. Older people who deliberately self harm are more likely to intend to die than younger people who do so.[9] At all ages, men are more likely to kill themselves than women and old men remain one of the highest risk groups for suicide.

## Detection

Although some people with recurrent depressive disorders may be well known to their GPs with recognisable "relapse

**Box 1:** Some of the factors which should alert the practitioner to a higher risk of depression

- Female gender (male gender in the presence of coronary heart disease or stroke)
- Other chronic illness (including cancer, cardiovascular disease, dementia) + CHRONIC PAIN
- Caring for someone with one of these illnesses (especially dementia)
- Social deprivation and poverty
- Isolation and handicap
- Frequent consultation pattern in primary care
- Hospital admission with physical illness
- Recent major life event (especiallybereavement)

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. Detection will be improved if practitioners systematically consider the possibility of depression whenever they see an old person especially when additional risk factors are present. If in doubt practitioners should ask about depression using two questions (Box 2) recommended by NICE.[1]

A positive answer to either of these should lead to an appropriate mental health assessment. Screening for depression should perhaps be an automatic procedure whenever a move to residential care is considered and whenever a person is seen who has been admitted recently to hospital for physical illness. The tendency of older people and men in particular to de-emphasise psychological and over-emphasise physical symptoms should be remembered.

## Diagnosis and management

### Diagnosis

NICE guidance prefers the American Diagnostic and Statistical Manual, edition IV (DSM-IV) definition of depression to the World Health Organisations International Classification of Diseases, edition 10 (ICD-10). A diagnosis of clinically significant ("major") depression requires at least five of the symptoms in Box 3.

Using these symptoms as anchor points, the NICE guidance identifies four different categories of depression as listed in Box 4 These categories are the basis of recommendations for "stepped care".

In making the diagnosis family and personal history of affective disorder are also important and enquiry should

**Box 2:** Questions to be asked when depression is suspected (NICE)[1]

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

also be made about possible "manic" episodes in order to exclude bipolar disorder. The patient's physical health and any medication received should also be noted. Some medications may cause depressed mood (Box 5) and, if the onset of depression appears to be linked to medication, alternatives should be considered.

This is a sensible evidence-based approach to interventions in depression and contains four clear steps which we present in modified form below.

### Step 1: recognition, assessment and initial management of all known and suspected presentations of depression:

This encourages practitioners to be alert to the possibility of depression in people with a past history of depression or any of the risk factors listed above. When there is a possibility the two questions in Box 2 should usually be asked. If either produces a positive answer or the practitioner is still concerned about the possibility of depression then a full mental health assessment is required. If there is an immediate risk of harm to self or others an urgent referral to specialist mental health services is indicated. People with depression (and their carers where appropriate) should be advised of the possibility that increased agitation, anxiety and suicidal ideation may occur, especially early in treatment and how to seek help should that occur. Practitioners should also monitor closely for this increase in risk. If suicide risk increases, increased support is necessary, usually including urgent referral to specialist mental health services.

### Step 2: recognised depression—persistent subthreshold depressive symptoms or mild to moderate depression

Anxiety is often present in depression and usually (though not always) resolves with treatment of the depression. In most cases it makes sense to treat the depression first but if there is lack of clarity about whether anxiety disorder might be the primary diagnosis, expert diagnostic help should be sought. Sleep disturbance is common and advice

### Case study

Mrs SC was a seventy six year old woman who lived alone and suffered from atrial fibrillation, hypertension and moderately severe osteo-arthritis of the spine. She was a frequent visitor to the GP surgery with a variety of complaints ranging from palpitations to headaches to general aches and pains. Examinations and investigations had failed to show any new pathology in the three years since her husband had died but an astute GP noticed that the frequency of her visits had approximately doubled since her husband's death. She thought the patient might be depressed and the next time she visited she asked the standard questions about whether the patient had been feeling down or depressed or had experience loss of interest or pleasure in doing things in the last month. The patient said "no" she had not really had much interest or pleasure in life since her husband died "but what can you expect when you get to my age with all these problems". She was adamant that it was the physical problems and the medication that were "getting me down". An attempt to make a valid formal assessment of the severity of her depression was problematic because of the way she attributed all her problems to her age and physical state. However the GP judged it was probably of moderate severity with low suicide risk. The patient was reluctant to consider antidepressant medication but, after discussion with the local old age psychiatrist, the GP decided to offer some bereavement counselling and cognitive behavioural therapy with an experienced and competent practitioner. After 20 sessions the patient was making some progress and was beginning to recognise the psychological nature of some of her problems. After 24 sessions she was doing well and had engaged in new activities to replace those formerly undertaken with her husband. The frequency of her visits to the practice diminished to pre-bereavement levels and the GP found that she no longer needed to prescribe as much medication for pain relief.

on sleep hygiene should be offered. If the depression is subthreshold or mild then discussion with the patient about the presenting problems and their concerns, the provision of information and a mandatory two week reassessment is sufficient. In persistent subthreshold depression or mild to moderate depression NICE[1] recommends one or more of the following "low intensity psychosocial" interventions:

- Individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
- Computerised cognitive behavioural therapy (CCBT)
- A structured group physical activity programme.

Group CBT an alternative for some patients but for the older patient it can probably only be delivered within the context of a day hospital or day care service.

Medication should not be used routinely to treat subthreshold or mild depression unless the patient has a past history of moderate or severe depression or symptoms have been present for two years or more or when symptoms persist after other interventions.

### Step 3: persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression

Here there are three alternatives:

- An antidepressant (usually a selective serotonin reuptake inhibitor (SSRI)
- High intensity psychological intervention (such as CBT or interpersonal therapy (IPT))
- Both of the above—which should be the "normal" intervention for moderate or severe depression.

Often older patients in this category will merit referral to specialist services for further assessment and expert help.

### Step 4: Severe and complex depression; risk to life; severe self-neglect

Where the severity of depression is life-threatening, where there are psychotic symptoms, where there is failure to respond to other interventions or where there is significant physical or psychiatric comorbidity or major social problems the patient should be referred to a consultant old age psychiatrist and associated community mental health team. Hospital admission may be necessary. Interventions will include at least some of the following:

- Medication (including combination or augmentation therapy)
- High intensity psychological interventions
- Electroconvulsive therapy (ECT)

## Psycho-social interventions

The availability of these interventions depends upon properly trained and supervised practitioners. NICE recommends that outcomes should be monitored using an appropriate validated scale. There are special issues about making these interventions with old people who may not be able (in some cases) to use computerised methods or attend clinic venues. CBT can be delivered in the patient's own home but this requires organisation (and travel time) for the therapist. In some cases day hospitals can be used as a vehicle for delivering these services. Without special arrangements there is a danger that older people

**Box 3:** Nine Depressive symptoms (DSM-IV)

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg. feels sad or empty) or observation made by others (eg. appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (eg. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

may be excluded from access to therapies; an example of "ageism" in failing to adapt services to the special needs of older people.

## Medical treatment of the acute episode

When antidepressants are used SSRIs are first choice. Citalopram and sertraline may be preferred for their relatively short half lives and fewer interactions with other medications. Good information assists in ensuring patients take prescribed treatments. If there is doubt, this should be monitored. Medications should be used at recommended doses for at least a month (often up to 12 weeks in older people) with a failure to respond before consideration is given to a change of medication. If depression is of moderate or severe degree every effort should be made to ensure that appropriate psychological therapy and support is delivered. Medications such as venlafaxine or lofepramine should be considered as second line treatment. Combination or augmentation therapy should only be initiated under specialist psychiatric supervision. Once a person has responded to an antidepressant, it should be continued for at least six months to a year (the normal minimum duration in older people) at therapeutic dose. If there are previous episodes of depression it is worth discussing the risks and benefits of longer term treatment with the patient. Antidepressants should be discontinued slowly with careful monitoring and reinstatement if necessary.

When psychotic symptoms are present treatment with one of the newer antipsychotics may help to control the psychotic symptoms and may also augment the antidepressant effect

## Primary and secondary prevention

Many factors may reduce the incidence and prevalence of depression. Some cases of late onset depression are related to vascular disease so measures that boost cardiovascular health in mid-life are likely to reduce incidence of this subtype of depression. Excessive alcohol intake may lead to depression so adherence to sensible drinking limits may be preventative. Physical fitness and exercise protect against depression. Being an active member of a church appears to have a protective effect.[10]

Once an episode has occurred, CBT provides some protection against relapse. Maintenance treatment with antidepressants or where the depression proves to be part of a bipolar disorder with mood stabilisers may also help.

## Conclusion

Depression is common in older people and particular subgroups are more vulnerable. It is hard to detect and often missed in old people. A systematic approach to detection helps to reduce these missed therapeutic opportunities. Once depression is detected management should follow the same stepped care principles as for younger adults. Funding for and access to psychological therapies may be a particular problem for older adults.[11-14]

**We have no conflict of interest**

## Box 4: Categories of depression in NICE guidance[1]

**Subthreshold depressive symptoms:** Fewer than five symptoms of depression

**Mild depression:** Few, if any, symptoms in excess of the five required to make the diagnosis, and symptoms result in only minor functional impairment.

**Moderate depression:** Symptoms or functional impairment are between "mild" and "severe"

**Severe depression:** Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms

Note that a comprehensive assessment of depression should not rely simply on a symptom count, but should take into account the degree of functional impairment and/or disability.

## Box 5: Some medications that may cause depression

| Class of Drug | Individual medications |
|---|---|
| Cardiovascular | Beta blockers, Methyldopa, Reserpine, Clonidine, Calcium channel blockers, digoxin |
| Analgesics | Codeine, other opioids, indomethacin |
| CNS | L-dopa, amantadine, tetrabenazine, anti-psychotics (especially "typicals"), benzodiazepines |
| Others | Steroids, etc |

## References


1. NICE. Depression: the diagnosis and management of depression in adults. London: National Institute for Health and Clinical Excellence, 2009.
2. Depression in adults with a chronic physical health

problem. London: National Institute for Health and Clinical Excellence, 2009.
3. Copeland JR, Beckman AT, Dewey ME, et al. Depression in Europe: Geographical distribution among older people. *British Journal of Psychiatry* 1999; **144**: 312–21
4. Wattis J and Curran S. Older men and depression. *Geriatric Medicine* 2006; **36**(11): 37–42
5. Mann A, Graham N, Ashby D. Psychiatric illness in residential homes for the elderly: a survey in one London borough. *Age & Ageing* 1984; **13**: 257–65
6. Burn WK, Davies KN, McKenzie FR, et al. The prevalence of psychiatric illness in acute geriatric admissions. *International Journal of Geriatric Psychiatry* 1993, Vol. **8**: 171–74
7. Prince MJ, Harwood RH, Blizard RA, et al. Impairment, disability and handicap as risk factors for depression in old age: the Gospel Oak Project V. *Psychological Medicine* 1997; **27**: 311–21
8. Wattis J, Curran S. Affective Disorders in the New Millenium. [book auth.] Curran S and Wattis J (eds). Practical Management of Affective Disorders in Old Age: a multi-professional approach. Abingdon: Radcliffe Publishing, 2008: 1–16
9. M, Nowers. Deliberate self-harm in the elderly: a survey in one London borough. *International Journal of Geriatric Psychiatry* 1993; **8**: 609–14
10. Wattis J, Curran S. Lifestyle and depression. *Geriatric Medicine*. 2009; **39**: 570–73
11. Burvill PW, Johnson KA, Jamrozik KD, et al. Prevalence of depression after stroke: the Perth community stroke study. *British Journal of Psychiatry* 1995; **166**: 320–27
12. Ahto M, Isoaho R, Puolijoki H, et al. Coronary heart disease and depression in the elderly: a poulation-based study. *Family Practitioner* 1997; **14**: 436–45
13. NIMH. Men and Depression. [Online] http://menanaddepression.numh.nih.gov/clientfiles/menanaddep.pdf. Accessed 10/04/12
14. Sheikh J, Yesavage J. Geriatric depression Scale; recent findings and development of a short version Geriatric depression Scale; recent findings and development of a short version. [chapter author] T Brink (Ed.). Clinical Gerontology: A Guide to Assessment and Intervention. New York: Howarth Press, 1986.