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Diagnosing and treating mood disorders in older people

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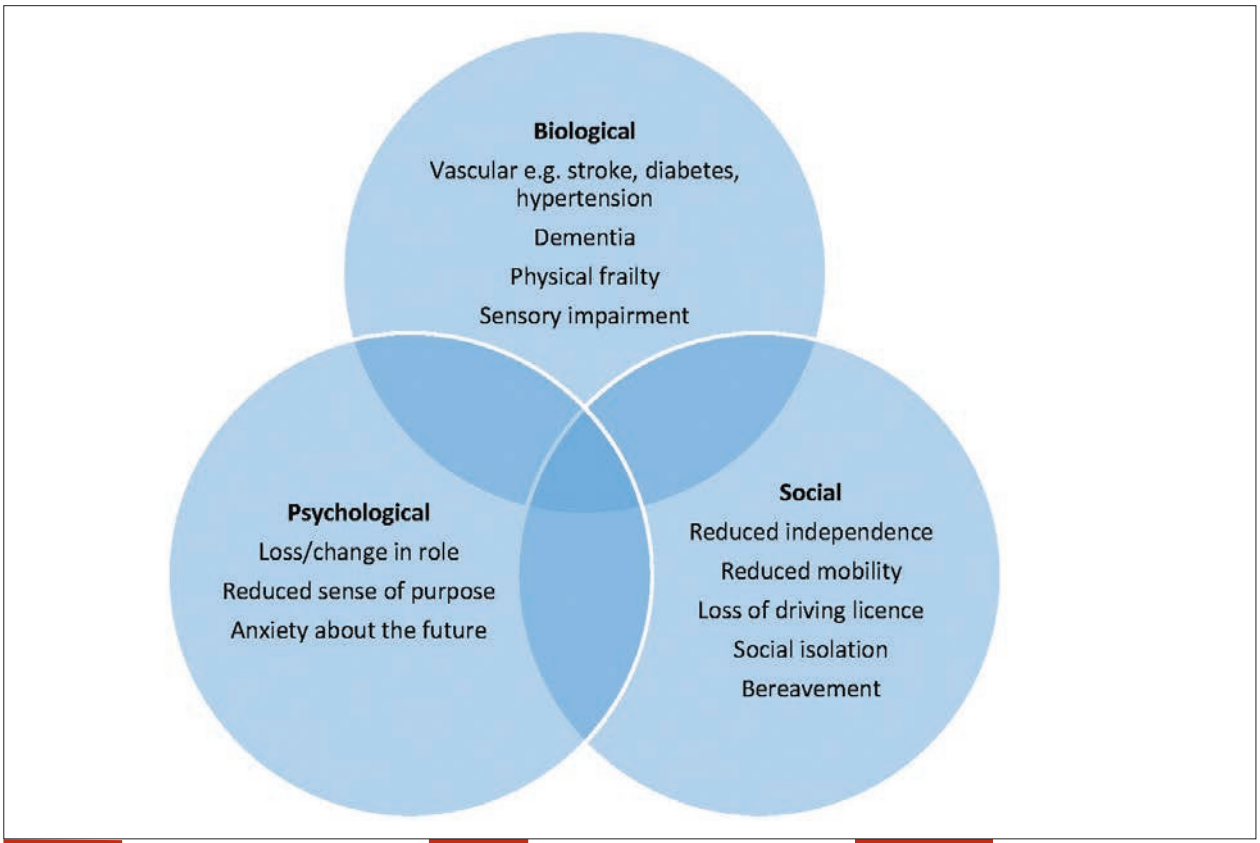


FIGURE 1 Biopsychosocial risk factors for late life depression

What are the main risk factors?

DEPRESSION IN OLDER ADULTS IS COMMON, WITH CLINICALLY SIGNIFICANT DEPRESSIVE SYMPTOMS affecting 15% of people over the age of 55,[1] and up to a third of people experiencing some depressive symptoms.[2] The prevalence increases in those over the age of 85 years in hospitals and in nursing homes.[1]

Depressive symptoms may be part of a recurrent depressive disorder, or experienced for the first time in later life as a result of changes in risk and resilience factors.

Depression may also be seen in the context of bipolar disorder; reviewing past history carefully and enquiring about past symptoms of mania is important. Bipolar disorder rarely presents for the first time in older adults[3] and a presentation of elevated mood and symptoms of mania should prompt investigations to exclude organic pathology and delirium.

RISK FACTORS

Risk factors for late life depression can be classified using a biopsychosocial framework. These risks are closely related and frequently overlap (see figure 1, above).

Cerebrovascular changes are common as people age and are associated with increased risk of depressive symptoms and depression.[4] Neuroimaging studies have repeatedly shown that cerebrovascular pathology, including white matter hyperintensities, can predispose, precipitate or perpetuate a depressive syndrome in the elderly.[5] Individuals with late life depression have greater white matter hyperintensities on structural imaging, and these are associated with poor outcomes.[6,7]

Diabetes mellitus and hypertension are particularly important risk factors for these end-organ changes in the brain.[8,9] Vascular risk factors not only increase the risk of depression, but also the risk of cognitive changes and dementia. There is a bidirectional relationship between depression and dementia, with common aetiological causes and shared risk factors.[1]

Physical illnesses, particularly those conditions associated with frailty, are important risk factors for depression. Conditions such as chronic or severe pain, Parkinson's disease and COPD, may have direct effects on the brain, or indirect effects on important psychosocial risk factors such as lack »

How should older patients be assessed?

Which patients should be referred?

of sleep, reduced mobility and social isolation. Additionally, the psychological and social effects of sensory impairment, particularly visual and hearing loss, can reduce communication and impact on wellbeing. Hearing loss can lead to low self-esteem, isolation, loneliness and depression.[10]

The ageing process requires ongoing psychological adaptation to changes in everyday life with alteration in roles and responsibilities (e.g. through retirement) and physical morbidity. Psychological adaptation to ageing, particularly when it is associated with loss of externally validating roles, can reduce an individual's sense of purpose and self-esteem.

There may be anxieties or fears over the future in relation to loss of independence, practicalities of obtaining support, financial pressures, or the dying process itself. Psychological adaptation may be harder for those who have historically responded poorly to stress or who have a history of multiple stressful life events.

As people age, illness is more common among their peers. The death of friends or family members (especially the loss of a spouse or partner) is a risk factor for depression.

Living alone and a dwindling social circle through death of friends or family or relocation can increase social isolation and loneliness. This may be compounded by reduced mobility and independence caused by musculoskeletal problems or stopping driving.

Changing needs of peers may require individuals to take on new caring roles, and while these may provide a greater sense of purpose, they can also be a source of stress contributing to risk for depression.

Bipolar disorder has been known to present for the first time as late as 86 years of age; risk factors are physical illness, cognitive impairment and previous depression.[11]

PRESENTATION

Identifying depression in an older patient may be a challenge for a number of reasons. It has a distinct presentation in late life and low mood may not be the predominant presenting symptom. Indeed, when asked directly, the older person may deny that they feel sad or low in mood.

Furthermore, the cognitive decline that can accompany depression may often be misdiagnosed as dementia.[12] It is therefore important to recognise other symptoms as potential indicators of depression in the older person.

The older person with depression may present with:[13]

- Physical symptoms
- Apathy
- Poor motivation
- Cognitive symptoms
- Agitation
- Retardation
- Fatigue
- Weight loss

These symptoms may trigger concerns of an underlying physical illness, however, the clinician should always consider depression as a cause of such symptoms in an older person. A recent study suggested that apathy symptoms may identify patients who are at increased risk of dementia.[14]

'A cognitive assessment should be completed in older people presenting with a possible mood disorder'

A further challenge in identifying depression in older people is posed when the patient has established cognitive impairment. A number of studies have found that depression is frequently comorbid with dementia, particularly vascular dementia, so it is essential to consider depression as a potential cause of any new symptoms in such patients.

Although less common, older people may also present with manic symptoms later in life. Mixed affective symptoms such as agitation or irritability are more common in older people than in those who present at a younger age. Understandably, this could be misdiagnosed as dementia in an older person. As such, in any older person presenting with a change in behaviour which seems atypical of dementia, mania should be considered a potential diagnosis. It is worth bearing in mind that the older person may also present with the typical manic symptoms seen in younger people such as elevated mood, poor sleep and risky and disinhibited behaviours.

Comorbidity

There is a correlation between low mood and:

- Chronic pain
- Any chronic physical illness
- Stroke
- Parkinson's disease
- Cognitive impairment (both as a cause and a symptom of depression)

Furthermore:

- Persistent severe depression is linked to the onset of dementia[15,16]
- There is a link between depression and worse outcomes for physical illness[17]
- There is a link between depression and increased mortality[17]

It is therefore essential to identify depression quickly and effectively, and to treat it adequately. If a patient has multiple comorbidities, a referral to a geriatrician may be helpful as a means of holistically approaching the patient's presentation, and in turn, this will be beneficial to the patient's mood.

ASSESSMENT

When an older person presents with possible symptoms of depression, the assessment should be similar to that of any younger person. A symptom check as per diagnostic criteria should be completed, bearing in mind the aforementioned predominance of biological symptoms in older people. The assessing clinician should also be vigilant for self-neglect and psychotic symptoms. Specific rating scales such as the Geriatric Depression Scale (GDS) are available to assess depressive symptoms in older people. The GDS is preferred to other commonly used tools such as the Patient Health Questionnaire-9 (PHQ-9), as it avoids questions about somatic symptoms (which in older people may be attributable to other causes). It is worth noting that the GDS is not a diagnostic tool but may be helpful in establishing severity of depressive symptoms.

A risk assessment in this group of people is vital as it will inform any management plan. The degree of mood disturbance may be impinging on the older person's functional ability, and as such, the individual may pose a risk to self and potentially others around the home. It is important to remember that many older people continue to drive and their ability and judgment may be impaired in this area.

Assessment of suicidality is essential: older people are far less likely to articulate their suicidal thoughts than younger people. The main risk factors for suicide in older people are social isolation and depression and they are more likely to use violent methods. It is worth bearing in mind that self-harm without underlying suicidal intent is rare in older people, therefore, any attempt at self-harm or suicide should be taken extremely seriously.

A cognitive assessment should also

be completed in older people presenting with a possible mood disorder. If there is a significant degree of impairment, information from a family member or another person may be helpful. On cognitive testing, you may find that a patient with an underlying dementia lacks insight into their memory loss, whereas an older person with a primary mood disorder maintains this insight. Another possible finding on cognitive testing may be preservation of higher function such as problem solving and speech but reduced concentration.

In older people, a medication review is essential as there are a number of drugs that may have been prescribed for comorbidities which may be contributing to their mood disturbance. Depression is a recognised side effect of certain beta-blockers, montelukast, corticosteroids and also proton pump inhibitors. Mania in older people should not be ignored and may indeed present later in life, with steroids being a relatively common cause of manic presentations.

If a patient presents with mood disturbance, either elevated or low mood, blood tests may help direct management should a contributory medical factor be identified. Suggested tests include:

- Full blood count
- Renal profile
- Thyroid function
- Vitamin B_{12} and folate
- Glucose

These tests may help identify potential causes of mood disturbance, as well as possible physical causes of somatic symptoms.

MANAGEMENT

Depression is not a normal part of ageing and, even if there are understandable triggers, this should not deter GPs from offering treatment. Indeed, early intervention is recommended, as a short duration of untreated illness improves the likelihood of response.[18] Management involves a stepped care approach.

For persistent subthreshold symptoms, or mild to moderate depression, low intensity psychological or psychosocial interventions should be considered. These could include sleep hygiene advice, behavioural activation, CBT, structured exercise, referral to a »

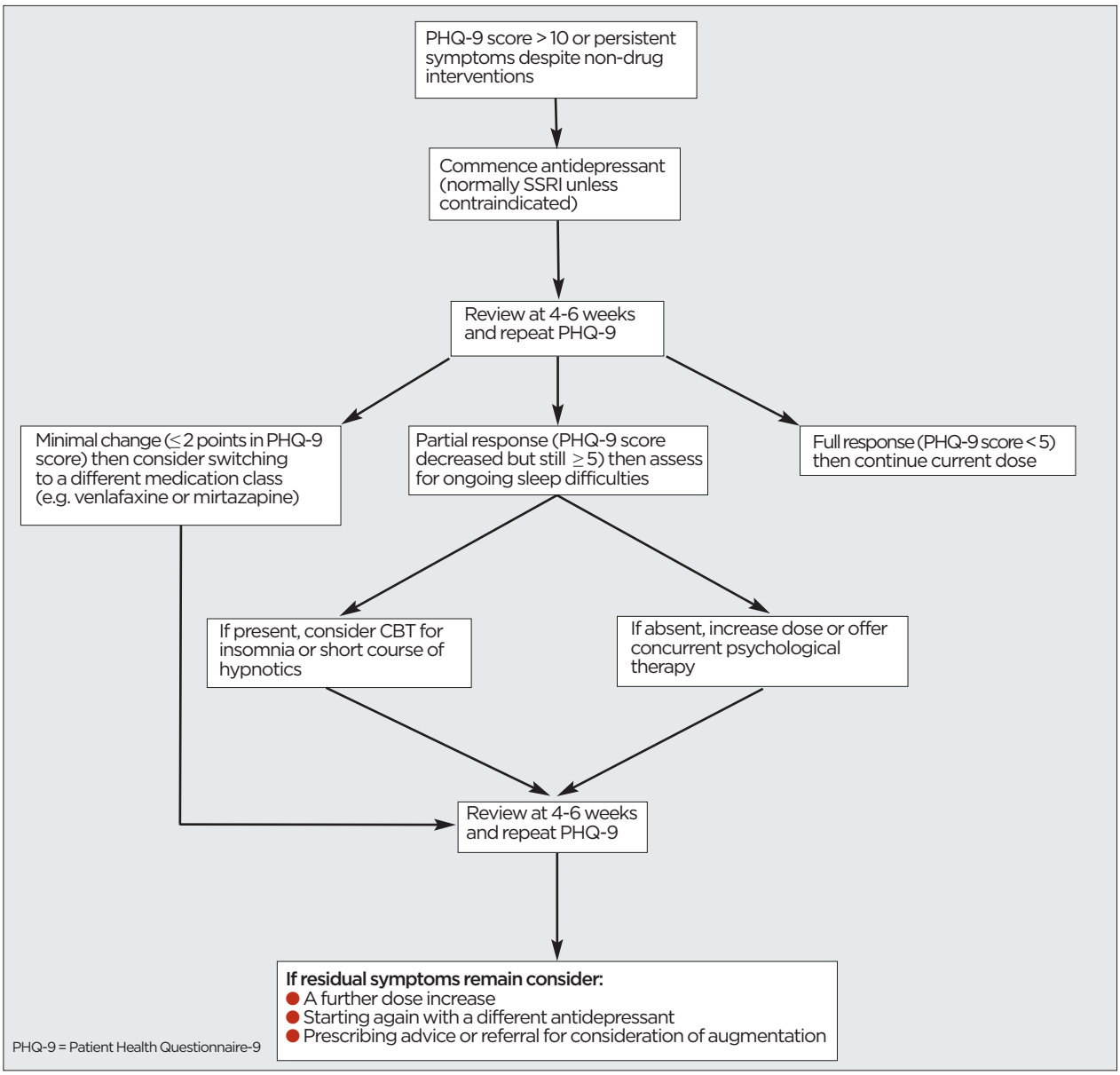


FIGURE 2
An example of a systematic approach to using pharmacological intervention in depression; adapted from ABC of Depression and Anxiety[29]

key points

SELECTED BY

Dr Phillip Bland
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Depression in older adults is common. Depressive symptoms may be part of a recurrent depressive disorder or experienced for the first time in later life as a result of changes in risk and resilience factors. Bipolar disorder rarely presents for the first time in older adults and a presentation of elevated mood and symptoms of mania should prompt investigations to exclude organic pathology and delirium.

Risk factors for late life depression can be classified using a biopsychosocial framework. There is an association between cerebrovascular pathology, vascular risk factors and depression. Physical illnesses, particularly those associated with frailty, are also important risk factors for depression. Conditions such as chronic or severe pain, Parkinson's disease and COPD may have direct effects on the brain, or indirect effects on important psychosocial risk factors such as lack of sleep, reduced mobility and social isolation. Visual or hearing loss can lead to low self-esteem, isolation, loneliness and depression.

Depression has a distinct presentation in late life and low mood may not be the predominant presenting symptom. Indeed, when asked directly, older patients may deny that they feel sad or low in mood. They may present with physical symptoms, apathy, cognitive symptoms, agitation, retardation, fatigue or weight loss. Cognitive decline associated with depression is often misdiagnosed as dementia. Moreover, depression is frequently comorbid with dementia, particularly vascular dementia, so it is essential to consider depression as a potential cause of any new symptoms in such patients.

Assessment of an older person presenting with possible symptoms of depression should be similar to that of any younger person. Assessment of suicidality is essential: older people are far less likely to articulate their suicidal thoughts. The main risk factors for suicide in older people are social isolation and depression. An assessment of cognition and a medication review should be carried out: depression is a recognised side effect of certain beta-blockers, montelukast, corticosteroids and PPIs. Blood tests include: FBC, renal profile, thyroid function tests, glucose, B_{12} and folate.

For persistent subthreshold symptoms, or mild to moderate depression, low intensity psychological or psychosocial interventions should be considered. These could include sleep hygiene advice, behavioural activation, CBT, structured exercise, referral to a befriending service or social prescribing. If symptoms persist or depression is moderate to severe, pharmacological or high intensity psychological therapies should be considered. SSRIs should generally be offered first line; sertraline and citalopram are often preferred because of the lower risk of interactions.

Referral to specialist mental health services may be indicated if there is: risk of suicide, risk of self-neglect, poor response to treatment, significant psychiatric comorbidity, psychotic symptoms, diagnostic difficulty (commonly differentiation between depression and early cognitive impairment) or new onset or undertreated bipolar disorder.

befriending service (such as one of those offered by Age UK, see Useful information box, p15) or social prescribing if available.[19] If symptoms persist or there is a moderate to severe burden, pharmacological or high intensity psychological therapies should be considered, see figure 2, p13.

When using antidepressant medication, assessing response systematically and utilising rating scales (such as the PHQ-9) have both been shown to reduce time to remission significantly as this prompts timely dose or medication change in those who fail to respond.[20,21]

SSRIs should generally be offered first line; sertraline and citalopram are often preferred because of their lower propensity for interactions. Be mindful that the risk of hyponatraemia with SSRIs increases with age and concurrent NSAID use. Combining antidepressants with NSAIDs raises the risk of bleeding in susceptible individuals or those on warfarin, and this includes the risk of brain haemorrhage.[22,23] Mirtazapine could be considered as an alternative.

Patients should be reassessed at four weeks after commencing medication. If there has been minimal change (2 points or less on PHQ-9), switching to a different class of antidepressant could be trialled. If there has been a partial response (PHQ-9 score decreased but still > 5) a dose increase could be considered. If there are ongoing sleep symptoms CBT for insomnia or a short course of hypnotics may help.

If residual symptoms remain despite dose optimisation of an antidepressant to which there was a partial response, augmentation could be considered, but this usually requires consultation with a psychiatrist.

The addition of lithium, quetiapine, aripiprazole and mirtazapine are common augmentation strategies. A systematic review of treatment resistant depression in older people found an overall response rate of 58% to antipsychotic augmentation and a 42% response rate to lithium.[24] Although not licenced, there is a growing body of evidence that aripiprazole is both an effective and well tolerated augmentation strategy in older people.[25] To reduce the risk of relapse, the medication(s) on which the individual achieved remission should be continued for at least a year in a first episode of depression, at least two years in a second, and perhaps indefinitely after a third.[26]

In those with moderate or severe depression and chronic physical health or complex needs collaborative care has been shown to be effective.[27] A care coordinator helps improve compliance with treatment and improves joint working between physical and mental health services.

In bipolar disorder treatment follows the same principles as for younger adults, although very few studies have been directed at older people. Generally, older people are more susceptible to adverse reactions, owing to end-organ sensitivity and impairment in both circulation and hepatic and renal clearance. This may be especially pertinent with lithium. Treatment doses are therefore generally lower than those used in younger adults and should be more carefully titrated.[28] The risk of switching to mania when using antidepressants without mood stabilisers is high in older people with bipolar depression and this should be avoided.

REFERRAL

Most patients with depressive disorders are treated in primary care. Referral to specialist mental health services may be indicated in the following cases:

- Risk of suicide
- Risk of self-neglect
- Poor response to treatment
- Significant psychiatric comorbidity
- Psychotic symptoms
- Diagnostic difficulty (commonly differentiation between depression and early cognitive impairment)
- New onset or undertreated bipolar disorder

Competing interests: None

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Useful information

MindEd
Educational resource on mental health
www.minded.org.uk

Royal College of Psychiatrists
Patient information leaflets
www.rcpsych.ac.uk/mental-health

Age UK Befriending services
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