Depression in late life

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Practice nurses have a considerable contribution to make in detecting depression in older adults who are regular attendees to general practitioner surgeries. It is well established that depression is the most common psychiatric disorder affecting older people living at home. Of relevance, is that one in seventeen older people have dementia, one in twenty-five delirium, while, one in seven have depressive disorders. Depression is also 2 to 3 times more common in patients with chronic medical conditions. In particular, in patients with the 3 C’s – cardiovascular disease, central nervous system disorders (e.g., stroke, dementia, Parkinson’s disease) and cancer. Although depression in late-life is highly treatable at primary care level, it is often undetected or ineffectively treated. Untreated, depression can cause substantial functional impairment and increase the risk of late life suicide. Practice nurses who manage chronic diseases are therefore ideally placed to improve detection and significantly contribute to depression management.

Risk factors for depression in late life

No single theory has adequately explained the cause of depression in later life. However, from a primary care perspective, it is imperative to understand that late life depression is often associated with medical conditions either as a precursor or, as a consequence. For this reason, practice nurses should have a high index of suspicion for depression in older patients attending for outpatient appointments. It’s also worth noting that a number of biopsychosocial risk factors infer vulnerability for depression including: neurochemical and structural brain changes, medical illness, functional decline and disability, caregiver strain, death of a spouse or other loved one, social isolation, stressful life events and perceived uncontrollability over events.

Challenges in differentiating depression from other comorbidities

The hallmark of depression among older people is that its symptoms may be masked or misattributed to physical illness and vice versa. It is also important to note that rates of depressive symptoms escalate with increasing co-morbidity.

Medical co-morbidity

Post stroke depression may occur in the context of vascular and organic brain changes and the psychological sequelae associated with loss of function. Post stroke depression affects 30-50% of patients in the first year and is difficult to assess because of the presence of aphasia, cognitive impairment, and emotional liability. To determine if depression is present in post stroke, the following core features are indicators to watch for.
Observations of general behaviour, appearance and speech e.g. avoiding eye contact, slow speech, excessive movement [agitation] or slowed up, may provide objective evidence of depression.

- persistent sadness
- loss of interest in activities previously enjoyed
- feelings of hopelessness, worthlessness and a burden on caregiver
- lack of motivation
- death wish and suicidal ideation

In coronary heart disease, depression has been shown to be an independent risk factor, while the disease itself also contributes to the development of depression. In patients with cancer, symptoms of depression such as loss of energy, tiredness and loss of appetite can easily be attributed to the effects of cancer or chemotherapy. Taken together, these presentations suggest that unique patient factors must be carefully explored to determine the mental and physical health status of the older person.

Dementia and depression
Depression is frequently masked in cognitive impaired conditions such as Alzheimer’s disease. Depression occurs in 27-53% of people with mild Alzheimer’s and in 36-68% of those with moderate to severe presentations. Depression and dementia share common symptoms including anorexia, fatigue, insomnia, weight loss, agitation and psychomotor retardation but can be differentiated by the following features:

- recent functional and behavioural changes including sad downcast mood
- sleep changes or increased irritability, with symptoms worse in the morning

If depression is suspected, practice nurses can augment their clinical assessment with the use of the Cornell Scale for Depression in Dementia.

Bereavement
Bereavement is a significant risk factor for depression among the elderly. Based on the DSM-IV criteria, where depression follows bereavement, a diagnosis of a major depressive disorder is not made until two months after the loss. Symptoms that distinguish a major depressive episode from a grief reaction include:

- feelings of guilt and worthlessness
- death wish and thoughts of suicide
- psychomotor retardation
- marked functional impairment

While it is important not to pathologize normal bereavement, it is equally important to diagnose and treat grief-related major depression, which can be persistent and gravely disabling and may even be life threatening in the absence of treatment. Social isolation has also been correlated with loneliness and this increases the risk of late life depression, while social support acts as a buffer. Therefore, strengthening social supports can be a protective factor.

Assessment
Differentiating between feeling down and clinically significantly depressive features is crucial. There is a set of symptoms and criteria that must be present to make a diagnosis of a depressive episode (see Table 1). The predominance of somatic symptoms, in particular, aches and pains and complaints of poor memory and concentration are key indicators. An older depressed person is also much less likely to report low mood and instead may present with anxiety and irritability. More commonly reported symptoms are loss of interest and enjoyment in living, hopelessness about the future, disturbed sleep, fatigue and psychomotor retardation. Subthreshold or minor depression, that is depression that does not meet the full criteria for major depression, is particularly common in late life. It is also important to assess for minor depression (see Table 1) and intervene appropriately as it is associated with functional impairment and distress comparable to major depression. Older patients are also not likely to volunteer feelings of depression. It is therefore important, particularly in the context of chronic medical illness, to ask the older person about depression. Asking two simple questions is a time-saving approach that can detect depression: 1. during the past month, have you often been bothered by feeling down, depressed or feelings of hopelessness? 2. during the past month have you often been bothered by little interest or pleasure in doing things? A ‘yes’ response to either question, is considered a positive test for depression that requires further assessment. A ‘no’ response to both questions suggests that depression is highly unlikely. This approach has been favourably endorsed by primary care nurses given its simplicity and usefulness to everyday practice.

Once depression is detected a more detailed exploration is then warranted so that a person centred care plan can be developed in the context of prescribed treatment. A comprehensive biopsychosocial assessment is required to determine the precipitating, predisposing and maintaining factors and the severity of symptoms in order to devise an intervention plan. Gathering this information should be undertaken in a systematic way using a semi-structured interview to explore the person’s full history and mental state and covering the core elements outlined in Table 2.

In conducting the interview, explore rather than ask ‘yes or no’ questions as a person may not attribute low mood, or changes in functioning, to depression. Start broad and ask how life has been since last contact and how they are coping with physical health problems. Determine if the degree of disability is disproportionate to an existing medical condition and explore any changes in feelings and behaviour. Check for any recent changes in sleep, appetite, energy or activity levels. Note any reduction in pleasure activities and enquire about supports. Find out if there is a death wish or if suicidal thoughts are present. Establish the range, duration and severity of symptoms (outlined in Table 1) and current functioning. Observations of general behaviour, appearance and speech e.g. avoiding eye contact, slow speech, excessive movement...
Practice nurses are in a unique position to assess patients for symptoms of depression and make appropriate referral to the GP.

Evidenced based treatment approaches

Pharmacological treatment

There are several classes of antidepressants agents which have similar efficacy in the treatment of late life depression. However, selective serotonin reuptake inhibitors (SSRIs) are usually the first-line antidepressant for older adults because they are better tolerated and have a safer side effect profile. It is important, however, to note that SSRIs are associated with particular adverse effects in the elderly which include hyponatraemia, increased risk of falls, platelet dysfunction and increased bleeding tendency. Antidepressants generally take 4-6 weeks for a therapeutic response at an optimal dose. If there is no improvement after this time, the chances of recovery are considered unlikely and a change to another antidepressant is recommended. Overall treatment response is between 40 and 50% after a first trial of an antidepressant. Of those who do not respond, half may improve if switched to an alternative antidepressant and about a quarter tend to have a poor response. Guidelines for the management of late life depression in primary care, recommend that antidepressants should be continued for at least 12 months after remission of a first onset of depression and for 36 months in cases of recurrent depression at a dosage that proved to be initially effective. Long-term maintenance treatment is recommended for those with multiple past episodes, poor health, chronic disability or severe social difficulties.

Psychotherapeutic interventions

There are number of well-established evidence based psychotherapy approaches for treating late life depression (see Table 3). Others include, cognitive bibliotherapy, brief psychodynamic therapy, and life review therapy. Based on what we know about the efficacy of psychotherapeutic interventions when used with the elderly, it must be communicated that age per se should not be a barrier to receiving psychological therapy. Interventions such as problem solving and behavioural therapy, especially activity scheduling have real merit as effective therapeutic strategies for primary care nurses.

Conclusion

Depression in late life frequently occurs in the context of other medical illness, can be difficult to diagnose and may go unrecognised. Older depressed persons can benefit from effective treatments but first depression must be detected. Practice nurses are in a unique position to assess patients for symptoms of depression and make appropriate referral to the GP. Practice nurses can also support the management of depressive disorders by taking a person centered, bio psychosocial approach to assessment of older persons and monitoring treatment response across a range of domains.

### Table 1. Diagnostic criteria: DSM-IV-TR: (American Psychiatric Association 2000)

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<thead>
<tr>
<th>1. Depressed mood</th>
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<td>2. Loss of interest or pleasure in nearly all activities (anhedonia)</td>
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<td>3. Sleep disturbance</td>
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<td>4. Appetite disturbance</td>
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<td>5. Decreased energy, tiredness and fatigue</td>
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<td>6. Poor concentrating or indecisiveness</td>
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<td>7. Feelings of worthlessness or inappropriate guilt</td>
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<td>8. Psychomotor agitation or retardation</td>
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<td>9. Recurrent thoughts of death or suicidal ideation</td>
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### Table 2. Elements of a clinical interview

- Presence of ICD – 10 criteria for clinical depression
- Number, duration and severity of depressive symptoms
- Impact of symptoms daily living activities
- Family and past history of depression or other psychiatric illness
- Previous treatment and response
- Living circumstances
- Relationships and social supports,
- Co-morbid medical illness
- Changes in social and occupational functioning,
- Recent stressors and coping mechanisms,
- Alcohol/substance use/abuse
So many symptoms...

Treat the CORE of depression with Lexapro

The No. 1 prescribed anti-depressant in Ireland

Abbreviated Prescribing Information: Please refer to the Summary of Product Characteristics before prescribing. Presentation: Lexapro® tablets 5 mg, 10 mg, 15 mg and 20 mg containing escitalopram (as oxalate).

Indications: Treatment of major depressive episodes. Panic disorder with or without agoraphobia. Social Anxiety Disorder. Generalized Anxiety Disorder. Obsessive Compulsive Disorder. Doseage: Major depressive episodes: Adults: Usual dosage is 10 mg once daily. The dose may be increased to a maximum of 20 mg/day. Panic Disorder with or without agoraphobia: An initial dose of 5 mg is recommended. Usual dosage is 10 mg once daily. The dose may be increased to a maximum of 20 mg/day. Generalized Anxiety Disorder: Initial dosage is 10 mg once daily. The dose may be increased to a maximum of 20 mg/day. Elderly (≥65 yrs): Initial dosage is 5 mg once daily. Depending on individual patient response the dose may be increased to 10 mg daily. The efficacy of Lexapro in social anxiety disorder has not been studied in elderly patients. Children and adolescents (<18 years): Not recommended. Poor metabolizers of CYP2C19: In known poor metabolizers of CYP2C19, 5 mg Lexapro is recommended for the first 2 weeks, the dose can be increased to 10 mg after assessment. Reduced hepatic function: In moderately impaired hepatic function an initial dose of 5 mg/day for the first two weeks of treatment is recommended, the dose may be increased to 10 mg/day. Caution and extra careful dose titration advised in patients with severely reduced hepatic function. Reduced renal function: Dose adjustment is not necessary in patients with mild or moderate renal impairment. Caution is advised in patients with severely reduced renal function (CrCl <30 ml/min). Contraindications: Hypersensitivity to escitalopram or to any of the excipients. Concurrent treatment with a nonselective, irreversible monoamine oxidase inhibitor (MAOI). Concurrent treatment with reversible MAO-A inhibitors e.g. moclobemide or reversible non-MAO inhibitors e.g. linezolid. (Lexapro may be started 14 days after discontinuing treatment with an irreversible MAOI. At least 7 days should elapse after discontinuing Lexapro treatment, before starting a non-selective irreversible MAOI). Lexapro is contraindicated together with medicinal products that are known to prolong the QT interval and in patients with known QT interval prolongation or congenital long QT syndrome. Fertility, Pregnancy & Lactation: Lexapro should not be used during pregnancy unless clearly necessary. Neonates should be observed if maternal use of Lexapro continues into the later stages of pregnancy, particularly the third trimester. Abrupt discontinuation should be avoided during pregnancy. Use of SRIs during pregnancy may increase the risk of persistent pulmonary hypertension (PPHN) in the newborn. Refer to the full prescribing information for a list of serotonin or dopamine symptoms, which may occur in the neonate after maternal SSRI/SNRI use in later stages of pregnancy. Breast-feeding is not recommended during treatment. Precautions: Patients should be cautioned about the potential risk to their ability to drive a car and operate machinery. No pharmacokinetic or pharmacodynamic interactions are expected with concomitant alcohol intake, however the combination is not advised. Insulin and/or oral hypoglycemic dosage may need to be adjusted in diabetes. Hypoglycaemia has been observed rarely with SSRI use, caution is required in patients at risk of hypoglycaemia. Caution is advised with coadministration of ECT and in patients with a history of mania/hypomania. Caution is advised with concurrent use of oral anticoagulants, products affecting platelet function and in patients with known bleeding tendencies. Avoid in patients with unstable epilepsy & monitor patients with controlled epilepsy. Discontinue if patient develops seizures or if there is an increase in seizure frequency. Caution is advised with concurrent use of serotonergic compounds. Stop treatment immediately if patient develops serotonin syndrome. Use at a low starting dose for panic disorder Avoid abrupt discontinuation. Gradual discontinuation by dose tapering is advised. As with all SSRIs it is advisable to closely monitor patients for suicide and self-harm risk in the first few weeks of treatment and until significant remission occurs. The use of SSRI/SNRIs has been associated with the development of akathisia, increasing the dose in these patients may be detrimental. Caution is advised in patients with coronary heart disease. As Lexapro has been found to cause a dose-dependent prolongation of the QT interval, caution is advised for patients with risk factors such as female gender, pre-existing QT interval prolongation, significant bradycardia, recent acute myocardial infarction, uncomplicated heart failure, hypoglycaemia, hypoglycaemia or other cardiac disease. Consider an ECG review before starting Lexapro in patients with stable cardiac disease. If signs of cardiac arrhythmia occur during treatment of Lexapro, the treatment should be withdrawn and an ECG performed. Drug Interactions: MAO inhibitors (see Contraindications), advice caution in use with irreversible MAO-B inhibitors [e.g. selegiline]. Medicinal products that prolong the QT interval (see Contraindications). Caution in use with lithium, tricyclics, serotonin medicinal products or with products capable of lowering the seizure threshold. Avoid concomitant use with St. John’s Wort. Caution is advised with co-administration of drugs metabolised by enzymes CYP2C19, CYP94A and CYP2D6. Co-administration with CYPI94A inhibitors, and general enzyme inhibitors e.g. simvastatin may require a reduction of the Lexapro dose. Lexapro is an inhibitor of CYP2D6, caution is advised with concurrent use of drugs (particularly those with a narrow therapeutic index) mainly metabolised by CYP2D6. Caution is advised with concurrent use of oral anti-coagulants, medicinal products known to affect platelet function and non-steroidal anti-inflammatory drugs (NSAIDs). Adverse Events: Adverse reactions are most frequent during the first or second week of treatment and usually decrease in intensity and frequency with continued treatment. Frequencies are not placebo-corrected. Very Common (≥1/10): Anaxia, Nausea (≥1/10 to <1/100): Uncommon (≥1/1000 to <1/10000): Rare (≥1/10000 to <1/100000): Very Rare (≥1/1000000): Weight increased, insomnia, somnolence, dizziness, paraesthesia, tremor, insomnia, yawning, diaphoresis, constipation, vomiting, dry mouth, swelling increased, aniridia, myalgia, decreased and increased appetite, fatigue, paresthesia, impotence, anxiety, restlessness, abnormal dreams, male & female libido decreased, female anorgasmia. Uncommon (≥1/10000 to <1/100): Depression, mania, confusion, agitation, dizziness, sweating, dyspepsia, disturbance of taste, clinical depression, dyspepsia, vascular disturbances, tremor, vertigo, gastroenterological haemorrhages (incl. rectal), urticaria, alopecia, rash, pruritus, oedema, menorrhagia, menosan, biliary, agitation, nervousness, panic attack, confinement state. Rare (≥1/10000 to <1/1000): Bradycardia, serotonin syndrome, amphetamine reactions, aggression, depersonalisation, hallucination. Not known (Cannot be estimated from the available data): Liver function test abnormal, thrombocytopenia, dyskinesia, movement disorder, convulsion, urinary retention, orthostasis, anorexia, inappropriate ADH secretion, hypoglycaemia, orthostatic hypotension, hepatitis, galactorrhoea, male Priapeanism, manic episode, suicide ideation, suicidal behaviour, psychosis, respiratory depression, akathisia, anorexia, P3G QT prolonged and ventricular arrhythmia including Torade de Pontes. Others: discontinuation symptoms [≥3980/1000]: increased risk of bone fractures [patients ≥50 year] [≥3900/1000]: Discontinuation: Clinical data on escitalopram overdose is limited and many cases involve concurrent overdoses with other drugs. Doses between 400-800 mg of Lexapro alone have been taken without any severe symptoms. Symptoms seen in reported overdose of Lexapro mainly relate to the central nervous system, the gastrointestinal system and electrolyte/fluid balance conditions. There is no specific antidote. Treatment is symptomatic and supportive with monitoring of cardiac and vital signs. In case of overdose ECG monitoring is advised in patients using concurrent medications that prolong the QT interval, in patients with altered metabolism (e.g. liver impairment) and in those with congenital heart failure and bradycardia. Caution: Lexapro and the use of antidepressants should be considered Legal Category: POM. Product Licence Holder: T Lundbeck A/S, Ottakringer Strasse 2, 1120 Vienna, Austria. References: 1. Combined IMS Hospital and HPL Unit Sales Data (YTD Dec 2012).
Clinical Review

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<tr>
<th>Intervention</th>
<th>Brief description</th>
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<td>Cognitive Behavioural Therapy (CBT)</td>
<td>CBT is based on the premise that how one thinks influences how one feels. The purpose of CBT is to change the thinking and behaviours that cause or maintain depression. Techniques used include activity scheduling, goal setting, and identification, monitoring and challenging core beliefs</td>
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<td>Behavioural Therapy (BT)</td>
<td>BT is based on the premise that depression results from lack of positive reinforcement achieved through pleasant and or, master events. Key techniques involve exploring the person’s current daily activity schedule, making a connection between pleasant or mastery activities and mood. Gradually introduce activities into routine schedule with a view to increasing pleasant activities.</td>
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<td>Interpersonal Psychotherapy (IPT)</td>
<td>IPT is concerned with current interpersonal relationships and focuses on areas such as adapting to role change, interpersonal conflict or unresolved brief. The approach taken is to help the patient explore options, enhance communication where there are interpersonal difficulties and help to develop coping skills.</td>
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<td>Problem Solving Treatment (PST)</td>
<td>PST is based on the premise that increased vulnerability to depression can occur where there are deficiencies in social problem solving skills. PST uses a structured systematic approach that involves working sequentially through a series of steps such as: 1. define exactly the problem 2. set an achievable goal 3. generate a list of solutions 4. evaluate each solution in terms of terms of pros and cons 5. select the most feasible solution, 6. make an action plan to implement the solution 7. review progress and reinforce all efforts</td>
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References

22. Van Orden, K., Conwell, Y. Suicides in Late Life Current. Psychiatry Reports. 2011; 1; (3) 234-241