PSYCHIATRY OF OLD AGE

Facts

- Department of Health policy has set a target of ensuring that not less than 90% of those over 75 years of age continue to live at home
- 8.5% of older people live in non-private households, which includes both medical and non-medical facilities
- Approximately 33% of those over 65 years of age live alone.
- Most people over 65 enjoy good mental health.
- The overall level of all mental disorders in those in this age group is approximately 20 - 25%
- Depression is the most common disorder with prevalence rates varying between 1% and 13% depending on the diagnostic criteria used (see below).
- The prevalence of the various anxiety disorders is about 12% in total.
- 5% of people aged over 65 years have a dementia while the prevalence in those over 80 years of age is about 20%.

Depression-epidemiology

Epidemiological studies using standardised criteria report a prevalence of 1% to 3% . Community surveys using methods designed for older people report higher rates [~13% depressed with a further ~10% having significant depressive symptoms]. Community surveys in both Dublin and London indicated that only 15-20% of older people with depression were being prescribed antidepressant therapy. Why should this be?
(i) It does not necessarily imply that general practitioners 'miss' depression but may reflect an attitude that depressive symptoms are often understandable in older people.
(ii) Atypical presentations, co-existent physical morbidity, institutionalisation, dementia, bereavement, and reluctance on the part of older people to disclose psychological symptoms often make it difficult to make a diagnosis of depression in this age group.

Depression-symptoms

Older patients may not directly complain of depressed mood. Instead, symptoms of depression in older people often include:

- agitation & anxiety
- physical complaints
- loss of appetite & sleep disturbance
- hopelessness & helplessness
- loss of interest & concentration
- less commonly, psychotic symptoms such as delusions of poverty or guilt.

Depression-suicide

Older patients are less likely to express suicidal intent, but when they do it should be taken very seriously.

- They tend to make fewer attempts per completed suicide
- use more violent methods
- have a greater proportion of males
- have a greater association with physical illness.

Risk factors for both completed suicide and non-fatal suicide attempts in older people include psychiatric and physical illness, being divorced or widowed, and living alone.

Depression & physical illness

Physical complaints may often mask depression and there is a temptation to only treat the physical illness. Particular attention should be paid to symptoms such as feeling like a failure, loss of interest in people, feeling punished, dissatisfaction, difficulty with decisions, crying, and suicidal ideation. Depression may be directly due to physical conditions such as hypothyroidism, malignancy, Parkinson's disease, hypercalcaemia, or to medications such as propranolol, L-Dopa, and cimetidine. In such cases appropriate medical treatment may improve the depression. In other cases depression may be secondary to physical illness, pain, and disability. Here, treating the depression may help physical recovery and rehabilitation.

Depression & dementia

The overlap between symptoms of depression and dementia is well recognised. Depressed older patients often complain of poor memory while patients with mild dementia may complain of depressed mood.

- Up to 30% of all patients with dementia also have symptoms of depression and the depression can occur at any stage of the dementia.
- In the more severely demented nursing home resident the most reliable indicator of depression may simply be a report from nursing staff [who know the patient well] that they feel the person is depressed.
- Depressive symptoms in dementia are significant and are worth treating.
- Late-life depression with cognitive impairment, which is reversed by antidepressant therapy, more often than not is a predictor of the development of an irreversible dementia.
- Converging findings from neuroimaging studies implicate cerebrovascular disease in a subgroup of late-life depression.

Depression-bereavement

Bereavement frequently results in depressive symptoms which can be alleviated by listening, understanding, and time. Most people will gradually recover over a period of one to two years. However, bereavement is also a risk factor for significant depressive illness. Depression may be differentiated from usual bereavement by the intensity and duration of symptoms. The person may not proceed along the usual pattern and not show any improvement. They may express anger, fail to express their feelings, misuse alcohol or hypnotics, or present with physical symptoms.

Depression-Treatment

The decision to intervene should not be affected by any understandability of the cause. Not all depressive symptoms require medication. Psychosocial interventions such as support and help with adjustment to retirement or institutionalisation, bereavement counselling, socialisation through day-care, etc. must not be overlooked.

Psychotherapeutic approaches, such as cognitive-behavioural therapy and interpersonal therapy, both alone and in combination with pharmacotherapy have clearly demonstrated efficacy. Antidepressants are effective in the treatment of depression. However, older people have an increased sensitivity to many drugs and a general principle is 'to go low and go slow'. The selective serotonin reuptake inhibitors [Sertraline, paroxetine, fluvoxamine, fluoxetine, and citalopram] generally require less dose titration than the tricyclic antidepressants [TCA's] and have fewer serious side effects or drug interactions [TCA's have problematic side-effects, particularly anticholinergic effects, and are less likely to be used in a therapeutic dose]. Other alternatives include venlafaxine, mirtazepine, moclobemide, nefazodone, and trazodone, but each clinician should try to stick to just one or two drugs and gain experience with their profiles.

Treatment should be continued for at least 6 months after recovery from a single episode of depression and in recurrent illness treatment should be for at least one year and may need to continue indefinitely. Long term therapy should be with the same treatment and at the same dose as was successful in the initial acute phase.

Electro-convulsive therapy [ECT] can be very effective and life-saving in severe depression where psychotic symptoms are prominent or when the depression is life-threatening through suicide or failure to eat or drink.

Anxiety

- Anxiety disorders in older people are less common than in younger adults and there is high rate of co-morbidity with depression [20-fold increase in the likelihood of depression in patients with symptoms of anxiety].
- Panic disorder [recurrent attacks of panic with intense fear accompanied by severe somatic anxiety symptoms] is extremely rare in older people.
- Anxiety disorders are associated with an increased mortality and increased physical morbidity.

Anxiety-treatment

Older patients with anxiety should be managed in primary care with only a limited role for specialist services through day hospitals [and only in exceptional circumstances through in-patient care].

Most cases of anxiety disorder in older people are not known to the services, and for those that are, pharmacotherapy is the usual management strategy in the primary care setting. Over-reliance on pharmacotherapy versus psychological treatments is unfortunate as the latter approach is effective and is safer. Psychological techniques include anxiety management, relaxation training, cognitive therapy, and behavioural techniques.

Cognitive therapy involves identifying, evaluating, controlling, and modifying the negative thoughts, cognitive distortions, and false attributions that occur in anxiety and depression. Insomnia due to anxiety is best managed by non-pharmacological strategies such as relaxation training, establishing a regular sleep routine, and addressing problems with 'sleep hygiene' [appropriate environment, reduction of caffeine intake etc.].

Benzodiazepines may provide relief but, due to their side effects should be used for a short period. Older people are particularly sensitive to the adverse effects of benzodiazepines. They are less efficiently metabolised with the consequent risk of accumulation, drowsiness and falls. The amnesic effects are obviously important, especially in patients who already may have mild cognitive impairment. However, there is still a place for benzodiazepines in the short-term management of severe anxiety in older people, so long as the above issues are carefully considered in each case. If there is any evidence of associated depression a trial of antidepressant therapy is indicated.