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REVIEW

Treating depression in old age: the reasons to be positive

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Abstract

Depression affects 10–15% of people over 65 living at home in the United Kingdom. It is the commonest and the most reversible mental health problem in old age. Depression is associated with physical illness and disability, life events, social isolation and loneliness. Depression in old age carries an increased risk of suicide and natural mortality. Recognition and simple intervention can reduce morbidity, demand on health and social services and the cost of community care. Despite a favourable response to treatment, depression remains largely undetected and untreated.

Keywords: *depression, old age, treatment*

Introduction

With a prevalence of 10–15% among the population over 65 [1], depression is two to three times more common than dementia. Of depressed elders at home, about one-third have moderately severe disease. The average general practitioner will have 30 active cases at any time and the minimum predicted incidence of 24 cases per 1000 per year [2] would produce 7–10 new cases each year.

Depression is not age-related and there is no reason to believe it to be part of normal ageing. It is more common among physically ill subjects in hospital and at home. About 25% of elderly people in general hospital wards are clinically depressed [3], and 30–40% of those in residential and nursing homes show clinically important depressive symptomatology [4]. About one-third of older people routinely attending general practice surgeries are depressed [5], as are 26–44% of those receiving local-authority care in their homes [6]. Higher rates of depression are found in people with dementia and other neurological disorders, particularly stroke and Parkinson's disease [7, 8].

Without treatment, depression in old age becomes a chronic disorder that produces high levels of morbidity and mortality. Copeland *et al.* [2] found two-thirds of those diagnosed with depression were either dead or psychiatrically ill after 3 years. The mortality rate from natural causes 12 months after a depressive episode is about 12% and remains raised for up to 4 years [9].

This represents a 2–3-fold increased risk of death compared with non-depressed elderly people, which is not satisfactorily explained by known co-existing physical illness [10].

Age is a risk factor for completed suicide. Depression is the most important psychiatric condition associated with successful [11] and attempted suicide in old age [12].

Untreated depression

Depression in late life is a largely undetected and untreated condition. No more than 10% of those detected in primary care will be offered antidepressant treatment and less than 1% will be referred to a psychiatrist [13]. In community studies, similar proportions of depressed patients are on antidepressants [2]. Depressed older people will consult their general practitioner two to three times more often than non-depressed elders, presenting opportunities to identify and treat depression. In general hospital wards, the detection of depression is also poor [3] and few patients will be referred for a psychiatric opinion [14].

In high-risk populations, the use of validated screening instruments can improve levels of detection. The best general-purpose instrument is probably the Geriatric Depression Scale [15]. A shortened version, which takes only 5 min to complete, is acceptable to primary-care attenders [16] (Appendix). The Geriatric

Depression Scale is recommended for screening in geriatric settings by the Royal College of Physicians and British Geriatrics Society [17] and for routine over-75 health checks in primary care by the Royal College of General Practitioners [18].

This poor medical response to depressed older people arises from several factors. Therapeutic nihilism based on misinformed preconceptions of age and psychiatric treatment may be common. Doctors may have inadequate diagnostic skills and poor understanding of the concept of depressive disorder. Too often, depression is considered a natural reaction to the vicissitudes of later life and is explained away as an inevitable and normal response. Ignorance of the associations of normal ageing make therapeutic apathy more likely with older than younger depressed people.

A study of antidepressant prescribing in primary care found that older patients were less likely to receive newer antidepressants than younger people, while almost half those on tricyclic drugs received therapeutically inadequate doses [19].

Physical treatment

The treatment of depression in old age is, ideally, an inter-disciplinary process that recognizes psychosocial as well as physical determinants.

Life events, social adversity and physical ill health are important risk factors [20], and social isolation, loneliness, physical impairment and disability are strong predictors of depression in old age [21, 22].

The benefit of a determined approach to antidepressant treatment with older people is demonstrated by Flint and Rifat [23], who report that 95% of 89 patients completing a sequential treatment study responded, with 84% doing so on an intention-to-treat basis.

Between 50 and 60% will respond to a single antidepressant intervention. A tricyclic antidepressant, selective serotonin re-uptake inhibitor or other new compound may be used. Older patients may take longer to respond to antidepressants and optimum benefit can take 8–12 weeks [24]. Non-concordance is the most common cause of failed response.

There have been few placebo-controlled antidepressant studies involving older populations, but most confirm the superiority of active treatment [25]. Newer antidepressant compounds are as effective as older tricyclic drugs, with almost all being compared in trials with tricyclic comparators [26]. Data from clinical trials confirm the high rate of side effects in older patients taking older antidepressants [25] and reveal the newer compounds to be usually better tolerated [26]. Tricyclic antidepressants are more likely to prove fatal if taken in overdosage than newer antidepressants [27].

Between 70 and 80% of elderly depressed patients respond to electroconvulsive therapy (ECT), and treatment is safe and life-saving for the most severely depressed elderly patients [28]. ECT is the treatment of choice for psychotic depression. In a prospective study of major depression with psychotic features (defined according to the *Diagnostic and Statistical Manual*, third version, revised) [29], the outcome of patients accepting ECT was compared with that of patients choosing pharmacotherapy with nortriptyline, perphenazine and lithium [29]. After 8 weeks of treatment, 88% of the ECT group and 25% of the drug-treated group responded to treatment. Furthermore, the response to ECT was faster and the preferential response to ECT was more marked than with younger patients.

There is no evidence that age is a predictor of response to treatment. In naturalistic studies comparing the outcome of younger and older subjects treated by routine clinical practice, elderly people fare well. Meats *et al.* [30] demonstrated a better outcome for older patients receiving clinically-determined treatment when evaluated 12 months after an inpatient depressive episode. Sixty-eight percent of the elderly group were well, compared with 50% of younger subjects. Only 3.6% of the older patients had been continuously ill, although 16% had died (compared with 29 and 8% respectively, in the younger group).

Wilkinson *et al.* [31] reported a similar effect with ECT. The oldest subjects showed the greatest degree of improvement of clinical symptoms and cognitive performance. Of 78 referred patients, 72% of those over 65 and 54% of those under 65 had a positive response to treatment. After 3 years, the superior response of the elderly patients was maintained and increasing age was a positive predictor of outcome [32].

Although there are no placebo-controlled trials, there is some evidence that lithium augmentation—the addition of lithium salts—can be effective in non-responders [33]. Alternative augmentation strategies are considered in resistant cases, although these have not been scientifically evaluated [34].

Studies of the natural history of late-life depression before antidepressant treatment was available suggested that the average time to spontaneous remission was 12–48 months. First-episode depression after age 60 has a 70% chance of recurrence within 2 years of remission [35]. Withdrawal of antidepressants after 4–8 months of continuation treatment resulted in recurrence of depression for two-thirds of elderly patients during the following 12 months [36]. Maintenance treatment with dothiepin 75 mg daily reduces recurrence for up to 2 years in comparison with placebo [37].

These studies indicate that maintenance treatment should be continued for 2 years after recovery from a depressive episode in old age. For individuals who have had two or more episodes, treatment may need to be continued for several years or even indefinitely. There are no data indicating the optimum dose of antidepressant for maintenance, but evidence from studies with younger

adults suggests that this should be the dose required to treat the acute episode.

The role of lithium prophylaxis in elderly subjects has not been addressed satisfactorily in controlled studies, but an elderly subgroup in a mixed-age study benefited as much as younger subjects [38].

Maintenance treatment with ECT has been used successfully to prevent recurrence without patients accumulating cognitive impairment [39].

Antidepressant trials in elderly patients in general medical wards are difficult to conduct [40], and often produce inconclusive results [41, 42]. The most successful study [43], purposely included seriously ill medical patients in a randomized placebo-controlled trial. By 8 weeks, twice as many patients treated with fluoxetine 20 mg daily showed a treatment response (67% *versus* 38%). The greatest gain was found in the most seriously physically ill, although numbers in these groups were small. Adverse effects were no greater for fluoxetine than placebo, and active treatment was well tolerated. Because contraindications to tricyclic antidepressants are common in this population [40], selective serotonin reuptake inhibitors would be the drugs of first choice for most patients.

Psychotherapy

The psychotherapies have been slow to develop for elderly people because of ageist assumptions [44]. There is evidence of clinical applicability, and interpersonal psychotherapies can be effectively employed with older people [45]. Family therapy can be valuable and the benefits have been described in case studies, although there have been no controlled trials [46].

Cognitive behavioural psychotherapy is the most evaluated psychological approach. It is more effective than occupational therapy, routine nursing care and waiting list controls in randomized studies [47, 48]. In comparative studies, cognitive behavioural psychotherapy, behavioural and psychodynamic approaches have similar efficacy and are superior to no treatment [49].

In a randomized placebo-controlled trial, cognitive behavioural psychotherapy was more effective than low-dose lithium or placebo in the 12-month prophylaxis of depression in old age [50].

Studies of treatment and outcome have usually involved secondary or tertiary care populations. Because the minority and most severe cases of depression in older people come to the attention of specialist services, it is important to know whether similar therapeutic gains can be achieved in primary care. Two studies identifying depressed patients at home who were not under psychiatric treatment would suggest that unreferred cases benefit from treatment [6, 51]. Both emphasized the importance of non-drug effects.

Conclusion

There is great potential and opportunity for detecting depression in older people. In addition to relieving great suffering, there is preliminary evidence that recovery from depression reduces service usage by older people [52]. One study from inner London estimated that the monthly cost of services used by depressed elders living at home was almost three times that of well elderly people, highlighting opportunities for cost savings [53]. The simple prescription of an appropriate antidepressant drug to all elderly people meeting case-level criteria for depression would be a beginning in tackling the most reversible mental health problem in old age.

Key points

- Depression is the most common mental health problem in old age and the most reversible cause of psychiatric morbidity and mortality in later life.
- Without treatment, depression follows a chronic course with high morbidity and mortality.
- Detection is poor and treatment of any sort is offered to a minority of cases, but age is not an adverse predictor of response to treatment and elderly subjects have a better outcome than younger patients in some circumstances.
- In high-risk populations, such as physically ill patients, screening with the Geriatric Depression Scale improves detection. In this context, selective serotonin re-uptake inhibitors are the preferred choice.
- Every older person with depression should be considered for antidepressant drug treatment or referral to a specialist in old age psychiatry

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Appendix. The Geriatric Depression Scale

Answer all the following questions by ringing either 'Yes' or 'No'

1.	Are you basically satisfied with your life?	Yes/*No*
2.	Have you dropped many of your activities and interests?	*Yes*/No
3.	Do you feel that your life is empty?	*Yes*/No
4.	Do you often get bored?	*Yes*/No
5.	Are you in good spirits most of the time?	Yes/*No*
6.	Are you afraid that something bad is going to happen to you?	*Yes*/No
7.	Do you feel happy most of the time?	Yes/*No*
8.	Do you often feel helpless?	*Yes*/No
9.	Do you prefer to stay at home, rather than going out and doing new things?	*Yes*/No
10.	Do you feel you have more problems with memory than most?	*Yes*/No
11.	Do you think it is wonderful to be alive now?	Yes/*No*
12.	Do you feel pretty worthless the way you are now?	*Yes*/No
13.	Do you feel full of energy?	Yes/*No*
14.	Do you feel that your situation is hopeless?	*Yes*/No
15.	Do you think that most people are better off than you are?	*Yes*/No

Score 1 point for each italicized answer; a total score of 6–15 suggests depression.