

# Geriatric Psychiatry

David A. Beck, M.D., F.A.C.P.

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## **Affective Disorders in the Elderly**

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- ❖ Epidemiology
  - ECA observed that major depression is less frequent in elderly.
  - ECA data indicate that for those over age 65.
    - Prevalence of major depression is 1.4% in women.
    - 0.4% in men.
    - Overall prevalence of 1%.
  - One-quarter of that in adults age 18-44.
- ❖ Epidemiology
  - 2% of the elderly – dysthymia.
  - 4% - adjustment disorder with depressed mood.
  - 15% - depressive symptoms that don't meet any criteria.
  - However, nonsyndromic depression does not appear to increase with age.
- ❖ Epidemiology
  - Prevalence studies have a number of methodological problems.
    - Tendency of elderly persons to express psychiatric symptoms in somatic terms.
    - Reluctance to recall and report psychiatric symptoms.
    - Use of diagnostic categories that are unsuitable for elderly individuals.
- ❖ Epidemiology
  - Cohort effect – low prevalence of depression in this generation of elderly persons.
    - Suicide studies showing that white men born in 1922 had lower suicide rates than cohorts born earlier.
    - Increasingly earlier onset in cohorts born in more recent years.
    - Narrowing in the differential risk for depression between genders.
  - Stirling County study failed to demonstrate a cohort effect.
- ❖ Epidemiology
  - High rate in special geriatric populations.
  - Elderly medical outpatients – 7-36%
    - -5% higher than in community samples.
  - As high as 40% in those hospitalized.
    - Combining major and minor depression.
  - Nursing home residents – Major Depression -12-16%.
    - Other depressive disorders – 30-35%
- ❖ Epidemiology
  - Geriatric depression is associated with.
    - Female gender.
    - Divorced or separated.
    - Low socioeconomic level.
    - Poor social support.
    - Recent adverse and unexpected life events.
    - Severe impairment in medical health resulting in disability.
    - Neurological, endocrinological, COPD, MI, malignancies.
- ❖ Epidemiology

- Depressive symptoms occur in the older geriatric population at a rate lower than that of younger adults.
- However, very high rates of depression occur in socioeconomically deprived, medically ill, disabled, and institutionalized elderly.
- ❖ Epidemiology
  - Underuse of mental health services is particularly common in the population over 65.
  - Health care provider bias that depression is a normal consequence of aging.
  - Collusion of hopelessness between caregiver and patient.
- ❖ Diagnosis
  - Overall medical severity and disability appear to be important risk factors.
  - Heterogeneous entity.
  - Large subgroup of patient with neurological brain disorders.
- ❖ Diagnosis
  - Compared with patient with early onset depression, those with late onset depression.
    - Less frequent family histories of mood disorders.
    - Higher prevalence of dementing disorders.
    - More impairment on neuropsychological testing.
    - Higher rate of dementia during follow-up.
    - Greater enlargement of lateral brain ventricles.
    - More white matter hyperintensities.
- ❖ Diagnosis
  - Depressive manifestations – 50% of dementia patients.
  - In Alzheimer's rates of major depression range 0%-87%, with most studies showing a range of 17%-31%.
  - Reports of relatives.
- ❖ Diagnosis
  - About 24% of those with cerebral vascular disease.
  - Cortical and lacunar infarct have higher rates of depression.
  - Binswanger's Disease – the lowest.
  - Left hemisphere lesions, especially close to the frontal pole.
  - Subcortical atrophy is also a predisposing factor.
- ❖ Diagnosis
  - Parkinson's disease patient – up to 50%.
  - Severity of depression does not appear related to the severity of motor disability.
- ❖ Diagnosis
  - Similarity of depressive manifestations to dementing disorders.
  - Both – Loss of interest, decreased energy, difficulty concentrating, agitation or retardation.
  - Sad, downcast mood and psychic rather than vegetative feature have been found useful in distinguishing depression-dementia patient from those with dementia alone.
  - Caregiver reports need to be included in evaluation.
- ❖ Diagnosis
  - Pseudodementia, dementia of depression, depression with reversible dementia.
  - Develop high rates of irreversible dementia, about 20% per year on follow-up.
  - These patients can be ordered along a continuum.

- Indication for thorough diagnostic workup and frequent follow-up aimed at the identification of treatable disorders.
- ❖ Diagnosis
  - Psychotic depression – 20-45% of hospitalized elderly depression patients, 3.6% of these in the community.
  - Delusions.
  - Themes of depressive delusions.
    - Guilt, hypochondriasis, nihilism, persecution, jealousy.
  - Requires treatment with combinations of antidepressants and antipsychotics or ECT.
- ❖ Course
  - Chronicity rate 7-30%
  - May be predicted by
    - History of long current episode.
    - Long previous episodes
    - Coexisting medical illness
    - High severity of depression
    - Nonmelancholic presentation
    - Delusions
- ❖ Course
  - 13-19% rate of relapse over one year.
  - Increases to just over one-third when followed to 3-6 years.
  - Increased
    - History of frequent episodes
    - Late age at onset
    - History of dysthymia
    - Concurrent medical illness
    - Possibly high severity and chronicity of the index episode
- ❖ Course
  - 40% will also have cognitive dysfunction.
  - Reversible dementia – permanent dementia at the rate of 9-25% per year.
    - 2.5-6 times higher than in the general geriatric population.
- ❖ Biological Dysfunction
  - Abnormal DST, (plasma cortisol escape from dexamethasone suppression)
    - More frequent in geriatric depression patients
    - One-third of dementia patients.
    - Lack of normalization-early relapse.
  - Blunted TSH response to TRH
    - 25% of depression.
    - Reported in Alzheimer's
- ❖ Biological Dysfunction
  - Enlargement of lateral brain ventricles in geriatric depression.
  - More pronounced in late-onset depression than in similarly aged early-onset depression patients.
  - Comparable to Alzheimer's
  - This may be a marker for poor response to treatment.
- ❖ Treatment

- Mild geriatric depression
  - Cognitive behavior therapy
  - Interpersonal therapy
  - Psychodynamic psychotherapy
- Psychotherapy remains underutilized in geriatric depression.
- Family approaches are important.
- ❖ Medications
  - Suggested that onset of antidepressant response occurs later in elderly adults than in young adults.
  - Pretreatment systolic orthostatic hypotension correlate with response to nortriptyline.
- ❖ Medications
  - SSRI's well tolerated and effective.
  - In elderly outpatients, SSRI's equally effective to TCA's in the acute treatment of depression.
  - Fluoxetine may prevent relapse or recurrence.
- ❖ Medications
  - Psychostimulants improve apathy and energy in medical patients.
  - Rapid onset of action, minimal side effects, little tolerance, minimal risk for addiction.
  - In younger depression patients, a combination of TCA's with SSRI's – earlier response.
- ❖ Bipolar Disorder
  - Mania or hypomania constitutes 5-10% of elderly inpatients.
  - Little is know of the prevalence in the community.
- ❖ Bipolar Disorder
  - Type I – Hospitalized at least once for mania and history of major depression.
  - Type II – Hypomania and depression.
  - Type III – Cyclothymia without major depression or mania.
  - Type IV – Manic states from medical illnesses or drugs (not antidepressants).
  - Type V – Histories of major depression only with a family history of bipolar.
- ❖ Bipolar Disorder
  - Heterogeneous disorder
    - Unipolar major depression who changed polarity in late life.
    - Incidence of late-onset mania is unknown.
    - Mania associated with medical disorders/drug treatment – onset after age 40.
    - Mania with onset during senescence – coarse brain disease.
      - Cerebrovascular disease, especially right-sided lesions.
- ❖ Bipolar Disorder
  - Course and outcome – unclear.
  - It is unclear whether reversible cognitive dysfunction in mania leads to persistent cognitive dysfunction.
  - Older age is associated with chronic mania.
- ❖ Bipolar Disorder
  - Later age at onset
    - Great duration of episode
    - Shorter intervals between episodes
  - Mortality rate is higher
    - Geriatric depression patients

- Elderly in community
- ❖ Treatment of Geriatric Mania
  - Lithium is effective.
  - High lithium plasma levels at relatively low dosages.
  - One-half to 2/3 of the dosage for young adults.
  - Half-life of lithium is about 24 hours at age 70.
- ❖ Treatment of Geriatric Mania
  - High incidence of pharmacodynamic sensitivity
    - Fine tremor and myoclonus.
  - Lithium levels need only be 0.3-0.6 meq/L.
  - Lorazepam or low dosages or high-potency antipsychotics may be used.
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  - Lithium may induce or worsen cognitive impairment.
  - Delirium may develop at sub therapeutic levels.
  - Parkinson's patients receiving antipsychotics are particularly prone to delirium.
  - Delirium and cerebellar dysfunction may last for weeks after lithium discontinuation.
  - Lithium may produce Parkinsonian symptoms.
- ❖ Treatment of Geriatric Mania
  - Lithium
    - Sinoatrial block.
    - Salt depletion
      - Vomiting or diarrhea
      - Thiazide diuretics, NSAID's, and ACE inhibitors
      - Raise lithium levels
      - Toxicity
- ❖ Treatment of Geriatric Mania
  - Carbamazepine and valproate are effective.
  - Patients with neurological brain diseases – valproate
  - Carbamazepine
    - Sedation, confusion, and ataxia
    - Dose dependent
- ❖ Treatment of Geriatric Mania
  - Carbamazepine – treated patient should have frequent CBC's.
    - Can cause leukopenia in about 2% of patients.
    - First 16 days of treatment.
  - Valproate causes leukopenia in 0.4%.
- ❖ Treatment of Geriatric Mania
  - ECT is highly effective in mania.
  - Approximately 80% improve.
  - ECT is effective even in those resistant to medications.
  - Comparable number of ECT treatments to depressed patients.
  - Lower seizure threshold than depressed patients.
- ❖ Suicide
  - More frequent in elderly individuals than any other population.
  - Rate of about 20.1 per 100,000.
    - Double that of the general population.

- Increase in males and reach their highest level in the oldest age group.
- Female suicide rates increase slightly with age, peak in middle adulthood and decline in late life.
- ❖ Suicide
  - White men older than 65 have the highest rate of 43.5/100,000
  - Nonwhite men – 15.7/100,000
  - White women – 6.3/100,000
  - Nonwhite women – 2.8/100,000
  - Almost all elderly suicide victims have had a psychiatric disorder.
    - Late-onset depression
- ❖ Suicide
  - About 60% of suicide victims are men.
  - About 75% of those who attempt are women.
  - Violent methods of suicide are more prevalent.
  - Physical illness and loss seem to be the most common suicide precipitants in late life.
- ❖ Suicide
  - History of alcohol use and psychiatric histories – less than in younger individuals.
  - Most elderly persons who commit suicide communicate their suicidal thoughts to family or friends prior to the act of suicide.

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