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Depression, Dementia and Suicide in the Elderly

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Summary

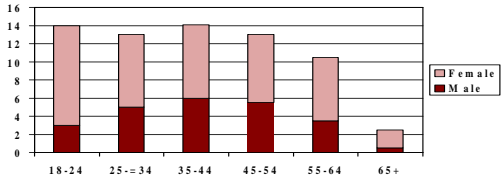
- Depression is common in old age
- The main risk factor is poor physical health
- Depression is frequently associated with dementia
- Depression is often unrecognised and untreated with considerable cost – including suicide
- Treatments for depression are reasonably effective

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How common is depression in Australia? Henderson et al, 2000



Age Group	Male	Female	Total
18-24	3	11	14
25-34	5	9	14
35-44	6	8	14
45-54	6	7	13
55-64	4	6	10
65+	1	2	3


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Depression in Older General Practice Patients (Pirkis et al, 2009)

- Survey of 22,251 GP patients aged 60+ in Australia
- Overall, the age-adjusted rate of clinically significant depression was 8.2%, with the age-adjusted rates for males being 8.6% and for females being 7.9%
- Overall age-adjusted rates for a major depressive episode was 1.8%

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Depression in older people in medical settings and aged care facilities

General Hospital Wards
clinically significant depression 23% - 45%

Medical Outpatients
clinically significant depression 20% - 24%

Aged Care Facilities
30-75% have depressive symptoms
6 - 25% depressive disorders

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Anxiety & Depression in Dementia

- 77% cumulative 5-year period prevalence of depression among incident cases of dementia (29% at baseline and 40-47% at subsequent yearly intervals), while 14% baseline and 24-32% at subsequent yearly intervals had anxiety

Steinberg et al (2008)


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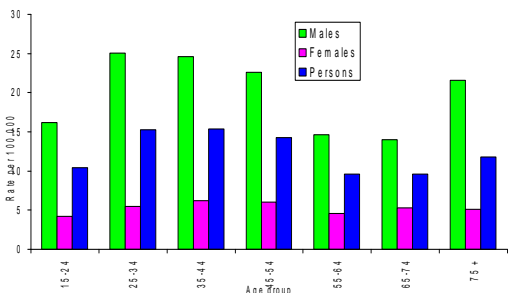
Outcomes of untreated depression

- Reduced Quality of Life
- Unnecessary suffering
- Burden – family, social, economic
- Suicide risk
- Increased health service use
- Increased physical morbidity and mortality

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Suicide in Australia Age specific rates, 2005.



Age Group	Males	Females	Persons
15-24	16	4	10
25-34	25	5	15
35-44	24	6	15
45-54	22	6	14
55-64	14	4	9
65-74	13	5	9
75+	21	5	12


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Vulnerability to Depression & Suicide in Late Life

- **Genetic factors** less important in late life but still have a role and may be mediated by vascular disease
- **Early Life Experiences**
 - Child Abuse (Draper et al, 2008)
 - Holocaust (Barak et al, 2005)
 - Childhood bereavement (father) (De Leo et al, 2002)
- **Interaction** between **early life experiences**, **acute life events** and **genetic risk** results in increased lifetime risk of depression and suicidal behaviour (e.g. Zalsman et al, 2006)

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Risk Factors for Depression in Late Life

Physical Health & Disability


- Main risk factor for depression in late life
- Increased risk with number of illnesses, illness severity, effects on function, presence of pain
- Neurological disorders particularly important e.g. strokes, Parkinson's disease, dementia
- Psychosocial consequences e.g. burden on family very important

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Other risk factors for late life depression

- Biological changes in brain – neurotransmitters & neurons
- Drugs and Alcohol
- Life Events – losses e.g. death, divorce
- Social factors – lack of support, social isolation, loneliness, poor accommodation, financial strain




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Protective Factors

- Good Physical Health
- Physical Fitness
- Adequate social support
- Marriage
- ??Social Activity
- ??Coping skills in early life
- ??Religion


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Factors hindering depression diagnosis in late life

- More frequent presentations with **non-dysphoric depression**
 - Memory problems
 - Physical symptoms – pain, fatigue, weight loss
 - Behaviour change – insomnia, loss of appetite, apathy
- Poor recognition by GPs
- Older people less 'psychologically minded'
- Ageism – 'Normal to be old & depressed'


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Cognitive Impairment and Depression in Late Life

- There are 3 scenarios
 - Depression with mild cognitive impairment
 - Depression complicating Mild/Moderate Dementia
 - Severe Depression causing severe cognitive impairment to the extent that the diagnosis of dementia is considered, so-called 'depressive pseudodementia'


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Late Life Depression with Mild Cognitive Impairment (MCI)

- Most depressed older people have mild cognitive changes – most frequently poor concentration, slowed reaction times, reduced STM
- Usually the patient is obviously depressed and the cognitive change resolves once the depression is treated
- Sometimes the MCI remains and the patient needs to be monitored over some years to see if dementia develops (about 50% chance)


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Depressive Pseudodementia

- Rarely severe depression causes such marked disproportionate cognitive disturbance that the diagnosis of dementia is considered
- Often in these circumstances the patient does not 'feel' depressed
- Collateral history usually identifies the typical depressive syndrome with subacute onset
- Responds to usual depressive treatments with resolution of cognitive change though increased risk of dementia developing in later years


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Depression associated with Dementia

- Presentations with a mix of depressive symptoms & cognitive impairment are common
- Often extent, duration and type of cognitive change is suggestive of early dementia and the severity of the depressive symptoms is insufficient to explain the change
- The main issue is usually 'how much depression & how much dementia?'
- Treatment of the depression is required to clarify this issue as depression magnifies the cognitive and functional impairment of dementia
- These patients have a high risk of suicidal ideation

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Suicidal ideation and dementia

DRAPER et al (1998)


221 memory clinic patients

On self report

- 5% "life not worth living"
- 3% "wish to die"
- 1% "suicidal ideation"

- All patients who "wished to die" or had suicidal ideation had significant depressive symptoms
- Two thirds were clinical depressed, one third had major depression
- Suicidal ideation and the "wish to die" were significantly associated with presence of depressive symptoms but only in patients with AD ($r = 0.49, p < 0.0001$)

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Suicidal Ideation and Dementia – Self Report vs Carer Report

SELF REPORT
1-2%

CARER REPORT
9-15%


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Suicide Risk in Dementia

- Historically, suicide regarded as uncommon in persons with dementia but data often excludes early dementia (Harris & Barraclough, 1997)
- Case reports of increased suicide risk in early dementia esp. with preserved insight, comorbid depression & frontal impairment
- Snowdon & Baume (2002) – 7% older suicides had possible dementia, most were depressed
- Waern et al (2003) – dementia had OR of 1.5 for risk of suicide

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Suicide Risk in Dementia

(Erlangsen et al, 2008)

- Nationwide longitudinal study from Denmark using register linkage data reported that hospital-diagnosed dementia was associated with an elevated risk of suicide particularly in those aged 50-69 years where the relative risk was 8.5 in men and 10.8 in women.
- The risk was higher in the first 3 months after diagnosis particularly in men where 25% died in this period
- Controlling for mood disorders reduced but did not eliminate the increased risk
- Risk higher in AD compared to VaD


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Management of suicide risk in the diagnosis of dementia

1. Tailor disclosure to suit the needs of the patient, using a stepped procedure to ascertain the person's desire to know and exploring patient reactions to diagnosis to minimise catastrophic reactions
2. Message should be given in a simple easy to understand manner, emphasising that progression is slow, QOL can be maintained and symptomatic treatments are available
3. Realistic hope about the future should be provided.
4. An ongoing commitment to provide support & care to patient & family
5. Living with Memory Loss Program
6. Treatment of depression

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Management of Depression

- Type of depression will influence choice of management strategies
- Major depression, particularly with melancholic and/or psychotic features, usually require physical treatment ± psychosocial therapies
- Minor depression/dysthymia often best treated with psychosocial therapies ± antidepressants


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Aims of Depression Treatment

- Therapy should aim for Remission not just Response to reduce relapse rates, improve functioning and reduce suicide risk
- Remission more likely with
 - Combined antidepressant/psychotherapy
 - ongoing involvement of community psychogeriatric team


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Non-pharmacological interventions

1. Cognitive Behaviour Therapy (CBT)
2. Interpersonal Psychotherapy (IPT)
3. Interpersonal Counselling (Mossey et al, 1996)
4. Exercise - progressive resistance training (Singh et al, 1997)
5. Music Therapy (Hanser & Thompson, 1994)
6. Pleasant Events Schedules (Teri et al, 1997)
7. Bibliotherapy (Landreville & Bissonnette, 1997)
8. Problem Solving Treatment (Ciechanowski et al, 2004)

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Activity Based Model of Dementia Care

(Brooker et al, 2007)

- Enriched Opportunities Programme in improving well-being, diversity of activity, health, and staff practice in nursing home care for people with dementia
- Five elements - specialist expertise; individualised assessment and case work; an activity and occupation programme; staff training; and management and leadership.
- Reduced depression & increased observed well-being, increased positive staff interventions.


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Antidepressant Medications

- Selective Serotonin Reuptake Inhibitors (SSRIs) currently first line largely due to being better tolerated than other classes
- The two main agents used in older people are citalopram & sertraline because they have a short half life & cause relatively few drug interactions through P450 metabolism

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Antidepressants in dementia

- Effectiveness in treating depression, anxiety and agitation in dementia is modest
- Meta-analysis by Thompson et al (2007) of depression in dementia included 5 DB placebo controlled studies involving 165 patients and found antidepressants efficacious with the number needed to treat being 5
- SSRIs are the first choice agents, especially sertraline (25-100 mg) and citalopram (10-30mg)

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Treatment of Severe Depression

- SSRIs may not work as well in severe depression so other antidepressant classes with dual neurotransmitter action (e.g. SNRIs, TCAs) might be needed or augmentation with other drugs e.g. lithium
- Electroconvulsive Therapy (ECT) is the most effective treatment for severe depression with psychosis and/or suicidality e.g. refusal to eat

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How long should antidepressants be continued?

- First episode major depression – antidepressants for at least 12 months, preferably 24 months
- Second episode major depression – antidepressants for at least 24 months, possibly indefinitely
- Three or more episodes – indefinite antidepressant maintenance

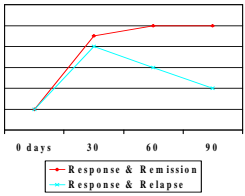
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Aims of Maintenance Therapy – Preventing Relapse


- Therapy should aim for **Remission** not just **Response** to reduce **Relapse** rates, improve functioning and reduce suicide risk



Days	Response & Remission	Response & Relapse
0	0	0
30	High	High
60	High	Medium
90	High	Low

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CONCLUSIONS


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The Hospital Dementia Services Project

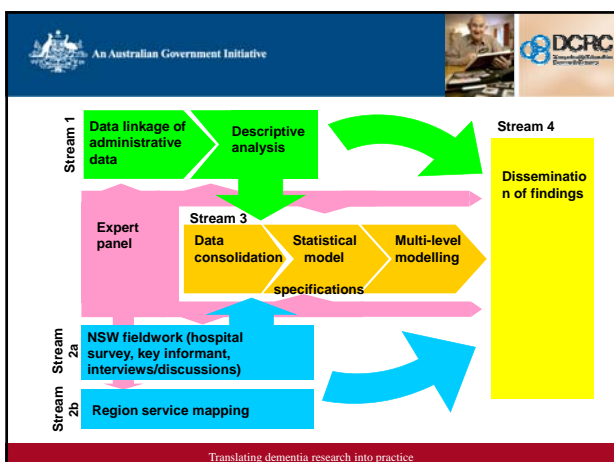


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DCRC
Dementia and Cognitive Research Centre

Thank You!

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http://www.dementia.unsw.edu.au/DCRC_web.nsf/page/Draper

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