Geriatric Psychiatry

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

Treatment of Geriatric Mania
- 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

- 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 an 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.
Epidemiology

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