Reading about

EDITED BY SIDNEY CROWN and ALAN LEE

Depression in the elderly

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A 'good read' which combines elements of depression with old age sounds like a contradiction in terms. Yet depression in later life is clinically fascinating and rewarding to treat. It is also very common, more common in fact than dementia.

Felix Post reminds us in the introduction to his monograph (Post, 1962), that the tendency of depression to run a less than benign course in old age is recognised in literature. As an example he cites Goethe's *Wilhelm Meister's Lehrjahre*. Augustin, a chronic depressive, is helped to recover by a sympathetic doctor-cum-priest. Not only does his depression lift but his 'senile habitus', as Post would have termed it, also disappears. Sadly, though a recurrence occurs which ends in his suicide.

The beginnings

The introduction to Post's monograph (1962) and the seminal paper by Sir Martin Roth (1955), in which affective disorders were unequivocally separated from the dementias by their different prognoses (dead, in-patient or discharged), are both good starting points. Willmuth (1979) traces the concept and suggests that despite any historical evidence that in old age depression is any worse than at other times of life, ageist attitudes fuelled a therapeutic nihilism which persists to this day. Berrios (1991) discusses the factor of ageing in the general history of affective disorders. Starting with concepts of the 'climacteric years' and of brain 'sclerosis', he provides an historical background to the important notion of 'involutional (senile) melancholia' of Kraepelin's era.

The North American response to Kraepelin was *The prognosis of involutional melancholia* by Hoch & MacCurdy (1922). It has the advantage of being a paper of historic importance written in English and accessible. Everyone ought to read something from the pre-ECT era. A statement such as "All patients who eventually recover show some improvement within four years after the onset", gives us a glimpse of the realities of psychiatric care at the turn of the century compared to those likely to dominate a century on, such as 'managed care'. In fact, 'involutional melancholia' has outlived those who have tried to bury it. As recently as 1984 Brown *et al* have provided evidence for something similar.

Epidemiology

Large epidemiological studies sometimes seem remote from everyday psychiatric practice. An exception is *The Mind and Mood of Aging* (Gurland *et al*, 1983). Not only are prevalences compared across the two sides of the Atlantic, but information is given about services, both delivered and needed, psychotropic prescriptions and other details which clinicians can make sense of. In the UK, John Copeland, co-investigator with Gurland, has pioneered similar clinician-friendly epidemiological data via the use of the ubiquitous 'Geriatric Mental Status Schedule' (GMSS; Copeland *et al*, 1976), the 'PSE' of geriatric psychiatry. As an indication of how far things have moved on, my first introduction to the GMSS and its computerised diagnostic algorithm, AGECAT, was via a stack of papers which had to be analysed via Copeland's own university computer. Now it's all done on a laptop computer, saving time, investigator patience and a good many trees. Of the many publications by Copeland's group the 1987 paper is a good introduction.

One of old age psychiatry's significant epidemiologists is David Kay. Classic papers worth reading from the Newcastle stable of the 1960s have 'old age mental disorders in Newcastle upon Tyne' as a running title (e.g. Kay *et al*, 1964). About a third of the population surveyed had a mental disorder, although this was using wide criteria. It was one of the first studies to survey 'neurotic' disorder and not only major mental illness in the elderly.

In *Epidemiology of dysphoria and depression in an elderly population* (Blazer & Williams, 1980) an important distinction is made between depressive symptoms and depressive illness in old age and the relationship of both to physical ill health is teased out; a classic paper.

Hospitalised elderly patients have a high prevalence of depression, with reports of between 12 and 45% (Koenig *et al*, 1988; Jackson & Baldwin, 1993). Ames' discovery (Ames *et al*, 1988) of 'significantly depressed mental state', closely corresponding to our notion of depressive illness, in almost two-fifths of local authority home residents is a disturbing but important paper.

Lastly, successful detection might improve treatment. The 'Geriatric Depressive Scale' (GDS; Yesavage *et al*, 1983) has been developed specifically for use with older people. It has some terms and some questions which seem rather inappropriate (for example, 'do you prefer to stay at home, rather than going out and doing new things?' may seem pretty irrelevant to an inner city resident with little income, poor public transport and ill health). Nevertheless, it has been extensively validated and is endorsed by the Royal College of Physicians and the British Geriatric Society (1992).

Rapp & Davis, in an often-quoted paper (Rapp & Davis, 1989), argue that the routine use of a scale such as the GDS would improve the detection of depression in medical wards considerably. They contrast the lack of use of such scales for depression with the routine use by physicians of screening instruments for dementia. They may be correct, although another view is that successful detection of depression does not guarantee that it will be adequately treated.

This seems to be the theme of another well-known paper by MacDonald (1986). Significant depressive symptoms were found in a third of elderly patients, this time in primary care attenders. The depression was often diagnosed but seemingly ignored when it came to treatment.

The clinical picture

Does depression in later life differ from that at any other time? On balance it seems that the adage 'depression is depression at any age' is largely true, but there are some significant differences. Early in my training I was helped by the clarity of more senior colleagues such as Brice Pitt whose book *Psychogeriatrics: An Introduction to the Psychiatry of Old Age* (Pitt, 1982) provides colourful and straightforward descriptions of depressive states. Another sensible

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'starter' for someone simply wishing to dip a toe into the waters of old age psychiatry is *The Practical Psychiatry of Old Age* by Wattis & Martin (1996). Both these books provide useful case vignettes in the relevant chapters on depression, although for those who want a more comprehensive overview to a greater depth, and who are willing to pay for it, the newer textbooks may be more appropriate (*vide infra*).

Textbooks rapidly become geriatric themselves. However, some of the best descriptions of the presentation of depressive illness in later life can be found among them. For example, Post's description of depressive 'pseudodementia' in *The Psychiatry of Late Life* (1982) contains a pithy account of the phenomenon, ending on a suitably sceptical note: "Perhaps the main point to be made about pseudodementia is that it should not be considered too seriously" – for clinically relevant depression is treated whatever the context.

On the theme of dementia, Burns and colleagues published a series of important papers in which they detail psychiatric symptoms and behaviours in a prospectively defined group of patients with Alzheimer's disease. One of them (Burns *et al*, 1990) is devoted to disorders of mood. Almost two-thirds of patients reported some depressive symptoms and almost half were considered depressed by their carer, although this fell to a quarter when rated by a trained observer. In a review, Allen & Burns (1995) point out that studies of depression in dementia show rates varying between zero and 87%. Using strict criteria they come up with a weighted average of 19% for 'depressive syndromes', a much higher rate than non-demented elderly people. Their review also endorses the commonly held notion that depression is more common in vascular dementia than Alzheimer's disease.

Aetiology

Over a quarter of a century ago Felix Post prophesied: . . . 'subtle cerebral changes may make ageing persons increasingly liable to affective disturbance" (Post, 1968). Jacoby & colleagues explored Post's hypothesis in a series of papers (Jacoby & Levy, 1980; Jacoby *et al*, 1981; Jacoby *et al*, 1983). They used computerised tomography (CT) to compare changes in three groups: normal elderly controls, patients with senile dementia, and a group with depressive illness. A sub-group of nine of the original 41 depressed patients was identified as having ventricular enlargement. The group was characterised by being older, having a later age of onset of depression, a more 'endogenous' clinical picture and a higher death rate from extra-cerebral causes at two years than the other 32. This tradition of research at the Institute of Psychiatry, London, has continued. A more recent excellent example is that of Abas *et al* (1990). Here ventricular dilatation was associated with subtle cognitive disturbance in depression. Interestingly, this did not always disappear with successful remission of the mood disorder, lending weight to the likelihood of a structural brain change being responsible for both abnormalities.

More recent research using magnetic resonance imaging (MRI) has largely confirmed the CT findings and extended them. I have summarised the recent MRI literature elsewhere (Baldwin, 1993). In brief, several recent studies have identified an unexpectedly high rate of particular brain changes (periventricular hyperintense areas, subcortical white matter lesions and subcortical grey matter lesions, especially in the basal ganglia) in the brains of elderly depressed patients compared to age-matched control subjects. The significance of these findings and their effect, if any, on treatment response is unknown, but I am sure more publications will follow soon.

Treatment

A major contribution comes in the form of a report of the US National Institutes of Health Consensus Development conference (Schneider *et al*, 1994). Their massive tome (500 plus pages) entitled *Diagnosis and Treatment of Depression in Late Life* covers not only physical treatments but also cognitive therapy and psychosocial interventions. It is written to a high standard, is essential reading for anyone conducting outcome or treatment research and can be dipped into easily by those who just want an update on selected topics. Unfortunately publication delays mean that it is just a little too out of date to incorporate much data about the newer antidepressants.

The prejudice that psychological treatments offer little to older depressed patients persists. In fact, some of the original work suggesting efficacy of psychotherapy was conducted well over a decade ago. Jarvik *et al* (1982) studied two groups of depressed patients with a mean age of 67 years. One group was treated with standard tricyclic antidepressants and the other given either dynamic or cognitive–behavioural therapy, both in groups. Although both groups fared better than a third placebo group, more of those treated with antidepressants enjoyed complete remissions. In another study (Steuer *et al*, 1984), two groups of patients with depressive illness were compared. One group received a psychodynamic approach and the other a cognitive–behavioural one. At nine months both groups had improved by an equivalent amount, suggesting little to choose between the treatment types. Lastly, Yost *et al* (1986) devoted an entire textbook to group cognitive psychotherapy with older depressives.

In the USA, Klerman's Interpersonal Psychotherapy (IPT) has likewise been adapted for use with older patients. Ellen Frank and colleagues write about it in a chapter in Klerman & Weissman's textbook on IPT (Frank *et al*, 1993). I found this immensely helpful and only wish that IPT were more readily available here. There is also evidence that it is effective (Reynolds *et al*, 1992).

Old age psychiatric services are rightly proud of their attention not only to the patient but to the family. Benbow and colleagues (1990) provide a useful overview of the principles they use in a 'family clinic' which includes depressed patients. Their approach is based on an adaptation of the life cycle, and illustrated with helpful case histories.

Formal evaluation of effectiveness of family therapy in depression, as against the standard multidisciplinary team approach to management, is lacking. Using the skills of the latter, Ong *et al* (1987) in a small but elegant study, found that an aftercare support group run by a social worker and a community psychiatric nurse was effective in preventing readmission and relapse in depressed elderly patients.

Prognosis and outcome

In these days of 'evidence-based medicine' good studies of prognosis are much needed. The task of assessing outcome has been made easier by a useful overview, described as a meta-analysis although strictly speaking it is not, of depression in later life involving nearly 1000 patients (Cole, 1990). About 60% of patients remain, in the medium and long term, either well throughout or, more usually are mostly well but have discrete recurrences.

Included in Cole's 'meta-analysis' was a study by Murphy (1983), whose work was the first to incorporate modern research approaches to the study of outcome. She found that only a third of patients fared well over one year and this provoked much debate and soul-searching among the new fraternity of 'psychogeriatricians'. Also included in Cole's study was our own research (Baldwin & Jolley, 1986), which was meant to be a response to Murphy's findings and an attempt to replicate the earlier work of Post (1962, 1972). Our results were more in keeping with Cole's later aggregated data.

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Clearly the last word has not been written, but it is interesting to ponder on one of the first, the contribution of Post in his monograph (1962). His findings were almost identical to the 'meta-analysis' of Cole! How ironic then that if Post were to start his research now it would stand little chance of being published, for it contains no operational criteria, outcome assessment was non-blind, and so on. Interestingly, though, I had to study Post's widely-quoted monograph in great detail to understand exactly how he arrived at his outcome figures, which are actually placed alongside his later, also classic, study of depression outcome in this journal (Post, 1972). Still, great work withstands fashion and Post's monograph can be read and re-read with benefit.

Suicide is another outcome. In Barraclough's study, nearly 90% of completed suicides in old age were associated with depressive illness (Barraclough, 1971) and psychiatric disorder was found in at least two-thirds of elderly attempters. A more recent 'psychiatric autopsy,' by Cattell & Jolley (1995) shows that little has changed. Although most recent studies of outcome in old age depression show only a little additional mortality from suicide, there are exceptions. The chief of these is a paper by Ciompi (1969), which followed the evolution of former neurotic and depressive states and showed that most of the excess mortality in these patients was due to suicide.

Mortality is increased in later life depression, even after allowing for the effect of suicide. Numbers of cardiovascular deaths are higher than expected. A good paper which shows this and explores the issues is that of Murphy *et al* (1988).

General texts

Geriatric Psychiatry: Key Research Topics for the Clinician (Murphy & Alexopoulos, 1995) is a book comprising a selection of papers taken from the *International Journal of Geriatric Psychiatry* (IJGP), a peer-reviewed research journal devoted to old age psychiatry. It is in seven parts and one of them concerns depression. A useful source-book of innovative research but not comprehensive enough for someone wanting a rounded view of depression.

That there are now several modern comprehensive textbooks devoted entirely to old age psychiatry is surely a mark of how successful and popular the speciality has become in a short period of time. A popular and well priced one is *Psychiatry in the Elderly* (Edited by Jacoby & Oppenheimer, second edition 1996). Busse & Blazer's *Geriatric Psychiatry* (1989) is perhaps less well known and probably superseded by *A Textbook of Geriatric Psychiatry* by Copeland & Blazer (1994). At £135 this is, however, a book for the library or the specialist; comprehensive and scholarly. All these books cover depression satisfactorily.

Last but not least, for those who want a textbook devoted only to depression, try *Depression in Old Age* by Cornelius Katona (1994). It runs to 148 pages, is well written, covers all the ground mentioned in this review and is cheap.

REFERENCES

Abas, M. A., Sahakian, B. J. & Levy, R. (1990) Neuropsychological deficits and CT scan changes in elderly depressives. *Psychological Medicine*, **20**, 507–520.

Allen, N. H. P. & Burns, A. (1995) The non-cognitive features of depression. *Reviews in Clinical Gerontology*, **5**, 57–75.

Ames, D., Ashby, D., Mann, A. H., *et al* (1988) Psychiatric illness in elderly residents of homes in one London borough: prognosis and review. *Age and Ageing*, **17**, 249–256.

Baldwin, R. C. (1993) Late life depression and structural brain changes: a review of recent magnetic resonance imaging research. *International Journal of Geriatric Psychiatry*, **8**, 115–123.

— & Jolley, D. J. (1986) The prognosis of depression in old age. *British Journal of Psychiatry*, **149**, 574–583.

Barraclough, B. M. (1971) Suicide in the elderly. In *Recent Developments in Psychogeriatrics* (eds D.W. K. Kay & A. Walk). Kent: Headley.

Benbow, S., Egan, D., Marriott, A., *et al* (1990) Using the family life cycle with later life families. *Journal of Family Therapy*, **12**, 321–340.

Berrios, G. (1991) Affective disorders in old age: a conceptual history. *International Journal of Geriatric Psychiatry*, **6**, 337–346.

Blazer, D. & Williams, C. D. (1980) Epidemiology of dysphoria and depression in the elderly population. *American Journal of Psychiatry*, **137**, 439–444.

Brown, R. P., Sweeney, J. & Loutsch, E. (1984) Involutional melancholia revisited. *American Journal of Psychiatry*, **137**, 439–444.

Burns, A. B., Jacoby, R. & Levy, R. (1990) Psychiatric phenomena in Alzheimer's disease. III Disorders of mood. *British Journal of Psychiatry*, **157**, 81–86.

Busse, E. W. & Blazer, D. (Eds) (1989) *Geriatric Psychiatry*. Washington, DC: American Psychiatric Association.

Cattell, H. & Jolley, D. J. (1995) One hundred cases of suicide in elderly people. *British Journal of Psychiatry*, **166**, 451–457.

Ciompi, L. (1969) Follow-up studies on the evolution of former neurotic and depressives states in old age. *Journal of Geriatric Psychiatry*, **3**, 90–106.

Cole, M. G. (1990) The prognosis of depression in the elderly. *Canadian Medical Association Journal*, **143**, 633–640.

Copeland, J. R. M., Kelleher, M. J., Kellet, J., *et al* (1976) A semi-structured interview for the assessment of mental state in the elderly. *Psychological Medicine*, **6**, 439–449.

—, Dewey, M. E., Wood, N., *et al* (1987) Range of mental illness among the elderly in the community: prevalence in Liverpool using the GMS-AGECAT package. *British Journal of Psychiatry*, **150**, 815–823.

— & Blazer, D. (1994) *Textbook of Geriatric Psychiatry*. Chichester: Wiley.

Frank, E., Frank, N., Cornes, C., *et al* (1993) Interpersonal Psychotherapy in the treatment of late-life depression. In *New Applications of Interpersonal Psychotherapy* (eds G. L. Klerman & M. N. Weissman). Washington, DC: American Psychiatric Association.

Gurland, B., Copeland, J., Kuriansky, J., *et al* (1983) *The Mind and Mood of Aging*. London and Canberra: Croom Helm.

Hoch, A. & MacCurdy, J. T. (1922) The prognosis of involutional melancholia. *Archives of Neurology and Psychiatry*, **7**, 1–17.

Jackson, R. & Baldwin, B. (1993) Detecting depression in elderly medically ill patients: the use of the Geriatric Depression Scale compared with medical and nursing observations. *Age and Ageing*, **22**, 349–353.

Jacoby, R. J. & Levy, R. (1980) Computed tomography in the elderly. 3: affective disorder. *British Journal of Psychiatry*, **136**, 270–275.

—, — & Bird, J. M. (1981) Computed tomography and the outcome of affective disorder: a follow-up study of elderly patients. *British Journal of Psychiatry*, **139**, 288–292.

—, Dolan, R. J., Levy, R., *et al* (1983) Quantitative computed tomography in elderly depressed patients. *British Journal of Psychiatry*, **143**, 124–127.

— & Oppenheimer, O. (Eds) (1996) *Psychiatry in the Elderly*. Oxford: Oxford University Press.

Jarvik, L. S., Mintz, J., Steuer, J., *et al* (1982) Treating geriatric depression: a 26 week interim analysis. *Journal of American Geriatric Society*, **30**, 713–717.

Katona, C. L. E. (1994) *Depression in Old Age*. Chichester: John Wiley & Sons.

Kay, D. W. K., Beamish, P. & Roth, M. (1964) Old age mental disorders in Newcastle upon Tyne. Part I: a study of prevalence. *British Journal of Psychiatry*, **110**, 146–158.

Koenig, H. G., Meador, K. G., Cohen, H. J., *et al*, (1988) Detection and treatment of major depression in older medically ill hospitalised patients. *International Journal of Psychiatry in Medicine*, **18**, 17–31.

MacDonald, A. J. D. (1986) Do general practitioners "miss" depression in elderly patients? *British Medical Journal*, **292**, 1365–1367.

Murphy, E. (1983) The prognosis of depression in old age. *British Journal of Psychiatry*, **142**, 111–119.

—, Smith, R., Lindesay, J., *et al* (1988) Increased mortality rates in late-life depression. *British Journal of Psychiatry*, **152**, 347–353.

— & Alexopoulos, G. (Eds) (1995) *Geriatric Psychiatry: Key Research Topics for the Clinician*. Chichester: Wiley.

Ong, Y.-L., Martineau, F., Lloyd, C., *et al* (1987) Support group for the depressed elderly. *International Journal of Geriatric Psychiatry*, **2**, 119–123.

Post, F. (1962) *The Significance of Affective Symptoms in Old Age*. Maudsley Monographs 10. Oxford: Oxford University Press.

— (1968) The factor of ageing in affective disorder. In *Recent Developments in Affective Disorders* (eds A. Coppen & A. Walk). Royal Medico-Psychological Association Publication No. 2. Kent: Headley.

— (1972) The management and nature of depressive illnesses in late life: a follow-through study. *British Journal of Psychiatry*, **121**, 393–404.

— (1982) Functional disorders I: Description, incidence and recognition. In *The Psychiatry of Late Life* (eds R. Levy & F. Post). Oxford: Blackwell Scientific Publications.

Pitt, B. (1982) *Psychogeriatrics: An Introduction to the Psychiatry of Old Age*. Edinburgh: Churchill Livingstone.

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Rapp, S. R. & Davis, K. M. (1989) Geriatric depression: physicians' knowledge, perceptions, and diagnostic practice. *The Gerontologist*, **29**, 252–257.

Reynolds, C. F., Frank, E., Perel, J. M., et al (1992) Combined pharmacotherapy in the acute and continuation treatment of elderly patients with recurrent major depression: a preliminary report. *American Journal of Psychiatry*, **149**, 1687–1692.

Roth, M. (1955) The natural history of mental disorder in old age. *Journal of Mental Science*, **101**, 281–301.

Royal College of Physicians and British Geriatric Society (1992) *Standardised Assessment Scales for Elderly People.* Report of Joint Workshops of the Research Unit of the Royal College of Physicians and the British Geriatric Society. London: RCP.

Schneider, L. S., Reynolds, C. F., Lebowitz, B. D., et al (1994) *Diagnosis and Treatment of Depression in Late Life.* Washington, DC: American Psychiatric Press.

Steuer, J. L., Mintz, J., Hammen, C. L., et al (1984) Cognitive–behavioural and psychodynamic group psychotherapy in treatment of geriatric depression. *Journal of Consulting and Clinical Psychology*, **52**, 180–189.

Wattis, J. & Martin, C. (1996) *The Practical Psychiatry of Old Age.* London: Chapman & Hall.

Willmuth, L. R. (1979) Medical views on depression in the elderly: historical notes. *Journal of the American Geriatric Society*, **27**, 495–499.

Yesavage, J. A., Brink, T. L., Rose, T. L., et al (1983) Development and validation of a geriatric depression screening scale: a preliminary report. *Journal of Psychiatric Research*, **17**, 37–49.

Yost, E. B., Beutler, L. E., Corbishley, M. A., et al (1986) *Group Cognitive Therapy: A Treatment Approach for Depressed Older Adults.* New York: Pergamon Press.

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