

Depression and Dementia

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Depression

- DSM 5
- 5/9 sms in same 2 week period
- Must include depressed mood or anhedonia
- Other 7 are significant wt. loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, decreased concentration or indecisiveness, and recurrent thoughts of death or suicide

Depression

- A Major Depressive Episode, can now be coded as mild, moderate or severe. Other modifiers include single episode or recurrent episode, with mood congruent or mood incongruent psychotic features, with anxious distress, with melancholic features, with catatonia, with seasonal pattern.

Depression

- Depression can be part of a unipolar or bipolar disorder. This will have significant treatment implications.
- DSM V has several new depressive disorders defined.
- Disruptive Mood Dysregulation Disorder is for children up to 18 who exhibit persistent irritability and frequent episodes of extreme behavior dyscontrol.

Depression

- Premenstrual Dysphoric Disorder
- Persistent Depressive Disorder (was Dysthymic Disorder)
- The Bereavement exclusion (MDE applied to depressive symptoms lasting less than 2 months after the death of a loved one) is omitted in DSM V.

Depression

- MDD is projected to be the 2nd leading cause (to CV disease) for disability by 2020
- In the U.S., 16.2% of the population have had MDD
- In the U.S., 6.6% of the population have had a MDE W/ 1 YR
- F:M 1.7:1

Depression

- If 1 episode, 50% chance of more
- If 2 episodes, 70% chance of more
- If 3 episodes, 90% chance of more

Depression and Older Adults

- Depression is not a normal consequence of aging vs sadness and grief
- The incidence is about 2% for older adults living in the community
- This can increase 10-20 fold for those elderly who require home health care, are in the hospital or particularly for those who are in nursing homes

Depression and Older Adults

- Health professionals may mistakenly think that persistent depression is an acceptable response to other serious illnesses and the social and financial hardships that often accompany aging - an attitude often shared by older people themselves. This contributes to low rates of diagnosis and treatment in older adults.

Depression and Older Adults

- Most people think sadness is a hallmark of depression but more often in older people it's anhedonia - they're not enjoying life. They may be more irritable and isolative. They may complain of physical symptoms.

Why Depression is missed in Older Adults

- Masked depression (somatic symptoms)
- Pseudodementia
- Primary symptom may be social withdrawal and lack of interest in such things as medical care (easier to withdraw when not employed)
- "They have reason to be depressed"

Depression Risk Factors

- Female gender
- Social isolation
- Lower SES
- Comorbid medical conditions
- Uncontrolled pain
- Insomnia
- Functional impairment
- Cognitive impairment

Depression and Medical Comorbidity

- In the first 6 months post MI, those with depression have a 4x increase in mortality
- Those who develop depression after a stroke, have a 3-4x increase in mortality during a 10 yr. follow-up period
- A diagnosis of MDD increases the risk of a hospital patient dying by 8 times, after controlling for severity of illness

Depression and Medical Comorbidity

- Patients with Depression and Cardiovascular Disease, Diabetes Mellitus, COPD and other chronic medical conditions, cost insurance companies about twice as much as patients with similar disease, but without depression.

Depression and Suicide in Older Adults

- Those over 65 are about 13% of the US population, but account for nearly 24% of completed suicides. They attempt suicide less often than younger people, but are more "successful."
- The overall suicide rate in the US is about 12/100,000. In men over 65 it is 29/100,000 and in white men over 85 it is 55/100,000

Depression and Suicide in Older Adults

- Risk factors for suicide in older adults include hopelessness, insomnia, agitation or restlessness, impaired concentration, psychosis, alcohol use or abuse, uncontrolled pain. A previous history of suicide attempts or a FH of suicide attempts, terminal illness and social isolation are also risk factors.

Depression and Suicide in Older Adults

- Family members, friends and medical personnel must be educated about what to do when an older person says "life is not worth living," "I don't see any point in living," "I'd be better off dead" or "My family would be better off if I died."
- Serious personal neglect is another warning sign; people can commit a kind of passive suicide by failing to eat, letting themselves become dangerously sedentary or not taking needed medication.
- If you suspect that someone maybe suicidal you must ask directly. You will not put the idea in anyone's head. Listen carefully, empathize and help the person get evaluated for treatment or into treatment.

Depression and Suicide in Older Adults

- Up to 75% of those who committed suicide visited their MD within one month.
- Studies suggest that in 75% of suicides, the suicide victims had told family members or acquaintances of their suicide thoughts.

Major Neurocognitive Disorder

- Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on :
 1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
 2. A substantial impairment in cognitive performance, preferably documented by standardized NP testing or, another quantified clinical assessment

Major Neurocognitive Disorder

- The cognitive deficits interfere with independence in everyday activities
- The cognitive deficits do not occur exclusively in the context of delirium
- The cognitive deficits are not better explained by another mental disorder (e.g. depression or schizophrenia)

Major Neurocognitive Disorder

- Specify whether due to : Alzheimer's Disease, Frontotemporal lobar degeneration, Lewy Body Disease, Vascular Disease, Traumatic Brain Injury, Substance/Medication Use, HIV Disease, Prion Disease, Parkinson's Disease, Huntington's Disease, Another Medical Condition, Multiple Etiologies.

Mild Neurocognitive Disease

- Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains based on concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function and there is a modest impairment in cognitive performance preferably via standardized NP testing or, in its absence, another quantified clinical assessment.

Mild Neurocognitive Disease

- The cognitive deficits do not interfere with capacity for independence in everyday activities
- The deficits are not caused by a delirium or another mental disorder

Major Neurocognitive Disorder

- Over 5 % of those over 65 and at least 40% of those over 85 have dementia.
- About 2/3 have Alzheimer's Disease. Vascular Dementia causes about 15% of dementias and Lewy Body Disease about 10%. Other causes include head trauma, Parkinson's Disease, Alcoholism, Frontotemporal Dementia, and other CNS illnesses

DEPRESSION AND NCD

- Depression can be experienced at any time during the course of a Major NCD, though it is most common in the early stages. Overall, 30-50% of those with a Major NCD will experience at least one episode of depression during the course of their NCD.

DEPRESSION AND NCD

- Cognitive impairment can be a significant component of depression, esp. in the elderly “pseudodementia.”
- Depression can be a significant component of dementia.
- Typical of “pseudodementia” is poor effort and frequent “I don’t know answers.”

DEPRESSION AND NCD

- Also typical of “pseudodementia” is difficulty concentrating, impaired attention, and difficulty with ST memory. Such people often resist cognitive testing, though they tend to do quite well. One should not expect the language or orientation problems associated with dementia.

DEPRESSION AND NCD

- Late life onset depression can represent an early stage of dementia. One large study suggests 50% of those with late life onset depression go on to a diagnosis of dementia within 5 years.
- Depression can also be superimposed on a diagnosis of dementia and can lead to further decline in functioning.

DEPRESSION AND NCD

- Some clinicians suggest a trial of an antidepressant in all patients before making a diagnosis of a neurocognitive disorder.

DEPRESSION AND NCD

- There are few studies to guide treatment
- Talk therapy is likely to be of limited benefit if the cognitive impairments are significant
- SSRI's are usually the first choice of antidepressants. However, fluoxetine has a very long half life and more drug interactions than others and paroxetine is the SSRI with the most anticholinergic side effects
- Addressing insomnia is critical

DEPRESSION AND NCD

- Do not overlook substance abuse or pain as triggers or comorbid conditions
- In this population, suicide risk must be assessed.
- It is always preferable to have the primary caregiver participate in the evaluation of someone who is being assessed for Depression and a NCD.
