Depression in Later Life

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Depression in Later Life

Jill Manthorpe and Steve Iliffe
CHAPTER 1

Why Focus on Depression?

Depression is the commonest mental health problem in later life. At least one in ten people aged 65 or more have significant symptoms of depression like sadness, loss of energy and difficulties sleeping (Sharma and Copeland 1989). Those with illness or disabilities that limit their capability to deal with the tasks of everyday life, or who depend on others for a great deal of help, are more likely to be depressed than those who are more independent or less burdened with ill-health. Older people visiting their general practitioner (GP) are particularly likely to be experiencing depression symptoms, particularly the ‘physical’ symptoms of depression like persistent fatigue, headaches or widespread muscular aches and pains, or poor concentration and memory, and these symptoms may not be recognized for what they are (Lyness et al. 1999; Olafsdottir, Marcusson and Skoog 2001; Watts et al. 2002). People who are housebound are twice as likely to experience depression than more mobile older people, perhaps not surprisingly (Bruce and McNamara 1992). People living in sheltered accommodation are even more likely to experience depression, with closer to one in four individuals reporting depressive symptoms (Field, Walker and Orrell 2002). High rates of depression are found among users of home care services (Patmore 2002). Poverty and depression seem to go together, and poorer and less educated older people show less awareness of the symptoms.
of depression and are less likely to seek help or treatment. Depression is more common in older women than in older men.

In this book we are going to use both medical and psychosocial models of depression, because both are useful. In the medical model patterns of symptoms are grouped together to make diagnoses, and these can guide professionals and patients alike towards optimal treatments. The medical model concentrates on brain biochemistry, and seeks to alter it in the depressed person. Social and psychosocial models of depression are equally helpful because they can enable us to make sense of the complexity of depression. Psychosocial perspectives focus on the ways people learn to deal with adversity (the development of coping strategies), or on the ways that negative thinking affects behaviour, or on the effects of social relationships on mood and psychological well-being. A ‘social model’ looks in particular at social causes of depression but, as Golightly (2004) points out, medical and social models only get separated in academic or research thinking, far less so in practice where most practitioners take both perspectives on board. One of the main emphases of a social model approach is that it looks at how factors interact to enhance vulnerability and this is particularly relevant to older people whose histories are long and whose circumstances are often changing. Golightly (2004) summarizes the central points of a social model as, first, the taking into account of individual predisposing factors, for example, our genes, our family, our life history; second, social causes such as living in poverty; and third, psychological factors such as loss, threat, highly critical relationships, a lack of resilience and limited networks of support.

All of us have experienced sadness, and many of us have experienced depression, but it is not always easy to tell the difference, either when you are experiencing these mood changes yourself or when observing someone else. How can we distinguish between depression and understandable sadness in a practical way? Using a medical approach to understanding the experiences of depression,
we suggest the following three rules of thumb, all of which must apply:

- **Duration**: Symptoms of depression (we discuss these in detail later) are present for at least two weeks. This time limit is, of course, somewhat arbitrary, but it does seem to be a cut-off point for the kinds of sadness that are triggered by normal life events like losses, illness and failure.

- **Lack of fluctuation**: Symptoms of depression occur on most days, most of the time. Other events do not distract the person, and ‘good days’ (or even periods of the day) are few.

- **Intensity**: The severity of depression symptoms must be of a degree that is definitely not normal for that individual, so that they say ‘I have never felt this bad before’, or describe tiredness more profound than usual in a busy life, sleeplessness more frequent and prolonged than in the past, and so on.

These rules of thumb help to separate understandable sadness from depression, but they do not tell you which symptoms are the key signs of depression, and which are possible but not diagnostic. In this medical model the key symptoms of depression are as shown in Box 1.1.

Other symptoms that suggest depression include:

- suicidal thoughts or behaviour
- loss of confidence or self-esteem
- feeling of helplessness
- inappropriate or excessive feelings of guilt
- feelings of hopelessness or worthlessness
- avoiding social contacts or going out
- poor concentration and/or difficulty with memory
• physical slowing or agitation (restlessness or fidgeting)
• sleep disturbance (particularly waking in the early hours and not being able to return to sleep)
• reduced appetite with corresponding weight loss.

Box 1.1 Key symptoms of depression (Alexopoulos et al. 2001)

An individual has depression if any of the following three criteria apply:

1. They have a depressed mood sustained for at least two weeks (on most days, much of the time).
   
   and/or
   
2. They have lost interest or pleasure in usual activities (in medical jargon, ‘anhedonia’).
   
   and/or
   
3. They report decreased energy, increased fatigue (in people who are physically ill this may mean feelings of fatigue even when not attempting exertion), or diminished activity.

We will return to the advantages of the medical model of depression later, but first want to mention some of its disadvantages. While treatments derived from a medical model work for some older people with depression, they do not work for all, and even when they relieve the symptoms there can be a high risk of relapse. And, to make the situation more complicated, doctors and nurses may not always use the medical model, with its rules about patterns of symptoms. This can be a practical problem in working with older people, in two ways. Expectations of ‘cure’ can be raised in discussing with someone why they should seek help for their depression, only to be disappointed when treatments have
little or no effect. Similarly, a lot of effort and negotiation can go into persuading a reluctant older person to describe his or her feelings and symptoms to a doctor, only to find that the doctor does not recognize the problem as depression at all. It is important to understand how these problems arise, and what can be done about them. We will return to the effectiveness of different treatments again, both in this chapter and in Chapter 3, but first want to explore the problem of recognition further.

As a whole it seems true to say that depression in later life is under-diagnosed and under-treated. Studies of older people living at home show consistent under-documentation of depression in medical records when these are compared with the known burden of depression in the wider population (Garrard, Rolnick and Nitz 1998). Only a small minority of depressed older individuals with significant symptoms receive treatment or referral for specialist care, even when their general practitioners recognize their depressed state (MacDonald 1986). The severity of the depression and high levels of anxiety expressed by the older person seem to be triggers for referral (Eustace et al. 2001). Both general practitioners and hospital doctors have been criticised for their tendency to miss depression in their patients (Audit Commission 2000) but as we shall see the manifestation and patterns of depression in older people in the community are so complex, and the uncertainties about the effectiveness of intervention are so great, that under-diagnosis is inevitable. Depressed people may think of themselves as weak if they admit to depression, and see it as a stigmatizing description to be avoided, and their perspective may divert attention from the mental health problem to physical explanations. Professionals may find themselves focusing on the headache, sleeplessness, back pain or other symptoms described by the depressed older person, or on a request for vitamins or a tonic, rather than thinking about underlying, but perhaps well hidden, disturbances of thinking and emotion.

Professionals and older people themselves underestimate the significance of late life depression despite evidence that:
• late life depression is associated with disproportionately high rates of suicide and high death rates from all other medical causes (Montano 1999)

• depression in later life is associated with high use of both medical and social services (Beekman et al. 1997) and depressed older people are more likely to be treated for anxiety (or physical symptoms like pain) than with anti-depressants or psychological therapies

• depression particularly affects those older people caring for others.

Not all of those older people whose depression is diagnosed are treated appropriately (with anti-depressants or psychological therapies), but they are likely to be treated for anxiety or physical symptoms like pain, which may be the surface manifestations of the underlying depressive disorder. Since the commonest drugs used for suicide by self-poisoning among older people are Paracetamol and Paracetamol-based compounds like Co-proxamol (Distalgesic), treatment of symptoms rather than causes can be hazardous, and caution is recommended in their use if an older person is depressed (Shah, Uren and Baker 2002). We will return to the risk of suicide in Chapter 6, and only mention it here to emphasize the importance of thinking beyond the surface pattern of symptoms in an older person to seek their cause, just as in any physical disorder or trouble affecting quality of life. The first practice example of Mr A illustrates how a diagnosis of depression could be missed because symptoms are misattributed to other causes, or the older person wants to avoid the diagnosis itself.

The general practitioner who sees Mr A does need to think about physical illnesses that might cause Mr A’s symptoms and should investigate to rule them out, but he or she should not lose sight of the possibility that Mr A is developing a serious depressive illness. Apart from his reluctance to consider depression, diagnosis in Mr A’s case may be relatively straightforward, but it is often not so clear-cut. The features of the encounter
Practice example: Mr A, aged 76

Mr A rarely visits his GP, but goes to the medical centre one day complaining that he has no energy, and is sleeping badly. He wakes frequently at night and feels weary when he gets up in the morning. He has lost his appetite. His wife died three years ago following a stroke. While he volunteers that he does not get out and enjoy himself these days he is adamant that he is not depressed. He wants a ‘tonic’.

Learning points

Note the typical symptoms of, and the possible trigger factor (bereavement) for depression. Like many of his generation Mr A does not want a stigmatizing psychiatric label.

Depression is more likely to be the cause of his symptoms and experiences than are physical illnesses, although it is important to make sure that he does not have iron or vitamin B12 deficiency, or diabetes.

We need to know what his previous (‘pre-morbid’) personality was like. How has he coped with adverse events before? As we shall see in Chapter 3, if he has not previously experienced depression the impact of anti-depressant treatment may be more limited. In any case, social support may be more important than medical intervention. The first task in responding to Mr A may be to get another person’s perspective on how he has changed.

between the older person and their doctor (or nurse, social worker or family member) that might wrongly reduce the suspicion of depression are:

• high levels of anxiety without other immediately obvious depression symptoms. If Mr A shows only anxiety, he may be offered treatments for it that fail to address his probable depression
• a disability that makes depression seem appropriate, with the other person thinking ‘I would be depressed in your position’

• a long history of depressed periods occurring so frequently that depression seems normal for the person (it may be, in some senses, but this does not mean that it is not serious in an older person)

• a recent loss that makes the depression understandable (again, this may be partially true, in that losses can trigger depression, but that is no reason to underestimate the significance of the symptoms)

• multiple and confusing physical symptoms, like aches and pains that migrate from place to place, and that are difficult to match with any known physical illness

• a very obvious problem of memory loss, confusion or poor concentration

• resistance to the idea of depression from the older person or the family

• a limited impact of the depression on others (a depressed older person may be quiet, even apathetic, and so easier to be with and look after)

From this list there are four very important clinical problems that those working with older people in social work, nursing, medicine and allied health professions need to understand when trying to unravel complicated patterns of symptoms: anxiety, disability, somatization and dementia.

**Anxiety**

Anxiety is common, to some extent normal and in some situations entirely appropriate. We devote Chapter 5 to it, but there are some basic issues about anxiety that have to be understood, to get
depression in perspective. Many psychiatrists have argued that anxiety symptoms are the visible face of depression, and that in later life anxiety is depression until proved otherwise. This may be an over-simplification, but it does capture the way in which anxiety symptoms can be layered onto depression, confusing the person experiencing them as much as they mislead those around the depressed individual. As we get older we are less likely to develop anxiety symptoms for the first time, although the number of older people with such symptoms at any moment in time remains substantial (Weiss 1996). Up to 1 in 10 older people living at home have symptoms of persistent anxiety (Flint 1994). A third of older people visiting their general practitioner have ‘generalized’ anxiety – multiple symptoms set off by lots of situations (Krasucki et al. 1999). ‘Phobic’ anxiety, with symptoms triggered by specific situations or settings – encountering spiders, travelling by bus, mixing with others – is also common, affecting between 5 per cent and 10 per cent of people aged 65 and over, particularly older women (Kramer, German and Anthony 1985). In the absence of disabling physical problems phobic anxiety may be the underlying cause of individuals becoming housebound in 20 per cent of cases (Exton Smith, Stanton and Windsor 1976), while recurrence of post-traumatic stress disorder may become a problem for veterans of war (Floyd, Rice and Black 2002) or similar exposure to violence. Anxiety symptoms are the commonest mental health problem associated with depression (Blanchard, Waterrus and Mann 1994), and the majority of older people identified as having generalized anxiety disorder (GAD) also have depression symptoms (Lindesay, Briggs and Murphy 1989). A third of depressed older people have had at least one lifetime anxiety disorder diagnosis, and this is associated with poorer social function and a high level of physical symptoms (Lenze, Mulsant and Shear 2000).

However, anxiety symptoms are also part of normal experience, as part of a healthy and necessary ‘fight or flight’ reaction to danger, and are by no means inappropriate or a sign of mental
ill-health. The older person being bullied, abused or exploited by others has every reason to be anxious, and should not be too speedily categorized as mentally ill. Likewise persistent anxiety symptoms should not be attributed instantly to frailty, prolonged disability, ‘a nervous disposition’ or similar explanations that fail to make strong connections between causes and effects. Professionals therefore walk ‘a fine line between pathologising a healthy response and failing to recognise neurotic dysfunction’ (Beinfeld et al. 1994). In practice this is not always an easy issue to unravel, even for experienced practitioners, and so we will return to explore the problem of anxiety overlapping with depression further in Chapter 5.

Disability and depression
Depression and disability commonly go together but most older people with disabilities are not depressed. Explanations about associations between disabilities, illness and depression symptoms that simply show the overlap statistically are not satisfactory, because disability and depression can cause each other, and increased disability due to depression is only partly explained by personal characteristics like age, sex, ethnicity, social class or education, or by medical conditions and cognitive ability (Lenze, Rogers 2001). Here we run out of strong evidence, largely because of the shortage of long-term studies of depression in the community (Katona 1989). The association between poor health and depression appears to be stronger for men and for those aged 75 and over than for women and ‘younger’ old people (aged 65–74 years). Poor health, loss of mobility and depression are linked with loneliness and social isolation (Cattan 2002). Subjective measures of ill-health like pain, or self-rating of overall healthiness and well-being, are more strongly related to depression than are more objective measures of illness or disability like the number of chronic diseases or the degree of functional limitation (Beekman, Kriegsman and Deeg 1995). Nearly a third of
older people with four or more medical problems are depressed, compared with 1 in 20 of those without a significant illness (Kennedy, Kelman and Thomas 1990), and the frequency of depression among patients with poor physical health attending their general practitioner is twice that of healthy older people (Evans and Katona 1993).

**Practice example: Mrs B, aged 81**

Mrs B has emphysema (a long-term lung disease) and type 2 diabetes (the type treated with diet and tablets, not insulin injections). Recently she learned that she has a cataract in one eye, after noticing a change in her vision. She gets very short of breath when walking, even on the flat, and stairs are becoming a major problem for her. Her husband died ten years ago, and her only son died from a brain tumour at the age of 35. She has started cooking classes at the local college, and has one or two friends whom she sees each month. She visits her doctor regularly with lots of vague aches and pains, saying she has ‘no get up and go’ and that she has ‘lived too long’.

**Learning points**

Disability and depression are linked, with disability provoking bereavement in relation to the loss of the able self. Depression impairs functioning, creating a ‘chicken and egg’ situation – in this case the physical problems are profound, and their amelioration may be an effective anti-depressant. Somatization can be an acceptable way of dealing with distress, and reducing it may not be the best option, but it needs containment, by which we mean attentiveness to the individual’s concerns without collusion with the beliefs attached to symptoms.
Physical symptoms and ‘somatization’

Making sense of physical symptoms and teasing out physical illness from depression are not necessarily easy. When are people ill, and when do they show depressive ‘somatization’ or a ‘somatization disorder’? To answer this we need to focus on the somatization process, and understand that somatization has four components:

1. seeking help for physical (somatic) manifestations of a psychiatric disorder
2. attribution of bodily symptoms to physical rather than emotional or psychological disturbance
3. a detectable psychiatric condition, using standard diagnostic criteria like those found in the National Institute for Clinical Excellence guidelines
4. relief of the somatic complaints (or their return to earlier levels) through treatment of the psychiatric disorder.

(Craig and Boardman 1990)

Somatization is common in depressed older people, especially in those with physical illness, as the example of Mrs B on page 17 illustrates. Psychological distress is not usually masked, but the best way to help these individuals is often unclear (Sheehan and Banerjee 1999). In principle, the aim is to re-attribute the symptom to psychological causes, and away from physical explanations. This requires a lot of skill, and is a reason for involving a clinical psychologist or community mental health nurse in supporting the depressed individual – provided there is consent.

Depression and dementia

Depression is more common than dementia, except among the very old (those aged 85 or more) but is not so visible to health and social care staff because it causes less dependency, and is not a cause for relocation to a care home. However, dementia may