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ARTICLE

Depression in dementia

SUMMARY

People with dementia of any type have a high incidence of major depression.

The occurrence of a first major depressive episode in an older adult is a risk factor for developing dementia.

Management of depression in a person with dementia should be enthusiastic with an aim to optimise quality of life.

Non-pharmacological and pharmacological strategies are both important in treating depression in dementia and management of these patients requires a collaborative approach.

Selective serotonin reuptake inhibitors are the first-line pharmacotherapy for depression in dementia, although they are less likely to be effective in older people.

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Introduction

Depressive symptoms are quite common in older people. However, sustained and disabling major depressive episodes are more common in those with dementia than in age-matched controls without dementia. The incidence of depression may be 30% in vascular dementia and in Alzheimer's disease, and over 40% in the dementia associated with Parkinson's and Huntington's diseases.[1,2] Practitioners caring for people with dementia should be alert to major depression as this will require specific management strategies.

The clinical picture

The symptoms and signs of major depression in dementia are often no different from depression occurring in any other group.[3] Mood is most commonly low but can be irritable, angry, or anxious. Disturbed biological rhythms in sleep, appetite and energy are common and patients may be negative, hopeless or even nihilistic. Ideas of worthlessness, guilt and self-harm also occur. Overall cognitive ability may decline significantly due to the depression alone. Attributing cognitive impairment to the dementia or the depressive disorder may be difficult until an adequate trial of treatment for depression has occurred.[4]

Some signs of dementia may strongly resemble those of a major depression such as social withdrawal, lack of interest in self or others, low initiative and poor motivation. The diagnosis of the depression may be made more difficult when the dementia has not been recognised before. Apathy is a particularly confounding sign for diagnosis, and specialist assessment may be needed. Also there are some individuals whose cognitive style has always been essentially negative and depressive, rather than this being a recent change. This may only be revealed by reliable family informants.

Typically a major depressive episode develops over weeks to a few months, and is a significant new impairment for the person. Conversely, the dementia alone may develop insidiously over months or years and be slow in progression.

The onset of the first major depression in an older adult may be the first sign of dementia that is developing or at risk of developing.[5-7] Diagnosis of the dementia will be difficult until the depressive episode has remitted or at least improved.

Assessment

For the older person who shows a significant decline in cognition and function, the differential diagnosis must include dementia and a depressive disorder. These are not mutually exclusive. Investigations that include haematological, endocrine and other biological tests, and neuroimaging, are relevant to both diagnoses. For someone with a known dementia, of any severity, who exhibits some of the symptoms and signs of major depression, the clinician should consider and investigate for:

- new or deteriorating physical illness and the possibility of delirium
- a major depressive episode
- a phase of acute deterioration in the dementia
- the impact of prescribed and non-prescribed medicines and substances.[8] Alcohol, marijuana, opioids and many prescribed drugs with sedative properties, can contribute to depressed mood and aggravate cognitive impairment.

Rating scales for depression validated in the elderly population may also provide useful additional information in the assessment (see Table).[9-13] Uncertainty of diagnosis should lead to consultation with a specialist psychogeriatrician or geriatrician.

Management of depression in dementia

An active step-wise approach to management that incorporates all potential strategies is advised in treating major depression in dementia.[14]

Non-pharmacological strategies

Strategies that apply to the depressed adult population can also be used for people with dementia and depression. If it is too difficult for the patient to continue with daily personal care (e.g. shopping, meal preparation, chores) during their depressive episode, relief and support should be offered. Daily activities that may raise mood, and pleasant but not onerous social and physical activity within the person's capability, should be maximised.

Positive, optimistic and 'glass half-full' thinking should be encouraged while negative thinking should be discouraged. The severity of the cognitive impairment in the depression or in the dementia may preclude useful cognitive therapy.

Although there is limited evidence for the effectiveness of specific cognitive behavioural therapies, interpersonal psychotherapy and counselling, they have been used with some benefit as part of a comprehensive management of depression and anxiety symptoms in mild dementia. These strategies require a patient to have only a mild degree of cognitive impairment for satisfactory implementation.[15]

Carers and family have a prominent role in supporting these strategies and may require the assistance of community nurses, social workers and occupational therapists through local community services (such as an Older Persons Mental Health Service or aged-care service).

Table **Depression rating scales that have been validated in older people**

Rating scale	Comment
Cornell Scale for Depression in Dementia[9]	Has particular validity in dementia.
Geriatric Depression Scale[10]	The 15-item version is useful when time is limited.
Montgomery–Asberg Depression Rating Scale[11]	Can be used as questionnaires and read to patients.[12,13] Requires training and pre-existing clinical experience in assessing depressive disorders and dementia.

Pharmacological strategies

Most of the original antidepressant trials did not include significant numbers of older people, or people with dementia. Clinicians often extrapolate from these trials to the dementia population, but should consider the full range of available antidepressants with caution. Antidepressants are likely to be less effective in older adults and people with dementia.[16,17] A selective serotonin reuptake inhibitor would be a recommended first-line drug, although mirtazapine has a role when initial insomnia is a dominant symptom. Tricyclic antidepressants can cause anticholinergic effects that may further impair cognitive function in people with dementia. Other prescribing advice in this population includes:

- Titrate doses slowly while monitoring therapeutic and adverse effects, and effects on existing illnesses. The highest tolerated dose should be used. It is not appropriate to continue an ineffective low dose of an antidepressant.
- Trial an antidepressant for 4–6 weeks at the optimum dose before changing. If there is no benefit after six weeks, it should be slowly tapered and stopped.
- Review the potential for drug interactions between the antidepressant and the patient's other medicines before prescribing starts.
- Check serum sodium before starting a medication, and then after a fortnight at least, because hyponatraemia is a common adverse effect of many antidepressants. It usually develops within the first weeks of treatment.

The management of major depression in dementia requires close collaboration between the clinician and carers (including family and residential care staff). Because the dementia, plus any cognitive impairment from depression, may prevent the patient being as effective in their own care and advocacy, the burden of supervising behaviour management strategies, and the monitoring of drug efficacy and adverse effects, falls to the whole management 'team'.

Referral

The management of a possible major depression in someone with dementia should not be delayed. Specialist advice from a psychiatrist, particularly one with expertise in treating older people, should be sought in cases of diagnostic uncertainty (for either the mood disorder or the cognitive disorder), or when the depressive disorder is complicated by psychosis, persistent self-harm ideas, and failure to respond to management. Nursing and other health professionals with the local Older Persons Mental

Health Service may be available for advice on practical management of the depression, support to family and carers, and information on helpful local service providers.

During assessment and management, advice from a geriatrician may also be required regarding physical illness and medications, and from a clinical psychologist regarding cognitive therapy and specific behaviour and activity programs.

Some people with dementia and a major depressive episode may need hospital care to facilitate investigations, for fluid and nutritional support, and for their own safety. Electroconvulsive therapy is effective and safe in older people with dementia.[18,19]

Conclusion

Depression is a serious disorder for older people with dementia. It requires early recognition, and specific assessment of contributing physical and social factors. A comprehensive treatment plan to support the patient and their carers involves the GP and community mental health and aged-care professionals. Concurrent use of non-pharmacological strategies and selected drug treatment gives the best opportunity for recovery from the depression and to reduce morbidity from the dementia. ≺

Conflict of interest: none declared

REFERENCES

1. Enache D, Winblad B, Aarsland D. Depression in dementia: epidemiology, mechanisms, and treatment. Curr Opin Psychiatry 2011;24:461-72.
2. Reijnders JS, Ehrt U, Weber WE, Aarsland D, Leentjens AF. A systematic review of prevalence studies of depression in Parkinson's disease. Mov Disord 2008;23:183-9.
3. Engedal K, Barca ML, Laks J, Selbaek G. Depression in Alzheimer's disease: specificity of depressive symptoms using three different clinical criteria. Int J Geriatr Psychiatry 2011;26:944-51.
4. Rushing NC, Sachs-Ericsson N, Steffens DC. Neuropsychological indicators of preclinical Alzheimer's disease among depressed older adults. Neuropsychol Dev Cogn B Aging Neuropsychol Cogn 2014;21:99-128.
5. Royall DR, Palmer R, Chiodo LK, Polk MJ. Depressive symptoms predict longitudinal change in executive control but not memory. Int J Geriatr Psychiatry 2012;27:89-96.
6. Zahodne LB, Stern Y, Manly JJ. Depressive symptoms precede memory decline, but not vice versa, in non-demented older adults. J Am Geriatr Soc 2014;62:130-4.
7. Boyle LL, Porsteinsson AP, Cui X, King DA, Lyness JM. Depression predicts cognitive disorders in older primary care patients. J Clin Psychiatry 2010;71:74-9.
8. Unützer J. Clinical practice. Late-life depression. N Engl J Med 2007;357:2269-76.
9. Alexopoulos GS, Abrams RC, Young RC, Shamoian CA. Cornell Scale for Depression in Dementia. Biol Psychiatry 1988;23:271-84.
10. Sheik JI, Yeasavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. Clin Gerontol 1986;37:819-20.
11. Montgomery SA, Asberg M. A new depression scale designed to be sensitive to change. Br J Psychiatry 1979;134:382-9.
12. Kørner A, Lauritzen L, Abelskov K, Gulmann N, Marie Brodersen A, Wedervang-Jensen T, et al. The Geriatric Depression Scale and the Cornell Scale for Depression in Dementia. A validity study. Nord J Psychiatry 2006;60:360-4.
13. Leontjevas R, van Hooren S, Mulders A. The Montgomery-Asberg Depression Rating Scale and the Cornell Scale for Depression in Dementia: a validation study with patients exhibiting early-onset dementia. Am J Geriatr Psychiatry 2009;17:56-64.
14. Pellegrino LD, Peters ME, Lyketsos CG, Marano CM. Depression in cognitive impairment. Curr Psychiatry Rep 2013;15:384.
15. Ortega V, Qazi A, Spector AE, Orrell M. Psychological treatments for depression and anxiety in dementia and mild cognitive impairment. Cochrane Database Syst Rev 2014;22:CD009125.
16. Banerjee S, Hellier J, Dewey M, Romeo R, Ballard C, Baldwin R, et al. Sertraline or mirtazapine for depression in dementia (HTA-SADD): a randomised, multicentre, double-blind, placebo-controlled trial. Lancet 2011;378:403-11.
17. Nelson JC, Devanand DP. A systematic review and meta-analysis of placebo-controlled antidepressant studies in people with depression and dementia. J Am Geriatr Soc 2011;59:577-85.
18. Oudman E. Is electroconvulsive therapy (ECT) effective and safe for treatment of depression in dementia? A short review. J ECT 2012;28:34-8.
19. Hausner L, Damian M, Sartorius A, Frölich L. Efficacy and cognitive side effects of electroconvulsive therapy (ECT) in depressed elderly inpatients with coexisting mild cognitive impairment or dementia. J Clin Psychiatry 2011;72:91-7.