UNIT NO. 2

MOOD

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ABSTRACT

Clinical depression is one of the most common and treatable psychiatric disorders in older adults but tends to be underrecognised and undertreated, leading to impaired functioning, greater service utilisation and increased morbidity and mortality including suicide. Depression in elderly represents a heterogenous group of mood disturbances and often occur in a complex medical psychosocial context. Screening for depression is important especially for high risk populations such as those with chronic debilitating illnesses or major physical illnesses, the recently bereaved and the socially isolated. Screening relies predominantly on the assessment of depressive symptoms as there are few, if any, reliable signs or biological markers for depression. Milder cases of depression can be successfully treated at primary care level with appropriate pharmacological, psychological and social interventions.

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BACKGROUND

Clinical depression is one of the most common and treatable psychiatric disorders in older adults. It not only causes distress and suffering, but leads to:

- Greater risk of hospitalisation.
- Disability from physical disorders and greater physical decline.
- Prolonged hospitalisation.
- Reduced adherence to medical treatment.
- Reduced quality of life.
- Increased mortality.
- Increased healthcare utilisation costs, and
- Inappropriate use of hospital beds.

Clinical depression is the single most important predictor of suicide in older adults.

The prevalence of major depression ranges between 1% and 2%. The prevalence of milder forms of depression among community-dwelling older adults range from 6% to 10% in primary care settings. Among the medically ill older adults, milder or sub-syndromal forms are reported by up to 50%. A National Mental Health Survey in 2003 performed by the Institute of Mental Health (Chiam et al) showed a prevalence of between 3.5% and 4%.

Persons aged 65 and older represent less than 13% of the population, but account for 25% of suicides. Studies show that these older adults had seen their primary care doctor within one month of suicide. However, the symptoms were either not recognised or treatment was inadequate.

Depression in older adults is often caused by a combination of factors which include the following:

- Personality, attitudes and coping abilities, past history of depression.
- Physiological changes: brain chemicals that control mood decrease with increasing age.
- Physical health problems: long term or sudden illness, stroke, diabetes, Parkinson's disease, hormonal disorders, sensory impairment, mobility problems.
- Medications: digitalis, ß blockers, steroids, sulfonamides, thiazide diuretics, cytotoxic drugs, analgesics, etc.
- Environmental and social triggers: retirement, financial problems, housing, interpersonal conflicts, loneliness, losses and bereavement.

ASSESSMENT

The 15-item Geriatric Depression Scale (GDS-15) is the recommended screening tool for depression among older adults. Screening for depression is important especially for high risk populations such as those with chronic debilitating illnesses or major physical illnesses, the recently bereaved and the socially isolated. Screening relies predominantly on the assessment of depressive symptoms as there are few, if any, reliable signs or biological markers for depression.

For further details about the GDS-15, refer to annex M1.

INTERPRETING RESULTS

Abnormal Results

Individuals who score 5 or more points on the GDS-15 must be referred to a primary care doctor for further assessment and treatment.

PRIMARY CARE ROLES AND RESPONSIBILITIES

DIAGNOSTIC CRITERIA FOR DEPRESSION

Diagnostic Criteria for Major Depression-DSM-IV (Diagnostic & Statistical Manual of Mental Disorders IV)

Five or more of the following (refer to Figure 1) must be present during the same 2-week period; of which, at least one symptom must either be 1 (depressed mood) or 2 (loss of interest or pleasure in most activities) below.

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Figure 1: Diagnostic criteria for depression

1	Depressed mood
2	Loss of interest or pleasure in most activities
3	Significant weight loss or gain (> 5% of body weight in one month)
4	Insomnia or hypersomnia nearly every day
5	Psychomotor agitation or retardation
6	Fatigue or loss of energy
7	Feelings of worthlessness or excessive guilt
8	Indecisiveness, inability to think or concentrate
9	Recurrent thoughts of death or suicidal ideation

Source: 'Community Functional Screening Follow Up Resource for Primary Care Doctors', March 2011

Psychotic symptoms of depression may include delusions which are false unshakeable beliefs centred on themes of poverty, guilt and/or ill–health (mood congruent). Hallucinations may comprise single voice condemning, scolding or saying, "You are worthless, useless", "You should die", "You should kill yourself."

Major depression in older adults often manifests in the same way as younger adults. However, several factors modify the presentation (Figure 2).

Major depression accounts for only about a third of older adults with depression. Non-major or sub-syndromal (sub-threshold) depression such as adjustment reactions, minor depression, dysthymia, mixed anxiety and depressive syndromes are more commonly seen. Such depression does not fulfill DSM major depression but are clinically significant. In 'minor depression', patients tend to present with low mood, negative cognitions, decreased energy and cognitive deficits, often in association with physical ill health. Dysthymia is a chronic disorder of mood characterized by several symptoms of depression lasting at least two years. Adjustment disorder with depressed mood is diagnosed when symptoms of low mood, often with anxiety, arise within 1 month of a stressful, major life event.

Figure 2: Factors that modify the presentation of major

•	A reduced complaint of sadness
•	Hypochondriasis and somatic concerns
•	Poor subjective memory or dementia-like picture
•	Marked anxiety
•	Apathy and poor motivation
•	Prominent sleep complaints

Source: 'Community Functional Screening Follow Up Resource for Primary Care Doctors', March 2011

CLINICAL EVALUATION

The primary care doctor should consider the following in evaluating an older adult presenting with depressive mood:

- History (core symptoms as stated above: onset of depression, triggers, previous history of and treatment for depression, factors that may maintain or potentiate depression, current medication list, history of alcohol or tranquillizer use); corroborative history from relatives will be helpful.
- Mental state examination to check for psychotic symptoms, suicidality etc.
- Risk assessment for suicide and self-neglect such as refusal to eat or drink, neglecting self-care.
- Physical examination to identify organic causes (e.g. hypothyroidism) or any contraindications to particular classes of antidepressants.
- Basic laboratory investigations such as FBC, serum chemistry, glucose, liver function, thyroid function test, B12, folate, if indicated.

Severity of Depression

Differentiation between mild, moderate and severe depressive symptoms relies on clinical judgment that involves number, type and severity of the (depressive) symptoms present (Figure 3). The extent of involvement in ordinary social and work activities is a useful general guide to the degree of severity of the episode.

Figure 3: Severity of depressive symptoms

MILD	**Few**, if any symptoms, in excess of those required to make the diagnosis; symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others. In other words, an individual with mild depressive symptoms is usually distressed by the symptoms and has some difficulty in continuing with ordinary work or social activities but will probably not cease to function completely.
MODERATE	Symptoms or functional impairment between 'mild' and 'severe'. An individual wth moderately severe depression will usually have considerable difficulty in continuing with social, work or domestic activities.
SEVERE (without psychotic features)	**Several** symptoms in excess of those required to make the diagnosis; symptoms **markedly** interfere with occupational functioning or with usual social activities or relationships with others. During a severe depressive episode, the sufferer will experience very limited capacity to continue with social, work, or domestic activities.

Source: 'Community Functional Screening Follow Up Resource for Primary Care Doctors', March 2011

MANAGEMENT

1. Differential Diagnoses

- Rule out organic causes of mood disturbances:
  - Drug or alcohol abuse
  - Medication side effects
  - Anaemia, hypothyroidism, other medical illnesses.
- Organic brain syndromes such as dementia and delirium.
- Bipolar disorder.

2. Treatment

Milder cases of depression can be managed by the primary care doctor. Ideally, management of depression comprises a combination of biological (medications), psychological (supportive counselling, grief work) and social (family intervention, support services, and activity programmes) strategies.

i. Pharmacological

All antidepressant drugs have comparable efficacy between and within classes of medications. Newer agents such as selective serotonin reuptake inhibitors (SSRIs) and serotonin and adrenergic reuptake inhibitors (SNRIs) present more favourable side-effect profiles and simpler dosing patterns compared to older classes of antidepressants such as tricyclic antidepressants (TCAs). The initial choice of antidepressants is based largely on:

- Safety or tolerability of side-effects for individual patients (e.g. during pregnancy).
- Other potential side-effects.
- Age-associated pharmacokinetics.
- Drug interactions.
- Depression type (psychotic/non-psychotic).
- Prior response to a particular agent.
- Co-morbidity (dementia, physical disorders).
- Patient preference, cost, adherence.

Guidelines for medication use

- Start at recommended dosage. To improve adherence, emphasise:
  - When and how often to take medication
  - Delayed efficacy (typically 2 to 4 weeks)
  - Need to continue medications for 6 to 12 months even after symptomatic recovery.
  - Consult doctor before discontinuing medication.
- Start low, go slow, but final doses may be similar to younger patients.
- Consider target symptoms and side-effect profiles.
- Consider medical co-morbidities and potential drug-drug interactions.
- Allow time for adequate medication trial.
- Maximise mono-therapy; if ineffective, refer to specialists.
- Stop antidepressants:
  - For patient with 1st depressive episode
  - When symptom-free with medication for at least 6 to 12 months
  - When the stressor for depression is resolved.

For further details about antidepressants, refer to Annex M2.

ii. Psychological

Supportive and more directive forms of therapies are useful when used alone or in conjunction with medication in ambulatory patients with mild to moderate depression. It may also involve referrals to appropriate community and social services for specific psychological therapies such as supportive, cognitive behavioural, problem-solving, inter-personal, brief psychodynamic, reminiscence therapies, and life reviews.

iii. Social

For all depressed older adults, it is important to work with their families as they may contribute in the aetiology, and can influence outcomes and management. Referrals to social agencies e.g. day care, befriender's services and family service centres (FSCs) will help in the aftercare and follow up.

CLINICAL PATHWAY

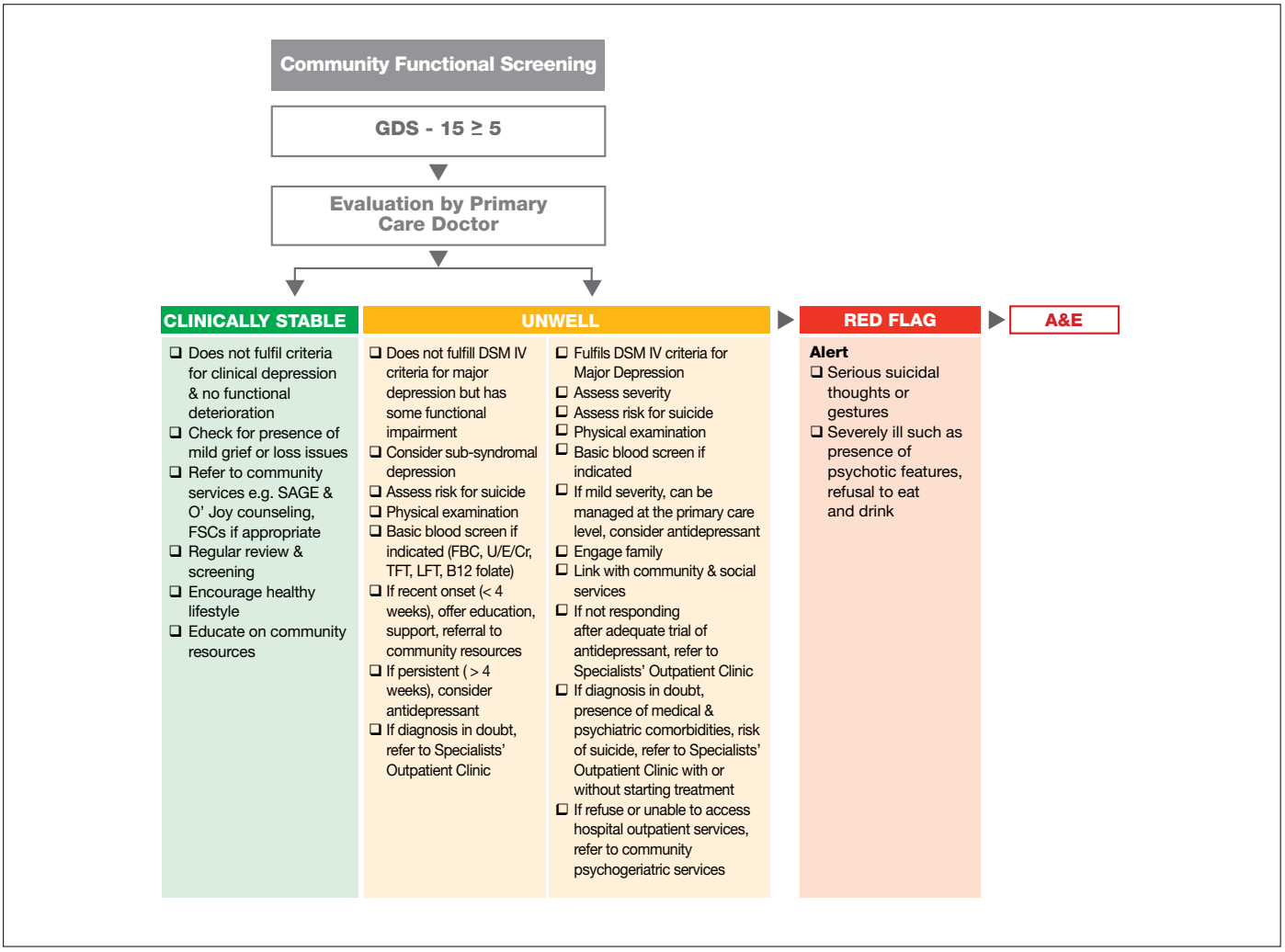
The clinical pathway to take from screening to intervention is shown in Figure 4.

REFERRAL

Patients should be referred to the Accident and Emergency Department if there is a current serious threat of harm to self or others (involuntary hospitalisation may be necessary), or if they are severely ill (presence of psychotic features, failure to eat and drink). They can be referred to the mental health specialists with or without starting treatment under the following circumstances:

- Diagnosis is in doubt.
- Bipolar disorder is suspected.
- Substance use disorder is present.
- Severe or recurrent depression.
- Significant impairment in socio-occupational and/or interpersonal functioning.
- Non or partial responders to treatment in polyclinic.
- Co-existing psychiatric disorders.
- Risk of suicide.

Figure 4: Clinical pathway from screening to intervention



Source: 'Community Functional Screening Follow Up Resource for Primary Care Doctors', March 2011.

RESOURCES

For advice on mental health, refer to the following helplines:

- HealthLine - 1800 223 1313 to speak to a Nurse Advisor (available in 4 languages)
- Helplines - http://www.ncss.org.sg/documents/LIST%20OF%20HELPLINES.pdf
- IMH Crisis Helpline (Psychiatric care and treatment) - 6389 2222
- Samaritans of Singapore (SOS) - 1800 221 4444
- Singapore Action Group of Elders (for older adults) SAGE Counselling Centre - 1800 555 5555, 6353 7159
- Singapore Association for Mental Health (SAMH) - 1800 283 7019
- Care Corner Mandarin Counselling - 1800 353 5800

Other important resources:

- Health Promotion Board website - http://www.hpb.gov.sg
- Family Services Centres (FSCs) - www.ncss.org.sg/documents/List%20of%20FSCs.doc
- Agency for Integrated Care - www.aic.sg
- Community Psychogeriatric Programme (CPGP) based at Changi General Hospital www.cgh.com.sg/medical/files/CPGP%20brochure.pdf
- Aged Psychiatry Community Assessment and Treatment Service (APCATS) based at Institute of Mental Health for those living in the central and western part of the island (Central, Northwest and Southwest CDCs) – 6389 2175, www.imh.com.sg/patients_visitors/For_Elderly_APCATS.html

USEFUL REFERENCES

1. Blazer D. Williams CD. Epidemiology of dysphoria and depression in an elderly population. Am J Psychiatry 1980; 137: 439-44.
2. Copeland JR et al. Is there more dementia, depression and neurosis in New York? A comparative study of elderly in New York and London using computer diagnosis AGECAT. Br J Psychiatry 1987; 151:466-73.
3. Weismann MM et al. Affective disorder in five United States communities, Psychol Med 1988; 18-141-53.
4. Henderson AS et al. The prevalance of depressive disorders and the distribution of depressive symptoms in later life: a survey using Draft ICD10 and DSM-III-R. Psychol Med 1993; 23:719-29.

LEARNING POINTS

- **The 15-item Geriatric Depression Scale (GDS-15) is the recommended screening tool for depression among older adults.**
- **Individuals who score 5 or more points on the GDS-15 must be referred to a primary care doctor for further assessment and treatment.**
- **Patients should be referred to the Accident and Emergency Department if there is a current serious threat of harm to self or others (involuntary hospitalisation may be necessary), or if they are severely ill (presence of psychotic features, failure to eat and drink).**
- **Differentiation between mild, moderate and severe depressive symptoms relies on clinical judgement that involves number, type and severity of the (depressive) symptoms present. The extent of involvement in ordinary social and work activities is a useful general guide to the degree of severity of the episode.**

ANNEX M1 – 15-ITEM GERIATRIC DEPRESSION SCALE (GDS-15)

Please choose the best answer for how you felt over the past week

Date: _____

No.	Question	YES	NO
1	Are you basically satisfied with your life?		
2	Have you dropped many of your activities and interests?		
3	Do you feel that your life is empty?		
4	Do you often get bored?		
5	Are you in good spirits most of the time?		
6	Are you afraid that something bad is going to happen to you?		
7	Do you feel happy most of the time?		
8	Do you often feel helpless?		
9	Do you prefer to stay at home, rather than going out and doing new things?		
10	Do you feel you have more problems with memory than most?		
11	Do you think it is wonderful to be alive?		
12	Do you feel pretty worthless the way you are now?		
13	Do you feel full of energy?		
14	Do you feel that your situation is hopeless?		
15	Do you think that most people are better off than you are?		
		TOTAL	

Calculate the score by adding up the ticks in the shaded boxes

Source: Yesavage J.A., Brink T.L., Rose T.L. et al. Development and validation of a geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17: 37-49
Jerome A. Yesavage, Geriatric Depression Scale. Psychopharmacology Bulletin, 1988; 24 (4): 709-711

ANNEX M2 – ANTRIDEPRESSANTS

Table 1: Side effect profiles of main antidepressants in Singapore

Class	Drug	Mode of action	Anticholinergic	Antihistaminic	α-adrenergic blocker
Tricyclic antidepressants	Amitriptyline	NA*++5HT#+	++++	++++	++++
	Imipramine	NA++5HT+	++	++	+++
	Dothiepin	NA++5HT+	++	++	++
Reversible inhibitors of monoamine oxidase A	Moclobemide	MAOψ	0/+	0	0
Selective serotonin reuptake inhibitors	Fluvoxamine	5HT	0/+	0/+	0
	Fluoxetine	5HT	0/+	0	0
	Sertraline	5HT	0/+	0	0
	Escitalopram	5HT	0/+	0	0
	Paroxetine	5HT	0/+	0	0
Noradrenaline and selective serotonin antidepressants	Mirtazepine	α 2,5HT2	0	++	0
Serotonin/Noradrenaline reuptake inhibitors	Venlafaxine	NA+5HT++	0/+	0	0/+
* Noradrenaline # Serotonin ψ Monoamines					

Table 2: Commonly used antidepressants

Drug	Therapeutic Dosage (mg)	Usual dose (mg)	Starting dose (mg)	Side effects
Amitriptyline	25-150	50-100	10-25	Dry mouth, blurred vision, constipation urinary retention, cardiotoxicity, postural hypotension, sedation, delirium
Imipramine	25-150	50-100	25	
Diothiepin	25-150	75-150	25	
Fluoxetine	10-40	10-40	10	Nausea, vomiting, diarrhoea, insomnia, anxiety, agitation, sexual dysfunction, headache, hyponatraemia, syndrome of inappropriate antidiuretic hormone secretion (SIADH)
Fluovoxamine	25-200	100-150	25-50	
Escitalopram	5-20	10-20	5	
Sertraline	25-500	50-150	25-50	
Moclobemide	150-450	300-450	150	Nausea, insomnia
Venlafaxine	25-200	75-150	25-37.5	Nausea, agitation, insomnia, tachycardia Elevations of blood pressure at higher doses
Mirtazepine	15-45	15-30	15	Sedation, weight gain

Source: Salzman C: Lippincolt, Williams and Wilkins, 2004. Clinical Geriatric Psychopharmacology(4th edition), ed.

The above extract is taken from the 'Community Functional Screening Follow Up Resource for Primary Care Doctors', published by the Health Promotion Board in partnership with Dr Ong Pui Sim, March 2011."