

## Depression in late life

# An historic account demonstrates the importance of making the diagnosis

Gene D. Cohen, MD, PhD, Series Editor

### Case presentation

London, December 1843. The patient, by historical accounts, was described as a melancholic, mean-spirited, misanthropic old man who took pleasure in making those around him miserable. It was said that “the cold within him froze his old features, nipped his pointed nose, shriveled his cheek, stiffened his gait, made his eyes red, his thin lips blue and spoke out shrewdly in his grating voice.” These signs and symptoms suggested a diverse differential diagnosis. For instance, “the cold within him,” suggested hypothyroidism, whereas his “nipped pointed nose,” might have indicated frostbite associated with hypothermia from the December cold. His “shriveled cheek,” might have been caused by dehydration and his “stiffened gait” from arthritis. Were his “red eyes” caused by conjunctivitis associated with acute glaucoma? Did his mean-spirited misanthropic qualities suggest that he was simply an embittered old man taking his anger out on the world? These qualities evolved over several decades, culminating in his later years.

Finally, three consultants were called to join the case. They reflected on “the cold within him” as well as his melancholic and behavioral manifestations and wondered if there was a

**Dr. Cohen**, a geriatric psychiatrist, is director of the Center on Aging, Health, and Humanities, and professor, departments of health care sciences and psychiatry and behavioral sciences. George Washington University, Washington, DC.

core problem producing the apparent diverse clinical signs and symptoms. The multidisciplinary team decided on a treatment plan, which included a series of home visits that was ahead of its time—more than 100 years before the community health outreach approach was introduced. Upon further assessment, the team decided to employ psychodynamic dream therapy to try and reach the patient—more than 50 years before Freud’s classic work, *The Interpretation of Dreams* (1899). The patient responded to psychotherapy with a gradual elevation in mood and a reduction in hostility. He became less reclusive and began to display more empathic and helpful responses to those around him. Becoming more emotionally open to others, he displayed generosity, a marked contrast to his long-standing miserly personality.

### Discussion

This, of course, is the famous case of Ebenezer Scrooge, documented in *A Christmas Carol*. It has been suggested that through this case history, the original historian, Charles Dickens, wanted to:<sup>1</sup>

- demonstrate how the diagnosis of depression in late life, even when severe, can be missed
- show how depression in older patients can present with somatic and behavioral manifestations
- prove that no matter how chronic the older patient’s depression, there is almost always an opportunity for meaningful intervention

- illustrate the role and therapeutic value of psychotherapy in older patients

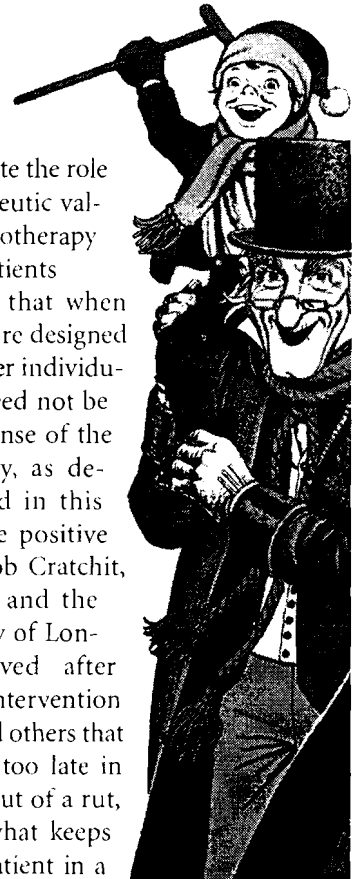
- prove that when programs are designed to help older individuals, they need not be at the expense of the community, as demonstrated in this case by the positive benefits Bob Cratchit, Tiny Tim, and the community of London received after Scrooge’s intervention

- remind others that it is never too late in life to get out of a rut, and that what keeps an older patient in a rut may not be aging, but depression.

### Late-life depression

Several factors associated with late-life depression may create barriers to an accurate diagnosis.

**Presentation.** Depression in older adults may present as somatic and behavioral manifestations rather than depressed mood. Depressed individuals often develop low self-esteem and negative interpretations of everyday perceptions. Studies of older patients show that depression is one of the most common explanations for memory complaints in patients who do not have verified memory deficits.<sup>2</sup> Normal forgetfulness in a depressed older person may be per-



ceived as failing memory associated with aging. The table provides a useful geriatric depression screening tool.

**Myths.** Long-standing societal myths that depression is a normal consequence of aging, and the belief that, "if I were old, I would be depressed too," contribute to late-life depression not being recognized as a treatable disorder.

**Appearances.** It is common for isolated, depressed older patients to put their best face forward when they have the opportunity for positive social encounters with their doctors. As a result, they may not appear depressed during these office visits.

**Insufficient questioning.** If older patients are not asked about depression, they are not likely to volunteer the information. This issue, coupled with the ever-shrinking amount of time primary care physicians have to see patients, may make physicians reluctant to raise emotional questions that might prompt lengthy discussions. But failing to inquire about depression can increase patients' risk for suicide, the rate of which is highest among older white men. A study of older patients who committed suicide found that 70% visited their physician within 4 weeks of their deaths.<sup>3,4</sup> This finding suggests that depression and suicidal ideation are not being discussed often enough during physician consultations with older patients.

## Treatment

Psychotherapy remains a valuable therapeutic tool in the treatment of late-life depression.<sup>5</sup> But the development of newer antidepressants that are easier to dose and have improved side effect profiles has placed emphasis on pharmacologic intervention. Interestingly, studies comparing the effects of psychotherapy with pharmacotherapy show that combining the two modalities is often the most effective method for treating depression in older patients.<sup>6,7</sup>

## Summary

Depression in older patients is common and responds well to treatment,


## Table Geriatric Depression Scale-Short Form

### A brief screening instrument for depression in older adults

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

Scoring: Answers indicating depression are highlighted in **purple**. Each highlighted answer counts as 1 point; scores greater than 5 indicate probable depression.

Source: Adapted from Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: A preliminary report. *J Psychiatr Res* 1982-83; 17(1):37-49. <http://www.stanford.edu/~yesavage/GDS.html> Used with permission from Jerome Yesavage, MD.

yet the diagnosis is often missed. Not only has this conclusion been confirmed by recent research, it also was suggested years ago in the famous case of Ebenezer Scrooge. 

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