Gruppo di ricerca geriatrica

Journal Club

20 Marzo 2008

COME PUO' UN GIOVANE MEDICO CAPIRE LA DEPRESSIONE NELL'ANZIANO?

Alessandro Giordano

La perplessità è l’inizio della conoscenza

Jibrān Khalīl Jibrān

Essere depressi non è semplicemente essere tristi…

UNA DIAGNOSI DIFFICILE…

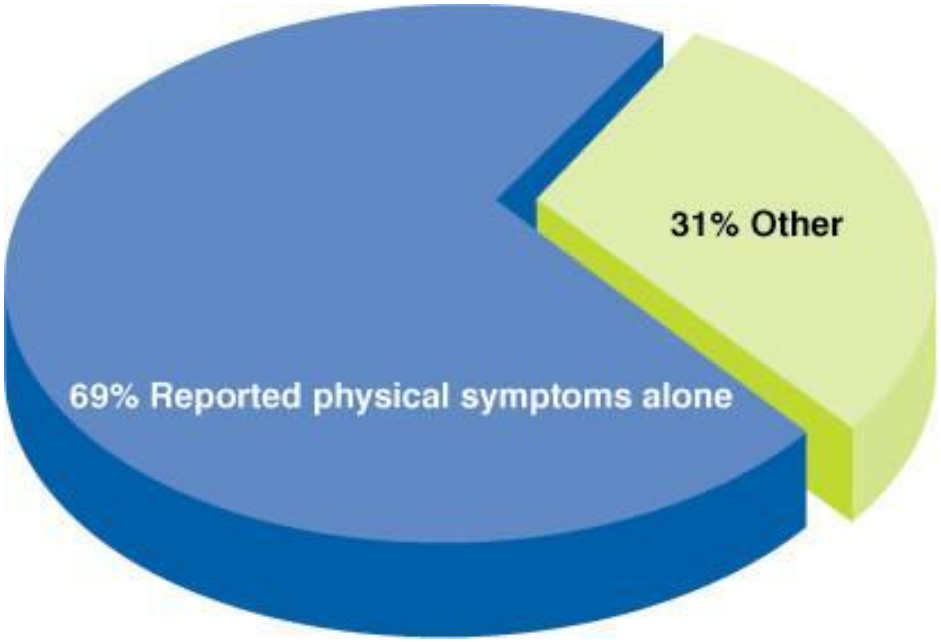
Guardando il paziente gli chiesi: “Cosa c’è che non va?” Non ho più fame, rispose, sto dimagrendo e non so come mai. Non mi è mai mancato l’appetito… cercai di capire “Ha mai vomitato? Ha dolore di stomaco?” No rispose, nulla di tutto ciò, però talvolta mi manca il fiato. Guardai gli esami, erano perfettamente normali. Gli chiesi “Come va l’umore?” malissimo mi rispose e da lì mi parlò di se stesso per 15 minuti, ininterrottamente.

UNA DIAGNOSI DIFFICILE…

- **Prevalenza di disturbi somatici, talvolta comuni ad altre condizioni mediche (insonnia, stanchezza, inappetenza, calo ponderale, ecc…)**
- **Scarsa disponibilità di tempo da parte del personale medico all'ascolto del paziente**
- **Negazione della malattia da parte del paziente o dei famigliari (depression without sadness)**

Depression – the physical presentation

In primary care, physical symptoms are often the chief complaint in depressed patients



N = 1146 Primary care patients with major depression

In a *New England Journal of Medicine* study, 69% of diagnosed depressed patients reported unexplained physical symptoms as their chief compliant[1]

N Engl J Med. 1999; 341(18):1329-1335.

Distinguishing Between Depression and Dementia in Older Persons: Neuropsychological and Neuropathological Correlates

Sara L. Wright, PhD, and Carol Persad, PhD

J of geriatric psychiatry and Neurology, 2007

Documented cognitive difficulties among older depressed, nondemented patients have been found in memory, attention, confrontation naming, verbal fluency, visuospatial ability, processing speed, and executive functioning. Although these decrements are also seen in patients with AD, cognitive impairments associated with early AD are more severe than in patients with depression in nearly every cognitive domain.

In contrast to nondemented older persons, presentations of depression in those who were eventually diagnosed with dementia were dominated by motivation-related symptoms, such as disinterest, low energy, and concentration difficulties.

Most studies have demonstrated that patients with depression onset late in life (with cutoffs ranging from 45 to 65 years old) are at higher risk for dementia than are patients with earlier onset.

With some exceptions, there is increasing agreement among epidemiologic studies that for a subset of older adults depression can represent the first symptoms of dementia.

There is now enough evidence from neuropsychology, epidemiology, and neuropathology to establish the existence of a relationship between AD and depression.

Neurobiological studies ascertaining an association between structural changes in depression and dementia also lend support for this contention. As discussed earlier, frontostriatal vascular compromise is known to produce both cognitive and emotional changes during late life.

DEPRESSIONE PSICOTICA

- **È una delle più comuni forme di depressione nell'anziano esordisce con sintomi severi, recidive più frequenti e remissioni spesso incomplete (Int J Geriatr Psychiatry 2001).**

- **Senso di inadeguatezza, di impoverimento e di colpa, pensiero persecutorio, deliri con scarsa percezione della realtà, costante ricorrenza al tema della morte, decadimento cognitivo, con un alto rischio di sviluppare demenza (Neurology 1999).**

La depressione dell’anziano non è una malattia tra le tante…

“Da quando ho avuto l’infarto non è più come prima, il solo pensiero di dover assumere tutte queste medicine mi mette di malumore fin dalle prime ore del mattino, e poi vivo con il pensiero che potrebbe succedere ancora…Già dopo l’ICTUS mi era stato difficile accettare di non poter camminare come prima; mi mancava solo questa! Forse sarebbe meglio morire.”

La depressione dell’anziano è una malattia della malattia?

DEPRESSIONE E VASCULOPATIA CEREBRALE ACUTA

- **Disturbi depressivi insorgono frequentemente in seguito ad un evento cerebrale acuto: 19,3% dei pazienti ospedalizzati; 23.3% tra i pazienti in comunità (Biol Psychiatry 2003)**

- **La malattia depressiva si associa spesso ad alterazioni croniche cerebrali al neuroimaging: "vascular depression" (Arch Gen Psychiatry 1997)**

ORIGINAL ARTICLE

Ischemic Basis for Deep White Matter Hyperintensities in Major Depression

A Neuropathological Study

Alan J. Thomas, MRCPsych; John T. O'Brien, DM; Sue Davis, PhD; Clive Ballard, MD; Robert Barber, MD; Rajesh N. Kalaria, FRCPath; Robert H. Perry, FRCPath

Arch Gen Psychiatry. 2002;59:785-792

Table 3. Anatomic Distribution of the 44 Ischemic and Nonischemic Deep White Matter Hyperintensities*

	Depressed, No.	Control, No.
Ischemic DWMHs		
Dorsolateral prefrontal cortex	12	0
Anterior cingulate cortex	4	6
Occipital cortex	0	2
Nonischemic DWMHs		
Dorsolateral prefrontal cortex	0	15
Anterior cingulate cortex	0	4
Occipital cortex	0	1

*Lesions were located in coronal slices of tissue from each cortical level from 20 subjects per group (see "Subjects and Methods" section for details). DWMHs indicates deep white matter hyperintensities.

Stroke
JOURNAL OF THE AMERICAN HEART ASSOCIATION

American Stroke Association℠
A Division of American Heart Association

Depressive Disorder, Dysthymia, and Risk of Stroke: Thirteen-Year Follow-Up From the Baltimore Epidemiologic Catchment Area Study

Sharon L. Larson, Pamela L. Owens, Daniel Ford and William Eaton

Stroke 2001;32;1979-1983

TABLE 3. Affective Disorder and Incidence of Stroke, Baltimore ECA Follow-Up, 1981–1993, 1996

Model	RR (95% CI)		
	Dysthymia Only	Depressive Disorder	Depression and Medical Risk Factors
Dysthymia only	2.65 (0.69, 10.11)		
Depressive disorder		3.08 (1.26, 7.52)	2.67 (1.08, 6.63)
Age, y*			
30–44	0.62 (0.18, 2.11)	0.59 (0.17, 2.02)	0.54 (0.15, 1.86)
45–54	4.52 (1.70, 12.06)	4.48 (1.68, 11.97)	3.39 (1.25, 9.24)
55–64	7.54 (3.08, 18.45)	7.48 (3.04, 18.37)	5.77 (2.30, 14.51)
≥65	29.95 (12.71, 70.62)	25.43 (10.62, 60.88)	19.62 (7.95, 48.43)
Female sex	1.22 (0.75, 1.99)	1.38 (0.82, 2.31)	1.46 (0.85, 2.52)
Race/ethnicity (black)†	1.42 (0.84, 2.40)	1.22 (0.71, 2.11)	1.01 (0.58, 1.77)
Other ethnic/racial groups‡	1.07 (0.34, 3.33)	0.74 (0.21, 2.68)	0.64 (0.17, 2.35)
Socioeconomic status (Nam-Powers index ≤35)	0.97 (0.60, 1.59)	0.85 (0.51, 1.41)	0.90 (0.53, 1.50)
No high school diploma	1.57 (0.92, 2.65)	1.77 (1.03, 3.06)	1.55 (0.89, 2.71)
Ever diabetes			1.35 (0.62, 2.97)
Ever heart problem			2.07 (1.19, 3.60)
Ever high blood pressure			2.14 (1.32, 3.48)
Currently smoke tobacco			2.03 (1.23, 3.33)
Model χ^2	190.10	165.9	191.15
df	10	10	14

*Reference age is 18–29 years.
†Reference group is white.
‡Reference group is white.

Depression in patients recovering from a myocardial infarction

- Post-MI depression is common. Major depression is found in about 1 in 6 patients soon after MI, it represents an indipendent risk factor for increased mortality
- Possible mechanisms:

1) Decresed adherence to risk-reducing recommendations
2) Increased susceptibility to ventricular arrhythmia; decreased heart rate variability
3) Increased platelet activation
4) Decreased use of cardiovascular procedures

JAMA 2001

Heart failure and depression

Table 3 Summary of characteristics of patients with heart failure included in studies of the prevalence of depression among patients with heart failure and of the tools used to assess depression in each study

Reference	Population	Sample	Male, %	Age, mean, y	Tool	% Depressed
Freedland et al[94] 1991	Hospitalized	60	43.3	78.4	DIS	17
Fraticelli et al[95] 1996	Hospitalized	50	50	77	GDS	54.2
Koenig[96] 1998	Hospitalized	107	47.7	55.1	CES-D, DIS, HAM-D	58
Friedman and Griffin[97] 2001	Hospitalized	170	51.2	72.7	CES-D	30
Jiang et al[17] 2001	Hospitalized	331	26.5	63.7	BDI and DIS	35.3/13.9
Vaccarino et al[16] 2001	Hospitalized	391	50.6		GDS	77.5
Tsay and Chao[98] 2002	Hospitalized	100	61	65.4	GDS	70.0
De Geest et al[99] 2003	Hospitalized	109	47	80	GDS	43
Freedland et al[100] 2003	Hospitalized	682	47.7	66	BDI and DIS	51/36
Fulop et al[101] 2003	Hospitalized	203	76.8	76.8	GDS and SCID-I/NP	36.0
Jünger et al[102] 2005	Hospitalized	209	86.1	55	HADS	30.1
Rumsfeld et al[103] 2005	Hospitalized	634	64.5	64.5	MOS-D	22.6
Havranek et al[104] 1999	Outpatient	45	68.9	54	CES-D	24.4
Murberg et al[14] 1998	Outpatient	119	71.4	66	SDS	13
Skotzko et al[105] 2000	Outpatient	33	90.9	65.4	CES-D	42
Steptoe et al[106] 2000	Outpatient	60	66.7	47	HADS	22
Rumsfeld et al[87] 2003	Outpatient	460	75		MOS-D	30
Gottlieb et al[57] 2004	Outpatient	155	78.7	64	BDI	48
Sullivan et al[107] 2004	Outpatient	142	77.5	53.2	PRIME-MD	29
Haworth et al[108] 2005	Outpatient	100	83	67	SCID-I	14.0
Westlake et al[109] 2005	Outpatient	200	84	57	BDI	47.5
Friedmann et al[13] 2006	Outpatient	153	89.9	60.6	BDI-II	36

Abbreviations: BDI, Beck Depression Inventory; BDI-II, Beck Depression Inventory, Version II; CES-D, Center for Epidemiological Studies Depression Scale; DIS, Diagnostic Interview Schedule; GDS, Geriatric Depression Scale; HADS, Hospital Anxiety and Depression Scale (depression component only); HAM-D, Hamilton Depression Scale; MOS-D, Medical Outcome Study, Depression Scale; PRIME-MD, Primary Care Evaluation of Mental Disorders (depression only); SCID-I/NP, Structured Clinical Interview for DSM-IIIR, Nonpatient Edition; SDS, Zung Self-rating Depression Scale.

Critical Care Nurse,2008

Examining a Bidirectional Association Between Depressive Symptoms and Diabetes

Sherita Hill Golden; Mariana Lazo; Mercedes Carnethon; et al.

JAMA. 2008;299(23):2751-2759 (doi:10.1001/jama.299.23.2751)

Association Between Hip Fracture and Depression in 766 Elderly Patients Admitted to a Geriatric Rehabilitation Unit.

	Total (N = 766)	Women (n = 565)	Men (n = 201)
Fracture Status	n/N (%)		
Not fractured	286/623 (45.9)	219/439 (49.9)	67/184 (36.4)
Fractured	68/143 (47.5)	57/126 (45.2)	11/17 (64.7)

Data are expressed as number of depressed patients over the total number of subjects for each specific group.

JAGS, 2007

Comorbidità?
Disabilità?
Nessuna delle due?

Depression in Later Life: A Diagnostic and Therapeutic Challenge

RICHARD B. BIRRER, M.D., M.P.H., St. Joseph's Healthcare System, Inc., Paterson, New Jersey
SATHYA P. VEMURI, M.D., Yuma, Arizona

AMERICAN FAMILY PHYSICIAN VOLUME 69, NUMBER 10 / MAY 15, 2004

Rates of depression are higher for older adults with comorbid medical illness and in general medical settings. Hospitalized geriatric populations have prevalence rates of depression over 30 percent, and patients with stroke, myocardial infarction or cancer have rates over 40 percent

Long-term Risk for Depressive Symptoms After a Medical Diagnosis

Daniel Polsky, PhD; Jalpa A. Doshi, PhD; Steven Marcus, PhD; David Oslin, MD; Aileen Rothbard, ScD; Niku Thomas, MD; Christy L. Thompson, MS

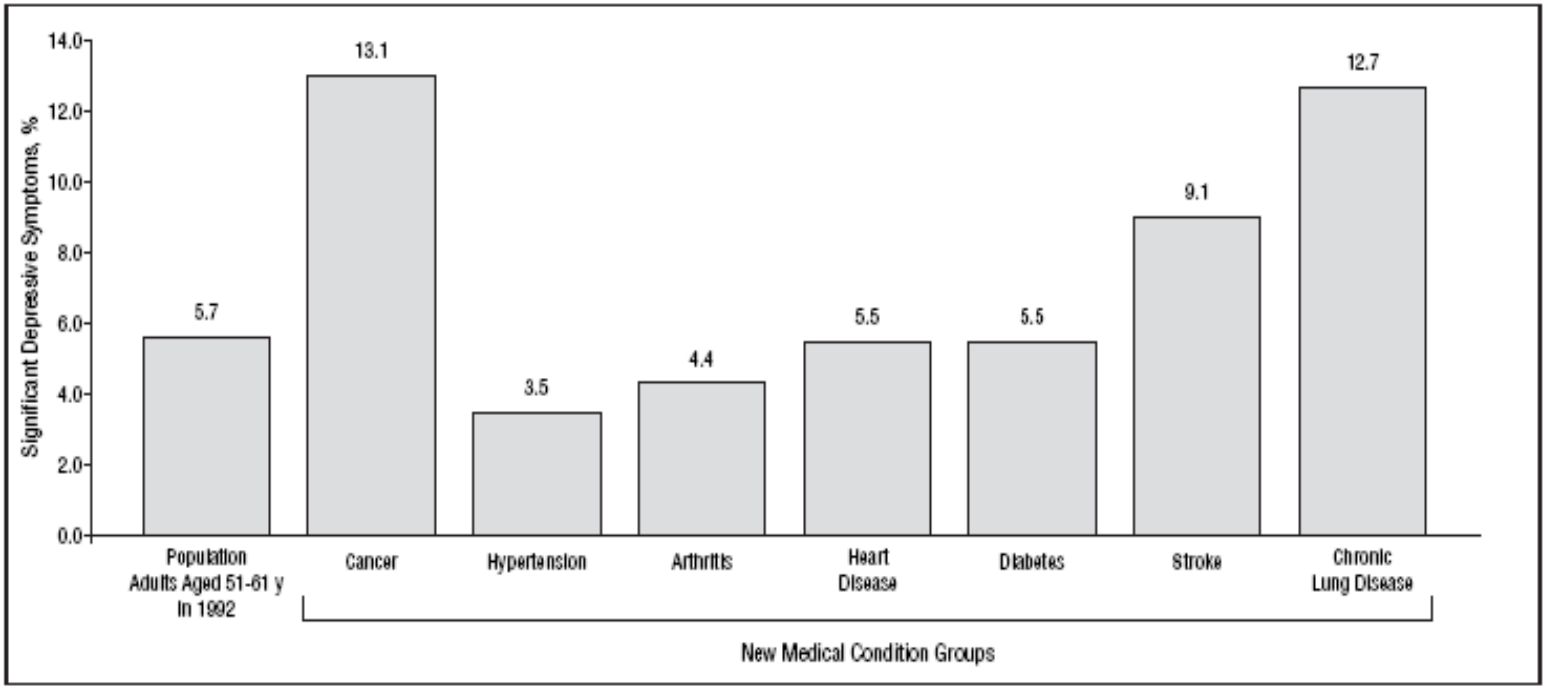


Figure. Unadjusted rates of significant depressive symptoms (ie, Center for Epidemiologic Studies Depression Scale score ≥5) within 0 to 2 years of each new medical condition.

Arch Intern Med. 2005

INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY
Int J Geriatr Psychiatry 2008; **23**: 238–243.
Published online 6 August 2007 in Wiley InterScience
(www.interscience.wiley.com) **DOI**: 10.1002/gps.1868

Depressive symptoms in late life: associations with apathy, resilience and disability vary between young-old and old-old

Mona Mehta, Ellen Whyte*, Eric Lenze, Susan Hardy, Yazan Roumani, Perera Subashan, Wennie Huang and Stephanie Studenski

Departments of Medicine, Psychiatry and Physical Medicine, University of Pittsburgh School of Medicine, Pittsburgh, PA, USA

Table 2. Multiple linear regression model results examining contribution of age, disability, apathy, resilience and comorbid disease burden to GDS score

	β–Estimate	Standard Error	p-value	Partial type-III R^2
All subjects ($n = 103$) (Model $R^2 = 0.49$; $F_{[4,102]} = 23.64$, $p < 0.0001$)				
ADL/IADL	−0.36	0.09	<0.0001	8.7%
Apathy	0.22	0.05	<0.0001	12.6%
Resilience	−0.26	0.06	<0.0001	10.3%
Co-morbidity Disease Index	0.12	0.17	0.47	0.3%
Subjects aged: <80 yrs ($n = 50$) (Model $R^2 = 0.57$; $F_{[4,49]} = 14.77$, $p < 0.0001$)				
ADL/IADL	−0.51	0.14	0.0007	12.8%
Apathy	0.21	0.06	0.002	10.4%
Resilience	−0.32	0.09	0.001	11.1%
Co-morbidity Disease Index	−0.04	0.27	0.88	0.02%
Subjects aged: ≥80 yrs ($n = 53$) (Model $R^2 = 0.47$; $F_{[4,52]} = 10.46$, $p < 0.0001$)				
ADL/IADL	−0.23	0.11	0.052	4.4%
Apathy	0.28	0.07	0.0002	18.7%
Resilience	−0.17	0.08	0.027	5.8%
Co-morbidity Disease Index	0.24	0.22	0.283	1.3%

β = Regression coefficient estimate; Partial type-III R^2 = (Type-III SS for the predictor/Corrected Total SS) × 100; SS = Sum of squares.

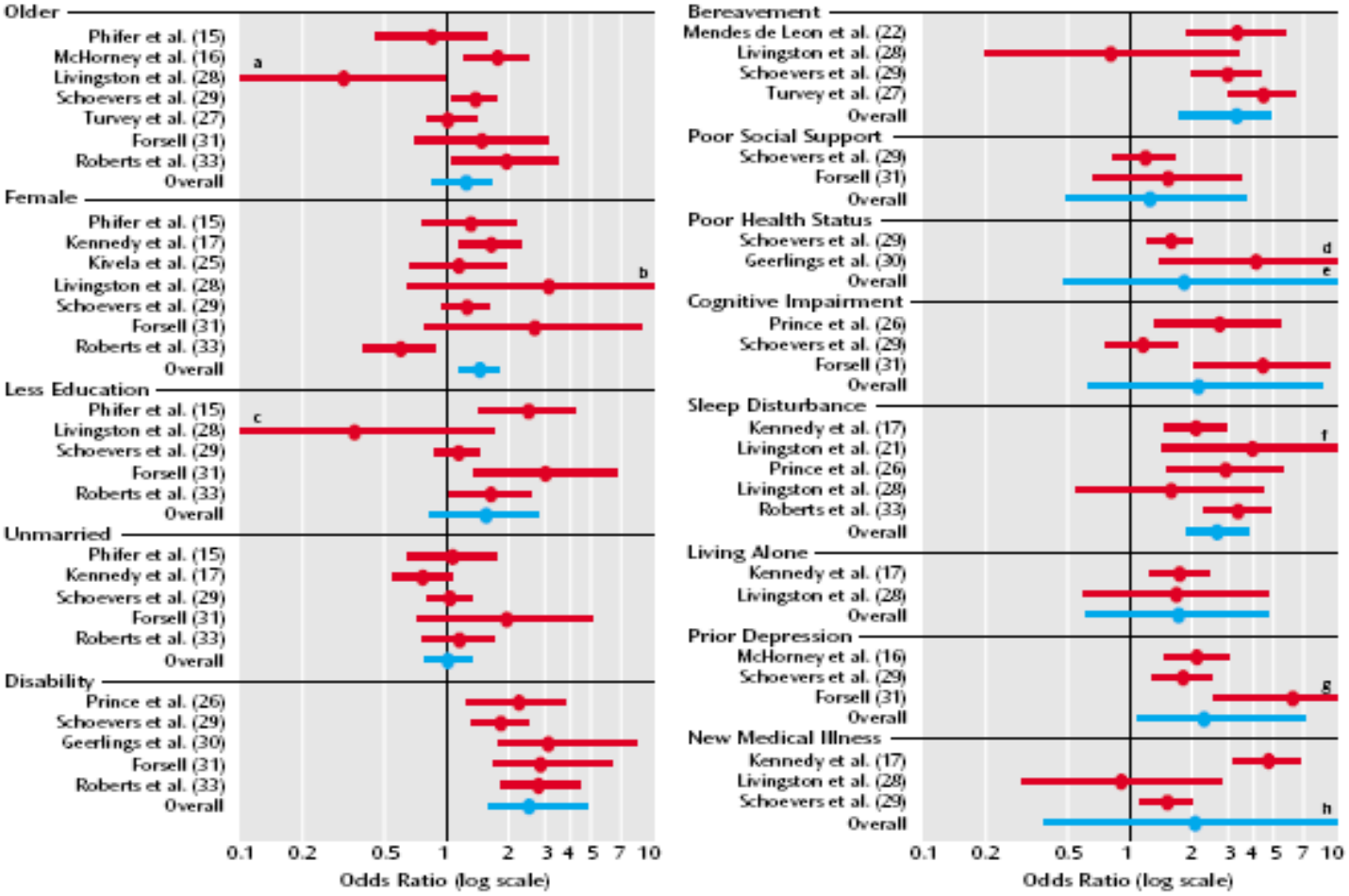
Prevenire è meglio che curare…

“Non avrei mai pensato che la morte del marito potesse cambiarla in questo modo, quasi non la riconosco più! Se l’avessi saputo avrei fatto di tutto per farla venire ad abitare da noi…”

Article

Risk Factors for Depression Among Elderly Community Subjects: A Systematic Review and Meta-Analysis

Martin G. Cole, M.D., F.R.C.P.(C.) AND Nandini Dendukuri, Ph.D.



(Am J Psychiatry 2003; 160:1147–1156)

Journal of Gerontology: PSYCHOLOGICAL SCIENCES
2002, Vol. 57B, No. 1, P87–P94

Negative Life Events and Depression in Elderly Persons: A Meta-Analysis

Vivian Kraaij, Ella Arensman, and Philip Spinhoven

Division of Clinical and Health Psychology, Leiden University, The Netherlands.

In a meta-analysis of 25 studies, the relationship of both specific types of negative life events and the total number of experienced events to depression in old age was studied. Almost all negative life events appeared to have a modest but significant relationship with depression. The total number of negative life events and the total number of daily hassles appeared to have the strongest relationship with depression (respectively, combined $r = .15$, $n = 5{,}037$, and combined $r = .41$, $n = 461$), whereas sudden unexpected events were the only cluster of negative life events that seemed not to be related to depression scores (combined $r = .05$, $n = 857$). These findings suggest that providers and developers of intervention and prevention programs for elderly people should pay attention to the occurrence of negative life events. Special attention should be given to elderly people who have experienced an accumulation of stressful events and daily hassles, because they seem to be a group at greater risk.

Table 2. Population Effect Size Estimates of Recent Negative Life Events

Life Event Cluster	*k*	*N*	Population Effect Sizes			
			WAES *r*	95% CI	*p*	Hom
Death of significant others	13	12,471	.103	.086 to .120	.000	no
Severe illness of self	2	369	.094	−.009 to .194	.036	yes
Severe illness of significant others	5	4,045	.103	.072 to .133	.000	yes
Negative socioeconomic circumstances	5	4,580	.098	.069 to .127	.000	yes
Sudden unexpected events	4	857	.047	−.020 to .114	.084	yes
Negative events with relationships	6	3,207	.102	.067 to .136	.000	no
Total number of negative life events	14	5,037	.150	.122 to .177	.000	no
Total number of daily hassles	3	461	.408	.328 to .482	.000	no
Abuse	2	1,096	.063	.004 to .122	.018	yes

Notes: *k* = number of studies; *N* = total sample size; WAES *r* = weighted average effect size *r*; CI = confidence interval; Hom = homogeneity of the set of study effect sizes.

Tutti gli uomini si nutrono,ma pochi sanno distinguere i sapori

Confucio

Da quando era morto il marito aveva cominciato a spegnersi, non cucinava più, si sentiva più agitata, la notte faticava ad addormentarsi, talvolta svegliandosi improvvisamente dicendo che le mancava il fiato. I famigliari sembravano sottovalutare la situazione. Il figlio commentava "Credo che quando si abbiano 80 anni sia normale non dormire, perdere l'appetito o non avere più l'entusiasmo di cucinare; non capisco perché la faccia così lunga…e poi questa storia del respiro che manca! Si sa che ha la bronchite cronica"

The NEW ENGLAND JOURNAL of MEDICINE

CLINICAL PRACTICE

Late-Life Depression

Jürgen Unützer, M.D., M.P.H.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

A 71-year-old man, whose wife died 6 months previously, presents with foot pain from diabetic neuropathy, poor sleep, lack of energy, and increasing frustration about his inability to "keep his diabetes under control." On examination, he also notes lack of interest in usual activities, decreased appetite, a weight loss of 4.5 kg (10 lb) over the past 3 months, and intermittent thoughts that he would be better off dead. How should his case be managed?

Late-life depression is often undetected or Undertreated in primary care. Reasons for undertreatment include stigma associated with depression and the belief that depression is a normal part of aging.

Late-life depression that is untreated can last for years and is associated with a poor quality of life, difficulty with social and physical functioning, poor adherence to treatment, worsening of chronic medical problems, and increased morbidity and mortality from suicide and other causes. Older men have the highest rates of completed suicide (with the use of firearms in most cases). Recognizing and treating depression and reducing access to firearms may be the most important things primary care providers can do to reduce the risk of suicide.

CHEST

Official publication of the American College of Chest Physicians

Depressive Symptoms as Predictors of Mortality in Patients With COPD

Jacob N. de Voogd, Johan B. Wempe, Gerard H. Koëter, Klaas Postema, Eric van Sonderen, Adelita V. Ranchor, James C. Coyne and Robbert Sanderman

Chest 2009;135;619-625; Prepublished online November 24, 2008;
DOI 10.1378/chest.08-0078

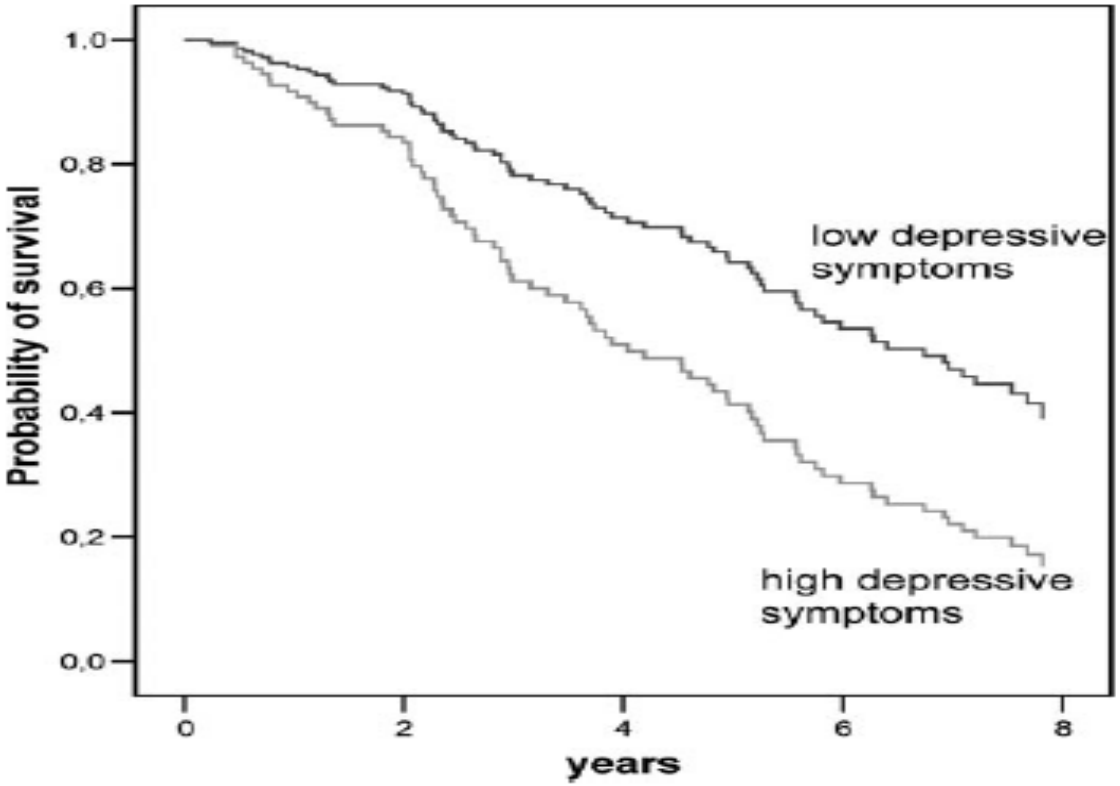


FIGURE 1. Kaplan-Meier curves for COPD patients with separate lines for high and low depressive symptoms (adjusted for the covariates sex, age, and Wpeak).

Depression and Major Outcomes in Older Patients With Heart Failure

Association Based on Cox Regression Analysis of Groups of Risk With 6-Month Mortality in 800 Hospitalized Elderly Patients*

Characteristic†	No. of Patients/No. of Events	Crude Analysis		Adjusted Analysis‡	
		RR	95% CI	RR	95% CI
No HF and no depression	353/14	1.0	Reference	1.0	Reference
No HF and yes depression	361/23	1.9	0.9-4.0	1.8	0.8-4.3
Yes HF and no depression	47/7	3.2	1.0-10.3	3.1	1.0-10.4
Yes HF and yes depression	39/8	6.9	2.6-18.3	5.8	2.1-16.6
Disability in BADL	143/22	2.8	1.6-4.9	2.2	1.1-4.6
Serum albumin <3.5 g/dL	112/16	2.4	1.3-4.4	2.0	0.9-4.1
APACHE score >5	76/14	3.3	1.7-6.2	2.3	1.1-5.0

*RR indicates relative risk; CI, confidence interval; HF, heart failure; BADL, basic activities of daily living; and APACHE, Acute Physiology and Chronic Health Evaluation.

†Variables failing to qualify for entering the multivariate regression model were age, male sex, cognitive impairment, anemia (hemoglobin level <8 g/dL), diabetes mellitus, chronic obstructive pulmonary disease, and gastrointestinal diseases.

‡Adjusted for potential confounders (disability in BADL, serum albumin levels <3.5 g/dL, and APACHE score >5).

Arch Intern Med, 2002

Prognosis of Depression in Old Age Compared to Middle Age: A Systematic Review of Comparative Studies

Alex J. Mitchell, M.R.C.Psych.

Hari Subramaniam, M.R.C.Psych.

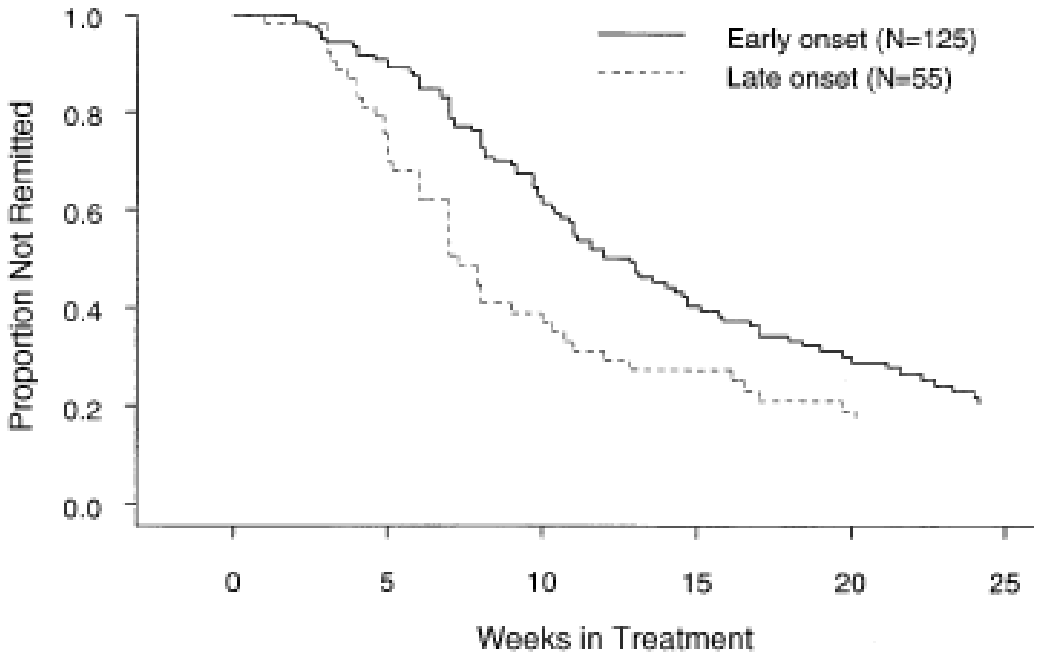
(Am J Psychiatry 2005; 162:1588–1601)

Effects of Age at Onset of First Lifetime Episode of Recurrent Major Depression on Treatment Response and Illness Course in Elderly Patients

Charles F. Reynolds III, M.D., Mary Amanda Dew, Ph.D., Ellen Frank, Ph.D., Amy E. Begley, M.A., Mark D. Miller, M.D., Cleon Cornes, M.D., Sati Mazumdar, Ph.D., James M. Perel, Ph.D., and David J. Kupfer, M.D.

Am J Psychiatry 155:6, June 1998

FIGURE 1. Kaplan-Meier Life Table Plot of Time to Remission for 180 Elderly Patients With Early-Onset Depression (First Episode at Age 59 or Earlier) or Late-Onset Depression (First Episode at Age 60 or Later)[a]



[a]Data for the patients who actually began treatment were analyzed. Time to remission was significantly longer in the early-onset group (Wilcoxon χ^2=11.04, df=1, p=0.001). Median time to remission was 12.9 weeks (95% confidence interval=10.6–14.7) for the early-onset group and 7.3 weeks (95% confidence interval=6.0–10.3) for the late-onset group.

BMJ

Outcome of depression in later life in primary care: longitudinal cohort study with three years' follow-up

E Licht-Strunk, H W J Van Marwijk, T Hoekstra, J W R Twisk, M De Haan and A T F Beekman

BMJ 2009;338;a3079
doi:10.1136/bmj.a3079

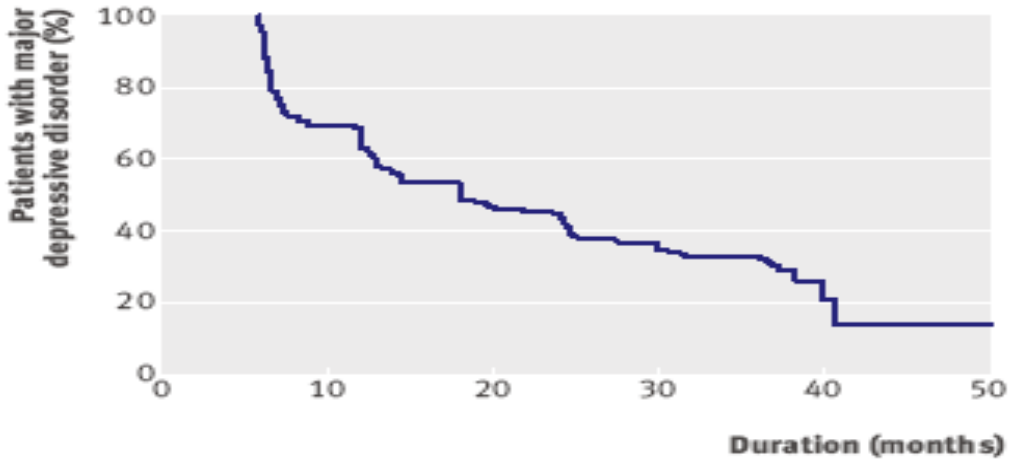


Fig 2 | Survival curve of 204 patients aged 55 years or more with major depressive disorder in primary care

CLINICS IN GERIATRIC MEDICINE

Clin Geriatr Med 19 (2003) 777–797

Late-life mood disorders

William J. Burke, MD*, Steven P. Wengel, MD

Department of Psychiatry, University of Nebraska Medical Center, 985580 Nebraska Medical Center, Omaha, NE 68198-5580, USA

Given the prognosis of depression, it is not surprising that **suicide rates in elderly patients are the highest of any age group** and are **the thirteenth leading cause of death**. Although older adults account for 12.7% of the population, they account for 18.8% of suicides . White males account for these high rates because rates for other segments of the population are not elevated. Other distinguishing features of suicide in elderly patients are that the elderly **give fewer warnings, they use more violent and potentially deadly methods, and they apply those methods with greater planning and resolve**

Non solo farmaci…

“Tanti medici mi hanno riempito di medicine, ma nessuno mi ha mai chiesto perché sono triste…”

SYSTEMATIC REVIEW

Effectiveness of treatments for depression in older people

Cathy J Frazer, Helen Christensen and Kathleen M Griffiths

MJA • Volume 182 Number 12 • 20 June 2005

The treatments with the best evidence of effectiveness are antidepressants, electroconvulsive therapy, cognitive behaviour therapy, psychodynamic psychotherapy, reminiscence therapy, problem-solving therapy, bibliotherapy (for mild to moderate depression) and exercise. There is limited evidence to support the effectiveness of transcranial magnetic stimulation, dialectical behaviour therapy, interpersonal therapy, light therapy (for people in nursing homes or hospitals),

MJA 2005

Table 2

Psychotherapies for Geriatric Depression

	Focus of Intervention	Specific Techniques
Cognitive-Behavioral Therapy (CBT)	Maladaptive thoughts and behaviors	Self-monitoring, increasing participation in pleasant events, challenging negative thoughts and assumptions
Interpersonal Therapy (IPT)	Unresolved grief, interpersonal disputes, role transitions, skills deficits	Exploration of affect, behavior change techniques, reality testing of perceptions
Problem-Solving Therapy (PST)	Problem-solving skills	Identifying specific problems; brainstorming, evaluating, implementing and reviewing solutions
Brief Psychodynamic Therapy	Lack of insight, relationship problems	Analyzing current problems in light of historical patterns, using the therapeutic relationship to identify issues and practice new ways of relating to others
Life Review	Integration of past and present experiences	Structured reminiscence, constructive reappraisal of the past, recollection of previously used coping strategies
Dialectical Behavior Therapy (DBT)	Negative affect, impulsivity, suicidal thoughts and gestures, interpersonal skills deficits	Increasing mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness skills
Family Therapy	Past and current family issues	Psychoeducation of patient and family, assessment of relationship difficulties, behavioral prescriptions
Caregiver Interventions	Stress and burden	Emotional support, encouragement of help-seeking and self-care, information about community resources, may include CBT and PST elements

Source: Moutier et al. (2003)

Sono partito da tanti dubbi approdando gradualmente a qualche certezza.

…Il malato anziano depresso va ascoltato, considerato e curato.