Geriatric Dysthymia

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This article reviews what is known about the epidemiology, clinical characteristics, and treatment of dysthymia in the geriatric age group. Although less common in the elderly than in young adults, dysthymia may have its onset in middle or late life. Geriatric dysthymia appears to have less associated psychiatric comorbidity and closer links to severe life stresses, particularly medical illnesses, than dysthymia with early-age onset. Preliminary reports of response to antidepressant medications are encouraging in the elderly, but randomized, placebo-controlled clinical trials are needed in samples of dysthymic patients in this age group. *(J Clin Psychiatry 1998;59[suppl 10]:13–15)*

There are several questions and issues that psychiatrists and mental health clinicians should consider when they think about geriatric dysthymia. The first question is, Does it exist? We are all familiar with dysthymia in young adults and middle-aged individuals, but does dysthymia actually occur in the geriatric age group? Secondly, if dysthymia does exist in the elderly, when does it make its appearance? Are geriatric dysthymic patients merely young dysthymic patients grown up, or can dysthymia have its onset at any phase in the life cycle? The third important issue is whether geriatric dysthymia is a separate diagnosis, that is, a nosologic entity separate from dysthymia in young adults and younger age groups. A fourth issue concerns the treatment of dysthymia in the geriatric age group. Is this a treatable condition? What kind of data do we have to address the treatability of dysthymia in geriatric patients?

There are 2 subtypes of dysthymia. Pure dysthymia is a mild, chronic depression of at least 2 years' duration (but often lasting for many years), and its onset usually occurs in childhood or adolescence. Double depression is major depression, with 1 or more episodes, superimposed on a prior history of dysthymia. Double depression is to be distinguished from the more familiar single and recurrent episodes of major depression.

Clinical trials have demonstrated response to antidepressant medication for the treatment of dysthymia in young and middle-aged patients. In the largest study of pure dysthymia to date,[1] over 400 patients were randomly assigned to sertraline, imipramine, or placebo treatment for 12 weeks. Stringent criteria were employed for defining remission; that is, there was no longer any report of depressed mood, and patients no longer met the DSM-III-R symptom criteria for dysthymia at the end of the 12-week trial. These criteria were met by 50% of the sertraline-treated patients, 44% of the imipramine-treated patients, and 28% of the placebo-treated patients. Both active drugs were significantly more efficacious than placebo.

Another study, which my colleagues and I conducted over the past several years, is, to my knowledge, the only published long-term maintenance study of the treatment of dysthymia or double depression.[2] Patients were entered into an acute and continuation phase of open treatment with desipramine. Responders were randomly selected to either continue active drug treatment or taper to placebo and were followed during a 2-year maintenance phase. The results showed an 11% relapse rate in the active medication group and a 52% relapse rate in the placebo group, demonstrating the efficacy of long-term maintenance treatment in adult patients with dysthymia.

The prevalence of dysthymia in the geriatric age group was addressed by the well-known Epidemiologic Catchment Area study of mental disorders in the United States.[3] This study found the rate of dysthymia in the overall sample to be 3.1%. In the sample of geriatric patients (over 65 years of age) in this study, the rates were 1% for men and 2.3% for women. This finding suggests that dysthymia does exist in the geriatric age group but that rates may be somewhat lower than those for dysthymia in the younger adult population.

AT WHAT AGE DOES ONSET OF DYSTHYMIA OCCUR?

More recently, 340 patients with double depression entered a large multisite study of treatment with sertraline or imipramine (data on file, Pfizer Inc). An examination of the distribution of age at onset of dysthymia in these 340 patients was informative and coincided with my clinical experience. The vast majority of patients had onset of dys-

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thymia at an early age. A substantial minority, however, reported onset of dysthymia at other stages in the life cycle, including after 50 years of age. When we compared findings for those patients who reported an early age at onset of dysthymia with those who reported a later age at onset, we noted certain differences. The younger dysthymic patients tended more often to be female and to have a greater number of episodes of major depression, a greater number of comorbid personality disorders, and a greater number of affective disorders experienced by their relatives. On the other hand, there were no significant differences between early- and late-onset dysthymia for severity of depression, range of social and functional impairments, and response to treatment. When both the sertraline and imipramine treatment groups were divided by age (current age 50 years or older and under 50 years), there were approximately equal overall response rates, with no significant differences between the 2 age groups, for each medication.

IS GERIATRIC DYSTHYMIA A DISTINCT NOSOLOGIC ENTITY?

Important data on geriatric dysthymia have been gathered by Devanand and colleagues at Columbia University in the late-life depression clinic.[4] Devanand et al. screened 224 patients and found that 40 (18%) of these geriatric depressed patients met DSM-III criteria for dysthymia. As opposed to younger adult dysthymic patients, the gender ratio for geriatric dysthymic patients was approximately 1:1. This was a fairly elderly group of dysthymic individuals. They had a long duration of reported depressive symptoms (mean = 12.5 years). This finding supports the idea that elderly dysthymic patients are not merely early-age dysthymic patients grown up. Only 2.5% of these 40 patients reported a young age at onset of dysthymia. In most instances, the dysthymia had a reported onset in middle age or later life. A large proportion of these geriatric dysthymic patients reported major stressors preceding the onset of the dysthymia. The issue of medical illness, particularly cardiac disease, was highly prominent as an area of stress in these patients.

It is interesting to speculate about the possible links or relationships between cardiovascular disease and dysthymia in the elderly. The question might be, Is there a way in which dysthymia leads to or predisposes toward cardiovascular disease? or Is the dysthymia a stress reaction or a consequence of a preexisting cardiovascular problem? Further research must be conducted, however, before either of these questions can be answered with certainty.

Another finding was that there was much less double depression in the geriatric dysthymia sample. Usually about 75% or 80% of younger dysthymic patients report that they have had a period of major depression in their lifetime. In the geriatric sample, only about 20% reported having had an episode of major depression.[4]

Also noteworthy among the elderly dysthymic patients was the general lack of psychiatric comorbidity. For example, there was a low prevalence of substance abuse and a low prevalence of comorbid anxiety disorders compared with those for younger dysthymic patients. Another striking finding was that only 10% of elderly dysthymic patients were found to have comorbid personality disorders. In younger cohorts of patients, 50% or more are usually found to have comorbid personality disorders.[4]

TREATMENT OF GERIATRIC DYSTHYMIA

The only prospective study of antidepressant treatment of dysthymia in the geriatric age group is an open study using fluoxetine reported by Nobler and colleagues.[5] This study included patients with primary dysthymia who were at least 60 years of age and had a Mini-Mental State Examination score greater than 24. Very few of these geriatric dysthymic patients had previously received adequate trials of medication. In fact, 40% of them had received no treatment at all, in spite of having been depressed for a mean of 12.5 years at the time their dysthymia was detected and diagnosed. They had an initial 2-week placebo run-in, followed by fluoxetine, 20 mg/day, for 3 weeks; and, if no response, 40 mg/day for the next 5 weeks. Twenty patients completed the study. The mean oral dose of fluoxetine was 35.5 mg/day, and 12 (60%) of the 20 met the criteria for response at the end of the 8-week trial. The medication was generally well tolerated.

Only one other set of data—a recent multisite study of sertraline and fluoxetine in geriatric major depression—has relevance to geriatric dysthymia treatment (data on file, Pfizer Inc). An analysis divided the sample of elderly depressed patients into those who were chronically depressed (that is, patients who had been depressed for 2 years or longer) and those who had episodes of depression lasting 2 years or less. The response rates were not significantly different between the more acutely depressed and chronically depressed, suggesting that chronicity of depression in this geriatric depressed cohort did not predict poor response to antidepressant medication.

The same study contained a small sample of patients who were over 70 years of age. In this sample, as well, chronicity did not predict less favorable response to treatment with these antidepressant medications.

CONCLUSIONS

In summary, geriatric dysthymia is, at this point, an understudied condition. We have few data at the present time about the treatment of geriatric dysthymia, although dysthymia definitely exists in the geriatric age group. It appears that the onset of dysthymia can occur at any point in the life cycle. In fact, dysthymia may make its first appearance in old age. It appears that older dysthymic patients

often undergo major life stresses, particularly medical illnesses. It appears, at least from preliminary results, that antidepressant medications hold some promise for the treatment of dysthymia in the elderly. However, placebo-controlled clinical trials are needed.

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