

LETTER

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Protection from late life depression

I respect and like Dan Blazer more than (or at least as much as) any other psychiatrist I've met. He is a world expert on late life depression and a pre-eminent researcher and teacher – but that is why statements made by him in a recent guest editorial in this journal (Blazer, 2010) must not be left unchallenged.

Blazer seeks an explanation of why the frequency of late life depression is estimated to be low, relative to the frequency in young adulthood and middle age, “as documented in many community-based epidemiological studies”. He confesses that “this has been a paradox to me for decades” and points out a host of reasons why we should expect to find the prevalence of depression to be higher in old age.

Although he does not specifically say so, it is evident that by “depression” he means “major depression”. He refers to the low frequency of depression reported by Blazer and Williams (1980) who found that 3.7% of a community-dwelling population fulfilled criteria for major depression. However, they reported that the total rate of dysphoric symptomatology in this population was 14.7%, including (in addition to those with major depression) 6.5% with substantial dysphoric symptoms associated with physical health impairment, and 4.5% who were simply dysphoric. Similar results were reported from various other studies that used structured interviews to identify clinically significant depression among older persons (Snowdon, 2003). A frequency of around 14.7% is not low!

Studies of the prevalence of DSM major depression in populations of older people have shown a huge variation, while studies that allow comparisons of rates of depression across different age-groups have been inconsistent in their findings (Snowdon, 2003). Several groups reported no age difference. Some showed peaks in younger adulthood, while others showed peaks at age 55–64 years or in old age. An Australian study of 10,000 adults was noted to have numerous methodological flaws (Snowdon *et al.*, 1998), which might explain why it found mood disorders to be more prevalent in early adulthood.

Most studies that compared the prevalence of depressive disorders in “young old” and “old old” groups found it to be higher in the older group (Snowdon, 2003).

Thus, Blazer's assertion that many studies show the prevalence of depression to be lower in old age than at other periods of life needs qualification. Blazer (1999) himself has said that whether depression is found to be more or less frequent in late life depends on how “caseness” of late life depression is defined. Surely depression is not just major depression! There is evidence that the clinical and prognostic consequences are just as serious in a large proportion of so-called minor depressions as they are in major depression or dysthymia.

Blazer (1994) declared a need for additional diagnostic categories to adequately classify depressive disorders experienced by elderly people. The DSM criteria for adjustment disorder with depressed mood do not apply when a “maladaptive reaction” persists more than six months. He referred to minor depression in late life as a unique syndrome that is associated with physical illness and cognitive difficulties. Beekman *et al.* (1997) examined a large sample of older adults and found, in multivariate analyses, that while minor depression was related to physical health and functional limitations, major depression was associated with partner loss and long-standing vulnerability factors, such as family history, locus of control and personal history.

Summarizing my concerns about the editorial, I think it inappropriate to perpetuate the notion that the prevalence of depression (a term encompassing persisting depressive disorders that cause distress and impairment severe enough to warrant clinical intervention) is lower among older persons than among the non-elderly. People can be suicidal and incapacitated by depressive symptoms and yet not fulfil criteria needed for “major depression”. The latter term is relatively meaningless in relation to origins, associated factors and treatment. It has been said that when geriatric psychiatrists in the U.S.A. talk about depression they are usually referring to major depression, and it is unfortunate that Blazer does this in his editorial. That is why he cites the Blazer and Williams (1980) study as evidence of a low frequency of depression in old age, whereas in fact (see above) it shows a relatively high frequency (14.7%). Primary care doctors and others should not be guided into thinking they will find less depression among their older patients.

Having said that, do we agree with Blazer's ideas about factors that might protect older people from getting depression? Do older adults de-emphasize future planning and prioritize goals which are emotionally meaningful in the present? Do they

selectively optimize the positive in experiences such as visiting the Grand Canyon, obliterating from their minds any thoughts of future difficulties and ongoing problems? *Yes, a lot do!* Not all. Those with characterological depressions, those with negative perceptions, will be just as depressed or more so when they see others enjoying the view. They may have coped with their negativities until aging-related difficulties imposed themselves. The difficulties may be “on-time” events or situations which the negative-thinking person has rehearsed, and which have engendered ever-increasing concern as “on-time” comes nearer. I can think of various patients who would fit into this group. The question Blazer raises is whether such vulnerable people become more or less numerous with age, and whether acquired wisdom helps protect them from characterological depression.

Research is needed. Maybe those who find a reduced prevalence of major depression in old age are right, and maybe this is partly explained by changes in vulnerability as suggested in Blazer’s editorial. But what about the other, larger, group whose late life depression would have been described by Blazer and Williams as dysphoria related to physical illnesses or other problems? This is the group for whom the protective factors mentioned by Blazer may have been less protective as the difficulties have increased – non-major but commonly just as needful of attention. A different approach is required.

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