Reliance on Relationships May Herald Depression

Individuals' dependence on social support can set them up for depression after adverse life events.

BY JEFF EVANS
Senior Writer

STOCKHOLM — People who rely chiefly on interpersonal relationships for support into old age may have a high risk for depression when adverse life events disrupt those relationships, Carolyn Mazure, Ph.D., said at the 12th Congress of the International Psychogeriatric Association.

Researchers have known that younger adults who highly value a need for independence and control appear to have a higher risk for depression after adverse life events than do those who place great importance on interpersonal relationships.

The association between adverse life events and cognitive styles, however, appears to reverse itself in older age, said Dr. Mazure, professor of psychiatry at Yale University, New Haven, Conn.

Dr. Mazure and her colleagues have used the premises of Aaron T. Beck's cognitive theory of depression to predict late-life depression. His theory proposes that life events influence mood based on the meaning that an individual assigns to the life events and suggests that people use certain cognitive styles, or characteristic ways of looking at themselves in the world, to form stable belief systems that influence their interpretation of events.

The two cognitive styles that are inherent to the cognitive theory of depression are sociotropy and autonomy. Sociotropy is characterized by a high investment in interpersonal relationships, a desire to please others to avoid disapproval in order to secure attachments and build relationships, and a fear of separation and abandonment, she said

Autonomy focuses on a need for independence, control, and personal freedom to reduce the possibility of failure.

"If someone's cognitive style is particularly sociotropic, they are going to be more vulnerable to an adverse event that is interpersonal in nature, such as loss of a loved one." Autonomous individuals, on the other hand, "are going to be more vulnerable to negative achievement events like a change in long-term residence," as occurs when an individual is forced to leave his or her home of 40 years to go into an assisted-living facility, she said.

The interaction of sociotropy and autonomy with adverse life events has been studied extensively in U.S. samples of younger individuals, but models that explore the relationship of life stress in the context of cognitive styles generally have not been extended to older adults, she noted.

In one study, Dr. Mazure and her colleagues prospectively matched 42 outpatients who developed major depression at age 60 years or older with 42 nondepressed individuals from the community. Patients with a predominantly sociotropic cognitive style who had an adverse interpersonal life event were 11 times more likely to be diagnosed with depression than were patients without either characteristic. Those who had a predominantly autonomous cognitive style and suffered a negative achievement life event were six times more likely to be diagnosed with depression than were those without either characteristic (Am. J. Geriatr. Psychiatry 2002;10:297-304).

Medical illness and diminished physical functioning were associated with depression, but even in the context of these effects, the interaction between adverse life events and cognitive styles predicted the onset of depression.

The presence of a predominantly sociotropic cognitive style without an adverse life event made an individual three times more likely to be diagnosed with depression. A predominantly autonomous cognitive style without an adverse life event made individuals 55% less likely to be diagnosed with depression than were those without an autonomous cognitive style, which differs from findings in younger populations.

The investigators excluded patients with dementia or those who scored less than 24 on the Mini-Mental State Examination, as well as those with dysthymia, psychosis, or a history of substance abuse. The investigators asked patients about adverse life events that occurred in the 6 months prior to their diagnosis of depression and asked control individuals about life events in the 6 months prior to their interview.

In other studies that Dr. Mazure and her associates have performed using the same methods, they have found that the risk of depression in people with sociotropic cognitive styles stays the same over the course of life, while autonomy imparts a higher risk for depression at younger ages but gradually drops to contribute less risk for depression than does sociotropy in older people. The interaction of autonomy and negative achievement life events on the risk for depression follows the pattern for autonomy alone, but the interaction of sociotropy and adverse interpersonal life events increases the risk for depression as people age. ■

Questions to Consider

Dr. Mazure identified three areas for future research involving cognitive style and late-life depression:

► Can modifying cognitive styles reduce the risk for depression, especially when individuals are confronted with adverse life events?

► Are there gender differences in the interaction of cognitive styles and adverse life events?

► What age-specific approaches have the potential to be clinically meaningful in reducing the risk for depression?

Screen for Geriatric Syndrome to Improve Care

BY TIMOTHY F. KIRN
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SAN FRANCISCO — Screening for the four common problems of old age that constitute geriatric syndrome—cognitive loss, falls, incontinence, and depression—offers a holistic way to meet the needs of elderly patients, William J. Hall, M.D., said at the annual meeting of the American College of Physicians.

These problems affect the patient's quality of life and compliance with treatment for other medical conditions, noted Dr. Hall, director of the Center for Healthy Aging at the University of Rochester (N.Y.).

"The fact is, when elderly people are depressed, they don't take their ACE inhibitors," he said. "It's as simple as that."

A good way to address geriatric syndrome during office visits, Dr. Hall said, is to focus on one the following components at each visit:

► **Cognitive loss.** The Mini-Mental State Examination (MMSE) is a good screen for cognitive loss. But a new mental status exam that is even more practical appears to be highly sensitive.

The exam includes a category fluency test (in 1 minute, the patient names as many things as possible in a category such as animals or cities) and a phonemic fluency test (in 1 minute, the patient names as many words as possible that start with a given letter). When a cutoff of 15 words is used for the category fluency test, it appears to pick up about 90% of cases of dementia—even mild dementia (Neurology 2004;62:556-62).

This test's flexibility means that it can be made culturally or intellectually appropriate for the patient. It may also provide differential information, because patients with vascular dementia have more impairment in the phonemic test than the category test, Dr. Hall said.

Treatments for cognitive impairment seem to have "reached the end of the line" with the cholinesterase inhibitors and memantine, at least for now, he said. Other strategies, such as antioxidant or anti-inflammatory approaches, and estrogen, vitamins, and statins, have not panned out. Much of the initial enthusiasm about the cholinesterase inhibitors has turned to skepticism recently. Donepezil (Aricept) was shown in one influential study to double the time it took for patients to enter a nursing home, but that study has not yet been replicated. In general, there is a dearth of independent studies of cholinesterase inhibitors not sponsored by drug manufacturers.

"I would have a very hard time not trying Aricept in dementia," he said. "There is so little hope otherwise."

► **Falls.** European geriatricians studying the stance and movement of elderly people who have serious falls have identified a "psychomotor disadaptation syndrome." The characteristic features include a stance with trunk bent forward, toes clenched, and knee flexion, or the presence of reactional hypertonia.

In the office setting, the "get-up-and-go" test offers a practical way to identify patients at risk of falling, Dr. Hall said. The patient is directed to rise from a chair, walk 10 feet, turn around, return to the chair, and sit down. The tester rates the patient's stability.

Muscle weakness appears to be the most important predictor of falls. "It trumps everything else by a substantial order of magnitude," including factors such as dementia or age over 80 years, Dr. Hall said.

Even minimal strength training can reap benefits, and several exercises can be used that do not require expensive equipment or supervision.

► **Urinary incontinence.** After age 65 years, 15%-30% of women have urinary incontinence, and 50% of all elderly patients living in institutions have it.

Even though urinary incontinence can greatly limit their activities, fewer than half of patients seek medical help without prompting. When patients do seek help, the average time from the beginning of a serious problem to the appointment is 41 months. Thus, physicians must be proactive in looking for the problem, he said.

The cough stress test is "really good" at picking up urinary incontinence. Leakage with a cough may signal either stress incontinence or overactive bladder. With stress incontinence, the leakage occurs immediately. With overactive bladder, it takes a few seconds, Dr. Hall explained.

Kegel exercises are highly effective for stress incontinence. A recent major review of the evidence suggested that women who did pelvic floor muscle training were 23 times more likely to have cure or improvement in their incontinence, without the need for other treatments such as biofeedback or electrical stimulation.

► **Depression.** Few elderly people develop full-blown depression that would meet diagnostic criteria. Rather, the elderly are prone to subclinical depression that can almost be described as a "failure to thrive," Dr. Hall said.

According to a Cochrane Collaboration review not yet published, effective screening for depression—even mild depression—can be done with two questions: "Have you been bothered in the past month by low interest in pleasure or doing things?" and "Have you been feeling down, depressed, or hopeless in the past month?" ■