Spouses Bear Caregiving Burden for MCI Patients

BY DOUG BRUNK
San Diego Bureau

San Diego — Spouses of men and women with mild cognitive impairment are assuming the role of caregiver and are experiencing the caregiver burden associated with the role, Linda Garand, Ph.D., said at the annual meeting of the American Association for Geriatric Psychiatry.

In a pilot study, nursing tasks such as administration of medication were significantly associated with symptoms of depression in the caregiver, while lifestyle constraints were significantly associated with symptoms of anxiety, she reported.

The finding suggests that spouses of people with mild cognitive impairment (MCI) "may be ideal targets for preventive interventions, to prevent the later development of psychiatric morbidity in the event that they do progress to become a dementia caregiver," said Dr. Garand of the University of Pittsburgh.

Although the negative mental health effects of dementia caregiving are firmly established in the medical literature, she added, "We know very little about what it's like to give care to a person with milder levels of [cognitive impairment]."

In a 7-month study funded by the National Institute of Mental Health, Dr. Garand and her associates conducted a cross-sectional study of 23 women and 4 men whose spouses met Alzheimer's Disease Research Center criteria for MCI. Spouses lived with the patients at home and understood English.

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Some nursing tasks were associated with symptoms of depression in caregiver spouses of MCI patients.

Self-reported cross-sectional data were collected in the home. The investigators used a variety of measures, including the Caregiver Burden Inventory, the Memory and Behavior Problem Checklist, the Center for Epidemiologic Studies–Depression scale, and the state portion of the State-Trait Anxiety Inventory.

Most of the spousal caregivers were white, married for almost 5 decades, and lived alone with their spouse. They ranged in age from 54 to 82 years, with an average age of 70 years. About three-quarters had at least a bachelor's degree.

Spouses performed an average of four household management tasks per day and 0-1 nursing tasks per day. The amount of time to self received the highest caregiver burden rating, while the amount of privacy and the amount of vacation time received the lowest caregiver burden rating.

The most common MCI-related behaviors spouses reported of their loved ones were asking the same question over and over again, having trouble remembering recent events, and losing or misplacing things. Spouses who performed nursing tasks such as administration of medication were significantly more likely to have depressive symptoms, while those with perceived lifestyle constraints were significantly more likely to have anxiety symptoms.

"The caregiving responsibilities in this sample were very diverse," Dr. Garand commented. "The fact that many of these responsibilities were introduced since the person had been diagnosed with MCI suggests that the burden and psychiatric morbidity are directly associated with the MCI in their spouse."

She noted that all of the spouses who reported responsibility for transportation, running the errands, and managing business affairs also acknowledged that these were new responsibilities since their spouse developed MCI.

Nearly one-half of the spouses reported being responsible for administering medications for their loved one, and a large proportion of that subsample said that it was a new responsibility since the onset of MCI.

Dr. Garand proposes an in-home intervention with spouses of men and women with MCI that will be built into another study. The intervention will include 1 month of in-home education followed by 2 months of support via telephone. The intervention "is going to be based on problem-solving therapy," she explained.

"I'm hoping that if I can equip these spouses with some real problem-solving tools early in their caregiving trajectory, I may be able to help them down the road as they become dementia caregivers, so they don't become so depressed or anxious." ■

Psychiatric Disorders May Be Undiagnosed in Elderly

BY MARK S. LESNEY
Senior Editor

A common perception, based on relatively few published studies, is that most psychiatric disorders other than depression occur much less frequently among the elderly. Community samples, however, suggest that many older adults who experience clinically significant pathologies are overlooked or misdiagnosed, according to Dilip V. Jeste, M.D., and colleagues.

This discrepancy points out the need to develop age-appropriate diagnostic criteria that can assess elderly psychiatric patients, according to Dr. Jeste of the department of psychology at the University of California, San Diego, and associates (Biol. Psychiatry 2005;58:265-71).

Five potential causes of diagnostic confusion in the elderly were detailed:

► True age-related differences, in which symptoms of the disorder vary according to age. In such cases, application of DSM-IV criteria sets based on the disorder at a younger age results in under-, over-, or misdiagnosis in the elderly.

► Physical and psychiatric comorbidities, which tend to occur more frequently in the elderly, including general medical conditions such as congestive heart failure or cognitive deficiencies such as dementia.

► Underreporting of symptoms, which occurs more frequently in the elderly, biasing both epidemiologic and clinical-based studies toward underdiagnosis.

► Variation through time of onset, such as in major depression, which can show different symptoms in late, compared with early onset, the investigators said.

► Subthreshold presentations, in which older patients might experience clinically significant symptoms that fall below standard DSM-IV criteria sets. "For example 'minor generalized anxiety disorder' might have a different significance and outcome in elderly than in younger adults," Dr. Jeste and associates reported.

Several categories of disorder can be subject to these various difficulties in diagnosis. For example, schizophrenia, though typically of early onset, also occurs in a sizeable minority of patients in middle or old age, and is often misdiagnosed as due to "organic" factors. According to the literature, 13% of all schizophrenia had onset between the ages of 41 and 50 years, 7% in patients aged 51-60 years, and 3% after age 60, they reported. Distinctiveness of symptoms in the "very late onset" indicates the illness may belong in a different category.

Anxiety disorders may be particularly difficult to pin down, according to the authors. For example, new-onset agoraphobic disorder would be less obvious, and thus underdiagnosed, in elderly patients who are less mobile and leave their houses less frequently.

Further research is needed to clarify the classification and incidence of late-life psychiatric disorders. "Most of the gaps in the current knowledge outlined … can be filled by systematic research and better attention to the potential presence of these disorders in elderly patients," Dr. Jeste and associates said. ■

Fears, Misconceptions Spur Elders' Reluctance to Use Antidepressants

New Orleans — Fears and misconceptions about antidepressant medications contribute to older adults' reluctance to use pharmacologic treatment for depression, a qualitative study has shown.

"Depression is highly prevalent but undertreated in elderly primary care patients, despite the availability of effective medications," Jane L. Givens, M.D., reported at the annual meeting of the Society of General Internal Medicine. Among the patient-level factors preventing appropriate treatment in this population are fear of addiction, concern about unnatural happiness or inability to feel grief and sadness, and fear of side effects.

Dr. Givens and her colleagues at the University of Pennsylvania in Philadelphia recruited a subsample of 68 older adults (mean age 75 years) with depression who participated in one of two qualitative, randomized treatment studies—the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) or the Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). Each of the patients participated in semi-structured home-based interviews, which were audiotaped, transcribed, and entered into qualitative data analysis software for coding and analysis.

"Four themes emerged from this review," Dr. Givens said. "Many expressed a fear of needing to take antidepressants for the rest of their lives or of becoming addicted. Some did not want to be unnaturally happy or to mute their capacity to feel sadness or to 'face reality.' "

Other patients resisted treating symptoms of sadness associated with the loss of a loved one, and some had previous histories of treatment with psychiatric medications, including tranquilizers, and were concerned about the side effects, particularly sedation, Dr. Givens noted.

Many studies have linked depression to excess morbidity and mortality in elderly patients because of insufficient screening and detection and inadequate treatment. The findings of this study suggest that identifying depressed patients and offering them pharmacologic therapy may not be enough. "There is a need for more patient education and dialogue about the characteristics of current antidepressant therapy," she concluded.

—Diana Mahoney