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DEPRESSION IN ELDERLY PATIENTS

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Keywords: depression, anxiety, comorbidity, noncommunicable illness, diagnosis, treatment

A depressive condition in the general elderly population is a major public problem due to their high occurrence and high somatic comorbidity. Furthermore, the prognosis of these depressive states is poor. According to many epidemiological studies, major depression occurs in 1% to 3% of the elderly patients [1; 2]. Moreover, from 8% to 16% patients have clinically significant depressive symptoms [1; 3]. Prevalence estimates for DSM-IV major depression criteria in adults aged 65 to 100 years in the community were reported about 3% in men and 4% in women [4]. In the primary medical care about 5% to 10% of older patients have major depression. Recent meta-analysis on median prevalence rate of depression in elderly population across India has been estimated about 21.9% [5]. Stress and core family pattern are some of the important psycho-social risk factor for the development of depression, which differ grossly between urban and rural areas.

In Ukraine, the health of the population under the age of 70 years, more than 18% of the daily need of social assistance, 82% regularly take medications, among people older than 80 years, 20% required a specialized psychiatric care [6]. In general, the health of the elderly population in Ukraine is gradually getting worse: the prevalence of disease among people older than working age has increased over the last decade by almost a third. And if the mortality of elderly people from all external causes of Ukraine is not very different from the EU countries, this figure is higher than the result of suicide in the EU is 1.6 times, as a result of murders – more than 7 times [7; 8]. The highest suicide rate is observed at the age of 80–84 years and males aged and elderly mortality due to suicide is 4–5 times larger than the female. Medical and psychological research in Ukraine indicate that the leading determinant of suicide among the elderly is their social isolation: almost half of those who commit suicide are living alone [9; 10].

Depression is a common but underdiagnosed and undertreated condition in older adults. Studies of depressed elderly adults indicate that those with depressive symptoms (with or without depressive disorder), have poorer functioning, in some cases worse than people with chronic medical conditions such as heart and lung disease, arthritis, hypertension and diabetes [11]. In addition to poor functioning, depression increases the perception of poor health, the utilization of medical services, and health care costs [12].

Patients with depression and poorly controlled diabetes, coronary heart disease, or both have an increased risk of adverse outcomes and high health care costs. According to single-blind, randomized, controlled trial in 14 primary care clinics in an integrated health care system in Washington State, involving 214 participants with poorly controlled diabetes and/or coronary heart disease and coexisting depression (in compared with usual care) an intervention involving nurses who provided guideline-based, patient-centered management of depression and chronic disease significantly improved control of medical disease and depression [13]. Depressive symptoms are an independent risk factor for mortality in the elderly. Elderly depressive men and elderly without chronic diseases seemed to have a greater mortality risk [14].

However, some studies provide that treatment of major depression can extend life. The biological, social, psychological, and behavioral links between depression and mortality provided strong rationale to examine whether improved management of depression can decrease mortality in older adults (fig. 1) [15]. PROSPECT and other studies show that treatment of major depression in primary care reduces symptoms of depression, induces remission, improves quality of life, and reduces functional impairment. Resent study found: a 24% lower mortality risk was seen after a median of 98 months among patients with major depression in practices provided with resources for depression care management compared with usual care. The decline in mortality was across all causes of death, but with fewer deaths from cancer among people with major depression in intervention practices [16].

A depression care manager working with primary care physicians to provide algorithm based care for depression can mitigate the detrimental effects of depression on mortality.

Depression and anxiety are common in elderly people with chronic diseases. They are often associated with

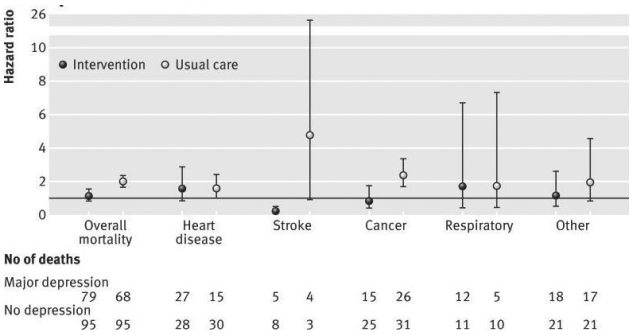

Fig 1. Adjusted hazard ratios (95% CI) for specific causes of death comparing major depression with no depression within intervention or usual care practices. Data from PROSPECT (1999-2008) [16].

increased disability and health-care utilization and with poor health status. Comorbid untreated anxiety and/or depression tend to persist, have relapsing courses, and are associated with increased vulnerability to social isolation, low self-esteem and confidence, nonadherence to medical treatment, and increased mortality [17].

We provide the pilot study of for psychiatric disorders' screening in 162 patients with chronic noninfectious diseases in primary health care using Hospital Anxiety and Depression Scale (HADS), including. 26.5% men above 55 (43 patients) and 40.1% women above 55 (65 patients). In the group of men above 55 level of subclinical anxiety is 44.4%, of depression is 22.2%, and level of clinical depression is 16.7%. In age group of women above 55 subclinical anxiety and depression is 14.3%, symptomatic anxiety is 14.3%, and depression is 57.1%. This data provides evidence of mental disorders (depression and anxiety) in a significant number of patients in general health care [18].

However, study determination the correlation of late-life depression with mild cognitive impairment (MCI) and dementia in a multiethnic community cohort revealed the association of depression with prevalent MCI and with progression from MCI to dementia, but not with incident MCI [19], suggests that depression accompanies cognitive impairment but does not precede it.

In German study [20], the general evaluation of depression among a large sample of non-demented individuals (75 years of age and older) living in private households in Germany, was substantial: 36.8 per 1,000 person-years in men and 46.0 in women. The incidence increased from 35.4 per 1000 person-years between the ages of 75 and 79 to 75.2 for subjects 85 years and older. This should alert general practitioners to look for signs and symptoms of depression particularly among the oldest individuals. The depression rating was significantly higher for subjects 85 years and older and for those with mobility impairment, vision impairment, mild cognitive impairment, subjective memory impairment and current smoking. The investigators note, to prevent late-life depression, it is important to call more attention to the impact of functional and cognitive impairment. The preceding findings suggest that depression in elderly community subjects is a serious problem. Probably fewer than 20% of cases are detected or treated . Even among those patients, the effectiveness of interventions appears to be modest . Escalating health care costs and shrinking health care resources challenge health care professionals to find more effective and less expensive approaches to depression in the elderly.

According to data of St. Vincent's Health Emergency Department, a significant proportion of elderly patients have preexisting conditions including depression, which associated with social isolation, physical and mental health problems, and barriers to accessing community services [21]. Patients aged 65 years and over were screened for depression using a short form of the Geriatric Depression Scale (GDS-15). Approximately one in four participants experienced mild to moderate depression that was related to medical factors and associated reduced mobility. This study suggests that an assertive outreach program, with the inclusion of community intervention and links to social supports and services, could improve the management of depression in the elderly and associated health outcomes.

Treatment of elderly patients with major depression represents a different set of challenges for the physician than the treatment of young adults. Elderly patients may have more comorbid medical illnesses, take more medication, have slower drug metabolism than younger patients. Cognitive impairment, lack of social support, transportation difficulties, financial limitations and disabilities can be barriers for elderly patients receiving treatment. These clinical problems indicate the likelihood that the elderly are excluded from clinical trials, which leads to a lack of data on the basis of processing information. For this reason, the research team convened in 2001 to address some of the clinical issues related to the treatment of late-life depression. The team sent a written survey of 50 national experts about treatment options for elderly patients, and a consensus was reached on most of the experts presented variants. Evidence-based treatment strategies prefer the experts were then developed to assist physicians in the treatment of elderly patients with depression [15].

Diagnosis	Treatment
Dysthymic disorder	Antidepressant + psychotherapy
Unipolar nonpsychotic major depression	Antidepressant + psychotherapy; ECT if depression is severe and unresponsive to antidepressants
Unipolar psychotic major depression	Antidepressant + an atypical antipsychotic; ECT
Delusional disorder	Antipsychotic

Fig. 2. Consensus treatments for late-life depression (Alexopoulos G.S., 2001).

According to expert consensus, patients with 1 episode of major depression should be treated with antidepressants for at least 1 year; if they have had 2 episodes, they should be treated for 1 to 3 years, and longer than 3 years if they have had 3 or more episodes. The challenge in geriatric depression is to get patients to adhere to treatment.

Many factors influence to treatment adherence in older adults. They are cognitive impairment, complex dosing

regimens, adverse side effects, a lack of understanding of depressive symptoms, cost, lack of family support, and the stigma associated with depression. The clinician should anticipate and directly address nonadherence behavior and help the patient develop a method of monitoring his or her own adherence. Other ways to improve treatment adherence are assessing the patient for cognitive or physical impairment, involving family members in the treatment plan, maintaining frequent patient contact, and providing clear and easy-to-understand information regarding the patient's diagnosis and treatment regimen [22].

Consensus guidelines recommend an antidepressant plus psychotherapy for the treatment of unipolar nonpsychotic geriatric depression, and recent evidence has supported this recommendation. The consensus also was that the treatment for dysythmic disorder or persistent minor depression should consist of an antidepressant combined with psychotherapy, or possibly either an antidepressant or psychotherapy alone. The preferred treatment strategy for unipolar nonpsychotic major depression of any severity was an antidepressant plus psychotherapy, although ECT was also considered for severe depression unresponsive to antidepressants. The SSRIs were considered the preferred antidepressant class. The preferred psychotherapies were CBT, supportive psychotherapy, PST, and IPT. In addition, the Expert Consensus Guidelines affirmed that psychosocial interventions such as family counseling and visiting nurse services are integral components of treatment programs for patients with late-life depression, along with careful screening and treatment for comorbid medical conditions that might contribute to or even cause patients' depression.

The guidelines recommend CBT, supportive psychotherapy, PST, and IPT as the preferred psychotherapeutic techniques for treating older patients with depression. What is more, CBT, PST, and the combination of an antidepressant and IPT were efficacious in the acute treatment of geriatric depression, with CBT and IPT combined with an antidepressant having the largest evidence base. Cuijpers and colleagues [23] found no significant differences in efficacy between CBT and other types of psychotherapy.

Since the publication of the guidelines, a type of problem-solving psychotherapy has been developed for patients with depression and executive dysfunction [24]. The goal of this therapy is to maximize the patient's ability to adapt to their environment. Specifically, patients are taught how to identify problems and define them concretely, set goals, generate solutions, evaluate these solutions, implement the best solution, and then verify the effectiveness of the solution. These problem-solving skills have been adapted to directly address symptoms of depressed patients with executive dysfunction, such as lack of energy, psychomotor retardation, and reduced insight. In addition, therapists make changes in patients' physical environments to accommodate disabilities and instruct patients' caregivers on how to help with tasks that the patients themselves are unable to perform. Maximizing patients' problem-solving skills and creating a favorable ecosystem reduces their experience of stress and may facilitate their recovery from depression.

Drug therapy in the opinion of experts is mandatory for geriatric depression. Meta-analysis confirmed that antidepressants are more efficacious than placebo for late-life depression. In addition, evidence suggests that antidepressants may have a protective effect against suicide in those aged 65 years or older [25].

The antidepressants preferred by the experts for all types of depression were SSRIs, with sertraline and citalopram rated highest for efficacy and tolerability, followed by paroxetine, which was another first-line option. Studies published since the guidelines have had mixed results on the efficacy of these agents in older patients. The experts also recommended the SNRI venlafaxine as first-line pharmacotherapy. Direct comparisons13–15 between venlafaxine and SSRIs so far have shown no differences in remission rates in the geriatric population. Since the publication of the guidelines, another SNRI, duloxetine, has shown good tolerability and significant improvement in depressive and pain symptoms versus placebo in older patients with major depression [26].

Augmentation therapy of antidepressants with atypical antipsychotics in geriatric depression has still not been systematically investigated. The use of atypical antipsychotics has been associated with increased mortality in older patients with dementia, but illness and other medication factors may confound these findings [27] The mechanism by which atypical antipsychotic drugs might increase mortality in elderly patients with dementia is not well understood, and it is unclear whether the lower dosages used in augmentation therapy for geriatric depression will substantially increase mortality [28]. The experts recommended caution when using atypical antipsychotic agents; for example, olanzapine and clozapine should be avoided in those who are obese or diabetic, and olanzapine and ziprasidone should be avoided in those with QTc prolongation or congestive heart failure [29]. However, atypical antipsychotics likely increase appetite and weight and may be beneficial in elderly patients who are emaciated because of depression or anorexia related to depression and perhaps exacerbated by comorbid medical illnesses. Placebo-controlled trials [30] demonstrated the efficacy of aripiprazole augmentation of antidepressants for adults with treatment-resistant depression.

The STAR*D study [31], which had a relatively small older population, found that bupropion and triiodothyronine were effective as augmentation to antidepressants in treatment-resistant major depression. Studies of this kind specifically for geriatric psychiatry are needed to provide a variety of augmentation therapies for this population. However, additional studies on geriatric depression are needed, particularly in regard to treatment strategies for patients with treatment-resistant depression.

So, elderly depression mainly affects those with chronic medical illnesses and cognitive impairment, causes suffering, family disruption, and disability, worsens the outcomes of many medical illnesses, and increases mortality. Ageing-related and disease-related processes increase vulnerability to depression. Psychosocial adversity-economic impoverishment, disability, isolation, relocation, caregiving, and bereavement-contributes to physiological changes, further

increasing susceptibility to depression or triggering depression in already vulnerable elderly individuals. Treatment with antidepressants is well tolerated by elderly people and is, overall, as effective as in young adults. Evidence-based guidelines for prevention of new episodes of depression are available as are care-delivery systems that increase the quality of diagnostics, and improve the treatment of late-life depression.

Consensus guidelines recommend an antidepressant plus psychotherapy for the treatment of unipolar nonpsychotic geriatric depression. Combining psychotherapy and antidepressants to treat both mild and severe geriatric depression continues to be first-line treatment. Psychotherapy is efficacious for treating late-life depression and may especially help with medication adherence and relapse prevention. Certain psychotherapies, such as CBT, IPT, and PST, have the most evidence of efficacy in treating depression in older adults, but additional controlled trials are needed to determine which types of psychotherapy work best for which patients. An antidepressant plus an atypical antipsychotic is the first-line recommendation for geriatric psychotic depression. Additional studies are needed in the elderly population to determine safe and efficacious strategies for late-life depression.

References

1. *NIH Consensus Development Conference: Diagnosis and treatment of depression of late life. // JAMA/ – 1992. – Vol. 268. – P. 1018-1029*
2. *Cole M. G., Yaffe M. J.: Pathway to psychiatric care of the elderly with depression. //Int. J. Geriatr. Psychiatry. – 1996. – Vol.11. – P. 157-161*
3. *Blazer D. Depression in the elderly. // N. Engl. J. Med. – 1989. Vol. 320. - P. 164-166*
4. *Steffens D. C., Skoog I., Norton M. C. et al. Prevalence of depression and its treatment in an elderly population: the Cache County study. // Arch Gen Psychiatry. – 2000. – Vol.57(6). – P.601–607.*
5. *Abhishekh H. A., Raghuram K., Shivakumar S., Balaji A. L. Prevalence of depression in community dwelling elderly: Study from rural population of India.// J. Neurosci. Rural. Pract. – 2013. – Vol. 4. – P. 138. Available from: http://www.ruralneuropractice.com/text.asp?2013/4/5/138/116470*
6. *Заклади охорони здоров'я та захворюваність населення України у 2011 році: Статистичний бюлетень. — К.: Державна служба статистики України, 2012. — 89 с.*
7. *Медикодемографічна ситуація та організація медичної допомоги населенню у 2010 році: підсумки діяльності системи охорони здоров'я та реалізація Програми економічних реформ на 2010–2014 роки «Заможне суспільство, конкурентоспроможна економіка, ефективна держава». — К.: МОЗ України, 2011. — 104 с.*
8. *Актуальні питання геронтопсихіатрії: навчальний посібник / [І. Я. Пінчук, В. В. Чайковська, Л. А. Стадник, О. А. Левада, М. М. Пустовойт, М. І. Ширяєва]. — Тернопіль: Термограф, 2010. — 431 с.*
9. *Пинчук И. Распространенность психических расстройств в Украине / И. Пинчук // Журн. АМН Украины. — 2010. — Т. 16, № 1. — С. 168176.*
10. *Пінчук І. Я. , Хаустова О. О. Проблема депресії в аспекті охорони психічного здоров'я осіб похилого віку // Вестник ассоциации психиатров Украины. – 2013. - №3. – http://www.mif-ua.com/archive/article_print/36851*
11. *Chan S. W., Chien W. T., Thompson D. R. et al. Quality of life measures for depressed and non-depressed Chinese older people.// Int J Geriatr Psychiatry. -2006. – Vol. 21(11). – P. 1086–1092.*
12. *Barry L. C., Soulos P.R., Murphy T. E. et al. Association Between Indicators of Disability Burden and Subsequent Depression Among Older Persons.// J. Gerontol. A. Biol. Sci. Med. Sci. -2013. – Vol. 68 (3). – P. 286-292.*
13. *Katon W. J., Lin E. H., Von Korff M., Collaborative care for patients with depression and chronic illnesses.// N. Engl. J. Med. – 2010. – Vol. 363 (27). – P.2611-2620.*
14. *Tengab P., Yehcd C., Leeae M. et al. Depressive symptoms as an independent risk factor for mortality in elderly persons: Results of a national longitudinal study. // Aging & Mental Health. – 2013. – Vol. 17. – P. 470-478.*
15. *Alexopoulos G. S., Katz I. R., Reynolds C. F. Pharmacotherapy of depression in older patients: a summary of the expert consensus guidelines. // J. Psychiatr. Pract. – 2001. – Vol. 7(6). – P.361–376.*
16. *Gallo J. J, Morales K. H, Bogner H. R. et al. Long term effect of depression care management on mortality in older adults: follow-up of cluster randomized clinical trial in primary care.// BMJ. – 2013. – Vol. 346. – f 2570. Published online 2013 June 5. doi: 10.1136/bmj.f2570*
17. *Yohannes A. M., Lavoie K. L. Overseeing Anxiety and Depression in Patients With Physical Illness.// Chest. – 2013. – Vol.144 (3). - P. 726-728.*
18. *Дзюба О. М., Бушинська О. В., Кардашов В. П., Тарновецька К. І., Прохорова О. В. Проблемні питання в курації психічних розладів у пацієнтів з хронічними неінфекційними захворюваннями //Архів психіатрії. - 2013. - Т. 19, № 2 (73). – С. 31 - 34*
19. *Richard E., Reitz C., Honig L.H. et al. Late-Life Depression, Mild Cognitive Impairment, and Dementia.// JAMA Neurol. – 2013. – Vol. 70(3). – P.383-389.*
20. *Weyerer S., Eifflaender-Gorfer S., Wiese B. et al. Incidence and predictors of depression in non-demented primary care attenders aged 75 years and older: results from a 3-year follow-up study// Age Ageing. – 2013. -doi: 10.1093/ageing/afs184First published online: January 11, 2013*
21. *Joubert L., McKeeverb U., Holland L. Caring for Depressed Elderly in the Emergency Department: Establishing Links Between Sub-Acute, Primary, and Community Care.// Social Work in Health Care. – 2013. – Vol. 52. – P. 222-238.*
22. *Wetherell J. L., Unützer J. Adherence to treatment for geriatric depression and anxiety. // CNS Spectr. – 2003. – Vol. 12(suppl 3). – P. 48–59.*
23. *Cuijpers P., van Straten A., Warmerdam L. et al. Psychotherapy versus the combination of psychotherapy and pharmacotherapy in the treatment of depression: a meta-analysis. // Depress. Anxiety. – 2009. – Vol. 26(3). – P. 279–288.*
24. *Alexopoulos G. S., Raue P. J., Kanellopoulos D. et al. Problem solving therapy for the depression-executive dysfunction syndrome of late life. //Int. J. Geriatr. Psychiatry. – 2008. – Vol. 23(8). – P.782–788.*
25. *Stone M., Laughren T., Jones M. L. et al. Risk of suicidality in clinical trials of antidepressants in adults: analysis of proprietary data submitted to US Food and Drug Administration. // BMJ. – 2009. – Vol.339. -b2880.*
26. *Raskin J., Wiltse C. G., Sheikh J. et al. Efficacy of duloxetine on cognition, depression, and pain in elderly patients with major depressive disorder: an 8-week, double-blind, placebo-controlled trial. //Am. J. Psychiatry. – 2007. – Vol. 164(6). – P.900–909.*
27. *Jeste D. V., Blazer D., Casey D. et al. ACNP White Paper: update on use of antipsychotic drugs in elderly persons with dementia. // Neuropsychopharmacology. – 2008. – Vol. 33(5). – P.957–970.*
28. *Simoni-Wastila L, Ryder PT, Quian J, et al. Association of antipsychotic use with hospital events and mortality among medicare beneficiaries residing in long-term facilities. Am J Geriatr Psychiatry. 2009;17(5):417–427.*
29. *Kales J. C., Valenstein M., Kim H. M. et al. Mortality risk in patients with dementia treated with antipsychotics versus other psychiatric medications. //Am. J. Psychiatry. – 2007. – Vol. 164(10). – P.1568–1576.*
30. *Berman RM, Fava M, Thase ME, et al. Aripiprazole augmentation in major depressive disorder: a double-blind, placebo-controlled study in patients with inadequate response to antidepressants. CNS Spectr. 2009;14(4):197–206.*
31. *Rush AJ, Warden D, Wisniewski SR, et al. STAR*D: revising conventional wisdom. CNS Drugs. 2009; 23(8):627–647.*

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Summary. Late-life depression negatively affect patients with chronic non-communicable diseases, increase cognitive impairment, are the causes of suffering and disability, worsens the prognosis of many systemic diseases and increases mortality. In turn, negative life events, disability, isolation contributes to pathological processes, increasing the susceptibility to depression or triggering depression in vulnerable older people. This is a problem for many countries , including Ukraine. The results of our pilot study also confirm the importance of the problem of depression in the elderly. Evidence-based guidelines to prevent new episodes of depression, quality of diagnosis and improve the treatment of late-life depression are available. For the treatment of geriatric unipolar nonpsychotic depression are recommended antidepressants plus psychotherapy . Antidepressant plus atypical antipsychotics is the first-line recommendation for geriatric psychotic depression. The combination of psychotherapy and antidepressant medication for the treatment of both mild and severe geriatric depression continues to be a first-line therapy. Psychotherapy is an effective treatment for depression in old age and can especially help with medication compliance and prevention of relapse. More research is needed in the elderly to determine the safest and most effective strategies for late-life depression .

Keywords: depressiom, anxiety, comorbidity, somatics, diagnosis, treatment

ДЕПРЕССИЯ У ПОЖИЛЫХ ПАЦИЕНТОВ

Е. А. Хаустова

Резюме. Депрессии позднего возраста негативно влияют на пациентов с хроническими неинфекционными заболеваниями, усиливают когнитивные нарушения, являются причинами страданий и инвалидизации, ухудшают прогноз многих соматических заболеваний и увеличивают смертность. В свою очередь, негативные жизненные события, инвалидность, изоляция способствует патологическим процессам, увеличивая склонность к депрессии или инициируя депрессию у уязвимых пожилых людей. Эта проблема актуальна для многих стран, включая Украину. Результаты нашего пилотного исследования также подтверждают актуальность проблемы депрессии у пожилых людей. Разработаны научно обоснованные рекомендации для предотвращения новых эпизодов депрессии, повышения качества диагностики и улучшения лечения депрессии позднего возраста. Для лечения монополярной непсихотической гериатрической депрессии рекомендуются антидепрессанты плюс психотерапия. Антидепрессант плюс атипичные антипсихотики является первой линии рекомендации для гериатрических психотических депрессий. Сочетание психотерапии и антидепрессантов для лечения как легкой, так и тяжелой гериатрической депрессии продолжает быть первой линии терапии. Психотерапия является эффективной для лечения депрессии позднего возраста и может особенно помочь с соблюдением приема лекарств и профилактикой рецидивов. Необходимы дополнительные исследования у пожилых людей для определения безопасных и эффективных стратегий для депрессии позднего возраста.

Ключевые слова: депрессия, тревога, коморбидные заболевания, неинфекционные болезни, диагностика, лечение

ДЕПРЕСІЯ У ЛІТНІХ ПАЦІЄНТІВ

О. О. Хаустова

Резюме. Депресії пізнього віку негативно впливають на пацієнтів із хронічними неінфекційними захворюваннями, посилюють когнітивні порушення, виявляються причинами страждань та інвалідизації , погіршують прогноз багатьох соматичних захворювань і збільшують смертність. У свою чергу, негативні життєві події, інвалідність, ізоляція сприяють патологічним процесам, збільшуючи схильність до депресії або ініціюючи депресію у вже вразливих людей похилого віку Ця проблема актуальна для багатьох країн, включаючи Україну. Результати нашого пілотного дослідження також підтверджують актуальність проблеми депресії у літніх людей. Розроблено науково обгрунтовані рекомендації для запобігання новим епізодам депресії, підвищення якості діагностики та покращення лікування депресії пізнього віку. Для лікування уніполярної непсихотичної геріатричної депресії рекомендуються антидепресанти плюс психотерапія. Антидепресант плюс атипові антипсихотики є першою лінією рекомендації для геріатричних психотичних депресій. Поєднання психотерапії та антидепресантів для лікування як легкої, так і складної геріатричної депресії продовжує бути першою лінією терапії. Психотерапія є ефективною для лікування депресії пізнього віку і може особливо допомогти з дотриманням прийому ліків і профілактикою рецидивів . Необхідні додаткові дослідження у літніх людей для визначення безпечних і ефективних стратегій для депресії пізнього віку .

Ключові слова: депресія, тривога, коморбідні захворювання, неінфекційні хвороби, діагностика, лікування