Old age depression: Do we need a special approach

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Clinical pharmacological management of polypharmacy in old age depression

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Polypharmacy is the rule in psychogeriatric patients, as they present frequently comorbidities such as depression, dementia [often including Behavioral and Psychological Symptoms of Dementia (BPSD)] and somatic diseases. Recommended treatments for geriatric depression are antidepressant medications, psychotherapy and psychosocial interventions [1]. Besides antidepressants, other psychotropic drugs are often co-prescribed, but somatic drugs are also needed for the treatment of other concomitant diseases. This situation increases the risk for adverse effects due to pharmacokinetic and pharmacodynamic interactions, especially since the organism of elderly patients displays a lowered homeostatic reserve and a decrease of functions, which allows resisting to xenobiotic influences.
On the other hand, there are also studies which suggest that in hospitalized psychogeriatric patients, the incidence of severe adverse reactions is lower in patients > 60 y than in those < 60 y [2]. This is one of the results of the AMSP-study group, which in German speaking countries has developed a pharmacovigilance program in psychiatric hospitals.
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Physical comorbidity and consequences for mortality and treatment

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Introduction Ageing is related to an increase rate of physical comorbidity. However, the interaction between physical comorbidity and the development of depression in the elderly is not yet clear. Depression may be the cause or consequence of physical morbidity. Both may increase mortality.
Methods A total of 9604 patients with depression and a control sample of 96040 patients who attended a general hospital were followed-up for up to 12 years. Physical comorbidity and mortality was assessed.
Results Twenty-nine physical disorders were more prevalent in subjects with depression, but the effect of individual disorders on mortality did not differ significantly in the depressed and control sample.
Conclusions Patients with depression suffer more physical health problems than control patients that lead to death. The implications for early treatment will be discussed, a preventative approach may be most relevant.
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Distinction of dementia and depression in various stages of the disease processes

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Old age depression is often difficult to discriminate from dementia (particularly of Alzheimer type) – particularly cross-sectionally. Incident dementia is frequently associated with depressed mood and agitation; depression in the elderly goes together with executive and memory dysfunctions; associated psychotic symptoms and activity-of-daily-life dysfunctions are shared by both conditions as well as major risk factors as vascular and metabolic factors. Frequently both syndromes are "masking" each other; depression may furthermore present as the first clinical sign of Alzheimers disease. Yet, both clinical syndromes/disorders emerging from quite different are pathogenic neurobiological mechanisms with differentiating neuropsychological, – imaging and – chemical features. Clinical tools can be derived and enable accurate differential diagnosis. Thus, the distinction between both syndromes is a first instance for biomarker supported differential diagnoses in psychiatry.
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Overcoming the stigma of mental illness: Current proceedings and initiatives

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Seven years after ratification of the UNCRPD: Are there any advances for patients with mental health conditions?

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The Convention on the Rights of Persons with Disabilities (CRPD) is the first highest international legally-binding standard which aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, including those with mental health conditions, and to promote respect for their inherent dignity. The CRPD embodies a 'paradigm shift', from the charitable and the medical approaches to disability to one, which is firmly rooted in human rights. It provides a clear path towards non-discrimination, full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity, equality of opportunity and accessibility just to name a few.
States which have signed the CRPD have an obligation to respect, protect and fulfil the internationally agreed upon set of standards

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guaranteed to all people included in the Convention. However, even in signatory states, violations often occur behind "closed or open doors" and go unreported and consequently unprevented. The growing number of people with mental health conditions in the world has further contributed to a level of attention paid to quality and human rights conditions in both outpatient and inpatient facilities, which has never been greater. Persons with mental health conditions need both de jure human rights protection and de facto human rights practices.

Seven years after the CRPD came into force the care available in many mental health facilities around Europe is still not only of poor quality but in many instances hinders recovery. The level of knowledge and understanding by staff of the rights of people with mental disabilities is very poor. It is still common for people to be locked away or to be chained to their beds, unable to move. Inhuman and degrading treatment is common, and people in facilities are often stripped of their dignity and treated with contempt. Violations are not restricted to inpatient and residential facilities; many people seeking care from outpatient and community care services are disempowered and also experience extensive restrictions to their basic human rights.

In the wider community, many people with mental disabilities are still denied many basic rights that most people take for granted. For example, they are denied opportunities to live where they choose, marry, have families, attend school and seek employment. There is a commonly held, yet false, assumption that people with mental health conditions lack the capacity to assume responsibility, manage their affairs and make decisions about their lives. These misconceptions contribute to the ongoing marginalization, disenfranchisement and invisibility of this group of people in their communities.

One of the underlying reasons it is difficult to move through the obstacles to fully embrace the CRPD, is that discrimination continues to affect people with mental health conditions on many levels. Changing laws is only a partial solution. We have to change the ways that we relate to each other at every level, and to offer people information and tools to make the transition to a more equitable social reality.

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Promoting stigma coping and empowerment: Results from the multi-center clinical trial STEM

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Introduction The stigma of mental illness is still a major challenge for psychiatry. For patients, stigma experiences and self-stigma are associated with reduced quality of life and increased vulnerability to a more chronicle illness course. Nevertheless, there is a scarcity of validated therapeutic approaches addressing strategies for coping with stigma.

Objectives and aims A manualized psycho-educational group therapy for stigma coping and empowerment (STEM) should be tested for efficacy in patients with depression and schizophrenia. The study was funded by a research grant of the Federal Ministry of Education and Research.

Methods A cluster-randomized RCT with two arms including 30 mental health care services (psychiatric inpatient services, day-units, and outpatient services, as well as inpatient psychiatric rehabilitation services) was conducted. The intervention consisted of 8 sessions regular psycho-education group therapy and 3 sessions addressing stigma coping and empowerment. Controls received 11 sessions regular psycho-education. Primary outcome variable was quality of life (WHO-QOL). Assessments were conducted directly before and after the intervention, and at 3, 6 and 12 months follow-ups.

Results A total of 469 patients participated and more than 300 participants (approx. 65%) completed the 12-month follow-up. First results of the analysis will be presented at the conference.

Conclusions Since the statistical analysis is currently in progress, no conclusions concerning the efficacy of the tested therapeutic approach can be done by now. Nevertheless there is a strong need for supporting patients in developing positive stigma coping strategies. STEM is the first therapeutic approach to our knowledge tested for efficacy in a RCT.

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Phenomenology of anxiety

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Temporality and spatiality of anxious experience

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Since the first descriptions of anxiety, it has been related with temporality and in particular with the dimension of future. Thus, we already find anxiety defined as a general feeling of threatening (from the future) in the German mystic Jakob Boehme (1575–1634). He also used the image of "the wheel of anxiety", with which he refers to its probable origin in a conflict between two forces which tend to separate themselves and are not able to do it, as a result from this centrifugal rotation movement of a wheel. This image also has a temporal character. In Kierkegaard, we read that "anxiety is always related with the future. . . and when we are disturbed by the past we are basically projecting toward the future. . ." In Heidegger's masterpiece, "Being and Time", there is a chapter dedicated to the temporality of Befindlichkeit, and in particular to anxiety. Fear and anxiety have their roots, according to Heidegger, in the past, but their relation with the future makes them different: anxiety arises from the future as possibility, while fear arises from the lost present. In this paper, we try to make a contribution to the phenomenology of temporality (and of spatiality) of anxiety in relation with the analysis of a concrete anxiety experience: flight phobia. The analysis allows us to show both the desolation and narrowing of anxiety space, and with respect to temporality, the disappearance of every plan (the future), of every history (the past), and the reduction of the present to a succession of mere punctualities, behind which there arises, threatening, the nothingness itself.

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Being on the edge: The psychopathology of the accelerated, agitated and anxious subject

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