Apathy in Late-Life Depression: Common, Persistent, and Disabling

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Objectives: *The aims of this study were to examine: (1) the relationship between apathy and disability in late-life depression, and (2) the functional significance of improvement in apathy following escitalopram treatment in terms of its relationship to disability.* **Methods:** *Subjects were 71 non-demented elderly with non-psychotic major depression. After a 2-week single-blind placebo period, subjects who had Hamilton Depression Rating Scale (HDRS) ≥18 received escitalopram 10 mg daily for 12 weeks. Apathy and disability were assessed with the Apathy Evaluation Scale (AES) and the World Health Organization Disability Assessment Scale II (WHODAS), respectively. These measures and the HDRS were administered at baseline and again following 12 weeks of treatment.* **Results:** *At baseline, 38% of depressed subjects had significant apathy (AES ≥36.5). Severity of apathy at baseline significantly correlated with severity of disability. In a multivariate regression model, baseline severity of apathy, but not the overall depressive syndrome (HDRS), significantly correlated with baseline disability. Following escitalopram treatment, improvement in apathy significantly correlated with improvement in disability measures, while change in the rest of the depressive syndrome did not. The overall change in apathy and disability in response to escitalopram treatment was significant but small.* **Conclusions:** *Apathy is common in late-life depression and is associated with disability above and beyond the influence of other depressive symptoms. Given the strong relationship between apathy and disability, understanding the neurobiology of apathy and developing treatments for apathy may improve the functional outcomes of late-life depression.* (Am J Geriatr Psychiatry 2014; ■:■−■)

Key Words: Apathy, amotivation, atypical depression, geriatric, function, disability

Late-life depression is challenging to treat. Developing effective treatments calls for the study of meaningful dimensions of this illness that directly affects clinical outcomes such as disability.

Apathy afflicts many older adults who suffer from late-life depression. Its presence predicts poor response of depressive symptoms to treatment and chronicity of depression.[1–3] Clinically significant

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apathy occurs in more than 30% of individuals with major depression, and is most prevalent in depressed older adults.[4–8] The syndrome of apathy is defined as a primary motivational impairment that, in depression, results in diminished goal-directed behavior, lack of intellectual interest, and indifference or flattening of affect.[9] These clinical signs translate into apathetic, depressed patients being poorly engaged, being more difficult to treat, and posing a greater burden to caregivers.[4,10]

In a previous analysis, we found that escitalopram only modestly improved apathy in a small sample of older depressed individuals.[11] Defining the clinical significance of apathy and of its improvement after treatment with escitalopram may contribute further to the identification of apathy as a clinically meaningful dimension of the late-life depressive disorder. Thus, this study examined the contribution of apathy to disability relative to the rest of the late-life depressive syndrome, and the functional significance of change in apathy following escitalopram treatment with respect to its effect on disability outcomes.

METHODS

Subjects

Subjects were 71 depressed older adults (age >60 years) from a university geriatric psychiatry clinic recruited from the community through radio and print advertisements for an escitalopram treatment trial. Subjects met DSM-IV-TR criteria for unipolar depression without psychotic features and had a score of 18 or higher on the 24-item Hamilton Depression Rating Scale (HDRS)[12] after a 2-week drug washout/placebo lead-in.

Exclusion criteria were: (1) history of other axis I psychiatric disorders prior to the onset of depression; (2) Mini-Mental State Examination (MMSE) score less than 24;[13] (3) mild cognitive impairment (MCI) according to criteria described by Petersen et al.;[14] (4) severe medical illness (i.e., metastatic cancer; brain tumors; unstable cardiac, hepatic, or renal disease; myocardial infarction; or stroke) within the 3 months preceding the study; (5) neurological disorders (i.e., dementia, delirium, history of head trauma, Parkinson disease, and multiple sclerosis); (6) diseases often associated with depression (i.e., endocrinopathies other than diabetes, lymphoma, and pancreatic cancer); and (7) treatment with drugs associated with depression (i.e., steroids, α-methyl-dopa, clonidine, reserpine, tamoxifen, and cimetidine). All subjects signed written and informed consent approved by the institutional review board of Weill-Cornell Medical College.

Treatment

After a 2-week drug washout and single-blind placebo lead-in period, subjects who still met DSM-IV-TR criteria for major depression and had an HDRS score 18 or higher received escitalopram 10 mg daily for 12 weeks. Subjects were assessed weekly throughout the treatment trial. Assessment consisted of a brief meeting with a research psychiatrist and ratings by a trained research assistant using the HDRS, a medication adherence questionnaire, and a vital signs form. The meeting with the research psychiatrist followed a medication clinical format focusing on psychiatric symptom and side effect evaluation. No participants received psychotherapy.

Measures

Major depressive disorder was diagnosed based on the Structured Clinical Interview for DSM-IV-R, administered at entry to the study. Depressive symptoms were assessed with the HDRS. Apathy was quantified using the self-rated Apathy Evaluation Scale (AES), a psychometrically validated instrument in older normal individuals and psychiatric patients.[15,16] Overall cognitive impairment was examined in a clinical interview and rated with the MMSE[13] and the Dementia Rating Scale (DRS).[17] Chronic co-morbid medical illness burden was rated with the Charlson Comorbidity Index.[18] Disability was rated with the World Health Organization Disability Assessment Schedule version II (WHO-DAS).[19] All measures were collected at baseline and again following 12 weeks of escitalopram treatment.

Data Analysis

Statistical analysis was performed with SPSS 19.0 (SPSS, Inc., Cary, NC). Mann-Whitney U, t tests, and paired sample t tests were used to analyze demographic and clinical aspects of the patient sample, and to quantitatively compare outcome measures