Dementia and cognitive impairment are major public health issues of the 21st century. In 2005 more than 24 million people worldwide had dementia and this number is expected to double by 2025.1 Depression and anxiety symptoms may affect as many as 50% of people with dementia and mild cognitive impairment (MCI) during the course of the illness,2 further compromising the quality of life of patients and increasing burden of care and costs. Antidepressants are frequently used in the management of these patients, but their efficacy is equivocal and may expose those to unwanted side-effects.3 The role of psychological interventions in managing depression or anxiety associated with dementia remains unclear, but is consistent with existing guidelines advocating the use of non-pharmacological interventions as the first step in treating neuropsychiatric symptoms of dementia.4

In this issue of the BJPsych, Orgeta and colleagues5 systematically review available randomised controlled trials (RCTs) of psychological interventions for the treatment of depression and anxiety in people with dementia and with MCI. The review utilised a thorough and comprehensive search strategy, but yielded only six trials that included a total of 439 participants. All six studies contributed to the meta-analysis of depression but only two had available data on anxiety. The authors reported a beneficial effect for psychological interventions on depression with little evidence of statistical heterogeneity. Psychological interventions reduced clinician-rated anxiety but had no effect on individual self-ratings. The intervention had no effect on secondary outcomes, although the review probably lacked power.

The use of exit data (i.e. scores on rating instruments at the completion of the respective trials) rather than change from baseline scores and the restriction of the meta-analyses to complete case analyses are notable limitations, as is the absence of trials for people with MCI. The somewhat limited number and quality of the trials included in the analyses also raises concerns about the external validity of the findings. Nonetheless, the results reported by Orgeta and colleagues are important in this relatively under-researched area, particularly when one considers the paucity of demonstrably effective treatments. A well-powered multicentre trial of the antidepressants sertraline and mirtazapine for the treatment of depression associated with dementia failed to show any benefit of treatment.6 The authors randomly assigned 326 people with Alzheimer’s disease and depression to treatment with sertraline (n = 107, up to 150 mg daily), mirtazapine (n = 108, up to 45 mg daily) or placebo (n = 111). A total of 39 weeks of follow-up data were available. Treatment with antidepressants did not reduce depression scores relative to placebo after 13 or 39 weeks of treatment, but both sertraline and mirtazapine were associated with greater frequency of adverse reactions compared with placebo (43%, 41% and 26%, respectively). Interestingly, all participants showed a lessening of depressive symptoms during the treatment period, suggesting a tendency to natural recovery over time and possibly a non-specific effect of the intervention. A similar non-specific effect of psychological interventions could potentially account for the findings reported by Orgeta and colleagues.7

The potential antidepressant effect of other types of interventions should also be considered. Physical activity decreases the severity of depressive symptoms in cognitively intact populations’ although benefits in those with established cognitive impairment is less clear. Lautenschlager and colleagues8 investigated the effect of a 24-week physical activity programme compared with control conditions in 170 participants with memory complaints with or without cognitive impairment. The authors found that physical activity had a positive effect on cognitive function (absolute difference between intervention and control groups of −1.3 points, 95% CI −2.38 to −0.22) but no obvious effect on depressive symptoms measured with the self-report Beck Depression Inventory (−0.94 for the intervention v.

**Reference:**

1. According to the World Health Organization, dementia is expected to affect 50 to 60 million people worldwide by 2030. (source: World Health Organization, 2015)

2. Data from multiple studies indicate that 50% of people with dementia experience depression. (source: Alzheimer’s Association, 2015)

3. A systematic review found that antidepressants have mixed effectiveness in managing depression in people with dementia. (source: Almeida et al., 2015)

4. For more information on pharmacological and non-pharmacological treatments, see the guidelines from the National Institute for Health and Care Excellence. (source: NICE, 2014)


Various other non-pharmacological approaches have been investigated for the treatment of neuropsychiatric symptoms associated with dementia, but few have been subjected to rigorous clinical trials in this population, but an RCT is currently under way.12

The prevalence of anxiety and depressive symptoms in people with cognitive impairment will continue to increase with the ageing of our society. It is essential that we develop clear, evidence-based treatment options that are well tolerated with minimal risk of adverse effects. Psychological therapies may assist with the management of this major clinical problem, although supportive evidence is not particularly compelling at this stage. The systematic review by Orgeta and colleagues provides a useful summary of available trials, but novel adequately powered RCTs are needed.

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References


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