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Psychotic depression in older adults following the sudden loss of a spouse during the COVID-19 pandemic: a case series

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Background. Little is known about the relationship between sudden loss, social isolation, and onset of major depressive disorder (MDD) with psychotic features. We report two cases of MDD with psychotic features that developed in older women after the sudden loss of a spouse in the setting of social isolation in the COVID-19 pandemic.
Case reports. Both women were brought to stay with family after their symptoms were discovered. Both experienced remission of symptoms on the combination of an antidepressant and a relatively low dose of risperidone (1.5-2 mg daily). Neuropsychological assessments were typical of normal ageing.
Conclusions. These cases suggest that unexpected loss and social isolation may precipitate psychotic depression, and providers may want to recommend social engagement for older adults experiencing bereavement.

Key words: psychosis, depression, geriatric, loss, isolation, COVID-19

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INTRODUCTION

Throughout the coronavirus disease 2019 (COVID-19) pandemic, communities have experienced sudden and unexpected death at unprecedented rates, and the restrictions in place to mitigate viral transmission have reduced opportunities for typical social support [1,2]. Stay-at-home mandates and social distancing have led to increased social isolation and limited opportunities for cultural and religious death rituals [1,2]. Research has shown increased rates of severe grief reactions during the pandemic, and the COVID-19 Mental Disorders Collaborators conclude that, throughout 2020, the pandemic led to a 27.6% increase in cases of major depressive disorders globally [3-5]. Among older adults in particular, unexpected loss and mood disorders, such as major depression, frequently co-occur [6]. However, little is known about the relationship between unanticipated bereavement, social isolation, and onset of major depressive disorder (MDD) with psychotic features. It is important to investigate this, because MDD with psychotic features in older adults causes great suffering and disability and is considered a difficult-to-treat condition [7].
Thus, we report on two older women with no prior psychiatric history who developed MDD with psychotic features after suddenly losing a spouse during

the pandemic. Both had previously led active social lives but experienced social isolation during their acute grief. Both presented to an outpatient geriatric psychiatrist after out-of-state family recognized their distress, brought them to stay with them, and pursued care. Verbal consent for publication was obtained from both patients.

CASE 1

An 81-year-old woman with no prior psychiatric history and medical history of hypertension, hyponatremia, and postoperative hypothyroidism experienced the unexpected loss of her husband of 59 years. She then developed anhedonia, anxious preoccupations about her health, and somatic delusions that her bowel movements indicated a fatal illness. She stopped tending to instrumental activities of daily living, including cooking, shopping, managing her finances, and driving, because she worried about making a mistake. Family became aware of her condition when she made daily phone calls voicing somatic delusions, which involved concerns related to the frequency of her bowel movements, beliefs that she had lost an excessive amount of weight, and overall fear of imminent death.

Six months after her husband's death, she presented for psychiatric care, and her presentation was concerning for MDD with anxious distress and psychotic features. She was started on duloxetine 20 mg daily to target anxiety and concern for depression. On her next visit a few weeks later, she reported high levels of distress with paranoia regarding the safety of her family members and worsened perseveration about her bowel movements and eating habits. Duloxetine was stopped, and quetiapine was titrated to 50 mg total daily dose to target her delusions. When she had not noticed any benefit a week later, she agreed to voluntary inpatient psychiatric hospitalization for acute stabilization. While hospitalized, labs were unrevealing, and brain MRI from an outside facility was unremarkable. Quetiapine was titrated up to a total daily dose of 200 mg, but it was discontinued when she had orthostatic hypotension and unremitting delusions involving beliefs that her family abandoned her, she was never leaving the hospital, and she was eating the wrong types of foods that were causing constipation, despite no objective evidence of constipation.

Once started on risperidone, which was titrated up to 1.5 mg daily, escitalopram 10 mg daily, and gabapentin 600 mg three times daily, she had complete remission of symptoms and was discharged to live with family. Neuropsychological assessment two months after hospitalization revealed intact cognition without indication of a neurodegenerative disorder. She remained in symptomatic remission until returning home, but then developed recurrence of depression and somatic preoccupations due to reminders of her husband, social isolation, and intense feelings of loneliness. After transitioning to an assisted living facility, she again reached full remission of symptoms. She remains in full symptomatic remission on a medication regimen of olanzapine 5 mg at bedtime, escitalopram 20 mg daily, and gabapentin 300 mg twice daily.

CASE 2

A 72-year-old woman with no prior psychiatric history and medical history of breast cancer in remission and hyperlipidemia experienced the unexpected loss of her husband. One month later, she developed profound insomnia and amotivation. This progressed to vivid "visions" involving demons and spirits, which she only saw when she closed her eyes. Over time, she began visualizing, hearing, and talking to them even when her eyes were open. She made out their voices commenting on what she was doing and predicting her behavior. Her family was made aware of her distress when she called to ask if they were causing demons to haunt her.

Eight months after her husband's death, she presented for psychiatric care, and her presentation was concerning for MDD with psychotic features. She was started on quetiapine 25 mg at bedtime for psychosis and sleep and sertraline, which was titrated up to 50 mg daily to target depression. A few weeks later, she agreed to voluntary inpatient psychiatric hospitalization for acute stabilization when she experienced worsening of auditory hallucinations and paranoid delusions about her family members' intentions. While hospitalized, labs were unremarkable. Brain MRI showed moderate chronic microvascular changes without any findings that would account for her symptoms. She was unable to tolerate quetiapine or olanzapine due to sedation.

She ultimately experienced rapid improvement and total remission of symptoms on risperidone 2 mg daily and sertraline 100 mg daily. Four months later, neuropsychological assessment revealed subtle deficits in attention, but otherwise grossly intact cognition, without evidence of a neurodegenerative disorder. The patient's symptoms remain in remission on a medication regimen of risperidone 0.5 mg at bedtime and sertraline 50 mg daily. She lives independently and maintains daily face-to-face contact with family and others at her church and gym.

DISCUSSION

These cases include striking similarities in presentation and treatment response. For both, psychosis was the

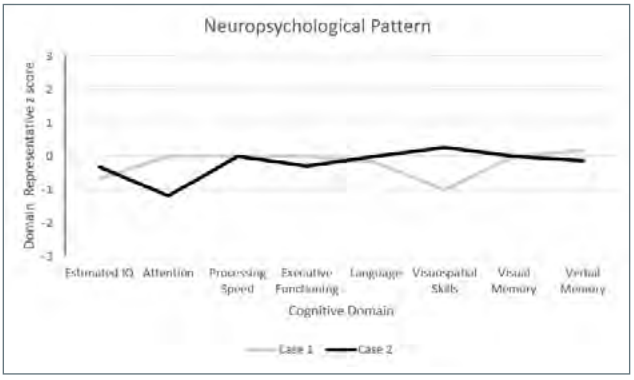

Figure 1. Neuropsychological pattern.

heralding symptom recognized by family after months of depression endured in social isolation. Although a neurodegenerative cause was suspected, neuropsychological assessments were more typical of normal ageing (Fig. 1).

We speculate that the courses of grief would have been different if not for the isolation necessitated by the pandemic. For example, both patients were interested in attending church-led grief support groups, but they were cancelled due to social distancing. We also suspect that milder depressive symptoms would have been noticed by loved ones earlier on in the setting of more normal social contact.

Based on these cases, providers may want to consider preventative interventions to mitigate the risk of MDD with psychotic features among older adults experiencing acute grief, a recommendation particularly important during the COVID-19 pandemic [1]. Specifically, it may be prudent for providers to recommend avenues for social engagement, such as consistent communication with loved ones, peer support groups, grief psychotherapy, and local senior center activities or other community initiatives, in the comprehensive treatment plan for older adults experiencing bereavement.

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Conflict of interest

The Authors declare no conflict of interest.

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Author contributions

All the Authors contributed in the development of this manuscript.

Ethical consideration

Verbal consent for publication was attained from both patients reported on.

References

1 Goveas JS, Shear MK. Grief and the COVID-19 Pandemic in older adults. Am J Geriatr Psychiatry 2020;28:1119-1125. https://doi.org/10.1016/j.jagp.2020.06.021

2 Eisma MC, Tamminga A. Grief before and during the COVID-19 pandemic: multiple group comparisons. J Pain Symptom Manage 2020;60:e1-e4. https://doi.org/10.1016/j.jpainsymman.2020.10.004

3 Eisma MC, Tamminga A, Smid GE, et al. Acute grief after deaths due to COVID-19, natural causes and unnatural causes: an empirical comparison. J Affect Disord 2021;278:54-56. https://doi.org/10.1016/j.jad.2020.09.049

4 Mayland CR, Harding AJE, Preston N, et al. Supporting adults bereaved through COVID-19: a rapid review of the impact of previous pandemics on grief and bereavement. J Pain Symptom Manage 2020;60:e33-e39. https://doi.org/10.1016/j.jpainsymman.2020.05.012

5 Daly M, Robinson E. Depression and anxiety during COVID-19. The Lancet 2022;399:518. https://doi.org/10.1016/S0140-6736(22)00187-8

6 Keyes KM, Pratt C, Galea S, et al. The burden of loss: unexpected death of a loved one and psychiatric disorders across the life course in a national study. Am J Psychiatry 2014;171:864-871. https://doi.org/10.1176/appi.ajp.2014.13081132

7 Gournellis R, Oulis P, Howard R. Psychotic major depression in older people: a systematic review. Int J Geriatr Psychiatry 2014;29:784-796. https://doi.org/10.1002/gps.4065