Late-Onset Agitated Depression With Anxious and Obsessive Features Triggered by Parental Decline: A Case for Integrated Pharmacology, Neuromodulation, and Psychodynamic Treatments

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Introduction

- Late-onset depression (onset after age 60) frequently presents with prominent anxious and obsessive features, complicating diagnosis and treatment (1, 2). This subtype often shows lower cognitive performance and lower response to standard pharmacotherapy (3, 6). Psychosocial stressors such as losing caregiving role or witnessing a parent's decline may act as critical triggers, disrupting identity and worsening mood (7, 9). Electroconvulsive therapy (ECT) remains a safe and effective option for severe, treatment-resistant late-life depression, with efficacy in relapse prevention and usually manageable cognitive side effects (5, 4, 8).
- We present a case of 65-year-old male veteran with no past psychiatric history but a late onset seizure disorder who developed severe, treatment-resistant depression after witnessing his mother's decline. His case illustrates the interaction between biological predisposition, obsessive traits, and psychodynamic conflict, leading to ECT and multiagent pharmacotherapy. This poster highlights clinical decision-making in complex late-onset mood disorders.

Case Presentation

Patient Profile	Initial Presenting Symptoms
Age/Sex: 65-year-old male	**Onset:** Sudden. Patient describes "switch flipped"
Occupation: Retired military (21.5 years)	**Symptoms:**
Marital Status: Married 3 times; current 5.5 years	- Panic-like anxiety, racing thoughts, intense fear
Support System: Wife, 2 sisters, brother-in-law (driver/companion)	- Severe insomnia, rapid weight loss
Medical History: Seizure disorder since 61, on Levetiracetam.	- Emotional numbness, anhedonia
Psych History: None prior to recent onset few months ago. Mother had history of depression and was/is a "negative person"	- Passive suicidal ideation (no active plan; strong faith)
Substance Use: Denies alcohol, tobacco, drugs	- Frequent pacing (esp. pre-lorazepam)
Social: No pets, limited contacts, wife with cognitive impairment and speech difficulties from remote MVA	- Multiple daily panic attacks, irritability
Personality/Hobbies: Type A, compulsive, busy; historically even-keeled. Former photography; now reads Bible	**Family Insight**: Isolation increased 2 years prior
Diet: Homemade, picky; low-calorie meals (salmon, quinoa, pears, yogurt, eggs); rarely eats out	**Trial of medications by PCP** prior to presenting at PHP: -Started Sertraline 50 mg two weeks prior -Lorazepam 1 mg Q12H PRN -Quetiapine for sleep →he did not like, "could not breath"

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Case Presentation Continued

Timeline & Key Events

Date	Event & Clinical Details
Month 1	Initial ED visit for sudden onset of panic-like anxiety, racing thoughts, intense fear, insomnia after visiting elderly mother.
Month 2	Brief psychiatric admission (1 night) but patient did not find it restful due to noise on the unit. PCP started sertraline 50 mg daily and lorazepam 1 mg BID PRN 2 weeks prior to PHP program presentation
Month 3	ED Psychiatry consult: panic-like anxiety, anhedonia, hopelessness, rapid weight loss, severe insomnia; discharged with PHP follow-up. PHP initial psych eval: sudden anxiety onset, no clear trigger, sister notes mother's nursing home visit "changed everything." Symptoms: emotional numbness, pacing, hopelessness.
Month 3-4	Medication adjustments: increased Sertraline → mirtazapine (discontinued due to restlessness/insomnia; concern for Bipolar)→ started Valproate, lurasidone and Lithium; persistent panic attacks, insomnia, irritability, poor appetite, intermittent depression
Month 4	Requested inpatient admission due to worsening depression, insomnia, anxiety; labs unremarkable, VPA level 65 Inpatient ECT started, after 5 treatments some mood improvement noted objectively and subjectively; still sudden labile crying at times
Month 4-5	IOP follow-up: reports gradual ECT benefits; still anxious but better concentration/mood; exhibits some catatonic features, continues fluoxetine 20 mg, lorazepam PRN; no SI/HI/AVH; sleep improved; weight stable at 180 lbs

Treatment Summary

Medication	Dose / Notes	Response & Adjustments
Sertraline	Initially 50 mg → increased to 100 mg, then back to 50 mg due to irritability	Some improvement ("glimmer" of change)
Mirtazapine	7.5 mg QHS	Stopped due to opposite response→ no sleep
Valproate	Started 250 mg BID → increased to 500 mg BID	Calmed agitation, helped mood stability
Lurasidone	Started 40 mg → increased to 80 mg	changed due to no response
Lorazepam	PRN, up to 3 mg/day	Helpful for panic attacks, concern for dependency
Lithium	Started 150 mg BID	Added as antidepressant adjunct, more depressed after 2 doses
Fluoxetine	10 mg → increased to 20 mg	Added during ECT hospitalization→ Continued as outpatient
Olanzapine	5 mg QHS (inpatient)	Did not like→ stopped
Trazodone	100 mg PRN (inpatient & outpatient)	Did not want to take → stopped

- **ECT:** Initiated inpatient; tolerated well, gradual mood improvement noted after 6+ sessions
- **Therapies:**
  - Receiving group CBT/DBT for symptoms management skills in IOP
- **Current Plan:** Continue outpatient ECT (pending cardiology clearance), fluoxetine; lorazepam PRN, and psychotherapy

Discussion

- This case illustrates late-onset major depressive disorder with prominent anxiety in an elderly patient without prior psychiatric history. Comorbid anxiety in geriatric depression is linked to greater symptom severity and cognitive challenges, though this patient's cognition remained intact except for transient ECT-related side effects [1,2].
- ECT is an effective treatment for severe, treatment-resistant late-life depression, with reversible cognitive effects and a favorable safety profile [3,5,6]. Our patient tolerated ECT well, showing gradual mood improvement and only transient cognitive symptoms [4].
- A multimodal approach including pharmacotherapy, neuromodulation, and psychotherapy, supported by a strong social network and group therapy, aligns with current recommendations for complex geriatric depression [7,8,9].

Conclusion

- In late-life depression with comorbid anxiety, cognitive function can remain preserved despite severe symptoms and ECT treatment. ECT is a valuable option for treatment-resistant depression with manageable cognitive effects. Comprehensive pharmacologic, neuromodulatory, and psychosocial interventions are essential to optimize outcomes [1–9].

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