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ELDER CARE

A Resource for Interprofessional Providers

Depression in Older Adults

M. Jane Mohler, NP-C, MPH, PHD, and Francisco Moreno, MD, College of Medicine, University of Arizona

Depression is commonly described as feeling sad, blue, unhappy, miserable, or down in the dumps. While many of us feel this way for short periods, true clinical depressive disorders are syndromes characterized by the impairment of mood regulation. The most common diagnoses include major depression and dysthymia, a disorder characterized by chronic low mood. Prevalent among older adults, depression is associated with a 1.5–3 times higher incidence of medical morbidity, and the lifetime risk of suicide is reported to be as high as 15%. Depression negatively affects functioning and quality of life, contributes to excess morbidity and mortality, and places extra stress on caregivers and the health care system. Of the estimated 6 million persons over age 65 with depression, only 10% receive treatment. In addition, less than half of hospitalized patients with depression are referred to a psychiatrist, and less than 20% of these are prescribed antidepressant medication.

Epidemiology

Depression is the most common geriatric psychiatric disorder, and can manifest as either minor or major depression. Eight to fifteen percent of the general population over 65 years of age has symptoms severe enough to meet diagnostic criteria for a depressive disorder, and the prevalence of major depressive disorder (MDD) is estimated to be 2%. In the hospitalized population, however, 25–40% manifest minor depressive symptoms. In assisted living and skilled nursing facilities an estimated 30% display mild depressive symptoms and an additional 12% of patients have MDD.

Risk Factors

Major risk factors for depression include the following: female gender, bereavement, stressful life events, social isolation, chronic pain, a past history of depression, fear of death, chronic disease, substance abuse, including alcohol, and being unmarried, widowed, or cohabitating.

Signs and Symptoms

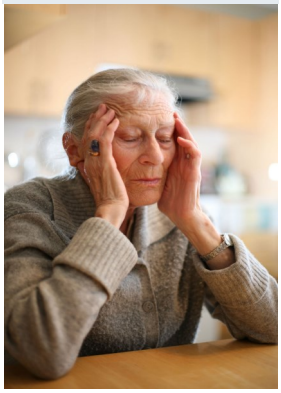
Depression in older patients can be difficult to diagnose, as signs and symptoms differ from those in younger adults and may not be in accord with DSM-V or ICD-10 criteria. Additionally, medical illnesses can confound the symptoms of depression. Older adults may not show or express sadness, their mood can be chronically irritable, and depressed elders can lose their ability to respond to positive external events. Somatic complaints and hypochondriasis are more frequent, and vegetative signs such as anorexia and weight loss may initiate concerns about underlying malignancy. About 10% of depressed elders may display psychotic symptoms. Between 38–58% of aging adults suffering from MDD also have anxiety disorder, which often presents as tension, unrest, feelings of insecurity or fear, irritability, and intense worry rather than as autonomic symptoms.

Screening and Diagnosis

The US Preventive Task Force recommends screening adults for depression only where "there are systems in place to assure accurate diagnosis, effective treatment and careful follow-up care." A quick, easy, two sentence screening tool is offered under Provider Tips. A positive result should prompt further evaluation and diagnosis. Remember that medical illness can sometimes present as depression. Recommended lab tests to rule out other causes include thyroid, liver and kidney function tests, serum calcium, and B-12 levels (or homocysteine and methylmalonic acid levels). Organic cognitive disorders must also be

Signs and Symptoms of Depression in Older Adults

- Lack of appetite
- Weight loss
- Fatigue
- Problems with concentration
- Stopping normal activities
- Guilt
- Melancholia
- Suicidal Ideation
- Feeling helpless
- Feeling hopeless



Suicide Risks in Those >50 Years

- Poor Health
- Family conflict
- Money worries
- Male
- White
- Veterans
- >84 yrs have twice the risk

TIPS FOR DIAGNOSING DEPRESSION IN OLDER ADULTS

Asking these two questions may be as effective as using longer screening tools:

- Over the past 2 weeks, have you ever felt down, depressed, or hopeless?
- Over the past 2 weeks, have you felt little interest or pleasure in doing things?

A positive response to either question is a very sensitive indicator of depression, but needs further validation with a more specific diagnostic interview.

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considered when diagnosing depression. It may be difficult to differentiate depression from dementia, and they may co-exist. Depression can precede, accompany or masquerade as dementia, and treatment of depression will often improve cognitive function. Neuropsychiatric evaluation can help to tease out depression from cognitive deficit. Acute neuropsychiatry or geriatric psychiatry referral should be sought when a patient is suicidal or homicidal, has delusions or hallucinations, or disabled by vegetative depression.

Treatment

A successful treatment plan includes addressing co-morbid conditions, implementing personalized pharmacologic therapy, consideration of psychotherapy, and close follow up. Antidepressant medication is usually the first line treatment for depressed older adults. Symptom improvement occurs with serotonin reuptake inhibitors (SSRIs) like sertraline, escitalopram, fluoxetine, and others; serotonin and norepinephrine reuptake inhibitors (SNRIs) like duloxetine, and venlafaxine; and various other medications like bupropion, or mirtazapine.

Unfortunately, antidepressant medication often takes 6 to 8 weeks to improve symptoms. If after 6-8 weeks a trial of one drug shows no effect, consider increasing the dose as tolerated. If no benefit is observed after optimizing dose and duration, alternative medications should be prescribed. Many options may be considered including switching within or outside an antidepressant class, using augmentation strategies like addition of buspirone, thyroid hormone, or combining two antidepressants from different classes.

Once improvement occurs, a minimum of 6 months of treatment is recommended. At that point a slow and carefully monitored weaning regimen may be attempted. Older patients, especially those with a history of previous depressive episodes, may require a longer duration of treatment. A geropsychiatry consult can help in situations when medication management becomes more complex.

Psychotherapy has been shown to be as effective as drug therapy, and small additional therapeutic gains are seen when provided in combination with antidepressants. The evidence is unclear with regard to the ideal type of psychotherapy, but those aimed at relieving depressive ideation, and efforts focused on instrumental activities of daily living, can improve geriatric depression.

Older adults, however, may refuse therapy, as many in this present generation consider therapy a sign of weakness. Patients with neurocognitive disorder, psychomotor retardation or sensory impairment may not be suitable for psychotherapy.

A meta-analysis of MDD trials provides evidence that omega-3 supplementation is safe and reduces symptoms of depression in combination with routine care. In addition, B12 insufficiency has been linked to depression in several small studies. B vitamin supplements are not yet recommended as standard of care, but, as with omega-3s, are easy to prescribe without fear of adverse effects.

Special Considerations

Bereavement Those going through uncomplicated bereavement are likely to experience a lack of energy and concentration, crying spells, and decreased appetite and insomnia. Most will need no formal intervention. Occasionally, such depression may deepen, resulting in overwhelming feelings of sadness, sometimes to the point of suicidal ideation. In this case, it can be helpful to talk with clergy or spiritual healers, or with a social worker, grief counselor, or therapist. Support groups can also be helpful. Antidepressants and counseling have been found to be effective in combination in grief.

Suicide Nearly 25% of older adults suffering from MDD will remit, either spontaneously or after treatment. Another 25% will not respond to any kind of intervention and will continue to manifest severe symptoms. The other 50% will have partial remission, or intermittent recurrence. MDD accounts for 65% of cases of elderly suicide. Screening for suicidal ideation in a depressed older adult is paramount. An acute life threatening illness (e.g., MI, stroke, or cancer diagnosis) may trigger suicidal plans. Don't be afraid to ask.

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Interprofessional care improves the outcomes of older adults with complex health problems

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The University of Arizona, PO Box 245069, Tucson, AZ 85724-5069 | (520) 626-5800 | http://aging.medicine.arizona.edu

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