DEPRESSION

An introduction to aging science brought to you by the American Federation for Aging Research
WHAT IS DEPRESSION AND WHY IS IT IMPORTANT?

Depression is a mood disorder with a number of physical manifestations in addition to its psychological effects. According to the World Health Organization, major depression is the leading cause of disability in high-income countries. In direct and indirect costs, depression costs the United States more than $30 billion per year. Estimates of its prevalence among older Americans vary from two to six million.

Depression ranks fourth among causes of disability in the world, and by 2030, it will rank second. Six percent of depressed patients commit suicide, and depression also increases the risk of dying from other medical diseases.

Types of depression include:

- Major depressive disorder
- Dysthmic disorder
- Sub-syndromal or minor depression

Major depressive disorder

Major depressive disorder is present in approximately five percent of community-dwelling older adults and 15 percent of nursing home residents. The diagnosis of major depression is made based on depressed mood or a loss of interest and pleasure that persists for at least two weeks, accompanied by other signs and symptoms. The criteria required for diagnosis of major depression include depressed mood that persists most of the day and/or a loss of interest and pleasure in activities (required for the diagnosis) plus three or four (for a total of five) of the following symptoms:

- Insomnia or sleeping too much
- Slowed cognitive function or agitation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Dysthmic disorder

This chronic form of depression occurs in less than one percent of older adults living in the community but affects over 10 percent of older adults in hospitals or in nursing homes. It involves two years or more of at least three of the above symptoms, plus a depressed mood, but symptoms do not reach the level of major depression. People with dysthmic disorders can, however, develop major depression.*

Minor depression

This form of depression affects up to 10 percent of older adults in the community and up to 20 percent of nursing home residents. Minor depression is characterized by depressive symptoms that affect well-being and quality of life, but do not meet the criteria for major depressive disorder or dysthymia.

RISK FACTORS FOR DEPRESSION*

A number of factors increase the risk of developing depression. They include:

- Age
- Gender
- Race
- Income
- Social support
- Physical illness
- Functional disability
- Chronic pain
- Medication use
- Grief
- Alcohol overuse
- Institutional living

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Socio-demographic characteristics
Rates of depression among healthy older adults (65+) are actually lower than for healthy younger adults. Similarly, African Americans have a lower prevalence of depression than whites or Hispanics. However, depression rates are significantly higher in some sub-groups of older people (e.g., those who have lost their independence, who are ill, or who live in nursing homes). For these sub-groups, suicide frequency is higher than in the general population. Men with depression are less likely to seek or receive treatment than women and are more likely to commit suicide. Low socio-economic status and poor social support increase vulnerability to depression.

Physical Illness
Older adults who are medically ill are particularly vulnerable to depression. Up to 40 percent of acutely ill individuals in hospitals are significantly depressed compared to three percent of healthy, community-dwelling individuals. Individuals with chronic conditions may experience depression secondary to other disease processes. Conditions associated with depression include Alzheimer’s disease, Parkinson’s disease, multiple sclerosis, thyroid disorders, diabetes, renal disease, liver disease, dementia, pancreatic cancer, adrenal disorders, congestive heart failure, coronary artery disease, stroke (even small, so-called “silent” or mini-strokes), chronic obstructive pulmonary disease, and vitamin B12 deficiency.

Functional disability
Older adults with functional limitations are at greater risk for depression, particularly when their disability interferes with meaningful activities. Severe hearing loss or visual impairment can lead to social isolation and thus contribute to depression. Likewise, chronic pain increases vulnerability to depression.

Medication use
A variety of medications can initiate or heighten depression in older adults. They include:

- Interferon or similar anti-viral medications
- Some blood pressure medications (alpha-methyldopa)
- Steroids (prednisone, methylprednisolone, dexamethasone)
- Drugs used for chemotherapy (vincristine, vinblastine)
- Anti-Parkinson’s disease medications

Of course, these medications have important (even life-saving) functions. Therefore, any decision to change a patient’s drug regimen should be made in consultation with the appropriate doctor or health professional.

Grief
Grief is a universal human response to loss. Unresolved (i.e. chronic) grief or multiple losses may contribute to depression. Bereavement is stressful, and many older adults become ill during this difficult time. Widowers frequently die during the first year after a loved one’s death. Coping with the loss of a loved one may take from one to two years or even longer. Many years after bereavement is resolved, anniversaries and experiences can still trigger painful episodes of acute grief.

Existential grief
Depression may also be related to anticipation of death. Older adults become aware that their time is limited, and this can give rise to a feeling of loneliness and despair.

Alcohol overuse
Alcoholics suffer higher rates of depression than non-drinkers and those who drink moderately.

Institutional living
Depression can be related to the impact of an institutional environment such as a nursing home. Neither religious beliefs nor social supports appear to buffer the impact of institutional environments in which individuals must relinquish considerable control.

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DIAGNOSING DEPRESSION*

In older adults, depression is not always characterized by a depressed mood. However, there are a number of observations in older people that can be helpful in spotting depression. Older adults are more likely to present with loss of appetite, insomnia, and lack of pleasure in life. Sleep disturbances are strongly associated with depression. Older adults may withdraw from their regular social activities and say: “It’s too much trouble,” “I don’t feel well enough,” or “I don’t have the energy,” rather than say, “I feel depressed.” The following list summarizes some of the common symptoms of depression in older adults.

Common Symptoms of Depression in Older Adults:

- Change in eating patterns (e.g., loss of appetite, weight loss)
- Loss of interest or pleasure in usual activities (e.g., apathy, sense of emptiness, exaggerated feelings of helplessness).
• Physical complaints (e.g., gas, constipation, heartburn, pain, fatigue)
• Change in sleeping patterns (e.g., early morning awakening, sleeping more)
• Decrease in sex drive or other problems with sexual function
• Slowed cognitive function (e.g., poor memory, slowed thinking, attention deficits, indecisiveness, difficulty concentrating)
• Thoughts of death or suicide.

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TREATMENTS FOR DEPRESSION*

The goals of treatment are to improve quality of life, increase functioning, and reduce the risk of death through suicide. Barriers to treatment of older people are common. Some older adults believe depression to be inevitable with aging; others are ashamed to admit they are experiencing it.

Most people with depression can improve with treatment. Antidepressant medications or psychotherapy can be very effective, and in some severe cases, a combination of medications and psychotherapy is more effective than either alone. Here are some of the approaches currently in use:

• Antidepressant medication therapy
• Electroconvulsive therapy (ECT)
• Psychotherapy
• Support groups
• Exercise
• Light (phototherapy)
• Combinations

Frail or very elderly older adults may be more sensitive to the effects of medications, so the general rule is to “start low, go slow.”

Antidepressant medication therapy
All antidepressants are relatively efficacious in adults, and the choice depends upon patient tolerability and response to therapeutic effects with minimum side effects. Frail or very elderly older adults may be more sensitive to the effects of medications, so the general rule is to “start low, go slow.” Medications are started at a low dose and increased slowly until the desired therapeutic effect is achieved, while monitoring closely for side effects. Compliance is a common problem; as many as one in two older adults don’t take their medications as prescribed. Side effects are among the most common reasons for discontinuing medications.

What treatments are best suited for an individual depend on symptoms, side effects, other co-existing illnesses, and financial constraints. Medicare does not always cover the cost of prescription medications or outpatient psychotherapy.

Some common antidepressants
Although well tested in younger populations, not all of these antidepressant medications have been systematically studied in older adults or in the medically ill.

Selective serotonin reuptake inhibitors (SSRIs). Common adverse effects include nausea, anxiety, insomnia, headache, and sexual dysfunction. SSRIs are commonly known by their brand names [e.g., Prozac (Fluoxetine), Celexa (citalopram), Paxil (Paroxetine), Zoloft (Sertraline)], among others.

Other antidepressants. These are often prescribed by generalist physicians in the treatment of depression. By and large, the adverse effects of these drugs are not as serious as those of older antidepressants such as tricyclic antidepressants or monoamine oxidase inhibitors (MAOIs). Examples of these include: venlafaxine, mirtazapine, and bupropion.

Tricyclic antidepressants. Most of these are not appropriate for the elderly as an initial therapy, but may be useful for younger adults. Common adverse effects include abnormal heart rhythms, low blood pressure, blurred vision, dry mouth, constipation, urinary retention, and sedation.

Monoamine oxidase inhibitors (MAOIs). These are an older class of antidepressants that are not recommended for older adults because of substantial side effects.

Methylphenidate (more commonly known as Ritalin®). This is sometimes used in low doses as a stimulant in the early phases of treatment in very serious cases of depression. It may be effective in more quickly relieving symptoms than SSRIs, tricyclics, or
other antidepressants. The use of this (and indeed all antidepressant) medication must be carefully monitored by your physician(s).

St. John’s wort (Hypericum perforatum). Herbal preparations have become increasingly popular for the treatment of a variety of complaints. One of the most commonly used herbal preparations is St. John’s wort. This herb is useful in the treatment of mild to moderate depression, but not more effective than placebo for adults with severe depression. Of note, it has many interactions with other drugs that limit its use in older patients.

Electroconvulsive therapy (ECT) If drug therapy is ineffective in treating serious depression, then ECT is often effective. Older adults are the largest age group that receives ECT; about 50 percent of those receiving ECT are over age 60. In the hands of an experienced psychiatrist, ECT is a safe and highly effective treatment for older adults that can be lifesaving for those who are actively suicidal, psychotically depressed (those with delusions, illusions or hallucinations), or for whom antidepressant medications were ineffective or contraindicated. ECT is effective in the short-term, but the relapse rate is high. Patients receive a muscle relaxant and a short-acting general anesthetic before the ECT. A course of about 10 treatments administered every other day is a typical treatment course. The most common side effects of ECT include headache, mild acute confusion and slight memory loss. Newer treatment techniques using a brief pulse stimulus have reduced cognitive side effects. For example, unilateral ECT on the nondominant side of the brain minimizes confusion and memory loss after seizures because the dominant side of the brain that contains speech and memory areas is not affected. The lowest electrical stimulus necessary for an adequate seizure is used. There is no agreement on how ECT improves serious depression or whether maintenance treatments prevent relapse.

Psychotherapy The goal of psychotherapy is to help individuals develop more effective coping behaviors. Psychotherapy can be effective by: teaching new skills, promoting assertive behaviors, increasing pleasurable activities, engaging in problem solving, and assisting patients in modifying their relationships or expectations about relationships. Most effective individual therapies (behavioral, cognitive, and problem-solving therapy) are time-limited, focused, and problem-oriented. Behavioral activation encourages patients to increase the frequency of, and focus attention on, pleasurable activities. Cognitive therapy works by helping patients identify and challenge pessimistic or self-critical thoughts that cause or perpetuate depression. Cognitive-behavioral therapy, the most commonly administered form of psychotherapy, helps patients increase positive experiences and focus on their accomplishments rather than dwelling on negative life experiences. Problem-solving therapy helps patients break larger problems into smaller pieces and identify specific steps toward change. Regardless of the approach, psychotherapy is an important part of the overall treatment of patients with depression and can be safely combined with antidepressant drugs.

Support groups Support groups should be led by an experienced and competent therapist. Many older adults grew up with values about keeping personal business and emotions private. However, in group therapy, people need to communicate, participate, and talk about their problems and feelings. The ideal situation occurs when the older adult feels safe enough in the group to share fears and anxieties so problems can be solved and behaviors can be examined and changed. The group can provide a sense of universality as people discover others share similar problems; a sense of support and relatedness; peer feedback; modeling of new behaviors; social skill building; reality testing, and a laboratory experience.

In a support group, a person can try out new behaviors such as asking for help or confronting others. In a bereavement group, people can talk about their feelings of loss, confront their problems, and develop a safe and supportive network. In one bereavement group for those whose loved one had committed suicide, older adults can share their agonizing questions. “Why did he or she commit suicide?” “Could I have prevented it?” “Could I have done something differently?” and “Was it my fault?” They can confront problems such as when and how to tell others of the suicide. In a supportive group, members allow each other to grieve, to laugh at the funny memories, to express feelings without being judged, and to go on with life.

Exercise Physical activity is a critical component of depression treatment. Exercise not only improves depressive symptoms but also has many other positive effects on physical health. Regardless of depression, adults should engage in moderate-intensity exercise for at least 150 minutes per week.
The effectiveness of depression treatment may also depend on how that treatment is provided. A study published in the December 30, 2010, issue of the *New England Journal of Medicine* found that a team care approach not only improved the effectiveness of depression treatment but also improved cholesterol, blood pressure, and blood sugar levels. Patients cared for by a team including a nurse care manager, a psychiatrist, and the patients’ primary care physician were less depressed and impaired after twelve months than patients undergoing normal care, and they reported greater improvements in quality of life. These patients also received more frequent fine-tuning of medication as well as more frequent counseling and psychotherapy.

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**DEPRESSION AND AGING**

According to the Geriatric Psychiatry Alliance, depression affects 15 percent of older Americans, or about six million people. It is particularly prevalent among residents of nursing homes. Many of the typical triggers for depression are more common among older adults. They include:

- Serious medical illness, such as heart disease or cancer
- Loss of a loved one or partner
- Significant disability, such as loss of hearing or vision

Suicide is always a risk for those who are depressed, and 25 percent of suicides are in older people. Rates of suicide among older people (particularly white males) are significantly higher than in the rest of the population. If you suspect an older (or any) adult may be depressed and considering suicide, you can get more information about recognizing symptoms and what to do about it at the American Foundation for Suicide Prevention.

Unfortunately, depression is all too often overlooked among older people. One survey found that over half of those 75 and older considered depression normal. Depression frequently goes unrecognized by physicians and family members, who attribute its symptoms to the slowing down and increased disability associated with normal aging. In fact, most older adults who commit suicide turn out to have seen their primary care doctor in the month before they died.