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 the United States and worldwide. 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.

Worldwide, depression ranks fourth among causes of premature mortality and disability, after heart disease, stroke, and tuberculosis. One reason for its high mortality rate is that 15% of depressed patients commit suicide, but depression also increases the risk of dying from other medical diseases.

Types of depression include:

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

Major depression
The diagnosis of major depression is made based on depressed mood or 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 or loss of interest and pleasure in activities (required for the diagnosis) and at least four of the following symptoms:

- Depressed mood
- Inability to feel pleasure
- Significant weight loss (5% of body weight) or gain in past month
- 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 milder form of depression is common among older adults living in the community and affects up to half of the older adults in hospitals or in nursing homes. It involves two years or more of at least three of the above symptoms and a depressed mood, but symptoms do not reach the level of major depression. People with dysthmic disorders can, however, experience major depression.

Sub-syndromal or minor depression
This form of depression affects up to one in four older adults in the community. The prevalence among elderly with medical illness or in nursing homes may be as high as 50%. Subsyndromal depression is characterized by depressive symptoms that affect well-being and quality of life, but that do not meet the criteria for major depression or dysthymia.

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RISK FACTORS FOR DEPRESSION

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

- Age and Gender
- Illness
- Disability
- Medications
- Hypochondriasis
- Grief
- Alcohol overuse
- Institutional Living

Age and gender
Rates of depression among healthy older adults (65+) are actually lower than for healthy younger adults. 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 or other institutional settings (see below)]. For these sub-groups, suicide frequency is very high, as well. Twice as many women as men suffer from depression, but men with depression are less likely to seek or receive treatment than women and more likely to commit suicide.

Illness
Older adults who are medically ill are particularly vulnerable to depression. Up to 40% of acutely ill individuals in hospitals are significantly depressed compared to 3% 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.

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.

Medications
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.

Hypochondriasis
Older adults who are depressed may appear hypochondriacal in their preoccupation with physical health complaints (e.g., constipation, heartburn). These complaints are often dismissed rather than recognizing them as representative of difficulties in coping with the stresses of illness or loss.

Depressed individuals are high users of medical care; therefore, failure to recognize depression can lead to costly hospitalization or unnecessary and expensive medical procedures.

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 as the prospect of mortality can no longer be ignored.

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 over the circumstances of daily living.

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DIAGNOSING DEPRESSION

How is depression diagnosed?
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 table below 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. Medicare does not currently cover the cost of prescription medications, and only covers about half the costs of outpatient psychotherapy.

About 7 out of 10 people with depression will improve with treatment. Antidepressant medications or psychotherapy can be very effective, and in some cases a combination of medications and psychotherapy is more effective than either alone.

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 sadly, finances.

Some common antidepressants
While 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 are 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)** 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. European reports have shown that this herb is useful in the treatment of mild to moderate depression, but recent multi-site studies in the United States do not suggest that St. John’s wort is more effective than placebo for adults with major depression.

**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% 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, engaging in problem solving, and assisting patients in modifying their relationships or expectations about relationships. Most individual effective therapies (behavioral, cognitive, and problem-solving therapy) are time-limited, focused, and problem-oriented. Psychotherapy is an important part of the overall treatment of patients with depression and is very often 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**
A recent, comprehensive review of the primary research on exercise and depression (Mead et al, 2010) concluded that exercise seems to improve symptoms in people with depression.

**Light (Phototherapy)**
Exposure to bright light—usually in the early morning—can be an effective treatment for both seasonal and nonseasonal major depressive disorder. In fact, some studies show that up to 80 percent of seasonal depression sufferers will get relief from phototherapy alone (Lieverse et al. 2011).

**Combinations**
Elderly patients in particular may need a combination of the different treatments discussed above. For example, the combination of psychotherapy and antidepressant medications appears to produce more robust long-term benefits in this population than either alone.

The effectiveness of depression treatment may also depend on who is providing that treatment. A study published in the December 11, 2002, issue of the *Journal of the American Medical Association* found that a team care approach more than doubled the effectiveness of depression treatment for older adults. Patients cared for by a team including a depression care manager, a psychiatrist, and the patients’ primary care physician were less depressed and impaired after three, six, and 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% 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% 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 or ignored among older people. One survey found that over half of those 75 and older considered depression normal, and it is frequently missed 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.