Depression in Older Adults

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Agenda

- Introduction
- Epidemiology
- Risk Factors
- Screening
- Treatment
- Special Considerations
  - Memory
  - Grief and bereavement
  - Suicide

Introduction

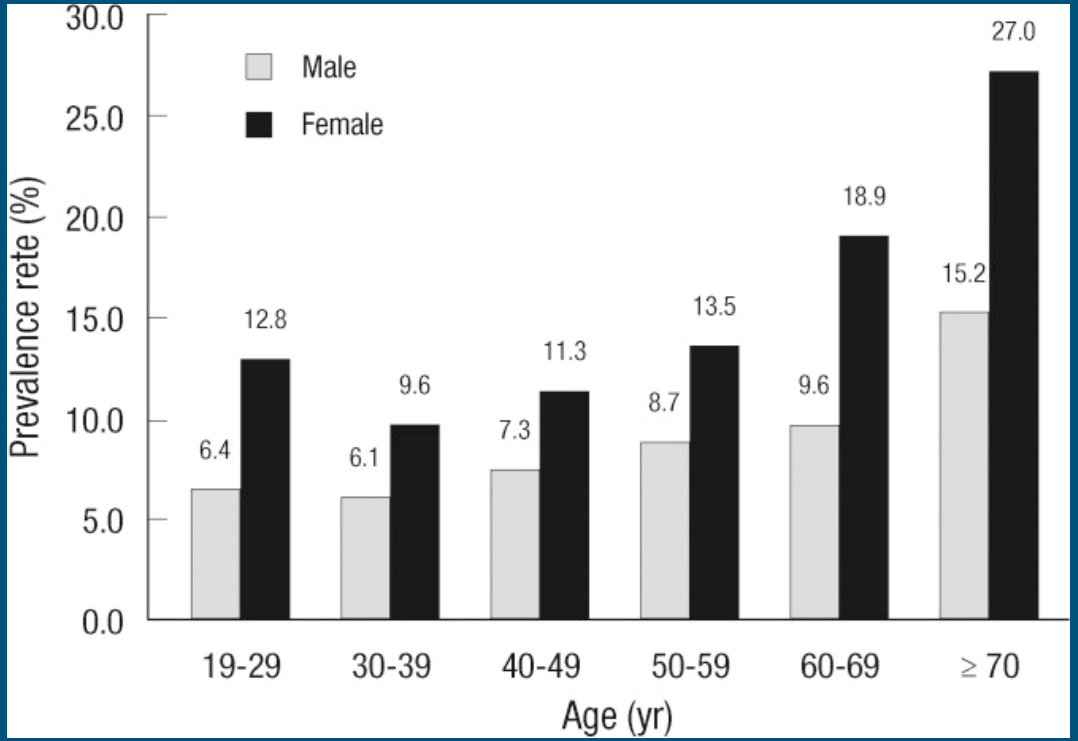
- Associated with increased medical comorbidities, impaired functioning, excessive use of healthcare resources, and increased all-cause mortality

- Approximately 3% of healthy older adults in the community have major depression and **75% initially present to their PCP for treatment**

- Treatment results in **improved quality of life, enhanced functional capacity, and increased longevity**

Epidemiology

- Prevalence of depression is **higher in women across all age groups**
- Older men, especially men of color, are at **greater risk of unrecognized and untreated** depression compared to the general population
- **Recurrence** rates are as high as 40%
- Rates of depression are significantly higher for people in **long-term care facilities (12-30%)**



Risk Factors

- Female sex
- Social isolation
- Not partnered
- Lower SES
- Comorbid medical conditions (MI, stroke)
- Pain
- Insomnia
- Functional impairment
- Cognitive impairment

- Less likely to have family history of depression or other mental health disorder

Screening

- **DSM-5 criteria** for major depression or persistent depressive disorder are the same

Screening tools:

- PHQ-2 and PHQ-9
- **Geriatric Depression Scale (5)**
  - Are you basically satisfied with your life?
  - Do you often get bored?
  - Do you often feel helpless?
  - Do you prefer to stay at home rather than go out and try new things?
  - Do you often have feelings of worthlessness?
- Cornell Scale for Depression in Dementia (19)

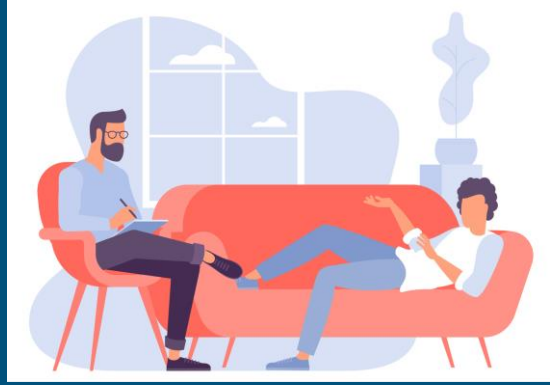
Challenges:

- **Concurrent medical illness** with overlapping symptoms
- **Lack of time** during visit given higher likelihood of complex medical issues
- Patient's less likely to communicate or seek care due to stigma of mental illness

Evaluation

- **Suicidality** (ideation, plan)
- Psychotic symptoms, insomnia, malnutrition
- Medication review - BZDs, opiates can have depressant side effects
- Alcohol use
- **Other medical conditions**: thyroid disease, DM
- Determination of **history of prior depressive episodes** including age of onset, prior drug therapy and response, length of remission
- Family history and response to medication

Treatment



- First-line: **psychotherapy (CBT) + pharmacotherapy**
  - Large meta-analysis effect size of psychotherapy vs medication was moderate/large and roughly equivalent, however gold standard is both together

- Antidepressants for late-life depression are effective, however **efficacy may be blunted in comparison to younger patients**

- **Medication acceptance factors:** fear of dependence, belief that medications would inhibit normal emotional responses, rejection of concept of depression as medical illness, prior negative experiences

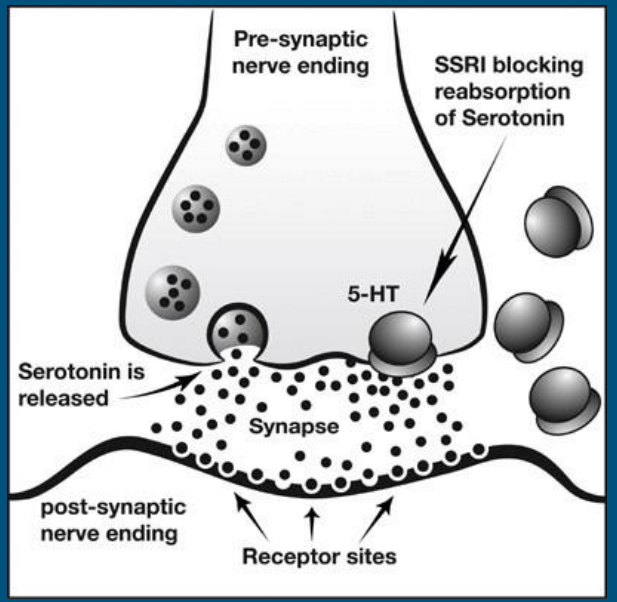
Pharmacotherapy

- In older adults, full antidepressant response may not occur until **8-12 weeks of therapy**
- **Monotherapy is preferred** to minimize side effects and drug-drug interactions
- Dose adjustment: initial medication should be **half usual dose of younger patients to account for decreased clearance and to minimize side effects**
  - Assuming it is well-tolerated, dose should be up-titrated to reach same range as in younger adults for full remission
- Duration: **6-12 months beyond full remission**

SSRIs and SNRIs

- SSRIs are first line - **tolerability, ease of use, safety**
- Best safety profile: **escitalopram (Lexapro), sertraline (Zoloft), citalopram (Celexa)**
  - Citalopram maximum dose 20mg daily d/t dose-dependent QT prolongation
- Side effects: Parkinsonism, akathisia, anorexia, sinus bradycardia, **hyponatremia**

- **SNRIs are second line** - can be useful for patients with comorbid pain d/o



Atypical antidepressants

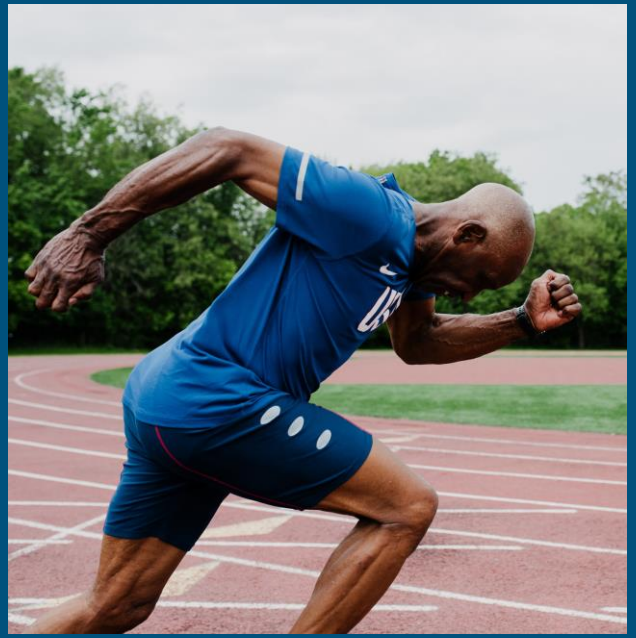
- Bupropion (2nd line) - activating agent so can be useful if patients have **chronic fatigue or if they suffer from daytime sedation/lethargy**
  - Avoid w/ seizure disorders, BZD use

- Mirtazapine (2nd line) - useful for patients with insomnia, agitation/restlessness, and anorexia/weight loss
  - Sedation: worse at initiation and low doses but typically diminishes with acclimation and improved at higher doses (noradrenergic > antihistaminergic)

- Adjunctive medications: methylphenidate, aripiprazole

Alternative therapies

- Exercise
- Bright light
- Collaborative care
- Home-based care
- Family support



- Electroconvulsive therapy - viable option for **resistant depression** that is **life-threatening** or significantly impairs functioning

Memory

- Depressive Cognitive Disorders - some degree of **cognitive impairment** has been shown to be present **~85% of the time** in older adults
  - Treatment is the same as previously discussed

- Studies have shown an **increased risk of dementia** in patients w/ late-life depression (specifically Alzheimer's and vascular dementia)
  - Significant amount (up to 70%) of cases diagnosed as depressive cognitive disorder transform into dementia within 5 years

Bereavement, Grief, & Depression

Bereavement: state of having lost a loved one to death

Grief: personal response to the loss, painful and disruptive but still tolerable and self-limited

- Feelings come in waves, self-esteem is usually preserved

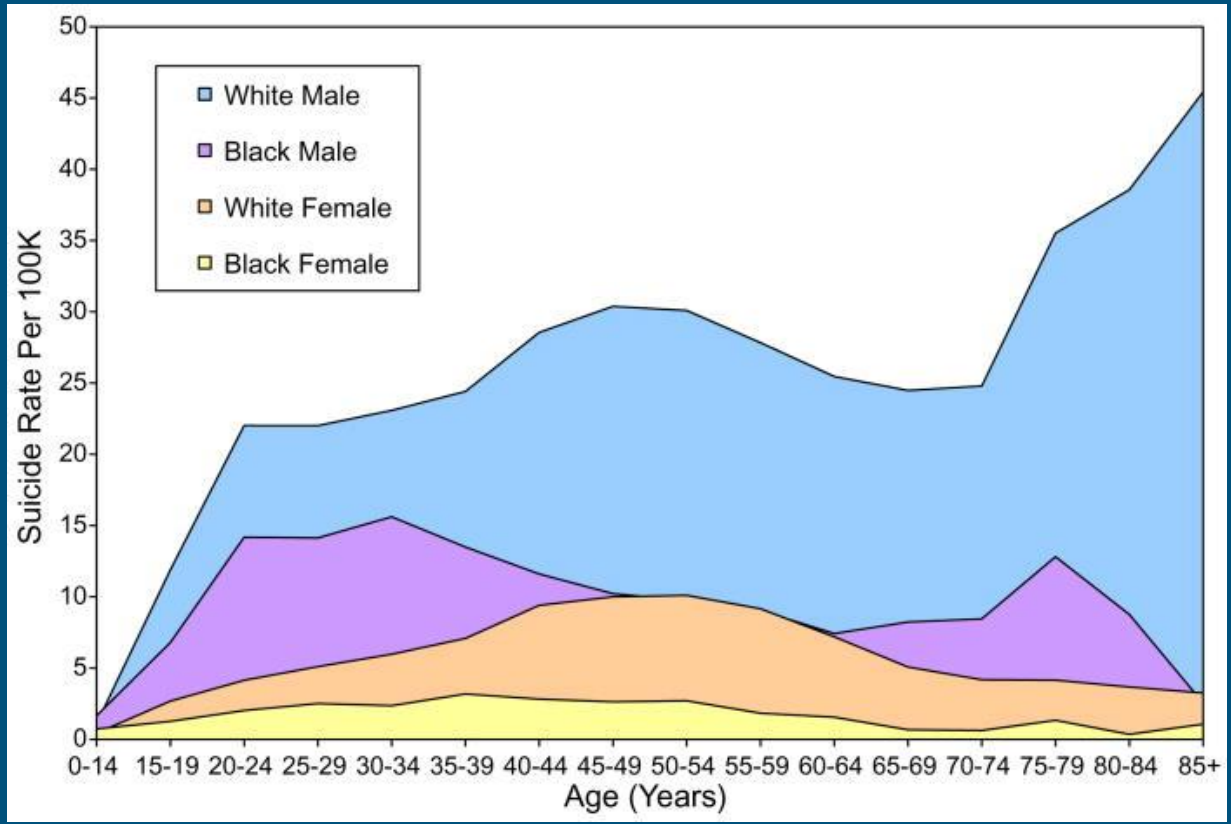
Complicated grief: persistent (>6 months) and disabling, dramatically interferes with function and quality of life, can be life-threatening and requires treatment

- Occurs in ~10% of bereaved individuals

Suicide

- Older adults make up ~13% of population, but account for ~24% of all completed suicides

- Most older adult suicide victims were in their first episode of depression and had seen a physician within their last month of life



Suicide

- Cumulative **risk of suicide increases with the number of acute and chronic medical conditions**
  - Older adults w/ 7+ chronic conditions had an approximately 9x greater risk for suicide
- Perceived meaning of illness and **impact on IADLs** was significantly associated with suicide
- Pain - studies suggest that patients with **severe, uncontrolled pain** had higher rates of SI (only observed in men, not women)
- Cognitive deficits - late-life suicidal behavior can in some instances be associated with **impaired frontal lobe executive function**

Social Factors

- **Stressful life events** (predisposing factors)
- **Social connectedness** (buffer to reduce suicide risk)
  - Interpersonal Theory of Suicide - thwarted belongingness + perceived burdensomeness

- Protective factors:
  - Live with friends/family
  - Participation in community activities
  - Have a hobby
  - Spirituality/religiousness

Conclusion

- Depression is **not** a normal part of aging
- Late-life depression often goes **undiagnosed and untreated** and has significant impact on QoL, health outcomes, and morbidity/mortality
- **PCPs** often are typically the first (sometimes the only) providers that have the opportunity to screen for depression in older adults

- First-line treatment = psychotherapy + pharmacotherapy (SSRIs)
  - Start with a lower starting dose
  - Close follow-up after medication initiation

Questions?

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