UNIVERSITY OF SOUTH FLORIDA GERIATRIC WORKFORCE ENHANCEMENT PROGRAM (GWEP)

FACULTY DEVELOPMENT MASTERWORKS SERIES

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services (HHS), under grant #U1QHP28739, ***USF Geriatric Workforce Enhancement Program*** for $2.24 M. This information or content and conclusions are those of the presenter and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS or the U.S. Government.

Detection & Treatment of Depression among Older Adults

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Myths of Mental Illness

- Mental illness is incurable
- Depression is a natural consequence of aging
- Preoccupation with death is typical of older adults
- Treatment of depression in older adults is ineffective

Prevalence in Older Adults

- Rates for older adults in community settings meeting the full (5) criteria for depression probably slightly less than in young adults
- Rates for dysthymic disorder (chronic minor depression where only 2 criteria are met) are slightly more in older adults
- Overall findings suggest that rates of depression for community dwelling older adults are similar to those of community dwelling younger adults

Prevalence of depression

- Most common late onset problem, and one of the most common late life problems
- Rates of depression in older adults are much higher in hospital, assisted living facility and nursing home settings than they are in community settings

Consequences of Late Life Depression

- Excess disability
- Functional decline
- Increased health service utilization
- Medical morbidity & mortality
- Reduced quality of life
- Caregiver burden – ½ of spouses depressed
- Suicide

Causes of Depression

- Genetics – inherited vulnerability
- Biological – changes in brain chemicals (decreases in norepinephrine, serotonin?) (but "chemical imbalance" theory has never been proven)
- Psychosocial – accumulation of losses – more typical of late onset depression

Common Losses of Aging

- Deaths of spouses, relatives, friends
- Retirement
- Parenting Role
- Health & Functioning
- Independence
- Prestige

Depression, Grief & Mourning

- Grief – personal emotional reaction to a loss
- Mourning – public display of grief
- Complicated Grief (CG) – Different from depression?
- DSM-5 allows labeling CG as MDD if depressive symptoms occur for 1 month after 6-month bereavement
- Persistent complex bereavement disorder (DSM-5)
  - Preoccupation with thoughts of the deceased & circumstances of death, intense suffering, social identity disruption > 12 months after the loss {Proposed for further study in DSM-5}
  - May need grief + PTSD work

Symptoms of Depression

- Persistent sad, anxious, or “empty mood”
- Feelings of hopelessness, pessimism
- Loss of interest or pleasure in activities
- Sleep disturbance (too much / too little)
- Crying spells

Symptoms of Depression (cont)

- Eating disturbance (too much / too little)
- Decreased energy, fatigue, ennui
- Suicidal thoughts, gestures, attempts – white males over 75 have highest suicide rate

Symptoms Particularly Prominent in Older Adults

- Difficulty with concentration, making decisions
- Vague physical symptoms or chronic pain not responsive to treatment
- Memory complaints
- Anxiety
- Irritability
- Depletion syndrome – withdrawal, apathy, less energy
- However, less sadness, guilt, admission of suicidality

Rules of Thumb to Distinguish Depression from Dementia

- Depressed older adults are more likely to have prior depressive episodes
- Self-reported memory problems are more common among depressed patients
- With depression, more typically a sudden onset of ‘memory’ problems

Rules of Thumb (cont)

- Depressed people show affective changes along with cognitive changes
- Errors on mental status exams variable & motivational
- ‘Pseudodementia’ = Acute global cognitive changes - biochemical concomitants of depression
- Depressed focus on disabilities; PWDs make light of memory problems

Involutional Melancholia

- Gradual onset age 40-55 (women) 50-65 (men):
- Anxiety & agitation & restlessness
- Somatic concern & Hypochondriasis
- Guilt ridden
- Occasional somatic or nihilistic delusions
- Insomnia
- Anorexia & weight loss

Depression comorbid with dementia

- Depression & dementia frequently co-exist
- Depression exacerbates memory problems
- Late onset depression is a risk factor for development of dementia – perhaps due to executive/vascular   involvement

Depression in Severe Dementia

- Resistance to care
- Lack of participation in care
- Refusal to eat
- Lethargy
- Increasing dependency
- Social withdrawal

Depression in Dementia (cont)

- Rapid deterioration in functioning
- Agitation, catastrophic reactions
- Delusions (e.g., about being poisoned)
- MDS has an item assessing depression
- Depression is now considered an indicator of QOL

Bio-psycho-social Intervention – Medical Approaches

- Physical – thorough exam should R/O physical causes of depression (med side-effects, lung cancer)
- Biological – SSRI anti-depressants (Zoloft, Prozac) more benign side-effect profile than Tricyclics (Elavil) – less cardiotoxic
- ECT – effective, but used as last resort – high relapse rates

Social Treatment

- Depression & social isolation are associated in older adults – older white males living alone without religious affiliation are highest risk for suicide
- Referral to Sr. Ctrs, volunteer organizations, church groups - replace losses, increase social support, feel productive again

Psychotherapy

- Helps older adults accept & replace losses
- Confronts myth that aged person cannot change

CBT

- Evidence-based treatment for depression in older adults
- Teaches ways of changing negativistic, over-generalized thinking patterns e.g., being unable to do what you used to be able to do doesn't mean that you are a complete failure as a person
- Gallagher-Thompson's work indicates that CBT may need to be supplemented by interpersonal therapy if older adult has a personality disorder

CBT Modifications

- Some older adults less familiar with psychotherapy – need to be educated about what its about before they accept it
- Need to adapt to sensory impairments such as vision or auditory problems e.g., use bigger print for homework assignment
- Older adults process information slower – need to simplify instructions, go slower, repeat, make sure person understands,
- Materials can be modified for those with cognitive impairment

Interpersonal Therapy

- IPT is effective in treatment of depressed adults & preventing recurrences
- Appears well suited to deal with the interpersonal losses of older adults:
  - Grief/loss
  - Role transitions
  - Interpersonal conflict
  - Poor social skills

Group & Family Therapy

- Group – Allows older individuals to discuss common aging issues; offers peer support
- Life review - Evaluative reminiscence gains perspective on the past & affirmation from others – ‘probably efficacious treatment for depression’ – usually conducted in groups
- Family – Addresses chronic or late life marital stressors; estrangement from adult children; grandparenting strains

Grief Therapy

- Controversial area
- Debate over whether all bereaved should be offered grief therapy – treatment should never be mandated
- Many older adults are resilient and manage fine on their own with time
- Challenge will be to identify those who are most at risk for development of complicated grief

Final Points

- Each older person deserves an individualized assessment & treatment
- Many need combined approaches i.e., those depressed with PDs may need CBT + interpersonal therapy + meds
- Health professionals should aggressively assess depression in older adults just as with young adults