National ECHO: Care of the Elderly

Mood Disorders (Focus on Depression)

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CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY | ACADÉMIE CANADIENNE DE GÉRONTOPSYCHIATRIE

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To promote seniors' mental health by connecting people, ideas and resources.
Coalition Canadienne pour la Santé Mentale des Personnes Âgées
Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

Project ECHO®

Faculty/Presenter Disclosure

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Mitigating Potential Bias

The information presented in this CME program is based on recent information that is explicitly “evidence-based”.

This CME Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in the CME/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards

Learning Objectives

By the end of this session, participants will be able to:

1. Identify key features of mood disorders in older adults
2. List differences between older and younger adults
3. Describe a clinical approach to the assessment and management of late-life depression

Overview of Mood Disorders

- Major depressive disorder
- Persistent depressive disorder
- Substance/medication-induced mood disorders
- Mood disorders secondary to a medical condition
- Bipolar disorder

Depressive Disorders

- Major depressive disorder
- Persistent depressive disorder
- Substance/medication-induced depressive disorder
- Depressive disorder due to another medical condition

➢ *sad, empty or irritable mood + somatic and cognitive changes that impact function*

Depressive Disorders

- Major depressive disorder (MDD)
- **Persistent depressive disorder**
- Substance/medication-induced depressive disorder
- Depressive disorder due to another medical condition

➢ *sad, empty or irritable mood + somatic and cognitive changes that impact function*

Major Depressive Episode

- **↓ Mood**
- **↓ Interest**
- Weight or appetite ↑↓
- Sleep ↑↓
- Psychomotor agitation or retardation
- Fatigue, ↓energy
- Feeling worthless, guilty
- ↓ concentration
- Recurrent thoughts of death

DSM-5

SIGECAPS Mnemonic

Sleep - increased or decreased

Interest - anhedonia

Guilt - worthlessness, hopelessness, regret

Energy - decreased

Concentration - decreased

Appetite – increased or decreased

Psychomotor – retardation or agitation

Suicidality

(Dr. C Gross)

Depressive Disorders with…

- **Anxious distress**
- **Mixed features**: ↑ mood, self-esteem, energy, ↓need for sleep, involvement in risky activities, talkative, racing thoughts
- **Psychotic features**
- **Seasonal pattern**

DSM-5

Minor Depression

- Also referred to as subsyndromal, sub-threshold or subclinical depression
- More common than major depression
- 20-25% of older adults in the community have subthreshold symptoms of depression
- Associated with being female, a high burden of physical illness and poor social supports

Lyness JM et al, *Ann Intern Med* 2006;144(7):496

Minor Depression

- Older adults with minor depression are more likely to use healthcare resources
- Increased suicidal ideation
- Diminished quality of life
- Among older adults with minor depression, the risk of developing major depression is 6x greater

Lavretsky H et al, *Am J Geriatr Psychiatry*. 2002;10(3):239.

Bereavement

- Responses to a significant loss (e.g., **bereavement, financial ruin, natural disaster, medical illness, disability**) can include intense sadness, insomnia and weight loss
- Grief can be distinguished from depression --- preoccupation with loss, feelings of emptiness but not of worthlessness or self-criticism
- If criteria for a MDD disorder are met a MDD can be diagnosed – there is no time restriction

DSM-5

Loss in Late-life

- Retirement
- Relocation
- Role changes
- Health, function
- Vision, hearing
- Independence
- Driving

True or False?

- Rates of depression are higher among older adults vs younger adults

False

- Prevalence and incidence are lower in older adults compared to younger
- Older adults have more functional impairment

Haigh EAP et al. Depression among older adults: A 20-year update on five common myths and misconceptions. Am J Geriatr Psychiatry. 2018 Jan;26(1):107-122.

Depression is Common

- Approximately 5% of older adults > 65 y in the community have major depression
- The rate of depressive symptoms in older adults in primary care settings is higher at 25%
- Among older adults who are medical inpatients it rises to 30% +
- In long-term care settings some studies have found prevalence rates as high as 45-50%

Luppa M et al. Age- and gender-specific prevalence of depression in latest-life--systematic review and meta-analysis. J Affect Disord. 2012 Feb;136(3):212-21.

Age Differences

Older adults:

- More agitation
- Somatic presentations - nausea, constipation, headaches, pain, fatigue

Younger adults:

- More guilt, loss of sexual interest

Hegeman JM et al. Phenomenology of depression in older compared with younger adults: meta-analysis. Br J Psychiatry. 2012; Apr;200(4):275-81; Kok RM, Reynolds CF 3rd. Management of Depression in Older Adults: A Review. 2017;317(20):2114-2122.

Depression in Older Adults

- Underrecognized
  - especially racialized seniors
  - may not report feeling depressed, especially in oldest old
  - changes in energy, reduced appetite, fatigue
  - medication side effects can mimic depression
  - self-stigma

Lyness JM et al. *Am J Geriatr Psychiatry*. 2002;. Licht-Strunk E et al. *Fam Pract* 2007. Fyffe DC et al. *Am J Geriatr Psychiatry* 2004.

Depression in Older Adults

- Undertreated (even when diagnosed)
  - therapeutic nihilism
  - ageism
- ➢ Worsening and persistence of symptoms
- ➢ Treatment of depression can improve outcomes of chronic medical conditions

Licht-Strunk E et al. *BMJ* 2009; Lin EH et al. *JAMA* 2003

Depression and Anxiety

- All anxiety disorders, especially generalized anxiety disorder are associated with depression
- Anxiety itself is a risk factor for depression
- Worse treatment outcomes including decreased rates of recovery, more impairment and reduced quality of life, **higher suicide risk**
- May miss diagnosis of depression; overuse of anxiolytics

Kessler RC et al, *Arch Gen Psychiatry* 2005; Kessler RC et al, *Depress Anxiety* 2010

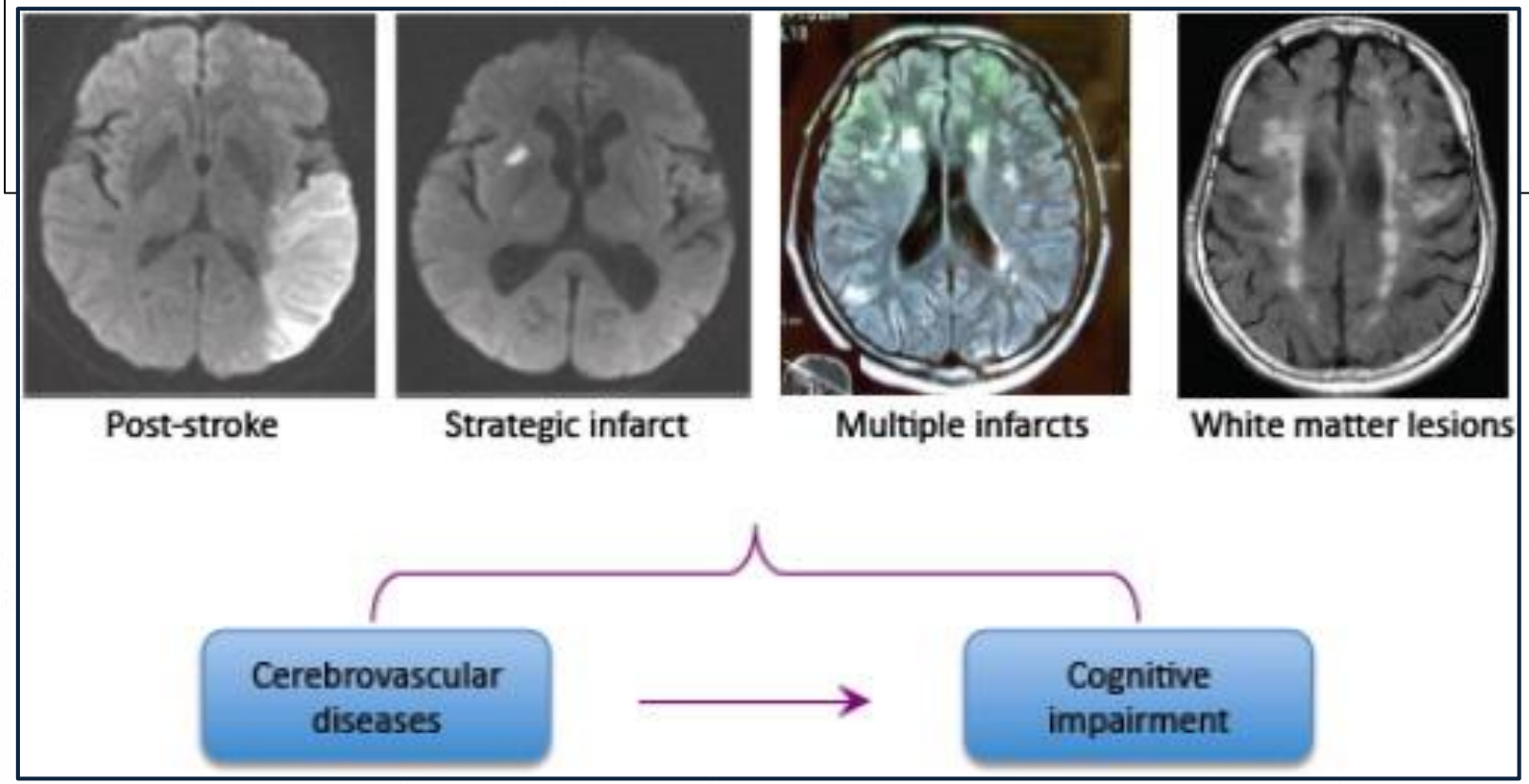
Depressive Disorders with Anxious Distress

- Feeling keyed up or tense
- Feeling unusually restless
- Difficulty concentrating because of worry
- Fear that something awful might happen
- Feeling that one might lose control

Vascular Depression

- Post-stroke depression
  - especially left hemispheric lesions
  - especially in the first 2 years post-stroke, with peak prevalence within 3-6 months
- Cerebrovascular disease leads to chronic ischemic changes
- Depression with frontal executive dysfunction - affecting motivation, organization, sequencing

Lyketsos CG et al, *JAMA* 2002



Steffens DC et al. *Am J Psychiatry* 2003; Iadecola C. *Neuron* 2013

Depression and Dementia

- Depressive symptoms in mid- or late-life increases risk for dementia, especially **vascular dementia,** Alzheimer's
- Late-life depression may be **early presentation** of dementia
- High rates of depression in major neurocognitive disorders
  - apathy, sleep disturbances, social withdrawal are common and **may be mistaken for depression**
  - depression can manifest as agitation

Barnes DE et al, *Arch Gen Psychiatry* 2012; Burke AD et al, *Neurol Ther* 2019

Bipolar and Related Disorders

- Bipolar I
- Bipolar II
- Cyclothymic disorder
- Substance/medication-induced
- Due to another medical condition

DSM-5

Manic/Hypomanic Episode

- Inflated self-esteem, grandiosity
- ↓need for sleep
- Talkative
- Flight of ideas, racing thoughts
- Distractibility
- ↑ goal-directed activity or psychomotor agitation
- Involvement in activities with potential for painful consequences

DSM-5

Bipolar Disorder

Bipolar I Disorder

- **Manic episode** +/- hypomanic or depressive episodes

❑ symptoms present for 1 week or more

Bipolar II Disorder

- **Hypomanic episode *and*** a **major depressive episode**

❑ symptoms present for 4 days or more

❑ *not* severe enough to cause marked impairment in social or occupational functioning

❑ no hospitalization

❑ no psychosis present

Older Age Bipolar Disorder

- Less prevalent
- F>M
- Less excessive sexual interest/behaviour
- Less comorbid anxiety and substance use disorders (but still common)
- Increased functional impairment

Sajatovic M et al, Psychiatr Clin North Am 2011;
Seedat S et al, Arch Gen Psychiatry 2009

Older Age Bipolar Disorder

- Medical comorbidity
  - cardiovascular disease, hypertension, DM, hyperlipidemia
  - cerebrovascular disease, increased risk of stroke
- Deficits in global cognitive functioning, frontal-executive function
- BD association with dementia unclear

Selveraj S et al, *Bipol Disord* 2012; Stanfield AC et al, *Bipol Disord* 2009;

MB Murri et al *J Affect Disord* 2019; A Szmulewicz et al, *Bipolar Disord* 2020; da Silva J et al, *Br J Psychiatry* 2013

First Presentation in Late-life?

Consider:

- Substance use/ medications
- Metabolic or infectious cause
- CNS pathology
- Neurodegenerative illness

Depp CA et al, *Bipolar Disord* 2004; Dols A et al, *Neuropsychiatr Dis Treat* 2016; American Psychiatric Association, *Am J Psychiatry* 2002

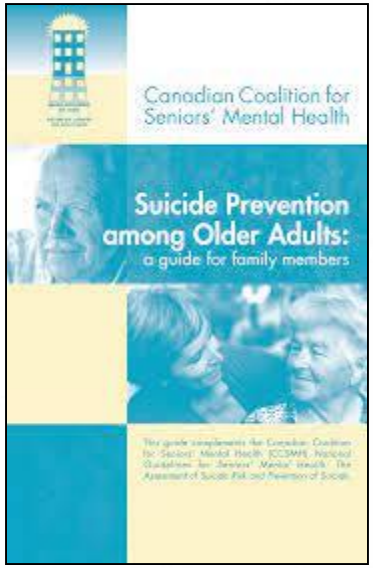
Outcomes of Mood Disorders

- Increased mortality
  - depression post-MI increases risk of death 4x
  - suicide
- Comorbidity
- Increased use of healthcare resources
- Use of substances and medications
- Impaired function and disability
- Decreased quality of life

Sajatovic M et al, *Bipolar Disord* 2015; Schoevers RA et al, *Br J Psychiatry* 2000; Ziegelstein RC, *JAMA* 2001

Suicide in Late-life

- Fewer but more successful attempts, especially males ≥ 85
- hopelessness
- agitation, restlessness
- ↓ concentration
- insomnia
- psychosis
- alcohol use
- personality disorders
- prior attempt
- comorbid physical illness
- chronic pain
- family history
- social isolation
- widowhood



Suicide in Late-life

I	**Ideation**	Threatening to hurt or kill self; looking for ways to die
S	**Substance Abuse**	Increased or excessive substance use (alcohol or drugs)
P	**Purposelessness**	No reason for living; no sense of purpose in life
A	**Anxiety**	Anxiety, agitation; unable to sleep
T	**Trapped**	Feeling trapped - like there's no way out; resistance to help
H	**Hopelessness**	Hopelessness about the future
W	**Withdrawal**	Withdrawing from friends, family and society; sleeping all the time
A	**Anger**	Rage, uncontrolled anger; seeking revenge
R	**Recklessness**	Acting recklessly or engaging in risky activities, seemingly without thinking
M	**Mood Changes**	Dramatic mood changes

- Created by the American Association of Suicidology

Assessment (Focus on Depression)

- Use of standardized scales (none specific for geriatric bipolar disorder)
- Assess severity symptoms of depression
- Determine effectiveness of treatment
- Monitor progress so can change therapy
- *Not* superior to clinical interviews
- Screening in primary practice

Two-Question Screen

1) During the past month, have you been bothered by feeling down, depressed or hopeless?

2) During the past month, have you been bothered by little interest or pleasure in doing things?

- If at least one positive answer, the screen can be followed up with the PHQ-9 or Geriatric Depression Scale-15

Tsoi KK, Chan JYC et al. Comparison of diagnostic performance of Two-Question Screen and 15 depression screening instruments for older adults: systematic review and meta-analysis. *British J Psych*. 2017 Feb

Patient Health Questionnaire

- PHQ-2 is validated for use in older adults who are outpatients, medically ill
- Freely available online: https://www.phqscreeners.com/

PHQ-9

- Self-report
- Primary care settings
- Outpatients, physically ill
- Covers all 9 DSM-5 criteria for major depression
- Used to assess response to treatment in individual patient care
- Available in public domain

Geriatric Depression Scale

- The short form has 15 items and can be completed in 5-10 minutes
- Outpatients, inpatients, physically ill
- Not valid for use among those with moderate to severe dementia

http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/short_long_geriatric_depression_scale_GDS.pdf

Geriatric Depression Scale

5 item version

- 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 going out and doing new things?
- Do you feel pretty worthless the way you are now?

Dementia and Depression

- **Cornell Scale for Depression in Dementia**
- Inpatients and outpatients
- Observer and informant based information
- For the week prior to the interview
- https://cgatoolkit.ca/Uploads/ContentDocuments/cornell_scale_depression.pdf

Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

Scoring System: a = unable to evaluate
0 = absent
1 = mild or intermittent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety anxious expression, ruminations, worrying	a	0	1	2
2. Sadness sad expression, sad voice, tearfulness	a	0	1	2
3. Lack of reactivity to pleasant events	a	0	1	2
4. Irritability easily annoyed, short-tempered	a	0	1	2

B. Behavioral Disturbance

What Makes People Vulnerable?

Assessment: Risk Factors

- Ms. B. is divorced and lives alone in a small apartment on a fixed income. Lately she's been quite worried that she'll run out of money
- She was the main caregiver for her 95 year-old mother who died a few months ago
- She doesn't get out much
- She admits that since her mother died she's been drinking 3-4 glasses of wine each night

Risk Factors for Depression

- Divorced, lives alone in a small apartment on a fixed income. Lately she's been quite worried that she'll run out of money
- She was the main caregiver for her 95 year-old mother who died 4 months ago
- She doesn't get out much
- She's been drinking 3-4 glasses of wine each night

Ms. B.

- Ms. B used to enjoy going for long walks, but pain from osteoarthritis in her knees now prevents this
- She smokes, has hypertension and diabetes
- She has difficulty sleeping

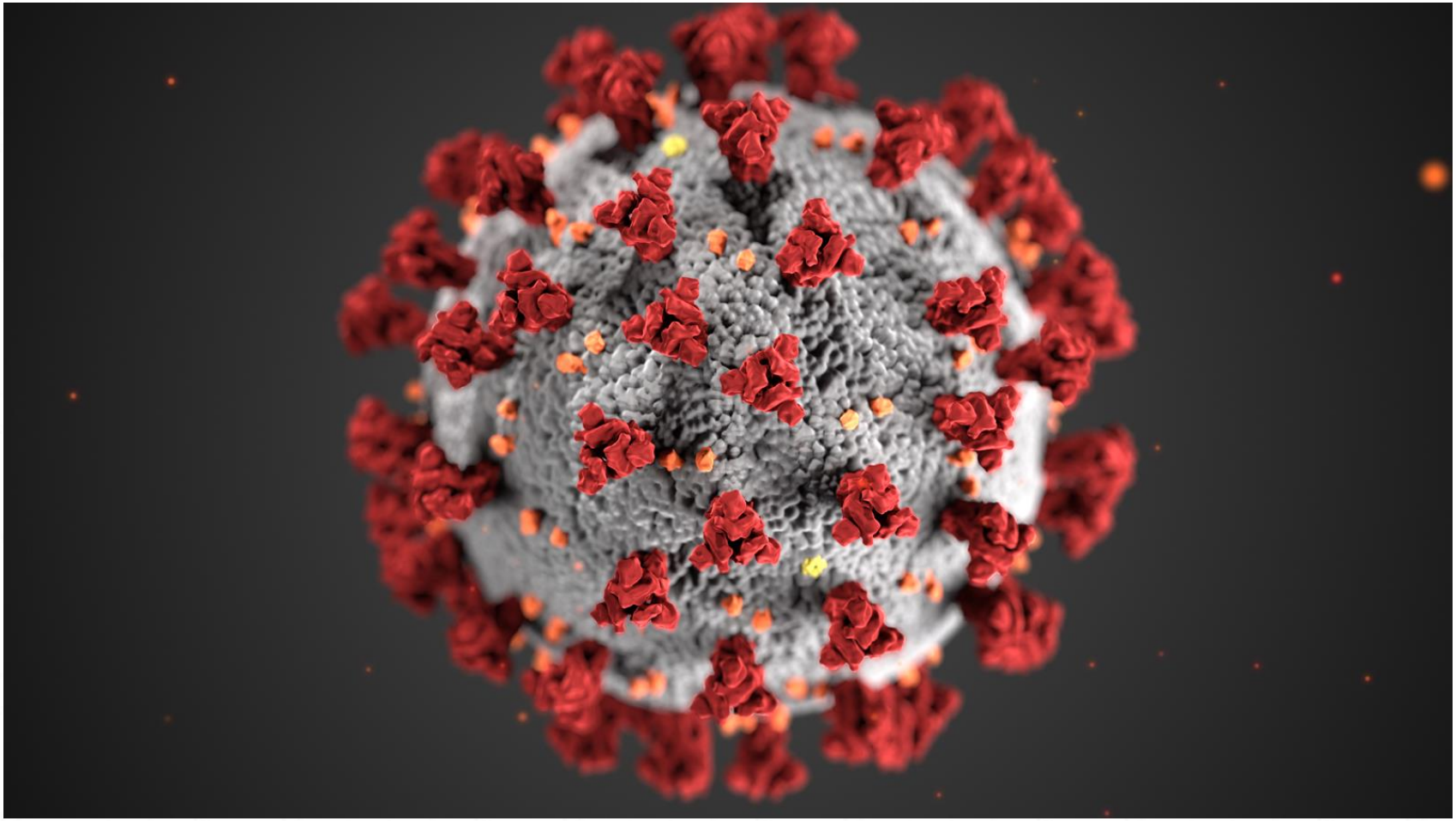
Risk Factors for LLD

- Ms. B. used to enjoy going on long walks, but pain from osteoarthritis in her knees now prevents this
- She smokes, has hypertension and diabetes
- She has difficulty sleeping
  - ? sleep apnea

Gallagher D et al. Late life depression: a comparison of risk factors and symptoms according to age of onset in community dwelling older adults. *Int J Geriatr Psychiatry*. 2010 Oct;25(10):981-7; Maurer D. *Am Fam Physician*. Screening for depression symptoms and risk factors. 2012 Jan 15;85(2):139-144; Aziz R, Steffens DC. What are the causes of late-life depression? *Psychiatr Clin North Am.* 2013 December; 36(4): 497–516.

Risk Factors for Late-life Depression

Psychosocial Factors	Psychiatric Comorbidity	Other Comorbid Factors
• Being female • Divorced, separated, widowed • Bereavement • Loss • Low socioeconomic status • Social isolation • Financial stress • Caregiving burden • (Family history)	• Anxiety • Insomnia • Substance abuse • Cognitive impairment	• Multiple illnesses • Recent hospitalizations • Poor self-rated health • Uncontrolled pain • Difficulty with ADLs • Reduced mobility • Living in long-term care



Management of Mood Disorders

- Collateral is very helpful
- Comprehensive biopsychosocial history
  - depressive, manic and hypomanic symptoms
  - anxiety, psychosis, substance use
  - safety assessment including suicidal ideation
  - medications
  - cognition
- Comorbid conditions
- Family and social history

Management of Late-life Depression

- Depression in late-life is harder to treat
- **T or F?**

T:

- response rates to antidepressants may be lower in older adults (but are better than placebo)
- more likely to become chronic, with frequent relapses

Late-life Depression

- Also F:

➢ older adults respond just as well as younger ones to non-pharmacological treatments

➢ they may be more responsive to electroconvulsive therapy

Cuijpers P et al. Managing depression in older age: psychological interventions. *Maturitas* 2014; 79:160-169; Pimontel MA et al. Executive dysfunction and treatment response in late-life depression. *Int J Geriatr Psychiatry* 2012; 27:893-899; Taylor WD: Clinical practice. Depression in the elderly. *N Engl J Med* 2014; 371:1228-1236

CCSMH 2020 Guideline Update

- Prevention is highlighted
  - exercise
  - reduce social isolation and loneliness
  - Instillation of hope and positive thinking
  - tools for setting and meeting health-related goals

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Optimal Aging: 5 Domains

fountain of health

The Fountain of Health Prescription: 5 Things You Can Do

Changing the way you think about aging might be one of the most important ways to stay healthy. As it turns out, attitude is key to longevity and happiness! Here are the 5 key actions that can help you stay healthy for life:

Positive Thinking

Social Activity

Physical Activity

Brain Challenge

Mental Health

1. How would you rate yourself in terms of being socially connected to others?
2. How would you rate yourself in terms of being interested in learning new things?
3. Using your own definition, how would you rate yourself in terms of successful aging?
4. How would you rate yourself in terms of how likely you are to seek mental health help if you needed it?
5. How would you rate yourself in terms of being physically active?

Beyond Prevention

- Subthreshold or minor depression - monitor
- Collaborative care
  - lowers rates of suicidal ideation for depressed older adults
  - fosters education and sharing of resources
- Approach to treating **mild to moderate** vs. **moderate to severe** depression…

Bruce ML et al, *JAMA* 2004; Unutzer J et al, *Am Geriatr Soc*, 2006

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Mild to Moderate Depression

- Non-pharmacological approaches
  - exercise and mind-body interventions (tai chi, yoga, mindfulness based stress reduction)
  - psychotherapies
    - CBT, Problem-solving therapy (PST)
    - behavioural activation, reminiscence therapy, interpersonal therapy, psychodynamic and supportive psychotherapy
      - individual and group, in-person and virtual

Mild to Moderate Depression

- For mild to moderate depression, non-psychological approaches *or* medication are both effective
- In addition, can consider light therapy
- Older adults may prefer non-medication approaches, especially if concerned about medication side-effects

Moderate to Severe Depression

- Evidence supports use of medication *and* psychotherapy with moderate to severe depression
- ECT for severe depression, especially with psychotic features, which can also be treated with combination therapy (antidepressant plus antipsychotic)

Medications

- Mild to moderate depression
- Moderate to severe depression
- **Sertaline or duloxetine**
- Escitalopram or citalopram as alternatives – but concerns about QTc prolongation
- Other options include venlafaxine, bupropion and mirtazapine

Key Considerations

- Start low and go slow (but go)
- Older adults may take longer to achieve response
- Follow q1-2 weeks to monitor for side effects and assess response
- Augmentation strategies include adding (lithium, aripiprazole), switching or combining (2 antidepressants, adding psychotherapy)

Miscellany

- Duloxetine and venlafaxine (SNRIs) target pain
- SNRIs and SSRIs can cause hyponatremia - check sodium after 2-4 weeks
- Mirtazapine (NaSSA) is associated with weight gain and sedation
- Above are safer in older adults as less anticholinergic side-effects and fewer drug-drug interactions – other ones work, too

Final Points

- As a group, older adults are very resilient
- Mood disorders greatly affect quality of life, function and health
- They are treatable if recognized
- Identify who is vulnerable – know risk factors
- Prevention involves positive health behaviours including exercise, social connections
- Both psychotherapy and pharmacotherapy are effective

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