Assessment and Management of Depression in Older Adults

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Faculty/Presenter Disclosure

- Faculty: Cindy Grief
- Relationships with financial interests:
  - no financial conflicts

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Disclosure of Financial Support

- This program has **NOT** received financial support other than the support of the MOHLTC
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- Potential for conflict(s) of interest: **None to be disclosed**

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 late-life depression
2. Discuss the assessment of late-life depression
3. Describe an approach to its management

Recognizing Depression

- Comorbid conditions
- Cohort effect
- Ageist assumptions
- Treatment nihilism
- Knowledge gaps

Recognizing Depression

- Culturally sensitivity and awareness
- It may take more time to elicit symptoms
- Depression is more likely to go unrecognized and untreated
- Even when recognized, less likely to be treated

Undertreatment of Late-Life Depression

- Increased cost to the healthcare system (ER visits, hospitalization)
- Affects medication use
- Impaired function and disability (worsening of comorbid conditions)
- Decreased quality of life
- Increased mortality

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

Older Adults vs. Younger

- Less guilt and fewer complaints about decreased sexual function
- May not report feeling depressed, especially the “oldest-old”
- Anxiety and agitation more prominent
- Cognitive impairment with depression
- Loss and bereavement common

Hegeman JM et al, *Br J Psychiatry* 2012; Kok RM et al, *JAMA* 2017;
Unutzer J, N Engl J Med, 2007; Licht-Strunk E et al, Family Practice 2007; BMJ 2009; Fyffe DC et al, Am J Geriatr Psych, 2004; Gallo JJ,
J Am Geriatr Soc, 199

Older Adults vs. Younger

- Older adults are *less* likely to become depressed than younger individuals
- However, they are
  - *more* likely to relapse
  - *more* likely to develop chronic depressive symptoms
  - *more* impaired when they become depressed

Haigh EAP et al, *Am J Geriatr Psychiatry,* 2018

How Common is Depression?

- Approximately **5% of older adults** > 75 years in the community have a **major depressive disorder**
- If you consider **depressive symptoms**, the rate is much higher – **more than 10%** of older adults in primary care settings

Sjoberg L et al, *J Affect Disord*, 2017; Kok RM et al, *JAMA* 2017; Luppa M et al, *J Affect Disord*, 2012

How Common is Depression?

- Among older adults who are medical inpatients, diagnoses of depression reach **30% or higher**

- In long-term care settings, some studies have found prevalence **rates of 45-50%**

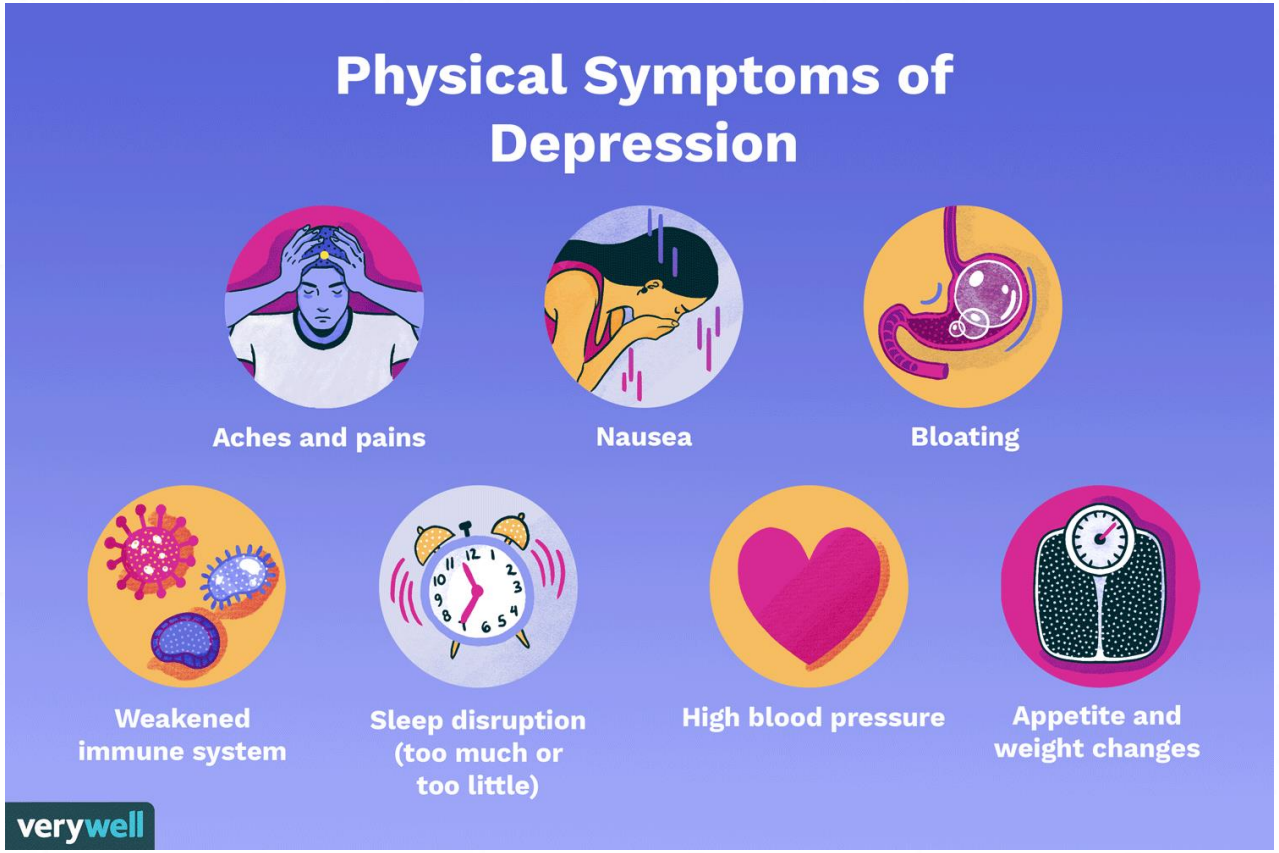
Sjoberg L et al, *J Affect Disord*, 2017; Kok RM et al, *JAMA* 2017; Luppa M et al, *J Affect Disord*, 2012

Depression

- “I’m so depressed”
- Depression is a symptom
- Depressive disorders

  presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function

Recognizing Major Depressive Disorder (MDD)



- Diagnostic features
- Associated features
- Negative health outcomes

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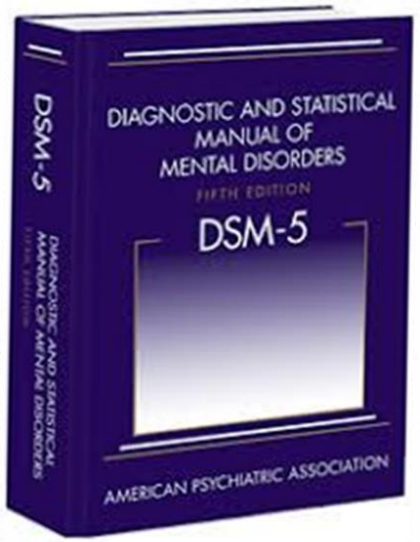
Major Depressive Disorder

Consists of a Major Depressive Episode

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



SIGECAPS Mnemonic

Sleep - increased or decreased

Interest - anhedonia

Guilt - worthlessness, hopelessness

Energy - decreased

Concentration - decreased

Appetite – increased or decreased

Psychomotor – retardation or agitation

Suicidality/**S**adness

Symptoms of Depression

knowmedge

Mnemonic: "A SAD FACES"

A	SAD	FACES
Appetite (Weight Change)	**S**leep (Insomnia / Hypersomnia)	**F**atigue
	Anhedonia	**A**gitation / Retardation
	Dysophria	**C**oncentration Diminished
		Esteem (Low) / Guilt
		Suicide / Thoughts of Death

Major Depressive Disorder

- 5/9 symptoms of depression are present for >/2 weeks
- Mild if fewer symptoms, intensity is distressing but manageable and there is minor impairment vs. moderate or severe depressive disorder
- What if there are fewer than 5 symptoms?

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)

Minor Depression in Older Adults

- Less than 5 depressive symptoms are present (subsyndromal or subthreshold)
- 2-3x more prevalent than major depression in community samples
- More common among women, especially those with few social supports
- More common than major depression in long-term care settings
- Associated with negative health outcomes

Rodriguez MR et al, *BMC Psychiatry* 2012; Meeks T et al, *J Affect Disord* 2011; Lyness JM et al, *Ann Intern Med, 2006*
Oh DJ et al, Aust N Z J Psychiatry 2020; Buchtemann D et al, J Affect Disord 2012

Minor Depression is Common

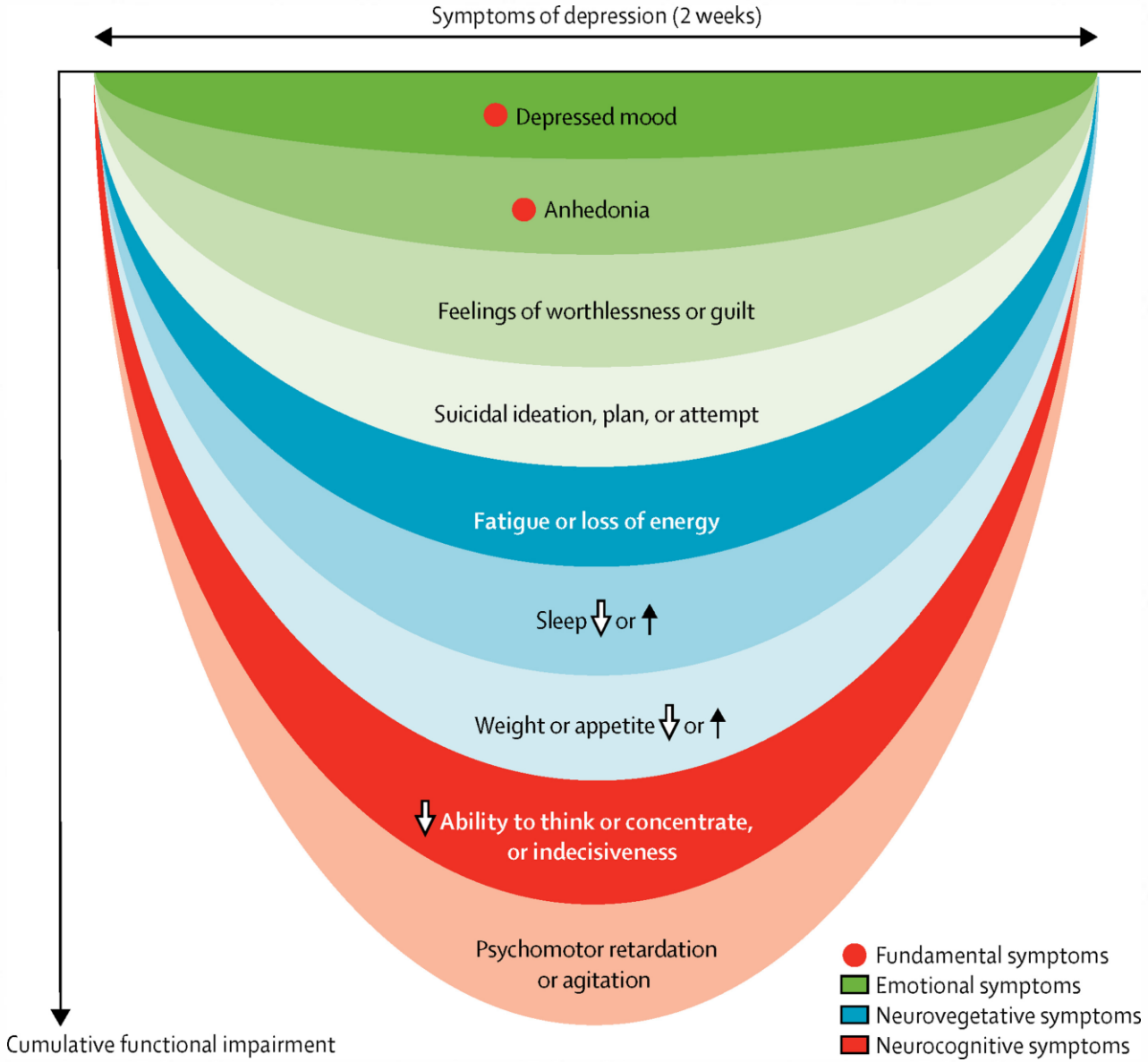
- **8-10%** of those with minor depression go on to develop a major depression within one year
- **6-fold risk** of developing major depression among those with minor depression at baseline

Rodriguez MR et al, *BMC Psychiatry* 2012; Meeks T et al, *J Affect Disord* 2011; Lyness JM et al, *Ann Intern Med,* 2006

Symptom Domains

THE LANCET

Malhi GS, Mann JJ, Depression. *Lancet* 2018; 392(10161), P2299-2312



Depressive Disorders

- Major depressive disorder
- Persistent depressive disorder (former dysthymia)
- **Substance/medication-induced depressive disorder**
  - disturbance in mood with intoxication or withdrawal
- **Depressive disorder due another medical condition**
  - causal relationship and the development of mood symptoms
- Premenstrual dysphoric disorder

Characterizing Depressive Disorders

- Depressive disorder….
  - with anxious distress
  - with mixed features
  - with melancholic features
  - with atypical features
  - with psychotic features
  - with catatonia
  - with seasonal pattern

Assessment

- Recognizing symptoms of depression
- **Common presentations**
- Risk factors
- Interview
- Rating scales

Bereavement

➢ **How do you distinguish between normal grief and depression?**

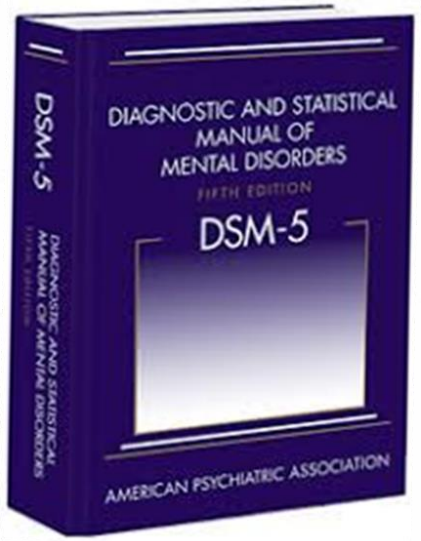
- Ms. B is 75, and was widowed suddenly 2 months ago
- She thinks constantly about her late husband
  - sleeping poorly, feeling tired
  - recently has stopped playing bridge
  - forgetful
  - “forcing” herself to eat

Bereavement

Normal Grief

- Intense feelings of sadness, emptiness
- Ruminations
- Insomnia
- Poor appetite with weight loss

➢ A diagnosis of depression can be made at any time



Normal Grief vs. Depression

Ruminations/thoughts

- preoccupation with deceased vs. self-critical, pessimistic thoughts of depressed
- **if bereaved individual may think about death and dying, but focus is on the deceased** vs. depressed person who wants to escape

Self-esteem

- **preserved in grief**
- with depression, feelings of worthlessness and self-loathing

DSM-5, pp125-126

Late-Life Losses

- Role changes
- Relocation
- Loss of health, cognitive changes
- Loss of mobility
- Loss of hearing, vision
- Loss of license
- Loss of independence

Mr. K

- 78 year-old married, retired accountant
- Very anxious
- Calling often
- He’s very worried about his health
- Feels nauseous, complains of headaches
- Denies feeling depressed

Major Depressive Disorder with Anxious Distress

- 2 or more symptoms
  - 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

Anxiety and Depression

- All anxiety disorders are associated with depression
- Anxiety itself is a risk factor for depression
- Depression and comorbid anxiety in older adults is associated with:
  - less response to treatment
  - more impairment of function
  - reduced quality of life
  - higher suicide risk

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

Anxiety and Depression

- Generalized anxiety disorder or GAD and depression often comorbid
  - GAD/depression 3x more prevalent than pure GAD
  - overlapping symptoms
- Panic attacks common in major depression
- Worries and ruminations
  - ensure not of a psychotic intensity
  - ensure not a manifestation of bipolar illness

Depression and Psychosis

- Depressive disorders with psychotic features
  - delusions and/or hallucinations are present
  - often consistent with depressive themes (inadequacy, nihilism)
  - somatic preoccupation (overvalued idea vs. delusion)
- Psychotic disorder
- Bipolar disorder

Ms. F

- 80 year-old woman, retired social worker
- MI 4 months ago, has recovered well
- Mobility reduced due to arthritis
- Has withdrawn from social activities
- History of severe depressive episodes
- Never treated with an antidepressant

Bipolar Disorder

Bipolar I Disorder	**Bipolar II Disorder**
• Manic episode +/- hypomanic or **major depressive episodes**	• Hypomanic episode *and* a **major depressive episode**

Mr. W

- 72 year-old widower with Parkinson's disease
- Difficulty coping
- Fatigue, lacks energy, significant weight loss
- Low mood, difficulty with sleep
- Still somewhat able to enjoy social interactions

Depression and Comorbidity

- Parkinson's, MS, chronic renal disease and *many* other conditions
- 3x risk of dying after a stroke if also depressed
- Depression following an MI increases risk of dying 4x
- Psychiatric comorbidity
- Depression affects participation in care

Park M et al, Clin Geriatr Med, 2015; Whyte EM et al, Whyte EM et al, J Am Geriatr Soc, 2004

Depression and Cognition

- Impaired concentration in depression
- Memory difficulties may be main complaint and mistaken for dementia ("pseudodementia")
- Late-life depression may be early presentation of dementia
- Depressive symptoms in mid- or late-life increase risk for dementia

Koenig AM et al, J Int Neuropsychol Soc 2014; Robinson RG et al, 2016; Steffens DC et al, 2003; Iadecola C, 2013

Depression and Dementia

- Depression upon diagnosis
- Depression can present as agitation
- Apathy, sleep disturbances, social withdrawal are common
- Depression in caregivers

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

Vascular Depression

- Vascular depression
  - apathy
  - frontal executive dysfunction
- Increased vulnerability to developing vascular dementia
  - vascular depression
  - If have major depression plus vascular risk factors
- Depression post-stroke

Assessment

- Symptoms of depression
- Common presentations
- **Risk factors**
- Interview
- Rating scales

Who is Vulnerable to Developing Depression?

- 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 admits that since her mother's death, she's been drinking 3-4 glasses of wine each night
- She doesn't get out much
- She acknowledges feeling lonely

What are Ms. B's Risk Factors for Depression?

- She's stopped going for walks
- She has significant knee pain from arthritis
- She smokes, has hypertension and diabetes
- She's been told that she snores

Ms. B's Risk Factors for Depression

- **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**
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What are Ms. B's Risk Factors for Depression?

- She's **stopped going for walks**
- She has significant knee **pain** from arthritis
- She **smokes**, has **hypertension and diabetes**
- She's been told that **she snores**

Risk Factors for Late-Life Depression

Psychosocial Factors

- Being female
- Divorced, separated or widowed
- Bereavement, loss
- Low socioeconomic status
- Social isolation
- Racism, marginalization
- Financial stress, poverty
- Caregiving burden
- Family history

Risk Factors for Late-Life Depression

Mental health comorbidity

- Anxiety
- Trauma
- Insomnia
- Substance abuse
- Cognitive impairment

Risk Factors for Late-Life Depression

Other comorbidity

- Multiple illnesses
- Recent hospitalizations
- Poor self-rated health
- Uncontrolled pain
- Difficulty with activities of daily living
- Reduced mobility
- Living in long-term care

Interview

- Collateral history is ideal
- Comprehensive history
  - timing and pattern of symptoms
  - stressors, coping and supports
  - comorbid symptoms/diagnoses
  - suicidal ideation
  - medications, including over the counter
- Comorbid medical conditions and cognitive status
- Family and personal history

Validated Rating Scales

- Patient Health Questionnaire (PHQ)
- Geriatric Depression Scale (GDS)
- Beck Depression Inventory (BDI)
- Zung Self-Rating Depression Scale (Zung SDS)
- Montgomery and Asberg Depression Rating Scale (MADRS)
- Hamilton Depression Rating Scale (HDRS or HAM-D)
- Cornell Scale for Depression in Dementia (CSDD)

Rating Scales

PHQ-2 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Scoring: A score of 3 or more is considered a positive result. The PHQ-9 (Table 3) or a clinical interview should be completed for patients who screen positive.

PHQ = Patient Health Questionnaire.

Adapted from Patient Health Questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed February 8, 2018.

Maurer DM et al, *Am Fam Physician*2018;98(8):508-515

Patient Health Questionnaire

- Both the PHQ-2 and PHQ-9 are validated for use in older adults in primary care, outpatients, medically ill and long term care
- Freely available online: https://www.phqscreeners.com/

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

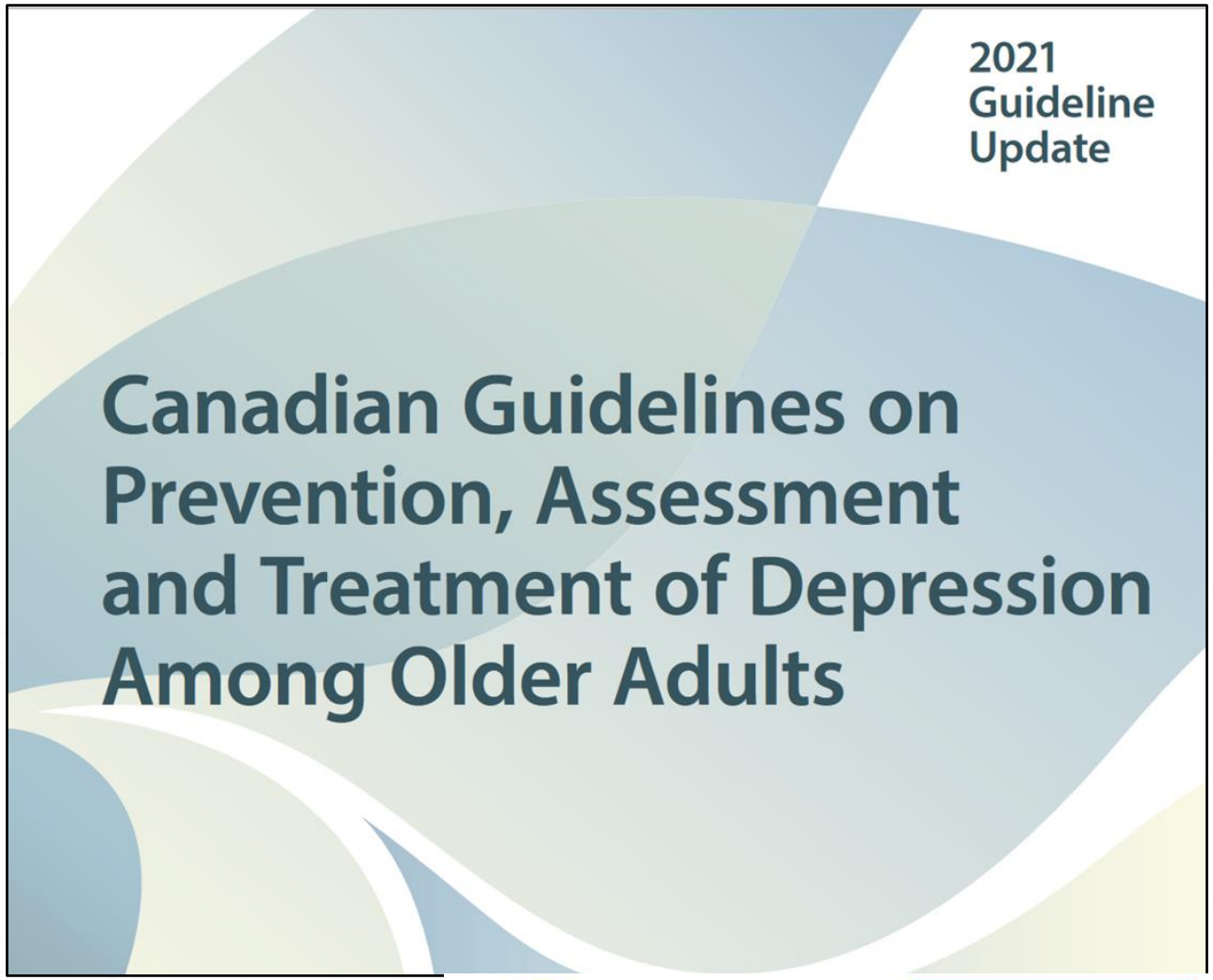
Kroenke K et al, 2003

Geriatric Depression Scale

- Short form has 15 items and can be completed in 5-10 minutes
- Outpatients, inpatients, medically ill
- Not valid for use among those with moderate to severe dementia
- https://web.stanford.edu/~yesavage/GDS.html
- GDS-30 https://psychology-tools.com/test/geriatric-depression-scale

Yesavage JA et al, 1983; Sheikh JI et al, 1986

Management



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Management

- **Prevention** is highlighted
  - ➢reduction of social isolation and loneliness
  - ➢exercise
  - ➢instillation of hope and positive thinking
  - ➢tools for setting and meeting health-related goals

    https://fountainofhealth.ca/

Canadian Coalition for Seniors' Mental Health, 2021

Management

- **Minor depression** - monitor
- Collaborative care
  - lowers rates of suicidal ideation for depressed older adults
  - fosters education and sharing of resources
- Consider whether depression is **mild to moderate** vs. **moderate to severe**
- Consider comorbidity

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

Mild to Moderate Depression

- Non-pharmacological approaches ***or*** medication are **both effective**
- In addition, can consider light therapy
- Older adults may ***prefer*** non-pharmacological approaches
- Concerns about side-effects and interactions

CCSMH Canadian Guidelines on Prevention, Assessment and Treatment of Depression among Older Adults, Updated June 2021

Mild to Moderate Depression

- **Non-pharmacological approaches**
  - exercise
  - mind-body interventions
    - tai chi
    - yoga
    - mindfulness based stress reduction

Mild to Moderate Depression

- **Non-pharmacological approaches**
  - psychotherapies
    - cognitive behaviour therapy
    - problem-solving therapy
    - behavioural activation
    - reminiscence therapy
    - interpersonal therapy
    - psychodynamic psychotherapy
    - supportive psychotherapy
      - individual and group, in-person and virtual

Moderate to Severe Depression

- Evidence supports use of **<u>medication</u>** ***and*** **psychotherapy** for moderate to severe depression

- ECT for severe depression, especially with psychotic features

CCSMH Canadian Guidelines on Prevention, Assessment and Treatment of Depression among Older Adults, Updated June 2021

Medications

- Mild to **moderate to severe** depression
- Sertraline or duloxetine; escitalopram or citalopram as alternatives
- Other options: venlafaxine, bupropion or mirtazapine
- lithium, lamotrigine and antipsychotics
- ? fear of prescribing antidepressants to older adults with significant cardiac, renal disease
- benzodiazepines are not a great choice, especially if the only medication used

CCSMH Canadian Guidelines on Prevention, Assessment and Treatment of Depression among Older Adults, Updated June 2021

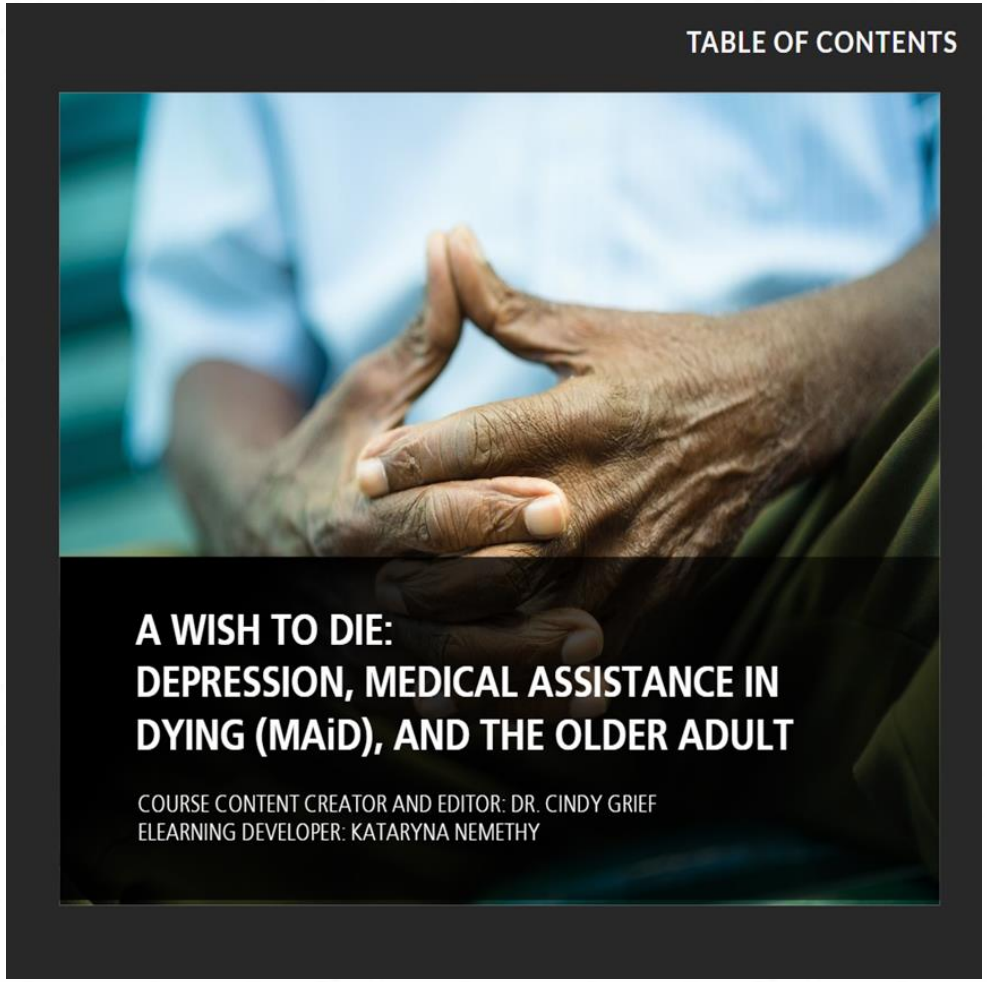
Key Considerations for Dosing

- 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

Final Points

- Identify who is vulnerable through knowledge of risk factors
- Depression greatly affects quality of life, function and health
- It is comorbid with many conditions
- Treatment can have a significant impact in all these spheres, so recognition is important
- Prevention involves positive health behaviours including exercise, social connections
- Both psychotherapy and medications are effective

Additional Resources



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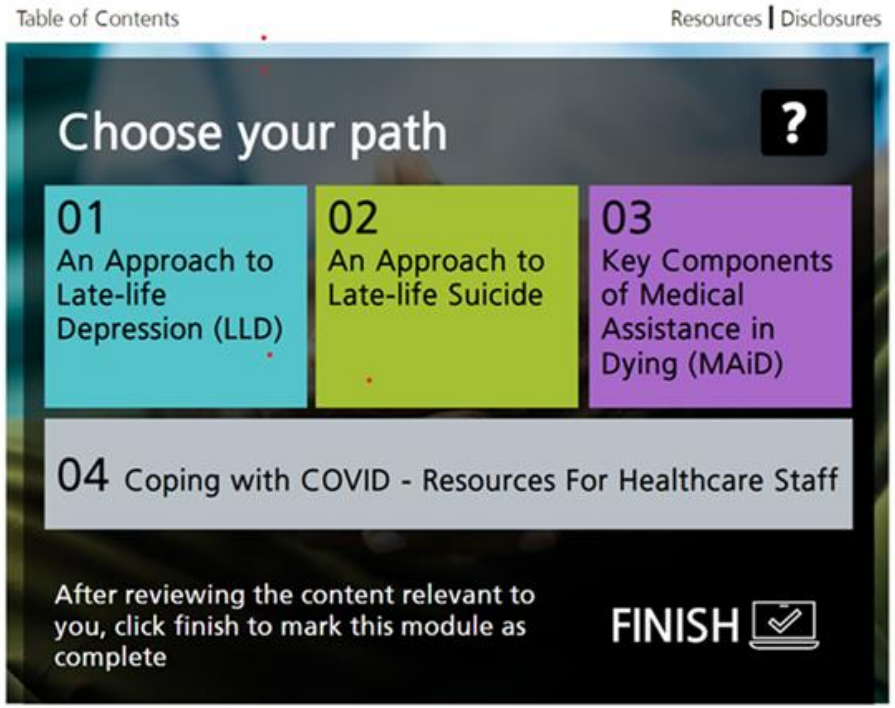

Additional Resources: Prevention

- psyched@baycrest.org
- Strategies to Promote Successful Aging: Wisdom, Resilience and Social Connections – Dr. Dilip V. Jeste
- Let's Connect: Developing Clinical Guidelines for Loneliness and Social Isolation among Older Adults – Dr. David Conn

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