

# Detecting and Treating Geriatric Depression

by Elizabeth Fried Ellen, LICSW

*Geriatric Times* • May/June 2001 • Vol. II • Issue 3

---

Approximately 15% of American seniors are depressed, according to figures from the American Association for Geriatric Psychiatry (AAGP) (2001). That figure jumps to 25% among patients with chronic illness; and depression is especially prevalent in seniors with stroke, Parkinson's disease, cancer, arthritis, Alzheimer's disease and ischemic heart disease. As many as 50% of elders who live in institutionalized settings meet diagnostic criteria for depression (AAGP, 2001).

Despite these statistics, depression continues to be underdiagnosed and undertreated in primary care settings (Rush et al., 1993). Patients and doctors may share the erroneous belief that depression is a normal part of aging, given the common stressors of physical illness, loss, and role changes associated with retirement and other psychosocial factors.

Cognitive difficulties, such as decreased attention span, may be more commonly observed in elderly patients with depression, while the sadness generally thought to be a hallmark of depression may be absent. Irritability, especially in male patients, can be another diagnostic tip-off. While such difficulties may bear an initial resemblance to dementia, depressed seniors are more likely to demonstrate problems with attention, motivation and concentration, as well as decreased speed of information processing. Since depression and dementia can exist concurrently, a thorough assessment is required to determine the best course of clinical action (Boswell and Stoudemire, 1996).

Depressed elders are far more likely to show up in primary care offices than they are to see mental health care professionals (Gallo et al., 1995, as cited in Gallo et al., 1999). Common signs of depression observed in primary care settings may include weight loss, headaches, fatigue, gastrointestinal symptoms, pain and multiple vague somatic complaints (AAGP, 2001; Boswell and Stoudemire, 1996).

Many seniors may be reluctant to talk about depression, based on generational stigma about mental illness. "They'll be sitting at home with terrible depression and then get themselves together to come to the doctor's office," said Massachusetts geriatric psychiatrist Gary Moak, M.D., in an interview with *Geriatric Times*. "They can manage to look good in the doctor's office and tend to underreport symptoms [psychiatric and otherwise] to the doctor... They'll even crack jokes and not disclose that most of the time they're pretty miserable."

He added that some seniors are reluctant to disclose psychological difficulties because they mistakenly believe they have Alzheimer's disease and worry that they'll end up in an institutionalized setting if they share their concerns with others. "They're thinking, 'If I can get through the doctor's appointment, then I can get home.' Their families also believe that."

The open-ended exploration that is often required to make the diagnosis can intensify the time crunch experienced by physicians. "Primary care doctors are trained to think about depression the way it's presented in the textbook," William Reichman, M.D., past president of the AAGP, told *GT*. "You have to really probe and devote more time to it. The physician has a lot to do...talking about mental health is not a big part of the visit," particularly when there are already existing medical conditions that require follow-up.

If a clinician suspects that an older person is depressed, there are a variety of assessment tools to help make -- or rule out -- the diagnosis. Differential diagnoses include organic (secondary) disorders, early onset dementia, delusional disorders, bipolar illness and substance-induced mood disorders (Rush et al., 1993). Among the numerous diagnostic tools that gauge depressive symptoms is the Geriatric Depression Scale, a simple self-rating questionnaire that can be easily administered in the primary care setting and is sensitive to differences in clinical presentation often observed in elders. A close look at a senior's existing medication regimen also can provide important clues. Moak remembered a case in which an elderly woman's depression cleared rapidly once she was taken off hypertension agents known to precipitate depression. This intervention occurred after a series of unsuccessful psychotherapy sessions based on the belief that the woman's depression was the result of increased dependency rooted in physical disability. "You can't assume that someone is depressed because their life is miserable," Moak said. "The opposite may be true."

Including family members in history taking and treatment planning is critical, according to Stephen Ryan, M.D., M.P.H., a Rochester, New York-based geriatrician and co-author of a 1999 study examining the attitudes, knowledge and behavior of family physicians treating late-life depression (Gallo et al., 1999). Without them, he told *GT*, "You're not looking at the whole person and the pieces that contribute to who they are now... We frequently turn to the family to give us the story."

Medication, electroconvulsive therapy (ECT) and cognitive-behavioral psychotherapy have all been successfully used to treat depression in elderly patients.

Since seniors often are on multiple medications for a variety of medical conditions, adding psychotropics can complicate an already delicate balancing act. Both selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) can be used safely and effectively. When prescribing any medication, it is essential to consider normally occurring changes in cardiac, hepatic and renal function, which create the necessity for regular monitoring to avoid toxicity (particularly when using TCAs) (Rush et al., 1993).

When prescribing an antidepressant, clinicians should keep in mind that the first -- or second -- choice of medication either may not work or may present an unmanageable side-effect profile. Candid, proactive discussion with patients about side effects and the length of time/dosage required to achieve therapeutic effect is essential to fostering a positive treatment alliance and encourages medication adherence. Regularly scheduled

appointments to address questions and concerns as they arise can be particularly effective.

Electroconvulsive therapy can be a lifesaving intervention for severely depressed (i.e., suicidal) seniors, those whose symptoms have not responded to medication or those who cannot tolerate a medication's side effects.

Regardless of the treatment options chosen by doctors and their patients, "collaboration and open, sustained communication is vitally important," said Reichman. "We should be doing much better than we're doing. With older people who are frail, it's very important for primary care physicians to know how the mental health issues affecting the patient can have an impact on the physical issues. Conversely, it's important to know how a patient's physical status may be impacting psychological feelings...Patients can only benefit from that."

## **References**

AAGP (2001), Late Life Depression: A Fact Sheet. Available at: [www.aagppa.org/p\\_c/depression.asp](http://www.aagppa.org/p_c/depression.asp). Accessed March 22.

Boswell EB, Stoudemire A (1996), Major depression in the primary care setting. *Am J Med* 101(6A):3S-9S.

Gallo JJ, Ryan SD, Ford DE (1999), Attitudes, knowledge, and behavior of family physicians regarding depression in late life. *Arch Fam Med* 8(3):249-256.

Rush AJ, Golden WE, Hall GW et al. (1993), Depression in Primary Care: Vol. 2. Treatment of Major Depression. Clinical Practice Guideline No. 5. Rockville, Md.: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services. AHCPR Pub. No. 93-0551.