Depression in Older Adults

Stephen Thielke
Psychiatry and Behavioral Sciences

Disclosures

I am an employee of the VA.

I have no financial relationships with pharmaceutical, medical device, or insurance companies.

I am not on any speaker's bureaus or commercial advisory boards.

I will be not discuss off-label uses of medications.

Objectives

Common beliefs

What depression is and is not

The human experience of depression

Epidemiology

Treatments

Dealing with suicidal patients

Common Beliefs

- Aging causes depression
  "How would you feel if all your friends had died and you were home-bound?"
- Depression is like having a bad day
  "We all feel down at times."
- Poor health causes depression
  "Of course she's depressed, she's really sick and old."
- Asking people about suicide will encourage them to act on it
  "If I ask, it will just give them ideas."
- Antidepressants fix depression
  "Antidepressants provide what your body is lacking; the less of it you're lacking, the better the antidepressant will work."

Depression Criteria

2 weeks or more of:

1. Low mood or apathy
2. ≥ 5 of the following:
   - -sleep (too much or too little)
   - -appetite (too high or too low)
   - -low concentration
   - -little interest
   - -low energy
   - -guilt
   - -less activity
   - -suicidal thoughts
   - -psychosis (voices / visions / paranoia)
3. Functional impairments as a result of these

Geriatric Depression Scale (GDS)

1. Are you basically satisfied with your life? (Yes/No)
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

SCORING:
0-4 Normal
5-8 Mild
8-11 Moderate
12-15 Severe

Center for Epidemiologic Studies Short Depression Scale (CES-D 10)

Please indicate how often you have felt this way during the past week:

	(less than 1 day)	(1-2 days)	(3-4 days)	(5-7days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I had trouble keeping my mind on what I was doing	0	1	2	3
3. I felt depressed	0	1	2	3
4. I felt that everything I did was an effort	0	1	2	3
5. I felt hopeful about the future	0	1	2	3
6. I felt fearful	0	1	2	3
7. My sleep was restless	0	1	2	3
8. I was happy	0	1	2	3
9. I felt lonely	0	1	2	3
10. I could not "get going"	0	1	2	3

Andresen EM, Malmgren JA, Carter WB, Patrick DL. Screening for depression in well older adults: evaluation of a short form of the CES-D (Center for Epidemiologic Studies Depression Scale). *Am J Prev Med*. 1994 Mar-Apr;10(2):77-84.

PHQ-2

- A screening tool; does not diagnose depression

"Over the past two weeks, how often have you been bothered by these problems?"

	Not at all	Several days	> Half of the days	Nearly every day
1. Little or no interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3

A score of **3 or** greater: complete the PHQ-9

PHQ-9

[All items scored 0 – 3, as with PHQ-2; "During the last week, how often were you bothered by these problems?"]

1. Little or no interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?
3. Trouble falling asleep, staying asleep, or sleeping too much?
4. Feeling tired or having little energy?
5. Poor appetite or overeating?
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down?
7. Trouble concentrating on things such as reading the newspaper or watching television?
8. Moving or speaking so slowly that others could have noticed, or being so fidgety and restless that you have been moving around a lot more than usual?
9. Thinking that you would be better off dead or that you want to hurt yourself in some way?

Depression is likely if the total score is greater than 10

9

Other Possibilities

- Bipolar disorder (periods of mania or hypomania)
- Cognitive impairment (apathy, functional problems)
- Grief (must lack suicidality)
- Adjustment disorder (identifiable stressor)
- Dysthymia (2+ years of being depressed more days than not)

The Experience of Depression

"The madness of depression is the antithesis of violence. It is a storm indeed, but a storm of murk. Soon evident are the slowed-down responses, near paralysis, psychic energy throttled back close to zero. Ultimately, the body is affected and feels sapped, drained."

"Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self – to the mediating intellect – as to be very close to being beyond description."

"... for over seventy-five years the word [depression] has slithered innocuously through the language like a slug, leaving little trace of its intrinsic malevolence and preventing, by its very insipidity, a general awareness of the horrible intensity of the disease when out of control."

"The gray drizzle of horrors induced by depression takes on the quality of physical pain."

-William Styron, *Darkness Visible*

"There is that cliché of a broken heart, but my ribs ached from the pain in my heart. I had to go to the doctor because I thought I was having heart attacks."

-Bob Geldof, after a breakup with his wife

Depression and Health in Aging

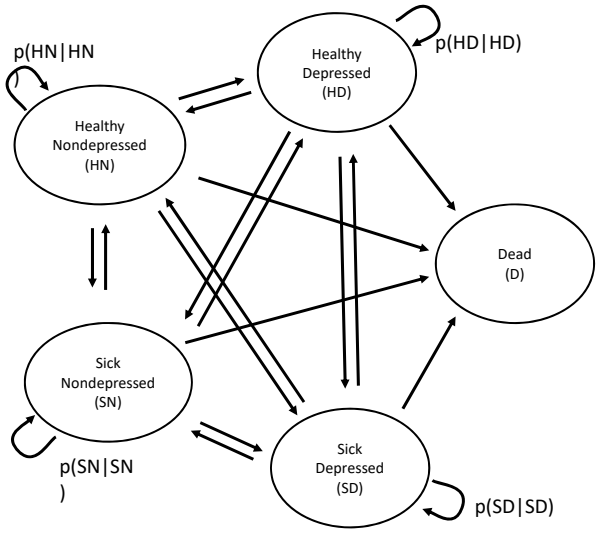
State Categories

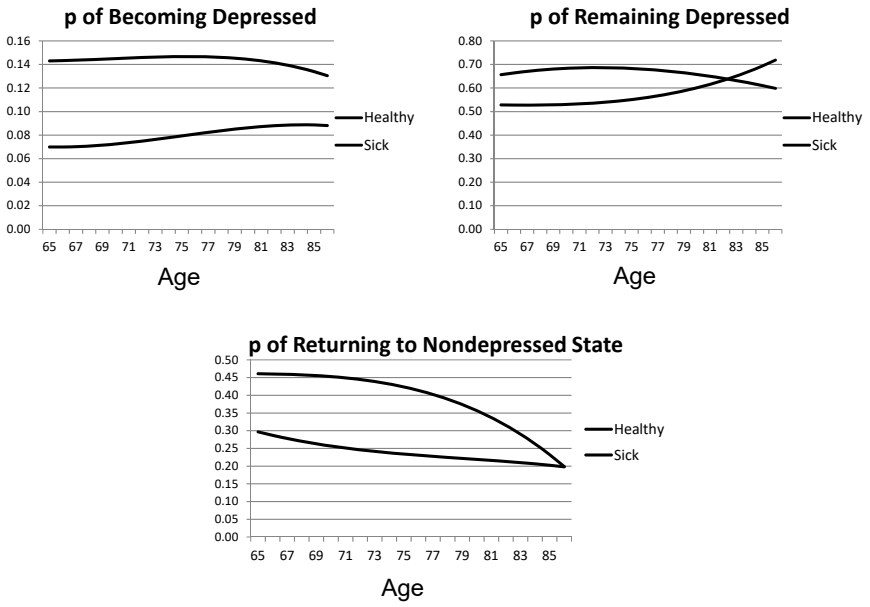
- Self-Rated Health: "Is your health excellent, very good, good, fair, or poor? (E VG G F P)"
- Depression: CES-D 10 score ≥ 10

Healthy Nondepressed -EVGGFP: "Excellent", "Very good", or "Good" -CES-D < 10	**Healthy Depressed** -EVGGFP: "Excellent", "Very good", or "Good" -CES-D ≥ 10
Sick Nondepressed -EVGGFP: "Fair" or "Poor" -CES-D < 10	**Sick Depressed** -EVGGFP: "Fair" or "Poor" -CES-D ≥ 10

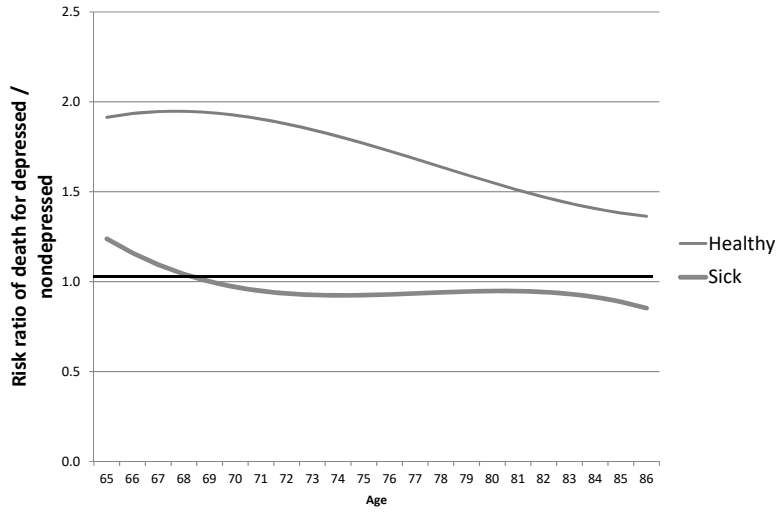
Dead: State X

Five-State Model





Depression confers a greater risk of death among the healthy, but not the sick.



Depression, Age, and Health

The incidence of depression does not increase with advancing age.

Self-rated sickness increases the likelihood of becoming but not remaining depressed.

Aging does not cause depression, but is associated with remaining in a depressed state.

Treatment

THE PROBLEM

vs

THE FIX

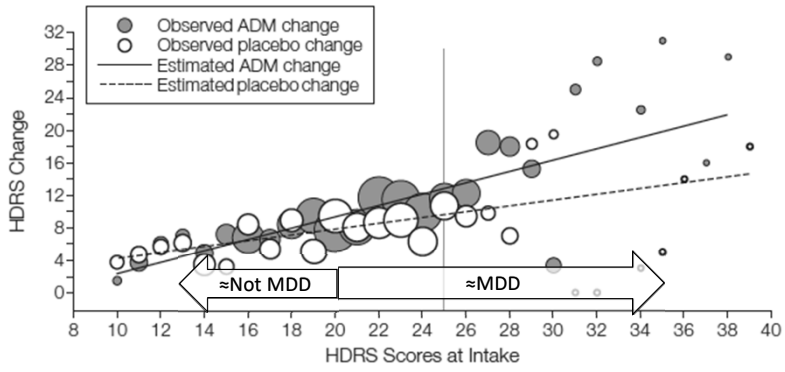
How Treatment Should Logically Work

A little depression → a little treatment → small dose of medication, a short course of therapy

A lot of depression → a lot of treatment → high dose of medication, a long course of therapy

Mild Depression

Antidepressants have little effect compared to placebo **unless there is major depression**



Fournier, J. C., et al. 2010 Antidepressant drug effects and depression severity: a patient-level meta-analysis. *JAMA* 303, 47–53.

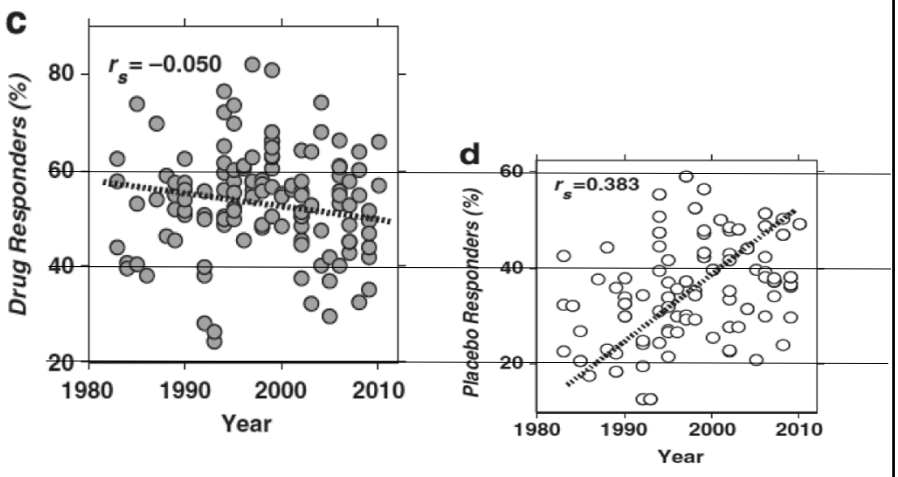
Real Evidence about Treatment

MILD DEPRESSION: no difference between treatment and placebo

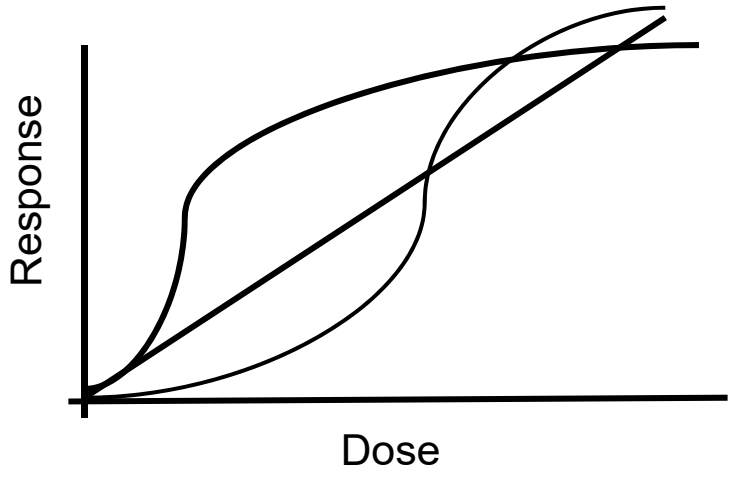
MAJOR DEPRESSION: the more severe the symptoms, the more effective the treatment

No clear dose-response relationship

The Ever More Powerful Placebo



Hypothetical Dose-Response Curves



Observed Dose-Response Curve

System Challenges to Treatment

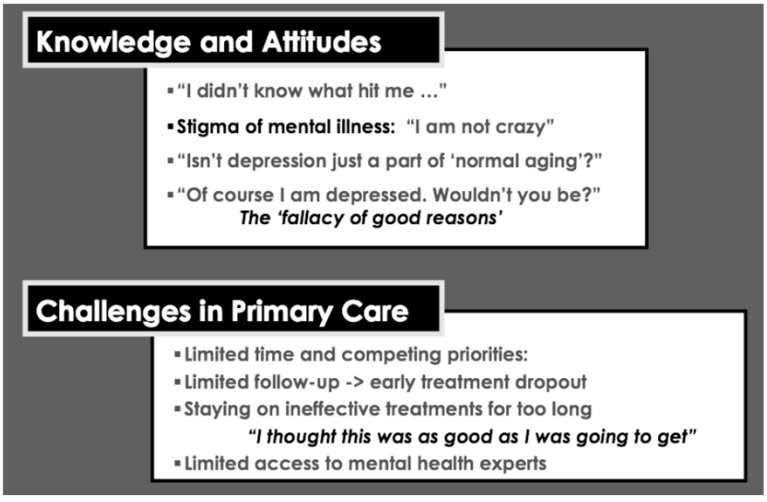
About 30% of patients referred for mental health treatment fail to show up

Of those who do come, about 25% fail to attend any follow-up appointment

About 30% of those who follow up fail to achieve a significant result

"Usual Care" for older adults with depression: 19% have remission at one year

Barriers to Treatment



What Works?

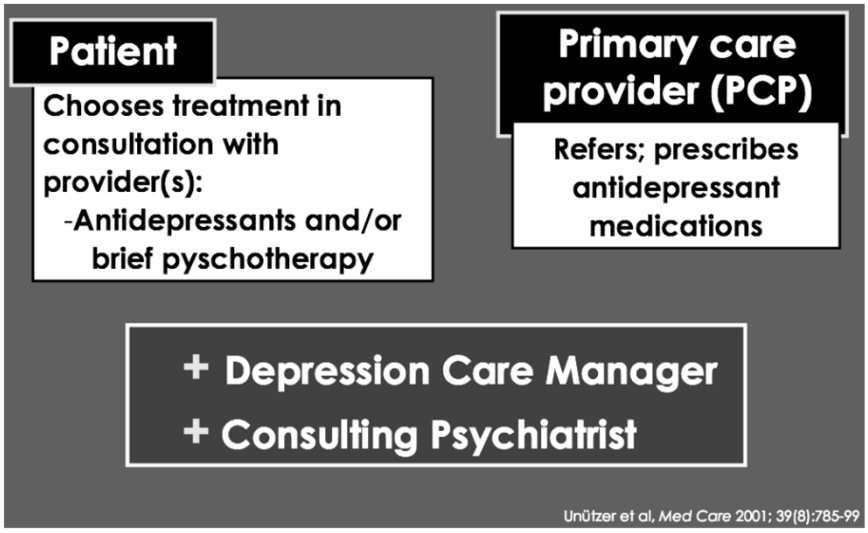
Antidepressants all have similar effects and benefits

-Side effect profiles can influence choice of medication, especially effects on sleep and appetite

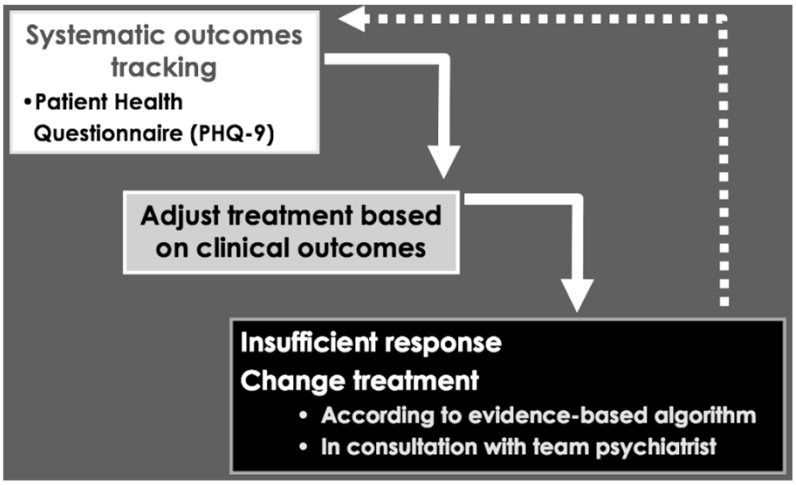
Various types of psychotherapy have demonstrated benefits

The productive APPLICATION of these treatments requires a systematic approach

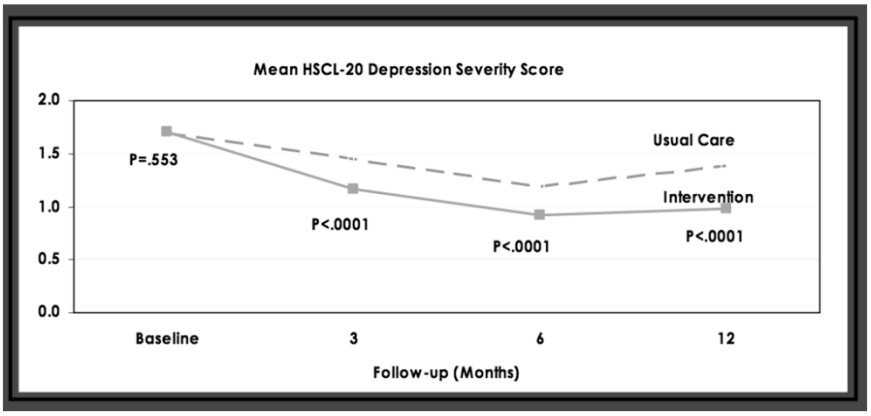
Collaborative Care



Collaborative Care Process

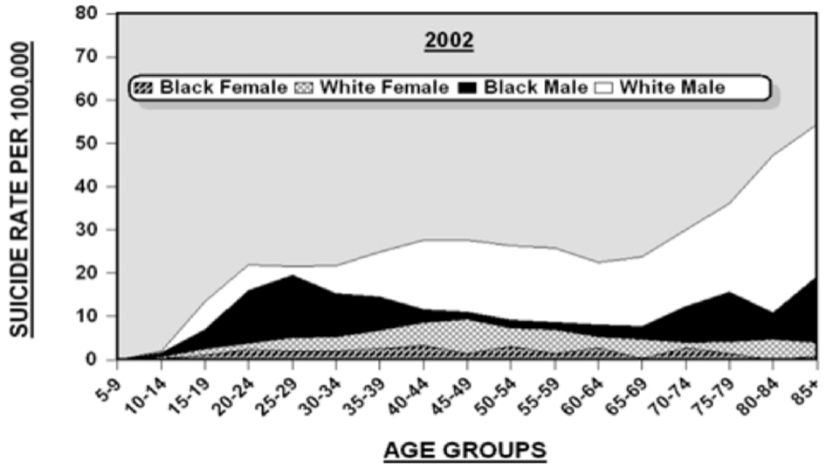


Depression Outcomes



Unutzer, et al. *JAMA* 2002; 288:2836-2845

Suicide Rates



Why would someone want

to commit suicide?

Warning Signs

Ideation

Substance Abuse

Purposelessness

Anxiety

Trapped

Hopelessness

Withdrawal

Anger

Recklessness

Mood Changes

Suicide Risk Factors

Older

White

Male

Substance abuse

Limited social contacts

Depression

Pain

Psychological Pain and Suicide

"Pain is the basic ingredient of suicide…in order to begin to understand suicide, we need to think about what anguish means, as well as why people entertain thoughts of death, especially death as a way of stopping unbearable misery. Suicidal death, in other words, is an escape from pain….

Pain is Nature's great signal. Pain warns us; pain both mobilizes us and saps our strength; pain, by its very nature, makes us want to stop it or escape from it. Pain is the core of suicide. Suicide is an exclusively human response to extreme psychological pain, the pain of human suffering."

Schneidman, Edwin. *The Suicidal Mind*. 1996.

Suicide Risk Factors

Case-control study: All subjects 65+, residents of Ontario, 1,354 completed suicides

	Odds Ratio of suicide
Ischemic heart disease	0.92 (0.76-1.12)
Parkinson's disease	1.11 (0.65-1.89)
Chronic lung disease	1.30 (1.06-1.58)
Congestive heart failure	1.36 (1.00-1.85)
Psychoses	2.60 (1.93-3.50)
Depression	3.94 (3.27-4.75)
Severe pain	4.07 (2.51-6.59)

Jurrlink et al. *Arch Intern Med* 2004;164:1179-84.

Suicide Risk Assessment

- Any patient can be at risk
- Do not assume you "know" the patient: ASK
- Asking about suicide does NOT encourage it
- Base risk mainly on:
  - What the patient tells you
  - The patient's previous behavior
- Risk assessment is not perfect, but is not mainly accurate
- You do not need to be a mental health expert to assess risk

MUST-DOs

For ALL patients with depression: ask about suicidal thoughts

"Have you had thoughts of hurting or killing yourself?"

If positive: ask about INTENT and MEANS

"Do you have a plan? What is your plan?"

"Do you have a gun?"

If there is imminent risk, take means to ensure the patient's safety (psychiatric admission, evaluation in ED or by mental health professional, contact legal authorities)

Other Important Steps

Document what the patient said and what you did

Make and document an assessment of degree of risk of suicide (very low; low; moderate; high)

Validate patient's feelings about how hard things are

Instill doubt that suicide is an appropriate response

Continue to check in

Useful Reflections

"It sounds like you are feeling like life just isn't worth it anymore."

"I'm sorry that you are feeling so distressed, your life is important to me and I'd like to discuss this further."

"Killing yourself sounds like a really bad way to try to solve your problems."

Data for Suicidal Patients

We do not know what happens to people after they die.

The children and friends of those who kill themselves are more likely to kill themselves.

Most of the people in the world believe that if you kill yourself you will be punished after death.

Main Points

Depression is not “just a bad day”

Depression involves suffering and pain

Depression is common in older adults, but is <u>not</u> a normal part of getting older

Depression can be treated, with the most benefit coming from structured programs

A little treatment will likely be ineffective

Be ready to interact with suicidal patients

Feel free to contact me

Stephen Thielke
sthielke@u.washington.edu
(206) 764-2815