Geriatric Behavioral Health Conference

Depressive disorders in Geriatrics

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Presentation adapted from:
Chapter 9 of The American Psychiatric Publishing Textbook of Geriatric Psychiatry, Fifth Edition (Editors: Steffens, Blazer, Mugdha, Thakur);

DSM5 & DSM-5® Clinical Cases (Editor: John W. Barnhill, M.D).
https://doi.org/10.1176/appi.books.9781585624836.jb04
https://doi.org/10.1176/appi.books.9780890425596.dsm04
Am J Psychiatry. 2016 November 01; 173(11): 1101–1109. doi:10.1176/appi.ajp.2016.15081101.
AmJPsychiatry 2016; 173:1110–1118; doi: 10.1176/appi.ajp.2016.16010118
International Society for ECT and Neurostimulation (ISEN)

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DISCLOSURE

- **I do not have any financial relationships with commercial interest companies to disclose.**
- **I will be discussing off-label use of a commercial product.**

MAJOR DEPRESSIVE DISORDER >60 YO

First onset episodes of major depression after 60 years are common, comprising ½ of all episodes in older adults.

Personality abnormalities and family history more common if depression is early onset (before 60).

Phenomenology similar between early onset and late onset MDD.

Diagnostic Workup

Thorough H&P
Screening (Geriatric Depression Scale, Mini Mental Status Exam)
Labs (CBC, metabolic panel, TSH, B12 or Folate)
Head Imaging
Polysomnography

Geriatric Depression Scale (short form)

Geriatric Depression Scale

DATE: TIME (24hr):
Choose the best answer for how you have felt over the past week:
Yes / No

- [] [] 1. Are you basically satisfied with your life?
[] [] 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?

TOTAL GDS:
(GDS maximum score = 15)
0 - 4 normal, depending on age, education, complaints
5 - 8 mild
8 - 11 moderate
12 - 15 severe

Geriatric Depression Scale (short form)

- Satisfied
- In a good spirit
- Happy
- Wonderful to be alive.
- Full of energy
- Empty
- Bored
- Helpless
- Worthless
- Hopeless
- Most people are better off than you are.
- Dropped activities and interests or prefer to stay at home.
- Afraid something bad may happen
- Difficulty with remembering and recalling information.

Differential Diagnosis

- Bipolar and related disorders
- Major depressive disorder
- Major depressive disorder with psychotic features
- Persistent depressive disorder or Dysthymia
- Depressive episode with insufficient symptoms
- Depressive disorder due to another medical condition
- Adjustment disorder with depressed mood

MDD with Psychotic Features

- Depressed patients over age 60 are more likely to have persecutory delusions rather than those of guilt.
- Delusional depression responds better to electroconvulsive therapy (ECT) compared to medications.
- Nihilistic delusions and abdominal focus are more common in later life, while hallucinations are less common in this population.
- Psychotic depression associated with lack of social support and bipolar illness.

Persistent Depressive Disorder (Dysthymia)

- May exist at any point in life cycle and can coexist with MDD
- May present differently in older vs. younger patients
- Symptoms must last at least 2 years with at least 2 of the following symptoms
- Feelings of hopelessness
- Too little or too much sleep
- Low energy or fatigue
- Low self-esteem
- Poor appetite or overeating
- Poor concentration

Adjustment Disorder with Depressed Mood

- Maladaptive reaction to an identifiable stressor
- AD must occur within 3 months of stressor and have a clear relationship with the stressor
- Stressors include marital problems, change of residence, or difficulty with children

MAJOR DEPRESSIVE DISORDER >60 YO IMPLICATIONS

Depression in late life is a term-vague and ill-defined.

Many older persons with atypical presentations of depression do not meet criteria for major depression yet have clinically significant depression.

The studies suggest that the DSM-5 depression categories do not apply to most depressed older adults in the community, and other surveys have confirmed the lower frequency of major depression in the community.

MAJOR DEPRESSIVE DISORDER >60 YO IMPLICATIONS

Underdiagnosed. About three-fourths of those seen in a primary care setting and about a third of elderly patients with depression are undertreated.

Prevalence is lower in the community, higher in the medically ill hospitalized patients and nursing home residents.

Increases health care costs, patient and caregiver distress and increased morbidity and mortality.

All cause mortality is a significant adverse outcome of late life depression.

HOSPITAL AND LONG TERM CARE SETTINGS

Frequency of major depression among older adults much higher than in community3.

~21% of hospitalized elders meet criteria for major depressive episode

An additional 20-25% have minor depression

Nursing homes show even higher rates, some studies showing rates >25%

CLINICAL COURSE

One study from the Netherlands, illustrates this chronicity. Among subjects with clinically sig. depression sx:

23% improved

44% experienced an unfavorable but fluctuating course

33% experienced a severe and chronic course

CLINICAL COURSE

Comorbid medical illnesses, functional, or cognitive impairment.

Comorbid depression is associated with a less favorable prognosis.

Poor social support and functional limitations, also increased the risk for poor prognosis.

CLINICAL COURSE

Classic studies of depression suggest that the duration of major depression throughout the life cycle is approximately 9 months if untreated.

However, as individuals age they may experience more frequent episodes, which can then merge into a chronic condition.

Patients with dysthymia experience a more chronic clinical course than persons with MDD

DEPRESSION AND MEDICAL PROBLEMS

Depression and medical problems are often comorbid, causal pathway is thought to be bidirectional.

Depression is a frequent cause of weight loss late in life

Similarly, Frailty → weight loss → clinically important depressive sx

Chronic illnesses associated with depression: Cardiovascular disease, DM, osteoporosis, hip fractures, cancers and more.

As an example, elevated platelet activation is present in older depressed patients, especially those with a specific polymorphism in the serotonin transporter linked promoter region, which increases one's risk for myocardial infarction. Organic vascular brain changes are associated with poorer outcome of depression in older populations.

DEPRESSION AND FUNCTIONAL IMPAIRMENT

The best established association between depression and physical problems is between depression and functional impairment

The working hypothesis for this bidirectional relationships include:

- Propensity for physical disability → higher frequency of negative life events → increased risk of depression.

Help in tasks necessary to ADLs can be protective of functional abilities and therefore buffer against the onset of depression.

DEPRESSION AND COGNITIVE IMPAIRMENT

Cognitive impairment is associated with depressive symptoms, with improvement in depression often improving cognitive symptoms.

Vascular lesions and structural brain changes in the brain can lead to onset of depression in older adults

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- Challenging cases, discussion, questions and answers.

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