



Geriatric Depression Webinar

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About Our Presenter

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VP Medical Director

Dr. Rao is a board-certified geriatric psychiatrist. She graduated from Stanford University, and completed medical school at Washington University in St. Louis. She did a residency and fellowship at UCLA Neuropsychiatric Institute. She worked in private practice in Los Angeles, where she cared for adult and geriatric psychiatric patients in a variety of settings. After moving to New Hampshire, she worked in community hospitals, focusing on nursing homes and geriatric inpatient psychiatric care. Currently, she sees geriatric psychiatry outpatients at a community mental health center in New Hampshire. Dr. Rao has been with Beacon for 10 years.

Learning Objectives

1. What symptoms can be characteristic of depression in older adults?
2. What factors can put older adults at higher risk for depression?
3. Which treatments for depression are preferable in older adults?

Agenda

1 Introduction and Statistics

2 Risk Factors

3 Signs and Symptoms

4 Screening Tools

5 Treatment Options and Considerations

6 Question and Answer

Chapter

01

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Introduction and Statistics

An Aging American Population

Older adults currently comprise 12 percent of the population; that number is expected to grow to 20 percent of the population by 2030.

There was a 25 percent increase in the older-adult population from 2003 to 2013, and it is expected to increase by another 50 percent in the next 25 years.



Depression: Prevalence in Older Adults

Women: 16%

Men: 11%

- 17 – 37% of individuals with depression are treated in primary care settings

Depression in Older Adults:

- **Underdiagnosed**

- Reporting of physical complaints rather than cognitive and mood complaints
- Overlap of symptomology with physical conditions
- Can be a side effect of certain medications
- Mistaken for anxiety
- Denial of symptoms
- Stigma

Depression in Older Adults:

- **Untreated**

- Inability to assess both physical health and mental health problems due to time limitations
- Inadequate mental health training for practitioners which leads to uncertainty about:
 - Diagnoses
 - Treatment
 - Outcomes

Depression in Older Adults: Suicide

- Depression in older adults is associated with suicide more than any other age and comprises of 16 – 20% of all suicides
- Of those older adults who completed suicide:
 - Two-fifths visited a PCP within the past week.
 - Three-quarters visited a PCP within the past month.

With an increasing population and depression being commonly undiagnosed and untreated, the likelihood of completed suicide will increase in this population.

Depression in Older Adults: Higher Suicide Risk

- Suicide is most frequent in the older age group, compared to any other population.
 - White men over 65 years old have the highest suicide rate.

Depression: Connection to Physical Health Conditions

- Commonly comorbid with:
 - Stroke (30 – 60%)
 - Coronary artery disease (up to 44%)
 - Cancer (up to 40%)
- Can be a predictor of the onset of:
 - Stroke
 - Diabetes
 - Heart disease
- Raises the risk of developing coronary heart disease and dying from a heart attack nearly threefold

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Risk Factors

Depression in Older Adults: Risk Factors

- Female
- Chronic medical illness
- Disability
- Loneliness or social isolation
- Personal or family history of depression
- Substance use disorder
- Stressful life events

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Signs and Symptoms

Depression in Older Adults: Signs and Symptoms

- Depression can manifest in different ways compared to younger adults.
- Many geriatric patients with clinically significant depression do not meet criteria for Major Depressive Disorder.
- A full evaluation must be completed to determine the degree of functional impairment.

Depression in Older Adults: Signs and Symptoms

- Common in older adults:
 - Memory loss
 - Confusion
 - Worry
 - Agitation
 - Unexplained somatic complaints
 - Loss of pleasure
 - Depressed mood
 - Sleep disorders and disturbances
 - Change in appetite
 - Concentration

Depression in Older Adults: Signs and Symptoms

Overlap with Dementia

- Apathy
 - Flat affect
 - Social withdrawal
 - Psychomotor slowing
 - Cognitive complaints
 - Sleep disturbances
- **Neuropsychological testing** can be useful in distinguishing between depression and dementia.

A 65-year-old married male presents with his wife because of suicidal ideation.

The patient has been having trouble with tasks such as paying bills and balancing the checkbook, which his wife has had to take over. He loses track of conversations.

Neuropsychological testing results were consistent with severe depression, not dementia.

Cognitive symptoms gradually improved as his depression was treated.



Depression in Older Adults

- If cognitive complaints are solely related to depression, they should improve with treatment of depression.
- However, people who experience “pseudodementia” of depression are actually at increased risk for later developing dementia.

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Screening Tools

Depression Screening

- By identifying and screening high-risk populations, prevention is possible.

Geriatric Depression Scale (GDS)

Self-report form designed specifically for further evaluation of depression in older adults

Long Form

- 30 yes/no questions
- Long and difficult for some

Short Form

- 15 yes/no questions
- Usually 5-7 minutes

Patient Health Questionnaire (PHQ)

PHQ-9:

- Designed to **diagnose** Major Depressive Disorder and to monitor treatment effectiveness
- 9 self-administered items
- Each item ranked 0-3

PHQ-2

- Designed to **screen** for depression
- First two questions of PHQ-9
- 2 self-administered items
- Each item ranked 0-3

Screening Tools: Next Steps

It is recommended that a referral for a full diagnostic evaluation be completed when screening tool scores are positive.



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Treatment Options and Considerations

Psychotherapy

- Therapeutic approaches that have been effective in treating depression in older adults:
 - Cognitive-Behavioral Therapy (CBT)
 - Interpersonal Psychotherapy (IPT)
 - Problem-Solving Therapy

Antidepressant Medications

- **SSRIs** – serotonin-specific reuptake inhibitors
- **SNRIs** – serotonin-norepinephrine reuptake inhibitors
- **Other** – newer, different mechanisms of action
- **Tricyclics** – older SNRIs with lots of side effects
- **MAOI** – monoamine oxidase inhibitors; **STRICT DIETARY RESTRICTIONS** due to potentially lethal drug interactions

Antidepressants – SSRIs

- **sertraline** (Zoloft)
- **fluoxetine** (Prozac)
- **escitalopram** (Lexapro)
- **citalopram** (Celexa)
 - FDA warning not to exceed Celexa 20mg daily in individuals over 60 years of age due to increased risk of cardiac arrhythmia
- **paroxetine** (Paxil)
 - Avoid paroxetine to due anti-cholinergic effects

Antidepressants- SNRIs

- **venlafaxine** (Effexor)
 - **duloxetine** (Cymbalta)
 - **desvenlafaxine** (Pristiq)
- Increase both serotonin and norepinephrine
 - Generally well-tolerated
 - Can help with pain

Antidepressants - Other

- **mirtazapine** (Remeron) - side effects of increased appetite and sedation can be helpful in elderly
 - no stomach upset
- **bupropion** (Wellbutrin)
- **vortioxetine** (Brintellix) – can improve cognitive deficits in depression
- **trazodone** – small doses for insomnia
 - can increase fall risk due to orthostatic hypotension

Tricyclic antidepressants

- **amitriptyline**
 - **nortriptyline**
 - **doxepin**
 - **imipramine**
 - **desipramine**
- “old” antidepressants
 - Potential side effects
 - Cardiac arrhythmia
 - Orthostatic hypotension
 - Urinary retention
 - lethal in overdose

MAOI antidepressants

- **tranylcypromine**
(Parnate)

- **phenelzine**
(Nardil)

- Require strict dietary limitations to avoid potentially lethal hypertensive crisis
- Require washout period before switching to a different antidepressant
- Cannot be combined with other antidepressants

71-year-old woman with major depression

Symptoms include

- Low motivation
- Poor concentration
- Increased appetite
- Sleeping excessively

She previously tried taking an antidepressant, but it made her even sleepier.

Her doctor prescribes bupropion.



Depression in Older Adults: Medication

Considerations when prescribing antidepressants to older adults:

- “Start low and go slow,” but know that the therapeutic dose ranges for adults and older adults are the same.
- Use as few medications as possible because complex medical issues are common.
- SSRIs and SNRIs should be considered over MAOIs or TCAs.
- Antidepressants take anywhere from 6-8 weeks for symptom relief in older adults.

ECT: Most Effective and Rapid Response

- Electroconvulsive Therapy (ECT) is even more effective in older adults.
- Rapid response when needed
- Can avoid medication side effects and drug-drug interactions
- Expected to help cognitive issues caused by depression

Depression: Additional Treatment Options

- Bright light therapy
- Repetitive transcranial magnetic stimulation (rTMS)
- Cranial electrotherapy stimulator (CES)

Treatment Considerations for Effective Care

- Older adults value maintaining a sense of independence and involvement in their treatment.
- Successful treatment includes involvement from contented family and other social supports.
- Comorbidity with physical illness is the rule, not the exception.
- Coordination and collaboration with all physical and mental health practitioners is essential.
- Serious problems can arise with even small amounts of substance use consumption.

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Question and Answer

Thank You

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