# Depression in Geriatrics

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## Objectives

- 1. Discuss risk factors and signs/symptoms for depression in geriatric patients
- 2. Identify different screening tools that are able to be utilized effectively in the geriatric populations
- 3. Select appropriate treatment options available to treat depression in geriatric patients that includes both pharmacological and non-pharmacological modalities.
- 4. Distinguish risk factors for suicide in geriatric patients.

# Depression in Geriatrics

- Depression may be seen in up to 35% of residents in long term care facilities
- Underreported and undertreated
- Causes of underdiagnosing include:
  - Atypical presentation in elderly
  - Focus on medical illness rather than mental health
  - View sadness or depressed mood is a normal sign of aging
  - Symptoms of depression mimic chronic medical conditions

# Case Study

- 77-year-old widowed white male
- PMH – Stroke
- Living in NH for 6 months
- Children live a couple hours away
- Now he is isolative, withdrawn over the past several week. Lacks motivation. Poor appetite, with increased sleep

# Risk Factors for Depression in Elderly

- Alcohol or substance abuse
- Medication use that is associated with depression
- Hearing or vision impairment
- History of suicide attempts
- History of psychiatric hospital admission
- Diagnosis associated with depression prevalence
- New changes in environment
- Stressful losses (not just death but also of function, etc.)
- History of depression or mood disorder

# Medications associated with depression

- Anti-arrhythmic
- Anticonvulsants
- Benzodiazepines
- Carbidopa/Levodopa
- Beta Blockers
- Clonidine
- Digoxin
- Glucocorticoids
- H2 blockers
- Opioids

# Diagnoses associated with Depression

- Alcohol use
- CVA
- Chronic pain
- Neurodegenerative disorders
- Cancer
- COPD
- CAD or open chest procedure
- Heart failure
- Diabetes
- MI
- Abuse
- Schizophrenia

# Signs and Symptoms

- Depressed mood
- Thoughts of suicide
- Difficulty making decisions
- Helplessness
- Worthlessness
- Hopelessness
- Guilt
- Psychomotor agitation or retardation
- Social withdrawal
- Change in appetite
- Difficulty concentrating
- Failure to thrive
- Fatigue
- Insomnia or hypersomnia
- Pain
- Weight loss

# Case Study

- Look at specific symptoms with duration
- Collaborate with caregivers
- Ask about self harm
- PHQ-9 =10

# Screening

- Recommended upon admission and if a change occurs in functional or medical condition
- Tools include:
  - Geriatric Depression Scale
  - Cornell Scale for Depression in Dementia (CSDD)
  - PHQ-9
  - PHQ-9OV

# Geriatric Depression Scale

- Most well studied
- Best sensitivity and specificity among the other screening tools listed
- Patients need to be cognitively intact
- 15 questions
  - Provider form has yes/no answers bolded. Patient receives 1 point for each bold answer
  - >5 is suggestive of depression and should have work up
  - >10 almost always indicates depression
- http://www.diamondhousecalls.com/wp-content/themes/diamondhouse/pdf/Geriatric+Depression+Scale.pdf

# CSDD

- Validated for residents with dementia and frailty
- Information is provided by caregiver as well as discussion and observation of patient
- Information is obtained from the week prior to administration of the scale
- Score is given from 0-3 or unable to evaluate
- Score >10 indicates probable depression
- Score > 18 indicates definite depression
- https://cgatoolkit.ca/Uploads/ContentDocuments/cornell_scale_depression.pdf

# PHQ-9 and PHQ-9 OV

- PHQ-9 OV is recommended by Medicare and Medicaid for residents who are not able to communicate for themselves
- PHQ-9 OV includes a symptom of irritability not seen on the PHQ-9
- https://www.mdcalc.com/phq-9-patient-health-questionnaire-9

# Case Study

- TSH = 2.01
- Recent UTI
- Vitamin B12 = 427
- Folate = 8.2

# Diagnostics to Consider

- Electrolytes
- Kidney function
- CBC
- TSH, free T4
- Vit B-12 and folate

# Major Depression Diagnosis

- Criteria includes depressed mood in addition to 4 symptoms for 2 weeks
- OR loss of pleasure in addition to 4 symptoms for 2 weeks
- Symptoms
  - Change in appetite
  - Change in sleep patterns
  - Change in psychomotor activity
  - Decreased energy
  - Feelings of worthlessness or guilt
  - Difficulty concentrating
  - Thoughts of suicide

# Case Study

- Try to increase activities
  - Focus on those he enjoys
  - Pastoral visits
  - Family visits (With COVID)
  - Outings from the nursing home
- Escitalopram 5 mg started
- Close follow-up recommended

# Treatment

- Consider pharmacologic and non-pharmacologic treatment
- Cognitive behavioral therapy
- Interpersonal therapy
- Exercise
- Light therapy
- Psychoeducation
- Participation in social activities

# Treatment

- SSRIs
- TCAs, consider avoiding in older adults
- Bupropion, usually used 2nd line
- SNRIs
- Trazodone, minimal effect for depression unless high dose
- Mirtazapine

# SSRIs

- SSRIs for use in elderly
  - Citalopram
  - Escitalopram
  - Sertraline
  - Fluoxetine for OCD
- Side effects may include hyponatremia, nausea or diarrhea
- Need to watch for QT prolongation with use of Citalopram
- Need to reduce dose in elderly for Citalopram and Escitalopram

# SNRIs

- SNRIs for use in elderly
  - Venlafaxine XR- may increase the blood pressure
  - Long taper needed if stopping or changing
- Skipping a dose by more than 2 hours may cause a flu like feeling in patient

# TCAs

- TCAs for use in elderly
  - Desipramine
  - Nortriptyline
- Side effects - Watch Anticholinergic side effects
  - Blurred vision
  - Urinary retention
  - Constipation
  - Dry mouth
  - Postural hypotension

# Bupropion

- May be a more stimulating medication
  - May cause jitteriness and insomnia
  - Good for use with daytime sedation, lethargy, or fatigue
- May lower seizure threshold
- Start with a lower dose and titrate up if needed

# Trazodone

- May cause sedation
  - Given frequently at low dose for sleep
- Maximum dose for the elderly is 300-400mg/day
- Usually well tolerated by elderly patients
- Does not have the anticholinergic effects of the TCAs

# Mirtazapine

- Multi-receptor anti-depressant
- Alternative for failed SSRI treatment or to augment pharmacological management
- May cause sedation at lower doses
- May cause increase in appetite

# Non-responders

- Reconsider diagnosis
- Ensure adequate dosing
  - Most geriatric patients are undertreated
- Change classes of medication
- Augment with another agent
- Consider geriatric psychiatrist

# Case Study Conclusion

- Escitalopram increased to 10 mg
- Resident doing well at next visit
- He has been participating in activities
- Sleeping less

# Case Study for SI

- "I no good anymore, no sense for me to be around"
- No concerns for planting idea of suicide if asking about suicide
- Goal is to stretch out the time in suicide risk
- Hierarchy
  - Ideation: troublesome no need to jump to conclusions
  - Intent: more problematic explore interventions
  - Plan/Means: Lethality, access to means of carrying out highest risk

# Risk Factors

- Adolescent, geriatric
- White male
- Single and widowed
- Military service
- Perturbation (emotional distress) plus Lethality of plan
- Previous attempt- most strongly linked
- Substance use
- Depression
- Crisis
- Schizophrenia
- Anorexia Nervosa
- Panic Disorder
- Family history of suicide
- Social isolation
- Recent Loss
- Anniversary of a loss
- Access the lethal means
- Unable to communicate
- Personality Disorder
  - Borderline, antisocial
- Homosexuality, experiencing harassment

# Assessing for SI

- Use of Geriatric Depression Scale has questions that indicate risk for suicide
  - Do you feel happy most of the time?
  - Do you feel that your life is empty?
  - Do you think it is wonderful to be alive?
  - Do you feel pretty worthless the way you are now?
  - Do you feel that your situation is hopeless?

# Assessing for SI

- Important questions to ask:
  - Are you suicidal?
    - Avoid asking if they want to harm self. Better to ask do you wish to be dead? Do you want to kill yourself?
  - Do you have a plan? If so, what is it?
  - What other plans do you have or have thought about?
  - Do you have access to the mechanism in plan?
  - How have you prepared?
  - Have you rehearsed?
  - What prevents you from acting?

# Assessing for SI

- Be aware of passive SI as well as active SI
  - Active SI- more aggressive forms of suicide- weapons, poisoning, hanging
    - Tend to be seen in younger patients
  - Passive SI- not eating, not drinking, not taking medications, not seeking help for emergency situations
    - Tend to be seen in older patients

# Suicide Prevention Programs

- Collaborative team approach- primary healthcare provider, nurses, social work, psychiatrist, therapist
- Education about treatment options for depression and mental health disorders
- Brief Psychotherapy
- Close monitoring of depression symptoms and medication side effects
- Close follow up

# Questions ?

# Reference


- American Medical Directors Association. (2011). Depression in the Long-Term Care Setting. Clinical Practice Guideline.
- Avasthi, A. & Grover, S. (2018). Clinic practice guidelines for management of depression in elderly. *Indian Journal of Psychiatry, 60*(Suppl 3), S341-S362.
- Brooks, S.E., Burruss, S.K., & Mukherjee, K. (2019). Suicide in the elderly: A multidisciplinary approach to prevention. *Clinics in Geriatric Medicine, 35*(1), 133-145.
- Chau, R., Kissane, D.W., & Davison, T.E. (2018). Risk factors for depression in long term care: A systematic review. *Journal of Clinical Gerontologist, 42*(3), 224-237.
- Tsoi, K.K.F., Chan, J.Y.C., Hirai, H.W., & Wong, S.Y.S. (2017). Comparison of diagnostic performance of 2 question screen and 15 depression screening instruments for older adults. *The British Journal of Psychiatry, 210*(4), 255-260.