

The Expert Consensus Guideline Series

Depression in Older Adults



A Guide for Patients and Families

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Depression is a common problem among older adults. Studies have found that about 15% of those over age 65 experience symptoms of depression that cause them distress and make it hard for them to function. In late life, depression affects primarily those with medical illnesses. Depression not only makes a person feel physically ill, but actually makes physical health worse and increases mortality. Late-life depression prevents a person from enjoying things he or she used to find pleasure in and can affect memory and concentration. It can make the person feel that there is no point in even getting up in the morning. Depression causes pain and suffering not just for those who are depressed, but also for those who care about them. Serious depression can cause great disruption and suffering for the family as well as for the person who is ill. But the good news is that effective treatments for depression *are* available and that most older adults who have depression can be successfully treated and start enjoying their lives again.

If you or someone you love has been diagnosed with depression, you probably have many questions about the nature of the illness, its causes, and the treatments that can help. This guide is designed to answer commonly asked questions about depression in older adults.

WHAT IS LATE-LIFE DEPRESSION?

A number of different kinds of depression, or mood disorders, can afflict older adults. These illnesses affect how people feel about themselves and the world around them. They can influence every aspect of a person's life, including appetite, sleep, levels of energy and fatigue, and interest in relationships, work, hobbies, and social activities. Of course, everyone feels blue or low sometimes, but a depressive illness is not just a passing blue mood. It involves serious symptoms that last for at least several weeks and make it hard to function normally.

Emotional stress or loss of function can sometimes trigger depression, although it can also develop without a clear precipitant. Strength of character or previous accomplishments in life do not prevent depression. Depression is not a sign of weakness or a problem that can just be willed away. People who have a depressive disorder cannot just “snap out of it.” Without proper treatment, their depressive symptoms can last for months or even years and can worsen. Research suggests that depressive disorders are medical illnesses related to changes and imbalances in brain chemicals called neurotransmitters that help regulate mood.

One of the most serious mood disorders is major depressive disorder. About 1%–2% of people 65 years of age or older have *major depressive disorder*. Some people have their first episode of major depression in late life, while others have had many episodes of major depression since a young age. The two main symptoms of a major depressive disorder are:

- Depressed mood most of the day, nearly every day for 2 weeks or longer *and/or*
- Loss of interest or pleasure in activities the person usually enjoys.

Other symptoms can include:

- Significant weight loss or weight gain or changes in appetite
- Trouble sleeping, waking very early, or sleeping too much
- Feeling restless, “keyed up,” and irritable
- Fatigue, lack of energy, or feeling slowed down
- Feelings of guilt, worthlessness, or hopelessness
- Difficulty concentrating, remembering, or making decisions
- Recurrent thoughts of death or suicide, suicide attempts.

If you or someone you know has thoughts of death or suicide, immediately contact a medical professional, or if this isn't feasible, a clergy member, a loved one, or a friend, or go to a hospital emergency room.

Severe major depressive disorder can sometimes be accompanied by delusions (believing things that are not true, such as that people are out to get you) or hallucinations (seeing or hearing things that are not there). When this happens, the depression is called *psychotic depression*. Psychotic depression is most common in late life.

The number one cause of suicide in the United States is untreated depression. Older adults have a suicide risk almost twice that of the general population. White men over age 65 have a suicide rate 5 times higher than the general population. Depression is the most common diagnosis in older adults who commit suicide, so it is critical that depression be recognized and treated as soon as possible.

Older people can have other kinds of depressive disorders, such as *minor depressive disorder* and *dysthymic disorder*, which are not as severe as major depression. Although these illnesses may not cause symptoms as serious as major depression, they can still make it very difficult for the person to function and should be evaluated and treated.

Many older adults have medical illnesses, some of which can *cause* depression. Illnesses that can cause depression include Parkinson's disease, stroke, heart attack, vitamin B₁₂ deficiency, hyper- or hypothyroidism, multiple sclerosis, systemic lupus erythematosus, certain kinds of cancers, vascular dementia, and Alzheimer's disease. Depression makes it more difficult to treat the other medical illness, since depressed patients may not take care of themselves and follow prescribed treatment. Depression caused by medical illnesses can be treated effectively, but it is important for patients to report their symptoms to the doctor who is treating them.

Many older adults are taking multiple medications. Many medications may cause or worsen depression; these include blood pressure medications, such as reserpine and beta blockers, antiulcer medications, medications for Parkinson's disease, muscle relaxants, and steroids. If you start to feel depressed after starting a new medication, tell your doctor right away. Your doctor may suggest switching you to another medicine.

What about bereavement and loss?

Many older adults experience the loss of loved ones and friends. They may also be affected by other major life changes, such as retirement, moving to a retirement or nursing home, financial difficulties, poor health, and loneliness. Some people have the mistaken idea that it is normal for older people to feel depressed. This is not true. Although stresses such as loss and major life changes can sometimes trigger depression, depression is not an inevitable consequence of such loss and life changes. While grief is expected after the loss of a loved one, if severe depression continues for longer than 2 months after such a loss, the person should be evaluated for depression.

How are the symptoms of depression different in older individuals?

Certain physical symptoms (such as changes in appetite and sleep patterns, or fatigue) are important signs of depression in younger adults. However, older people who are not depressed often experience such changes as a natural part of the aging process or as a result of medical illness. For this reason, doctors often fail to recognize depression in older patients, especially since older patients are less likely to report emotional symptoms than younger patients. To recognize depression in an older patient, the doctor needs to be made aware of certain emotional and psychological symptoms. These include a sad, downcast mood; recurrent thoughts of death or suicide; loss of interest in activities; feelings of hopelessness, worthlessness, guilt, or helplessness; feelings of being keyed up or slowed down; avoidance of social interactions; poor concentration and memory; and difficulty starting new projects or making decisions. Sometimes it can help if a family member of the patient's choice, who can describe the problem, goes along with the person to the doctor.

HOW IS DEPRESSION EVALUATED IN OLDER PATIENTS?

If you or someone you love is having the kinds of symptoms described above, it is important to see a doctor. The primary care doctor or internist may be able to treat the depression or may refer you to someone who can. The doctor will take a complete psychiatric and medical history. He or she will want to know when the depressive symptoms started, how long they have lasted, and how severe they are. The doctor will also want to know if anybody else in the family has had depression and how he or she was treated. It is important to tell the doctor about any medical conditions you have and what medications you are taking. The doctor will perform a complete physical examination, obtain some laboratory tests, and assess your mental status (ability to think clearly, remember, make plans). The purpose of this workup is to determine if a medical condition or medication may be causing or contributing to your depression.

HOW IS DEPRESSION TREATED?

All patients benefit from receiving education about their illness and from other kinds of interventions that help them learn to cope better. There are two main types of treatment for depression: *medication* and *psychotherapy* (talk therapy). Sometimes one or the other type

of treatment is used alone; at other times, medication and psychotherapy are used together. Another treatment the doctor may use to treat very severe or treatment-resistant depression or psychotic depression is *electroconvulsive therapy* (ECT).

Because most studies of treatments for depression have been done with younger adults, there is limited research to guide clinicians in choosing the best treatments for older patients. For this reason, we surveyed a panel of 50 experts on the treatment of depression in older adults. The information presented in the following sections is based on available research and the recommendations of that panel of expert doctors.

What medications are used to treat depression?

In most cases, late-life depression can be effectively treated with *antidepressants*. These medicines act on neurotransmitters in the brain that control mood. Many different antidepressants are available with different chemical actions and side effects.

To treat depression in older patients, the experts prefer a type of antidepressant that increases levels of the brain neurotransmitter serotonin. These medicines are called selective serotonin reuptake inhibitors (SSRIs). They are the most widely prescribed type of antidepressant in the world and have been taken by millions of patients. The following SSRIs are available in the United States: citalopram (Celexa), fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft). Among the SSRIs, the experts gave the highest ratings to Celexa and Zoloft for the treatment of depression in older patients. Celexa and Zoloft, which have similar chemical profiles, are effective and well tolerated in older patients and are the least likely to cause drug interactions or problems when stopped. Paroxetine (Paxil) is another good choice among the SSRIs. The experts also consider venlafaxine XR (Effexor) an appropriate alternative to SSRIs for depression in older patients. Effexor is an antidepressant that affects the levels of two different neurotransmitters, serotonin and norepinephrine. Other antidepressants the experts would consider using are bupropion (Wellbutrin), a tricyclic antidepressant (e.g., nortriptyline, desipramine), and mirtazapine (Remeron). Although a number of herbal and alternative treatments (e.g., St. John's Wort) have received a lot of media attention, there are no data concerning the use of these agents to treat depression in older adults, and the experts do not recommend them.

If a patient has psychotic depression (depression accompanied by delusions and hallucinations), the doctor will usually prescribe a medication called an *antipsychotic* along with an antidepressant. A number of new antipsychotics are available that are effective and much less likely to cause serious side effects than older medications of this kind. For psychotic depression in an older patient, the experts recommend risperidone (Risperdal), olanzapine (Zyprexa), and quetiapine (Seroquel), and would also consider ziprasidone (Geodon), a recently approved antipsychotic.

What are the side effects of antidepressant medications?

All antidepressants have some side effects. One reason the experts prefer the SSRIs is that they generally do not cause dangerous side effects. The side effects of the SSRIs, which include nervousness, insomnia, restlessness, nausea, headaches, diarrhea, and sexual problems, affect only a minority of patients who receive these drugs. While they can be annoy-

ing, the side effects of SSRIs do not pose a serious risk to the patient's health. Side effects differ from one person to another. Many people may not have any side effects or only very mild ones, and many side effects go away by themselves in a few weeks. To try to reduce the risk of side effects, doctors will often start with a low dose and increase it slowly. If you have any problems with side effects, tell your doctor right away. If side effects persist, your doctor may lower the dose or suggest trying a different antidepressant medication.

Are antidepressants safe to take with other medications?

Older patients often take many medications. It is important to inform your doctor of all the medications you are taking, including over-the-counter medicines. Some medicines that are safe to take alone can cause serious, or even dangerous, side effects when combined with other medicines. Although there are only a few combinations of medicines that the experts would recommend not taking, certain combinations require extra monitoring to be sure no drug interactions occur. If you are taking several medicines, tell your doctor about any new symptoms or side effects you have.

Alcohol (wine, beer, hard liquor) can also interfere with the effectiveness of antidepressant medications. It is generally a good idea to avoid the use of alcohol when you are taking an antidepressant. This is something you should discuss with your doctor.

What is ECT and when is it used?

ECT is the administration of a carefully measured electrical stimulus to the brain. ECT can be a life-saving treatment for severe or medication-resistant depression. Studies have found that ECT is effective for depression in older patients and can be used safely in many patients who have medical conditions that make it difficult for them to take antidepressant medication. The experts recommend ECT for psychotic depression, either from the start or if the person has not been helped by a combination of antidepressant and antipsychotic medications. The experts would also consider using ECT for patients with severe but nonpsychotic depression, especially if the person is suicidal or has failed to respond to several antidepressant medications or has a medical illness that makes it hard to use antidepressant medication.

Although there has been a lot of negative publicity about ECT, the way it is given has improved greatly in recent years. The person is first given anesthesia and a muscle relaxant, and then ECT is administered in a carefully monitored medical setting. Patients typically receive 6–10 treatments over a few weeks. The most common side effect of ECT is temporary memory problems, but most memory problems related to ECT usually subside within 1–2 months after the end of treatment.

What types of psychotherapy are used to treat depression?

A number of different types of psychotherapy (often called “talking” therapies) can help people with late-life depression. Many of these therapies are short term, involving 10–20 weeks of treatment. (Note that there are certain situations in which psychotherapy will be of limited or no help, such as when the person has advanced dementia.) The experts recommend *cognitive-behavioral therapy*, *supportive psychotherapy*, *problem-solving therapy*, and *interpersonal therapy* to treat depression in older patients. Both cognitive-behavioral

therapy and interpersonal therapy have been proven effective in studies of older patients with major depression. In *cognitive-behavioral therapy*, the therapist helps the person identify and change pessimistic thoughts and beliefs that can lead to depression. *Supportive psychotherapy* involves providing emotional support to help the person cope with and resolve difficulties that may worsen the depression. In *problem-solving therapy*, the therapist helps the person learn more effective ways to manage problems. In *interpersonal therapy*, the therapist works with the person to improve problems in relationships that may be contributing to the depression.

Psychotherapy involves meeting with a therapist either individually or in a group setting. The therapist may also assign “homework” to help the patient practice and master what is being taught in the therapy sessions. When used alone, psychotherapy usually works slowly and may take 2 months or longer to show significant effects. However, the effects may be long-lasting. Often the best results are obtained when antidepressant medication and psychotherapy are combined.

What else may the doctor recommend?

The experts recommend that all patients and families receive education about depression and its treatment. The more patients know about their illness, the more likely they are to follow prescribed treatments accurately. The experts also recommend other types of interventions, depending on the patient’s needs and availability of services in the community. These include family counseling, visiting nurse services, participation in bereavement groups for those who have suffered loss of a loved one, and attending a senior citizen center.

What treatment strategy is best for me?

Whether your doctor will begin with medication or psychotherapy or both will depend on the kind of depressive symptoms you have and how severe they are. The experts generally recommend a combination of antidepressant medication and psychotherapy for all types of depression. If the person has psychotic depression (depression accompanied by delusions or hallucinations), the doctor will usually prescribe an antipsychotic medication along with the antidepressant, or may suggest ECT. Sometimes psychotherapy alone or medication alone is used for milder major depression or for minor depression or dysthymic disorder. However, psychotherapy alone is not an appropriate treatment for an older person with severe or psychotic major depression. If a patient’s depression appears to be related to external stress, such as bereavement or major life changes, psychotherapy or support groups, either alone or in combination with antidepressant medication, can help the person cope better and adjust to the changes.

What if the first treatment does not help?

Sometimes people need to try several antidepressants before they find one that works for them and does not cause troublesome side effects. However, it is important to give each medication a fair chance to work. Although some improvements in mood may appear in the first few weeks of treatment, it usually takes at least 3 or 4 weeks and may take as long 6–8 weeks for medication to have its full effect. Sometimes patients will experience side

effects before they see any beneficial effect on their symptoms. It is important to tell your doctor about any side effects you may be having and *not to stop your medication or change your dose on your own, without consulting your doctor.*

Some people may not achieve enough relief with any single medication and may require treatment with a combination of two medications to get the best effect. If you are showing some response to one medication, but it is not enough, your doctor may suggest adding another antidepressant or other medication to the first one to see if that will produce a better response.

What if I still feel anxious or have trouble sleeping?

Some people continue to have trouble sleeping or feel anxious, even when their depressive symptoms have improved. If this happens to you, your doctor may try raising the dose of your antidepressant, switching to a more sedating antidepressant, or may add a mild dose of a sedating antidepressant, such as trazodone (Desyrel) for sleep.

How long will I need to be in treatment?

The best way to prevent depression from returning is to continue the prescribed treatment for as long as your doctor recommends. How long this will be will depend on how many episodes of depression you have had and how severe they were. If you have had only one severe episode, most experts recommend continuing medication for at least a year. If you have had two such episodes, the experts recommend continuing medication longer, perhaps for 2 or 3 years or even longer. If you have had three or more episodes of severe major depression, all the experts on our panel agree that long-term antidepressant medication is needed to prevent the depression from coming back. If an antipsychotic medication was needed, most experts would recommend continuing it for 6 months or longer.

WHAT CAN I DO TO HELP MYSELF GET BETTER?

The most important thing you can do to help yourself recover from depression is to follow your doctor's instructions. Depending on the treatment your doctor recommends, this means taking medication as prescribed and going to your psychotherapy sessions. It is also important to give your doctor accurate reports about how you are doing and any symptoms or side effects you are having. It may help to keep a diary of any symptoms or side effects you have as they occur and bring it with you to the doctor.

A number of other things can help you recover from depression and stay well. Try to get enough sleep, keep regular hours, and eat a healthy balanced diet. Exercise is important for your mental and physical well-being. Be sure to follow through with medications and treatments your doctor has prescribed for any medical problems you may have. Here are some other tips that may help you feel better:

- Try to get out and participate in activities you used to enjoy (hobbies, games, sports, movies, plays, or concerts).
- Spend some time with other people. Find someone you know and trust to talk with.

- Set realistic goals; don't take on more than you can handle at one time.
- Don't expect too much too soon. Both medication and psychotherapy *take time to work*. At first, improvement may be so gradual you won't notice it. Ask your loved ones if they notice any difference in your mood. Sometimes family members recognize improvement before the patient does.
- Try not to make important decisions while you are depressed. Depression can cloud your judgment.
- If negative thoughts and feelings interfere with your life and relationships, remember they are part of your depressive illness and that things will look better when your treatment starts to work.

HOW CAN FAMILY AND FRIENDS HELP?

If someone you love is depressed, you are probably feeling a lot of pain, but don't really know how to help. Depression clouds how people think and feel and fills their minds with negative thoughts. Just telling the person that "everything will be ok, don't feel sad" is usually not much help. However, there are some practical things you can do to help your loved one and yourself.

- If you suspect that your loved one is depressed, encourage him or her to see a doctor for evaluation and treatment right away. The sooner treatment is started, the sooner the person will start to feel better. Just knowing that the feelings are caused by a treatable illness can help people feel better.
- If your loved one has been diagnosed with depression, the most important thing you can do is encourage him or her to stick with treatment. If one treatment doesn't help, encourage the person not to give up but to keep trying until something helps. Many people need to try several medications before they find one that works for them.
- Offer emotional support and affection. Be patient and encouraging. Listen with understanding. Let the person know that you believe the treatment will help and he or she will feel better soon.
- If the person talks about death and suicide, take this very seriously, and let the person's doctor know right away. If you cannot reach the doctor, take the person to the hospital emergency room or contact a clergy member. You could be saving the person's life.
- Encourage the person to participate in activities he or she used to enjoy. Invite your loved one to go with you to cultural activities, and encourage him or her to come to social gatherings of family and friends.
- If the person is irritable or says negative things, try to remember that it is the depressive illness that is causing this.
- Finally, it is important to take care of yourself and make time to do things you enjoy.

RESOURCES

National Institute of Mental Health

Information Resources and Inquiries Branch
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513; TTY: 301-443-8431
Useful brochures on depression may be ordered by calling 800-421-4211
or downloaded from the Web site: www.nimh.nih.gov

National Depressive and Manic Depressive Association

730 N. Franklin, Ste. 501
Chicago, IL 60610
312-642-0049; 800-826-3632
Web site: www.ndmda.org

American Association for Geriatric Psychiatry

7910 Woodmont Ave.
Bethesda, MD 20814-3004
For referral to a geriatric psychiatrist, call 301-654-7850 (Ext. 100)
or email main@aagponline.org
Web site: www.aagponline.org

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Blvd., Ste. 300
Arlington, VA 22201-3042
703-524-7600; HelpLine: 800-950-NAMI
Web site: www.nami.org

National Foundation for Depressive Illness, Inc.

P.O. Box 2257
New York, NY 10016
212-268-4260; 800-239-1265
Web site: www.depression.org

Alzheimer's Association

919 N. Michigan Ave., Ste. 1100
Chicago, IL 60611-1676
312-335-8700; 800-272-3900
Web site: www.alz.org



Reprints of the full guidelines publication, *Pharmacotherapy of Depressive Disorders in Older Patients*, may be obtained by sending a shipping/handling fee of \$12.95 per copy to Expert Knowledge Systems, 21 Bloomingdale Rd, White Plains, NY 10605.

For more information on the Expert Consensus Guidelines, or to download other publications, visit the Web site

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