ASSESSMENT OF GERIATRIC DEPRESSION

Objectives

- Provide prevalence rates for geriatric depression across diverse populations
- Identify risk factors for depression for older adults
- Discuss cultural considerations
- Present a summary of symptomatology
- Contrast differential diagnosis with dementia and delirium
- Highlight common assessment instruments

Importance of Diagnosis

- Depression affects 15 out of every 100 adults over age 65 (Geriatric Mental Health Foundation, 2011).
- Rates of depression in the community range from 1-13%:
  - Major depressive disorders (MDD) - 1.8%
  - All depressive syndromes considered clinically relevant -13.5%
  - Depression among residents of long-term care (LTC) during the first year - 54.4%
- Negative outcomes of depression include cognitive decline, mortality, suicide, and hospitalization.
- Suicide rates are highest among the elderly.
Risk Factors for Depression

- Disability
- Cognitive impairment/decline
- New medical illness
- Poor health status
- Prior depression
- Loneliness & isolation
- Low socioeconomic status
- Poor self-perceived health
- Sleep disturbance
- Recent bereavement
- Institutional placement

Depression in Sub Populations

Race/ethnicity
- Compared to non-Hispanic Whites, minorities have a higher prevalence of depression.
- African American older adults are more likely to internalize stigma and less likely to seek treatment (Connor et al., 2010).

Gender
- Women have twice the rate of depression than men.
- Men are 3-5 times as likely as women to die from suicide, and depression is the most common associated condition (Grigoradis & Robinson, 2007).
- White men over age 85 have the highest rates of suicide of any group.

Suicide Rates* Among Persons Ages 65 Years and Older, by Race/Ethnicity and Sex, United States, 2005-2009

Footnote: *All rates are age specific. Rates based on less than 20 deaths are not shown as they are statistically unreliable. **AI/AK Native: American Indian/Alaskan Native, PI: Pacific Islander. Source: Centers for Disease Control and Prevention (2014).
A Discussion About Cultural Considerations

- This podcast features Dr. Ugochi Ohuabunwa, Assistant Professor of Medicine Emory University and Medical Director of the Grady Memorial Hospital Geriatric Center in Atlanta, Georgia.
- Dr. Ohuabunwa will talk about her experience assessing and diagnosing depression in minority older adults.
- She will highlight the cultural issues that are part of assessing older adults from diverse cultural groups and things that healthcare providers should consider when assessing this population.
- Click on or copy and paste the weblink below to listen to the podcast:
  - https://gsu.sharestream.net/ssdcms/i.do?u=a1a2f63ba0144f3

Table 1. Primary DSM-IV depression disorders, criteria for adults

<table>
<thead>
<tr>
<th>Depression Diagnosis</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>1. Depressed mood/interest or pleasure in usual activities.</td>
</tr>
<tr>
<td>Minor Depression</td>
<td>1. Depressed mood/interest or pleasure in usual activities.</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>1. Depressed mood/interest or pleasure in usual activities.</td>
</tr>
</tbody>
</table>

Depression: “SIG-E-CAPS”:
- Sleep Disturbance (insomnia or hypersomnia)
- Interest (anhedonia or loss of interest in usually pleasurable activities)
- Guilt and/or low self-esteem
- Energy (loss of energy, low energy, or fatigue)
- Concentration (poor concentration, forgetful)
- Appetite changes (loss of appetite or increased appetite)
- Psychomotor changes (agitation or slowing/retardation)
- Suicide (morbid or suicidal ideation)
Atypical Presentation of Depressed Older Adults

- Deny sadness or depressed mood
- May exhibit other symptoms of depression
- Unexplained somatic complaints
- Hopelessness
- Helplessness
- Anxiety and worries
- Memory complaints (may or may not have objective signs of cognitive impairment)
- Anhedonia
- Slowed movement
- Irritability
- General lack of interest in personal care

(Gallo and Rabins, 1999)

Compared to Younger Adults, Older Adults:

- Are more likely to report somatic symptoms than depressed mood.
- Are more likely to experience sleep disturbance, fatigue, psychomotor retardation, loss of interest in living, and hopelessness about the future (Christensen et al., 1999).
- Are less likely to endorse cognitive-affective symptoms of depression, including dysphoria and worthlessness/guilt (Gallo et al., 1994).
- Are more likely to have subjective complaints of poor memory and concentration (Tyler et al., 2009).

Suicide Risk

National Guidelines for Seniors Mental Health: Part 2.2.1

Non modifiable risk factors include:

- Old age
- Male gender
- Being widowed or divorced
- Being hospitalised or in care
- Losses (e.g. health status, role, independence, significant relations)

Potentially modifiable risk factors include:

- Social isolation
- Presence of depression
- Presence of diagnosed or undiagnosed medical conditions
- Presence of substance use disorder
- Presence of hopelessness and suicidal ideation
- Access to means, especially firearms

Behaviors to alert clinicians to potential suicide include:

- Agitation
- Giving personal possessions away
- Reviewing one’s will
- Increase in alcohol use
- Non-compliance with medical treatment
- Taking unnecessary risk
- Preoccupation with death
Assessment and Diagnosis of Depression

Eve Byrd is a Family Nurse Practitioner, Psychiatric Clinical Nurse Specialist, and Executive Director of the Fuqua Center for Late Life Depression, located in Atlanta, GA.

Click on or copy and paste the weblink below to view a lecture on assessment and diagnosis of depression in older adults:

http://www.youtube.com/watch?v=NadEQBnVTZ4

Case Study 1

Ms. G is a 75-year old female living alone in her apartment in New York City. Her husband died suddenly two years ago of a heart attack. Their two children are alive and living out-of-state. Both of her sons maintain weekly phone contact with Ms. G and visit usually once a year. Ms. G has been doing well until about 6 weeks ago when she fell in her apartment and sustained bruises but, did not require a hospital visit. Since then, she has been preoccupied with her failing eyesight and decreased ambulation. She does not go shopping as often, stating she doesn’t enjoy going out anymore and feels “very sad and teary.” Ms. G states that her shopping needs are less, since she is not as hungry as she used to be and she states, “I’m getting too old to cook for one person only”.

Case Study 1: Questions

What risk factors might account for Ms. G’s Depression?

What are Ms. G’s depressive symptoms?
Types of Depression

- **Endogenous depression** (biological) – chronic or lifelong state of depression for which there is no apparent precipitating cause, genetic link
- **Exogenous depression** (reactive) – short-term depression caused by loss or extreme trauma
  - Most common form of depression in older adults
  - Diagnosed as an adjustment disorder with depressed mood
  - Mild to moderate case that occurs after a significant loss or in response to serious life adjustment.

Older Adults Are Often Misdiagnosed: Differential Diagnosis

- Thyroid disorders (hypo- and hyperthyroidism)
- Dementia (or mild cognitive impairment)
- Bereavement
- Anxiety Disorder
- Substance Abuse Disorder
- Personality Disorder
- Diabetes mellitus
- Underlying malignancy
- Anemia
- Medication side effects
Video and Case Study 2

- Video - Dementia, delirium and depression are the three most prevalent mental disorders in the elderly. Click on or copy and paste the following weblink to view a 45-minute video exploring the work up and management of elderly persons presenting with these mental disorders by Dr. James Bourgeois, professor of Clinical Psychiatry at UC Davis.
  - http://www.youtube.com/watch?v=lNs9d9cpQos

- Case Study – Click on or copy and paste the weblink below to a review and case study of Depression, Delirium, and Dementia in older adults.
  - https://mcnmedia.illinoisstate.edu/flash/hartford/activity10.html

Assessment Instruments at a Glance

<table>
<thead>
<tr>
<th>TOOL</th>
<th>ORIGINALLY DESIGNED FOR</th>
<th>ITEMS</th>
<th>TIME TO COMPLETE</th>
<th>METHOD OF ADMIN.</th>
<th>RESPONSE</th>
<th>SENSITIVITY/ SPECIFICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>GERIATRIC DEPRESSION SCALE</td>
<td>Geriatric patients</td>
<td>30</td>
<td>10-15 minutes</td>
<td>Self-Administered</td>
<td>Yes/No</td>
<td>92%/95%</td>
</tr>
<tr>
<td>BECK DEPRESSION INVENTORY</td>
<td>Patients with previously diagnosed depression</td>
<td>21</td>
<td>5-10 minutes</td>
<td>Self-Administered</td>
<td>0-3 Ranked Responses</td>
<td>100%/96%</td>
</tr>
<tr>
<td>HAMILTON DEPRESSION SCALE</td>
<td>All populations</td>
<td>21</td>
<td>15-20 minutes</td>
<td>Professionally administered interview</td>
<td>0-2 or 0-4 Ranked Responses</td>
<td>Not Available</td>
</tr>
<tr>
<td>CES-D</td>
<td>Adult community members</td>
<td>20</td>
<td>5-10 minutes</td>
<td>Self Administered</td>
<td>4 point Likert Scale</td>
<td>82%/94%</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>All populations effective for Geriatrics</td>
<td>9</td>
<td>5 minutes</td>
<td>Self-Administered</td>
<td>4 point Likert Scale</td>
<td>88%/88%</td>
</tr>
</tbody>
</table>

Geriatric Depression Scale (GDS)

- Designed specifically for persons age 65 and older.
- Unlike other instruments, there is no somatic component to the GDS, because many physical manifestations of depression can easily be associated with other simultaneous illnesses in older adults.
- Not suitable for assessing depression in individuals with cognitive disorders and cannot be used to assess the effects of pharmacological therapy.

Sample Questions
- Are you in good spirits most of the time? YES/NO
- Do you feel full of energy? YES/NO
- Have you dropped many of your activities and interests? YES/NO
  (Olin et al., 1992; Yesavage et al., 1983)
Beck Depression Inventory (BDI)

- Initially designed to measure the severity of previously diagnosed depression, but has since been validated for use in the geriatric population.
- Uses ranked responses ranging from 0-3 to allow the BDI to assess variations in the severity of depression over time.
- Some studies show higher non-response rates associated with the BDI for the geriatric population, particularly concerning questions related to "sexual interest".

Sample Questions

Sadness
0  I do not feel sad.
1  I feel sad.
2  I am sad all the time and I can’t snap out of it.
3  I am so sad or unhappy that I can’t stand it.

Loss of Energy
0  I have as much energy as ever.
1  I have less energy in the past two weeks.
2  I don’t have enough energy to do very much.
3  I don’t have enough energy to do anything.

(Jefferson et al., 2000; Oliveu et al., 1992)

Hamilton Depression Scale (HAM-D)

- Created with emphasis on the psychological aspects of depression across a variety of populations.
- For proper results a professional is required to perform a "semi-structured" interview and then answer and evaluate the resulting score provided by the tool.
- Not validated for the geriatric population, but considered useful in populations with cognitive defects.
- Several questions relate to somatic symptoms.

Sample Question

Suicide
- 0 = absent
- 1 = feels life is not worth living
- 2 = thinks he was stupid or any thoughts of possible death to self
- 3 = suicidal ideas or gesture
- 4 = attempts at suicide

(Hauting & Vaeren, 1979)

Center for Epidemiologic Studies Depression Scale (CES-D)

- Designed to screen adult community members for research purposes, but also validated as an assessment tool for use in other populations, including the elderly.
- Responses are based on frequency of occurrence, which enables the CES-D to follow changes in depression over time.
- Considered useful for elderly across different racial, ethnic, and economic backgrounds because of its exceptional psychometric properties.

Sample Questions

I was bothered by things that don’t usually bother me:
- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

I felt hopeful about the future:
- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

(Ross et al., 2011)
PHQ-9

- Can track severity of depression as well as the specific symptoms that are improving or not with treatment.
- Has proven effective in a geriatric population (Li et al., 2007)
- Nine items are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV.

Sample Questions:
Over the last 2 weeks, how often have you been bothered by any of the following problems?
Response (not at all, several days, more than half the days, nearly every day)
- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless
- Thoughts that you would be better off dead, or of hurting yourself in some way (Li et al., 2007)

IMPACT

- IMPACT is an evidence based depression program specifically designed for older adults.
- The IMPACT website (http://impact-uw.org/) provides a source of information and materials designed to help clinicians and organizations implement IMPACT in a variety of settings.
- Click on or copy and paste the weblink below and go to Tools- PHQ-9. Scroll down the page to view a video showing an administration of the PHQ-9.

Fuqua Center for Late-Life Depression 10th Anniversary Video

- The Fuqua Center for Late-Life Depression is a non-profit organization whose mission is to improve the community’s understanding and recognition of mental illnesses in older adults and improving access to geriatric psychiatric services.
- Click on or copy and paste the weblink below to view a collection of patients and community partners speaking about the Fuqua Center's contributions to the mental health of older adults.
  - http://www.youtube.com/watch?v=uPMeAOBtfpw
References


References con’t