

'Growing old' versus declining miserably: Some facts about depression and the older adult

By Richard Lakeman

The twentieth century has been described as the "age of melancholy" (Barker, 1992, p.24). Whilst first world countries such as New Zealand have enjoyed great improvements in life expectancy we have also become increasingly miserable. Epidemiological studies suggest a ten-fold increase in the prevalence of depression since the Second World War (Barker, 1992). The notion of 'growing' older, has for many people been replaced with a reality of hopelessness and despair. What is particularly frightening is that depression is perceived by many people (including health professionals), as a normal and expected part of ageing. This article aims to explore some of the myths and realities of depression so that health professionals might better recognise and assist the older person experiencing depression and facilitate "growth" in ageing.

Depression is under-recognised and under-treated by health professionals (Kessler, Lloyd, Lewis, & Gray, 1999). Although some surveys have found that nurses often have the knowledge to recognise symptoms of depression in older adults, they have been found to rarely use this knowledge in assessment (Proffitt, Augspurger, & Byrne, 1996). The public have been found to have some sympathy with those that are depressed, but are reluctant to consult with health professionals when depressed themselves and often hold erroneous beliefs about medical treatments (Priest, Vize, Roberts, Roberts, & Tylee, 1996). Older people in particular have been found to be less likely to acknowledge depressive symptoms or seek help (Allen, Walker, Shergill, D'Ath, & Katona, 1998). In light of the many losses and sometimes complex health problems that may surface with age, signs and symptoms of depression may be construed as inevitable, normal and untreatable by health professionals and lay people alike.

As a recent nursing graduate I was involved in providing care to a couple on a general medical ward. This vignette (with specific details omitted and names changed) illustrates the complexity of recognising depression in the older adult and the potential adverse outcomes that may arise when treatment isn't forthcoming:

Billy was well known to all the staff on this medical ward. He had visited his wife Bonny daily as she was nursed through end stage cancer. Over time Bonny faded to a shell of a human being as 'cerebral metastasis' destroyed even recognition of Billy, her companion for over forty years. During the last month of Bonny's life Billy spent most of his time lying in a hospital bed beside Bonny, holding her hand, and leaving the ward only to visit a nearby public bar. His emotional pain was palpable and he would sometimes talk about how he felt guilt for not being a "good" husband. It was as if he was trying to make amends for his perceived shortcomings by his near constant vigilance. He was also not physically well himself and long before Bonny's admission to hospital had been admitted for complications relating to long-standing alcohol miss-use, rheumatoid arthritis, gout, non-insulin dependent diabetes mellitus, hypertension and heart failure. Nursing staff ensured that his basic physical needs were met and that he received his extensive list of medications. After Bonny's death Billy was formally admitted to the ward. He refused to eat or drink anything except brandy mixed with milk, stating that he wanted to starve himself to death. His request for medical and nursing staff not to do anything to forestall death was honoured. He died within weeks.

The purpose of this vignette is not to chastise nursing or medical staff for their actions or in-action. Even in my most critical moments I cannot fault the compassion and sensitivity to this couple's distress that was shown by the health-care team. Nevertheless, I do wonder if the outcome would have been different for Billy if his response had been viewed as a consequence of a treatable depression. Whilst Billy's case evoked much emotion and discussion amongst the team I cannot recall anyone requesting a psychiatric consultation. If Billy was 20 years younger or Bonny's son

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rather than husband, would the team have been more likely to offer pro-active rather than palliative care? What if Billy didn't have a raft of physical health problems which impinged on his quality of life - would his choice to die have been so readily accepted? These are academic questions in relation to Billy, but Billy's case does reflect what might be described as the 'swampy ground' of clinical practice (Schön, 1983), where the ambiguity, complexity and uniqueness of a case defy easy classification or text book solutions. Such is often the case in the practice of nurses with older adults, where they may be confronted with features of depression which are confounded with recent losses, bereavement, major social stressors, and complex physical health problems. The health professional is particularly challenged to identify what features of a person's response reflect depression when the person themselves may attribute symptoms to other causes, and when the expertise of staff and the treatment setting is geared towards the treatment of physical health problems.

What is depression?

Depression is undoubtedly part of the human condition. Probably long before Hippocrates coined the term "melancholia" in the fourth century BC (Conrad & Schneider, 1980), societies have recognised prolonged low mood as un-usual or undesirable experience. Depression may be considered on a continuum of severity from mild reactions, which most people will experience and cope with, through to severe responses, which may render the person disabled. It is considered a response to adverse life events, a side-effect of medical treatment and drugs, and part of a number of psychiatric syndromes such as bi-polar affective disorder. The American Psychiatric Association (DSM-IV, 1994, p.327) identify two forms of depression including 'dysthymia' (characterised by at least 2 years of depressed mood, accompanied by symptoms which do not meet the criteria for major depression) and 'major depression' (a severe and more acute form of depression - See Table One).

Whilst emotions such as 'sadness' may be considered "normal", in major depression they are abnormal in that they are prolonged, pervasive, cause disabling physical and psychological symptoms and cause marked functional impairment. In severe depression people may become psychotic and experience delusions and hallucinations which can be extremely distressing.

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DSM-IV Criteria for Major Depression:

- A. At least one of the following three abnormal moods which significantly interfered with the person's life:
1. Abnormal depressed mood most of the day, nearly every day, for at least 2 weeks.
 2. Abnormal loss of all interest and pleasure most of the day, nearly every day, for at least 2 weeks.
 3. If 18 or younger, abnormal irritable mood most of the day, nearly every day, for at least 2 weeks.
- B. At least five of the following symptoms have been present during the same 2 week depressed period:
1. Abnormal depressed mood (or irritable mood if a child or adolescent) [as defined in criterion A].
 2. Abnormal loss of all interest and pleasure [as defined in criterion A2].
 3. Appetite or weight disturbance, either:
 - Abnormal weight loss (when not dieting) or decrease in appetite.
 - Abnormal weight gain or increase in appetite.
 4. Sleep disturbance, either abnormal insomnia or abnormal hypersomnia.
 5. Activity disturbance, either abnormal agitation or abnormal slowing (observable by others).
 6. Abnormal fatigue or loss of energy.
 7. Abnormal self-reproach or inappropriate guilt.
 8. Abnormal poor concentration or indecisiveness.
 9. Abnormal morbid thoughts of death (not just fear of dying) or suicide.
- C. The symptoms are *not* due to a mood-*incongruent* psychosis.
- D. There has *never* been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.
- E. The symptoms are *not* due to physical illness, alcohol, medication, or street drugs.
- F. The symptoms are *not* due to normal bereavement.

Table One: Diagnostic criteria for major depression
(Source: American Psychiatric Association, 1994, p.327)

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Many older adults may not meet diagnostic criteria for major depression but have 'clinically significant' depressive symptoms. The experience of depression may be likened to putting on a very dark pair of sun-glasses. Depression is like a negative filter, which can lead the person to view themselves and the world in a pervasive negative light. This altered perception may have an insidious or acute onset. The person may not feel sad but may derive little pleasure from experiences, which they have previously found pleasurable, or feel 'hassled' by daily stressors that would not usually bother them. The presence of pessimism, guilt, shame, perceptions of inadequacy, lack of energy, social withdrawal, difficulty concentrating, confusion, problems with memory, transient confusion, should all alert the health professional to the possibility of depression.

There is some evidence that older adults may experience depression somewhat differently from younger people. They may for example have a less depressed affect but more symptoms of anxiety, and somatic symptoms (Gottfries, 1998), disturbed sleep and general health worries (Norris & Woehr, 1998). Those that have their first depressive episode in latter life may experience more apathy than those whose first experience was earlier in life (Krishnan, Hays, Tupler, George, & Blazer, 1995). It has also been suggested that somatic and anxiety related complaints may mask depression in older adults (Reynolds, 1995). Depression may mirror and precede subtle and early signs of dementia (Gottfries, 1998) and the National Advisory Committee on Health and Disability (1997, p.23) suggest that a trial of antidepressant medication is often indicated when depression is suspected, as reliable diagnosis is difficult.

The prevalence of depression

Depression in any age group is not "normal" but it is relatively common. Unfortunately, those over the age of 65 have been generally excluded from epidemiological research in New Zealand (Melding, 1997). Findings from other western countries suggest one-month prevalence of major depression in those over the age of 65 to be in the range of 0.7 to 2.9%, and less severe forms of depression to range from 2 to 13% (Melding, 1997). According to Kurlowicz (1993, p.31), "Available community surveys report that major depression is less prevalent among those 65 years and older, than in younger persons", but some depressive symptoms which may have a significant impact on physical function may not be accounted for by the tools used to measure depression, leading to an underestimation in the prevalence of depression in older adults".

The older adult may be of greater risk of depression as a consequence of:

- reaction to age related changes, disease, disability and hospitalisation.
- the physiologic effects of medical problems
- the treatment used for medical problems

In those older adults who are hospitalised or institutionalised the prevalence of depression is 3 to 4 times greater than the general population (Melding, 1997). The prevalence has also been found to be higher for those older adults who are required to care for a dependent relatives (Livingston, Manela, & Katona, 1996), and for those with specific medical problems, such as coronary artery disease (Freedland & Carney, 1998), cancer, post-stroke, dementia and metabolic and endocrinological diseases such as diabetes and vitamin B12 deficiency (National Advisory Committee on Health and Disability, 1996). Table two lists some broad classes of medical conditions which are strongly associated with depression. In these conditions features of the

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disease may mirror depressive symptoms or 'depressed mood' may be a side effect of pharmacological treatment of the primary problem.

▪ Stroke	▪ Cancer
▪ Dementia	▪ Chronic fatigue syndrome
▪ Metabolic and endocrinological diseases	▪ HIV - AIDS
▪ Coronary artery disease	▪ Fibromyalgia
	▪ Parkinson's Disease

Table Two: Medical conditions associated with symptoms of major depressive disorder (Source: National Advisory Committee on Health and Disability, 1996)

Many medical treatments which are used to treat common, or age related health problems in the older adult are known to lead to depressive symptoms. Antipsychotics, sedatives, digitalis preparations, steroids, anti-hypertensives, opiates, anticonvulsants and cimetidine may causes depressive symptoms (Pinals & Satlin, 1997). The very treatments, which may extend life and enhance quality of life for some people are implicated in reducing the quality of life in others. It is imperative that health professionals explore medical pharmaco-therapies as a possible source of depression even in the face of stressors, which may seem to explain the depressive response.

The course and complications of depression

There is some evidence to suggest that older adults are more likely than younger people to suffer a relapsing course of depression with poorer outcomes, although Pinals and Satlin (1997) suggest that no studies to date offer strong evidence that major depression is significantly more chronic in latter life. Forsell, Jorm, and Winblad (1998) followed up 78 older adults who were diagnosed with major depression, and 39 with dysthymia three years after initial interview. They found that 48% of those without dementia were depressed, and although 77% had consulted a physician recently, only 17% were being treated for depression (Forsell et al., 1998). Chronicity and disability may be more strongly related to failure to recognise and treat depression.

In studies which have followed the course of medically ill and depressed older adults, depression and disability appear to go hand in hand (Koenig & George, 1998). Depressed thinking, anxiety, retardation, and weight loss have been found to be related to impaired performance of instrumental activities of daily living, independent of medical burden (Alexopoulos et al., 1996). Depression may also predispose people to specific health problems. A recent case-control population study found that the risk of ischaemic heart disease was three times higher among men with a recorded diagnosis of depression than among controls of the same age (this was not true of women) (Hippisley-Cox, Fielding, & Pringle, 1998). Depression makes disability worse, impairs recovery from illness, impedes growth and reduces quality of life.

The most devastating outcome of untreated depression is suicide. In almost every western the highest rates of completed suicide tend to be in men over the age of 65 and rates tend to increase with age (Duffy, 1997). In New Zealand there has been considerable public concern about the rising rate of suicide in those aged 15-24, which has quadrupled since the early 1970s (Skegg, 1997). When the aggregate mortality rates due to suicide by age are examined for the period 1984 to 1993, the rates of suicide for non-Maori men in the 75-84 year age group are considerably higher than youth (Skegg, 1997). Older non-Maori males have tended to use more violent and lethal means to suicide such as hanging or shooting, whereas females have tended to use means such as

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drowning or poisoning (Melding, 1997). There is considerable evidence from recent studies that those who attempt suicide are likely to have a diagnosable mental illness such as major depression. Those that have been widowed in the past year, have physical or depressive illness, alcoholism or mild dementia may be of particular risk of suicide.

The rate of suicide in older adults is also likely to be understated. The cause of death for those that deliberately do not comply with nutritional requirements or medical interventions in order to hasten their death is seldom recorded as suicide (Melding, 1997). In Billy's case (in the vignette outlined earlier) there was no consideration of his death being due to suicide. Ganzini, Lee, Heintz, Bloom and Fenn (1994) interviewed 43 people on admission to a psychiatric inpatient unit and at discharge about their desire for specific medical therapies in their current state of health and in two hypothetical scenarios of medical illness. They found that severely depressed patients overestimate the risks of treatment, or underestimate the benefits of treatment and recommend that people should be encouraged to defer advance treatment directives until depression is treated.

Causes of depression in the older adult

Like many forms of mental illness the causes of depression are multi-faceted and are likely to include a complex web of biological, social, psychological and spiritual factors unique to individuals. Examination of particular risk factors also suffers from the 'chicken and egg' problem, that is, what comes first? For example physical disability may predispose a person to depression, but depression will worsen disability; social isolation may be broad risk factor but the nature of depression frequently causes the person to become increasingly withdrawn and isolated from others. There exists a complex interplay between factors, which may have a mutual influence on each other so that untreated depression may lead to a spiralling escalation of problems in the older adult.

Biological explanations have focused on structural and functional changes in the brains of depressed persons. Decreased levels of the neurotransmitters such as serotonin and norepinephrine have been found to be associated with depression, and help explain the effectiveness of antidepressants, which tend to work in various ways to raise the levels of these chemicals (Kermis, 1986). Physical problems such as hypothyroidism may be very clearly the cause of depression and need to be identified and treated.

For many people depression may be considered a reaction to life events. With age people develop some resilience and experience in coping with adverse life events and can anticipate and plan for some changes and losses. However, stressors are more likely to be characterised by changes involving loss of relationships and some stressors such as disability may be unremitting. Social isolation, loneliness and lack of social support play a role in the development of depression and the availability of a confidant and helping others have both been found to buttress against depression (Hays et al., 1998). It has been suggested that changes in the dominant values of western societies which have come to embrace independence, autonomy, personal responsibility and emphasise personal worth as a function of economic productivity is responsible for an increase in depression across the life span (Barker, 1992).

Examination of suicide trends may provide some illumination on factors which protect against depressive reactions. Suicide rates in Maori tend to buck the trend of non-Maori by decreasing with age. Whereas many non-Maori may look forward to reduced responsibility and increased leisure time upon retirement, for Maori age may bring increased responsibility and esteemed roles such as kaumatua or kuia. There is no doubt that feeling useful, remaining active and the

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maintenance of a mutually supportive web of relationships protects against depression. Barker (1992) observes that those who belong to more 'traditional' cultures appear to be largely unaffected by the melancholic epidemic characteristic of first world societies, and a sense of collective responsibility, spiritual and social connection buffers a person from experiencing a sense of personal failure and hopelessness (Barker, 1992).

The treatment of depression

Despite, the complex, physical and social aetiology of depression in the older adult, it remains one of the most 'treatable' forms of mental illness. For milder forms of depression most will recover without medical intervention by adapting to disability, loss and through the maintenance or establishment of supportive relationships. Older people tend to have a resilience, wisdom and a capacity to adapt borne of coping with adversity and an anticipation of life changes. For others professional assistance will be required. Even when social isolation and extreme disability are present, or medical treatment for depression is not provided there is considerable evidence that a relationship with a registered nurse can make a difference (Banerjee, Shamash, Macdonald, & Mann, 1996).

Antidepressant medications

Older patients appear to benefit as much as, but perhaps more slowly than, midlife patients from treatment of major depression with antidepressants (Reynolds et al., 1996). Reynolds et al. (1994) suggest that treatments can be as effective and life-enhancing for older adults as they are for the young. At this time all antidepressants generally take between two and six weeks to have any therapeutic effect, and all appear to be effective. Pinals and Satlin (1997, p.255-256) suggest that the following issues must be considered in the prescription of pharmacological treatment in the older adult:

- Medical evaluation - Physical examination and laboratory testing.
- Pharmacokinetics of psychotropic drugs - Hepatic and renal clearance decreases with age; Fat soluble psychotropics are distributed more widely and remain in the body longer.
- Pharmacodynamics and neurotransmission - Aging leads to reduced concentrations of neurotransmitters and altered sensitivity of certain receptors.
- Medication regimen - More prescriptions increase the risk for drug interactions and may reduce compliance.

All health professionals should be aware of the main classes of anti-depressant medications and their potential side effects. It is beyond the scope of this paper to examine these in detail, but common side effects include sedation, anticholinergic effects, insomnia and sedation. Newer classes of antidepressant medications such as the selective serotonin re-uptake inhibitors e.g. fluoxetine and sertraline have fewer side-effects and are often tolerated better by older adults (Porter & O'Brien, 1998). It is important to correct the mis-perception held by many that antidepressants are some form of "happy pill" or a pharmacological "crutch".

Electroconvulsive Therapy (ECT)

ECT has had some 'bad press' in the past and continues to carry a stigma which can obscure the reality of ECT has an effective and relatively safe treatment for certain types of depression. Indeed ECT may be the most effective and safest treatment available to older adults with symptoms of

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psychosis, guilt and neurovegetative signs (Pinals & Satlin, 1997). My first experience with ECT highlighted that ECT can be a life saving treatment for some people and can have a remarkably quick effect:

Mr Jones was 72 years old and was admitted to an acute psychiatric ward with catatonic depression. Over a couple of weeks Mr Jones had become increasingly autistic and amotivated to the point that he (seldom) communicated and then only with grunts, didn't move from his chair, was incontinent of urine and didn't eat or drink. He and his partner consented to ECT with few expectations that it would work. He was taken to theatre, given a general anaesthetic and muscle relaxant prior to ECT being administered. When he awoke 20 minutes later he enquired where he was and what was going on. He chuckled when told that he had just received ECT for a severe form of depression. His apparent lift in mood wasn't sustained for very long. However, he continued to receive ECT every third day and on each occasion his mood appeared to lift a little more and was sustained for longer periods. After six treatments Mr Jones was discharged home but continued to come in as an out-patient for a further six treatments.

Talking Treatments

Individual, group, and family psychotherapy is integral to comprehensive treatment of depression. O'Rourke and Hadjistavropoulos (1997) suggest that talking therapies are as effective with older adults as younger adults. Cognitive behaviour therapy (CBT) is based on the premise that a person's negative thoughts lead to a negative appraisal of themselves, their future and the world in general (National Advisory Committee on Health and Disability, 1996). Cognitive behavioural therapists use a range of methods to assist the person change negative, or self-defeating thoughts in order to alleviate depression or prevent a relapse in depression. Depression has a profound affect on people's thinking and their capacity to solve problems. People may feel overwhelmed and failure to solve problems further reinforces a person's sense of helplessness and despair. A recent randomised controlled trial found that after 12 weeks 60% (n=18/30) of patients given problem solving treatment (an average of 3 1/2 hours of coaching) had recovered from depression, compared with 52% (n=16/31) given amitriptyline and 27% (n=8/30) given placebo (Mynors-Wallis, Gath, Lloyd-Thomas, & Tomlinson, 1995). These authors concluded that problem solving treatment is effective, feasible, and acceptable to patients with depression in primary care (Mynors-Wallis et al., 1995).

Talking therapies may be useful as the sole treatment in mild to moderate forms of depression and as an adjunct to other medical treatments in severe depression (National Advisory Committee on Health and Disability, 1996). Talking therapies require a competent, trained and supervised therapist and health professionals should be aware of their competency and boundaries in using particular approaches. Nevertheless, all health professionals may at sometime be in the position to provide support and assist the older person who is depressed solve problems.

Nursing and depression

It has been suggested that nurses are in an ideal position to provide useful support and treatment for depression in the older adult (Blixen, Wilkinson, & Schuring, 1994; Hughes, 1992). The nurse is often in a position to sustain a medium or longer term relationship with the person in the community and to gain a holistic over-view of the person's situation. In practice the nurse can be with the person who is depressed, use strategies derived from cognitive behaviour therapy in routine interactions, provide support to carers, assist the person in establishing or maintaining

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meaningful social supports, provide accurate information about medical treatments, and refer people to appropriate services.

The nurse (in whatever setting) can play a crucial role in identifying depression in older adults and may also instil a sense of hope in what may appear to the depressed person to be a hopeless situation. Barker (1992) suggests that the following principles provide the basis for good care and therapy:

- Focus on significant details, not everything that is wrong with the person's life.
- Deal with 'here-and-now' issues.
- Focus on people's experience - a simple diary of feelings may be helpful.
- Collaborate with the person to enable them to appreciate what they can do without your support.
- Deal with the whole person as depression disturbs the body, mind, soul and family. Any number of interventions may prove helpful, for example exercise, massage, reading, music or prayer.
- Recognise that just as depression has no single cause, there is unlikely to be one single answer.

Above all nurses should be alert to the symptoms of depression and take caution in discounting symptoms as 'normal' and not amenable to treatment. Nurses can bring a realistic optimism, which can be translated into hope for consumers, knowing that depression is treatable. Nurses must also recognise that their relationship and way of being with depressed people can have a significant impact on that person and their health outcomes. Depression can arise from alienation and can cause further alienation from others. The emotional, psychological and social responses in depression can lead people to feel enormously isolated and alone. People are not naturally drawn to others who are depressed and nurses must often make a concerted and conscious effort to spend time with the depressed person. The response of the nurse to the person can validate the person's sense of worth, or further reinforce the person's sense of worthlessness.

I would like to believe that Billy's case was exceptional but since then I have been exposed to numerous anecdotal and first hand experiences which suggest that similar scripts are played out on a daily basis in rest homes, hospitals and the community at large. There will be times when nurses must facilitate referral of older adults to specialist psychiatric services. However, depression in the older adult is the concern of every health professional who has contact with older people. As health professionals we owe it to people like Billy and to ourselves (as we will inevitably confront similar losses) to be open to the possibility of depression in the older adult, recognise it as a treatable condition and ensure that people receive the best possible medical and nursing care.

Key Points

- Depression in the older adult is a common, but often unrecognised and untreated problem.
- Depression may be manifested differently in the older adult.
- The causes of depression include biological factors, adverse life events, the consequences of disease, and disability, lack of social supports and the consequences of medical treatments for common health problems.

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- Medical problems may mirror depressive symptoms making detection difficult.
- The consequences of untreated depression in the older adult include reduced quality of life, poorer general health outcomes, and premature death.
- Depression is treatable in the older adult and treatments include antidepressant medications, electro-convulsive therapy, talking therapies, and a range of interventions which acknowledge the holistic nature of people.
- Nurses can play a major role in the recognition, treatment and on-going support of older adults with depression.

Essential resources on depression and the older adult

- The World Wide Web site "www.mentalhealth.com" contains extensive 'evidenced based' papers on depression and the older adult as well as other mental disorders.
- The National Health Committee have produced guidelines on the treatment and management of depression by primary healthcare professionals, as well as guidelines for the support and management of people with dementia. These are freely available from the New Zealand Health Information Service via the Ministry of Health.
- For a synthesis of overseas and local research on the epidemiology of mental disorder in New Zealand the book 'Mental Health in New Zealand from a Public Health Perspective', available from the Ministry of Health is second to none.

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