How to Recognize and Diagnose Late Life Depression

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A Clinical Presentation

• Depression is not always as obvious as seen in Van Gogh’s painting
• Rating scales can only assist the clinician at the “front end” of the diagnostic interview and to some extent in following outcomes.
• The assessment of depression is multidimensional, not simply a symptom count.

A Practical Differential Diagnosis of Depression in the Elderly for Primary Care

• Demoralization and minor depression
• Major depression
• Depression associated with cognitive impairment
• Depression associated with physical illness

Presentation of Symptoms

A Clinical Presentation

• Elements of the evaluation include:
  – Presentation of symptoms
  – Diagnostic workup
  – Assessment of suicide potential
  – Clinician and patient factors
### Demoralization

- Things get worse with aging
- I am no longer of any use
- Life brings no satisfaction to me
- I never plan ahead

### Diagnostic Criteria for Major Depression - DSM-5

Five or more of the following symptoms reported for two weeks or more. At least one of the symptoms either depressed mood or loss of interest of pleasure.

- Depressed mood (less frequent endorsement)
- Diminished interest or pleasure (no change)
- Significant weight loss or gain (weight loss only)
- Insomnia or hypersomnia (insomnia only)

Criteria are applicable if depression not comorbid with physical illness or cognitive dysfunction.

### Diagnostic Criteria for Major Depression - DSM-5 (cont.)

- Psychomotor agitation or retardation (can see both)
- Fatigue or loss of energy (frequent)
- Feelings of worthlessness or excessive/inappropriate guilt (less frequent)
- Diminished ability to think or concentrate (no change in complaints, more actual impairment)
- Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt (suicide more frequent in white males, suicidal ideation probably less frequent)

### Vascular versus Nonvascular Depression

- Vascular depression more frequent in oldest old, with late age of onset, nonpsychotic depression. Family history of depression somewhat less frequent. Anhedonia and functional disability more frequent. Executive function is impaired.

### Executive Function and Late Life Depression

- Executive dysfunction, including disturbances in planning, sequencing, organizing, and abstracting, has been associated with late life depression.
- Executive dysfunction, in contrast to memory impairment, is associated with late onset depression in late life and also with relapse and recurrence.

### Depression Associated with Dementia (approximate)

Two to three of the following symptoms present for at least two weeks with one either depressed mood or loss of interest/pleasure.

- Symptoms of major depression
- Irritability, anxiety, fluctuating affect

The symptoms do not precede the onset of dementia. The symptoms are not due to a medical illness.
Differentiating Depression and Dementia

Dementia  
- Insidious onset  
- Symptoms long duration  
- Mood and behavior fluctuate  
- “Near miss” answers typical  
- Conceals disabilities  
- Cognitive impairment relatively stable

Depression  
- Rapid onset  
- Symptoms short duration  
- Mood is consistently depressed  
- “Don’t know” answers typical  
- Highlights disabilities  
- Cognitive impairment fluctuates greatly

Depression Associated with Physical Illness (approximate)

- Symptoms of major depression present for at least two weeks.  
- Symptoms not associated with dementia.  
- Symptoms do not precede the onset of the physical illness.  
- Symptoms are greater than would be expected given the severity of the physical illness.

Differentiating Depression and Hypochondriasis

Depression  
- Will discuss feelings and social life with minimal coaxing  
- A history of episodes of somatic difficulties less frequent in middle life

Hypochondriasis  
- Insist on discussing physical ailments to the exclusion of personal issues  
- Frequent episodes of somatic difficulties in min-life

Differentiating Depression and Hypochondriasis

Depressive disorders  
- Appear to suffer from their symptoms  
- Anger directed in  
- Social withdrawal is prominent and often dysfunctional

Hypochondriasis  
- Despite symptoms, do not appear to suffer significantly  
- Anger directed outward  
- Social interaction is often decreased but not dysfunctional

Symptoms and Signs Which Might Predict a Good Response to Pharmacotherapy

- Relatively rapid onset  
- Good premorbid functioning  
- Meets full criteria for major depression  
- Clear signs of melancholic depression, such as sleep abnormalities, anhedonia, appetite disturbance and weight loss, diurnal variation  
- No clear major ongoing life stressors  
- Response to medications in the past

Older Persons can blunt depressive symptoms and may be psychologically protected against symptoms.
The Adaptive Capacity of Older Adults to Loss

Cumulative Wisdom

On -Time Versus Off -Time Losses

What is wisdom and how is it associated with life satisfaction?
- cognitive qualities (objectivity, intellect, logical analysis, intuition)
- reflective qualities (tolerance of ambiguity, introspection, invulnerability to criticism)
- affective qualities (empathy, displays compassion, candid)
- Clearly associated with life satisfaction

Diagnostic Workup

The Diagnostic Work-up of Late Life Depression
- Late life depression is diagnosed by a careful history!
- Screening scales (GDS, Beck, CES-D) the diagnostic work-up which include complete blood cell count, urinalysis, thyroid screen, chemistry screen, and electrocardiogram. These studies are more helpful in documenting medical problems that may complicate therapy than in diagnosis.
- Imaging studies may be helpful in diagnosis of vascular depression.

The Diagnostic Work-up of Late Life Depression
Older men are less likely to endorse core depressive symptoms, and less likely to have received prior depression treatment.

Certain symptoms on depression inventories may be endorsed at a greater level by cognitively impaired individuals, such as greater emotional withdrawal and less psychomotor agitation independent of there overall endorsement of depressive symptoms. They are no less likely to endorse depressed mood.

Laboratory Examination - Elective

Polysomnography

Vitamin B12 and folate assays

Thyroid function tests

ECG
Assessment of Suicide Potential

Definitions

Suicidal Ideation
Attempted Suicide
Completed Suicide

Acute vs. Chronic Suicide

• Suicide usually implies an acute, decisive action which leads to death, e.g. overdosing on medications
• Yet chronic suicide may be far more common in late life than acute suicide. For example, older persons may refuse to eat, consciously abuse drugs or refuse to use life-sustaining medications (such as insulin).

Suicide Attempts in the Elderly

• Expressed thoughts about death and a desire to die are similar across the life cycle, about 5%.
• Suicide attempts are lower in the elderly, 0.3% vs. 1.2% had a history of suicide attempts.
• The ratio of suicide attempts to completed suicides drops from around 20:1 for those below 40 to 4:1 after the age of 60.

Suicide Risk - Direct Assessment

• Suicidal ideation
  – “I’m tired of life.”
  – “I am going to kill myself.”
• Suicidal attempts
  – Taking five aspirin tablets and calling a friend (gesture, parasuicide or manipulative suicide attempts)
  – Any deliberate act of self-damage which the person committing the act could not be sure to survive

Risk for Suicide in the Elderly - Indirect Assessment

• History of suicide attempt
• History of serious psychiatric illness (especially major depression)
• Poor perception of physical health
• Family history of psychiatric illness and/or suicide
• Poor social support
• Alcohol and drug abuse
• Muted affective responses and constricted range of interest
• Presence of a gun in the home
• Biological risk factors (lower levels of brain serotonin)
If a Suicide Occurs While Caring for an Elderly Patient

Convene a meeting with the staff to:
• Review the progression of events
• Encourage verbalization of feelings
• Foster mutual support

Meet with the family to:
• Allow them to ask questions
• Encourage them to verbalize their own feelings
• Discuss mutually the feelings of guilt shared by all involved with the patient

Patient and Clinician Factors

Patient Factors

- Anxiety

The increased stress of a new situation, such as visiting the clinician’s office or being interviewed in the hospital setting, may lead to intense anxiety, impairing the older person’s ability to communicate effectively. Anxiety may not be easily appreciated by the clinician. Tension and agitation may be manifested directly, or they may be diverted into symptoms of withdrawal, shame, fear, or uncooperativeness.

- Sensory Problems

Hearing loss is usually the most difficult sensory problem for the elderly. It affects men more often than women and occurs in 30% of older persons. The most common auditory problem that older persons experience is understanding speech. Specific auditory deficits contribute to this lack of comprehension. These deficits include loss of sensitivity to frequencies above 1000 Hz, decreased pitch discrimination, and decreased sound localization.

- Cautiousness

Older persons tend to make fewer errors of commission than errors of omission. When a clinician is obtaining a history from the older adult he or she must be aware that elders may omit important aspects of their history. Older people also take longer to respond to inquiries. The clinician who rushes through the history interview may overlook valuable information.

- Transference

The older patient may develop an unrealistic view of the clinician based on previous experiences. This process has been called transference in psychoanalysis. Older persons may view the clinician as a parent, leading to marked dependence or as a child, leading to inquiries about the clinician’s health and behavior. The parental transference reaction is likely to occur when the therapist is of similar age to the patient’s children, leading to inquiries about the clinician’s family.
Physician Factors - Negative Attitude Toward the Elderly

Fears of aging and death are frequent in our youth oriented society. This "gerontophobia" may severely limit the clinician's ability to establish a therapeutic relationship with the patient. Recognizing these fears is of utmost importance in establishing effective communication with the older adult.

Physician Factors - Countertransference

Evaluating and treating older adults may rekindle the clinician's unresolved conflicts with parents and grandparents. Omission of a sexual history from the interview of older patients may represent an unconscious prohibition against discussing sexual matters with one's elders (i.e., one's parents).

Conclusions

The clinician who looks for depression in the elderly will be able to recognize depression in the elderly.

It is critical for the clinician to recognize depression, for where depression is found, both the patient and clinician have found hope.