

Precepting Tips for Geriatric Depression



Overview

- **Prevalence of Depression in Older Adults 65+ Years**



In community living, 18.4% of older adults experience depressive symptoms;



more older women (14%) than older men (9%).



The highest rate of depressive symptoms is found in adults 85+ of age.

- **Risk Factors:** One or more chronic health condition, especially heart disease and cancer; women have a higher risk of depression than do men; history of adverse childhood events (ACES), and living in residential institutional settings.
- **Minor or subsyndromal depression** is likely more prevalent than major depression, characterized by depressed affect and other diagnostic symptom(s) of major depression, doesn't meet threshold diagnostic criteria for duration or number of symptoms, and can be forerunner of major depression in older adults.
- **Higher risk of suicide and poorer medical and functional health outcomes** are found in older adults with all types of depression. Men 75 years or older are at greatest risk of death by suicide.
- **Suicide rates increase with age.** Suicide is associated with psychiatric and cognitive disorders, social exclusion, loneliness and bereavement, physical illnesses, physical and psychological pain. Those 85 years or older experienced the second highest suicide rate, 18.6%.
- **Minority older adults** are more likely to experience major depression than are white older adults.

Presentations and Symptoms

DSM-5 Criteria for Major Depression: 5 or more of the following criteria (SIGECAMPS) in the same 2-week period; a change from previous functioning; evidence of either depressed mood or loss of interest or pleasure.

Sleep disturbance
Loss of Interest or pleasure in usual activities
Excessive feelings of Guilt or worthlessness
Decreased Energy and increased fatigue
Diminished ability to think or Concentrate
Appetite change with weight gain/loss
Mood is low most days
Psychomotor agitation or retardation
Suicidal ideation

Screening and Assessment

Initial Screening at annual Medicare wellness visit or with emerging symptoms and/or increasing dysfunction.

- Prime-MD Patient Health Questionnaire (PHQ-2):
 - Over the past 2 weeks, have you often had little interest or pleasure in doing things?
 - Over the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?
- Relevant labs to rule out physical illness as a cause of depressive symptoms: TSH, B12 and folate, calcium, liver and kidney function tests, electrolytes, UA, CBC

Further Assessment

- Family and personal history of depression, bipolar illness, anxiety, and suicide, and include treatment history and tolerability of medications
- Follow up assessment of depression: GDS-15; [PHQ-9](#) Cornell Scale for Depression in Dementia
- Assessment of substance use, including pain medications
- Evaluation of cognitive status and dementia
- Possible neuroimaging for very late onset of first episode of depression
- Assessment of willingness to accept treatment
- If warranted, further suicide assessment to determine intent and means. At the Columbia Lighthouse Project, scroll down to: [C-SSRS Screener with Triage for Primary Care Settings](#).
- Medication review for drug-drug interactions

Psychiatric Referral

- History of bipolar illness and/or psychosis
- Actively suicidal
- Long history of antidepressant use; limited or unresponsiveness to first and second line treatments; need for electroconvulsive therapy (ECT)
- Current use of alcohol or other substances

Differences Between Depression and Dementia

	Depression	Dementia
Onset:	Fairly rapid	Gradual
Progression:	Usually rapid	Slow
Mental Process:	May/may not be impaired	Progressive impairment
Speech:	Understandable/sparse	Sparse; repetitive
Behavior:	Details cognitive losses; emphasizes disabilities/dysfunctions throughout the day	Vaguely complains of cognitive loss; conceals disabilities; increased dysfunction at night
Mental Status Exam:	Inconsistent; “I don’t know”	Progressive impairment

Management of Geriatric Depression

Non-pharmacological Treatment

- Lifestyle management: Adequate diet/nutrition, exercise as tolerated, maintaining or improving social networks, including pleasurable activities in daily routine, daily gratitude practices
- Psychotherapy: Cognitive-behavioral therapy, problem-solving therapy, interpersonal therapy, life review/reminiscence, and mindfulness for mild to moderate depression
- Somatic Therapies (least to most intrusive): Full-spectrum light, transcranial magnetic stimulation (TMS), electroconvulsive therapy (ECT), deep brain stimulation (DBS)

Pharmacological Treatment

- First line: SSRIs: Sertraline has the most evidence in older adults; or SNRIs
- Second line: Mirtazapine or vilazodone
- Third line: Augmentation of first or second line medications with atypical antipsychotics
- Ketamine: Esketamine (Spravato) nasal spray FDA approved for treatment resistant depression, but no evidence specifically in older adults and should be avoided
- More at: [Depression in Older Adults—Pharmacotherapy](#)



Key Principles

Start low and go slow—but don't stop until symptom remission, inadequate response, or increased side effects.

- First, consider monotherapy vs combination.
- When discontinuing medications, go slow to prevent discontinuation symptoms.
- Always consider the high risk for falls.

Teaching Tips: Ask students to . . .

- Assess for depressive symptoms in older men and women of different ages, such as those aged <70 years, between 70-85 years and >85 years; in those with comorbid medical conditions, and in minority older adults.
- Practice asking about suicidal ideation vs wishing for death. More at: [Screeener with Triage for Primary Care Settings](#).
- Use and compare results of different depression assessment scales: GDS, PHQ-9, Beck Depression Inventory (BDI).
- Review a patient's current medication list for drug-drug interactions which may cause depression or whose side effects may mimic depressive symptoms.
- Ask an older adult about Adverse Childhood Experiences. More at: [What's Your ACE Score?](#)
- Conduct a functional assessment with a patient who has depression vs one who is not depressed to identify the impact depression has on day-to-day function.
- If possible, interview the family of a patient who is depressed to identify caregiver issues/concerns ([Depression and Caregiving Tip Sheet, Family Caregiver Alliance](#)®).

Preceptor Resources

- [Treatment of Depression in Older Adults. Older Adult, Family, and Caregiver Guide. SAMHSA Evidence-based KIT-Knowledge Informing Transformation](#)
- [Help Guide: Depression in Older Adults: Signs, Symptoms, Treatment. HelpGuide.org](#)
- [Patient Education Tip Sheets \(Centre for Clinical Interventions\)](#)
- [How to Help an Elderly Person with Depression: Tips for Family Caregivers \(Institute on Aging\)](#)