Diagnosing Depression in Older Adults

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Background

- Late-life depression (LLD) impacts about 2-5% of older adults (OAs) in the community (Steffens DC et al, *Arch Gen Psychiatry* 2000;57(6):601-7).
- However, in medical and skilled nursing settings, it occurs in up to 25%. So, always screen patients for it in these locations.
- The diagnosis is often missed because it's seen as an "understandable reaction to getting-old" or it's misdiagnosed as anxiety.
- Depressive symptoms in OAs, which don't full criteria for MDD, can result in similar disability as full depressive episodes and may still warrant treatment.

Clinical Presentation

- In younger adults, we typically assess for low mood plus 4 out of 8 of the classic SIGECAPS symptoms. While these are also applicable in OAs, there are some variations and special considerations
- **Tips on Assessing SIGECAPS in OAs:**
    - **M**ood**:** "How have your spirits been over the last 2 weeks?" "Have you felt so down that your entire life has been affected?"
        - Some OAs won't endorse feeling "depressed" but they will admit to having low spirits, feeling sad, increased irritability, being discouraged, never feeling happy, or becoming desperate. Some patients will feel a constant sense of "nervousness" or "anxiety" but on further assessment they'll have major depression rather than an anxiety disorder.
    - **S**leep: "Have you slept well or poorly over the last 2 weeks?"
        - The most common complaints are difficulty falling asleep and frequent nighttime awakenings. Patients may have early morning awakenings but these are also more common with older age.
    - **I**nterest decrease: "Have you been able to enjoy doing anything over the last few weeks?"
        - Ask about changes in activities or pastimes previously enjoyed. Look for signs like social withdrawal, neglecting hobbies/friends, or lack of enthusiasm for things once enjoyed.
    - **G**uilt: "Do you feel that you are a good person? Do you still have hope? Have you felt guilty about things you've done or haven't done?"
    - **E**nergy decrease: "How has your energy level been over the last couple of weeks? Is it taking longer than usual for you to get things done?"
        - Rather than decreased energy, OAs with depression my endorse weariness.
    - **C**oncentration: OAs will be more likely to present with memory problems as opposed to the distractibility or concentration issues, seen in younger adults. Specific memory complaints include increased forgetfulness, more trouble finding the right words, difficulty reasoning through decisions, and slowed thinking.
    - **A**ppetite decrease: "Have you felt like eating? Have you lost weight lately?"
        - OAs rarely gain weight as a result of depression. Significant weight loss is a major concern since it can lead to frailty from which some OAs never recover. Recommend adding Ensure or Boost to the meals of patients who have lost a lot of weight.

- **P**sychomotor retardation or agitation: This is usually diagnosed more by observation than by asking questions, but you can ask, “Have you felt like everything has become slowed down?” or “Have you felt unusually restless or agitated?”
    - When there is psychomotor retardation, patients will describe slowness. With psychomotor agitation, complaints center around nervousness, agita, and insomnia.
- **S**uicidality: “Have you had thoughts of wishing you were dead? Have you been thinking about ways to end your life?”
    - OAs endorse suicidal thoughts less often but can have more thoughts of death and dying. Hopelessness and worthlessness are major red flags that an OA may be thinking of suicide. (See Fact Sheet XX)

Other aspects of depression in OAs

- **Cognitive impairment:**
    - Depression is a risk factor for dementia, so do a cognitive screen on any OA with depression and follow them closely for the possible emergence of dementia once depression improves.
    - Cognitive impairment due to depression often begins acutely and with the onset of the depressive episode, whereas dementia has a slowly progressive, insidious course which at times might include periods of depression.
- **Grief:**
    - Loss is common in older people, so ask about grieving and try to distinguish acute grief symptoms from depression (though the presence of grief doesn’t automatically exclude major depression).
- **Medications that can trigger depression:**
    - Commonly used agents that can cause depression or other mood changes are ACEI, beta-blockers, calcium-channel blockers, corticosteroids, levetiracetam, metoclopramide, and opioids.
- **Psychotic depression:**
    - Psychosis is much more likely to accompany depression in OAs than in younger patients (20-45%). Assess for persecutory, nihilistic, or hypochondriacal, often focused on GI function, delusions.
    - OAs less frequently have hallucinations.
- **Somatic Symptoms:**
    - OAs with depression can complain of increased pain or stomach issues.
    - Many somatic symptoms, like changes in energy or sleep, will overlap with the effects of medications and comorbid disease.
    - LLD is can be triggered by medical conditions such as heart disease, diabetes, Parkinson’s disease, strokes, and cancer.

Assessment

- **Steps in Assessment:**
    - Clarify present and past history; Obtain collateral history from a family member/ caregiver; Assess nutritional status, functional status, medical history, and current medications; Screen for cognitive dysfunction (MoCA, MMSE).
- **Tools:**

    - **The Geriatric Depression Scale (GDS),** short form, is available in the public domain (https://geriatrictoolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF) and has 15 yes/no questions, takes 3 to 4 minutes to complete, and has sensitivity of 85% with specificity of 75% (Mitchell AJ et al, *Am J Geriatr Psychiatry* 2010;18:1066–1077).
- **Laboratory tests** to rule out other causes of depression typically include: CBC, Chem 10, LFTs; Free T4 and TSH; U/A, Utox; Vitamin B12 and folate levels; RPR and HIV if appropriate; Head CT or Brain MRI if not already done; EEG/PET/SPECT if indicated.