

Healthy Aging

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Late-Life Depression

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What is depression?

Having the occasional period of feeling sad or blue, which then resolves on its own is a normal part of life and is not considered depression. When symptoms become more common, or more intense, however they should not be ignored. A physician, psychiatrist, or licensed clinical psychologist should be consulted in order to determine the type of depression that may be present, so the person can be treated effectively.

The types of depression differ in terms of symptoms, impact on daily life, and treatments. Major depression, often referred to as “clinical depression,” includes additional symptoms beyond just feeling sad, and if a person experiences enough of these symptoms and they are present every day for at least 2 weeks, the individual may be experiencing major depression. The additional symptoms include feelings of guilt or worthlessness, difficulty with concentration, feeling restless or fidgety, sleep difficulties, change in appetite, and/or loss of interest in people and activities (National Institute on Aging, 2016). “Persistent depressive disorder” (also known as “dysthymia”) is a milder form of depression that is primarily characterized by a chronic feeling of sadness lasting 2 or more years. If a person exhibits symptoms related mostly to the physical body such as pain, insomnia or sleeping too much, significant fatigue, and weight gain, this is called “somatic” or “atypical” depression. Others get depressed only at certain times of the year (typically during long, cloudy, cold winter periods), and this pattern is referred to as “seasonal affective disorder” or SAD.

Can older people become depressed?

Depression can affect people at all stages of the lifespan. Just because a person is older, does not mean the symptoms are normal, or expected. Late-life depression may cause suffering, family disruption, and disability, also complicating medical illnesses, and increased risk for mortality (Alexopoulos, 2005), therefore, just like at other ages, late-life depression should be treated. When a person has depression in late life, who also had depression at younger ages, this tends to be more strongly associated with a family history where others in the family have also been depression sufferers. In contrast, when a person has their first depressive episode in late life, this tends to be more associated with late-life vascular health such as having had one or more strokes (Alexopoulos, 2005). Also, the pattern of depressive symptoms often differs between younger vs. older adults, with late-life depression more likely than depression at younger ages to include sleep disturbance, subjective memory complaints, concentration difficulties, loss of interest (Butters et al., 2004), and hopelessness about the future (Christensen et al., 1999).

How common is depression among older adults?

Although the majority of older adults do not have depression, depression is by no means a rare condition. It has been estimated that clinically significant depressive symptoms are present in 15% of older adults who reside “at home,” outside of long-term care facilities, but range from 14 to 42% in older residents of long-term care facilities (Blazer, 2003). Rates of depression appear to be

higher in women than in men, but this gender difference is not as common in older adults as it is across the rest of the lifespan where there is roughly a two-fold higher risk in women (Djernes, 2006). Evidence suggests that depression is less common and tends to be less severe with age; however, lower-severity depressive symptoms can also greatly impact quality of life and should be addressed as well (Judd et al., 2002).

Risk factors for depression

There are several factors that may put a person at higher risk for depression. Besides being female, having other family members with depression tends to increase a person's own depression risk. Experiencing major life stressors can also increase depression risk, including such experiences as: death of spouse, serious illness (particularly if it causes disability), large financial losses, and being socially isolated, or having very few friends (Substance Abuse and Mental Health Services Administration, 2011; Heikkinen & Kauppinen, 2004).

There is some evidence that if your spouse has depression, you may be at greater risk of developing depression, too (Goodman & Shippy, 2010). This could be due in part to sharing the same stressful experiences, or it could be due to the sadness that results from just being around a loved one with major depression. Some scientists believe that we tend to marry someone who is similar to ourselves without realizing it, making it more likely we are similar to our spouse in being prone to depression. Because of this similarity in depression rates among spouses, we can see the importance of monitoring mental health and well-being for both spouses in older couples, especially because many stressors that are directly experienced by one spouse (such as developing a disability) can impact on the other spouse (who may be providing physical care, plus managing their own emotional stress).

Is it genetic?

In recent years, scientists have begun to study how a person's experiences change the way specific genes operate (Wein, 2010). For example, Belsky and colleagues (2009) found that a certain gene was linked to higher depression only among women caregivers (a group who has to manage many stressful experiences) but was actually linked to lower depression levels in a group of non-caregivers

(who likely experienced much less stress). In other words, the influence of the gene on the outcome of depression, may be influenced by the person's exposure to stressful life experiences, but without the stressful experiences, perhaps the gene does not have as strong an influence on the development of depression. Though more research is needed in this area, the good news is that genes alone do not tell the whole story, and depression risk is likely the result of a complex interplay between genetics and life experiences, many of which are within a person's control.

Personality, social support and depression

Scientists are beginning to find that certain personality traits are linked to depression risk. Oddone and colleagues (2011) found that older adults with depression were less outgoing and open, less conscientious, and were more anxious and nervous than people without depression. They also reported lower levels of social support and less frequent interaction with family and friends than non-depressed adults. Studies like these suggest that personality and social support may somehow play a role in late-life depression.

Seeking help/Stigma

The good news is that there are effective treatments for depression. It is important, however, to seek medical attention so the physician can do a thorough work-up to determine the real cause of the symptoms. Sometimes depressive symptoms can be the result of another untreated medical condition such as hypothyroidism or "low thyroid" (Roberts et al., 2006), or may be a side effect of medications for other ailments (Celano et al., 2011), or it may simply be that levels of brain chemicals known as "neurotransmitters" are too low (Nutt, 2008). The challenge is that people, especially those of earlier generations who are now in the later years of life, may feel that they should be able to "pull themselves up by their bootstraps" and just "buck up" and bear through any psychological stress. They may worry that others will judge harshly anyone who admits they are having depressive symptoms as being somehow a weak person. Others don't want to see a doctor for depression out of a desire to avoid being prescribed more medicines (if they are already taking several medications for other conditions).

Depression is often under-reported and particularly so, among older adults (Friedhoff, 1994). In a study of late-life depression in Cache County, Utah, it was found that 47.9% of men and 38.2% of women who met criteria for having had major depression over their lifetime, told researchers that they had never told a doctor about their depression and 20-50% were untreated (Steffens et al., 2000). Thankfully, younger generations are becoming more accepting of mental health services. People of all ages can help turn the tide on this cultural stigma by being supportive and caring to depression sufferers, encouraging them to speak up and get the help they need. When older adults experience depression, it is important to get the correct mental health diagnosis and treatment. In time, they may grow to understand that treating their depression is just as important as treating physical illnesses, and that everyone has a right to be happy, and feel well.

Treatments for depression

In some cases, the doctor may adjust medications for other health conditions, if that is believed to be the source of the problem. Adopting other healthy lifestyle factors such as exercise (Palmer, 2005) and becoming more connected with others socially may also be suggested by the doctor or therapist. Also, counseling therapy may be recommended with a referral to a clinical psychologist or other mental health professional, in order to help the person better understand how different things in daily life may be causing or aggravating depressive symptoms. Counseling therapy can also help the person to learn effective coping methods such as problem-focused strategies and help-seeking behaviors. A panel of mental health experts, including clinicians and researchers, report that a specific kind of therapy called cognitive behavioral therapy, or “CBT,” is the preferred counseling approach when treating depression (Steinman et al., 2007).

In many instances, antidepressant medications are prescribed in order to improve levels of important brain chemicals, like the neurotransmitter serotonin. These medications can take some time to be fully effective, and sometimes the doctor may need to try more than one kind of medication to find one that works the best for that particular person. When a patient with severe depression does not respond to other treatments, electroconvulsive (ECT or “shock”) therapy may be used to improve brain

chemistry and remove depressive symptoms, however this treatment option is not common.

Interestingly, compared to other states throughout the U.S., Utah was found to have the highest rate of antidepressant use (Express Scripts, 2000). The actual reason is unclear, but may be due to a higher average education level and therefore a greater willingness to turn to the medical profession to treat depression symptoms. Since Utah has high numbers of individuals who are members of the Church of Jesus Christ of Latter-day Saints (LDS), higher rates of prescription antidepressant use might be because the influence of the LDS Church makes people less likely to turn to alcohol or tobacco to cope with life’s challenges.

Suicide risk

Most episodes of depression among older adults do not rise to the level of suicide; however, it is a real risk especially among older Caucasian men (Canetto, 2015). In most regions of the world, for both men and women, rates of suicide (# of deaths by suicide, out of all deaths) are highest in people aged 70 and older (WHO, 2014). In the United States, the rate of suicide for men 70 and older is more than double the overall suicide rate (CDC, 2016). Warning signs that loved ones should watch for include the older adult: emotionally withdrawing from people and activities they once enjoyed, having thoughts about suicide, and particularly, having concrete plans to carry it out. When suicidal thoughts and/or plans are revealed, loved ones should seek immediate medical help for the person. With successful treatment and learning healthy coping strategies, many individuals are able to move away from suicidal thoughts or intentions and lead much happier lives.

Depression and dementia

Older adults who have depression have approximately double the risk of later developing dementia (Jorm, 2001). Despite this association, scientists are still uncertain whether this is because depression just increases a person’s risk for dementia, or because depression may appear as an early symptom in the pre-diagnosis phase of dementia (Brommelhoff et al, 2009). The relationship between cognitive problems and depression is complex, and we need more studies to better understand this link.

Summary

While it is not a normal part of aging to experience depression, it does occur in this population, and while rates are fairly low for older people living at home, the rates are higher for people living in long-term care facilities. Depression in later life could be caused by a variety of reasons—both physical health and the stress and emotional difficulties surrounding many of life's challenges and adversities. It is sometimes confused with dementia because it can bring about cognitive symptoms as well as depressed mood, so getting the proper diagnosis by a trained medical professional is important. This will help to ensure that the older adult with depression is not left to somehow manage on their own, but instead, receives the correct treatment to begin a period of recovery and a new lease on life. Family members and friends can play a role by, not only including older people in their lives and activities, but also to support and encourage the idea that everyone—both young and old—deserve all the resources available to them for a chance to be happy and live a good life.

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