Running Head: Major Depressive Disorder

Literature Review on Major Depressive Disorder in the Elderly

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Abstract

The DSM-5 categorizes Major Depressive Disorder as one of the most significant forms of depression, but it does not address age or aging in its diagnosis. Despite the availability of effective assessment tools and treatments for depression, older adults are nonetheless underdiagnosed and undertreated. As the older population increases, this gap in diagnosis is a growing problem. The elderly's lack of awareness of depression as well as the lack of training of health care professionals may contribute to this underdiagnosis. Because this population is growing, it is essential to increase the knowledge of medical and mental health professionals about depression in this population. This paper provides an overview of the current research on the difficulties of diagnosing depression in the elderly, risk factors of depression to be aware of in older populations, and treatment of older individuals with depression. It then discusses the gaps in the literature and important areas for further research to support improving diagnosis and awareness of depression in the elderly.

Literature Review on Major Depressive Disorder

Background

The American Psychiatric Association categorizes major depressive disorder as one of the most significant depressive disorders recognized in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.)[DSM-5]. Depressive disorders have the common features of "the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (American Psychiatric Association, 2013, p. 155). In an elderly population, it may be more difficult to clearly attribute these factors to any one cause.

Major Depressive Disorder is diagnosed by at least five of the following symptoms during the same 2-week period (these symptoms must represent a change from previous functioning):

1. Depressed mood most of the day,
2. Diminished interest or pleasure in all, or almost all, activities most of the day,
3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day,
4. Insomnia or hypersomnia nearly every day,
5. Psychomotor agitation or retardation nearly every day,
6. Fatigue or loss of energy nearly every day,
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day,
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day,

9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

It is also required that the symptoms cause clinically significant distress or impairment of functioning and that the episode is not attributable to the physiological effects of a substance or another medical condition (American Psychiatric Association, 2013). It is important to note that there is no distinction made in the depression criteria based on age. In an aging population, changes in the type and quantity of medications, physical and mental challenges, and social and family situations are occurring concurrently and are sometimes significant. Relying solely on the major depressive disorder criteria of the DSM-5, in the presence of these confounding variables, may lead to under detection during assessments of the elderly and thus under treatment of depression (Brailean et al., 2015). The DSM-5 approach, which is designed to make diagnosis more objective across a wide range of patients, can be an obstacle in diagnosing elderly patients because older individuals often have other significant medical illnesses and tend to focus on their physical symptoms rather than their emotions (Haigh et al., 2018).

Significance

Depression in the elderly is a common public health problem that often goes undetected and untreated (Kok & Reynolds, 2017). Older individuals are often reluctant to seek help, and this reluctance is exacerbated by the stigma attached to mental disability (Abood et al., 2020). In a study of depression in nursing homes, only 15% of nursing home residents received a formal diagnosis of depression, which was three times lower than the number of individuals who presented depressive symptoms (Jerez-Roig et al., 2016). This underdiagnosis in the elderly could occur due to low awareness of the elderly regarding depressive symptoms or the lack of awareness and training of health care professionals.

Older adults are vulnerable to depression because they are often experiencing common stressful life events such as death of a spouse, deterioration in physical health, and financial strain (Ho, 2007). Depression is very disabling in the elderly, and older, depressed patients as a group have much more significant functional loss than younger patients (Casey, 2017; Haigh et al., 2018). Functional deficits may include giving up activities, staying in bed, exaggerated helplessness, dependency, and extreme negativism (Casey, 2017). Depression diminishes older individual's quality of life and is often associated with suicide attempts, more frequent hospitalizations, cognitive impairments and family burden (Kok & Reynolds, 2017).

Depression in the elderly is a treatable condition, not a normal part of aging (Casey, 2017). It is the most prevalent psychological disorder in the elderly, and its management and treatment are vital and possible (Abood et al., 2020). It is for this reason that it is essential to increase the knowledge of medical and mental health professionals about depression in the elderly population. This paper will discuss the difficulties of diagnosing depression in older individuals, risk factors of depression to be aware of in the elderly, and the treatment of older individuals with depression.

Methods

The research was conducted as a literature review aggregating published research and studies found through the Wake Forest University Z. Smith Reynolds Library website. A review of major depressive disorder in the DSM-5 provided a description of major depressive disorder and its formal diagnosis. Two computer databases, PubMed and PsycINFO, were searched for relevant articles on depression in the elderly. The keyword "depression" was used with the Boolean operator "and" combined with terms such "elderly" and "older adults" and "geriatric." The search was further limited to articles published in English and dated 2007 or later.

PsycINFO produced the most relevant articles. Citation lists from these articles were then used to locate more related sources. Articles were manually sorted based on perceived relevance. Sources included the DSM-5, books, review articles, and original research articles.

Results

Diagnostic Difficulties

Early diagnosis is the first step to managing depression, but depression in the elderly often goes undiagnosed and, therefore, untreated (Mowla et al., 2019). Diagnosis of older individuals is complicated by the sheer number of possible causative or contributory factors, such as social/environmental pressures, insufficient serotonin, poverty, chronic physical illness, social isolation, lack of social support, personal or familial history of depression, trauma, or bereavement (Abood et al., 2020). Due to all of these factors, depression often goes undiagnosed because it is often mistaken for a different medical illness, dementia, or grief (Casey, 2017).

Depression in late life often occurs in the context of multiple medical issues. Older individuals frequently minimize the emotional aspects of illness and focus on their physical symptoms. They present their health care provider only with their somatic complaints: fatigue, weight loss, pain, medical symptoms, memory complaints (Vieira, 2015; Kok & Reynolds, 2017; Mowla et al., 2019; Brailean et al., 2015). Although there is an interplay between depression and physical medical illness, it complicates diagnosis of depression particularly in the elderly (Casey, 2017). The presence of many possible explanations often leads to misdiagnosis. In addition, many commonly prescribed medications used by the elderly for other chronic illnesses contribute to their depressive symptoms (Casey, 2017). When the elderly patient focuses on physical symptoms, clinicians must be proactive and remember that depression could be the underlying cause of certain complaints.

Cognitive symptoms are another challenge to recognizing depression in older adults (Vieira et al., 2014). Among the elderly, depression often has a negative impact on cognition. In this population, depression may even be misdiagnosed as a dementing illness. More prominent cognitive impairment can complicate depression detection (Vieira et al., 2014; Kok & Reynolds, 2017). Jerez-Roig et al. (2016) found that late life depression and dementia share a common physiological pathway, and that depression could be a risk factor for dementia. Depression in patients who present with cognitive impairment might be explained away with illnesses more expected for this age group.

A depression diagnosis is also complicated by the presence of loss, grief, and anxiety in the elderly (Casey, 2017; Vink et al., 2008). Frequently symptoms of depression are viewed as a normal response to loss or illness (Casey, 2017). The DSM-5 addresses loss and bereavement by explaining that it is a clinical judgement as to whether it rises to the level of a depressive episode (American Psychiatric Association, 2013). Another complication to diagnosis is that the symptoms of depression have been found to be similar to those of anxiety in the elderly (Vink et al., 2008). It was, however, important to distinguish between the two because the optimal treatments are not the same (Vink et al., 2008). Due to the aging process and their stage of life, the elderly experience many stressful life situations which makes it difficult to diagnose depression.

Diagnosis of depression in the elderly is complicated by other illness and medications, cognitive dysfunction, and stressful life circumstances (e.g., bereavement, grief, anxiety). Low awareness of depressive symptoms by the elderly and lack of awareness of and training in this difficult diagnosis by health professionals may result in underdiagnosis (Jerez-Roig et al., 2016). To deal with these complications, medical and mental health professionals need specific training

to diagnose depression in older populations. Additional useful infrastructure could include organized support and standardized referrals and communication of information (Vieira et al., 2014).

Risk Factors to Consider

Early detection of depression is key to successful treatment. A cost-effective way to improve detection of the elderly who suffer from depression is to pay special attention to those who are at risk. To do so, we need to know what factors influence diagnosing depression in older individuals. Knowledge of the overlooked risk factors for depression in this age group can help increase its detection by health care and mental health professionals (Casey, 2017). Awareness of the risk factors also enables preventive interventions.

Factors associated with late-life depression are vast, but most diagnosed elder depressives are women (Yilmaz & Karaca, 2020). Although women are more likely to be depressed than men, Brailean et at. (2015) found other differences between men and women. They found that the DSM-5 classification of major depressive disorder could be clustered into two dimensions: disturbance of mood/affective suffering and disturbance of motivation. There was a higher level of affective suffering in females compared to males. Females, however, had higher levels of motivation than males (Brailean et al., 2015).

Elders with chronic medical illness and nursing home residents had higher rates of depressive symptoms as well (Casey, 2017). A study to determine the prevalence of depressive symptoms and identify its associated factors in institutionalized elderly discovered not only a higher prevalence of depressive symptoms in nursing home environments than in community settings, but also more frequent association between functional impairment and depression in institutionalized elderly (Jerez-Roig et al., 2016).

A few other risk factors of depression include cognitive impairment, functional impairment, lack of close social contacts, stressful life events (bereavement), illiteracy, and a history of depression (Kok & Reynolds, 2017; Wilkinson et al., 2018; Yilmaz & Karaca, 2020; Vink et al., 2008). Isik et al., (2020), found a positive relationship between depression and loneliness stating that loneliness was a major factor affecting depression in the elderly. Runcan added losses and forced retirement to the list through her qualitative study (Runcan, P., 2013). Finally, geriatric depression has been found to be associated with many negative factors such as lack of interest and ability to perform normal daily activities, low level of self-esteem, and low contentment or fulfillment with life (Abood et al., 2020).

Although diagnosing depression is difficult, taking notice of all of these factors can help. Awareness of these factors also plays a part in prevention, treatment planning and depression management (Kok & Reynolds, 2017). Early diagnosis, assessment and management of depressive symptoms are essential for mild symptoms to be identified and treated early to prevent the progression to more severe levels of depression (Abood et al., 2020). Depression detection is an extremely important component of care (Vieira et al., 2014). It is important to have approaches for screening of depression in older adults and procedures to refer them to their primary care physician and mental health specialists. Family may be useful in noticing some of these factors, even when elderly are reluctant to seek mental health help on their own.

Prevention and Treatment

The first step in reducing depression in the elderly is prevention. Almeida (2014) reviewed available observational and trial data on prevention of depression. Prevention included altering risks such as abnormal body mass, physical inactivity, smoking, and harmful alcohol consumption (Almeida, 2014). These individual risk factors increased the chance of exposure to

depression. Changes in lifestyle or the appropriate management of health hazards could potentially modify the risk of depression in the community (Almeida, 2014). Early intervention could stop the adoption of hazardous lifestyle practices as well as the social and health complications that seem to increase the risk of depression.

After prevention, the next step is treatment. Although depression in the elderly is difficult to treat, it is treatable and should be approached with the goal of achieving remission. Early detection and treatment help to reduce symptoms, increase quality of life, and avoid an unfavorable prognosis (Vink et al., 2008). Once depression is diagnosed, its treatment can lead to dramatic improvement in overall functioning, especially in the elderly (Casey, 2017). Doctors and mental health professionals should consider psychotherapy, medications, and electroconvulsive therapy when treating this disorder in older populations (Casey, 2017).

Depression specific psychotherapy is recommended as an initial treatment choice for older patients with mild to moderate depression. Cognitive behavioral therapy is the best studied psychotherapeutic intervention, and its effectiveness has been confirmed (Kok & Reynolds, 2017; Casey, 2017; Haigh et al., 2018). A study by Abood et al. (2020) found that logotherapy was also successful with the elderly. They discovered that a common contributory feeling of many elderly persons suffering from depression was that their lives were meaningless. Logotherapy tackled the complications and frustrations of this stage of life, and helped the participants cope with the difficulties and deficiencies of daily life which inherently cause depression. Logotherapy helped the elderly find meaning in their life. Logotherapy group sessions were effective in the alleviation of depressive symptoms and improved life satisfaction, even one month later (Abood et al., 2020).

Another therapeutic option is peer counseling. Peer counseling provided informal social support (instrumental, emotional and informational) to the depressed elderly (Ho, 2007). After participating in a peer counselling program, the elderly with depression showed significant improvements in their perceived health status and level of depression. Through peer counseling, they had increased access to social support. Peer counseling was an early detection device and intervention for depression and prevented the elderly with depression from getting worse and thus needing more advanced treatment and care (Ho, 2007).

As for medications, remission was achieved in about one-third of all older patients who were treated with antidepressants (Kok & Reynolds, 2017). Haigh et al.'s (2018) research also supported the efficacy of antidepressants compared with placebos for the treatment of major depressive disorder in older adults. It is important to be aware that often elderly patients receive lower than recommended antidepressants for too short a time. Nonpharmacological treatments can always be combined with antidepressants.

Electroconvulsive therapy has been found to be the most effective treatment for older patients with major depression (Casey,2017, Haigh et al., 2018; Kok & Reynolds, 2017). Electroconvulsive therapy was associated with a faster rate of remission than antidepressant therapy (Haigh et al., 2018). Older adults who use this type of therapy experienced greater benefits, such as rapid remission and lower re-hospitalization rates (Haigh et al., 2018).

Frequent relapse and recurrence underscore the looming public health implications of depression in older adulthood. Obtaining and maintaining remission status is a significant challenge, which requires close monitoring and possible maintenance treatment (Haigh et al., 2018). Medications can worsen depression symptoms so they must be monitored carefully (Kok & Reynolds, 2017). It is also important to assess cognition, because depression can lead to

cognitive impairment. Often elderly patients receive no treatment. Without treatment, prognosis for depression in the elderly is poor. Kok and Reynolds (2017) found that the Geriatric Depression Scale was good for monitoring the effectiveness of ongoing treatment and assuring remission is achieved in older populations. Family member involvement can facilitate treatment adherence and may lead to improving depression as well.

Discussion

Depression in the elderly is hard to diagnose, but it is treatable. It is hard to diagnose because the elderly often suffer from multiple chronic illnesses and are taking all types of medications. Also, depression may get mistaken for cognitive dysfunction. Finally, loss, grief, and anxiety are common stressors for the elderly that resemble depression. All of these factors make it difficult to diagnose depression in older populations, and they often go undiagnosed and therefore untreated.

Knowing the risk factors helps with prevention and intervention with depression. There are many risk factors that may lead to depression. Medical doctors and mental health professionals should use these to either (a) prevent depression or (b) catch depression early and intervene.

Depression can be and has been successfully treated with therapy. There has been success using cognitive behavioral therapy, logotherapy, and peer counseling. Medications and electroconvulsive therapy have also been used to effectively treat depression in the elderly.

The greatest limitation in the research of depression in the elderly is that there is not sufficient prevention. Prevention efforts should be prioritized and studied as an alternative strategy for reducing the burden of depression in older adults. Successful prevention efforts

could capitalize on their ability to identify risks for a variety of age specific biological and behavioral vulnerability factors.

Eliciting relevant information from elderly patients can be challenging, but we need to learn how to be successful in this endeavor. Doctors and mental health professionals need to know if their patient suffers from mild dementia or other chronic illnesses. It is important to be aware that they may be withholding useful information. One potential approach is to increase the involvement of caregivers in the diagnosis process. The role of caregivers in a depression diagnosis should definitely be a topic of research.

Depression in the elderly does not need to be a normal part of the aging process. It can often be treated, or better yet, prevented. Existing research details many of the challenges in diagnosis; but additional research in institutionalizing mechanisms to prevent, detect, and treat depression in the elderly will be of increasing importance as this community continues to go.

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