Assignment 7.1 – Special Topics Paper: Depression in the Elderly

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Introduction

The global population is getting older. Given the increasing life expectancy across most countries worldwide, the proportion of elderly individuals has substantially increased over the past few decades. This is important to counselors because several mental health disorders are increased among the elderly (Disu et al., 2019)

"Depression is the most common psychiatric disorder in the elderly occurring four times more frequently than in the general population" (Menon & Jacoby, 1993, p. 417). Depression is a mental disorder, characterized by persistent sadness, decreased interest in daily life activities, concentration difficulties, poor memory, and a lack of energy (Ju et al., 2022). Prompt and adequate treatment of depression can reduce morbidity, especially in the elderly.

But depression is often missed in seniors. There are several reasons for the under assessment of depression, but one that stands out is the under reporting by seniors themselves. "There is stigma associated with mental disorders among many older adults that leads to an initial reluctance to seek help for this problem" (Heller et al, 2013, p. 215). "Older adults generally are reluctant to admit to depressive symptoms, they tend to report somatic, rather than psychological, symptoms, and often believe that depression, when it does occur, is the inevitable consequence of aging" (Heller et al, 2013, p. 216). Depression can also go undetected among the elderly, due to communication and cognitive impairment, clinicians' focus on treating medical conditions, normalization of depression in later life, and lack of training in mental health among staff in long-term care facilities (Huang & Carpenter, 2011).

Leaving depression untreated can lead to deterioration in health, behavioral problems, low quality of life, increased risk of comorbidity and mortality in the elderly. Depression in older adults also attacks activity levels and leads to decreased social participation in daily functioning. "Social isolation increases the likelihood of suicidal thoughts and attempts." (Pak & Bae, 2023, p. 2). "It is well known that the highest suicide risk may occur among the elderly. Suicidal ideation should always be included in the mental status examination of the elderly. The elderly have the highest rate of suicide risk but society pays more attention to other age groups as if it were less important to protect the lives of the elderly" (Bellini & Matteucci, 2001, p. 37).

The intertwined problem of 1) low recognition and treatment and 2) higher prevalence of depression points to the need for more research in the area of depression in the elderly. Knowledge of the causes leading to underestimation, under treatment and miss treatment of senior depression, is, therefore, absolutely of vital importance.

Review of Existing Literature

In the elderly, depression is common and a major public health concern. What causes depression in the elderly? What are the risk factors? Disu et al. found that the "Risk factors for depression included living in a rural area, having a history of previous personal and / or family depression, not engaging in daily life activities, not exercising regularly, having no hobbies, having a poor diet, and not engaging in religious practices regularly" (Disu et al., 2019, p. 165). Studies have also "shown that factors such as sex, age, and subjective economic level were found to have a significant correlation with depression among the elderly" (Pak & Bae, 2023, p. 1). Additionally, Pak and Bae found loneliness had a positive correlation with depression, while aging satisfaction and life purpose were found to have an inverse association with depression in

older adults. This study suggests that having a positive outlook on life and aging is crucial in preventing depression in older adults (Pak & Bae, 2023).

Zhou et al. found that a health promoting lifestyle was significantly negatively related to the depression of elderly people, suggesting that a health promoting life style was a protective factor in depression. "If the elderly adopt a positive attitude toward aging and maintain a good mood, the occurrence of depression can be reduced. The elderly should be encouraged and guided to adopt a health promoting lifestyle, increase health promoting behaviors, and develop healthy habits, which can greatly reduce the adverse effect of unhealthy lifestyles on their aging perceptions, and thus reduce the risk of depression" (Zhou et al., 2020, p.10). This study also found that social support played a moderating role in the relationship between aging perceptions and depression in the elderly. Social support alleviates the effect of negative aging perceptions on elderly depression. "The current study indicates that for elderly with a higher level of social support, although the effect of aging perception on depression is still significant, the effect is far less than the elderly with low social support" (Zhou et al., 2020, p.10).

The impact of depression on seniors cannot be ignored. The aim of a study by Shrestha et al. (2020) was to analyze the sociodemographic, prevalence, associated factors and quality of life of elders with symptoms of depression. "The findings of the study concluded that depression among institutionalized elders was a substantial problem and affected their quality of life" (Shrestha et al., 2020, p. 1). Depression in the elderly was found to have negative correlation with the quality of life in the study. This is probably because older people with depression have less control over their physical, psychological, social and environmental domains. (Shrestha et al., 2020).

Depression is extremely difficult to diagnose and treat in the senior population. Obstacles to diagnosing and correctly treating late onset depressive mood disorder and their causes must be identified, in order to reduce the occurrence of suicide in the depressed elderly. The possible favorable outcome of late onset, elderly depression, may develop into the worst, i.e., suicide, if the clinical profile is not recognized, diagnosed, and correctly treated. Psychopathological screening instruments have proven sufficiently sensitive and specific to recognize depressive mood disorder in the elderly, enabling suicide rates to be identified and corrected. (Bellini & Matteucci, 2001).

Depression in elderly patients is under diagnosed, and new, simple and reliable methods for the early identification of depression in these patients are urgently needed. A study by Ju et al. was the first to report an association between Comprehensive Geriatric Assessment parameters (such as cardiovascular disease, peptic ulcer disease, Mini Nutritional Assessment score, calf circumference, and albumin) and depression in elderly patients (2022). Early identification and prevention of depression in the elderly has become critical. The Comprehensive Geriatric Assessment can assist in the early identification of depression in the elderly population (Ju et al., 2022).

Finally and most important, depression in the elderly is treatable. "Depression in the elderly has received special attention in recent years with particular emphasis on physical management of depression" (Menon & Jacoby, 1993, p. 417). Tricyclic antidepressants are effective but may have disadvantages for use in the elderly. The new generation of selective serotonin reuptake inhibitors seems to be effective without some of the drawbacks of tricyclics. Electroconvulsive therapy also plays a large part in the treatment of elderly depression. Its role

has been refined by recent research. Current advances in relation to duration of treatment, relapse, prevention, and resistant depression still need to be reviewed (Menon & Jacoby, 1993).

Case Study

Fred is an 82 year old Caucasian male. His appearance is disheveled, and he seems agitated while sitting in your office (wringing his hands and shifting in his seat). Fred was a small town attorney his whole working life (he is now retired). He has been married to his wife, Merna, for 61 years. Merna is also 82 years old.

Merna is dying of bladder cancer and has been referred to Hospice. Fred went to see his family physician because he is not sleeping at night and is having trouble concentrating on the daily crossword puzzle that he used to enjoy. Fred explains to you that he started to cry in the doctor's office, and he "never cries." Fred's primary care physician recommended that Fred see a psychiatrist for medication management as well as come to counseling.

Fred has never been to counseling before and is not aware of any mental illness in his family. He gets angry in your office and shouts, "I was a lawyer for many years and drafted many wills. I can handle death, but it the process of dying that I am having a hard time with."

Fred and Merna live in the independent living phase of a retirement facility. Fred and Merna used to enjoy spending time with other residents in the facility but they are no longer able to do so. Other residents rarely stop by these days. Fred and Merna have help come in everyday from 10am until 4pm to assist Fred in taking care of Merna who is now confined to a wheelchair with some cognitive deficiency. While help is there, Fred used to take a two mile walk everyday; but he has not felt up to it lately.

Fred and Merna have three children. Their eldest son is estranged from the family (no contact). The second son lives across the country from Fred and Merna (they live in Chapel Hill,

NC while their son lives in Denver, Colorado). Their youngest, a daughter, lives about 30 minutes away from Fred and Merna and comes to see them regularly 2 to 3 times a week.

Case Formulation

Fred's lack of sleep and depressive symptoms (crying, inability to concentrate and enjoy his daily crossword puzzle, stopping exercising) (presentation) seem to be his reaction to his wife's illness and impending death (current precipitant) as well as his lack of social support (continuing precipitant). Also, throughout his life, Fred has always been able to take care of himself and his family, without needing the help of others; as a result, he has a limited social network and has a hard time asking for help. He feels out of control and angry (pattern: maladaptive).

Fred wants to take care of Merna (and be a good husband) but his depression is making that difficult. His depression seems to stem from Merna's illness and Fred's lack of control over it. From a person centered therapy point of view, the incongruence between his self concept (being a good husband and the man that takes care of everything) and his experience (Merna dying of bladder cancer) has led to feelings of depression as well as anxiety (predisposition). Fred's physical health seems good because he is able to walk two miles every day (he just has not done so recently). Also, he does have some support with Merna from 10am until 4pm every day. In addition, his daughter comes by two or three times per week. Fred and Merna have each other and have been together sixty one years. Finally, Fred and Merna live in a retirement community where they can obtain extra support with a phone call (protective factors). Fred's pattern is maintained by Fred's unwillingness to ask for help (except his paid help), his social isolation and lack of social support from his peers, and his feeling of lack of control of Merna's illness (perpetuants).

Fred is an 82-year-old Caucasian male living in a predominantly Caucasian retirement community. He is of a higher socioeconomic status (cultural identity). Fred appears to be highly acculturated, and there is no obvious indications of acculturative stress. Due to the fact that he is in an expensive retirement community, Fred is surrounded by individuals similar to himself (Caucasian, upper SES) (Cultural Stress and Acculturation). Fred believes that his current problems stem from his lack of control over the process of Merna's death. In the past, Fred was able to handle any problems that came his way but he cannot "fix" Merna's impending death (cultural explanation). Finally personality dynamics are predominant and adequately explain Fred's presenting problem and pattern, but examining his sense of control and his own experience of being a heterosexual white male may be useful to address in therapy (culture and / or personality).

The challenge for Fred Is to function more effectively during Merna's illness and feel safer in asking for the help that he needs in coping (treatment pattern). Treatment goals include reducing depressive symptoms, establishing a supportive social network at Fred's retirement facility, and learning to cope with Merna's illness (treatment goals). The treatment focus is troublesome situations triggered or exacerbated by Fred's incongruence (where Fred's self concept of being a good husband and taking care of everything does not match his experience of feeling out of control regarding Merna's illness) (treatment focus). Fred's treatment strategies supportive of the treatment goals and focus should include stress management training, support, and possible group therapy for dealing with terminal illness and death (treatment strategy). Supportive techniques will be used to affirm Fred and encourage him to increase his social network. Supportive techniques will include unconditional positive regard, empathy, and congruence on the part of the counselor. Skills such as anger and stress management can be

fostered and developed in individual and group sessions. Individual and group therapy will also be helpful for Fred in dealing with Merna's terminal illness. It is important for the counselor to remain nonjudgmental and remember that the client knows his situation best of all (treatment intervention). Fred comes across as very angry that he cannot "fix" Merna's illness. He is used to handling problems on his own and may not be receptive to counseling. He also does not have a good social network that he can rely on (treatment obstacles). The primary influence is personality dynamics, but we will need to examine Fred's sense of control and his own experience of being a heterosexual white male in therapy (treatment – cultural). Finally, because Merna is terminally ill and Fred has to come to terms with her impending death, his prognosis is fair (treatment prognosis).

Advocacy and Legal/Ethical Considerations

When working with elderly patients, it is important to remain focused on mental competency. Working with seniors is tricky, and their mental capacity can change depending on the time of day (literally). The ACA addresses competency in two different sections. ACA Code of Ethics Section B.5. states, "when counseling … adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received – in any medium – in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards" (2014). The ACA Code of Ethics Section A.2.d. also explains, "When counseling … incapacitated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf" (2014). If

an elderly patient is incompetent, the counselor must abide by these provisions of the ACA Code of Ethics and include the senior individual in the decision making process as much as possible.

Counselors must also remain aware of elderly abuse. Domestic abuse, neglect, and exploitation of disabled or elder adults is a criminal offense in North Carolina (N.C. Criminal Law Code, 1995/2005). Any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the director of the county department of social services in the county in which the person resides or is present. A disabled adult shall mean "any person 18 years of age or over or any lawfully emancipated minor who is present in the State of North Carolina and who is physically or mentally incapacitated due to an intellectual disability, cerebral palsy, epilepsy or autism; organic brain damage caused by advanced age or other physical degeneration in connection therewith; or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances" (N.C. Social Services Code, 1973/1981). Abuse, neglect and exploitation can be physical, emotional or financial; and it is essential that counselor's stay cognizant of the environments in which their elderly patients live.

The elderly are often an ignored population by the counseling profession. There are many additional factors to consider with a senior patient that are not required with the younger population (competency, neglect, exploitation, etc.). The key is to be aware of these factors and make sure you are constantly assessing for them. The elderly need our advocacy and our help.

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