GERIATRIC DEPRESSION

Abstract:

The evidence shows that depression is a common mental illness but it is not a normal part of aging. Major depression in the geriatric population involves many factors such as genetics, social factors, physical ailments, chronic disease, and emotional factors. A person is born susceptible to having a major depressive disorder, and the condition develops as the person is exposed to specific risk factors. Depending on the clinical picture, major depressive disorder is categorized as mild, moderate, or severe. Major depression can be incapacitating.

Screening for depression should be a part of routine health care. Medication and psychotherapy are the mainstays of treatment for major depressive disorder, however, depression can be very difficult to treat. Antidepressants and psychotherapy may not be enough to reduce depressive signs and symptoms. Alternative therapies and self-help can be supportive additions to the person's treatment plan that can make a major difference in progress.

Learning Objectives:

1. Identify those seniors who are at risk of depression.
2. Explain the signs and symptoms of depression.
3. Describe the process of conducting the Geriatric Depression Scale

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Introduction

Depression is one of the most common mental illnesses in the United States. Depression affects millions of children, adolescents, adults, and the elderly. Depression inflicts significant emotional and psychological pain not only on the elderly but on their families and those who care for them. Depression in the elderly is one of the major causes of suicide. Mental health issues for everyone but especially the elderly impairs quality of life and affects the ability to deal with other health issues. The two most common types of depression are major depressive disorder and persistent depressive disorder (also called dysthymia). There are a variety of reasons why someone suffers from depression and there is a number of different treatment options.

Incidence of Depression

It has been estimated that the lifetime incidence of major depressive disorder is approximately 20% in women, and 12% in men. At any single point in time, depression affects approximately 10% of the population in the United States. Depression is most common in adults between the ages of 18 to 29. In addition, approximately 2% of school-aged children and almost 5% of adolescents have been reported to have depression. The disease is especially severe in the elderly and this population depression can easily go undetected and undiagnosed. The Centers for Disease Control and Prevention estimates the percentage of older people living in the community who are experiencing major depression range from less than 1% to about 5% but rises to 13.5% for those who require home healthcare and to 11.5% for those that are hospitalized and those living in long term care facilities.

The prevalence of dysthymia has been estimated to be 6%, not as common as a major depressive disorder but still significant. Studies have shown that Baby Boomers (those born between 1946 and 1964) have higher rates and earlier diagnoses of depression. People born prior to 1945 have lower rates of depression than Baby Boomers. This is thought to be that Baby Boomers are more willing to admit to their

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depression than the generation before them and are less bothered by the stigma of seeking help. Depression in the elderly often goes undiagnosed and untreated. This is because seniors usually do not seek help, family members do not recognize the signs of depression, and health care professionals may think that depression symptoms are a normal response to aging and other life changes. Untreated depression results in a reduction of quality of life, increased illnesses, and suicide.

Diagnosis of Depression

Depression can be used to describe "the blues", sadness, loss, and the pain that accompanies it, or grief and loneliness which for many is a temporary condition. Clinical depression is serious and can affect anyone at any age. The American Psychiatric Association's Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies the depressive disorders as:

1. Disruptive mood dysregulation disorder
2. Major depressive disorder (including major depressive episodes, persistent depressive disorder (dysthymia)
3. Premenstrual dysphoric disorder
4. Depressive disorder due to another medical condition

In addition, depressive disorders may be further categorized by specifiers that include:

1. peripartum onset
2. seasonal pattern
3. melancholic features
4. mood-congruent
5. mood-incongruent psychotic features
6. anxious distress
7. catatonia

The common feature of any of these depressive disorders is the presence of a sad, empty, or irritable mood, accompanied by somatic

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and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

Major Depressive Disorder

Major depressive disorder is the form of the disease that most people think of when they think of depression. The diagnosis of major depression can be made if a patient has five or more of the symptoms listed in the table below. These symptoms must be present for two weeks, represent a major life change or change in mood, and interfere with their ability to live their life.

TABLE 1: SYMPTOMS USED TO DIAGNOSE MAJOR DEPRESSION

1. Continual sad/depressed mood for most of the day and almost every day.
2. Little or no interest in pleasure in hobbies and day-to-day activities.
3. Poor appetite and unintended weight loss or overeating and weight gain.
4. Insomnia or oversleeping nearly every day.
5. Restlessness or irritability.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness, guilt, or helplessness.
8. Difficulty concentrating, making decisions, or remembering.
9. Thoughts of death, thoughts of committing suicide, a suicide attempt, *or* a specific plan to commit suicide, or committing suicide.

These symptoms cannot be because of a substance use disorder, medication side effects, or a medical condition. Diagnosing depression in the elderly can be difficult for a number of reasons. Medication and medical conditions can cause depression symptoms, disguise symptoms, or make them worse. Older adults usually have a number of non-specific physical symptoms that may be other treatable conditions or it may be depression. Depression causes noticeable changes in a person's activities and moods, robs them of the pleasures of living, and

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seriously disrupts the person's personal, and social life. This condition also puts the depressed person at risk for suicide.

Persistent Depressive Disorder

Persistent depressive disorder (dysthymia), is a depressed mood that is present more often than absent and has lasted for at least a two-year duration. The depressed mood and the symptoms are not explained by a medical condition, a drug side effect, a substance use disorder, or another significant psychiatric illness such as schizophrenia.

Dysthymia is the Greek word for "bad state of mind" or "ill humor". Older adults with dysthymia usually do not have a history of depression or other psychiatric disorders, and usually have a low incidence rate when it comes to a family history of mood disorders. Dysthymia in older adults is usually a result of the loss of a loved one, loss of social support, or chronic disease. Some of the chronic diseases that lead to elder depression are heart and lung disease, stroke, and any chronic disease that causes pain such as osteoporosis, osteoarthritis, and diabetes. Studies have shown that people who have diabetes, heart or lung disease, or diagnosed with cancer and have a co-occurring diagnosis of depression die five to ten years earlier than patients without depression. There are no gender differences in older adult dysthymia, unlike in younger adults where women make up the majority of those diagnoses.

A depressed mood will be accompanied by two or more of the following symptoms.

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

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People who have major depressive disorder or dysthymia are at risk for developing other serious psychiatric illnesses such as anorexia nervosa, borderline personality disorder, bulimia nervosa, obsessive-compulsive disorder, panic disorder, and substance use disorders.

Signs and Symptoms of Depression

Depression in the elderly may look different than what is described in the DSM-5 as well as the elderly may describe their symptoms of depression differently than younger adults. Older adults tend to primarily complain of physical ailments. Table 2 gives the signs and symptoms of depression in the elderly population.

TABLE 2: SIGNS AND SYMPTOMS OF DEPRESSION IN ELDERLY

1. Lack of interest, enthusiasm, or concern (apathy)
2. Sleep disturbances (insomnia or hypersomnia)
3. Physical complaints or generalized discomfort
4. Agitation and anxiety
5. Difficulty concentrating and memory problems
6. Neglect personal appearance and become sloppy with personal care habits
7. Irritability or restlessness
8. A movement that serves no purpose such as pacing around the room, toe-tapping, or talking rapidly
9. A feeling of constant tiredness or weakness (fatigue)
10. Hardened stools and difficulty emptying the bowels (constipation)
11. Reluctance to talk about symptoms
12. Older women may have more appetite issues or anxiety
13. Older men may have substance abuse issues, antisocial behaviors, and agitation

Major Depressive Disorder (Dysthymia) Causes

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The causes of major depressive disorder (dysthymia) are unknown but they are probably the result of a combination of vulnerabilities such as biology, genetics, stressful life events, and personality. Depression can happen because of one or more of these vulnerabilities.

Genetics:

Depression runs in families. For example, first-degree family members such as children or siblings of someone who has major depressive disorder are two to four times more likely to develop the same condition as would be a random member of the general population. Depression that happens early in life is usually related to genetics but the depression that happens in later life is usually caused by physical illness and stressful life events.

Brain Chemistry:

The chemicals in the brain, which can be inherited, play an important role in mood and regulation of emotions. The level of chemicals in the brain can contribute to depression.

Low levels of certain brain chemicals such as norepinephrine, serotonin, and dopamine can be associated with various aspects of depression. When the body produces low levels of these neurotransmitters, the odds of experiencing symptoms of depression can increase.

Environment and Personality:

Depressive disorders can occur without outside stressors, but there are life events that can initiate depression. There are also personality characteristics that can put someone at risk to develop depression.

TABLE 3: ENVIRONMENTAL/PERSONALITY RISK FACTORS FOR DEPRESSION

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1. Chronic stress such as financial, divorce, caregiving, homelessness
2. Experiences of abuse, particularly as a child
3. Disability or depression in a spouse
4. Living alone
5. Loss of a loved one or family member
6. Chronic illness
7. Lack of social support
8. Substance abuse
9. Chronic pain
10. Maladaptive coping strategies
11. Feelings of helplessness/lack of control
12. Negative thoughts, of self or the world
13. Living in a long term care facility

Medical Conditions:

Depression can be the result of poor physical health especially if there is more than one chronic health condition. Depression can also make current chronic health conditions worse, as it may decrease physical activity, decrease immune functions, change eating patterns, and have negative effects on sleep. Depression can make physical symptoms worse or increase the risk of developing new symptoms.

Screening for Depression

The clinical presentations of major depressive disorder and dysthymia can be obvious, or it can be subtle and their presence can be overlooked. Screening for depression should be a part of routine healthcare visits and can be performed by many different health care professionals. Studies have shown that in the primary care setting less than 5% of the elderly are screened for depression. This is a missed opportunity as depression in the elderly is a very treatable condition. When screening for depression it is very important to build a trusting relationship. This is done by encouraging conversation so that the older person feels heard. This allows the screener to ask further questions as

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well as to better understand the answers to the questions. A person may be sad due to the loss of a loved one, loss of health, or other losses. Remember that sadness is not a problem unless it interferes with daily functioning or lasts for an extended period of time.

There are numerous depression screening tools available. Should you suspect a person is depressed, ask them if they are feeling blue or sad. Asking older adults if they are sad will get better information than asking them if they are depressed. To obtain further information the two most common screening tools for the geriatric population are the Geriatric Depression Scale and the Patient Health Questionnaire (PHQ-9). These brief screening assessments are valid and reliable tools for depression among adults and older adults

Geriatric Depression Scale:

The Geriatric Depression Scale includes the following questions and is used for adults and older adults.

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think most people are better off than you are?

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These are *yes* or *no* questions and if the person has more than five answers that are suggestive of depression then depression is likely and follow-up is indicated.

Patient Health Questionnaire- 9 (PHQ-9):

The Patient Health Questionnaire-9 (PHQ-9) is quick and easy to use and has been shown to be very sensitive to detecting depression. The patient is asked the following questions:

Over the past two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?
3. Trouble falling asleep, staying asleep, or sleeping too much?
4. Feeling tired or having little energy?
5. Feeling bad about yourself or that you are a failure or have let yourself or your family down?
6. Poor appetite or overeating?
7. Trouble concentrating on things such as reading the newspaper or watching television?
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you have been moving around much more than usual?
9. Thoughts that you would be better off dead or of hurting yourself in some way?

The patient should also be asked: How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? (Note: This question is not scored.)

With regard to the scored questions, a patient can answer the questions in the following manner and this gives a more detailed look at the possibility of depression.

1. Not at all

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2. Several days
3. More than half the days
4. Nearly every day

The answers are scored 0, 1, 2, and 3, respectively, and a patient is considered to be mildly depressed if the patient has a score of 5 and severely depressed if the score is 20 or above.

Progression of Major Depressive Disorder and Dysthymia

Depression with the right treatment will have a significant improvement in mood and a significant reduction in the intensity of symptoms in 70%-80% of people. Some people may have long periods of time during which they are symptom-free while others may almost seldom have relief from their symptoms.

People who have a major depressive disorder and a significant level of anxiety, delusions, hallucinations, a substance use disorder, and/or other serious mental health problems are less likely to respond to treatment. Other factors that influence the course of major depressive disorder are the severity of symptoms, how long they have been depressed, age, how many times they have been depressed, and the length of time after symptom onset that treatment begins.

Major depressive disorder tends to return even after improvement of symptoms. Within two years after recovery from a major episode of depression about 40% of all people will have another major depressive episode (a *recurrence*) and within five years this figure increases to approximately 75%.

Depression and Suicide

Major depressive disorder is one of the most common causes of suicide, and the possibility of suicide and/or suicidal behavior is almost

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always present during serious depression. Depression is considered to be a major factor in more than one-half of all suicide attempts, and it has been estimated that the lifetime risk for suicide in people who are depressed and are not treated is 20%. Male gender, prior suicide attempts, living alone, and feelings of hopelessness increase the risk for suicide, as does the presence of borderline personality disorder. For the elderly suicide rates are higher among older men starting at 65 and by 85, having one of the highest rates in the country. Older adults are much more likely to die from their attempt than younger adults. The reasons for that is that they are less likely to recover from their attempt, they use more deadly methods, and they are less likely to be discovered and rescued. The main risk factors for suicide in the elderly are chronic illnesses especially those with mutiple chronic illnesses and the loss of the spouse.

Suicide assessment is not included in many depression screening tools. It is important to ask about thoughts of suicide, these questions include:

1. Have you thought you would be better off dead?
2. Do you have active thoughts of suicide?
3. Do you have a plan?
4. Do you have the means to commit suicide?

Asking questions about suicide will not "plant" the idea or encourage them to commit suicide. This information is important in helping to prevent suicide. Removing means such as guns or pills is an important step in prevention as well as treatment

Treating Major Depressive Disorder and Dysthymia

Many older adults believe that they should be able to will their depression away or that it will simply pass in time. For some this is true and their depression will ease over time but for most their depression will get worse or return. Untreated depression in the elderly can make

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their chronic medical conditions worse and can prevent them from living independently.

Antidepressant drugs and psychotherapy are the two effective ways that major depressive disorder and dysthymia can be treated. Each treatment can be effective on its own. There is no way to determine which people will respond better to one or the other but a combination of antidepressant drugs and psychotherapy is the preferred approach, as many studies have shown that combination therapy is superior to either antidepressants alone or psychotherapy alone. It is important to know that antidepressants only treat the symptoms of depression and may not always address the cause, that is why it is important for the person to participate in combination therapy.

Each person's choices and wishes should be considered when choosing a treatment. Some patients may have a medical condition that prevents them from taking antidepressants. Some patients may not want to take medication because the side effects of the drug are unbearable, or for some other reason. For some people, psychotherapy may be cost-prohibitive or unavailable. Finally, the person may simply prefer one type of therapy over another.

Antidepressants

Antidepressants work by increasing the levels of chemicals in the brain called neurotransmitters. These neurotransmitters can affect mood and emotion. Different medications affect different neurotransmitters and each person's brain chemistry is different. That is why it is important to have a wide variety of antidepressants. At this time there is not a way to know what medication works best for each person but that is changing with the development of genetic testing.

Until genetic testing is commonplace the selection of what antidepressant to use is decided by the person's condition, other chronic conditions, possible side effects, and cost. At this time what antidepressant to use is usually done on trial and error under close

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supervision with the prescriber. There are times when a combination of medications is necessary to treat depression.

There is a wide variety of antidepressant medications that can be used to treat someone who has depression. The most commonly prescribed are listed below. This list is not a complete list. There are more drugs in each class than what is on the list and there are also antidepressant products that are a combination of medications.

TABLE 4: COMMONLY PRESCRIBED ANTIDEPRESSANTS

1. *Atypical antidepressants*: Bupropion, mirtazapine, trazodone
2. *Monoamine oxidase inhibitors* (MAOIs): Phenelzine, selegiline
3. *Selective serotonin reuptake inhibitors (SSRIs)*: Citalopram, escitalopram, fluoxetine, paroxetine, sertraline
4. *Tricyclic antidepressants*: Amitriptyline, doxepin, imipramine

All types of antidepressants can help reduce the severity of depressive and alleviate symptoms but there are more selective serotonin reuptake inhibitors commonly prescribed than other medications and for good reason.

Atypical Antidepressants:

An atypical antidepressant is any antidepressant medication that acts in a manner that is different from that of most other antidepressants. Atypical antidepressants are used in patients with major depression who have inadequate responses or intolerable side effects during first-line treatment with SSRIs.

Side effects:

Side effects may occur with antidepressants, including atypical antidepressants. Some side effects may go away after time, while others may lead you and your doctor to try a different medication. Because of

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the different ways atypical antidepressants work, each has unique characteristics and varying possible side effects. For example:

1. Most of the atypical antidepressants list dry mouth, dizziness, or lightheadedness as possible side effects.
2. Some antidepressants may help you sleep and are best taken at night, while others may cause insomnia.
3. Some antidepressants may cause constipation, while others may increase the risk of diarrhea.
4. Some antidepressants may increase your appetite, resulting in weight gain, while others may cause nausea.
5. Some antidepressants are more likely than others to cause sexual side effects.

Table 5 includes the atypical antidepressants that the Food and Drug Administration (FDA) has approved.

TABLE 5: ATYPICAL ANTIDEPRESSANTS APPROVED BY THE FDA

1. Bupropion (Wellbutrin SR, Wellbutrin XL)
2. Mirtazapine (Remeron)
3. Nefazodone
4. Trazodone
5. Vilazodone (Viibryd)
6. Vortioxetine (Trintellix)

A new antidepressant called esketamine (Spravato) is FDA approved for treatment-resistant depression. It's a nasal spray intended for use in combination with an oral antidepressant.

Monoamine Oxidase Inhibitors:

Monoamine oxidase inhibitors (MAOIs) are a separate class from other antidepressants, treating different forms of depression and other nervous system disorders such as panic disorder, social phobia, and

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depression with atypical features. Examples of atypical features are oversleeping and overeating.

MAOIs were the first antidepressants introduced, but they are not the first choice in treating mental health disorders due to several dietary restrictions, side effects, and safety concerns. MAOIs are only a treatment option when all other medications are unsuccessful.

The monoamine oxidase enzyme breaks down different types of neurotransmitters from the brain: norepinephrine, serotonin, dopamine, and tyramine. MAOIs inhibit the breakdown of these neurotransmitters thus, increasing their levels and allowing them to continue to influence the cells that have been affected by depression.

The most frequently encountered side effects of MAOI medications are:

1. dry mouth
2. nausea
3. diarrhea
4. constipation
5. drowsiness
6. insomnia
7. dizziness
8. lightheadedness

MAOIs prevent the breakdown of tyramine found in the body and certain foods, drinks, and other medications. Patients that take MAOIs and consume tyramine-containing foods or drinks will exhibit high serum tyramine levels. A high level of tyramine can cause a sudden increase in blood pressure, called the tyramine pressor response. Even though it is rare, a high tyramine level can trigger a cerebral hemorrhage, which can even result in death.

Foods that are high in tyramine are highly processed or aged foods. Table 7 contains an extensive list of these foods and beverages.

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TABLE 7: FOODS AND BEVERAGES HIGH IN TYRAMINE

1. Strong or aged cheeses (aged Cheddar, Swiss, Parmesan, blue cheeses, American cheese, cottage cheese, ricotta, farmer cheese, and cream cheese)
2. Cured meats (summer sausages, pepperoni, and salami)
3. Smoked or processed meats (hot dogs, bologna, bacon, corned beef, or smoked fish)
4. Pickled or fermented foods (sauerkraut, kimchi, caviar, tofu, or pickles)
5. Sauces (soy sauce, shrimp sauce, fish sauce, miso, and teriyaki sauce)
6. Soybeans and soybean products
7. Snow peas, broad beans
8. Dried or overripe fruits (raisins or prunes, or overripe bananas or avocados)
9. Meat tenderizers
10. Yeast-extract spreads (Marmite, brewer's yeast, or sourdough)
11. Alcoholic beverages (beer, red wine, sherry, and liqueurs)
12. Combination of foods that contain any of the above ingredients.
13. Improperly stored foods or spoiled foods.
14. Beverages with caffeine

MAOIs can potentially cause drug-to-drug interactions, drug-food interactions, and overdoses. For example, patients should not be mixing MAOIs with other antidepressants like selective serotonin reuptake inhibitors (SSRIs).

Selective Serotonin Reuptake Inhibitors:

SSRIs have become the most commonly prescribed and popular drug for the treatment of depression. SSRIs are also a good drug choice for the elderly. The SSRIs have been shown to be at least as effective in treating depression as the monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants (TCAs), and atypical antidepressants. They also have several significant advantages over these drugs.

Safety:

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People who are depressed are at high risk of committing suicide and taking a drug overdose is a common method of trying to cause self-harm. The MAOIs and the TCAs can be very dangerous when taking too much of these medications and can cause arrhythmias and seizures.

The SSRIs have been used in the United States since the late 1980s, about 40 years, and experience has shown that even when a very large amount of an SSRI is ingested, serious adverse effects are uncommon and death is rare. In addition, the MAOIs require careful attention to diet as there are drug-food interactions that can be potentially harmful.

Side Effects:

The SSRIs have side effects as do all medications. But when compared to the MAOIs and the TCAs the side effects of SSRIs are relatively mild and many patients find these drugs easier to tolerate than MAOIs and TCAs.

The SSRIs are considered to be the first-choice drug for the treatment of major depressive disorder and dysthymia and the following sections will focus on their uses, advantages, and side effects.

The table below lists the SSRIs that are currently available in the United States; these are all oral medications. The generic name is given first and the trade name is in parentheses.

TABLE 5: SSRIS AVAILABLE IN THE UNITED STATES

1. Citalopram (Celexa®)
2. Escitalopram (Lexapro®)
3. Fluoxetine (Prozac®)
4. Fluvoxamine (Luvox®)
5. Paroxetine (Paxil®)
6. Sertraline (Zoloft®)
7. Vilazodone (Viibryd®)
8. Vortioxetine (Brintellix®)

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The SSRIs work by inhibiting the reuptake of serotonin. Serotonin is a neurotransmitter that is found in the part of the brain that control appetite, emotions, mood, and sex drive. Serotonin is released from nerve endings and stimulates a specific area of the brain. It produces a certain effect, and serotonin is then returned to the nerve endings. The SSRIs inhibit the reuptake of serotonin back into the nerve endings, increasing the amount of available serotonin. The theory of SSRIs and their effect on depression is that with more circulating serotonin the area of the brain that controls emotions and mood is consistently stimulated and the patient is less depressed.

There are many SSRIs and there is no evidence that any particular SSRI is more effective than any other drug in this class. The person is started on the lowest dose that can be prescribed and this can be gradually increased as needed. It is important to know that older adults usually start on a lower dose than younger adults because older adults' digestive systems are slower and this can cause a build-up of medication.

A noticeable improvement in symptoms usually happens one to two weeks after starting therapy with an SSRI. If the person does not have a good response after six to eight weeks of therapy the prescriber will usually switch to another SSRI. The usual duration of therapy with an SSRI, if this is the first major depressive episode, is four to nine months. Patients who have had two or more major depressive episodes may need a longer course of therapy.

The SSRIs have fewer and more tolerable side effects than the other antidepressants but as with any drug they can produce unpleasant side effects. Some of these side effects such as headache, sleepiness, and being tired may be mild but some are serious enough that people quit taking the SSRI. One study estimated that up to 43% of all patients taking an SSRI had stopped taking the drug within three months of beginning therapy. Two side effects of SSRIs that are common and distressing for patients are weight gain, decreased sex drive, or other sexual side effects.

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Approximately 25% of people who take an SSRI will gain some weight and this can be as much as 50 pounds. Decreased sex drive and other sexual side effects (difficulty attaining orgasm) are less common but are still a problem. Each patient reacts differently to the SSRIs so if a patient cannot tolerate one SSRI, the patient should be prescribed another.

The use of SSRIs may increase the risk of suicide, especially when SSRIs are prescribed to children, adolescents, and young adults who have a major depressive disorder. The medication does not cause suicidal thoughts, the medication helps the patient as they feel better to act upon the suicidal thoughts they have been having. It gives them the energy to follow through with suicide. The prescribing information for each SSRI has a warning that states when an SSRI is used for these patient populations, the benefits and risks must be carefully examined and the patients must be closely observed for suicidal ideation or behaviors.

Therapy with an SSRI should not be stopped abruptly. The drug dose must be reduced slowly, usually over a period of two to four weeks. If therapy with an SSRI is stopped suddenly or is reduced too quickly, the patient may suffer from discontinuation syndrome. Discontinuation syndrome causes a wide range of symptoms such as dizziness, fatigue, headache, and nausea. Discontinuation syndrome is usually mild, lasting one to two weeks, but it can be severe and last longer.

Tricyclic Antidepressants:

Tricyclic antidepressants (TCAs) help keep more serotonin and norepinephrine available to your brain. These chemicals are made naturally by your body and are thought to affect your mood. When keeping more of these chemicals available to your brain, tricyclic antidepressants help elevate your mood.

Some tricyclic antidepressants are also used to treat other conditions, mostly in off-label uses. These conditions include obsessive-

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compulsive disorder (OCD) and chronic bedwetting. In lower doses, cyclic antidepressants are used to prevent migraines and to treat chronic pain. They are also sometimes used to help people with panic disorder.

Possible side effects when taking a tricyclic antidepressant medication include:

1. dry mouth
2. dry eyes
3. blurred vision
4. dizziness
5. fatigue
6. headache
7. disorientation
8. seizure
9. drowsiness
10. constipation
11. urinary retention
12. sexual dysfunction
13. low blood pressure
14. weight gain
15. nausea

The different cyclic antidepressants that are currently available are listed in Table 6.

TABLE 6: TRICYCLIC ANTIDEPRESSANTS AVAILABLE

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1. amitriptyline (Elavil)
2. amoxapine (Asendin)
3. desipramine (Norpramin)
4. doxepin imipramine (Tofranil)
5. maprotiline (Ludiomil)
6. nortriptyline (Pamelor)
7. protriptyline (Vivactil)
8. trimipramine (Surmontil)

Psychotherapy

There are many psychotherapies that can and have been used successfully to treat patients who have major depressive disorder and dysthymia. Cognitive Behavioral Therapy (CBT), group therapy, interpersonal psychotherapy, and supportive psychotherapy are examples of helpful psychotherapeutic approaches, and there is no evidence that one type of psychotherapy is better than another for treating patients who have these depressive illnesses. The specific psychotherapy that is used will depend on availability and patient preference.

Alternative Therapies and Self-Help

There are many alternative therapies that have been used as treatments for depressive disorders, they include electroconvulsive therapy (ECT), over-the-counter supplements, St John's wort, SAMe (S-adenosylmethionine), omega-3 fatty acids, acupuncture, and music therapy. Aside from ECT, these alternative therapies have not been well-studied and it is not clear how effective they can be. In and of themselves they would be unlikely to cause harm; the harm would be in using an unproven alternative therapy in place of antidepressants and psychotherapy.

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Electroconvulsive therapy, commonly known as shock therapy, has been used for decades to treat patients who have severe, treatment-resistant depression. In ECT the patient is medicated, electrodes are attached to the skull, and a powerful electric current is given. This current causes seizures, it is not clearly understood how this works but, these induced seizures can significantly reduce the severity of depression.

Self-help is an important part of treatment for depression. These activities can do much to brighten a patient's mood, and they can help break the vicious cycle of decreased activity and social isolation caused by depression that leads to more depressed feelings. Self-help activities include activity, following treatment recommendations, exercise, healthy habits, sleep, socialization, support groups, and patience.

Activity:

People who are depressed often have no energy for or interest in doing anything. Inactivity *worsens* feelings of depression so people should be encouraged to be active and involved.

Treatment Recommendations:

Following the treatment plan that has been prescribed is very important. Skipping therapy sessions and/or not taking antidepressants as prescribed will slow down or stop the recovery process.

Exercise:

Exercise has been shown to be a very effective mood brightener and it has many other health benefits. Many healthcare providers recommend exercise as a therapy for patients who have depression.

Healthy Habits:

The patient should be encouraged to maintain good health habits. For example, overeating or undereating or the use of alcohol or drugs

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may give someone *temporary* feelings of relief and distraction from depression but alcohol itself is a depressant. Alcohol and drugs are a risk of becoming a substance use disorder and harmful, and a poor diet can cause a lack of energy and health problems.

Sleep:

People who are depressed often do not get enough sleep or sleep too much, and too little or too much sleep can exacerbate feelings of depression.

Socialization:

People who are depressed often do not want to socialize. However, just as inactivity can increase depression so can social isolation and although someone who is depressed often does not want to interact, being alone can be harmful and unhealthy. People should be encouraged to socialize or at least not to isolate themselves.

Support Groups:

Comparing experiences can be a helpful way of recovering from and managing depression, and the patient's primary care provider or therapist can provide contact information for support groups.

Patience:

Depression can be successfully treated but recovery is a long process. It takes time for antidepressants to begin working and finding the right type of therapy and/or medication is often a process of trial and error. Patients want to feel better as fast as possible and if it appears to them that the treatment plan is not working, there may be a strong temptation to think there is no hope and to give up. It can be difficult to be patient during the recovery process but it is essential.

Health Care Professional's Role in Management of Depression

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1. Report any changes in behavior such as withdrawal, depressive thoughts, or suicidal actions
2. Listen to the person without expressing judgment
3. Encourage the person to make friends
4. Try to find out the cause of the person becoming sad or blue
5. Spend extra time with the person when possible to let her/him know that the staff cares about them
6. Touch the person in a caring manner
7. Encourage the person to talk but do not provide false cheeriness

Summary

Depression is one of the most common and serious mental illnesses. Depression affects millions of children, adolescents, adults, and the elderly and it not only inflicts significant emotional and psychological pain but depression in the elderly is the major cause of suicide. Mental health issues for everyone but especially the elderly improve quality of life and affect the ability to deal with other health issues.

The cause or causes of depression are not clearly understood but research suggests that depression is probably due to genetics, chemicals in the brain, and exposure to life stressors that act as triggers and initiate the disease process. The signs and symptoms of depression are different for each person but feelings of hopelessness and sadness, fatigue and lack of energy, and disinterest in daily activities are very common. Major depressive disorder is one of the most common causes of suicide.

A combination of antidepressants and psychotherapy is the recommended approach for treating patients who have major depressive disorder or dysthymia, but either one of these can be used alone. Depression can be successfully treated but this can be a long process and relapses are possible. Successful treatment of depression depends on early detection, the prompt use of the correct therapies,

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and patient compliance with the treatment plan. All members of the health team should understand the benefits and risks of antidepressant medication.

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