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Member's Editorial

Dealing with Depression

Most seniors enjoy good mental health. Being mentally healthy means feeling good about yourself, interacting positively with others, and avoiding harmful behaviour. But even mentally healthy people feel a little melancholy sometimes – it's a natural response to life's ups and downs. However, if it happens regularly and seems to go on and on, maybe it's more than just the blues. Perhaps it's depression.

There are many unanswered questions about seniors and depression – exactly how many seniors experience it, precisely what causes it, how it affects physical health, etc. Moreover, depression often goes undiagnosed in seniors because of preconceptions, misconceptions, or lack of expertise. The good news is that, once diagnosed, depression is treatable, no matter what your age.

Yet many depressed seniors don't seek treatment. Maybe they're ashamed, seeing the symptoms as signs of weakness or failure. Maybe they don't know where or to whom to turn. Or they're leery of mental health professionals. They may think, as movie mogul Sam Goldwyn expressed it, that "Anyone who sees a shrink ought to have his head examined." Or they may not realize they're

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depressed, seeing their feelings as a normal part of aging. At the same time, health professionals may overlook depression as a diagnosis, especially if a senior has recently been ill or bereaved.

At NACA we see a need for greater professional and public awareness to destigmatize depression, combat

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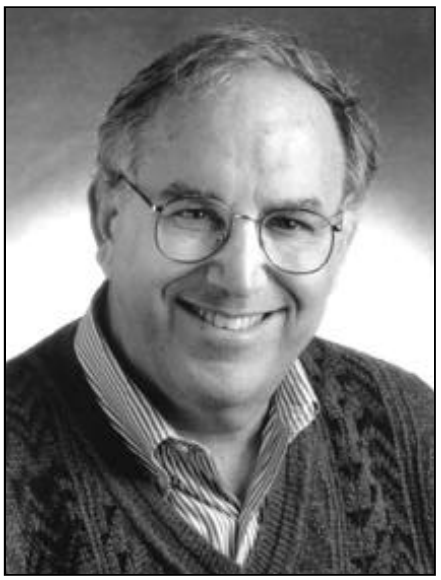

stereotypes, and break down other barriers to timely identification and treatment of this illness. We also need to tackle the circumstances that can precipitate or aggravate depression – financial insecurity, the aftermath of life-threatening illnesses, caregiving for an ailing spouse or other family member – to determine where services and support are needed and how best to provide them. These are major challenges and the subject of on-going research. What follows is an initial look at this troubling subject

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Healthy Mind, Healthy Aging

Depression is a combination of symptoms, both psychological (you're sad, you feel worthless or guilty, you lose interest in your favourite things) and physical (you're tired, you can't sleep, you sleep too much, you have no appetite). You feel that all your mental and physical processes are slower. You can't concentrate or make decisions. You may be anxious or agitated.

What's the difference between depression and a simple case of the blues? Depression has multiple symptoms that may last for months, affect your ability to function in daily life, and don't usually go away on their own. Depression isn't just the sadness that follows an event like bereavement (see *Expression*, volume 12, number 1). It's when sadness and hopelessness persist after a normal grieving period, or occur several months later.

How mentally healthy are Canadian seniors?

Although most seniors enjoy good mental health, as many as 20% of people age 65+ suffer mild to severe depression, ranging from perhaps 5 to 10% of seniors in the community to as many as 30 to 40% of those in institutions.[1]

The causes of depression are not well understood, for it's a complex phenomenon with multiple potential sources. Four factors seem to be involved in making some people more vulnerable than others:

- **chemical imbalances** in the brain, which may be genetically transmitted, because some forms of depression run in families
- **personality type** – people who are hard on themselves and very self-critical, or who are abnormally passive and dependent
- **social isolation** – people who have trouble forming and maintaining satisfactory social relationships
- **state of health** – illness can interfere with activities and social connections and reduce a person's feelings of control and independence.[2]

'Primary' depression occurs when someone who has been well begins to have symptoms of depression either 'out of the blue' or in response to painful events such as a death in the family or a sudden illness. 'Secondary' depression is linked to certain drugs or illnesses. Drugs used to treat arthritis and cancer, for instance, can produce depression, while Parkinson's and thyroid dysfunction are believed to

be strongly associated with depression. Some research has linked depression in some cases to 'silent' strokes – small strokes that may not be detected but are known to interrupt the brain's chemical balance, which in turn is linked to depression.[3]

Despite the remaining scientific puzzles, we do know three important things about depression: first, it often goes undiagnosed and untreated in seniors; second, its consequences can be very serious; and third, it is very amenable to treatment in most cases.

You have to diagnose it to treat it

The *Canadian Family Physician* reported in May 1999 that seniors are among the most under-treated populations for mental health, estimating that mental health problems go undetected in more than one-third of the population age 65+. "Family doctors will have to assume more of a leadership role," says **Dr. Tony Reid**, scientific editor of *CFP*. "Early detection and treatment can have a significant impact in slowing down or even reversing some mental disorders."

Why is depression often overlooked in seniors? There are several possible explanations:

- **Negative stereotypes about seniors** – characterized by attitudes such as 'older people are cranky and moody', 'they don't want to (or can't) change', and 'depression is natural – a lot of depressing things happen to old people'.
- **Depression is qualitatively different** in older adults than in younger adults. Seniors' depression is more often marked by anxiety, agitation, physical complaints and memory symptoms. As a result, depression might be misdiagnosed as dementia or mistaken for a physical problem.
- **Blurring of the line** between impaired mental health and physical problems – people with cardiovascular disease, cancer and chronic pain are often depressed, and drugs to treat high blood pressure and heart disease can cause mood swings. Depression can also mimic diseases such as Alzheimer through symptoms such as confusion and attention deficit.
- **Masking of depression** by other problems, such as grief or dementia.
- **Seniors are less likely to report** psychological problems, and **social isolation** means fewer opportunities for others to detect a problem.

The warning signs

If several of these symptoms last more than two weeks, see a doctor:

Changes in behaviour
- general sluggishness (or agitation)
- loss of interest or less enjoyment in anything that once gave you pleasure
- withdrawal, decrease in social activities

Emotional changes
- feeling empty, sad, or down most of the time
- demoralization, despair
- irritability
- anxiety

Cognitive changes
- concentration difficulties and memory loss
- self-criticism, self-depreciation
- suicidal thoughts

Physical changes
- sleep disorders – insomnia, abnormal early waking, sleeping too much
- increase or decrease in appetite or weight
- lack of interest in sexual activity
- unexplained physical discomfort – constipation, headache

More than a mental health problem

Failure to detect and treat depression has serious consequences: social withdrawal, alienation of persons who might provide support, dependence on alcohol or sedatives. Depression can also interfere with the motivation needed to comply with a drug therapy or rehabilitation program after an accident or illness. Equally serious, a mental health problem that would be considered mild in a younger person can interfere with a senior's independent functioning if combined with physical health problems and/or social isolation.[4]

Indeed, a depressed senior often declines physically. Researchers at the University of Chicago speculate that depression may alter the immune, hormonal and nervous systems, making the body more vulnerable to illness. This can lead to a downward spiral, says **Dr. Jack Guralnik**. Losing physical ability leads to depression, which contributes in turn to further decline. Another possibility is that a depressed person is less likely to engage in physical activities, with consequent declines in strength, stamina and mobility.[5]

Finally, suicide is a serious risk. In Canada, 822 people over age 55 committed suicide in 1997 (the latest year for which figures are available).[6] Passive suicide is also a risk – not eating enough, not taking prescribed medications, drinking too much alcohol, delaying treatment for an illness, taking physical risks. In addition, depression in a person with a life-threatening illness can lead to requests for assisted suicide.

Seniors caring for a spouse with dementia are also at risk; they experience more depression and chronic health problems than those caring for a non-demented person. Spouses provide the care in 37 per cent of cases of people with dementia being cared for in the community. The demands of caregiving can produce feelings of overload, resentment, isolation and loss, often leading to depression.[7]

Treatments tried and true

The key to success in treating depression is early recognition and appropriate diagnosis. Between 60 and 80% of depressed people can be treated successfully with psychotherapy and/or drugs, and other options are available, depending on the nature and source of the depression.

The professionals who can help include your family doctor, a geriatric specialist, a psychiatrist, a psychologist and other professionals with mental health training, such as social workers and nurses. Many people also find assistance through self-help and support groups.

Antidepressant drugs are often tried first, because they can help improve mood, sleep, appetite and concentration. Many mood elevators and antidepressants are available; most but not all are suitable for treating depression in older adults. They are not habit-forming, but they need to be used under close medical supervision, for several reasons:

- **Side effects**, such as falls or confusion may occur, and adverse interactions with foods or other drugs have to be monitored closely.
- **Drugs take time to work**. The first sign a drug is working may take 2 to 4 weeks to appear, with full effects between 6 weeks to 3 months. Treatment should continue for at least 6 months to avoid relapse. Many suggest that responders who have recurrent depression stay on medications indefinitely.

Before you take a drug for depression, you and your doctor should consider all prescribed and over-the-counter medications you're already taking and any physical problems you have. The doctor should choose an appropriate drug, start you out with a small dose, and build to the correct dose. The doctor should also give you precise instructions about when and how to take the medication and which other drugs and foods to

avoid. If the first drug proves ineffective or has unpleasant side effects, another can usually be substituted.[8] For severe depression, more intensive treatment, such as a day hospital or inpatient care in a special psychiatry unit, may be necessary.

A complement or alternative to drug therapy is ***'talk' therapy***, offered in many forms by counselling professionals. Individual or group therapy addresses the feelings and thought patterns linked to depression (sadness, demoralization, emptiness, self-criticism). The goal is to help you recognize and change negative thinking patterns or improve relationships with people as a way to reduce feelings of hopelessness and despair. It is often combined with drug therapy for maximum benefit.

One form of talk therapy is cognitive therapy, which has been shown to work relatively quickly – within 2 to 3 months of treatment for those for whom it is appropriate. It's based on the idea that since people *learn* their negative views of themselves, the way the world works, and what the future holds, they can *unlearn* them as well. With a therapist's help, the depressed person learns to develop more valid ways of understanding events. The result is better skills to cope with adversity in the future.[9]

One study suggested that cognitive therapy has more long-lasting effects and is more helpful than drugs in treating mildly depressed seniors. This is especially promising for people who have trouble tolerating a drug because of side effects or dietary restrictions.[10]

A disadvantage of talk therapy is that it may not be covered by private or public health care plans if it is not provided by a doctor, putting it financially out of reach for many seniors, and sometimes there are long waits for an appointment with a therapist. In addition, many seniors – raised on self-sufficiency and keeping their own counsel – aren't comfortable with the idea of psychotherapy.

This is where ***support groups*** and ***self-help groups*** come in, especially when depression arises from a traumatic life event, such as bereavement, illness, or caring for an ailing spouse. Groups deal with a full range of issues and emphasize coping skills, information exchange, and mutual support between peers (see *Expression*, volume 2, number 4).

The risk factors

Seniors are more likely to be depressed if they...

- are recently bereaved
- are socially isolated
- are in poor health or have a physical disability
- have low socio-economic status
- are experiencing stressful life events
- have used drugs (sedatives, tranquillizers) over a long period
- have sensory deficits
- are genetically vulnerable[4]

An ounce of prevention

What if we could prevent depression altogether? Many older people cope remarkably well with illness, bereavement and other stressors. Research confirms that an individual's psychological resources play a significant role in mental health. For example, seniors with a sense of mastery and control are less likely to be depressed, even if they have a physical disability. The important factors are a positive perception of their situation and the belief that they can still control daily routines. Seniors who feel more in control take a more active role when facing illness or disability, thereby lessening adverse effects on well-being. This has

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implications for the kinds of supports seniors might want – whether they live in the community or in institutions.[11]

Preventing depression or reducing its impact also means caring for all aspects of physical and mental health (see Tips).

And good mental health for all

Seniors who take responsibility for their psychological well-being and enjoy good mental health are clearly in the majority. Researchers even detect a decline in the prevalence of depression among Canadian seniors over the past three decades.[12] Yet our society needs to do a better job of reaching out to those who, as they slide into depression, lose their means to cope with the disease.

Canada's National Population Health Survey showed that mental health tends to improve with age at least until the middle years and, on one measure (sense of coherence, which is a measure of psychological well-being), well into the senior years. But there are also socio-economic factors at work in mental health. We know that regardless of age, people with higher social and economic resources have only half the odds of being affected by depression or anxiety arising from distressing life events.

Timely access to affordable, appropriate treatment for depression is therefore an issue for society. We must also establish for all ages and all socio-economic levels strategies to promote resilience and other psychological coping mechanisms that can contribute to reducing or even preventing mental health problems.[13] The mental health sector is recognized as one of the weak links in Canada's health system. Yet without incurring extraordinary costs in time and money, attention and resources could be dedicated to:

- training to ensure that health professionals have specific skills to recognize and treat depression in seniors
- developing and strengthening community resources designed specifically to help seniors with mental health problems (or at risk of developing them)
- promoting the benefits of the whole range of therapies for treating seniors with depression, including cognitive therapy and other supportive therapies
- designing culturally appropriate approaches to treatment for Aboriginal seniors and seniors who belong to particular ethnic groups.[14]

Finally, we need to support the work of senior caregivers at risk for depression. Some caregivers have said they prefer telephone and newsletter support, citing barriers to participating in support groups: the need to find a replacement caregiver, time constraints, lack of transportation. Respite services and online support groups might also overcome these barriers.[15]

Good mental health doesn't happen by accident: it happens when individuals take responsibility for their health, when health professionals and the general public are aware of mental health risks and remedies for seniors, and when society provides appropriate support for those who are most vulnerable to mental health problems. Caring for mental health is an integral part of caring for health, because good mental health is essential to seniors' ability to continue living autonomously in the community and to achieve full, satisfying lives. ■

Tips...

If you think you're depressed...

- Don't be ashamed to seek treatment for depression – you wouldn't refuse help for diabetes or a broken leg.
- If you're puzzled by symptoms, stop worrying and talk to a doctor. Don't be tempted to self-diagnose. If you suspect a problem or just know something's wrong but can't put a finger on it, get professional help.
- Antidepressant medications don't work overnight. Find other sources of help and support – counselling, a self-help group – while waiting for the effects to kick in.
- Investigate supplementary treatments such as cognitive therapy, which can help you learn new ways of thinking about life and coping with adversity.

To prevent depression...

Get enough sleep, eat well, exercise regularly.

- Increase the number of pleasant activities each day to help counteract the impact of unpleasant events.
- Maintain social contact with positive, optimistic people who boost your self-esteem. Nurture relationships and maintain ties with family and friends so you'll have support when trouble comes your way.
- Find a sense of meaning in your own existence – through spiritual growth, or commitment to social responsibilities.
- Stay involved in pursuits that keep mind and body active and in touch with others. Make new acquaintances, try new things, take risks, keep an open mind.
- Make your own decisions. Gather information and opinions from others but weigh them exercising your own judgement.
- Follow instructions when using medicines to reduce the risk of depression as a drug side effect.
- Ask for help when you need it – it's not evidence of weakness or incompetence but a sign of health and maturity, of being in control.
- Meet life's ups and downs with flexibility, adaptability and a sense of humour.

If a senior you know is depressed...

- Don't ignore the warning signs if someone you love is sad, withdrawn, lethargic, or neglects personal appearance or hygiene.
- Take all talk about death or suicide seriously.
- Pep talks don't work. Urging the person to "cheer up" or "snap out of it" isn't helpful. Instead, support them in their search for appropriate help.
- Listen to the depressed person without criticizing or feeling responsible for the person's unhappiness. Be supportive and understanding without feeling guilty – you didn't cause the depression.

If you're caring for someone who's depressed...

- Take time to take care of yourself – exercise, eat right, get enough sleep. Learn about relaxation techniques (breathing exercise, yoga). Take a stress management course
- Try to keep a balanced perspective – don't let the disease dominate your life. Keep to your normal routine – don't rearrange your life around the depressed person.
- A depressed person is often irritable, hostile, pessimistic. Living with a depressed person is challenging; don't be hard on yourself for feeling angry. Find constructive outlets for anger.
- Set realistic standards for yourself and learn to say no.
- Share the load. Talk things out with friends and associates. Enlist others to provide support for the depressed person. Get help for yourself and other family members if you need it.

Find out more...

■ Canadian Mental Health Association, *Depression, an overview of the literature* (Ottawa: 1995). A guide to the types of depression and their treatment.

■ National Advisory Council on Aging, *Mental Health and Aging* (Ottawa: 1991). Although this publication is a decade old, it remains one of NACA's most requested publications. Contains chapters on depression, loneliness and grief; fear and anxiety; alcohol use and abuse; suicide.

Online

■ www.canadian-health-network.ca – funded by Health Canada in partnership with dozens of health organizations across the country, this site lets you search by topic (mental health), by group (seniors, women), by resource type (organizations, health promotion tools), and by province/territory.

■ www.cmha.ca/english/olinks/htm – Canadian Mental Health Association has links to other sites with information about mental health and seniors.

■ www.alzheimer.ca – offers a checklist of the 10 signs of caregiver stress, many of which are related to depression. There's also a caregiver forum for sharing information and personal experiences.

■ www.mfaaa.org/center/agepage/depression_tre.html – National Institute on Aging (U.S.) offers tips on treating depression and links to other information sources.

■ www.feelingblue.com - The PsychCanada site, for information and a quick test to determine if you are likely suffering from depression.

Notes

1. Robert N. Butler and Myrna I. Lewis, "Late-life depression: when and how to intervene", *Geriatrics* 50/8 (August 1995); K.L. McEwan, *Mental health problems among Canada's seniors: Demographic and epidemiologic considerations* (Ottawa: Health Canada, 1991).
2. Blossom T. Wigdor, *Mental Health and Aging* (Ottawa: National Advisory Council on Aging, 1991).
3. National Institute on Aging (U.S.), "Depression: a serious but treatable illness", AgePage (see "Online, please"); D.C. Steffens et al., "Cerebrovascular disease and depression symptoms in the cardiovascular health study", *Stroke*, vol. 30.
4. *Mental health problems among Canada's seniors.*
5. *Ottawa Citizen*, 4 June 1998, reporting on an article in the *Journal of the American Medical Association*; J.C. Hays et al., "Social support and depression as risk factors for loss of physical function in late life", *Aging and Mental Health* 1/3 (1997).
6. Canadian Press story, 7 February 2000.
7. Canadian Study of Health and Aging Working Group, "Patterns of caring for people with dementia", *Canadian Journal on Aging* 13/4 (1994).
8. Dr. Guillaume Galbaud du Fort, "Depression: a problem often unrecognized in seniors", *Vital Aging* 5/2 (February 1999), p. 2; Mark J. Berber, "Pharmacological treatment of depression", *Canadian Family Physician* 45 (November 1999).
9. Canadian Mental Health Association, *Depression: an overview of the literature* (Ottawa: 1995), p. 48; Alastair J. Flint, "Anxiety disorders in late life", *Canadian Family Physician* 45 (November 1999).
10. N. O'Rourke and T. Hadjistavropoulos, "The relative efficacy of psychotherapy in the treatment of geriatric depression", *Aging and Mental Health* 1/4 (1997).
11. S.H. Zarit et al., "Prevalence, incidence and correlates of depression in the oldest old", *Aging and Mental Health* 3/2 (1999).
12. Federal-Provincial-Territorial Advisory Committee on Population Health et al., *Statistical report on the health of Canadians* (Ottawa: Health Canada, 1999).
13. T. Stephens et al., "Mental health of the Canadian population: a comprehensive analysis", *Chronic Diseases in Canada* 20/3 (1999).
14. National Advisory Council on Aging, *1999 and beyond: challenges of an aging Canadian society* (Ottawa: 1999).
15. Professor Angela Colantonio in "Caregivers need flexible support systems, survey shows", at www.library.utoronto.ca/researchnews/tips/ feb22a_99.html; see also the Alzheimer Society web site.

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