

Older Adults

Depression and Suicide Facts

Major depression, a significant predictor of suicide in older adults,¹ is a widely underrecognized and undertreated medical illness. In fact, several studies have found that many older adults who commit suicide have visited a primary care physician very close to the time of the suicide: *20 percent on the same day, 40 percent within one week, and 70 percent within one month of the suicide.*² These findings point to the urgency of enhancing both the detection and the adequate treatment of depression as a means of reducing the risk of suicide among the elderly.

Older Americans are disproportionately likely to commit suicide. Comprising only 13 percent of the U.S. population, individuals ages 65 and older accounted for 19 percent of all suicide deaths in 1997. The highest rate is for white men ages 85 and older: 64.9 deaths per 100,000 persons in 1997, about 6 times the national U.S. rate of 10.6 per 100,000.³

An estimated 6 percent of Americans ages 65 and older in a given year, or approximately 2 million of the 34 million adults in this age group in 1998, have a diagnosable depressive illness (major depressive disorder, bipolar disorder, or dysthymic disorder).⁴ In con-

trast to the normal emotional experiences of sadness, grief, loss, or passing mood states, depressive disorders can be extreme and persistent and can interfere significantly with an individ-

ual's ability to function. Dysthymic disorder as well as depressive symptoms that do not meet full diagnostic criteria for a disorder are common among the elderly and are associated with an increased risk of developing major depression.⁵ In any of its forms, however, depression is *not* a normal part of aging.

Depression often co-occurs with other medical illnesses such as cardiovascular disease, stroke, diabetes, and cancer.⁶ Because many older adults face such physical illnesses as well as various social and economic difficulties, individual health care professionals often mistakenly conclude that depression is a normal consequence of these problems—an attitude often shared by patients themselves.⁷ These factors conspire to make the illness underdiagnosed and undertreated.

Both doctors and patients may have difficulty identifying the signs of depression. NIMH-funded researchers are currently investigating the effectiveness of a depression education intervention delivered in primary care clinics for improving recognition and treatment of depression and suicidal symptoms in elderly patients. In addition, NIMH has developed this cue card for older adults.

Older Adults...

Before you say,
"I'm fine" ...

Ask yourself if you feel:

- nervous or "empty"
- guilty or worthless
- very tired and slowed down
- you don't enjoy things the way you used to
- restless or irritable
- like no one loves you
- like life is not worth living

Or if you are:



- sleeping more or less than usual
- eating more or less than usual
- having persistent headaches, stomach aches, or chronic pain

These may be symptoms of **Depression**, a treatable medical illness.

But your doctor can only treat you if you say how you are really feeling.

Depression is not a normal part of aging.

Talk to your doctor.

  www.nimh.nih.gov
toll-free: 1-800-421-4211
Mental Health FAX 4U: 301-443-5158

Research and Treatment

Modern brain imaging technologies are revealing that in depression, neural circuits responsible for the regulation of moods, thinking, sleep, appetite, and behavior fail to function properly, and that critical neurotransmitters—chemicals used by nerve cells to communicate—are out of balance.⁸

Genetics research indicates that vulnerability to depression results from the influence of multiple genes acting together with environmental factors.⁹ Studies of brain chemistry and of mechanisms of action of antidepressant medications continue to inform the development of new and better treatments.

Antidepressant medications are widely used effective treatments for depression.¹⁰ Existing antidepressant drugs are known to influence the functioning of certain neurotransmitters in the brain, primarily serotonin and norepinephrine, known as monoamines. Older medications—tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs)—affect the activity of both of these neurotransmitters simultaneously. Their disadvantage is that they can be difficult to tolerate due to side effects or, in the case of MAOIs, dietary and medication restrictions. Newer medications, such as the selective serotonin reuptake inhibitors (SSRIs), have fewer side effects than the older drugs, making it easier for patients including older adults to adhere to treatment. Both generations of medications are effective in relieving depression, although some people will respond to one type of drug, but not another.

Certain types of psychotherapy also are effective treatments for depression. Cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) are particularly useful. Approximately 80 percent of older adults with depression improve when they receive appropriate treatment with medication, psychotherapy, or the combination.¹¹

In fact, recent research has shown that a combination of psychotherapy and antidepressant medication is extremely effective for reducing recurrence of depression among older adults. Those who received both interpersonal therapy and the antidepressant drug nortriptyline (a TCA) were much less likely to experience recurrence over a three-year period than those who received medication only or therapy only.¹²

Studies are in progress on the efficacy of SSRIs and short-term specific psychotherapies for depression in older persons. Findings from these studies will provide important data regarding the clinical course and treatment of late-life depression. Further research will be needed to determine the role of hormonal factors in the development of depression, and to find out whether hormone replacement therapy with estrogens or androgens is of benefit in the treatment of depression in the elderly.

For More Information

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⁶Depression Guideline Panel. *Depression in primary care: volume 1. Detection and diagnosis. Clinical practice guideline, number 5.* AHCPR Publication No. 93-0550. Rockville, MD: Agency for Health Care Policy and Research, 1993.

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