Older Adults, Alcohol and Depression

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For more information on alcohol issues affecting older adults see, Seniors and Alcohol www.agingincanada.ca

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Introduction

This overview describes what is currently known about depression among older adults who are also experiencing alcohol problems. It has been prepared to help build service providers' awareness of how alcohol and depression are connected in later life and to introduce some key considerations for helping in an effective manner. The information is geared to those who work with older adults, but who may not have extensive familiarity with depression or alcohol issues among older adults.

1. What is Depression?

Depression is a mood disorder where a person strongly feels sadness, despair, and discouragement. Depression can cause a significant and enduring disruption in the older person's emotional wellbeing and overall functioning. Left untreated, it can cause serious health problems or even death.

Depression is bio-chemical in nature. Three major neurotransmitters in the brain (serotonin, dopamine and norepinephrine) need to be in the correct balance for people to have a positive, stable self image and optimistic mood. If these chemicals are not in balance, the person can become depressed.

In general, when serotonin levels drop, depression can quickly settle in, and when serotonin levels rise, a contented mood generally results. Personal and genetic factors can pre-dispose some people to depression.

Depression in later life is not the same as when an older person is temporarily feeling "blue", or experiencing grief immediately following death of his or her spouse, or other people or things that may be important to them.

Depression lasts much longer, and does not go away by itself. The person often describes the condition of being depressed as feeling very different than his or her former self.

2. How Common is Depression Among Older Adults?

According to the National Advisory Council on Aging:

> "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. " (*citing Butler, also McEwan)*

Depression is fairly common among people who are in acute care or chronic care settings (12-20%), in other words, those who are in hospitals and nursing homes. (Blazer, 1999) Depression is also very common where a person is developing dementia, but is not yet showing clinical signs of the dementia. (Visser, 2000)

Take a Moment to Consider:

Severity of the symptoms and duration.

3. How Common is Depression Among Older Adults Experiencing Alcohol Problems?

According to the most recent national figures available, approximately 67% of peopled in Canada aged 65-74 are drinkers, as are 51% of people aged 75 and over. By that, researchers mean the people consume alcohol occasionally or regularly.

In the United States, the figures are somewhat lower, with 48% of people aged 65-74 and 36% of people aged 75 and over consuming alcohol in the past year. (Schoenborn & Adams, 2001)

In both countries, approximately 6-10% of older drinkers develop alcohol related problems. It is estimated that between 138,000 and 220,000 older adults in Canada, and between 880,000 and 1,467,000 older adults in the United States experience alcohol related problems. (Spencer, 2003)

Depressed older adults are three to four times more likely to have alcohol related problems than are older people who are not depressed. Between 15 and 30% of people with major late life depression also have alcohol problems. (Devanand, 2002)

4. Are There Different Types of Depression Associated with Alcohol Problems?

Older adults who are dependent on alcohol may experience either one or both of two these forms of depression:

a) Transient depression: Older adults who have been drinking heavily may become depressed on a short term basis, either directly from being intoxicated or as they withdraw from the alcohol. This form of depression will pass on its own as the drinking subsides or after the person has gone through the acute and post acute phases of alcohol withdrawal.

* If the depression continues six to eight weeks after a person has gone through alcohol withdrawal, it is probably an underlying depression, not the transient form.

We currently have little information on what percentage of older adults experience transient depression. Emotional support and good nutrition for older people who are experiencing transient depression can go a long way to helping reduce the intensity of the depression while it lasts.

b) Underlying depression: When depression or other symptoms persist unchanged for weeks or longer after the person has stopped drinking, then it is considered to be a "co-morbid disorder". (Atkinson, 2002) By that, people mean that the depression was occurring at the same time as the alcohol problem. People who drink and have an underlying depression often have had other periods of depression earlier in life, a family history of depression, and currently have major life stressors. (Atkinson & Misra, 2002)

5. What's "Causes" Depression?

The short answer is "We are not certain". There seem to be several factors that leave some people with a greater chance of developing depression in their lifetime. For example, depression is more common among

- women than men (Sonnenberg, et al, 2000)
- people who have few social supports,
- people who are experiencing stressful life events. (Scheider & Amerman, 1995)

Depression in late life is more common where there has been

- previous depression,
- a family history of depression,
- a personal history of alcohol or other substance abuse problems,
- serious medical illness or chronic pain,
- prior suicide attempts.

6. What Does Depression in Later Life Look Like?

The Many Faces of Depression in Later Life

For some older adults, depression is a chronic illness, existing throughout most of their lives. It recurs and ebbs.

For others, depression is a reaction to specific situational stress (e.g. death of a spouse, or significant change in the person's own health or functional ability). It can also arise in the context of forced retirement, or loss of a job or volunteer position that has been important to the person. Depression in an older adult might develop after the person loses their driver's license or moves from their community, after the death of a loved pet.

Women experience depression about twice as frequently as men. Women are also at greater risk for significant chronic disabilities in later life (such as arthritis), often with inadequate pain management for those conditions. Inadequate pain management is a very important factor associated with depression and with a person's desire to die. (Roscoe, 1999)

Take a Moment to Consider :

What is lost for this person? What is changing in his or her life?

Depression can show up in a diverse group of older adults.

An older person who is drinking and who is depressed can easily be

- an 75 year old man whose spouse of 55 years died a year ago, or a man divorced 20 years ago whose former wife recently died;
- a 63 year old woman who has had several spells of depression throughout her life;
- a women in her late 50s who feels life has no meaning because nothing is happening in her life and she feels "stuck";
- a 60 year old formerly very active man, now facing many health problems;
- a 63 year old woman who suffered abuse or traumas forty years ago that have never been adequately addressed;
- a 66 year old whose mother and brother have both had depression;
- a 66 year old college teacher recently forced into retirement;
- a 78 year old woman whose 52 year old daughter has recently died;
- an 85 year old veteran whose memories of losing his war buddies in violent circumstances are beginning to surface, possibly for the first time in his life;
- a 63 year old man caring for his 93 year old mother.

Older women who have lost their daughters tend to have significantly higher levels of depression than widows, possibly because it "feels wrong" that a child should predecease a parent. (Leahy, 1992-3)

Depression can also occur in the context of caregiving. An older adult can become overwhelmed giving care to a spouse or family member. An older wife or older husband giving care may feel they have not only lost their life and personal freedom, but also have lost the spouse they once had, even though the person is still physically present. Drinking sometimes becomes the person's emotional "escape hatch".

Women tend to experience more caregiving demands than do men and as a result, women caregivers may be more likely to be depressed. However, many older men

are not used to caregiving roles, and more older men than older women drink. This might suggest that depression or alcohol problems may be more common among the men who are caring for a frail, ill or disabled spouse or parent.

Research shows depression is more common

- if the person who is giving care is in poor health, receives little help from family and friends, or feels overwhelmed in giving the care. (Pruchno, & Resch, 1989; Clyburn, et al, 2000).
- in a caregiver as the frequency of disturbing behaviours by the person receiving care increases.

7. How to Identify the Problem

Some of the typical signs of depression are:

- Loss of interest and pleasure in activities the person used to enjoy
- Lack of energy
- Poor sleep
- Loss of appetite and weight
- Expressing feelings of worthlessness and sadness
- Being unusually emotional, crying, angry or agitated
- Increased confusion

Depression is sometimes mistaken for the apathy, lack of initiative and cognitive decline, which are signs that people associate with early dementia. That is why some people will refer to depression as 'pseudodementia'. (See Appendix A)

However there are important differences between dementia and depression. In depression, the person's abilities to think abstractly and remember will vary from day to day, week to week, and the level of impairment fluctuates. When someone is depressed, she or he may complain of poor memory and confusion. In a dementia such as Alzheimer disease, the person is much less likely to have insight that she or he is having a problem remembering. (Denton, 2002)

Late life depression is often overlooked

Health care providers working with older adults or others in contact with the older adult such as family may overlook or not recognize depression among older people. For example, a recent study showed that one half of depressed older adults were not being identified as such by home care nurses (Brown et al, 2003). This can occur for several reasons.

A. Different signs

- There is considerable variation in the kinds of signs and symptoms for depression in older adults. Some older adults live with a constant, low-level form of depression known as *dysthymia* which the older adult may not even recognize it as depression or think can be treated.

- Frequently depression does not manifest itself in older adults in the same way as younger adults. For example, inactivity is often seen in depressed younger adults. However, many older adults can experience anxiety and agitation during depression. Older adults are sometimes mistakenly prescribed tranquilizers (e.g. benzodiazepines for this anxiety) when in reality they are depressed.

- Not only will depression in later life have different clinical signs, these vary with different older adults (not all older adults show the same signs).

- Older adults who are depressed are less likely than younger people to say they *feel depressed*. Depressed older adults are also less likely than younger people to acknowledge other feelings such as guilt, low self esteem or suicidal ideas, each of which is commonly associated with depression. Instead, the depression may show up more as somatic complaints (constipation, abdominal cramps, weight loss), or feelings of anxiety.

- Older depressed persons often show signs of depression by responding more slowly, slower mental processing, an inability to make decisions, and inappropriate social responses**.** So, not surprisingly, depression can easily be confused with dementia. (See Appendix A)

- Some older depressed persons may have somatic worries that leave them pre-occupied (“I can’t eat properly anymore. I must have cancer in my stomach”) or may express feeling persecuted by family or friends. A depressed older person may have attempted suicide yet not expressed suicidal thoughts to others. (King & Markus, 2000)

- A common sign of depression is flat affect (emotion). When asked how they feel, people sometimes respond “I don’t know [how I feel], I don’t care. Leave me alone”. The person simply “shuts down”.

B. Ageism

Service providers may inadvertently overlook or discount relevant symptoms and changes in functioning if they view depression as a normal or if they consider it as an inevitable aspect of growing older.

Sometimes people erroneously consider depression as a normal response to a medical illness or a loss of function. (e.g., "Oh course he's depressed. Who wouldn't be depressed after having a stroke and losing the ability to walk?")

Depression is not inevitable and although it may occur with a medical illness, it should not simply be ignored.

Many medical conditions that are more common in later life have symptoms that mimic depression (e.g., multiple sclerosis, Parkinson's disease, chronic obstructive pulmonary disease). (King & Markus, 2000)

Depression is also common among older adults who are experiencing self neglect. (Dyer et al, 2000). This may reflect a person's deteriorating ability to take care of herself or himself because of an illness or disability. Self neglect can also be a manifestation of the depression-- giving up on life and neglecting self, losing all the energy or the will to eat, clean, or go out.

8. What Are Some of the Ways of Assessing and Recognizing Depression in Older Adults?

Asking about feelings of depression

When there is a positive, caring and trusting relationship, two or three questions can go a long way to finding out whether the person feels depressed. Ask if they feel their life is empty. Ask if they are satisfied with their life. Ask if they feel happy.

Also look for both emotional and somatic signs of depression (loss of appetite, difficulty sleeping).

Screening tools such as Geriatric Depression Scale (discussed below) are commonly used. Screening tools do not replace getting a thorough history from the person. A physical examination can also help determine if there are other reasons for the signs the person is showing. The assessment should include

- a complete neurologic and mental status assessment (to help rule out dementia)
- a review of the person's alcohol use as well as their prescription, over the counter, herbal and other drug use

If the person is showing signs of dementia or is not very communicative, obtaining a history from family members or other informants about the person and changes in the person's life is essential. (Merck)

Take a Moment to Consider :

How are the signs of depression different for older adults from younger people? In what ways are they the same?

Formal Screening Tools

The Geriatric Depression Scale (see Appendix B) is a commonly used tool for assessing depression in older adults. The short form is composed fifteen questions that can be answered "Yes" or "No"; and the long form has 30 questions. On the short scale, a score of 5 suggests depression, and more than 10 almost always indicates depression.

There have been attempts to shorten the Geriatric Depression Scale to 4 questions to make it more useful for clinical practice. English, French and other language versions of the Geriatric Depression Scale are available. (van Marwijk et al. 1995)

The Beck Depression Inventory II is another tool sometimes used. It is comprised of 21 questions. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. A score of 11-16 indicates mild mood disturbance; 17-20 for borderline clinical depression. 21-30 for moderate depression; 31-40 for severe depression; and over 40 for extreme depression. The useable age range for it has been expanded to 13-80 years of age.

What are other commonly used depression scales?

- The Hamilton Depression Rating Scale – is dependent on the rater's skills in asking the questions.

- The Cornell Depression Scale is used for older people who have a cognitive impairment. It works better with people who have mild to moderate cognitive impairment, but can be used with information coming from family or caregivers for people with significant cognitive impairment. (Holroyd & Clayton, 2002)

9. Where Do We Start?

Begin by Acknowledging People's Fears, Lack of Knowledge, and Resignation

Fear: Many older adults fear letting others know that they are depressed. Depression is still a very stigmatizing mental health problem, and many older adults consider it as a personal failure because they have not been able to deal with it on their own.

It is important to build trust and rapport with the person, with the general rule being "Go slow, take care, and show caring". Recognize and address the stigmas associated with having depression and the stigmas of having an alcohol problem early on. Otherwise the older person will likely discontinue with the treatment or any other help being offered (Sirey et al, 2001).

People including family and service providers do not always respond positively to older adults who have been brave enough to say "I'm depressed" or "I'm struggling with depression". Some inadvertently treat the older person in a patronizing or condescending way. Educating older adults, their families and service providers about depression is very important, particularly by showing that depression in later life is common, and often treatable.

Take a Moment to Consider :

What is the best way to build trust and rapport with the person?

Lack of Knowledge: When service providers do not feel they have the necessary skills to help depressed older adult who has an alcohol problem, or if they do not know someone in the community who has those skills, they are more likely to feel helpless and treat the situation as hopeless. (Ignaczak, 2002) But as people learn

more about why alcohol problems develop in later life and learn about depression in later life, offering assistance in an effective way becomes easier for them.

Older adults who have depression and who also have an alcohol problem are frequently placed in an untenable position. They are often told by mental health workers “First, stop drinking. Get the alcohol problem under control, then we’ll help you.”

In other instances they may be told by addiction workers, “I can’t help you with your alcohol problem until your depression is treated.” In either of these situations it is very easy for older adults to “fall between the cracks” or not receive any real help until the depression has deepened even further and a crisis has arisen, making recovery that much more difficult.

The research and clinical practice is very clear: Both the depression and the alcohol problem should be addressed at the same time.

Resignation: Research also shows that while service providers may recognize the depression and suicidal risk in situations involving younger and older adults, they are less willing to treat an older suicidal person than a younger one. In one study using case examples involving older and younger persons who were suicidal, the physicians were

- more likely to consider an older patient’s suicidal thoughts as rational and normal; and
- less willing to use therapies to help the older patients.

The physicians also tended to not be optimistic that psychiatrists or psychologists could help the older suicidal patient. (Uncapher & Arean, 2000)

10. Do All Drinkers Become Depressed?

No. However, depression often goes hand in hand with alcohol problems, not simply with drinking. Drinkers who have never experienced alcohol problems tend not to develop symptoms of depression.

Research also indicates that people who experienced alcohol problems both before and after age 60 have the highest rates of depression. In other words, they are likely to become depressed again. It has been suggested if a person has had depression earlier in life (around ages 20 and 40), the person is more likely to develop depression in later life. (Reifman & Welte, 2001)

It is important to understand that stopping drinking does not stop depression from happening. Former drinkers who have previously had an alcohol dependence problem are four times as likely to have major depression as former drinkers who never had an alcohol problem. (Haslin & Grant, 2002)

11. How Does Depression Affect Older Adults' Health

In addition to the significant effects on the older adults' mental health, depression can be linked to changes in the person's physical health. Some medications used to reduce blood pressure (anti-hypertensives such as beta-blockers, reserpine, methyldopa, guanethidine, clonidine) can cause depression as a side effect of the medication. (Compton & Neneroff, 2000)

There is a strong and complex relationship between depression and heart disease, as well as depression and chronic pain. Depression left untreated can lead to heart disease. The National Institute of Mental Health (NIMH) notes:

> "Depression and anxiety disorders may affect heart rhythms, increase blood pressure, and alter blood clotting. They can also lead to elevated insulin and cholesterol levels. These risk factors, with obesity, form a group of signs and symptoms that often serve as both a predictor of and a response to heart disease."

12. What is the Role of Alcohol in Depression?

People are frequently told that alcohol is a "depressant" and may erroneously think that alcohol *causes* depression (makes a person become emotionally depressed). This is a misconception. For people who have been alcohol dependent for a long time, alcohol can have a toxic effect on their serotonin neuro-transmitters, but that does not necessarily lead to depression or anxiety. In other words, not all heavy or long time drinkers will become depressed. (Berrgren, et al, 2002)

It is more accurate to say that alcohol contributes to the development of depression. It does this in several ways:

A. Effect on Cortisol: Depression is related to the amount of serotonin and other neurotransmitters in the brain. Alcohol increases the amount of circulating cortisol in the brain. Cortisol, in turn, reduces serotonin levels as well as the other important neurotransmitters norepinephrine and dopamine that are integral to thwarting off depression. In general, when serotonin levels drop, depression can quickly settle in.

Acute alcohol exposure elevates serotonin levels in the brain (so, it may make the person feel less depressed in the short term). However, in the long term, alcohol exposure interferes with the neuro-transmitters. (Lovinger, 1999)

B. Exaggeration of Feelings: Alcohol influences the part of the brain responsible for coordinating the senses, perception, speech and judgment. It produces slurring of speech and errors in the thinking process. Although alcohol depresses bodily functions (for example, brain function, breathing, pulse rate), it often stimulates inhibitions. Emotions are more easily expressed because that part of the brain which enables us to control our behavior is depressed or relaxed, so the emotions become exhilarated.

A person's mood is exaggerated by the use of alcohol. Alcohol can increase anxieties and sadness. If a person is depressed while drinking, the person may become more depressed. Taking other drugs can increase the effect of both the alcohol and the other drug, especially if the other drug is also a central nervous system depressant, such as a tranquilizer or antihistamine.

Alcohol can act as a tranquillizer reducing stress for moderate drinkers. However, heavy drinking can increase stress, particularly when the drinker stops for a time or becomes tolerant to the effects**.**

C. As a Coping Mechanism: People who have depression or anxiety may drink an attempt to relax them and relieve the anxiety, agitation, feelings of emptiness or other negative feelings they are experiencing. (Carpenter & Hasin, 1999) As the feeling of depression deepens, the more the person may drink to try to escape or numb the overwhelming feelings of sadness, hopelessness, and despair. Alcohol becomes a form of "self-medication".

D. Increased Vulnerability: Some people seem to have a lower serotonin level to begin with. Early onset alcohol problems in men seem to be tied to having decreased serotonin activity. (NIAAA, 1997)

E. Alcohol as an Intermediary in Depression: Alcohol stresses blood sugar control and can cause episodes of hypoglycemia (low blood sugar). (NIAAA, 1994) As well, alcohol disrupts sleep. Both of these factors increase the risk and the severity of depression.

13. What are Effective Strategies for Helping Seniors Who Are Experiencing Both Alcohol Problems and Depression?

A. At an Agency and Community Level

Many service providers may spend considerable amounts of time trying to separate out “Is it the alcohol or is it the depression?” and in the end, may do nothing. Doing nothing is often harmful to the older person.

Begin by Removing Barriers: Many mental health services and addiction services inadvertently create barriers for older adults who are depressed when they have policies that state: “We won’t treat you if you are drinking.” When this happens, older adults will often simply be left to struggle on their own with the despondency caused by depression. (Oslin et al, 2000).

Older adults can face other barriers to receiving appropriate services if a service provider does not understand the nature of depression or the treatments for it. For example, people are sometimes turned down for detoxification services because they are on an anti-depressant (“You have to be off all drugs; you can’t take any drugs while in here”). It is important for service providers to understand the need to maintain the person on the anti-depressant for the person’s health, just as they would for anti-hypertensives to keep the person’s high blood pressure under control.

Working collaboratively can lead to successes (see below). Because depression in later life is complex and because it can imitate or mask other problems such as dementia, it is helpful to work with others who have the geriatric or mental health skills to help identify if the presenting symptoms are depression or something else.

Develop a good link to person in mental health system. Mental health teams are a fairly common resource in many communities. If there is geriatric mental health worker, link up with them. They can be a valuable resource and allay.

B. Working with the Individual

Contact

- **Use outreach (visiting the person in their home) whenever and wherever possible.** An older person who is experiencing depression and an alcohol problem is unlikely to just call you up and say “Hi. I think I need help. May I come to your office?”
- **Build trust and rapport.** An older person is unlikely to admit being depressed unless they trust you. Many times it involves gradually unearthing the issue.

- **Understand the strength it takes the depressed older person** to pick up the phone to call you or make it to your office; to get dressed for a home visit; to wash the dishes. Acknowledge these efforts; complement it.

  An older person once described being depressed in this way:

  "It's like wearing a 75 lb helmet, or carrying that kind of weight on each of your hands. That's what it is like when I'm depressed. Thinking, doing, …everything becomes so much harder."

- **Give people hope that the situation will get better.** The fact that you are there and are involved can help to move the person in the right direction.
- **Reinforce the positive.** Let the person know when you are seeing improvement in their situation. They are often the last one to see the change.
- **Validate the person's experiences and feelings**, but do not try to problem solve for them.

Identification

- **Identify the depression early and begin to address it as soon as possible.** This helps the person from sinking into a deeper depression.
- **Be respectful and considerate in your dealings with the person:** People with depression are often very sensitive to indications from others that they are somehow not worth the effort. A person is not respectful if not listening, allowing the phone to interrupt the session, or if the person makes promises that are not kept.
- **Don't be afraid to ask.** Ask the older adult "Do you ever feel that life is not worth living? Have you thought of harming yourself?" You are not giving an older person the idea to kill himself or herself or making them despondent; you are acknowledging these feelings happen, and are an uncovering otherwise hidden issue.
- **Watch for the subtle signs of depression relapse**; for example, putting on an act of being "up", pretending they are fine.

Reducing Harms

- **Encourage the older adult to reduce drinking** Getting the person to reduce the consumption even moderately will help the level of depression (Oslin et al., 2001)

Use of Medications

- **Recognize the concerns the older person may have about the use of anti-depressants.** Although an older person may be drinking to self medicate his or her depression, some actively resist anti-depressants "because that's a drug".

- **Help the person understand the ways that anti-depressants work.** Explain that these medications are not like taking an aspirin for a headache. Anti-depressants do not give immediate relief. It takes time for the body to have enough of the chemical circulating to make a difference.

- **If the older adult is on an anti-depression medication, encourage him or her to stay on it.** It typically take several weeks for the medication to "kick in."

- **Re-assess**. If the particular medication does not seem to be working after 4- 6 weeks, or if there are important side effects negatively affecting the person, work with the person and the physician to find another anti-depressant, or a combination of medications that will work.

Education and Skill Building

- **Help the older adult to identify successful coping strategies** they have used at other points in life. (Watt& Cappeliez, 2000)

- **Recognize the person may need new coping skills and help them develop new ones too**. It can be harder for an older person to use the same coping skills when his or her body doesn't work the same as years ago. (e.g., someone who used to take a long walk to make them feel better, but who can now no longer walk very far.)

- **Work with the older adult to enhance support.** Help the older adult to have others around who will be good reflections for them; people they can safely share their feelings with. When the older adult is isolated, the chasm is greater.

- **Avoid giving simplistic advice** – (such as "Why don't you get some exercise? It will help you".) While it is true that exercise can help moderate a person's mood, the decreased activity is part of the cycle of depression. An older person who is depressed may intellectually know how to do it or what needs to be done, but often does not know how to carry it along.

  Service providers may not realize how devastating it is to be to be given platitudes when a person is depressed (e.g., someone who says "Get a good night sleep, you'll feel better"). These responses are condescending to the older adult, and show that the other person really does not understand.

- **Educate the older adult** to recognize their personal symptoms of depression early on to help avoid depression relapse. (e.g., sleeping days on end)

14. What Are Some Effective Ways for Treating Depression in Later Life?

Having both an alcohol problem and depression at the same time can complicate helping the older adult significantly. However there is growing evidence that the best possible outcome occurs when successful treatment of depression is combined with reduction of alcohol use. (Oslin et al, 2000a)

What Works

It is important to recognize that for depression, “One size does not fit all”. Research indicates that a combination of counselling and medications works best. For major depression, counseling helps reduce the symptoms while the anti-depressant medication takes effect. (King & Markus, 2000)

- **Good Assessment:** This is critical. Know what you are dealing with.
    - Find out the person’s history of depression.
    - Find out the person’s history of drinking. Have a good understanding of how much the person is drinking
    - Find out how long the current symptoms of depression have been there and how severe they are.
    - Rule out other causes for the symptoms, such as other medical conditions or medication side effects. Rule out everything else that mimics or causes depression. If it is another cause, see that it is being properly addressed.
    - Ask whether the person is suicidal. Continue to re-asses for suicidal thoughts. In some cases as the person starts getting better, they are in a better position to carry out a suicide plan.
- **Counselling:** Depression can be caused by a number of psychological factors in the person’s life, and as the depression increases, more and more negative thinking intrudes. Cognitive therapy and other types of counselling may help break that cycle to help improve person’s outlook to a more optimistic, resourceful one. Counselling can also be helpful to educate older adults to recognize personal signs and symptoms. Having depression is highly stigmatizing for some older adults. Counsellors can acknowledge this and address the stigma early on by normalizing the condition (letting older people know it is not uncommon to feel this way, and that with help, things can improve for them). (Sirey et al, 2001)
- **Information for family.** Normalize depression. By that we mean, let family members know that depression is a common disease especially for older adults

and that it is very treatable. Help given them realistic expectations about the course of the depression.

- **Nutrition:** Certain vitamins, minerals, amino acids, or fatty acids (for example, tryptophan Vitamin B6, *and* omega 3 fatty acids are used by the body to make and use serotonin). If these are deficient (the older adult is not consuming enough of them or is not absorbing them well), this can increase the likelihood of depression. Nutrient deficiencies can be determined by dietary analysis and by testing of blood, urine, and hair samples.

- There is considerable research on the role of folate in depression and dementia (Alpert & Fava, 1997; Lindeman, Romero, & Koehler, 2000). Studies suggest that folate deficiency may occur in up to one third of patients with severe depression, and that treatment with the vitamin may enhance recovery of the mental state. (Bottiglieri, et al. 2000)

- **Antidepressants:** These medications are quite effective for many people (60 -75% of the time), but the medications often take several weeks to have an effect. An ant-depressant medication that works for one older person will not necessarily work for another, so finding the right anti-depressant is often involves a trial and error process. Certain antidepressants are recommended for older adults, and other must be avoided because of their serious side effects.

There are three categories of drugs that are used commonly used to treat depression: Tricyclic anti depressants (TCAs); Mono Amine Oxidase (MAO) Inhibitors; and - Selective Serotonin Reuptake Inhibitors (SSRIs) (e.g., Zoloft, Paxil, Prozac, Luvox). There are four other compounds that do not fall into the traditional three categories: bupropion (Wellbutrin), nefazodone (Serzone), venlafaxine (Effexor), and mirtazapine (Remeron).

SSRIs have fewer side effects because these drugs are designed to only affect the serotonin level in the brain and leave the rest of the neurotransmitters unaffected. They tend to be considered safest for most older adults. SSRI are relatively free of cardiovascular and other side effects associated with the MAO inhibitors and TCAs. (King & Markus, 2000)

According to the Merck Manual of Geriatrics, the usual starting dose in otherwise healthy older patients is typically one half the usual adult dose. However, it has been suggested that there is no need to adjust the dosage of SSRI sertraline (Zoloft) for older patients solely based on age. (Muijsers, Plosker, & Noble, 2002)

Serzone is being tested in a small scale study at the University of Texas Southwestern Medical Centre to examine its usefulness for concurrent depression and alcohol dependence. (Dhanani, n.d.)

Avoid the Common Mistakes

There are several common mistakes made in the use of anti-depressants for older adults:

- too high an initial dose, which leads to serious side effects, so that the person wants to stop;
- inadequate trial period (e.g. an older adult who is given four different medication trials in four weeks. None of these drug trials is adequate to judge their potential efficacy.) A minimum of 4-6 weeks is needed to conclude that a particular medication has not worked.
- inadequate dosage, and
- too brief use of the medication to continue maintenance to prevent depression relapse. (Medscape)

15. Which Anti-Depressant Medications Work Well When a Person is Drinking and is Depressed?

SSRIs are typically the type of anti-depressant prescribed to older adults who continue to drink. (Atkinson and Misra, 2002) SSRIs work in a different way than the tri-cyclic anti-depressants.[1] The SSRIs either have little effect when combined with alcohol or they may mildly antagonize the depressant effects of alcohol (See, Preskorn).

There is evidence that Fluoxetine, in particular, is effective for decreasing both the depressive symptoms and the drinking among people who have a major depression and an alcohol use disorder. (Cornelius, in press)

SSRIs can have side effects. For example, they cause ongoing insomnia, which is likely to interfere with the person's ability to recover from depression.

[1] Alcohol taken in conjunction with some tricyclics such as Tofranil (Imipramine) or Prothiaden may actually worsen the person's depression. Combining either with alcohol can lead to increased sedation, confusion or delirium, particularly in older adults.

16. What Else Helps?

What helps? Depression in later life tends to be more likely to improve when

- all the people involved have a common definition of the problem ("What is causing this for Harry?");
- the service providers have taken the time with the older person to develop a trusting, therapeutic relationship;
- where there is a personalized treatment plan that includes the older person's preferences (for example, an older adult might indicate "Yes, I would like to try an anti-depressant medication to see if it will improve things", "No, I don't believe in medications", or "Not right now"; or might say "Yes", "No", or "Not right now" for counselling or support groups);
- where there is proactive follow-up with the older person both in a supportive role and to determine if the approach being taken is working for this person; and
- where there are protocols for what is referred to as "stepped care" (if one approach or medication isn't working, following a plan to change the dose or type of medication, adding other therapies to existing ones).

Both self-management therapy and educational group therapy are beneficial adjuncts to the use of medications. These help the older adult learn more about the causes and triggers of his or her depression and give the person additional skills to manage the condition on a daily basis (Rokke, et al, 2000)

Dealing with Losses

- **Recognize that alcohol has often been a good (and sometimes only) friend to the older person.** Giving up drinking means losing that companion. It is another thing that the older person has to "grieve" (come to terms with that loss).

17. What About the Help of Family?

Depression affects not only the individual but those close to him or her ("All Together Now: How Depression Affects Families", Health Canada, & CMHA).

Family members' understanding of the condition, and their interpretation of the reasons for the older person's action or inaction can have a significant effect on how well supported the older person is while actively dealing with depression or in watching for signs of relapse. Educating family on depression and educating them about alcohol problems in later life can be as important as educating the older person on it.

Critical or demanding interactions from friends and family increase the likelihood of depression in later life. (Seeman, 2000)

18. How Well Do Depressed Older Adults Do?

A. Often, Quite Well

A four year Canadian study showed that 70% of the older adults on antidepressants did well, and the depression did not recur. (Flint & Rifat, 2000). Depression was more likely to recur when it took the depressed older person a long time to begin to respond to treatment and where the older person had high levels of anxiety before starting treatment.

It can be harder for older adults to completely recover from depression than younger adults, but that is largely because older adults with depression also have physical illnesses, or dementia. However for many older people, treating their depression can lead to improvement in their functional limitations as well as the activities of daily living that keep them independent. (Oslin et al, 2000b)

In December, 2002 the Journal of the American Medical Association reported a large scale study called IMPACT (Improving Mood-Promoting Access to Collaborative Treatment). Working with 1801 depressed older adults, it involved a depression care manager collaborating with primary care practitioners, patients, and specialists (Unützer, Katon, et al., 2002). The control subjects only received the anti-depressant.

By the end of one year, 45% of the IMPACT participants had a 50% decrease in their depression, compared to 19% of the control group. The IMPACT patients also reported being more contented with their treatment, they experienced more reduction of functional loss and an improved quality of life compared to patients who received conventional treatment.

However even in the IMPACT study, only 25% to 30% of the seniors became completely free of depressive symptoms. The researchers felt that might have been due to greater medical co-morbidity than younger people face (the seniors had an average of 3.2 chronic medical illnesses and 65% were living with chronic pain). (Unützer, Katon, et al., 2002).

B. Address the Pain Too

Older adults can experience emotional pain with intense feelings of hopelessness and despair when they are depressed. It is important to recognize and address these feelings in a positive way that does not downplay what the person is feeling.

At the same time, in later life chronic pain (e.g. lower back pain, arthritis) and depression are frequently linked. Just as depression in later life gets treated by some service providers as “normal”, so does chronic pain. Many people erroneously assume that physical pain and aging go hand in hand or they may minimize the amount of pain that the older adult is experiencing. There are a lot of mistaken assumptions that older people who develop alcohol problems will necessarily become dependent on pain medications.

It is important to help the older adult find ways to relieve the underlying chronic pain, otherwise the alcohol problem and/ or the depression is likely to recur. There are three keys to successful pain intervention: access to appropriate pain treatment, coordination of care between pain medicine specialists and primary care physicians, and the use of rehabilitation services that improve self-care and health maintenance activities. (Gallagher et al, 2000)

C. When Everyone Has Tried Their Best

In some cases the depression or the alcohol problem may never improve despite people’s best efforts. In these circumstances, it is important to work with family, helping them to understand that the older adult may never regain her or his former level of activity. Sometimes the only realizable “success” is family supporting the person at a lower level of functioning. It is important for family to not see this as a personal failure.

19. How Do Older Adults Who Have Alcohol Problems Fare When Treated for Depression?

This is the good news. Many do quite well.

In a relatively recent large scale study of 2666 older persons hospitalized for depression, 11.1% were drinking before admission, and 3.5% were drinking daily. At follow-up, the patients in the “excessive drinking” category at admission had the greatest improvement in functioning. Overall, 80% of those who were drinking at the time of admission reduced their drinking by more than 90% during the follow-up period. (Oslin, et al. 2000, a)

20. Why Are People Concerned About the Concurrent Use of Alcohol and Antidepressants?

Alcohol affects the way that many anti-depressants are metabolized. In general, acute intoxication inhibits the antidepressant drug's metabolism, whereas chronic abuse (without intoxication) induces the drug's metabolism. (Cadieux, 1999). As noted earlier, some anti-depressants are safer than others if the person is drinking.

In the best of worlds, older adults are forthright with their physicians and physicians are willing to help depressed older adults who continue to drink. In the real world, some older adults know that their physician may not prescribe them anti-depressants if they are drinking and so they don't tell their physician that they are. Some self monitor their alcohol consumption by not drinking within a window of time before or after taking the anti-depressant.

People are sometimes concerned that the person will use the anti-depressants in combination with the alcohol to commit suicide. However, the more appropriate practice may be to continue to monitor their response to the anti-depressant as well as the suicide risk, rather than deny depressed older persons access to medication therapy that can be beneficial. The suicide risk of untreated depression among older adults is high.

21. How Can We Prevent Depression Relapse?

It is very important to work with the older person towards preventing a relapse into a depressed state. One of the ways of doing this is to help the person work on psycho-education, relaxation and concentration training, social skills training, and cognitive training.

This includes helping them understand their depression better, to use old coping skills and learn new ones, and helping them begin to build new supportive people and roles into their lives.

Appendix A

Signs of Depression in Older Adults that May Be Confused With Dementia.

Features of depression in later life masquerading as dementia

- depressed affect/mood
- neuro-vegetative signs (e.g., insomnia, weight loss, and decreased appetite, energy and sexual drive)
- slow, monotonous speech , doesn't say things to people voluntarily
- gap in time between your question and their answer
- frequent "I don't know" responses
- quick to give up, but persists with encouragement
- disoriented
- impaired attention/distraction
- incomplete responses
- forgetfulness - particular deficits in learning new information, although memory may be patchy
- poor abstract thinking
- typically makes errors of omission (leaving things out), vs. errors of commission (filling things in)
- is aware of his or her cognitive difficulties
- may have concern over memory deficits - "Do I have Alzheimer's? See, I can't remember anything!"
- if psychosis, delusions typically nihilistic, self-deprecatory, paranoid
- no signs of not being able to speak (aphasia), apraxia, or not knowing people (agnosia)
- greater similarity to subcortical dementias, such as Parkinson's disease.

Appendix B

Geriatric Depression Scale

This scale was developed as a basic screening measure for depression in older adults. Created in the early 1980s by Yesage & Brink, the original scale is in the **public domain**.

MOOD SCALE

(short form, with scoring)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**

2. Have you dropped many of your activities and interests? **YES** / NO

3. Do you feel that your life is empty? **YES** / NO

4. Do you often get bored? **YES** / NO

5. Are you in good spirits most of the time? YES / **NO**

6. Are you afraid that something bad is going to happen to you? YES / NO

7. Do you feel happy most of the time? YES / **NO**

8. Do you often feel helpless? **YES** / NO

9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO

10. Do you feel you have more problems with memory than most? **YES** / NO

11. Do you think it is wonderful to be alive now? YES / **NO**

12. Do you feel pretty worthless the way you are now? **YES** / NO

13. Do you feel full of energy? YES / **NO**

14. Do you feel that your situation is hopeless? **YES** / NO

15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score of greater than 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

Questions 1, 3, 6 and 7 have been validated in short-short form of the scale.

Appendix C

Identifying Drinking Problems in Seniors

Although there are several different tools around to help gauge whether the person has a drinking problem, most have been developed with the younger person's situation in mind. That means they may not correctly identify the older person as having a problem. * See Seeking Solutions "Identification " for more information.

Avoid only looking at the quantity and frequency of the person's drinking. More importantly, look at the person's health, functioning and whether alcohol is having a negative impact on their life. It is the effect, not the quantity of the alcohol that is the relevant consideration for seniors.

Harmful or hazardous older drinkers who are most often undetected by existing tools include drinkers who also have

- concurrent health problems,
- functional impairments,
- medication use, and
- people who report binge drinking.

Consider ... the Drinking Level, Drinking Pattern and Medication Use

Often an older person may feel uncomfortable talking about his or her alcohol consumption, particularly if the person feels you are drawing conclusions about them as a person.

Introduce the questions about alcohol into a place that works for them. If the questions seem to upset the person, place those questions in the broader context of sleeping, eating, and smoking habits. Determine any medications the person is on, as there are many negative interactions between anti-depressants and drugs commonly prescribed to older adults.

Ask ...

- About things that are changing in the person's life- changes in their health, death of people who are important to them, anxiety about other events.

- About how much they are drinking.

- Whether they occasionally have a drink to help them go to sleep.

Depression Resources for Seniors

- **All Together Now: How Depression affects Families**. Canadian Mental Health Association & Health Canada (1999). Online at:

  www.hc sc.gc.ca/hppb/childhood youth/cyfh/pdf/together.pdf

  Geared more to younger families but useful information for both families and persons who have depression.

- **NACA "Dealing with Depression"** Online at.

  www.hc sc.gc.ca/seniors aines/pubs/expression/13 3/exp13 3_2e.htm

  Good down to earth explanation about depression for older adults.

- **Depression: You don't have to feel this way** (Ask Your Family Doctor Series), College of Family Physicians of Canada. Online at: www.cfpc.ca/programs/education/pated/depression.asp

Resources for Service Providers

B.C. Partners for Mental Health and Addictions Information. The Primer: Fact Sheets on Mental Health and Addiction Issues. Online at: www.healthservices.gov.bc.ca/mhd/pdf/primer.pdf

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