Chapter 6
Depression in Elderly Women: Clinical Challenges

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Abstract Geriatric depression is one of the commonest problems seen in the elderly populations. Men and women are equally inflicted with the disorder. This disorder aims to look at the unique clinical challenges posited by women that suffer from depression. There are unique socio-demographic variables and environmental factors that contribute to depression in women. Multiple factors like hormonal factors and menopause play a role in the genesis of depression in elderly women. This is coupled with factors like death of a spouse, loneliness, and the empty nest syndrome. There are also challenges in the accurate detection and management of depression as well as the long-term management of the disorder. It is also important to look at the overlap and differences between depression and dementia in women. The chapter highlights specific clinical aspects of depression in elderly women and highlights future research needs for the same.

Keywords Depression · Elderly women · Dementia · Loneliness · Geriatric depression

Introduction

Depression is among the leading cause of mental health problems and disability with work loss in the world and is a serious public health problem among geriatric populations (Lépine & Briley, 2011). Geriatric depression is equally common in men and women, and many seek help from primary care physicians as they have a large number of medical problems that complicate their physical condition (Watson & Pignone, 2003). When treating patients with geriatric depression, it is prudent to address not only their mental health problems but also to treat their acute and chronic medical conditions that are common and that coexist with depression (Fountoulakis et al., 2003). Depression in the elderly is often chronic and persistent, and recurrent research studies have demonstrated that geriatric depression can be treated

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effectively when mental health professionals and treating physicians provide effective consultation and collaborative care together (Cole, 2005). In this chapter, we will provide a contextualized overview of geriatric depression in women and discuss trends in geriatric depression noted specifically in relation to women and recommend future directives for the effective management of geriatric depression in women in the community.

Epidemiology of Geriatric Depression in Women

In community settings, studies have noted that above the age of 65 years, about 5–10% of adults meet the clinical diagnostic criteria for major depression (Ganguli et al., 2006) and 8–25% have probable subsyndromal depression (Jain & Aras, 2007). Recent epidemiological data show overall rates of depression to be similar between developed countries and developing countries, but the rates in the elderly tends to increase with age in many developing countries (Papadopoulos et al., 2005). The rates of geriatric depression increase to 12–30% in psychiatric wards and 50–60% for nursing homes and old age homes with long-term care (Seitz et al., 2010). Depression has been seen to be equally distributed in both genders, and more men come for help than women. It has also been noted that geriatric depression in women is often considered to be normal, and they are not brought to a mental healthcare facility for treatment (Alexopoulos & Kelly, 2009). Specific epidemiological data that highlight differences between geriatric depression trends in men and women are sparse, and hence, firm conclusions cannot be made.

Geriatric Depression in Women in Underdiagnosed

Depression is very common in elderly women and is often under-detected, underdiagnosed, untreated, and undertreated in most cases. Studies have shown that primary care physicians successfully detected only 40–50% of depression among older adults (men and women), and this was less than the rate at which they were successful in detecting depression among younger adults (Djernes, 2006). Many women with geriatric depression did not receive effective treatments for depression, and this leads to poorer outcomes and further serious public health problems. Studies on suicidality in geriatric cohorts have found that during the year prior to a suicide attempt, just 4–8% of the elderly had been diagnosed with depression before the attempt and only 57–65% received treatment even after the attempt (Meeks et al., 2011). The barriers to effective late-life depression treatment in women are at a patient, physician, hospital, and healthcare system level. Many women with geriatric depression present with somatic rather than emotional complaints, deny the presence of depressed mood, and thus decrease the likelihood of being diagnosed with depression (Wuthrich & Frei, 2015). Many elderly women with depression resist a diagnosis of

depression and often attribute symptoms to many physical causes or as a part of aging rather than depression or psychological factors (Park & Unützer, 2011). The stigma associated with seeking psychiatric help, lack of awareness among the patient and doctors, and poor compliance to any treatment has been also identified as barriers to elderly women receiving care. Lack of specialized geriatric care services, time pressure, inadequate knowledge about diagnosing geriatric depression, and lack of psychosocial orientations and poor insights into different clinical presentations of geriatric depression may also hamper diagnosis (Wetherell & Unützer, 2003). The lack of mental health coverage in many healthcare policies, limited availability of geriatric mental health specialists, and inadequate continuity of care also affects the outcome of geriatric depression in women (Sarkisian et al., 2003).

Factors Implicated in Geriatric Depression in Women

Risk Factors

The risk factors for developing depression in women after the age of 65 is akin to those in young adults. Female gender is a risk factor to develop depression. Apart from that being single, widowed, belonging to the poorer strata, the presence of chronic physical or medical illnesses, social isolation and loneliness, presence of a family history of depression, and past history of depression when younger are all important risk factors. The other important factors for women include early death of a spouse, the following loss, and grief with caretaking responsibilities. The presence of any cognitive impairment, age greater than 70 years, a lack of or poor social support, presence of substance or alcohol abuse, and lower educational level are also a risk factors for depression in elderly women (Maurer, 2012; Rajkumar et al., 2009; Weyerer et al., 2008).

Protective Factors

Protective factors for geriatric depression in women include good social and family support, being busy and active with social activities such as volunteering for a good cause and regular physical activity. Religiosity and spirituality may play protective roles in many older women with depression and may serve as a protective factor from worsening of depression and from suicidality. This may help them negotiate personal losses and life's challenges, reducing the risk and severity of depression. Religion is interlinked mental health via social connectedness, good social support derived from taking part in religious and associated social activities, and belonging to prayer and religious groups. Religion may also serve to reduce guilt associated

with depression in elderly women (Marty et al., 2010; Roh et al., 2015; Yaka et al., 2014).

Spousal Loss and Grief

All over the world, millions of women lose their spouse each year, leaving many million widows that may constitute 5–12% of the population (Galatzer-Levy & Bonanno, 2012). The death of a spouse is associated with reduced mental and physical health, increased suicidality, and medical problems leading to non-suicide mortality and reduced finances (Williams, 2005). Major depressive disorder, substance abuse, anxiety and panic disorders, and post-traumatic stress disorder are common within the first year of a spouse's death in elderly women. A total of 29–58% of widowed women meet criteria for major depressive disorder at one month, while 25–40% meet these criteria at three months after the death of a spouse (Sikorski et al., 2014). Spousal loss is an extremely stressful experience for women, and widowhood leads to higher rates of depressive symptoms in older women than in the general population (Alpass & Neville, 2003). Many older women may experience far more devastating losses like the death of their children and sometimes the death of grandchildren either due to accidental or medical causes that can be far more traumatic and cause depression of a greater severity in those affected (Catalano, 2005).

Depression in Women Who Are Caregivers

The risk of depression is higher in older women who are taking care of someone with serious medical or cognitive impairments (Covinsky et al., 2003). The caregiving process is a burdensome and complex one, and the burden from caregiving can compromise the physical health of the individual and increase the risk for medical morbidity and mortality both physical and psychological (Sanders & Adams, 2005). Depression is common in older women that are caregivers for spouses or relatives or parents with dementia or any other major mental illness (Epstein-Lubow et al., 2008).

Depression in Women with Medical Illnesses

A total of 65–90% of older women have one or more chronic medical illnesses and around 15–20% women may have more than four medical conditions coexisting together. These medical conditions often interact with each other and impair the quality of life of the patient. Rheumatoid arthritis, osteoarthritis, hypertension, diabetes, heart disease, hearing impairment, urinary incontinence, thyroid problems,

cancer, visual problems, and stroke complicate the picture in elderly women (Birrer & Vemuri, 2004). Medical illness is an established risk factor for depression in the elderly (Niti et al., 2007). Conversely, comorbid depression in elderly women has shown to be associated with increased morbidity and mortality, prolonged recovery, and negative prognosis among those with medical problems (Lyness et al., 2006).

Several biological mechanisms have been proposed to explain the relationship between depression and comorbid medical illness which is bidirectional and far more complex than what any single theory can encompass (Himelhoch et al., 2004). Depression in elderly women also leads to poor adherence and compliance to treatments, poor physical activity, dietary deficiencies, and poor quality of life in general. Depression in elderly women thus affects the outcome and prognosis of coexisting medical conditions as well (Drayer et al., 2005).

Clinical Features of Geriatric Depression in Women

The diagnosis of geriatric depression faces substantial challenges. This is due to the ensuing biological changes in the aging brain, comorbid physical and medical illnesses, developmental trajectories due to aging itself, and heterogenous symptoms at first presentation (Sözeri-Varma, 2012). Thus, these patients present substantial diagnostic and clinical challenges. The phenomenon of geriatric depression in women are often attributed to normal aging itself, spousal loss and grief reactions, onset of dementia, and poor quality of life due to medical illnesses, and thus, many women may thus not undergo treatment for an eminently treatable health problem (Lapid & Rummans, 2003).

Older women with depression may always not fit the typical picture of depression and many may never report symptoms such as sadness or low mood. The presence of loneliness, anhedonia, avolition (lack of will), multiple unexplained physical or somatic symptoms, chronic fatigue, and vague symptoms may all be seen. These symptoms are always attributed to medical conditions that are underlying and stressful life events (Yates et al., 2004). These patients may not be receptive to psychological interventions and may not be positive about occupational therapy or psychotherapy when offered as a treatment. They may refuse antidepressant medication, and this may be due to their low self-esteem and feeling that nothing is going to work for them (Heok & Ho, 2008).

In older women with medical illness, depressive symptoms may be undiagnosed because they are thought to be due to or as a result of the concurrent medical illnesses. The symptoms of depression such as fatigue, loss of appetite, sleep disturbances, lack of attention and concentration, and lack of appetite are all seen in chronic medical illnesses (Alexopoulos et al., 2005). Many studies have found a strong relationship between depressive symptoms in elderly women and chronic physical pain (Forlani et al., 2014). Although pain may be an indicator for depression, we must mention that not all pain signifies geriatric depression as many medical conditions in old age are painful by nature. Untreated physical pain is a bad prognostic indicator of treatment

response in geriatric depression, and an effective pain management is a must for successful alleviation of depression (Hegeman et al., 2012).

Subsyndromal Depression in Elderly Women

Many older women with clinically significant depressive symptoms do not meet the clinical diagnostic criteria for major depressive disorder or dysthymia. The presence of clinically significant non-major forms of depression like minor depressions and subsyndromal depression is common in elderly women. The reason that these women do not meet diagnostic criteria for depression is either lesser symptoms or lower duration of symptoms (VanItallie, 2005). It is important to detect this subsyndromal depression in elderly women as they are at a high risk for the subsequent development of major depressive disorder with suicidal thoughts and also sustain a fair degree of functional impairment and poor quality of life (Chopra et al., 2005). There is a scarcity of literature on the diagnosis and management of subsyndromal depressive conditions, and clinicians are confounded on how to diagnose the same.

Treatment of Geriatric Depression in Women

Many older women are less likely to access adequate mental healthcare services than their younger counterparts and may receive poor care as well. Poor treatment adherence and compliance are other factors that affect the management of the condition. Geriatric depression in women is a very treatable condition if effective treatments are provided, with remission rates of 50–75% shown in studies (Crystal et al., 2003). Antidepressants and/or psychotherapy is recommended as the first-line treatment, and a combination always works better than both treatments individually (Alexopoulos, 2005).

Early Detection and Diagnosis

Geriatric depression in women as mentioned earlier is often undetected, undiagnosed, and undertreated. There are many simple rating scales and tools available for the screening of patients with depression in the elderly. Using a single question, like, "*Do you often feel sad or depressed?"* to which the patient is required to answer either "yes" or "no" was tested and found to help in early detection of cases (Lenze, 2003). Such brief screening methods can be easily administered by general physicians or nurses during a routine health checkup. There are many established rating scales for geriatric depression that may be used, and these include the geriatric depression scale (GDS) (Wancata et al., 2006), the nine-item patient health

questionnaire (PHQ-9) (Löwe et al., 2004), and the Beck Depression Inventory scale (Wang & Gorenstein, 2013). These can also be used to clinically monitor the patient weekly and assess improvement with various treatment modalities. On detection, it is prudent that appropriate referrals be made and the patient receives treatment immediately.

Managing Patient Adherence and Compliance

The use of health services by elderly women is a variable that depends on location, socio-demographic, clinical, financial, and many social factors. The presenting complaint, symptoms, mobility, medical problems, and lack of social support are other factors that affect patient compliance. The great amount of negativity and myths that surround psychiatric intervention also plays a role in the regularity with treatment (Ayalon et al., 2005). The nature and approach of the mental health professional handling the psychiatrist plays a vital role in the same as well. Many older women may in general find it difficult to engage in therapy and also complete a proper course of medication as prescribed. Researchers have suggested several methods to increase treatment adherence among older patients with depression which are—(Alexopoulos et al., 2008).

(a) Personalizing treatment of depression to improve adherence
(b) Identify the risk factors that may contribute to poorer treatment outcomes
(c) Develop comprehensive care algorithms that shall target these populations.

Supportive family members play a vital role in treatment adherence and compliance to treatment. Many elderly women stop medication prematurely, and poor social support is a critical predictor of adherence (Zivin & Kales, 2008).

Approach to the Treatment of Geriatric Depression in Women

There is a need for algorithmic approach in the management of geriatric depression in women. Simple approaches are started first followed by more complex approaches as simple approaches may fail. Behavioral activation approaches like pleasant event scheduling, physical or social activities. A variety of psychotherapeutic interventions play a role in the management of geriatric depression. Self-help interventions with brief psychotherapy and cognitive behavior therapy also must be applied (Wilkins et al., 2010). Sound psychoeducation about pharmacological interventions along with the correct choice of antidepressants is prudent in the management of geriatric depression. Most patients can be treated on an outpatient basis, while some patients may need inpatient admission to assess them in detail. Stigma reduction must also be applied where necessary (Mackin & Arean, 2005).

Collaborative Care in Women with Geriatric Depression

There is a need for a team approach for the management of geriatric depression in women. This has been applied in the US, UK, many European countries, and Australia. The core tenet of collaborative care and the team approach is that general physicians work closely with a mental health professional to treat depression in elderly women (Chang-Quan et al., 2009). A case manager like typically a nurse, social worker, or a psychologist is responsible for assessing a patient's needs, coordinating appropriate levels of treatment, monitoring treatment adherence and compliance, family psychoeducation, and assessing treatment outcomes. This will ensure regular follow-up and shall also handle the multifaceted needs of depressed older women. The case manager works with the mental health professional by educating patients about depression, coaching patients in behavioral activation like pleasant event scheduling and supportive counseling techniques (Adli et al., 2006).

Health Care Issues that Must Be Addressed

Certain groups of elder women are at a high risk for not receiving treatment. These groups include older women with low socioeconomic status, poorer education, women living alone, and those who are residents in old age homes. The level of satisfaction with the neighborhood environment, availability of transportation, and economics are important determinants of depression among older women (Wuthrich & Frei, 2015). Many older women may have difficulty in coordinating clinic visits and reaching the clinic due to lack of transportation and reduced mobility in general. Cultural beliefs and practices of mental health and attitudes toward depression care also serve as a barrier in many women. Many patients may have less faith in the neurobiological causes of depression, are more doubtful about the efficacy of antidepressant medications, and show stronger pull toward counseling rather than drug treatments (Lawrence et al., 2006).

Evidence suggests that treatment for depression that offers both pharmacological and non-pharmacological treatment options can increase the use of treatments and improve health outcomes in older women. There is no one form of treatment and one must individualize the treatment to meet the specific needs of patient, combining multiple treatments and meeting the preferences of individual patients and families (Bartels et al., 2004).

The Role of the Family

A large number of young adults provide mental health care to their elder family members and those with depression need more care than other elderly. Family

members of depressed older women may experience certain levels of caregiver stress, extra burden, and burnout during the caregiving process. There is a need to support family caregivers of depressed older patients as this may serve to help both the patients and family caregivers. Families have a huge role in improving healthcare utilization by the elderly, monitoring treatment adherence, and positive treatment outcomes while they also shall manage the coexisting medical disorders that may be present (Taqui et al., 2007). Older women with good social support are less likely to be in hospital or in old age homes. Good family support is protective and beneficial to the patient and are predictors of outcome and mortality in depression (Aylaz et al., 2012). By providing support to patients and family members with managing depression and navigating the healthcare system, we may be able to prevent negative health outcomes in both the patients and their family members (Routasalo et al., 2004). Studies have demonstrated the effectiveness of education for elder adults and their family members, including a psychoeducational workshop for elderly with recurrent major depression and providing psychotherapy and counseling for both families and the patient (Horowitz et al., 2003).

Specific Areas that Need to Be Addressed

Need to Create Awareness About Geriatric Depression

There is a need for the community and patients as well as caregivers to be made aware of the problem of geriatric depression. Very little attention is anyways given to the mental health of the elderly and recognizing depression is a major challenge. Patients who are started on treatment for geriatric depression often get no information about the nature and long-term goals of treatment (Schulz et al., 2005). Many patients thus drop out of treatment and do not follow up for the entire duration of the treatment. Depression management and screening must be a part of regular medical care of elderly women and must be addressed when they come for the management of chronic medical conditions such as diabetes, hypertension, and other medical disorders. The need to integrate psychiatric treatments into mainstream medical geriatric care rather than segregate them shall go a long way to ensure that many elderly women with depression receive effective treatments (Prakash & Kukreti, 2013).

Training of Family Physicians and Mental Health Professionals

Psychiatric training in the assessment and management of late-life depression must be made an educational priority for family physicians and mental health professionals alike. They must be made equal members of collaborative and interdisciplinary teams that look after geriatric patients. The roles of psychiatrists in these teams vary from routine outpatient consultations and need training in new skills like individualized geriatric consultations, psychotherapy in the elderly, and dealing with patients in diverse medical settings (Lodha & Sousa, 2018). Mental health professionals, psychiatric nurses, social workers, and psychologists or counselors need to acquire new skills such as supporting medication management in geriatric depression, family psychoeducation, using rating scales for depression, and providing evidence-based brief psychosocial treatments in the elderly. A multidisciplinary team may include members from a broad range of disciplines with varying degrees of training, and they must all empower each other (Bartels & Naslund, 2013).

Overlap of Depression and Dementia

There is an evidence base to suggest that depression may be a future risk factor for the development of dementia (Leyhe et al., 2017). A past history of depression is known to exponentially increase the risk of developing dementia in both men and women. Studies have shown that a past history of depression nearly doubles the risk of developing dementia in the elderly. Neurobiologically, prolonged damage to the hippocampus due to hypercortisolemia states linked to stress and depression has been proposed to start a cascade that may later cause dementia like processes (Mast, 2005).

Many scientists feel that the geriatric depression may sometimes represent a predementia syndrome or that it serves as a start of cognitive decline in the elderly. Elderly men and women with depression go on to develop dementia within a few years after the onset of depression (Tagariello et al., 2009). Multiple genetic, vascular, familial, or environmental determinants also play a role. Depression can also unmask clinical cognitive impairment and serves to compromise existing cognitive reserves and allow the symptoms of dementia to be manifested behaviorally and cognitively earlier than they would have been seen (Pattanayak & Sagar, 2011).

Conclusions

Geriatric depression in elderly women in a complex and vexing problem. There are many specific factors that need to be considered when addressing the problem of

depression in elderly women. The chapter has tried to provide an overview of these factors and has outlined the risk and protective factors for geriatric depression in women, diagnosis and treatment needs, the need for awareness, and the overlap of depression and dementia that may happen. There is a need for future research into the gender differences in the genesis, coping, and symptoms of geriatric depression as well as treatment differences when it comes to elderly women. The lives of elderly women in modern society are multipronged, and when depression strikes, it needs to be addressed in a scientific and clinically sound manner.

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