Depression is a prevalent issue in older adults and often affects their quality of life. It's important to understand that it is not a normal part of aging.

BY SUSAN MIEDZIANOWSKI, Ph.D., CSA, CPC
Harry, age eighty-seven, was an avid gardener, and his tomatoes were always his pride and joy. He had suffered a stroke, and had been placed in a long-term care facility. He was withdrawn, refused to participate in physical therapy and had been diagnosed as depressed. One day, a friend came to visit and brought him a miniature tomato plant as a gift. One of the aides suggested that Harry help her replant the tomato into a bigger pot so it could grow. What was noted was that as the little plant grew, so did Harry’s interest and interaction. He cared for the plant, keeping it moist and turning the soil. Noting this new interest, a larger box was obtained and Harry planted more, and soon was “in charge” of most of the plant life in the reception area. Finding new meaning in previously enjoyed activities began to turn life around for Harry. He began to participate in physical and occupational therapy and was even known to sport a smile or two. As his tomato plant grew and bloomed, so did Harry.

The process of aging creates new and sometimes challenging experiences. These can include retirement, the death of loved ones, loss of mobility, and medical problems, all of which may lead to decreased mobility and increased isolation. The result of these changes may create a scenario ripe for depression. While clinical depression is a common problem among older adults, it is not a normal part of aging. And because it’s not always obvious, it’s often not recognized or is misdiagnosed.
Depression

Depression is one of the more prevalent issues in older adults and often affects their quality of life. The effects of depression are far more serious than being sad, feeling down, or in a “depressed mood.” Robinson, Smith, and Segal (2015) stated that depression “also impacts your energy, sleep, appetite, and physical health”. However, depression is not a normal part of aging. Frequently, older adults fail to recognize or acknowledge the symptoms or seek treatment. Robinson et al. (2015) state that there are multiple reasons why older adults do not recognize the symptoms, such as feeling there is a good reason to be sad, and assume that depression is a normal part of aging. They may fail to identify that their physical symptoms and complaints are signs of depression or don’t take the steps to get the help they need. Finally, they may not be able to or feel the need to ask for help. It is important to help families know how to recognize symptoms, where to go to address them, and how best to treat and manage this condition.

Morewitz and Goldstein (2010) noted that at least 25 percent of all nursing home residents suffer from depression. In the general older population, these authors also state that the risk of depression in older women is 10-25 percent and the risk for older men 5-12 percent, but the overall risk for older adults with chronic diseases increases to 25-33 percent. The onset of clinical depression in older adults may be affected by the presence of chronic diseases such as diabetes, hypertension, or COPD, for example. These chronic illnesses may affect both mobility and independence, creating a change in the way they live, view their situation, or are able to relate to others.

Each and every reaction, feeling, emotion, and thought generates electrical impulses within the brain. Since the brain is the command center for the body, it is important to understand how the various aspects of substances called neurotransmitters are affected in people with depression. These impulses travel from one nerve cell to another in less than 1/5,000 of a second, which allows the body to respond instantaneously—for example, to pain or temperature change (Biological 2013). According to Sapolsky (2004), there is evidence to suggest that depression involves physiological changes including abnormal levels of neurotransmitters—specifically norepinephrine, serotonin, and dopamine. These three neurotransmitters “function within structures of the brain that regulate emotions, reactions to stress, and the physical drives of sleep, appetite, and sexuality” (All About Depression 2013). Although it is accepted that neurotransmitter systems are pathologically involved, no specific neurotransmitter appears to be more responsible than the other. Additionally, patients with depression are also known to secrete excess levels of cortisol which is regulated by the pituitary gland and excreted by the adrenal glands.

MRI has been used to study those who are depressed, and results demonstrate that there is also reduction in the size of the hippocampus, which is located in the limbic system of the brain. The limbic system regulates activities such as emotions, physical and sexual drives, as well as the response to stress and mood regulation (All About Depression 2013, Frodl et al. 2006), as well as an increase in the size of pituitary volume. This is perhaps due to the increased production of cortisol-stimulating hormone. Reports of newer information posit a gene-environment interactive (GXE) relationship. Saveanu and Nemeroff (2011) state that the GXE relationship in depression is similar to the model present in other diseases such as cancer, hypertension, and diabetes. Finally, 30 percent of the risk of development of depression is thought to be heritable, while 70 percent influenced by the environment.

Again, it is important to remember that depression is not a normal part of the aging process, and the symptoms must be carefully and thoroughly evaluated by professionals. In addition, depression is not just about being sad, a character weakness, nor personal failing. It is a real disease, affects multiple areas of life, and can rob individuals of their perspective, quality of life, and their will to live, which can be exhibited by loss of hope and morale. Morewitz and Goldstein (2010) cited research in which older adults appear to be at a greater risk for depression as a result of vascular changes in the brain as part of the aging process. Depression accounts for more disability than any other disorder worldwide. Three partially overlapping symptom dimensions have been described that may be superimposed on the basic symptoms, including melancholic, anxiety, and physio-somatic dimensions (Maes et al. 2012).

The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) defines clinical depression as demonstrating at least five of the following symptoms that must be present for a minimum of two weeks. Additionally, these symptoms must represent a change from previous levels of functioning and that at least one of the symptoms must be either a depressed mood or the loss of interest or pleasure (Criteria 2014). The symptoms must not be able to be aligned to a medical condition, mood-incongruent delusions, or hallucinations. The stated symptoms include:

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (feels sad...
or empty), or observation made by others (appears tearful).

• Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

• Significant weight loss when not dieting or weight gain (a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day.

• Insomnia or hypersomnia nearly every day.

• Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

• Fatigue or loss of energy nearly every day.

• Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

• Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

• Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (Criteria 2014).

Additional observations noted by the National Institute of Mental Health (2014) state that the depressed person may also display the following signs:

1. Talking about feeling trapped or in unbearable pain
2. Talking about being a burden to others
3. Increasing the use of alcohol or drugs
4. Acting anxious or agitated or behaving recklessly
5. Sleeping too little or too much
6. Withdrawing or feeling isolated
7. Showing rage or talking about seeking revenge
8. Displaying extreme mood swings

One issue faced by many older adults is the loss of someone close to them, or even the prospect or reality of surrendering their driver’s license, can affect their independence or mobility. Based on these factors,
many seniors experience increased sensations of isolation. This feeling may also be a result of the grieving process, and for many, it becomes a challenge to distinguish between normal grieving and the issues brought on by clinical depression (Johnson et al. 2015). Even the perception of social isolation can become a struggle for many seniors (Stevenson 2014).

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When working with families, it is important to remember that the grieving process has no timetable, but those who are grieving can exhibit a wide range of emotions ranging from deep sadness to the ability to laugh and enjoy the company of others. Families should also be aware of symptoms such as a deep pervasive sense of guilt, suicidal ideation, feelings of worthlessness and without hope, the inability to function at work or in the home (different than before) and in some cases hallucinations (Johnson et al. 2015) of suicide or a preoccupation with dying.

It is also possible that a person’s depressive symptoms could be a result of polypharmacy interactions. Those who are on multiple medications are at a higher risk for depression. “While the mood-related side effects of prescription medication can affect anyone, older adults are more sensitive because, as we age, our bodies become less efficient at metabolizing and processing drugs” (Johnson et al. 2015).

Madeline had been the leader of the scrapbooking club in her town until her rheumatoid arthritis made it too difficult to create the images on paper. As the pain and debility increased, she became withdrawn and depressed, no longer wanting to participate with the group. One day, her granddaughter asked her to help create a project for school about her family, and to use some of the pretty things she made to frame them. Madeline helped her place the pieces to create the perfect pages. Over time, she found that teaching and helping provided her much joy. She began volunteering at a local school helping children learn the fun of scrapping.

Depression and Quality of Life
Steiger and Kashdan (2010) state that our ancestors faced challenges of survival that were best met through participation with reliable others in a social group, and acceptance in that group improved the survival rates. This innate need has not changed. Those individuals suffering from depressive symptoms are posited to react more strongly to threats of social exclusions which in turn affect their well-being and quality of life.

Depression has been reported to also have an effect on the quality of life of the affected individual. Quality of life (QOL) is a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life (Damron-Rodriguez and Carmel 2014). What makes quality of life challenging to measure is that, although the term has meaning for nearly everyone and every academic discipline, individuals and groups can define it differently. Being able to see a card drawn by a grandchild is quality of life to some, while maintaining the ability to maintain an active lifestyle is quality for another.

Although health is one of the important domains of overall quality of life, there are other domains as well—for instance, jobs, housing, schools, the neighborhood. Aspects of culture, values, and spirituality are also key aspects of overall quality of life that add to the complexity of its measurement. Nevertheless, researchers have developed useful techniques that have helped to conceptualize and measure these multiple domains including quality, will to live and satisfaction and how they relate to each other. The will to live and life satisfaction in older adults are affected by those diagnosed with clinical depression.

According to Damron-Rodriguez (2014), the variables related to will to live, quality of life and depression are “psychosocial, depending upon one’s religiosity, subjective well-being, self-esteem, fear of death, quality of life, and living arrangements.” Additional factors include overall health status, number and severity of chronic illnesses, and disability. Depression has also been determined to be a factor although the ability to cope and adapt and the influence of social support may affect depression and increased mood may affect quality of life and will to live.

Additionally, Blando (2011) notes that there is evidence to support that a positive affect and participation in pleasurable activities are associated with more positive self-ratings of health and improved quality of life. This can be challenged in those with depression.

Carmel, Shrira, and Shmotkin (2013) discussed the overall will to live concept as it relates to life satisfaction (quality). They note that the will to live reflects the outcome of the thinking process that considers quality, meaningfulness, and worthiness of living and has, in previous research, been found to be strongly associated with mental health. Those older adults with a high will to live are continuously motivated
to search and find meaning and satisfaction in their lives despite various losses. It is posited, therefore, that those who are clinically depressed may not be able to do so. Sapolsky (2004) concurred in that he felt that the phenomenon of will to live is related although not caused by depression.

Karppinen et al. (2012) in their longitudinal study, concluded that although in terminal illness, certain factors such as depression were associated with the will to live, this phenomenon and depression were two distinct concepts. Damron-Rodriguez and Carmel (2014) stated that “the will to live not only reflects one’s general well-being, but also the motivation to hold on to life.”

Summary and Conclusion
Depression in older adults is a complex issue with causation stemming from many factors and presentation of symptoms often masked by disease processes or medication side effects. The symptoms of depression have a significant influence on health and the ability to function and quality of life. Brenes (2007) summarized this well, saying that “quality of life among depressed adults is more impaired than that of adults with diabetes, hypertension, and chronic lung disease.”

Steger and Kashdan (2009) in their study posit that older adults who demonstrate more intense depressive symptoms report more negative social interactions. They also experience a more intense reaction to them as well as lower satisfaction in their need to belong to family or social interactions. In their conclusions, they proposed that finding the new need to belong often promotes mood and increases satisfaction, quality, and meaning in life. This approach provides increased possibilities to work with older adults such as Harry, who was helped with the garden, or Madeline who was able to redefine her passion into teaching others.

It is important for qualified professionals to help older adults and their caregivers find the right combination of therapy and meaning to manage and reverse the depression, and improve quality of life. ☉CSA

REFERENCES


Susan Miedzianowski is a faculty member for SCSA and chair of the CSA Journal editorial board. With more than forty years in the health care industry, she is an assistant professor of gerontology at the University of Phoenix, Detroit campus, and teaches online courses at several universities. She holds a bachelor’s degree in nursing, a master’s degree in health care administration, and a Ph.D. in human services. Contact her at smiedz@yahoo.com.