Older Adults Depression and Suicide Facts

Depression, one of the most common conditions associated with suicide in older adults, ¹ is a widely underrecognized and undertreated medical illness. In fact, several studies have found that many older adults who die by suicide—up to 75 percent—have visited a primary care physician within a month of their suicide. ² These findings point to the urgency of improving detection and treatment of depression as a means of reducing suicide risk among older persons.

Older Americans are disproportionately likely to die by suicide. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates (when categorized by gender and race) were white men age 85 and older: 59 deaths per 100,000 persons in 2000, more than five times the national U.S. rate of 10.6 per 100,000.³

Of the nearly 35 million Americans age 65 and older, an estimated 2 million have a depressive illness (major depressive disorder, dysthymic disorder, or bipolar disorder) and another 5 million may have "subsyndromal depression," or depressive symptoms that fall short of meeting full diagnostic criteria for a disorder. Subsyndromal depression is especially common among older persons and is associated with an

increased risk of developing major depression.⁶ In any of these forms, however, depressive symptoms are not a normal part of aging. In contrast to the normal emotional experiences of

Older Adults...

Ask yourself if you feel:

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

Or if you are:

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

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

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

Depression is not a normal part of aging.

Talk to your doctor.



www.nimh.nih.gov toll free: 1-866-615-NIMH (6464) Mental Health FAX4U: sadness, grief, loss, or passing mood states, they tend to be persistent and to interfere significantly with an individual's ability to function.

Depression often co-occurs with other serious illnesses such as heart disease, stroke, diabetes, cancer, and Parkinson's disease.⁷ Because many older adults face these illnesses as well as various social and economic difficulties, health care professionals may mistakenly conclude that depression is a normal consequence of these problems—an attitude often shared by patients themselves.8 These factors together contribute to the underdiagnosis and undertreatment of depressive disorders in older people. Depression can and should be treated when it co-occurs with other illnesses, for untreated depression can delay recovery from or worsen the outcome of these other illnesses. The relationship between depression and other illness processes in older adults is a focus of ongoing research.

Both doctors and patients may have difficulty identifying the signs of depression. NIMH-funded researchers are currently investigating the effectiveness of a depression education intervention delivered in primary care clinics for improving recognition and treatment of depression and suicidal symptoms in elderly patients.⁹

Research and Treatment

Research has revealed varying patterns of clinical and biological features among older adults with depression.⁸ As compared to older persons whose depression began earlier in life, those whose depression first appears in late life are likely to have a more chronic course of illness. In addition, there is growing evidence that depression beginning in late life is associated with vascular changes in the brain.

Both antidepressant medications and short-term psychotherapies are effective treatments for late-life depression.8 Existing antidepressants are known to influence the functioning of certain neurotransmitters in the brain. The newer medications, chiefly the selective serotonin reuptake inhibitors (SSRIs), are generally preferred over the older medications, including tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), because they have fewer and less severe potential side effects.¹⁰ Both generations of medications are effective in relieving depression, although some people will respond to one type of drug, but not another.

Research has shown that certain types of short-term psychotherapy, particularly cognitive-behavioral therapy and interpersonal therapy, are effective treatments for late-life depression.8 In addition, psychotherapy alone has been shown to prolong periods of good health free from depression. Combining psychotherapy with antidepressant medication, however, appears to provide maximum benefit. In one study, approximately 80 percent of older adults with depression recovered with combination treatment. 11 The combination treatment was also found to be more effective than either treatment alone in reducing recurrences of depression.12

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

For More Information

National Institute of Mental Health (NIMH)

Office of Communications 6001 Executive Boulevard, Room 8184, MSC 9663

Bethesda, MD 20892-9663 Phone: 301-443-4513 or

1-866-615-NIMH (6464), toll-free TTY: 301-443-8431; FAX: 301-443-4279

FAX 4U: 301-443-5158 E-mail: nimhinfo@nih.gov Web site: http://www.nimh.nih.gov

All material in this fact sheet is in the public domain and may be copied or reproduced without permission from the NIMH. Citation of NIMH as the source is appreciated.

References

¹Conwell Y, Brent D. Suicide and aging. I: patterns of psychiatric diagnosis. *International Psychogeriatrics*, 1995; 7(2): 149-64.

²Conwell Y. Suicide in later life: a review and recommendations for prevention. *Suicide and Life Threatening Behavior*, 2001; 31(Suppl): 32-47.

³Office of Statistics and Programming, NCIPC, CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™): http://www.cdc.gov/ncipc/ wisqars/default.htm.

⁴Narrow WE. One-year prevalence of depressive disorders among adults 18 and over in the U.S.: NIMH ECA prospective data. Unpublished table.

⁵Alexopoulos GS. Mood disorders. In: Sadock BJ, Sadock VA, eds. *Comprehensive Textbook of Psychiatry, 7th Edition, Vol. 2.* Baltimore: Williams and Wilkins, 2000.

⁶Horwath E, Johnson J, Klerman GL, Weissman MM. Depressive symptoms as relative and attributable risk factors for first-onset major depression. *Archives of General Psychiatry*, 1992; 49(10): 817-23.

⁷Depression Guideline Panel. *Depression* in primary care: volume 1. Detection and diagnosis. Clinical practice guideline, number 5. AHCPR Publication No. 93-0550. Rockville, MD: Agency for Health Care, Policy and Research, 1993.

⁸Lebowitz BD, Pearson JL, Schneider LS, Reynolds CF 3rd, Alexopoulos GS, Bruce ML, Conwell Y, Katz IR, Meyers BS, Morrison MF, Mossey J, Niederehe G, Parmelee P. Diagnosis and treatment of depression in late life. Consensus statement update. *Journal of the*

American Medical Association, 1997; 278(14): 1186-90.

⁹Bruce ML, Pearson JL. Designing an intervention to prevent suicide: PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial). *Dialogues in Clinical Neuroscience*, 1999; 1(2): 100-12.

¹⁰Reynolds CF 3rd, Lebowitz BD. What are the best treatments for depression in old age? *The Harvard Mental Health Letter*, 1999; 15(12): 8.

¹¹Little JT, Reynolds CF 3rd, Dew MA, Frank E, Begley AE, Miller MD, Cornes C, Mazumdar S, Perel JM, Kupfer DJ. How common is resistance to treatment in recurrent, nonpsychotic geriatric depression? *American Journal of Psychiatry*, 1998; 155(8): 1035-8.

¹²Reynolds CF 3rd, Frank E, Perel JM, Imber SD, Cornes C, Miller MD, Mazumdar S, Houck PR, Dew MA, Stack JA, Pollock BG, Kupfer DJ. Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. *Journal of the American Medical Association*, 1999; 281(1): 39-45.

NIH Publication No. 03-4593 Printed January 2001 Revised May 2003



