

# Late Life Depression



Adi Shafir, MD

Thursday February 12, 2026

# Disclosures



- I have no disclosures
- This work is partially funded through the HRSA Geriatrics Workforce Enhancement Program (GWEP)
- My views do not represent the perspective of HRSA or the US Government
- Slides partially adapted from Laura Byerly, MD

# Session Objectives

By the end of this hour, you will be able to:

- Identify depression **risk factors** for older adults
- Describe how **depression symptoms** in older adults differ from younger adult patients
- Identify **risk factors for suicide** in older adults
- Describe existing **screening tools** for depression in older adults
- Describe initial pharmacologic and non-pharmacologic **treatment approaches** to older adults with depression
- Describe how a **team-based** approach helps treat depression in older adults



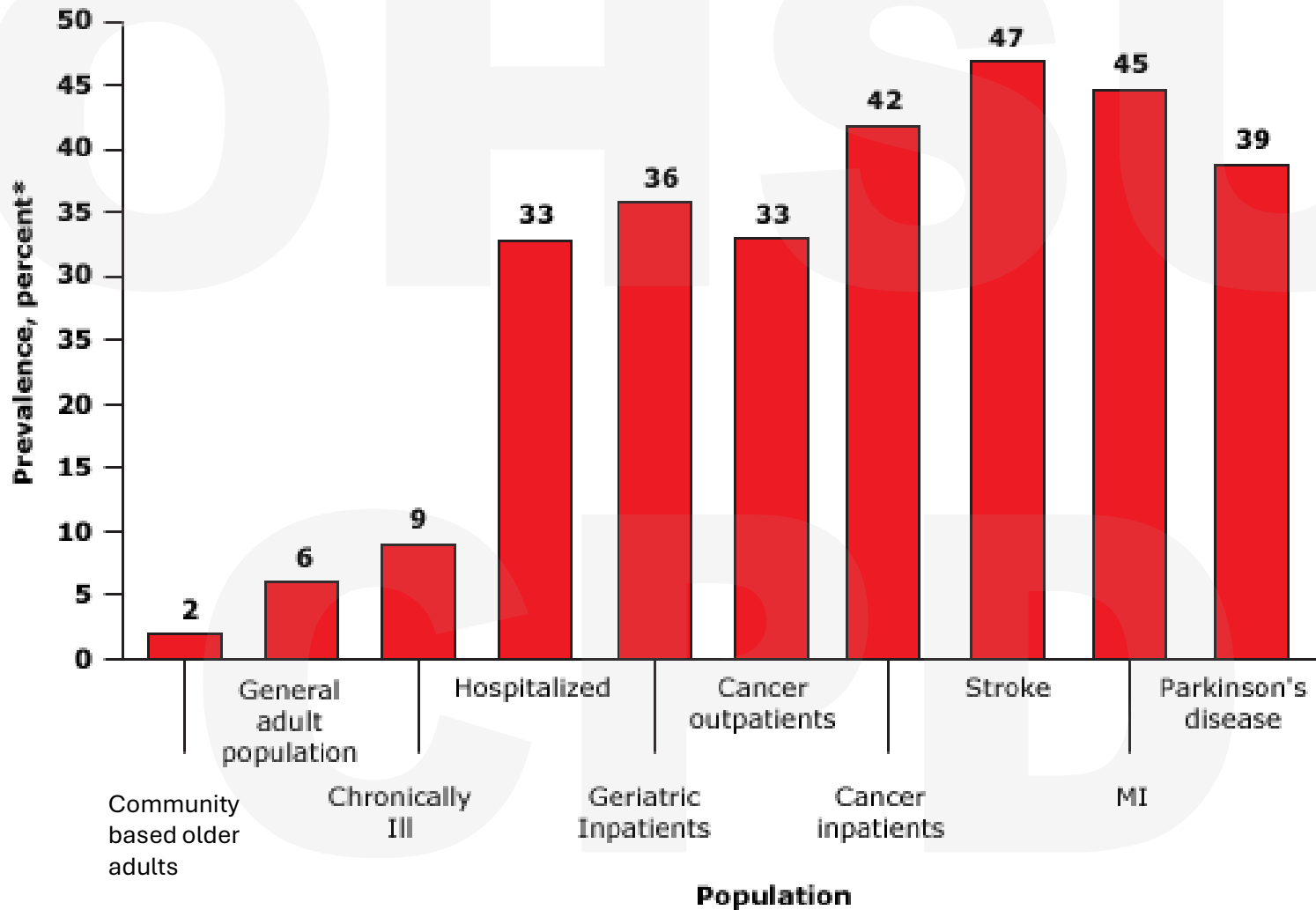
**What is late life  
depression and how is  
it different?**

OH  
SU  
CPD

# Why are we talking about this?

- Late-life depression (LLD) **increases incidence of medical morbidity** (1.5-3x)
- Cost! Up to **52% more expensive** in outpatient setting compared to non-depressed older adults
- Late-life depression is highly treatable
- Higher burden of impact on function and quality of life
- We do a bad job of identifying depressed older adults

# How common is it?



# How is late life depression different?

- Less sadness/blue feelings vs younger onset depression
- Late-life depression symptoms:
  - **Irritable**/frustrated
  - Lost ability to enjoy positive events
  - **Loss of interest** in activities (anhedonia)
  - Lack of energy/Fatigue
  - **Somatic complaints**
    - Poor sleep
    - Low appetite/weight loss
    - Pain
  - Cognitive slowing – “pseudodementia”
  - Psychotic symptoms (up to 10%)

# Depression symptom burden

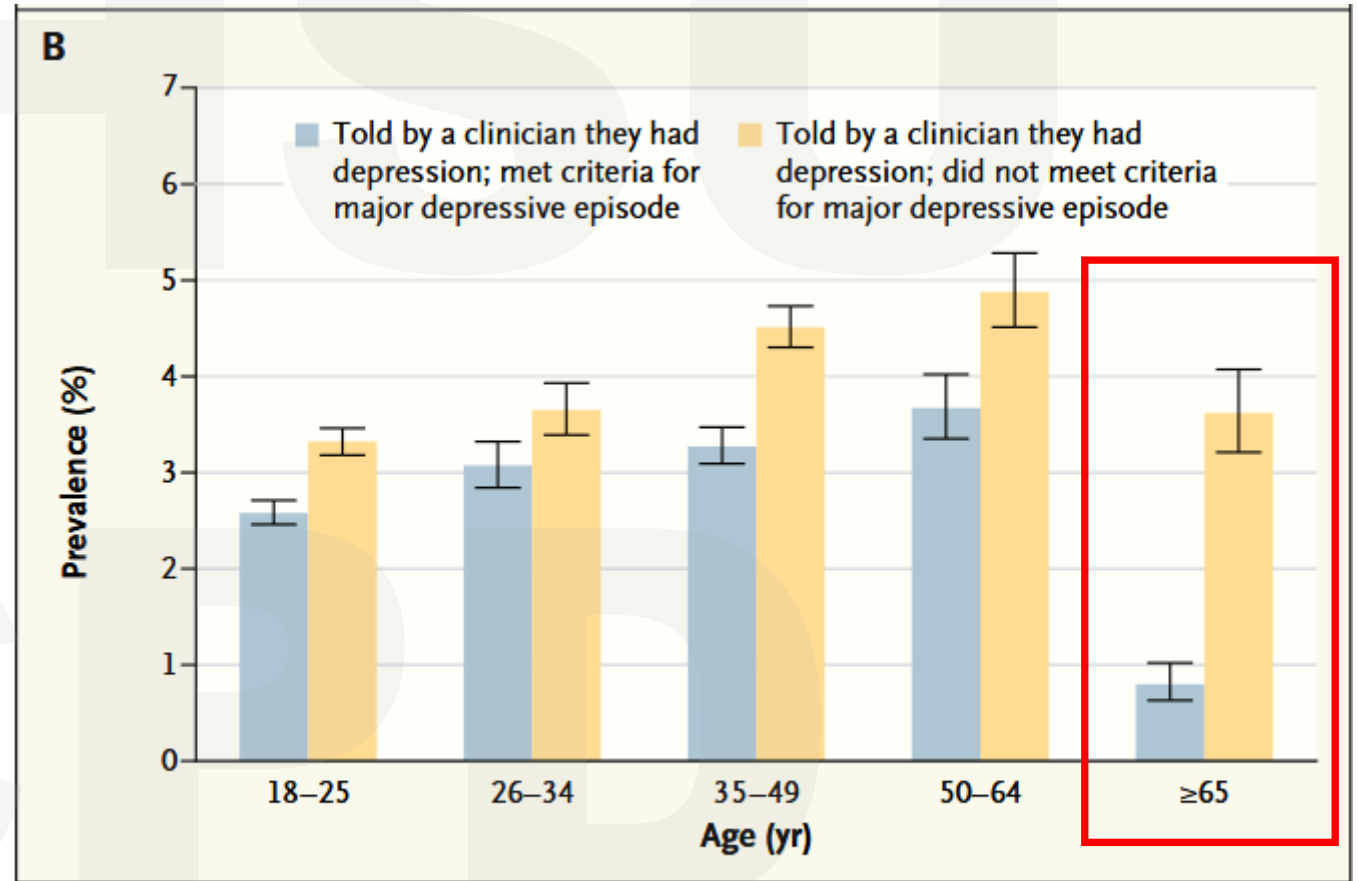
Categories of Reported Symptoms of Depression in Adults 65 Years of Age and Older; NHANES Depression Screener, United States, 2005-2010

	Did not experience symptom	Did experience symptom	Several days	More than 1/2 the days	Nearly every day
	%	%	%	%	%
Little interest in doing things	82.02	17.98	13.31	2.47	2.19
Feeling down, depressed, or hopeless	82.98	17.02	12.67	2.32	2.03
Trouble sleeping or sleeping too much	65.61	34.39	20.18	5.60	8.62
Feeling tired or having little energy	56.88	43.12	27.30	7.13	8.69
Poor appetite or overeating	85.86	14.14	8.64	2.80	2.69
Feeling bad about yourself	90.73	9.27	7.21	0.89	1.17
Trouble concentrating on things	90.19	9.81	6.73	1.16	1.92
Moving or speaking slowly or too fast	93.60	6.40	4.44	0.99	0.97
Thought you would be better off dead	97.55	2.45	1.87	0.28	0.31



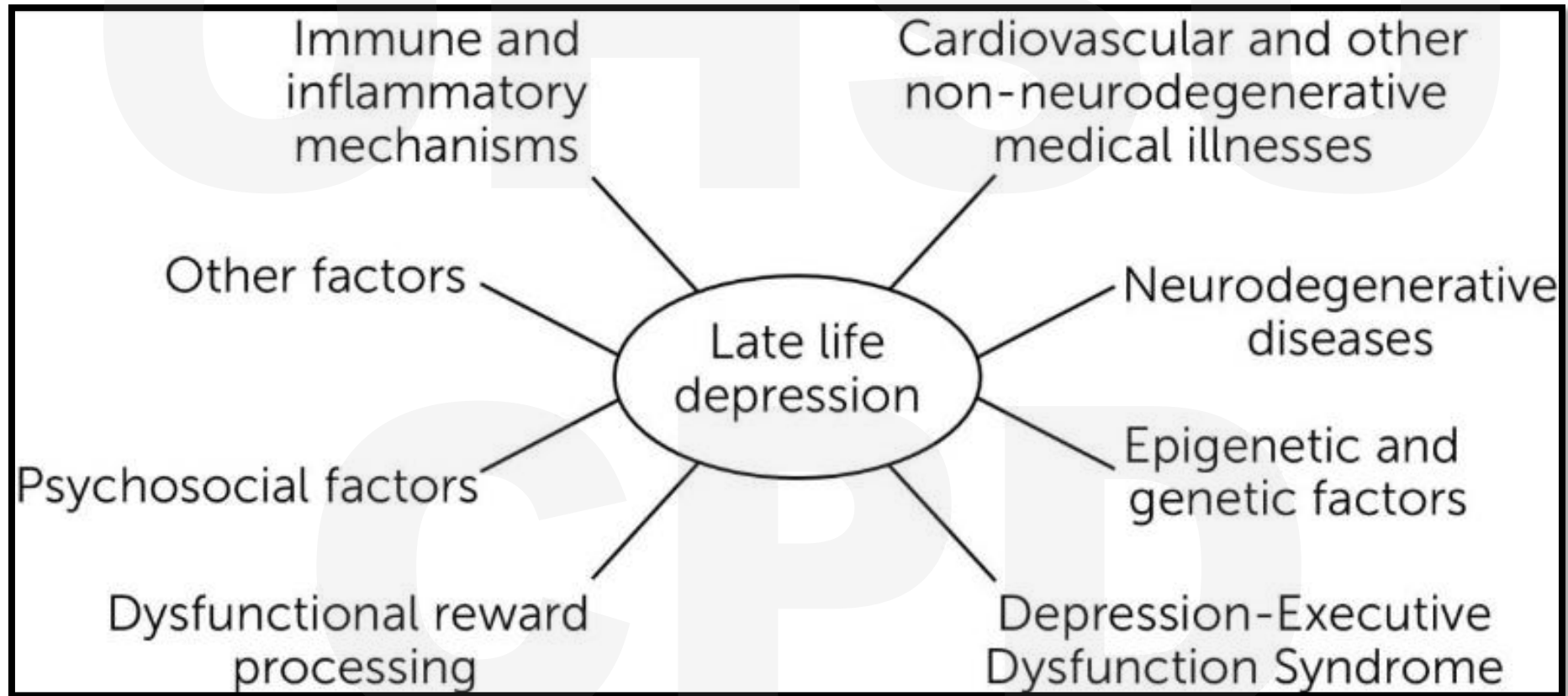
# Diagnostic quandary

- Many medical conditions can cause changes to sleep, concentration, appetite, and activity in later life
- Use of these symptoms alone may lead to over-diagnosis and false positive diagnosis



Prevalence of Major Depressive Episodes in Relation to Antidepressant-Medication Use and Clinician-Diagnosed Depression, 2005–2010.

# Unique pathophysiology – multifactorial

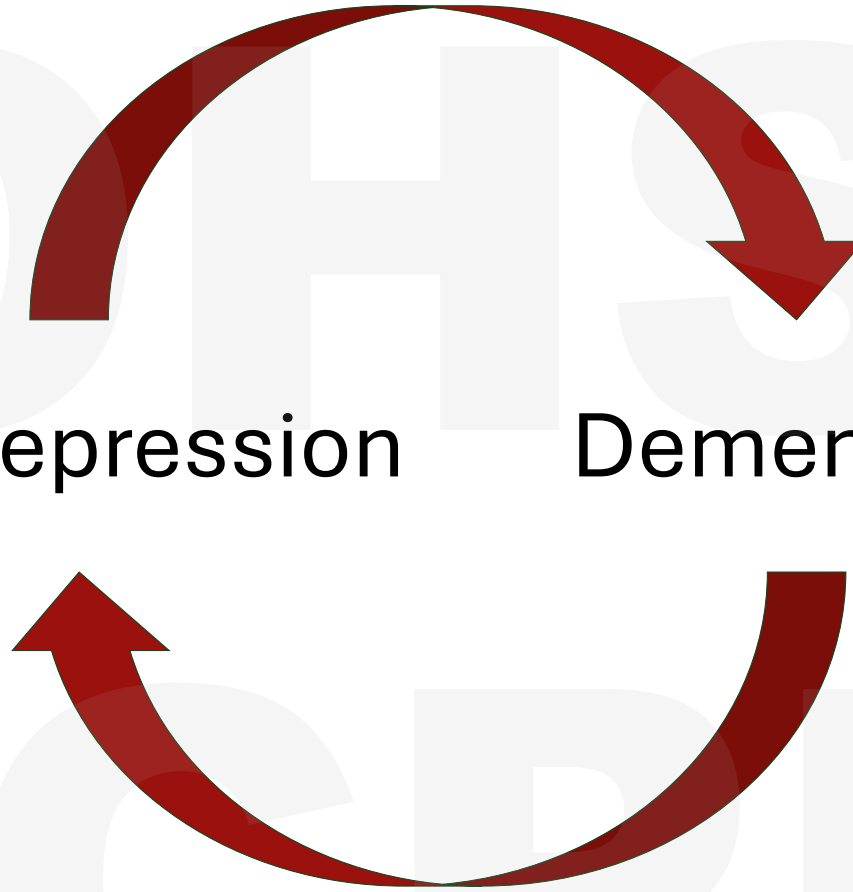


- Risk factor and manifestation of cognitive decline
- Associated with increased risk of dementia

Depression

Dementia

- Coexisting cognitive impairment is common
  - Impacts executive function, attention, and memory
- Cognitive deficits indicate brain changes that predisposes to and perpetuates depression



# Depression Executive Dysfunction Syndrome

## Executive Function:

- Planning
- Sequencing
- Organizing
- Abstracting



## Symptoms of DEDS:

- Apathy
- Anhedonia
- Suspiciousness
- Planning challenges
- Difficulties with goal setting
- Psychomotor retardation

*Predicts poor response to antidepressants and CBT*

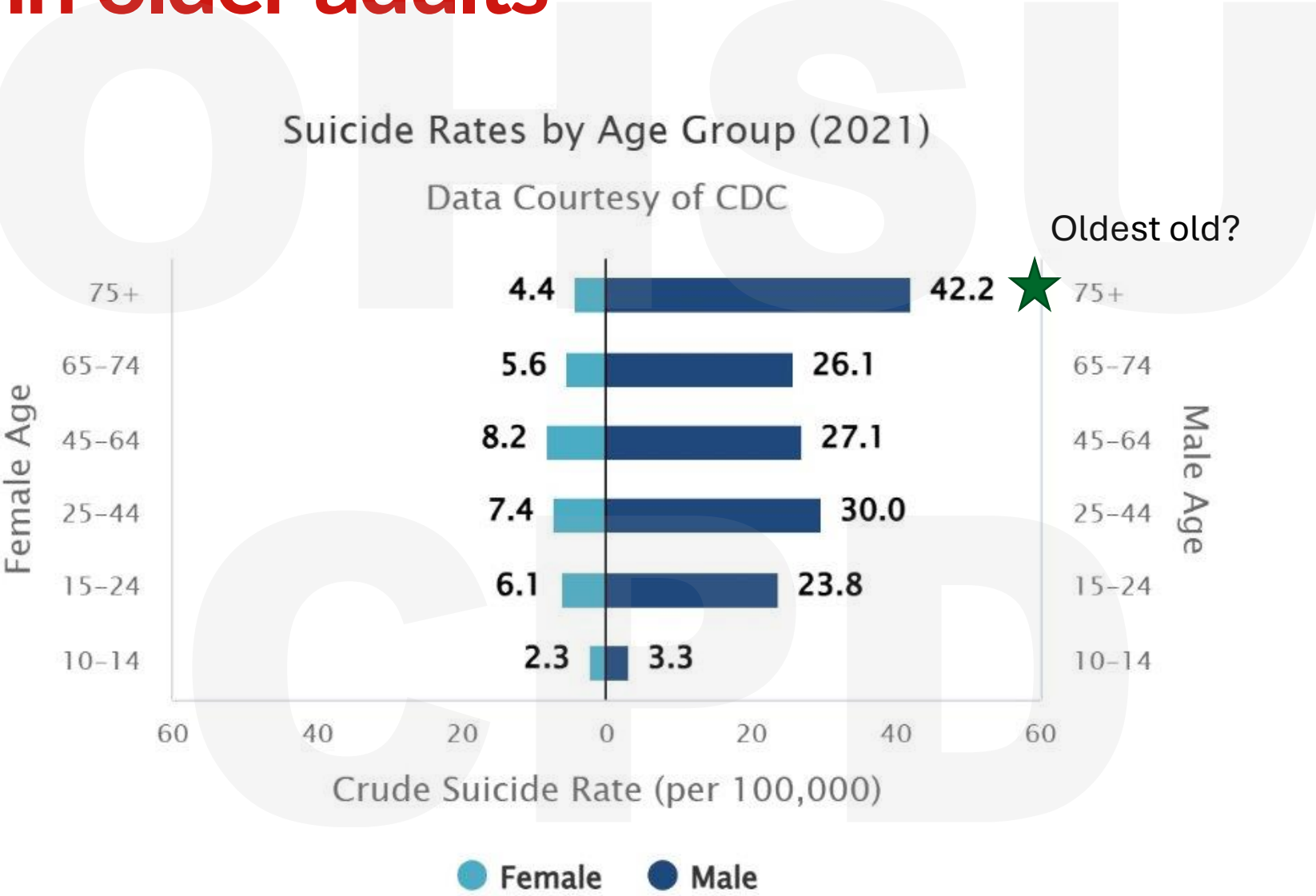
# Risk factors

Psychosocial	Medical/Physiologic
Unmarried status	Cognitive impairment/Dementia
Lack of social support	Cardiovascular Disease/Stroke
Caregiving role (approximately 25-50% of family caregivers experience depression)	Cancer
Lower socioeconomic status	Parkinson's disease
Lower household income	Lung disease
Living alone	Arthritis
Negative life events including bereavement	Sensory impairment (eg, hearing, vision)
Positive family history of depression	Diabetes mellitus
Prior depressive episodes	HIV-related illness
Prior suicide attempts	Substance abuse





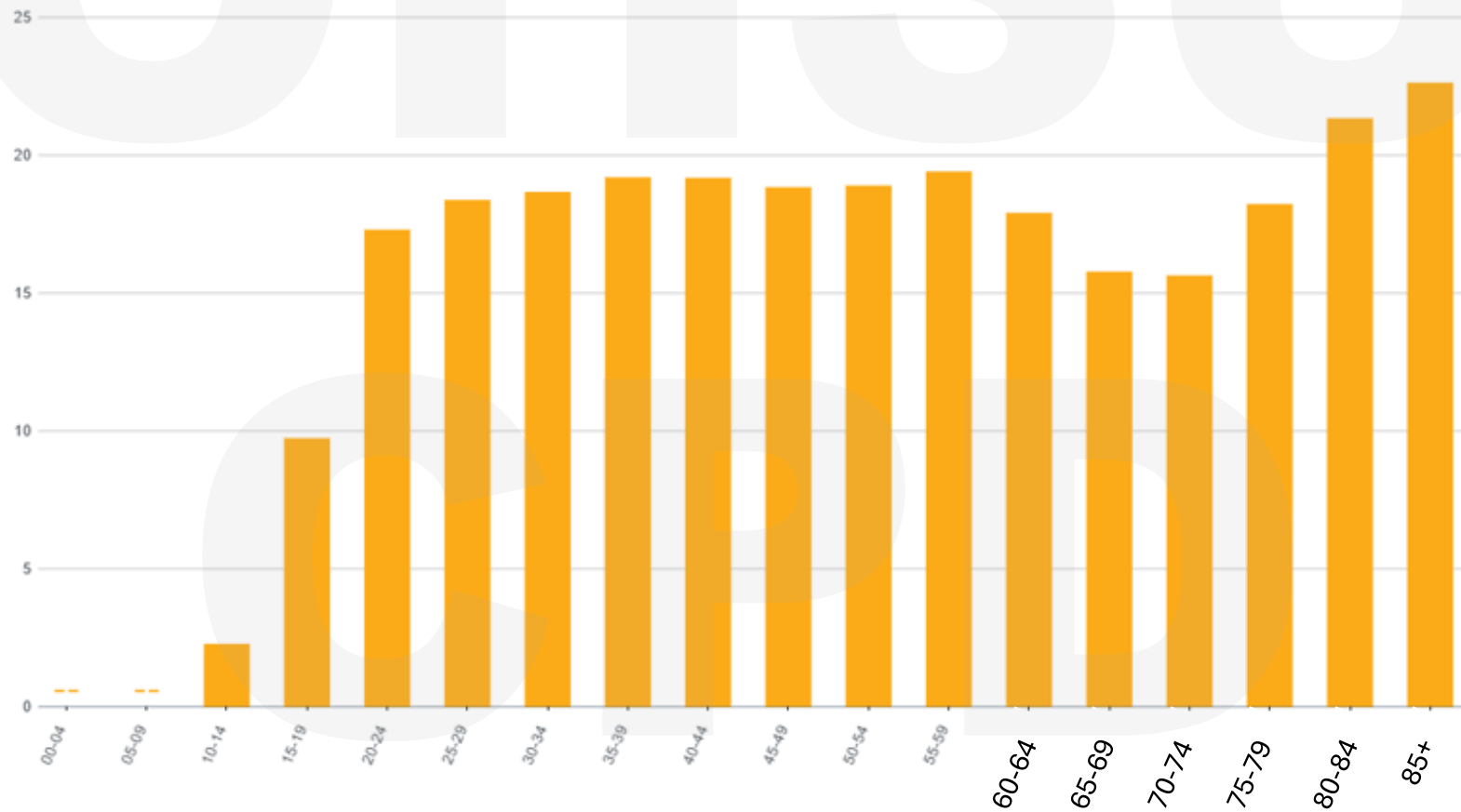
# Suicide in older adults





# Suicide in older adults

Distribution by Age



# Suicide in older adults

- Suicidal behavior is more **lethal** in later life
  - More frail (*more likely to die*)
  - More isolated (*less likely to be rescued*)
  - More planning (*more determination*)
- Firearms remain the most common method (60-65%)
- **Asking a patient about suicide** reduces risk of suicide

Source: Hasselberg, Rochester ECHO

# Risk factors for suicide in older adults

Age (particularly >85yo)

Identify as male

Isolation

Veteran status

Ethnicity/Race

Poor health

Financial worries/hardships

Family conflicts

Firearm access

OH SU  
CPD

How do you diagnose  
it?



# Diagnosis – Screening Tests

Screening tools for clinic:

- PHQ2 and [PHQ9](#)
- Geriatric Depression Scale ([GDS](#)) – yes/no questions
- [Cornell Scale for Depression](#) – longer interview
- Or just ask: “Do you often feel sad or depressed?”
  - Sensitivity 69-85%
  - Specificity 65-90%

# Screening – Geriatric Depression Scale

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing things?
10. Do you feel that you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

# Medications that may cause depression

## Cardiovascular drugs

Clonidine (Catapres)  
 Digitalis  
 Guanethidine (Ismelin)  
 Hydralazine (Apresoline)  
 Methyldopa (Aldomet)  
 Procainamide (Pronestyl)

## Propranolol (Inderal)

Reserpine (Serpasil)

## Thiazide diuretics

## Chemotherapeutics

6-Azauridine  
 Asparaginase (Elspar)  
 Azathioprine (Imuran)  
 Bleomycin (Blenoxane)  
 Cisplatin (Platinol)  
 Cyclophosphamide (Cytoxan)  
 Doxorubicin (Adriamycin)  
 Mithramycin (Mithracin)  
 Vinblastine (Velban)  
 Vincristine

## Antiparkinsonian drugs

Amantadine (Symmetrel)  
 Bromocriptine (Parlodel)  
 Levodopa (Larodopa)

## Antipsychotic drugs

Fluphenazine (Prolixin)  
 Haloperidol (Haldol)

## Sedatives and antianxiety drugs

Barbiturates  
 Benzodiazepines  
 Chloral hydrate  
 Ethanol

## Anticonvulsants

## Carbamazepine (Tegretol)

Ethosuximide (Zarontin)  
 Phenobarbital  
 Phenytoin (Dilantin)  
 Primidone (Mysoline)

## Anti-inflammatory/ anti-infective agents

## Ampicillin

Cycloserine (Seromycin)  
 Dapsone  
 Ethambutol (Myambutol)  
 Griseofulvin (Grisactin)  
 Isoniazid (INH)

## Metoclopramide (Reglan)

## Metronidazole (Flagyl)

Nalidixic acid (NegGram)

## Nitrofurantoin (Furadantin)

## Nonsteroidal anti-inflammatory agents

Penicillin G procaine  
 Streptomycin  
 Sulfonamides  
 Tetracycline

## Stimulants

Amphetamines (withdrawal)  
 Caffeine  
 Cocaine (withdrawal)  
 Methylphenidate (Ritalin)

## Hormones

Adrenocorticotropin  
 Anabolic steroids

## Glucocorticoids

Oral contraceptives

## Other drugs

Choline  
 Cimetidine (Tagamet)  
 Disulfiram (Antabuse)  
 Lecithin  
 Methysergide (Sansert)  
 Phenylephrine (Neo-Synephrine)  
 Physostigmine (Antilirium)

## Ranitidine (Zantac)

## Lab workup

- CBC
- BMP
- TSH/free T4 – hypothyroidism can mimic depressive symptoms
- Vitamin B12/folate
  - Prevalence of B12 deficiency increases with age
  - Low levels may contribute to depression



**What are the  
treatments?**

OHHSU

CCPD

# Treatment of late life depression

- Best evidence supports combo of psychotherapy + medications
- Best psychotherapy is cognitive behavioral therapy (CBT)
- No one “best” antidepressant – what matters more is what works for the patient
- Side effects are more common in older adults
- Why a “placebo” helps:
  - Instills hope, raises expectations of improvement
  - Therapeutic alliance

# Pharmacotherapy

Taylor WD. Clinical practice. Depression in the elderly. *N Engl J Med*. 2014

Class and Agent	Initial Daily Dose	Therapeutic Daily Dose	Side Effects	
			Common	Serious but Rare
<b>First-line therapy</b>				
SSRIs			Nausea, diarrhea, headaches, sexual dysfunction, increased risk of falls	Abnormal bleeding (due to altered platelet function), hyponatremia
Sertraline	25–50 mg	50–100 mg, to a maximum of 200 mg		
Escitalopram	10 mg	10–20 mg		
<b>Second-line therapy</b>				
SNRIs			Nausea, diarrhea, headaches, sexual dysfunction, diaphoresis, dry mouth	Hypertension
Duloxetine	20–30 mg	60 mg, to a maximum of 120 mg†	Possible increased risk of falls	
Venlafaxine XR	37.5–75 mg	150 mg, to a maximum of 225 mg		
<b>Antidepressants with novel mechanisms</b>				
Bupropion XL	150 mg	300 mg, to a maximum of 450 mg	Jitteriness or agitation, headaches, tremors	Seizures (avoid in patients with risk factors for seizures)
Mirtazapine	15 mg at bedtime	30 mg, to a maximum of 45 mg	Dry mouth, sedation, weight gain	Increased serum cholesterol levels

# Drug pearls



Start at 50% usual starting dose  
if new to treatment

Sertraline 25mg  
Mirtazapine 3.75mg  
Escitalopram 2.5 or 5mg



Failure of 1 SSRI/SNRI doesn't mean failure of all



Mirtazapine for low appetite, Wellbutrin will drop appetite



Remission rate is about 30-40% (combine with therapy/exercise!)



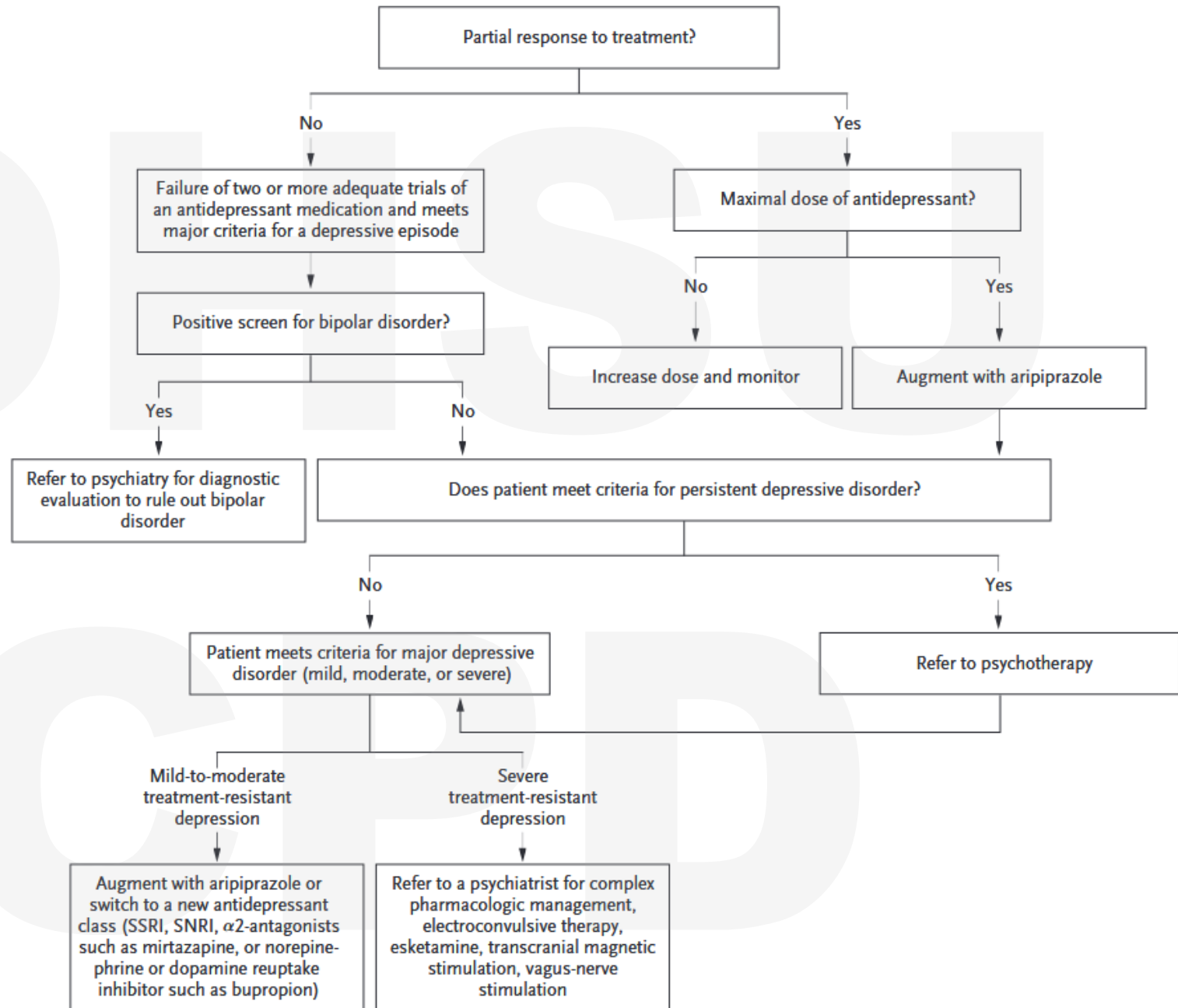
Treatment resistance more common if executive function deficits  
or dementia as primary illness



# Monitoring treatment

- Usual guidance of 4-6 weeks to show benefit; dose adjust if partial benefit
- Hyponatremia more common in older adults
  - Check BMP 2-4 weeks after starting SSRI/SNRI

# Treatment resistant depression



# Therapy modalities

## Cognitive Behavioral Therapy

- Identifying and reframing negative, dysfunctional thoughts
- Increasing participation in pleasurable and social activities
- Less effective for cognitively impaired individuals

## Problem Solving Therapy

- Learn new skills to tackle problems
- Structured goal setting and progress
- Effective even with co-existing cognitive deficits and executive dysfunction

## Interpersonal Therapy

- Focuses on role transitions, grief, and interpersonal relationships

# Non-Pharmacological Treatment

- **Restful Sleep**
  - Sleep hygiene!
  - Mirtazapine if wanting to treat both
- **Exercise**
  - Reduction in depressive symptom severity
  - Improved perceived QOL
  - Improved pain and sleep
  - All types of exercise are beneficial, particularly if self-selected
- **Tai Chi**
  - Improves measures of depression and anxiety



# Activity scheduling

- Collaborative and interprofessional approach
- Addresses social isolation by increasing daily activities
- Has been shown to be as effective as CBT
- Wide range of activities:
  - Exercise, Shopping, Singing in choir, Lunch with family/friends, Community events, Journaling, Medication management, Looking at photos
- Give patient “homework” to engage
  - Formal “calendar” or informal list of activities

# Activity scheduling

**Table 2. Sample Activity Scheduling Calendar**

Time	Mon	Tues	Weds
7-8 am	Breakfast	Breakfast	Breakfast
8-9 am	Call daughter	Meet with Fran in the park	Balance checkbook
9-10 am	Go for walk		Go for walk
10-11 am	Therapy apt	Food shopping	Write letter to son
11 am - noon	Lunch w/Sal	Lunch	Lunch
noon-2 pm	Reading time	Reading time	Reading time
2-3 pm	Piano	Piano	Dr appointment
3-4 pm	Garden work	Computer class	Dr appointment
4-5 pm	Garden work	Computer class	Dr appointment
6-8 pm	Cook and eat	Cook and eat	Cook and eat
8-9 pm	Watch TV	Watch TV	Watch TV




# Other resources



# Oregon Behavioral Health Resources

- Greater Oregon Behavioral Health Inc. ([GOBHI](#))
  - Rural Oregon focused
  - Behavioral Health Care Organization
  - Primarily Eastern Oregon
- Oregon Older Adult Behavioral Health Initiative ([OABHI](#))
  - Regional resources
  - Training modules for providers
  - Working with communities



**Remember:**  
Geriatric psychiatrists are  
rare in Oregon → most  
patients will be treated  
within the primary care  
office

# Senior Loneliness Line

## The Support You Need to Thrive

Feeling alone or disconnected? Make meaningful connections and enjoy uplifting conversations with our friendly team. We're ready to listen, chat, and connect with you today!

5:30am – 11:30pm Daily | Free | Confidential | For Anyone in Oregon | Age 60+

 [Call 1-800-282-7035](tel:1-800-282-7035)

¿Necesitas hablar en español? Llame al 1-800-282-7035, manténgase en la línea y lo conectaremos con alguien que pueda hablar con usted.

English and Spanish-speaking counselors are available.  
Interpreters are provided for other languages.



**OREGON  
WARMLINE**

**1-800-698-2392**  
**Peer Support 24/7**





# Oregon Senior Peer Outreach

Older Adult Telephone Support

**833-736-4676**



# Behavioral Health Crisis Response System: 988

# 988

## SUICIDE & CRISIS LIFELINE

If you need to talk, the 988 Lifeline is here.

At the 988 Suicide & Crisis Lifeline, we understand that life's challenges can sometimes be difficult. Whether you're facing mental health struggles, emotional distress, alcohol or drug use concerns, or just need someone to talk to, our caring counselors are here for you. You are not alone.

 Call

 Text

 Chat

 ASL Now

# Oregon Psychiatric Access Line (OPAL)

**OPAL-K** about Kids

**\*\*OPAL-A** about Adults

- Free, same-day consultation by phone  
9 a.m. – 5 p.m.  
Monday through Friday, excluding  
major holidays

## The Oregon Psychiatric Access Line (OPAL)

Offering curbside psychiatric and pediatric developmental phone consultation for patients of all ages. Staffed by board certified child and adult psychiatrists & developmental behavioral pediatricians, this service is funded by the state of Oregon.

503-346-1000  
855-966-7255

[www.ohsu.edu/opal](http://www.ohsu.edu/opal)

Oregon  
Health  
Authority



Questions?

OH SU

CPD

