Health & Wellness Webinar: Demystifying Depression in Older Adults

December 13, 2023

Transcript

[0:00 Introduction and overview]

Dr. Anthony Levinson: Welcome, everybody, and I'm excited about tonight's talk and thanks, everybody, for sending so many great questions in advance as well. So just by way of brief introduction of my colleague, Dr. Sophiya Benjamin is a geriatric psychiatrist and an Associate Professor in our Department of Psychiatry and Behavioral Neurosciences here at McMaster. She is also the Schlegel Chair in Mental Health and Aging at the Schlegel University of Waterloo Research Institute for Aging and the co-founder of GeriMedRisk, which provides education and consultations to physicians and others about best use of medications for older adults. So, thank you so much for joining us this evening, Sophiya.

Dr. Sophiya Benjamin: It's a pleasure to be here, Anthony, and happy birthday. I look forward to this discussion today.

Dr. Anthony Levinson: Thank you so much. So, maybe kick us off with a quick overview.

Dr. Sophiya Benjamin: So, over the next hour, Anthony and I will discuss the assessment and diagnosis of depression. We'll discuss treatment and management strategies as well as present some resources around this area. I think the key takeaway that I would say is depression is a very treatable illness with multiple treatment options. And hopefully over the next hour, we'll convince you of it.

[1:18 What is depression?]

Dr. Anthony Levinson: So, to start things off, I'd like to introduce you to a fictional woman named Elizabeta. So, Elizabeta is a 72-year-old of eastern European origin. Fairly vibrant, happy person at baseline, despite some challenging early life events. After her husband's death and her daughter Anna moving abroad, she seemed to get a little bit more flat in terms of her mood. She lost some of her spirit. Her mood was deteriorating slowly. She stopped gardening, which she used to love to do, and then gradually stopped doing and lost interest in some of her other hobbies. She spent hours sometimes just sitting in a bit of a daze around the house. Started neglecting her hygiene and her appearance and was struggling with sleep and became quite overtired with low energy. Over time, over the course of about a month or so, she even started withdrawing from more and more social activities, stopped attending church, and became essentially a bit of a recluse in her own home, declining invitations to connect with

friends as well. Conversations with her daughter, who would call her, tended to be fairly short and kind of distant and emotionless, which was very uncharacteristic for their previous relationship. She lost a lot of her interest in food. Stopped preparing meals for herself as often, and was even noticeably losing weight over the course of a couple of months. Sometimes she'd sit in front of the TV for hours, but couldn't really focus on either the news or the plot of her favourite show. And she even thought her memory was going because she was forgetting to take her prescribed medications on occasion. She really also started to have more negative thoughts as well, that she maybe didn't deserve to live in her nice house, and started to feel a bit like a burden to her daughter.

Dr. Sophiya Benjamin: That was a pretty classic description of major depression. And sometimes major depression can also be called clinical depression. When we diagnose major depression, we look for certain symptoms and diagnostic features. So there are two core features that is an integral part of a depressive syndrome. The first is having a depressed mood almost all of the time for a significant period of time. So it can be two weeks or longer. Some people, rather than experiencing a pure depressed mood, may experience anhedonia. And what we mean by this is a lack of pleasure or lack of ability to derive joy or engage in activities that were once of interest to them. So when people are not able to do this, that is another core feature of depression.

There are other diagnostic features, many of which Dr. Levinson described in Elizabeta. So, having sleep disturbances, having changes in appetite, feeling really fatigued, and not being able to engage in activities. People find it very difficult to concentrate even on simple activities, like having conversations with friends or reading a good book. And also, depression impacts the way we think and see the world. And sometimes we can feel really guilty about things that we feel like we might have done. Feelings of worthlessness. So all these are very common in depression. And finally, and very importantly, many people with depression experience suicidal thoughts. So thoughts of wanting to die, and many of them can even attempt suicide. And so it's really important to check for these.

Dr. Anthony Levinson: And as you said at the beginning, too, this is more than just a brief bout of the blues. This has to last at least two weeks, where people feel like this most of the day, every day, most days, and really has an impact on day-to-day function as well.

Dr. Sophiya Benjamin: Absolutely.

[5:39 What causes depression?]

Dr. Anthony Levinson: The interesting thing about depression and major depression is we don't actually fully understand all of the causes or exactly what causes it. There are quite a few theories. It could be more than one thing or combinations.

Brain chemistry is one of the thoughts, in part because medications work on different nerve cells in the brain. So, one theory is that there's an imbalance between different types of neurotransmitters, things like serotonin or dopamine, that may lead to the development or risk of depression.

Genetics seems to be an important factor. If you have a first degree relative, you're at about three times the risk of developing depression versus somebody who doesn't have a family history of depression. Though even people without family histories can develop a depression as well.

Stressful life events such as the death of a loved one, a major trauma, adverse childhood experiences, a divorce, social isolation, are all potential triggers for depression.

A variety of medical conditions, having chronic pain or coping with serious illness, chronic illness can lead to depression and many medical conditions that affect the brain, as we'll talk a little bit through some of the questions, are at increased risk of developing depression, things like Parkinson disease.

And then substances and medications can also be associated. So some medications may put you at increased risk. Things like steroid medications and then substances like alcohol can either cause or make depression worse.

[7:34 What are some of the risk factors for older adults?]

Dr. Sophiya Benjamin: There are some risk factors that older adults are particularly vulnerable to when it comes to developing depression. As we know, as we age, it can be a time of many losses both of people we may love and becoming socially isolated. So these are particularly important risk factors for developing depression.

In addition to this, having memory difficulties, developing chronic medical conditions that can sometimes cause pain, sometimes be difficult to manage, all of these can also be risk factors.

When we see someone who is finding it hard to take care of themselves, neglecting their personal care, is not eating, it's another sign that they should be screened for a depressive illness. Late-life can also be a time of various transitions. Sometimes there could be prolonged hospitalizations. People may receive diagnoses of dementia and move to long-term care. And these are all times when individualsare at higher risk for developing depression.

[8:44 How is depression assessed and diagnosed?]

Dr. Sophiya Benjamin: So how do we assess for depression? Often it may start with someone suspecting this. Either a family member who alerts a family physician and a screening tool may be completed. So, two commonly used screening tools for depression, one is the Geriatric Depression Scale, the other is the PHQ-9, both of which are self-report scales and can be done at a primary care level. But it's important to remember that screening is not diagnosis.

So after the screening, and if someone scores positively on this, then the next step is to do a comprehensive assessment. And there are various parts to this. The first is to understand the current symptoms of depression, how severe it is, how it impacts functioning.

It's also important to understand what other medications the individual is taking, and other medical conditions that they may have. So a detailed medical history is a part of it. We also try to understand the person's family history. So those who have mood disorders and other psychiatric illnesses. It's important to know, for example, if they have a family history of bipolar disorder, because sometimes an antidepressant can unmask mania in someone who has a family history of bipolar disorder. So these things are important to elicit in the comprehensive exam.

We also do a physical exam to rule out certain medical conditions that can look like depression. And Dr. Levinson will talk about some of these examples. We order lab tests again to rule out these medical conditions. And once we have ruled out things that can look like depression and the person has the necessary criteria, then a diagnosis of depression can be made.

Some elements that I often see in older adults is that people can present with memory complaints almost as a primary complaint, or with physical symptoms, like pain or fatigue, and sleep problems. And sometimes this can mislead the diagnostic process into something else. So that's why the comprehensive interview is really important.

And it's also critical that we assess for suicide. Particularly in older adults, older men have a higher risk of completed suicide compared to the rest of the population.

Occasionally people might present like they have anxiety, and on further interview, we might understand that this anxious distress is a part of a larger depressive syndrome.

Dr. Anthony Levinson: So if we were sort of putting it in all of that information in context for Elizabeta, it might go something like this, where she goes to see her family physician. Her family doctor might even book the last appointment of the day to spend a bit more time with her, because a comprehensive assessment can take more time.

She would take that thorough history to try and understand the symptoms that she's been having and how she's been managing in terms of day-to-day activities.

She may ask Elizabeta to fill out a questionnaire like the PHQ-9 and possibly do a brief cognitive screen as well, if she's subjectively complaining about memory issues.

And then it would be typical that her doctor might order some basic lab work, like a complete blood count, thyroid function test, basic electrolytes, and possibly something like a vitamin B12 to check for deficiency. And then she would book a follow-up to see her within one to two weeks, for example, review the results.

And in this case, Elizabeth's lab works and investigations have all come back within normal limits, essentially at least a preliminary way of ruling out a medical cause for her depressive symptoms. She diagnoses Elizabeta with major depression, and they begin a conversation together about the various treatment options available.

So one of the important things that we've talked about is this 'ruling in and ruling out'. So what are some of the things that might look like depression, but actually be due to another condition?

So, for example, we might have Robert, who's 65, and he actually will have low thyroid, but he presents looking like he might have depression. He has fatigue and weight gain, a lack of motivation, low energy, poor focus, but he also has some other physical signs. Dry skin and hair, a slowed heart rate, a little bit more muscular weakness, and he doesn't complain of sadness per se, and he's missing some of the other depressive symptoms.

When he is assessed, his doctor checks his thyroid hormone, he is diagnosed with hypothyroidism, and he's given treatment. So that's one example of a common, relatively common medical condition that's often associated with depression.

Helen might be another example of somebody who has mild cognitive impairment and what we call apathy. So predominantly that lack of motivation. And apathy can look a lot like major depression. So she's been experiencing this lack of interest in social activities and hobbies and family events, but she's not describing sadness per se, and she doesn't have other depressive symptoms. She is having both subjective and objective difficulties with her short term memory when she's assessed and struggling with some other tasks in terms of her cognition.

So when she is assessed and cognitive screening and testing is done, she's diagnosed with apathy as the presenting part of mild cognitive impairment, and her doctor gives her things that she can do to reduce her risk of dementia, and stay active and engaged.

Another example might be George, who is drinking quite heavily. He's having some of the symptoms of depression while intoxicated or in withdrawal, where he's having sleeping problems. He's feeling hopeless. He may feel more sad when he's intoxicated. He has no prior history of depression. He doesn't have some of the other symptoms, and they're only occurring in the context of his heavy alcohol use. So he is diagnosed with alcohol use disorder and connected with treatment resources, and over time, his depressive symptoms also improve.

So just wanted to give those as a few examples of important medical conditions that can often present looking like depression.

[15:51 What are common misconceptions about depression in older adults?]

Dr. Sophiya Benjamin: There are some common myths or misconceptions that really get in the way of people getting appropriate treatment. The first thing to remember is that depression is not a normal part of aging. There are many older adults who, as they age, have no depressive symptoms. So if this is something that you have, then it deserves assessment, and there are lots of treatment options.

Which kind of brings me to the next myth that there's no treatment. There are lots of effective treatments for depression. Again, late life can be a time of loss and grief, and there are times when people experience what is known as bereavement. Bereavement also can be treated.

It's not the same as depression, but if it doesn't go away after a while or if it clearly has depression-like symptoms like suicidal thinking and challenges with reality testing that we see in depression, then it is beyond bereavement or grief.

And as we get older, yes, some physical illnesses can cause tiredness, but tiredness can also be part of depression. So it's important that to not lump these as parts of aging and to request assessment, and people deserve treatment for it.

Thank you.

[17:27 How is depression treated?]

Dr. Sophiya Benjamin: So, like I said, there are many treatment approaches for depression. One thing that we like to emphasize is a stepped care approach for depression, and there are two principles that this is based on. One is that depressive symptoms exist along a spectrum. So there can be mild levels of depression all the way up to very serious depression, with psychosis sometimes, and suicidality. And so we might pick treatments based on the level of depression. And the other principle is that people may progress through these steps, and if one doesn't work, then there are other treatments that we can pick from. So the stepped care approach has self-help, psychotherapy, medications, ECT and rTMS, and we'll talk about each of these.

So, discussing some of the self-help strategies. So if one has mild depressive symptomsand they don't quite reach the threshold of moderate to severe depression, then it may be fine to use some self- management approaches and watch and wait and see if the symptoms get better. So some of these include providing education about depressive symptoms, as well as about resources and supports that are available.

Behavioral activation actually has a lot of evidence when it comes to the treatment of depression, and what this means is engaging in pleasurable activities. So identifying activities that the individual enjoys and making an effort, or creating a system where the person actually does them. And this in and of itself can be reinforcing and improve the person's mood.

There's lots of evidence around physical activity and exercise decreasing depressive symptoms. So that's another great self-management strategy.

And mind-body interventions like mindfulness, Tai Chi, yoga all have some evidence when it comes to self-management of depression.

Getting enough sleep and sleep hygiene is also an important part of this.

So there are various self-management strategies that you could try, including light therapy. But when the self-management strategies don't work, then medications and psychotherapy have equal level of evidence when it comes to the treatment of moderate depression.

And some of the common medications that we use are SSRIs such as sertraline or Zoloft,

escitalopram or Cipralex, and then SNRIs like duloxetine or venlafaxine and many other medications. So even though we've just shown a few classes, it's important to know that there are many drugs in each of these classes, and there are multiple other classes that we can also use. So there are lots of options.

The way we pick the medication for depression is based on individual preference, but also on other comorbidities they may have. So other illnesses they may have. Like, for example, if someone has challenges with renal clearance because they have trouble with their kidneys, then we might pick a drug that we don't have to correct for renal dysfunction, for example. So all of these thought processes go into selecting the right medication for that individual.

Regardless of the medication that we pick, there are some principles that are important in the treatment. The first is, as we age, our ability to metabolize drugs, as well as the effect of drugs on our body changes. And because of this, it's important to start the medication at a lower dose than one might in a 40-year-old individual, for example. And so it's important to start low, and we titrate the dose slowly while monitoring for side effects. But it's also important to remember that we have to get to a therapeutic level of the medication. So each medication has a kind of window within which it is most effective. And if we don't get to that level, then the medication may not be effective, and sometimes people might assume that the medication doesn't work because they've just been on a lower dose. So that's ensuring that each person gets an adequate trial. When the person does not experience full improvement, then it may be that we switch the medication or augment with an additional medication. And again, the decision between when we should switch or when we augment is based on individual patient factors.

To give you an example, if someone has experienced fairly good response with a medication, but have had no side effects, but they're not all the way better, we might choose to augment with a different medication in addition to the first one that they're already taking. But if they started a medication and they have a lot of side effects, or they've had very little response, then in that person, switching might be the right option. So it's really a conversation with the care provider and the individual receiving treatment about whether to switch or augment. It's also important to remember that psychotherapy is a great augmentation strategy for many individuals.

Dr. Anthony Levinson: So I don't want to be like one of those ads in the U.S. Where I now talk in the background about 48 side effects for you, but adverse effect considerations are really important, and this is the case with any age group. Serotonin-related side effects, because the most commonly used antidepressant medicines are the SSRIs and the SNRIs, so often people will have some side effects, like jitteriness or anxiety, maybe even some nausea or diarrhea or headaches. Those are sort of relatively frequent, but tend to go away after a week or ten days. One of the rationales for starting the dose lower is to make sure that people can tolerate the medication with fewer side effects.

There are some medications and a lot of over-the-counter drugs, but some of the antidepressant medications, especially some of the older classes, that have a lot of anticholinergic side effects. The cholinergic system is very important for a lot of different functions, including memory, but also gastrointestinal mobility and urination. So anticholinergic side effects cause a wide range

of different issues, including memory issues, confusion, risk of delirium, as well as constipation and other issues. So really important to look at the medicine that you're choosing and also whether the person is on other medicines that might have anticholinergic side effects.

This general principle, especially as many older adults may have other medical conditions and be on other medications, being attuned to whether there are any interactions between the antidepressant that you're looking at and the other medications that might be necessary for managing the person's chronic diseases. So, having a good understanding of the co-existing medical conditions, medicines that they might get started on, drug interactions, becomes really important.

Well, this is not super common, but there is a side effect to many of the SSRIs, particularly, that is seen in older adults more frequently than in younger people. And it's this syndrome that causes the sodium in the blood, one of the electrolytes, to become very low, in some cases dangerously low. And people may not realize it, but they might feel nauseous or tired or a bit lightheaded. And then when they go to get blood work done to see what's going on, their sodium may come back low. And it's a chemical that's very tightly regulated in the body. And so that's one of the things that we sometimes see in the medical context of the hospital, and it sometimes means you have to switch to a different medication, a different class.

There's a very low risk of bleeding with SSRIs. It's probably about the same as being on an aspirin, but a lot of people are on blood thinners anyway. And it's important for people to realize that they may be at a slightly increased risk of a GI bleed, a gastrointestinal bleed. So just giving people a heads-up, knowing that if they do see any kind of blood in their stool or if they develop an anemia, keeping in mind that the SSRI or SNRI may be associated with that slight increased bleed.

Rarely as well, the medications can cause an increase in what's called the QTc. And this is something that you see on an electrocardiogram. It's not an arrhythmia in itself, but if the interval gets longer, it can put somebody at increased risk for a more serious heart rhythm issue. So often in older adults, before they're started on any antidepressant, we will get an EKG to see what their QTc interval is like before even starting the medication.

And then it's important to realize that, like with many medications that affect the brain, you should never stop them abruptly. So if you stop antidepressants abruptly, not only do you run the risk of withdrawal-emergent side effects, you can also increase the risk of recurrence or relapse. People who stop their antidepressants too quickly have a higher rate of recurrence of their depression. But even if you miss doses of your antidepressant for sort of two days or three days, many people start to experience either headaches or restlessness or unpleasant sensation, and these are sort of withdrawal-emergent. So important to if you are starting on an antidepressant, work closely with your doctor if you do decide to come off of it rather than stopping abruptly.

Dr. Sophiya Benjamin: So, as Anthony mentioned, it's important to monitor for side effects.And one way that you can do this is you work closely with a healthcare professional, be it your family doctor, whoever's doing the prescribing. And I will add that many people may not

experience these side effects. And overall, antidepressants are a relatively safe group of medications to use, and most physicians have a fair bit of experience using these medications, but it's still important to monitor for side effects. And if someone has a side effect, then there are other options or other classes that can be tried. So that's the importance of monitoring.

The other part of monitoring is to see how one progresses with treatment. Is it actually helping their symptoms? Are they getting better? Some people may experience a partial response, which basically means their depression gets a little bit better, but not all the way. But what we really want to aim for is remission, where the person is not depressed anymore. And that's what most people want. They don't want to be depressed, and it is possible to get to remission. And this may take more than one treatment trial, but it's worth keeping that as the main outcome that you are working with a care provider.

The other key part of monitoring is that depression can be a recurrent disease. So even after you experience full remission, it is possible that you experience depressive symptoms again. So it's important to monitor for those. No need to be kind of hypervigilant that it's going to come back any moment, but if you experience those symptoms, then it's good to keep an eye on that. And when you are feeling better, when you're not depressed, then it's important to also continue to take the medication.

So antidepressants first take a while to act, and it's important to take them for at least six months especially if it's your first episode and you've experienced full remission. But if an individual has had multiple episodes of depression or they've had multiple trials to get them to a placeof remission, or if they've had severe symptoms in the past, then two years may be a better window to actually take the medications before attempting to come off of them. And there are some patients who I work with who choose to continue to take those medications beyond two years because they feel that the risk of experiencing a relapse at their stage in life is not worth the risk. So each person's timeline is different, and you'll work with your physician to determine what's best for you.

Dr. Anthony Levinson: So if we were using Elizabeta as an example, in conjunction with her family physician, she started on one of the first-line antidepressant medications. In this case, she started on a low dose of sertraline or Zoloft at half the normal dose initially. She tolerates it well. So after two weeks, the dose is increased. She continues to stay on it, and she's maintained on this therapeutic dose for about a year. And then she and her doctor have a conversation at that point about whether to stay on the medicine or very carefully taper it off with close observation and reassessments to make sure that she doesn't have a recurrence.

Let's say she had run into problems, like her sodium had gotten low and she couldn't tolerate it. Again, that's when she would work with her family doctor to choose a different class of medication that is less likely to cause the same type of adverse effect.

Dr. Sophiya Benjamin: So psychotherapies or talk therapy or counselling are as effective as medications. And for many older adults, this may be the best option, especially in those who have multiple medical problems or are having side effects from multiple medications,

psychotherapy is a great option. And there is a lot of evidence to back the effectiveness of these types of therapies. So cognitive behavioural therapy is one of the most commonly studied types of psychotherapy. It can be done guided by a therapist, it can be done individually or in a group setting. There are also lots of Internet-based resources which Anthony will talk about in the latter part of this talk that one can utilize, and they are also available in self-help book formats.

Some of the principles behind cognitive behavioural therapy is that it teaches us to challenge some of the persistently negative cognitions that we tend to develop when we are depressed. And by challenging them and replacing them with more positive, and in many situations, more reality-based thoughts, we slowly retrain our brain out of this depressed state.

There are also other types of therapy called problem solving therapy, refocus therapy, interpersonal therapy. All of these have been found to be effective.

Some of the of course, the advantage of psychotherapies is that there are fewer medication-related side effects and there is equal evidence. But the one downside might be that it might take individuals a little bit longer to experience full response with a psychotherapy and one has to be invested and go to the therapist and have access to a trained therapist. And I think we are getting better with this. There is more access to psychotherapies now than we did before. So keep this option in mind as you are reviewing your own treatment options.

Dr. Anthony Levinson: I think there was maybe also a bit of stigma previously about offering psychotherapies to older adults, but the evidence is quite clear that older adults respond very well to these evidence-based psychotherapies.

Dr. Sophiya Benjamin: That's right.

Dr. Anthony Levinson: I just want to pause briefly on, talk a little bit about neurostimulation. There's two different treatments that fall under this category. Electroconvulsive therapy, or ECT, is a medical treatment primarily used for more severe cases of depression, especially when other treatments haven't worked, or if somebody really can't tolerate medications or psychotherapy for some reason. In this treatment, basically a small, carefully controlled amount of electric current is passed through the brain while the patient is under general anaesthesia and they're asleep and don't feel anything. They're basically having a brief seizure within the brain in this controlled environment.

And although it may sound scary, ECT is safe and one of the most effective treatments available, especially for severe depression or depression that hasn't responded to other medication treatments or other treatments. So, we still don't know exactly the way it works. It's not fully understood, but it's believed to cause changes in some of the chemical signalling, the brain chemistry, and can rapidly reverse symptoms of major depression in some cases. So, many patients report significant improvements. Typically requires about six to twelve treatments, and then you would still go on maintenance medication after the depression goes into remission.

rTMS or repetitive transcranial magnetic stimulation is another sort of neurostimulation treatment. It's not offered in quite as many centres, but it's a noninvasive treatment for depression. It involves using a magnetic device or a coil placed on the scalp to deliver magnetic pulses to specific parts of the brain. They stimulate brain cells in those areas involved in mood and mood control and depression.

The patient is awake, like you're not under anesthesia for this, you're alert during the procedure, doesn't require anesthesia. Typically has very few side effects. Some people will have mild headache. Unlike ECT, the rTMS doesn't cause a seizure. It's a good option for individuals who may not be able to tolerate ECT, or haven't responded to antidepressant medications or want to avoid the side effects. There's still quite a bit of research being done on what are the optimal settings and treatments. So while it is offered in some centres, in a lot of other centres it's considered more understudy or you may have to enter clinical trials. McMaster has a centre where they're doing more and more research with advanced techniques around that. So again, the exact way it works, not totally understood as well, but may be a safer alternative to ECT for some patients who are not responding to other treatments.

Dr. Sophiya Benjamin: So once someone has experienced remission from depression, there are things that they can do to prevent a future episode, and these are very similar to the self-management strategies that we talked about. This includes exercise. So there's a lot of evidence to show that physical activity significantly decreases the odds of developing a depressive disorder.

Self-help books or bibliotherapy, practicing mindfulness-based stress reduction, as well as reducing social isolation or loneliness, all of these have been shown to prevent depression and worth considering as a way of maintaining one's remission, as well as just healthy practices to prevent getting a first episode.

[39:16 What resources and supports are available?]

Dr. Anthony Levinson: So I'm going to do the rapid resource round so we can get to the Q&A, but I will ask Jessica to share with everybody a handout. This will be sent if you're watching on YouTube Live. We'll send this out by email as well. Every resource that I'm going to rapidly touch on now is included in the handout.

So, a lot of the evidence-based guidelines that Sophiya and I have been talking about are produced by the Canadian Coalition for Seniors' Mental Health, the CCSMH. They also do have resources on their site about depression and education for the public.

Health Quality Ontario produces quality standards on various conditions, and a few years ago, they published a quality standard on care for adults and adolescents with major depression. And they have some really good recommendations for what to expect with quality care, such as a comprehensive assessment and how long you should have follow-up. And they have a variety of resources, including a patient guide as well as the full quality standard, which is based on high-quality evidence.

This is not as well-known a resource, but is actually a very good in-depth resource that goes into a fair amount of detail about different treatment options, in particular, for depression. So it's produced by CANMAT, which is an organization that produces guidelines in Canada around depression and mood disorders, and this patient guidelines Choice-D. It's a free downloadable PDF and is also available in several languages on their website as well. So again, the link is in the handout that I'll be providing.

And as far as community resources, so Sophiya spoke about some of the preventative guideline and ways to avert social isolation, be more active in the community,211, which you can phone pretty much anywhere in Canada, or you can go to 211.ca, is basically an enormously helpful inventory of community and social systems and programs. So, if you are looking for pretty much anything in terms of community and the social system in your community, call 211. They'll provide advice to you. If you're looking for childcare, you're looking for a day program for activities, you can pretty much locate anything through them.

The YMCA offers great programs for community environment. On the YMCA website you can find your local YMCA. They are across the country, and they offer lots of programs for older adults and others to stay active and engaged and physically active as well.

Wellness Together Canada was an initiative by the federal government and others that was spawned, I think, during the pandemic, but they have lots of information in terms of where you can access supports. They also have a helpline and they have good educational content on their site as well.

One of the programs that was developed and now is hosted by the Canadian Mental Health Association is called BounceBack. It's informed by cognitive behavioural therapy, and it is essentially a free program. It does use CBT techniques. It works on skill-building in terms of some of those helping to analyze your cognitions. It's available to adults and youth over the age of 15, you can self-refer. They also do like it if your primary care provider is aware of the referral. They offer sort of some more in-depth but also some more like self-help types of programs, and has been shown to reduce depressive and anxiety symptoms.

The Ontario Structured Psychotherapy Program, I know not everybody here is from Ontario, but I suspect in some of the other jurisdictions there may also be now efforts to improve access to structured psychotherapies like cognitive behavioural therapy. So in Ontario, this is a relatively new program where psychotherapy based on CBT is funded by the government. And so you can get a referral and information you can find online. And I have the link in the handout. They'll do therapist led CBT, or they can also connect you with a program like BounceBack if you're looking for something less intensive.

This [Mindbeacon] is a paid service that is basically therapist-guided Internet CBT. It was funded during the pandemic, but since Ontario has launched their structured psychotherapy, it's no longer funded. But for many people, it might be funded by their benefits plan if you have insurance.

And there's two programs [Mindbeacon and Telus Health] that I'm aware of that offer this therapist-guided Internet CBT. They're both paid services but seem to be covered by most benefit plans. So Telus Health also has a CBT program as well.

For those of you who are looking for more self-help type of meditation or mindfulness, Headspace is a very good app.It is a freemium-premium, so it's a fairly steep cost. It winds up being about $80 a year, I think $90, but it is very good for meditation, for sleep. They have uses principles of mindfulness, tends to have very high reviews. If you're a Netflix subscriber, they had some content on there as well.

Two other good apps, one of them is free. Calm is very similar to Headspace. It's also a paid app. The Healthy Minds program was developed by a non-profit and also has simple, well-structured meditations. So, that's one that you could try.

On the bibliotherapy front, I would say one of the most popular books, even for people who are working with therapists, is one called Mind Over Mood. It's excellent. It has sort of a workbook- type quality to guide you through. So almost like you can do it on your own in a self-guided way or working with a therapist. But that's probably one of the most common sort of CBT for depression books that's used. Another good one is David Burns' The Feeling Good Handbook which is also predicated on CBT principles.

So, that's a quick rundown so that we can get to all the excellent questions. I think Sophiya and I will do kind of a rapid-fire approach based on some of the pre-submitted questions, and we might stay a little longer and try and answer a few of the other questions, but I also want to be respectful of people's time.

[46:42 Can one heal completely from depression?]

Dr. Anthony Levinson: So, question, "Can one heal completely from depression?".

Dr. Sophiya Benjamin: Absolutely. I think we have a lot of evidence to show that a stepped care approach can lead to remission of depression, which basically is another way of saying completely healed from depression.

[47:00 When should depression be treated by a specialist?]

Dr. Anthony Levinson: "When should depression be treated by a specialist?"

Dr. Sophiya Benjamin: Most depression will be treated at the primary care level. But if the individual has tried two or more treatments and they're not getting better, or if they are experiencing significant side effects, or if they have a lot of complex medical morbidity, which means they have multiple medical conditions that's interfering with the treatment, or if they have severe symptoms, like suicidal thinking or psychotic symptoms, then they might need referral to a specialist.

Dr. Anthony Levinson: And I would say, too, sometimes if people have tried maybe more than two treatments and are not improving, that might be the time or a combination of medication and psychotherapy, they might get referred to a specialist.

[47:53 Why do I need a medication? Shouldn't I just be able to cope?]

Dr. Anthony Levinson: This question is sort of, "Why do I need a medication? Shouldn't I just be able to cope?'.

Dr. Sophiya Benjamin: Yeah. So if we think of depression as an actual illness, right, treating mental health disorders, which are no different from physical disorders like diabetes or hypertension, and we may go for a good part of our life being able to control hypertension with exercise, or maybe it just didn't manifest until later in life, but we wouldn't say, well, now we have to cope with hypertension. We would treat it both with lifestyle modifications as well as with medication. So I like to think of depression, really as any other chronic disease that we manage in medicine.

Dr. Anthony Levinson: And I think it is an interesting angle. There's a few other angles to this short question, but it's like, one, you might not need a medication. Like, if you have a major depression, psychotherapy might be an appropriate modality for you. And then I guess the other thing, back to things that look like major depression but might not be. So there are people who may have a stressful life event. I see a lot of people with a medical illness, or you mentioned grief. Not all of those immediate stressors, or we sometimes talk about an adjustment reaction to a major stress or an adjustment disorder, not all of those will require medication. They may require some supports for a brief period to bolster coping skills. But those are other examples of things that might not need a medication, but might still come to benefit from a therapist or supports.

[49:42 Are people who have had bouts of depression in their younger years more likely to be depressed in old age?]

Dr. Anthony Levinson: "Are people who have bouts of depression in their younger years more likely to be depressed in old age?"

Dr. Sophiya Benjamin: Generally, yes. Because if people have bouts of depression when they're younger, they likely have a biological predisposition to depression. And you mentioned earlier the different causes. So there's probably a genetic or familial cause, which then makes them more vulnerable to developing depression as they age. So the short answer is yes.

Dr. Anthony Levinson: And I think the other thing that you alluded to before, if you've had an episode and then had a recurrence, you're actually more likely to have future recurrences as well. So that's why in some cases, if people have had more than three previous episodes, they may opt to stay on maintenance treatment, and many of our patients do.

[50:35 How can one encourage someone who refuses to seek help?]

Dr. Anthony Levinson: Here's a challenging one. "How can one encourage an older adult who refuses to seek help?" And there was a similar question. "How should we address depression when the older adults and the caregivers deny depression?"

Dr. Sophiya Benjamin: Yeah, this can be hard, and it's not uncommon. I think what I would advise the person who is concerned or is trying to care for this individual, if possible, is to make an appointment together with the person to see the family doctor where they can discuss their concerns. And the family doctor might be able to do the assessment and might be able to encourage them to take treatment.

The other way is to point them to resources that destigmatize the illness and provide hope that there are multiple medication options or non-medication options, too, that they can try. But it's tough. It's tough, not easy.

Dr. Anthony Levinson: Yeah, it may take patience, but I think you're right. There's an element of stigma that can sometimes lead to that resistance. And we certainly see that where sometimes in the hospital, people are referred to the psychiatrist, and when I show up, they get angry with me. "I'm not crazy!" It's like, still a lot of these sort of outdated concerns, stigma about that. So information, education, and then if you're still aren't making any headway from that standpoint, probably engaging in some of the other lifestyle factors, like self-help factors, like physical activity and engaging people. But, yeah, very challenging.

[52:18 How is seasonal affective disorder treated?]

Dr. Anthony Levinson: Here's one. "My husband suffers from seasonal affective disorder." So this is basically a type of timing of the depression in our northern hemisphere, this typically occurs in the winter and is thought to relate to sort of cyclical patterns, with decreased exposure to light being a major factor. "So is there something that he can do to get help?" So, this is where Sophia mentioned earlier, light therapy. You can actually get high-quality commercial light boxes at health stores, like various ones. Even Costco at one point was selling good quality light boxes. There's sort of a right kind of box with the right brightness or lumens that you kind of have to dose it appropriately for the right duration of time. But light therapy has been shown to be effective for seasonal affective disorder.

The other thing that's been shown to be equally effective, if not more, is cognitive behavioural therapy. So both of those are good treatments for seasonal affective disorder, and both are probably preferred over medications, but medications can also be used.

[53:37 Can certain medications lead to or increase the risk of depression?]

Dr. Anthony Levinson: There were quite a few different questions that came up in this batch about certain medications either leading to or increasing the risk of depression. So one was a generic one about prescription drugs, but then this person said, "I was prescribed mirtazapine

for a sleep problem, and I'm sure that caused my depression." And somebody else was prescribed duloxetine for memory issues, but it seemed to cause apathy and confusion. And the final cluster was about medications that are used for treating seizures, like Keppra. So any comment about those?

Dr. Sophiya Benjamin: Yeah, so those are great questions. And the short answer is that, yes, there are medications that can affect mood, and it's really important to get a comprehensive history of medication. So for the listeners out there,I would say take your medication list every time to your family doctor and tell them exactly what you're taking. So that's important.

Whether a medication can cause depression, so that depends on the specific medication. Among the ones that were mentioned today, mirtazapine and duloxetine are actually antidepressants. So they are used to treat depression, and they are unlikely to cause depression. However, mirtazapine can cause tiredness in some people, and it can make them feel sleepy. And that could be interpreted as,"Oh, am I feeling worse?". So this is another place where you might want to closely work with your healthcare provider, describe your symptoms, and then they might be able to answer the question.

Now, if the person already was experiencing apathy and cognitive impairment, like the case that Anthony described, and they were prescribed duloxetine, antidepressants may not work for apathy. So it may not be that the duloxetine is causing the depression, but it may be that the underlying cause is different in that person with cognitive impairment. So when we discuss specific medications, then it gets kind of complex.

But to address the Keppra or the levetiracetam question, that is a medication that can cause depression and significant mood symptoms. So in that case, the answer is they would have to work with the neurologist to understand what the reason for prescribing the levetiracetam or Keppra is and whether, it can be replaced by another antiseizure medication that doesn't affect mood.

Dr. Anthony Levinson: Yeah, and I would say with that one, that is one where we often work closely with the neurologist. And neurologists are sometimes reluctant to prescribe Keppra if they know somebody has a past history of depression.

I think the other thing that I see quite often is people who are on supratherapeutic doses. So just like you spoke about, start low, go slow. You want people to be on a therapeutic dose, but there's very little evidence for supratherapeutic dosing. And so I think sometimes people, they just keep going up and up rather than thinking about, maybe I should augment or combine or switch to a different medication. But supratherapeutic dosing is probably more likely to lead to adverse effects.

[57:10 How do you handle important life transitions to avoid becoming depressed?]

Dr. Anthony Levinson: A couple of good questions about life transitions. Here's somebody who started said, "I had a busy, often frenetic life and career. Now things are quiet and I'm feeling

rudderless, even though I have lots of friends. Is that normal?"

And also another, "How do you manage the significant personal losses as you get older, like grief or bereavement?"

Dr. Sophiya Benjamin: Yeah. So aging is a time of life transition. Right. And exactly as the question described, that people retire. We change roles.We don't have to be someplace every morning at 09:00 a.m. And it really changes our whole social rhythm in many ways, and it can affect mood. One thing that I would say about these life transitions is certain types of psychotherapy, like interpersonal therapy, actually focus on role transitions and can be particularly helpful to address loss and grief. And so I think it's worth looking into. And one doesn't have to be depressed to access counselling or psychotherapy, and it can really help smoothen these transitions.

Another common transition in later age is moving to long-term care. And this can put people at increased risk of depression, but it doesn't have to be that way.Many long-term care homes now have lots of activities that get people engaged. That being said, I see patients in long-term care, and I will say it is a tough transition. When we think about it, we are used to living in a home where we make the rules. We can do what we want. People are not watching. I mean, it's not that people are trying to watch you in long-term care, but it is a communal living environment and so it can be a tough transition. And trying to put in as much social support around that as possible and giving them some time to adjust is helpful because many of them do transition well and eventually don't have depressive symptoms. But there are some who will develop depression during this time. And for them, it's important to get help.To talk to their family doctor and maybe even get a referral.

Dr. Anthony Levinson: And I thought it was interesting in the most recent Coalition for Seniors' Mental Health guideline about depression, as you mentioned, they talked about prevention strategies and a lot of that work and evidence comes from prevention strategies in long-term care homes, including interventions to try to reduce social isolation and loneliness and the role of physical activities. So both of those have been shown to help prevent depression in the long-term care home environments as well.

[1:00:00 Is there a relationship between depression and dementia?]

Dr. Anthony Levinson: A few questions here about depression and dementia. "Is there a relationship between depression and dementia?"

Dr. Sophiya Benjamin: Yeah, this could be a whole talk in and of itself, but we'll try to give the short version. So there is a correlation, there is a relationship. So we know that depression is a risk factor for dementia, but what's also really interesting is if the depression is well treated, then it's no longer a significant risk for dementia. So treating depression in midlife is important.

But people can present with mood symptoms even when they are developing dementia. So it can almost be like a harbinger of dementia eventually. And so that's important to remember, too, and monitor them, not just for mood, but also for cognition. But it's also important to treat

the mood symptoms because there are those with mood symptoms who can present with memory complaints because they can't concentrate. So it's a really complex interrelationship between the two illnesses that we have to carefully parse out by history and treat and monitor.

Dr. Anthony Levinson: Unfortunately, there is some evidence that depression in patients with dementia may respond less well to medications. But it doesn't mean that there are not other treatment options, including ECT, for more severe forms of depression in dementia. Some of the other causes of dementia, like Parkinson's disease dementia.

As I was saying earlier, many disorders that affect the brain, many neurological conditions like Parkinson's do have higher rates of depression associated with them. But again, people with Parkinson's generally respond to standard treatments for depression.

[1:02:22 Are psychedelics beneficial for treating depression?]

Dr. Anthony Levinson: These substances come up quite a bit. But this person said, "I've been reading research where psychedelics were used therapeutically and were beneficial for depression". Any thoughts on this?

Dr. Sophiya Benjamin: So there is a lot of emerging research on psychedelics. We do not have an approved psychedelic treatment in Canada at this time. So that's important to remember, that it's really not a mainstream option. They are offered at certain research centres. And when we read research about depression, we also have to see, has it been replicated or specifically studied in older adults. So often the research kind of emerges in the general adult population, and then we have to see, well, how does it affect our brain as we age specifically? I don't think that work has been done, so we don't really have it being recommended in any guidelines, and we don't fully understand the risks as well in this population.

Dr. Anthony Levinson: I think it's very interesting research. It is exciting for people who have not responded to other treatments. So most of the research is looking at people who have been treatment resistant or treatment refractory, so they haven't responded to other conventional treatments. There's also a population with post-traumatic stress disorder who have not responded to other treatments, who appear to, in some of the recent trials, respond really well to even like a single treatment session.

It has to be done in a safe environment. As Sophiya mentioned, it's not offered as sort of standard treatment. And very, very few studies involving older adults, and there are lots of concerns about adverse psychiatric and potentially cognitive effects. So most of the studies are also, they also want to make sure that somebody doesn't have a past history of psychosis or a psychotic disorder that might risk being destabilized by it.

[1:04:39 Will using cannabis help or worsen depression?]

Dr. Anthony Levinson: So on another note, on a cannabinoid note, "Will using cannabis or pot help or worsen my depression?". And I think this is another area where there has not been very much research. We know that inhaled or smoked cannabis is certainly bad for your lung health,

but there really haven't been enough high-quality clinical studies where they've controlled the dose and the route of administration. So McMaster has been lobbying through the DeGroote Centre for Medicinal Cannabis Research to improve the quality of clinical trials in this area. And I know they are actively looking at the research literature, and I just don't think there is enough high-quality science and evidence at this point to either recommend for or against. Other than there are certainly a risk of adverse effects in older adults.

And there are also a lot of older adults, though, who may have comorbid conditions like cancer. So people with cancer often are prescribed or authorized, rather, cannabinoids for help with nausea or other symptoms. And as long as it's done in a controlled way, it can help some of those symptoms. But I've not seen it used for depression, per se.

A couple questions that have come in from the Q&A. Well, here's a quick one. What's the PHQ-9? Do you want to just describe that?

Dr. Sophiya Benjamin: It's the Patient Health Questionnaire 9. It's part of a larger set of very well validated self-report questionnaires that's completed by the patient at a primary care level, and it screens for various disorders. The PHQ-9 specifically screens for depression.

Dr. Anthony Levinson: Another question was around is bereavement a form of situational depression? So we don't really have a diagnostic term, technically called situational depression. We do talk about grief and bereavement as its own thing because it is such a common reaction. And as Sophiya said, if you have a bereavement as a response to the death of a loved one, you may go on to develop a fully-fledged major depression anyway. So, we usually call bereavement bereavement or grief. I suppose it's a special type of adjustment disorder in the context of somebody dying. But, it doesn't preclude somebody going on to potentially develop an actual depression.

[1:07:44 If you are photosensitive, can you use light therapies to treat depression?]

Dr. Anthony Levinson: Question is, "If you're photosensitive, can you still use light therapy?". Not a great idea. So there are some people who are quite sensitive to light therapies. A lot of people get headaches if the exposure. So I would think if you have photosensitivity, it might not be the right fit for you.

[1:08:04 If you have been on an antidepressant for many years, will it continue to be effective as you age?]

Dr. Anthony Levinson: So here's a question that I was going to get to as well. "I've been on an antidepressant for 30 years. The general question will it continue to be effective as I age?"

Dr. Sophiya Benjamin: So there's no reason why an antidepressant that worked wouldn't be effective. Though I think every individual person's experience is valid. And if the person is experiencing depressive symptoms, then it's important to assess it. But what is also important to

remember is we may be on medications for a very long period of time, and the way our body responds to it due to aging, that can change. So someone might be, for example, on an anticholinergic medication, which is an antidepressant, and might have been able to tolerate it from their 40s to their 60s, but as they age into their 70s, their ability to tolerate the medication may change. And so it's a different answer, but kind of to the same line of thinking that aging does change how we respond to certain medications. So it's important to keep an eye on that.

[1:09:25 What do you do if you don't have access to a primary care provider?]

Dr. Anthony Levinson: I am conscious of the time. We'll answer one more question because I think it's a good one to highlight the challenges with access. So this is a question. "There's a significant presumption that the client has a family doctor looking after them that they can consult. What are the options for people who don't have a family doctor, or if the doctor has retired or died?"

And I do appreciate this question, because access to high-quality primary care, while it is an aspiration in Canada, there are many people without access, who don't have a family doctor, or who cannot access family doctor appointments because of the volume.

So, some of the resources that I've mentioned are okay for self-help or community engagement or those activities for behavioral activation. It doesn't replace a good, comprehensive assessment from a family physician. I think there are some other options with respect to accessing therapy. I mentioned a couple of paid options, sometimes through employment assistance programs, if that's offered through your workplace. But I would still highlight the importance of a comprehensive medical assessment because of the higher rates of medical illness that may present with depressive symptoms in the older adult population.
Any thoughts, Sophiya?

Dr. Sophiya Benjamin: No. This is a real struggle and one that we cannot ignore. And I think access to specialists is even lower. Even after referral to a specialist sometimes people can be on waitlists for months. And this is something that is difficult. And I agree with you that some of the self-help resources, psychotherapy, I think, are good resources to start with. But it's still important, if you're going on a medication, it's almost dangerous to do it without monitoring. And so that's why I think it has to be with the medical assessment.

Dr. Anthony Levinson: And I do think many provinces, I hope, will continue to work to improving accessto psychotherapy, but it's still so important to have that comprehensive assessment.

I'm going to just quickly move into the home stretch. I want to thank everybody for the questions. We probably could do another one, because there's like 100 more questions, too. I guess, I'll let you summarize a few of the key points here.

Dr. Sophiya Benjamin: So, I think things that we would like to emphasize are that everyone might experience depression differently. And so the signs and symptoms of depression may vary from person to person. The key point that we hope you will take away is that depression can be treated and has multiple effective treatments. So it's important to get support from family and friends. Try different lifestyle options. Everyone can try that. And there are, again, to emphasize many different treatment options, but don't give up hope. And I think this is something that happens in depression when we feel hopeless. So if there are those around who are invested in our care. I would advise them to advocate for the person when they are not feeling so hopeful about treatment because they can get better.