Case Study, Part 1

Daniel, a 65-year-old, married, retired lawyer, and father of three adult children, is coming in for his annual visit. He has no prior mental health history, and was successfully treated for prostate cancer at the age of 51. While speaking with his primary care physician, Daniel reports difficulty with sleeping and that his mood "just isn't what it should be." The primary care clinician probes further and discovers that Daniel has experienced a mild loss of appetite and that his energy has been low. Other than this, Daniel does not report any other symptoms of depression, or anxiety, and denies any suicidal thoughts.

As the interview progresses, Daniel continues to elaborate on his current life circumstances. "Things have just been different since I retired. I don't understand this idea of not working, and taking it easy. It's a load of crap! I retired because I thought it was what I was supposed to do, but I should have just kept working. Without work, I don't feel I have much purpose."

Seeing the distress in Daniel's face, the physician asks, "How bad have things really gotten?"

"It's been rough. Not to the point where I would kill myself. Don't get me wrong -- I love my family, and wife, and believe suicide is wrong. I know I shouldn't strictly define myself by my work, but it was always important to me, especially after I was diagnosed with cancer. Without work I don't think I would have made it through treatment. I'll be fine; I just need to get my legs underneath me. But tell me, Doc, am I actually depressed. or is this just normal?"

Case Study, Part 2

Daniel returns 1 year later for his annual visit and tells the clinic nurse that his wife died suddenly, a victim of a car accident. The nurse notes Daniel "looks really different. He must have lost 20 pounds since last year." The physician enters the room and immediately notices Daniel's slumped, somewhat haphazard appearance. This was in stark contrast to the extroverted, and generally well-dressed patient he had grown to know over the past 15 years. The physician sits and extends his condolences, but Daniel barely raised his head.

The physician is concerned that Daniel could be severely depressed and screens him as such. Daniel has positive responses for virtually every depressive symptom but does not endorse suicidal thoughts.

Still concerned, the physician asks Daniel what still brings him joy in his life. Daniel responds, "Being with my wife. She is still my everything. I never knew how much she meant to me. She was with me through law school and every part of my life. She gives me hope." As Daniel speaks, the physician notes he seems somewhat

distracted, looking off into space as if having another conversation. The physician asks Daniel about it. "I was just talking to Sarah; I thought you realized she is here. She's all around us. She talks to me every day. One day soon, I'm going to join her, and she will tell me the path to take."

The physician again asks Daniel if he is suicidal.

"No, I'm not suicidal, I just need to be reunited with my wife, and that's what she tells me every day." The physician excuses himself from the room, and asks the nurse to arrange transport for Daniel to the nearest emergency room. "I think he is psychotic," he says.

Basic Principles of Geriatric Behavioral Health in Primary Care Settings

- Late-life depression often goes undetected and has a significant adverse impact on quality of life.
- The majority of older adults with depression initially present to primary care, often with somatic complaints. Endorsement of "low mood" is frequently not the presenting complaint.
- Depression is not a normal consequence of aging.
- Healthy independent elders have a lower prevalence rate of major depression than the general population.
- Rates increase greatly with medical illness, particularly cancer, MI, and neurological disorders such as stroke and Parkinson's disease.
- Minor depression in late life is more prevalent than major depression, has significant health consequences, and responds to treatment.

Cognitive deficits may be pronounced and similar to dementia. However, both depressive symptoms and cognitive impairment respond to treatment.

Recognition and Management of Suicidal Geriatric Patients

- Suicide rates are almost twice as high in the elderly, with the rate highest for white men over 85 years of age.
- Older adults who commit suicide had seen a clinician within the previous month.
- Delusional (psychotic) depression is a very severe illness and can be lethal.