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Difficulties in recognizing and treating depression in the elderly : implications for counselors

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Abstract

Diagnosing elderly depression is a difficult, overlooked process. Many elderly seek out family physicians, but few visit mental healthcare professionals (Lyness et al., 1997; Sable & Dunn, 2002). When assessing elderly depression, it is important for counselors to be aware of symptoms, ensuring correct treatment.

According to Friedrich (1999), it is difficult for healthcare professionals, including counselors, to diagnose depression in the elderly. As elderly may not display traditional depressive symptoms, it is necessary to distinguish between depression, bereavement, and illness, all common in late life. Once depression has been diagnosed, treatments including: medication, psychotherapy, or perhaps the most beneficial combination of the two is available (Seligman, 1990). Counselors must be aware of elderly depression and the many treatments available.

DIFFICULTIES IN RECOGNIZING AND TREATING DEPRESSION IN THE ELDERLY: IMPLICATIONS FOR COUNSELORS

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Diagnosing elderly depression is a difficult, overlooked process. Many elderly seek out family physicians, but few visit mental healthcare professionals (Lyness et al., 1997; Sable & Dunn, 2002). When assessing elderly depression, it is important for counselors to be aware of symptoms, ensuring correct treatment. According to Friedrich (1999), it is difficult for healthcare professionals, including counselors, to diagnose depression in the elderly. As elderly may not display traditional depressive symptoms, it is necessary to distinguish between depression, bereavement, and illness, all common in late life. Once depression has been diagnosed, treatments including: medication, psychotherapy, or perhaps the most beneficial combination of the two is available (Seligman, 1990). Counselors must be aware of elderly depression and the many treatments available.

Difficulties in Recognizing and Treating Depression in the Elderly: Implications for Counselors

Accurately recognizing depression in the elderly is essential for many reasons. First, depression is not a natural part of aging. However, for millions of elderly the occurrence of depression is rather common, up to 50% (Heun, Papassotiropoulos, Jessen, & Maier, 2001). What is many times forgotten is that if depression is recognized and treated appropriately, it is often a curable illness. It is when depression is left untreated that the general quality of life starts to diminish. All areas of life and treatment are affected by depression, the mental, the physical, and the social (Martin & Haynes, 2000). In the most serious situations suicide may result. One difficulty the elderly face when diagnosing depression is the idea of the statistically diagnosable patient. Often times a person will suffer from symptoms of depression, but may either not score high enough on a depression inventory, or symptoms may be attributed to bereavement or illness. When this occurs, the patient is more or less pushed aside with minor treatment or no treatment at all. When dealing with depression, whether minor or major, all people should be treated accurately and appropriately. In order to do this, an accurate diagnosis of symptoms is necessary.

When discussing depression in the elderly, it is important to understand

the differences and the similarities between depression, delirium, dementia, and dysthymia (Seligman, 1990), as well as the most common physical diseases that usually coexist with depression: Alzheimer's disease, heart disease, and diabetes. It should be noted that as people age some signs of mental decline are normal, however when dealing with depression, these are high levels of decline that should be examined (Kurlowicz, 2002). Depression is a common mental disorder at any age, but tends to increase among older persons. It is commonly known that the sources of depression are not fully understood but include some potential causes such as genetics and the environment, and is further convoluted by the fact that depression may come and go, and worsen or diminish without any defined reason (Martin & Haynes, 2000).

Reasons for Misdiagnosis

Some common symptoms of depression noted by the Diagnostic and Statistical Manual, 4th edition, Text Revised [DSM-IV-TR] (American Psychological Association [APA], 2000), include: irritability, restlessness, anhedonia, weight fluctuation, sleeping difficulties, and perhaps suicidal ideation. The likelihood a person may experience depression differs from individual to individual, however, influences from heredity, medication side effects, and bereavement may make a person more likely to experience depression. In addition, headaches, digestive disorders, and chronic pain could be ways

depression can manifest in an individual. With depression affecting as many as 40% of older Americans with onset ages between 20 and 40 (Martin & Haynes, 2000), not recognizing the emotional, physical, and social suffering of these people is not a viable option.

According to Weksler (2000), the elderly usually do not report feelings of sadness associated with their depression. Rather, feelings related to social withdrawal, loss of pleasure, and somatic symptoms including loss of appetite and lack of energy are more common among the elderly population. Elderly may have physical complaints that cannot be explained by physicians. Poor hygiene and a generally slow demeanor may be common for the depressed elderly. A common mistake made by physicians is their need to determine where a patient's depression comes from, rather than determining if depression is apparent at all (Gallo & Rabins, 1999). It is suggested by Gallo and Rabins (1999) that if a cause for depression can be found, treatment is less likely to follow. With patients displaying symptoms in many different ways, it is essential that doctors look deep within these physical complaints to accurately determine if depression is present. As reported by Weksler (2000), depression is associated with functional disability, with 15-25% of nursing home residents suffering from major depression, while 30-50% suffer from minor depression. In addition to depression, dysthymia is another mood disorder that makes accurately diagnosing

depression in the elderly a difficult process.

Dysthymia is a chronic, mild, form of depression that generally occurs equally in women and men. People with dysthymia experience depressive symptoms for at least two years, with at least two of the following symptoms: appetite changes, sleeping difficulties, low energy, and feelings of hopelessness (APA, 2000). This type of mood disorder is not severe enough to be called Major Depression, however, dysthymic disorder lasts much longer than Major Depressive disorder and there are no manic phases. According to the DSM-IV-TR (APA, 2000), people with dysthymia usually meet all criteria for major depression, but no thoughts of suicide are present. It is very difficult to distinguish dysthymia from depression, because a person with dysthymia has more or less "been this way" his or her whole life. To a person suffering from dysthymia, feeling down or sad is normal. Dementia on the other hand, is a much more serious condition.

Dementia is caused by the destruction of brain cells, a condition that is irreversible. According to the DSM-IV-TR (APA, 2000), dementia includes multiple cognitive deficits including difficulties learning new information or recalling already learned information, and one or more of these possible cognitive disturbances: language, motor activity, object recognition, or abstract thinking. The difference between dementia and depression is not only the irreversible state,

but that there is usually a leveling off point that people reach and improvement is virtually nonexistent (Martin & Haynes, 2000). With the prognosis of dementia being very poor, over time the daily tasks of caring for oneself may become impossible, requiring assistance from others. On the other side of the spectrum is delirium, which is essentially the opposite of dementia.

The DSM-IV-TR (APA, 2000) reports that unlike dysthymia or dementia, the confusion involved with delirium is quite rapid and can be reversed with treatment and changes in memory, motor ability, and sleep patterns are common. However, these negative changes are usually due to the interaction, overdose, abuse, or withdrawal of either over the counter, prescription, or illicit drugs. For many people, delirium is more of a confused state of mind that is sudden and brief (Martin & Haynes, 2000). Martin and Haynes (2000) state that the incidence of delirium may be associated with hospitalization, as there are as many as 24% of patients who have delirium upon admission, and 35% of people will develop delirium during their hospital visit. These percentages are increased by factors such as age, health difficulties, and overall health prognosis. Often times a patient can be misdiagnosed with depression, when they really suffer from delirium. Because depression is commonly treated with antidepressant medication, it is important to accurately distinguish between these two conditions as administering antidepressants to someone with delirium may in fact worsen the person's

condition (Farrell & Ganzini, 1995). To help accurately diagnose a person's condition, information from those who are close to the person is very helpful.

In outpatient settings, doctors must rely on patient information from family and friends. Information such as driving difficulties, repetition in language, or difficulty remembering familiar people is imperative in determining what action steps need to be taken. Holzer and Warshaw (2000) state that Alzheimer's disease alone increases morbidity, and Alzheimer's disease makes up approximately 67% of all dementia cases. Attempting to intervene and make plans for dealing with Alzheimer's disease may eventually minimize particular symptoms of Alzheimer's in the future for those 60 years and older, according to Holzer and Warshaw (2000).

Symptoms generally reported with Alzheimer's disease are often times similar to those associated with depression. Memory difficulties, sad affect, and the onset age of above 60 are the most common. Because there is a genetic component to depression as well as Alzheimer's disease, those who have a history of these conditions may be more susceptible to the dementia that accommodates Alzheimer's disease (Huen, Papassotiropoulos, Jessen, & Maier, 2001). General practitioners may find it difficult to determine whether or not an elderly person is depressed, as seniors may present non-classic signs of depression in their routine

doctor visits. Depression is generally underdiagnosed or undiagnosed in the elderly because symptoms or signs that elderly present may look like dementia, especially if Alzheimer's disease is present. Symptoms such as confusion, anxiety about surgery, poor hygiene, etc. are all somewhat common in the elderly person who is suffering from depression (Holzer & Warshaw, 2000). It is suggested that there are a small cluster of symptoms that general practitioners can keep in mind to detect Alzheimer's disease at an early, treatable stage. Some symptoms include: getting lost, inability to recall familiar places or people, repeated thoughts or conversations, and poor ability to maintain personal hygiene (Holzer & Warshaw, 2000). Another condition that may make diagnosing depression difficult other than Alzheimer's is heart disease.

Ferketich, Schwartzbaum, Frid, and Moeschberger (2000) argue that depression not only increases the chance of death for individuals with coronary heart disease, but that heart disease could be preceded by depression. Looking at subjects from 1982-1984 and 1992 interview dates, the National Health and Nutrition Examination Survey [NHANES I] found that depression was associated with a heightened risk of coronary heart disease for both sexes, but only the mortality of men was affected (Ferketich, Schwartzbaum, Frid, & Moeschberger, 2000).

Comorbidity of illnesses is common amongst the elderly. In addition to

coronary heart disease, diabetes is another condition that is connected to depression. Anderson, Freedland, Clouse, and Lustman (2001) conducted a study to look at the incidence of depression in those people who have diabetes. According to the study, those who have diabetes need to keep their depression under control, for easier symptom management of both conditions. Results of this study showed that diabetic women had a much higher rate, 28%, of concurrent depression than men at 18% (Anderson, Freedland, Clouse, & Lustman, 2001). It is noted by Anderson, Freedland, Clouse, and Lustman (2001) that the general occurrence of diabetes more than doubles the chances a person will suffer from depression; as measured by the Beck Depression Inventory. The findings examined the possibility that even though depression may occur after diabetes is recognized, it may also be the case that the incident of depression doubles the risk of type 2 diabetes (Anderson, Freedland, Clouse, & Lustman, 2001). However, this study may have come up with different, more reliable results if data was collected using additional information or a different inventory.

Diagnosis

Self-report inventories along with information from close family and friends are essential in order to accurately diagnose depression and manage symptoms (Weksler, 2000). In addition to these important resources, other

scientifically based inventories may be used. Of the many depression-screening inventories available, few may be appropriate for the aging population (Lyness et al., 1997). Numerous depression-testing tools assess depression, but because the elderly may experience different symptoms than a younger person, these tools may not be accurate in determining depression for this population. As stated previously, depressed older adults report different symptoms connected with their depression. It is common for the elderly to present with irritability, social withdrawal, physical complaints, memory loss, sleeping difficulties, appetite, and weight changes (Weksler, 2000).

Even though studies support the idea that depression does have a genetic component, Sable and Dunn (2002) found that patients with late-life onset depression are less likely to see depression run in their family, but have an increased risk of developing dementia. For example, if a woman has a low income, a small support network, is divorced or separated, or has another illness of some sort, it is suggested she is more likely to experience late-life depression, according to Sable and Dunn (2002). Additionally, it is important to note that depressive disorders could require the same amount of hospitalization and treatment as many other medical conditions. The pain and suffering associated with depression can be very similar to those that accompany other illnesses (Sable & Dunn, 2002).

The DSM-IV-TR (APA, 2000) requires that at least five of nine symptoms must be present in order to be diagnosed with major depression. This does not imply that a person failing to meet DSM-IV-TR criteria should not be treated. Studies have shown that treatment of mild depression through antidepressant medication has frequently improved well-being and functioning in patients. According to Kurlowicz (2002), one depression-screening inventory that is widely used in the elderly population is the Geriatric Depression Scale [GDS]. The GDS is a brief 30 question inventory that breaks down patient scores into three categories: 0-9 = normal, 10-19 = mild depression, and 20-30 = severe depression. The GDS may be used with a wide variety of patients, including those who are healthy or ill, and has been used frequently in outpatient as well as inpatient facilities (Kurlowicz, 2002). It is important for healthcare providers to understand that the GDS should not replace an extensive interview by a professional; it is to be used as a screening instrument to assess depression (Kurlowicz, 2002). Another depression-screening tool is the Center for Epidemiologic Studies-Depression Scale [CES-D]. One of the benefits of using the CES-D is that this scale has provided a higher cutoff point than the GDS, which is useful in assessing major depression in patients. Lyness et al. (1997) compares the two depression-screening instruments and suggested that because of the simple format of the GDS, it may be more useful for assessing minor

depression. Both instruments are still considered appropriate depression screening tools for the elderly population.

Approaches to Treatment

There are several approaches to effectively treating depression in the elderly including electroconvulsive therapy [ECT] for severe cases, psychotherapy, medication, or the collaboration of both psychotherapy and medication. Friedrich (1999) suggested that psychotherapy and medication should be used together for ideal results. Even though each approach is somewhat successful alone, greater success is achieved when combining these methods. When using medication for depressed elderly patients, it is crucial that the correct dosage and side effects are known. Also, with older patients, patience is essential, because the time frame in which therapy and medication begin to work and results are visible may be much longer than with younger populations (Friedrich, 1999). Relapse amongst the elderly is quite common; therefore the number of therapy sessions needed to make progress may also be drawn out. Friedrich (1999) noted that once symptoms are under control a minimum of six months should be used as a recommended time frame for therapy. Although there are several therapy techniques that could be used, generally when working with depressed elderly, a cognitive-behavioral therapy [CBT] approach is most effective (Sable & Dunn, 2002).

Cognitive-behavioral therapy focuses on changing behaviors and irrational beliefs, which are necessary to change the emotional state of a person. Strategies of a cognitive-behavioral approach may include guided imagery, cognitive restructuring, and systematic desensitization of objects or situations (Lang & Stein, 2001). During therapy, determining long-term goals, short-term objectives, and therapeutic interventions are necessary. Common long-term goals for those with depression include: to dissolve depressed affect, return to an appropriate level of performance, to acknowledge and handle negative depressive feelings, change negative thinking patterns and a negative self-concept to positive feelings that can be useful in life, and to eventually let go of depressed feelings and thoughts in order to return to a state of mind that is appropriate for social functioning (Jongsma & Peterson, 2003). Short-term objectives according to Jongsma and Peterson (2003) include: describing personal feelings of depression, to determine the cause of depression if possible, to commit to symptom-reducing medications, and engaging in positive thoughts. Possible therapeutic interventions could include: determining how depression is affecting a particular person's everyday life, working with the client to pin point specific things that he or she is depressed about, stressing to the client the importance of expressing feelings, both those of depression as well as anger and pain, clarifying the intertwining that can occur between depressive feelings and past feelings of anger,

assigning homework for the client, and eventually getting the client back into society by assisting him or her in finding social activities and people he or she can connect with (Jongsma & Peterson, 2003). Therapy, whether individual, group, marital/couples, or family; allows the client to explore the many different avenues of his or her depression and help determine the best treatment plan. Other behavior techniques include activities such as: self-monitoring and self-evaluation, relaxation exercises, assertiveness training, and cognitive skills training to improve cognitive self-control and problem solving. Besides cognitive-behavioral therapy, interpersonal psychotherapy takes on a different role and may be beneficial to some clients.

Interpersonal psychotherapy takes the stance that depression is a disorder that "happens" to the client. Using this technique, there is no blame assigned with the depression. Interpersonal therapy focuses on improving overall social functioning through grief work, encouraging healthy relationships, resolving negative relationships, and taking on new roles in life in order to build self esteem and self worth. When seeing a counselor or therapist, a client can not only learn techniques that can be used in session, but techniques that he or she can utilize on his or her own. Self-help techniques for dealing with depression may include: meditation, self-hypnosis, goal setting and time management, relaxation techniques, exercise, and support groups. Even though therapy may be beneficial,

sometimes this approach is not enough. In many cases, medication is needed to help cope with and minimize depressive symptoms.

As far as medications, there are many options. The most popular choices include, tricyclic antidepressants and selective serotonin reuptake inhibitors [SSRI's]. As with many medications, antidepressant medication must be taken regularly for several weeks before results can be seen (Sable & Dunn, 2002). SSRI's are commonly used in the elderly population because: they can treat comorbid conditions such as anxiety and depression, they are given in appropriate doses to minimize overdose, there are minimal side effects, and there is a lowered risk of abuse and physical dependence (Lang & Stein, 2001). Common SSRI's include: Celexa, Prozac, Luvox, Paxil, and Zoloft.

Tricyclic antidepressants are the next drug most physicians and psychiatrists utilize if SSRI's fail to have significant therapeutic influence. These drugs have an increased risk of sedation and weight gain, but are still considered appropriate for people that have tried the SSRI's and found little or no results (Lang & Stein, 2001). According to Lang and Stein (2001), certain tricyclic antidepressants are not appropriate for those with major depression, but each person will respond differently to each drug. Examples of tricyclic antidepressants include: Norpramin, Aventyl, and Pamelor (Lang & Stein, 2001).

When discussing medication for any population, cost is always an issue. It

is important to remember that if a patient cannot afford a monthly supply of an SSRI, there is a good chance the prescription may not get filled (Friedrich, 1999). Especially in the elderly, medication compliance may be more complicated than whether or not a client is taking their medication. Healthcare professionals should take the cost of these medications into account as much as they can before prescribing them. According to Friedrich (1999) often times there is a generic form that is far less expensive.

Who receives adequate treatment in long-term care settings? According to Huffman (2002), physicians tend to attribute depressive feelings to other medical conditions, therefore leaving the depression untreated. According to Huffman (2002), fewer than 1 out of 4 patients in nursing home settings are adequately treated for their depression. The results of the Huffman (2002) study showed that those 85 years and younger and Caucasian were more likely to receive treatment than those above 85 and who were African-American. Additionally, those patients who suffered from diabetes were more likely to receive antidepressants, compared to those diagnosed with multiple clinical conditions (Huffman, 2002).

When depression is overlooked for an extended period of time, symptoms tend to get worse. In the most serious cases, some individuals feel the only way to end the suffering is to commit suicide. Late-life depression can be fatal as suicide is common in old age. According to Draper, MacCuspie-Moore, and

Brodaty (1998), as many as 4% of dementia patients had some sort of "wish to die." This study found that dementia, along with other comorbid diagnoses; make up nearly 14% of elderly suicides as well as 8-26% of elderly attempted suicide. Suicide and depression are often cocurrent for any age group, however the elderly that have coexisting conditions such as Alzheimer's disease tend to have a stronger and more frequent wish to die, up to 30% (Draper, MacCuspie-Moore, & Brodaty, 1998). Also found in this study, of those diagnosed with minor depression, 12% had suicidal thoughts compared to 45% of those with dementia. Draper, MacCuspie-Moore, and Brodaty (1998) report that 1% of those in the study had suicidal ideation, where 3% had a wish to die. Draper, MacCuspie-Moore, and Brodaty (1998) concluded that there is an association between the wish to die, suicidal ideation, and the depressive symptoms that accompany Alzheimer-type dementia.

Nugent and Williams (2001) looked at what life factors may influence suicidal ideation and eventually suicide. They suggested that demographic and situational characteristics could explain and somewhat accurately predict suicidal ideation. Some of these characteristics include: age, gender, ethnicity, relationship status, and social support (Nugent & Williams, 2001). Also, it has been suggested that people with lower socioeconomic statuses could be at a higher risk. In this study depression is the number one psychosocial problem that

has been related to suicidal ideation, followed by aggressive behavior and anxiety.

Results of this Nugent and Williams (2001) study implied that the connection between self-esteem and severity of suicidal ideation highly depends on whether the person is male or female and the degree of their depression. This means that as the severity of depression increases, self-esteem and thoughts of suicide become more negatively connected. According to this article, for men that are moderately depressed there is a large relationship between self-esteem and suicidal ideation, where as for women, this relationship is maximized when severe depression occurs. A major point of this study is the idea that practitioners should not just think of the co-occurrence of problems, but rather the power multiple problems can have on self-esteem and suicidal ideation. According to Nugent and Williams (2001), suicidal behavior can include the mere thought of suicide, which is by itself associated with a 10 to 100 times higher risk of suicide compared to a person who does not have suicidal thoughts. Even though this study provides useful information about those who have suicidal ideation, it is only concentrating on those depressed persons who choose to come forward with these symptoms. It should not be forgotten that there are many people of all ages that do not divulge this sort of information, but may be suffering from depression and thoughts of suicide (Nugent & Williams, 2001).

Diagnosing depression is complicated in any age group. Taking into

account that there are relationships between depression and other illnesses, states of mind, external people or situations, and possibly drugs or alcohol, it is not surprising that many depressive cases get overlooked. The different levels of severity and symptom manifestation can vary from individual to individual, thus the fight for accurately diagnosing depression and suicidal ideation is rather complicated. Draper, MacCuspie-Moore, and Brodaty (1998) suggested that while 1 in 2 elderly will attempt suicide and 3 in 4 who attempt actually succeed, in approximately 14% of elderly completed suicides and 8-26% of attempted cases, depression was the major diagnosis. In this study by Draper, MacCuspie-Moore, and Brodaty (1998), all patients in the sample met full criteria for dementia. Subjects were placed in groups based on dementia type (Alzheimer's disease, Parkinson's disease, alcohol-related, and atypical). Additionally, a connection was made between depression and the 'wish to die' (Draper, MacCuspie-Moore, & Brodaty, 1998). A connection was not found between the severity, type of dementia, age of subject, or gender.

Although studies (Draper, MacCuspie-Moore, & Brodaty, 1998; Nugent & Williams, 2001) show there is a significant relationship between depression, the wish to die, and suicidal thoughts, it is important to broaden the scope and acknowledge that some people who attempt suicide, and many times complete suicide, may have minimal depressive symptoms. A person does not necessarily

have to be clinically diagnosable in order to think that suicide is an option. In a study completed by Jorm, Henderson, Scott, Korten, Christensen, and Mackinnon (1995), factors such as marital status, gender, and age were looked at as possible reasons for having a wish to die. The purpose of this study was to determine whether or not other life factors, outside of depression, affected a person's suicidal tendency. Results showed that many of the variables that are correlated with suicidal ideation are the same factors that may increase the chance for depression in a particular person. Some of these factors include: auditory difficulties, visual complaints, inpatient or outpatient status, romantic relationship status, and some sort of disability (Jorm et al., 1995). Most subjects in this study did suffer from some level of depression, however there were a few subjects that denied depressive feelings but did have at least one other health problem. This study is important because it is not uncommon for doctors and other healthcare professionals to see a physical health problem and overlook the possibility of depression. This study is a great example, showing that depression can be found in all types of older people, those who are ill as well as those who are relatively healthy.

Effects of Depression on Caregivers

One last point to mention is that depression is not an illness that only affects the particular person who is being treated. Depression is an illness that

affects many people; whether an elderly person is placed in a hospital, nursing home, or if they remain at home and are cared for by a loved one, depression can be very difficult for a number of people. Research has explained that depression is more prevalent in a hospital or nursing home setting, where doctors, nurses, and other staff are not only directly involved with the person whom is depressed, but the depression itself (Huffman, 2002). Just as in these settings, those who are taken care of at home, family and friends are placed right in the center of all the symptoms and responsibilities of this illness. It is not uncommon for family members to become stressed out, agitated, burnt out, or depressed themselves; while taking on the tremendous responsibility of caring for a mentally ill family member, no matter what the setting. Axelrod, Geismar, and Ross (1994) examined the tolerance of behaviors and coping resources for families of patients with a chronic mental illness. In order to receive the best possible healthcare, developing coping skills and being aware of personal limits is essential. Axelrod, Geismar, and Ross (1994) suggest that often times the children of the mentally ill family member take on parental responsibilities, including feeling as though they have caused this illness. Over time research has shown that mental illnesses have many causes including both the environment and biology. Burdens such as finances, social readiness, and psychological preparedness are a few of the factors this study used to determine the family's ability of taking on the role as a

caregiver (Axelrod, Geismar, & Ross, 1994).

Children or other family members who decide to take on the responsibility of caring for the mentally ill have several dilemmas. The word "family" suggests that the only moral thing to do is care for the relative, however being willing to essentially give up a fraction of independence and take on a situation that will more than likely cause financial struggles, overwhelming emotional aspects, and having certain feelings of causation are more difficult (Axelrod, Geismar, & Ross, 1994). Accompanying any mental illness are behaviors that could be somewhat difficult to tolerate. In assisting the family with dealing with behaviors that are unwanted or not understood, the family needs education. The family must understand the illness itself, scientifically the cause of the illness, as well as their perception of the etiology, their level of responsibility in the care-giving process, and what exactly their expectations are in this situation.

Results of Axelrod, Geismar, and Ross (1994) study showed there was a correlation between the size of a family and the overall tolerance of behaviors. As the family size increased, so did the amount of tolerance. It is suggested that the bigger the family, the less noticeable the mentally ill family member is, therefore making behaviors less stressful and vibrant. A common resource for family members in the caregiver role is other family members. Greater tolerance of behaviors and a greater sense of emotional and physical support occur when

family members who live close by are willing to share responsibility (Axelrod, Geismar, & Ross, 1994).

In order to successfully manage any mental illness, it is imperative to not only concentrate on the specific person who is receiving treatment, but the loved ones that are assisting in the treatment and support. With healthcare costs skyrocketing more and more, families are deciding to take on the responsibility of caring for their ill loved ones. Treatment and support no longer just applies to those who have been diagnosed, but to everyone involved. There would be many mentally ill persons left without support if loved ones did not take responsibility. One of the most important aspects of good healthcare, treatment, and support for the mentally ill, especially those suffering from depression, is the care for those who are directly involved. Those who are suffering from depression, heart disease, Alzheimer's disease, or diabetes need all the support they can get. Working from this mindset, it is just as important to treat the family members, as it is to treat the actual patient.

Conclusion

Depression in any form is complex, both in accurately diagnosing and selecting a treatment plan. It is important for family physicians as well as mental healthcare professionals to understand the different forms depression may present itself in an individual, especially when working with the elderly population. The

aging population seems to deal with a whole different set of symptoms and tend to react to drug and therapy treatment plans in a much more delayed manner. It is essential for healthcare providers, including counselors to be knowledgeable about the different drug therapies that are available, and how an elderly person will respond. Cognitive-behavioral therapy seems to be the most effective form of psychotherapy for this population; however, the combination of therapy and medicine is ideal in most cases. When determining if an elderly person is depressed, many other factors must be taken into consideration.

As people age other health concerns may be either partially or fully responsible for depressive symptoms. Instruments such as the Geriatric Depression Scale are very helpful and accurate in narrowing down why a person is depressed, and perhaps can give a clue as to a treatment option that will be the most beneficial for the particular patient. As with anyone whom is depressed, the risk of suicide is increased. As stated previously, depression in the elderly is rather common, and since a significant number of depressed people either attempt or complete suicide, it cannot be overlooked that an elderly person suffering from depression may be contemplating suicide.

Besides treating the depressed person, and hopefully minimizing or eliminating feelings or thoughts of suicide, it is again important to try to treat those in the support network of the patient. Depression is not an illness that

affects just the identified patient; family, friends, and healthcare workers are often just as affected as the individual patient. Depression, when accurately diagnosed and treated, can many times be alleviated. Healthcare professionals in all arenas have a huge responsibility to not only understand depression and the illnesses that may accompany, but also to provide quality, effective treatment appropriate for the specific symptom manifestation and age population being affected. When working with the elderly population, this point cannot be stressed enough. Even though determining whether or not an elderly person suffers from depression or another serious illness is often times a difficult procedure, it is essential that family, friends, and healthcare professionals collaborate and take the time to fully treat a patient to the best of their abilities.

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