Minor Depression in the Elderly

Case Study and Commentary, Eleanor Valdes Dwyer, LCSW, Patricia Areán, PhD, Kristine Yaffe, MD, and Christopher M. Callahan, MD

INSTRUCTIONS

The following case study, “Minor Depression in the Elderly,” is accompanied by a continuing medical education (CME) evaluation that consists of 5 multiple-choice questions. After reading the case study, carefully consider each of the questions in the CME evaluation on page 51. Then, circle your selected answer to each question on the CME evaluation form on page 52. In order to receive one CME credit, at least 3 of the 5 questions must be answered correctly. The estimated time for this CME activity is 1 hour.

OBJECTIVES

After participating in the CME activity, primary care physicians should be able to:
1. Screen patients for depression.
2. Identify associated risk factors for depression in the elderly.
3. Correctly diagnose major depression, minor depression, and dysthymia using DSM-IV criteria.
4. Identify treatment options for minor depression in the elderly.
5. Develop pretreatment interventions to increase likelihood of adherence to minor depression therapy.

INTRODUCTION

Depression is the most common psychiatric disorder in the elderly, with major depression occurring in approximately 1% of community-dwelling residents older than 65 years [1]. Much less attention has been given to the study of persons with milder forms of depression despite growing evidence of the prevalence and disabling nature of so-called “subsyndromal,” “subclinical,” or “minor” depression. Recent studies suggest that minor depression is associated with increased rates of occupational and social dysfunction, physical disability, medical illness, health care utilization, and increased risk of a major depressive episode [2–5]. Minor depression is particularly prevalent in persons older than 60 years, occurring in as many as 27% of patients in this age-group [1,2].

Despite available evidence, the validity of minor depression as a distinct diagnostic entity is still debated [6] and clear guidelines regarding treatment have not yet emerged for primary care physicians, the physicians most likely to encounter minor depressive syndromes [7–9]. This article discusses methods of assessment and treatment options for geriatric patients presenting with minor depression in a primary care setting.

CASE STUDY

Initial Presentation

A 61-year-old African-American man presents to a primary care clinic with a specific complaint of skin growths on his right forehead that have increased in size over the past 3 months.

History

There has been no change in color of the lesions, and the lesions are nonpainful and without discharge. Past medical history is significant for multiple childhood ear infections leading to ear surgery and permanent hearing loss. Other significant historical factors include a positive PPD skin test at age 21 and treatment for syphilis and gonorrhea at age 30. Three years ago, a right apex nodule was found on digital rectal examination; a subsequent measurement of prostate-specific antigen (PSA) level was 2.6 ng/mL and biopsy was negative. The patient has no known allergies and denies a history of diabetes, hypertension, and cardiac disease. An HIV test was negative approximately 1 year ago. The patient is not taking regular medication. He reports no history of alcohol or drug abuse and denies problems with appetite or sleep.

The patient is a divorced high-school graduate with a 35-year history of working in retail. He was laid off from his last job 8 months ago and currently is supported by minimum

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unemployment benefits. He relates that since being laid off he has felt increasingly tired and has “dropped” some of his usual activities.

The patient lives alone in an apartment. He is in a monogamous relationship with his girlfriend of 1 year. He has occasional contact with his adult son and two grandchildren.

Physical Examination
Physical examination reveals a tired-appearing, slightly overweight, casually groomed man wearing a hearing aid on his left ear and in no apparent acute distress. Height is 5’7”, weight is 175 lb, and vital signs are normal. Skin appears scaly but has normal pigmentation and is without rash. A raised 7-mm x 5-mm skin lesion with black pinpoint colorations is present on the right side of his forehead. Pupils are equal, round, and reactive to light. The patient is anicteric. Throat is clear, with no evidence of thrush. Lungs are clear to auscultation bilaterally. Abdomen is nontender and without organomegaly.

Neurologic Examination
The patient is oriented with no evidence of overt cognitive deficits or thought disorder. There is no evidence of psychomotor retardation.

Dr. Callahan:
Diagnostic Considerations
The patient presents with the problem of skin lesions, but during the history reveals the complaint of low energy. Loss of energy, or fatigue, occurs with many medical and psychiatric illnesses. Patients may complain of “tiredness,” “lack of pep,” or “no get up and go.” These complaints may be interwoven with complaints of muscular weakness, poor sleep, lack of interest or ambition, indifference, or other emotional symptoms, including feeling depressed or “down.”

Most organic etiologies of fatigue can be ruled in or out by history and physical examination. Medical illnesses in which fatigue and other nonspecific symptoms are prominent include anemia, hypothyroidism, occult neoplasm, sleep apnea, chronic inflammatory diseases such as chronic hepatitis, and slowly progressive cardiac or pulmonary disease. The case patient has a history of a positive PPD test, so one might consider the possibility of a reactivation of tuberculosis. In addition, the abnormal prostate examination raises the suspicion of prostate carcinoma, and the patient is in an age-group at increased risk for colon cancer. Psychiatric disorders that may present as fatigue include depression, anxiety, and the somatoform disorders. Loss and subsequent psychosocial stressors often precipitate onset of a depressive episode [10,11]. In addition, the patient’s medical history includes a self-reported history of syphilis and gonorrhea in the 1960s; while unlikely, it is possible that a psychiatric illness such as depression or psychosis may be the prominent feature of neurosyphilis [12].

Further Questioning of Patient
The physician tells the patient that he will provide a dermatology referral for his skin growths, but wants to know a bit more about how things are going in his life, noting that being unemployed can be a stressful time. The patient admits that he feels depressed and socially isolated as a result of being out of work and that his depression and poor job prospects are making it difficult to follow through on his job search. His inaction makes him feel bad about himself and causes him to put himself down, which further paralyzes him and leads to feelings of worthlessness.

• What are the diagnostic considerations in this patient?

Ms. Dwyer:
Criteria for Depressive Disorders
Depression is not a single disease but a group of syndromes categorized as mood disorders in the Diagnostic and Statistical Manual, 4th edition (DSM-IV) [13]. Primary mood disorders may be divided into two broad categories: major depression and dysthymia. The differential diagnosis is based on severity and duration of symptoms, and confirmed by clinical observation and assessment of patient’s distress and impairment of function in the areas of self care, occupation, relationships, and social activities.

The criteria for major depressive disorder are shown in Table 1. A patient with major depression has at least 5 of the 9 symptoms listed for at least 2 weeks. Dysthymia is defined as a chronically depressed mood most of the day for more days than not for at least 2 years. In dysthymia, during periods of depressed mood at least two of the following additional symptoms are present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, feelings of worthlessness or guilt, poor concentration or difficulty making decisions, or feelings of hopelessness. Dysthymia is less severe than major depression and it is usually present for many years and difficult to distinguish from the person’s “usual” functioning.

• Does this patient meet the criteria for either of these disorders?
Ms. Dwyer:

Probable Diagnosis
To meet the criteria for major depression, a patient must have at least 5 of the 9 symptoms listed in Table 1. The case patient reports the symptoms of depressed mood, anhedonia, fatigue, and feelings of worthlessness, but because he endorses no other depressive symptoms, he does not meet the criteria for an episode of major depression at the time of assessment. Dysthymia can be ruled out in this patient because he has had his symptoms for only 8 months.

As the patient’s symptoms do not meet criteria for DSM-IV diagnoses of major depression or dysthymia in terms of intensity or duration, how should he be diagnosed? His condition might best be described as minor depression, a syndrome that has been identified and studied in epidemiologic and clinical studies but has not yet been specifically defined in DSM-IV. A patient may be considered to have minor depression if the patient has had depressive symptoms, including depressed mood or loss of interest in activities, for at least 2 weeks that cause the patient significant distress and impairment. The key distinction between major and minor depression is that patients with minor depression have three to four symptoms, whereas patients with major depression have five or more. Although minor depression has fewer symptoms, the symptoms can persist chronically without periods of remission [9]. Minor depression is coded as a Depressive Disorder Not Otherwise Specified (NOS) in DSM-IV.

• Is depression normal for an older man who is medically ill and financially strained?

Dr. Areán:

Depression is not a normal part of aging. Longitudinal studies on mental health and aging have found that while older adults are faced with a number of life stressors, they are incredibly resilient to psychosocial changes [14] and have lower rates of major depression compared to the general population. Older adults with depression seen in primary care practice usually have milder forms of depression. Major depression in the elderly is usually a recurrence.

• What should be part of the additional workup in this patient?

Dr. Callahan and Ms. Dwyer:

Appropriate investigations should be done to rule out any potentially life-threatening illnesses. This would at least include a follow-up PSA test and a chest radiograph to rule out tuberculosis.

The differential diagnosis of depressed mood includes a number of disorders. All patients with depressed mood should be screened for current or past abuse of alcohol or drugs to rule out substance-induced mood disorders. Because depression and anxiety disorders are often comorbid conditions, [15], the primary care physician should also ask about excessive worry, fears, panic attacks, or anxiety in response to a severe traumatic event. In addition, the physician should rule out psychotic disorders, ask about a history of mania or hypomania (to rule out bipolar disorder), and determine if the mood disturbance is the direct physiologic consequence of a specific general medical condition (eg, multiple sclerosis, stroke).

Dr. Yaffe:

A serum test for treponemal antibodies and possibly a lumbar puncture for cerebrospinal fluid analysis should be considered to evaluate for neurosyphilis. A routine chemistry panel, complete blood count, thyroid-stimulating hormone measurement, and a test for vitamin B₁₂ deficiency would be useful to rule out medical conditions.

Additional Workup

The physician empathizes with the patient’s situation and asks about additional psychiatric symptoms. The physician makes a presumptive diagnosis of minor depression. He tells the patient that he would like to run a few tests to rule out any physical causes, but in the meantime he would like him to fill out a questionnaire that will help the physician in completing his assessment and developing a management plan.
What assessment tools are available to detect and evaluate patients with depressive symptoms?

Is routine screening recommended in asymptomatic patients?

Dr. Areán:

Assessment Instruments

Numerous scales are available for assessment of depression. An established screening instrument for use in older populations is the Geriatric Depression Scale (GDS) (Table 2) [16]. The GDS takes about 5 minutes to complete; its format (true/false) and relatively short length (30 items) make it less cumbersome than some other scales. A GDS score of 15 or higher is typically associated with “severe” depression. In a study of 130 patients older than 60 years of age, a GDS score of 10 or higher was associated with a sensitivity of 100% and a specificity of 84% in detecting major depression [17]. This study also suggested that accuracy of the GDS and other screening instruments may be lower in screening for minor depression. A drawback of the GDS is that it excludes somatic symptoms, which may be more commonly endorsed by older primary care patients. Other self-report questionnaires include the Beck Depression Inventory (BDI), the Center for Epidemiological Studies–Depression Scale (CES-D), and the Zung Self-Rating Depression Scale (ZSRDS). These scales have been shown to be reliable and are sensitive for depression.

The PRIME-MD questionnaire [18], developed specifically for use by primary care practitioners, assesses for depression and other psychiatric disorders (anxiety, alcohol abuse, eating disorders). It consists of 26 questions about symptoms and signs present during the last month plus one question about overall health and yields a DSM-IV diagnosis. It takes approximately 8 minutes to complete. PRIME-MD is very specific (> 80%) for depression but has not been validated on older populations.

The most widely used instrument in clinical research is the Hamilton Rating Scale for Depression (HRS-D) [19]. This instrument takes longer to administer and must be completed by the clinician. However, it may have slightly greater specificity than do self-reports in detecting depression [20]. Measurements such as the SF-36 and SF-12, which assess functional status and emotional well-being, are helpful for evaluating the impact of symptoms on quality of life and are computer-scored for ease of use in the busy outpatient setting [21].

Screening Recommendations

The U.S. Preventive Services Task Force holds that there is insufficient evidence to recommend for or against the use

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**Table 2. Geriatric Depression Scale**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you basically satisfied with your life?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. Have you dropped any of your activities?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Do you feel your life is empty?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Do you often get bored?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. Are you hopeful about the future?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6. Are you bothered by thoughts you can’t get out of your head?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Are you in good spirits most of the time?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8. Are you afraid that something bad is going to happen to you?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Do you feel happy most of the time?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10. Do you often feel helpless?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Do you often get restless and fidgety?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12. Do you prefer to stay at home rather than going out and doing new things?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Do you frequently worry about the future?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14. Do you have more problems with memory than most?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. Do you think it’s wonderful to be alive now?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>16. Do you often get downhearted and blue?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>17. Do you feel pretty worthless the way you are now?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>18. Do you worry a lot about the future?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>19. Do you find life very exciting?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20. Is it hard for you to get started on new projects?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>21. Do you feel full of energy?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>22. Do you feel your situation is hopeless?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>23. Do you think that most people are better off than you are?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>24. Do you frequently get upset over little things?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>25. Do you frequently feel like crying?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>26. Do you have trouble concentrating?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>27. Do you enjoy getting up in the morning?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>28. Do you prefer to avoid social gatherings?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>29. Is it easy for you to make decisions?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>30. Is your mind as clear as it used to be?</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

of standardized questionnaires to screen for depression in asymptomatic patients [22]. It does, however, recommend screening for patients who have risk factors for depression, such as family history of depression, lack of social support, stressful life event, sleep disorders, multiple somatic complaints, current alcohol or substance abuse, or chronic pain or illness. Data suggest that the severely medically ill have high rates of depression [23]. Thus, in a patient whose complaints of fatigue are accompanied by signs and symptoms of congestive heart failure, there is a high likelihood that the symptom of fatigue is not solely attributable to the medical problem and a diagnosis of depression ought to be ruled in. Up to 20% of the patients presenting to a public primary care setting meet criteria for depression [24], but as they do not always present with classic vegetative signs, the condition often goes undetected. Thus, a lower threshold for screening than that upheld by the Task Force may help to improve the current low recognition rates for this illness.

**Assessment of Depressive Symptoms and Initial Treatment Plan**

The physician administers the GDS. The patient scores a 21, indicating severe depression. Due to the patient’s distress, loss of functioning, and high GDS score, a trial of antidepressant medication is considered.

- What pharmacologic agents are useful for treating depression in the elderly?

**Dr. Yaffe:**

**Antidepressants**

Preliminary studies indicate that effective treatments for minor depression include antidepressant medications used alone or in combination with psychotherapy [25,26]. One study suggests that psychopharmacologic treatment is indicated when a patient presents with higher severity of minor depressive symptoms, higher neuroticism, and a history of either dysthymic disorder or two or more episodes of major depression [9]. When a trial of medication is considered, assessing patients’ preconceptions and concerns about medication is often helpful in determining the likelihood that they will take the medications as prescribed. A medication assessment questionnaire [27] can impact on adherence by aiding the primary care physician in focusing the discussion on the particular beliefs of the patient (Figure 1). The more information the patient has about antidepressant medication and side effects, the more likely the patient is to comply with the regimen [28].

If an antidepressant trial is initiated, the consensus statement of the National Institutes of Health expert panel on Diagnosis and Treatment of Depression in Late Life [3] recommends starting the patient on a selective serotonin reuptake inhibitor (SSRI). A recent open-label trial of fluvoxamine in 30 subjects with minor depression treated for 8 weeks demonstrated improvement on a variety of depression scales [29]. A meta-analysis of randomized controlled trials suggests that SSRI treatment of depression results in outcomes in the elderly comparable to other populations [30]. If the patient has a poor response to the first-choice SSRI, an increase in dose may be considered, but if not tolerated well, the physician may elect to switch to another agent. The Agency on Health Care Policy and Research provides an excellent guideline for acute-phase medication management of major depression that can be referenced by primary care providers [31]. However, there are no good data comparing SSRIs and the traditional tricyclic antidepressants for the treatment of minor depression in the elderly.

Additional studies are needed to determine the optimal dose, length of pharmacotherapy, and cost-benefit ratio, particularly for a subpopulation like the elderly. Patients treated with antidepressant medication should show significant improvement in depressive symptoms within 4 to 8 weeks [31]. If no significant improvement is evident within that time, reevaluation of the depression, diagnosis, and treatment plan is recommended.

- What are other treatment options?

**Dr. Callahan:**

**Primary Care Management**

One option involves the primary care physician using active listening, providing advice and support, and encouraging patients to utilize informal counseling support from their religious or social affiliations [27]. Often misrepresented as “watchful waiting,” this model involves the primary care physician in active engagement with the patient, scheduling regular follow-up appointments to evaluate depressive symptoms and suggest alternative treatment options if needed. The high rate of spontaneous remission of minor depression suggests that this type of primary care management may be more cost-effective relative to more active treatment [32]. Two randomized trials conducted at Group Health of Puget Sound have supported the notion that informed primary care management is more cost-effective than antidepressant treatment or cognitive behavior therapy in the treatment of minor depression [32]. These results are suggestive, although it is unclear whether they are generalizable to the treatment of older populations, in whom minor depression may be
MINOR DEPRESSION

Sometimes we have beliefs about medications that make using medications successfully more difficult. Put an “X” by any of the following statements that you believe, even a little, concerning medications or drugs prescribed by doctors for treatment of anxiety and depression.

**Belief**

[ ] These kinds of drugs are not the answer to problems in one’s life.
[ ] These kinds of drugs are a crutch.
[ ] I would be the one to get severe side effects.
[ ] I should be able to get by without using these kinds of drugs.
[ ] I could get addicted.
[ ] My family would not want me to use these kinds of drugs.
[ ] I will not be able to work if I take these kinds of drugs.
[ ] These kinds of drugs are overused.
[ ] It is harmful to take too many different kinds of drugs.
[ ] These kinds of drugs should not be taken long-term.
[ ] Drugs that doctors prescribe for anxiety and depression are dangerous.


more persistent and costly if left untreated. One study of 117 subjects over the age of 65 concluded that neither depression nor anxiety generally remitted spontaneously in older adults [33].

A useful resource for primary care physicians interested in treating depression is *Treating Depression in Primary Care* by Robinson et al [27]. The manual guides primary care providers in selecting levels of care using a Depressive Symptoms Assessment System, providing the patient with education about the nature of depression, and developing with the patient a personalized Coping Plan incorporating behavioral and cognitive interventions that can be introduced and monitored within the usual 15-minute medical visit.

**Dr. Areán and Ms. Dwyer:**

**Collaborative Care**

To date, one of the most successful methods of providing treatment for patients with depression in primary care clinics has been through the integrated staff or behavioral medicine model adopted at several large hospitals and health maintenance organizations. Mental health specialists, including social workers, psychologists, and clinical nurse specialists, become primary care team members and consult on-site, offering specific psychotherapies adapted to primary care in close proximity to the primary care clinic.

On-site consultation improves access to mental health services by eliminating the barrier of having to travel to another clinic. Also, the consultation services improve coordination and integration of medical and behavioral health needs. Many consultations are single-session visits, with feedback about medication and/or psychological intervention strategies made immediately available to the referring provider. Interventions with patients are simple, “bite-sized,” and compatible with the types of interventions that can be provided in a 15-minute health care visit (eg, teaching abdominal breathing). Follow-up consultations are arranged to reinforce and build upon the health care provider’s interventions. The consultant remains in partnership with the physician or other members of the medical care team, at “arm’s length” for patients who need longer term surveillance.

* When is referral indicated?

**Dr. Areán and Ms. Dwyer:**

**Indications for Referral**

A mental health referral may be appropriate when a primary care physician’s time constraints prevent a comprehensive assessment. Assessment of chronic psychosocial problems, extent of suffering, functional impairment, and adequacy of coping skills is important in assessing symptoms of minor depression.

Referral to a mental health specialty provider or clinic staffed by licensed clinical psychologists, social workers, master’s level counselors, or clinical nurse specialists for an in-depth course of psychosocial/behavioral treatment may be appropriate when depressive symptoms interfere with a patient’s ability to implement the behavioral strategies initiated by the primary care physician [28]. Referral could also be considered when the patient refuses medication for idiosyncratic reasons but is willing to use “talk therapy” as an alternative to medication or in combination with the medication. Psychotherapies provided by licensed clinicians have been demonstrated to be efficacious in the treatment of minor depression [25,34–37] (Table 3).

Phone consultation with and/or referral to a psychiatrist should be considered when the primary care provider identifies medication issues such as a poor response to medication treatment or severe side effects or ongoing complex health problems concurrent with the depression.

Primary care physicians should consider logistical factors like clinic location and transportation when deciding on treatment options. It may not be convenient for a patient to follow through with mental health services.
What can the primary care physician do to enhance treatment and compliance?

Ms. Dwyer, Dr. Areán, and Dr. Yaffe:

Pretreatment Education

Pretreatment education about depression and its treatment can play an invaluable role in patient care and, ultimately, in treatment compliance. The physician can inform the patient that depressive disorders are often precipitated by psychosocial stress and that depression is a spectrum of disorders with a range of severity. It can be helpful to tell the patient that depression is a medical illness, not a weakness of character. The primary care physician should further engage in a dialogue with the patient about his or her personal and cultural beliefs about depression. In doing so, the primary care physician can use the patient’s own words to tailor the delivery of the information about treatment options [38,39].

To underscore the importance of treatment, patients should be told that the combination of medical problems and depression generally has an additive effect on symptomatology and disability [5], and that older adults with symptoms of depression are more disabled by their illnesses, report being in greater pain, and have poorer treatment responses than older patients who have no symptoms of depression [29,40–42]. Low-income medical patients with few social supports and scarce environmental resources could find it more difficult to return to baseline functioning without intervention [43].

Referral to Mental Health Services

Despite education to dispel misconceptions about medication, the patient refuses a trial of antidepressant medication because he does not want to take “mind-altering drugs.” The physician reinforces the importance of treating the depressive symptoms and suggests a referral to a mental health clinic at the local hospital that interfaces with the community health care system. With the discrepancy between the number of depressive symptoms reported and the high GDS score, further evaluation of the patient’s depressive symptoms is warranted to confirm the diagnosis and more fully assess severity. The physician reassures the patient that the mental health providers will remain in close communication with his office and assures him that treatment will be reevaluated in 4 to 6 weeks. With the patient in the office, the primary care physician calls the mental health clinic and obtains an appointment within the week.

Evaluation and Treatment

At the mental health clinic, a psychiatric evaluation confirmed the diagnosis of minor depression. The clinical interview substantiated that the precipitant of the depression symptoms was job loss and that ongoing psychosocial stressors of unemployment and financial stress contributed to the maintenance of the depressive symptoms. A comprehensive psychiatric interview and functional assessment revealed that the patient had begun to isolate himself from friends and decrease his level of activities, which created a vicious cycle of low mood, low activity, and low social support.

The treatment team recommended cognitive behavior therapy (CBT) (Table 3). The therapeutic “hook” to engage the patient as a partner in therapy was to explicitly agree that one measure of success or failure of CBT would be if he was able to find gainful employment during the course of treatment. Therapy goals included stabilizing mood, restoring functioning to pre-episode level, and learning skills to prevent future episodes of depression.

CBT group therapy was called the “depression class,” a moniker that increases receptivity to therapy in older adults.

Table 3. Psychotherapies Useful in the Treatment of Minor Depression

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Interpersonal psychotherapy</td>
<td>Helps patients cope with interpersonal struggles, such as unresolved grief, role transition, role dispute, and interpersonal deficits</td>
</tr>
<tr>
<td>Reminiscence therapy</td>
<td>Helps older patients overcome their depression by exploring their past and any regrets they may have about their lives</td>
</tr>
<tr>
<td>Cognitive behavior therapy</td>
<td>Focuses on helping patients alter or revise maladaptive or distorted thoughts and attitudes that contribute to the onset and maintenance of depressed mood. CBT has been demonstrated to be an effective treatment for both major and minor depression [20].</td>
</tr>
<tr>
<td>Problem-solving therapy</td>
<td>Developed by Nezu and Perri and modified by Mynors-Walls, PST holds that there is an association between major negative life events, daily stress, and poor coping and problem-solving abilities and subsequent depression. PST has been shown to be highly effective in older adults [33] and was found to be as effective as antidepressant medication in primary care patients [31,32].</td>
</tr>
</tbody>
</table>
The CBT group met for 2 hours per week for a contracted 16 weeks. Initially, the patients received education regarding the symptoms of minor depression and were provided an overview of the CBT treatment model. The program consisted of three modules: Thoughts, Activities, and People. The Thoughts Module focused on identifying and restructuring negative thoughts or “mistakes in thinking” [44] that contribute to the onset and maintenance of depression. For example, when the patient stated, “I have lost complete control,” he was taught several strategies to dispute this statement so that it more accurately reflected reality, including the “Yes, but” technique (“Yes, it is true there are some things I don’t have control over, like my age, but I do have control over the time I spend job hunting”) [45].

The behavioral component, or Activities Module, taught that the more depressed one feels, the less one does, and the less one does, the more depressed one feels. The patient discovered that positive activity allowed him a distraction from his depression and an opportunity to replenish his energies to tackle the business of job hunting. During the People Module, the patient shared his thoughts about his relationships outside of the group, eg. “I have always been the rock in my family, the one who takes care of others. I should never have to depend on others.” These maladaptive cognitions were disputed when the patient experienced the benefits of reciprocity in the group therapy environment.

Within the group setting, the patient was open to emotional support from his fellow group members and subsequently was able to accept financial assistance from friends. In doing so, the patient increased his sense of connection to others, which improved his self-worth.

The patient’s treatment was coordinated with the primary care provider. After the intake evaluation, the therapist called the primary care provider to advise the physician of the confirmation of the diagnosis and the treatment plan. They agreed that worsening observed by either the primary care physician or therapist would prompt another phone contact.

After 16 weeks, the patient denied feeling depressed and was managing his mood by engaging in pleasant activities in addition to job hunting. His GDS score dropped to a 1 and he no longer met criteria for minor depression.

At the conclusion of therapy, the therapist telephoned the primary care provider to report that the patient no longer met criteria for depression and to identify the interventions that were most helpful to the patient. The therapist also informed the primary care provider of the patient’s personal relapse prevention plan so that the physician could continue to monitor symptoms along with the patient and reinforce the patient’s adherence to the plan.

How should primary care physicians monitor patients whose depressive episode remits?

Ms. Dwyer:
Patient Monitoring
No definitive monitoring guidelines have been established for minor depression. Therefore, individual patient monitoring is critical to identify relapse. The primary care physician can remind the patient of the difference between normal periods of sadness, which are to be expected, and clinical depression as a persistent mood state. Primary care physicians can request that patients inform them if their symptoms recur.

Epilogue
With his depressive symptoms in remission, the patient found a full-time job as a customer service representative through an employment agency. Eighteen months later, his symptoms remain low, with his GDS score slightly higher but well within the normal range.
CONCLUSION

Ms. Dwyer, Dr. Areán, and Dr. Yaffe:

This case highlights the importance of recognizing and treating minor depression in the elderly. CBT facilitated the patient’s return to his previous level of functioning by focusing on increasing his pleasurable activities, changing his negative cognitions, and resolving his interpersonal problems. CBT specifically addressed the immediate life problem that precipitated the depressive episode while teaching the patient critical skills for coping with depression. The patient also learned to recognize depression and to take proactive steps to prevent future episodes.

Controversy remains about the relative costs and benefits of different treatment options. Empirically based treatment options for major depression, including antidepressant medication and CBT, may not improve the already relatively high rates of remission observed in minor depression. Some controlled research suggests that antidepressant treatment and CBT do not improve upon “watchful waiting” in younger age-groups. Lacking is evidence about the relative merits of more or less aggressive and costly treatment approaches in the elderly. At least one study shows relatively low rates of spontaneous remission in older patients and suggests that the elderly may require empirically based intervention to recover from minor depression [29]. Studies of treatment approaches that differ in their intensity and mental health specialist involvement are needed to evaluate the cost-effectiveness of various clinical pathways for minor depression in primary care settings. Additionally, naturalistic studies of the long-term course, outcomes, and service utilization patterns would be useful in evaluating the effects of minor depression in the elderly.

In the absence of controlled cost-effectiveness trials, this article has made knowledge and treatment recommendations by translating knowledge of best practices in the management of major depression consistent with our limited knowledge about the treatment of minor depression. The prevalence and potential consequences of depression in primary care settings demands that future research identify best practices across the full spectrum of depressive disorders and patient populations.

References

MINOR DEPRESSION


A 68-year-old woman with arthritis presents to her primary care physician for her routine appointment with complaints of chronic pain, loss of interest in going to church, and fatigue. She reports feeling down since her adult daughter moved out of state 2 months ago and having difficulty making decisions. Physical examination findings and results from a chemistry blood panel are normal. The patient denies substance abuse and past history of psychiatric illness. She does not demonstrate cognitive impairments or thought disorder. Her Geriatric Depression Scale score is 12.

1. What is the likely diagnosis?
   (A) Minor depression
   (B) Major depressive episode
   (C) Dysthymia
   (D) Fibromyalgia

2. Treatment options for minor depression include all of the following EXCEPT
   (A) Primary care management
   (B) Collaborative behavioral medicine
   (C) Psychotherapy
   (D) Biofeedback

3. Which of the following pretreatment interventions may increase the likelihood of adherence to treatment for minor depression?
   (A) Prescribing medication
   (B) Characterizing depression as “normal”
   (C) Educating patients and discussing beliefs about depression
   (D) Exploring childhood origins of depression

4. Dysthymia is distinguished from minor depression by which of the following factors?
   (A) Number and severity of symptoms
   (B) Duration of symptoms
   (C) Social and occupational dysfunction
   (D) Concurrent medical illness

5. All of the following statements about depression are true EXCEPT
   (A) Up to 20% of patients presenting to primary care meet criteria for depression
   (B) The severely medically ill have high rates of depression
   (C) Minor depression is associated with occupational and social dysfunction
   (D) Older people have higher rates of depression compared to the general population
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