DEPRESSION NEEDN'T ACCOMPANY OLD AGE, SAYS CHARLES REYNOLDS

INTERVIEW BY TERRY GROSS

LOOKING OUT FOR OLD FRIENDS

On September 11, the University of Pittsburgh's Charles Reynolds (Res '80) was featured on National Public Radio's Fresh Air with Terry Gross, *produced in Philadelphia by WHYY and distributed by NPR. What follows are excerpts of the interview.* (*© 2007, WHYY. Printed with permission.*)

GROSS: Older people often suffer with undiagnosed and untreated depression. My guest, Dr. Charles Reynolds, says depression should not be regarded as a normal part of aging. Reynolds directs a research center for late-life mood disorders that is funded by the National Institute of Mental Health. It's based at the University of Pittsburgh medical school, where he's a professor of psychiatry, neurology, and neuroscience. Dr. Reynolds, welcome to *Fresh Air.* You know, there are so many reasons to be depressed if you're very old. There's declining health; that's probably not going to improve. Maybe you've lost a spouse. You've probably lost friends. You're facing more decline as you get older, and you know that that's just going to be followed by death. So you'd maybe say that depression is a natural and even almost sensible state to be in given what you're facing. What would you say to that?

THE PARK AT THE SAINT-PAUL HOSPITAL, 1889, VINCENT VAN GOGH. THE BRIDGEMAN ARCHIVE/GETTY IMAGES

REYNOLDS: What's really, I think, surprising, Terry, is how many older people are resilient to clinical depression. Despite the losses that accompany old age … most people don't in fact develop the symptoms and signs of clinical depression. Rather, they're able to cope actively with the challenges of old age. Perhaps two in 10 people do, however, become clinically depressed, and it's important that they be identified and offered appropriate treatment.

GROSS: Now, I was once told by a doctor, by an internist, that antidepressants aren't as effective in the elderly as they are with other people. And that, also, antidepressants won't be as effective if an older person's depression seems to be situational—like the loss of a spouse or like facing chronic health problems. Do you think that doctor was correct?

"I've known older people who will look at you and say, 'I'm not crazy. Therefore I don't need to see a psychiatrist, and I certainly don't need any medication.'"

REYNOLDS: The data really do suggest otherwise, and let me tell you what I mean. Clinical trials involving the use of antidepressant medications have matured in the last 10 to 20 years. And what we've shown, in essence, is that situational depression, such as depression following bereavement, in fact is quite responsive to antidepressant medication and allows the person who is bereaved to be in a better position for doing the work of grief. It removes one of the barriers to doing appropriate grief work and to adjusting to life, say, without the spouse.

GROSS: Do you find that a lot of elderly people are resistant to even talking to a psychiatrist? … I've known older people who will look at you and say, "I'm not crazy. Therefore I don't need to see a psychiatrist, and I certainly don't need any medication."

REYNOLDS: I do think that is the case. The older generation of Americans, I think, have a very different personal model of what depression is. And we should say that depression doesn't mean that you're crazy. It's a treatable medical illness.

At the same time, I think many older Americans may take the view that depression may somehow represent a moral failing or a character or logic flaw, rather than an illness like diabetes or hypertension, which can be diagnosed and treated. …

My own view happens to be that it's very appropriate for most older Americans living with depression to be treated in the primary care setting. Depression treatment is often a very straightforward medical undertaking. Geriatric mental health specialists like myself can be called in as consultants, or we can offer an opinion on a particularly difficult-to-manage situation.

GROSS: When you do talk therapy, as I assume you do with some older patients who you see …

REYNOLDS: Correct. Yes.

GROSS: ... can you give us a sense of what therapy is like—like what topics you'd bring up? … Especially if somebody is older and their memory isn't as good as it used to be. Maybe they even have a little bit of dementia. I mean, how does talk therapy work when your mind isn't what it used to be?

REYNOLDS: Talk therapy is actually very helpful for older people with depression. I think it's important to emphasize that all of these therapies are relatively brief. They're very active. The patient is not lying on a couch, as you might think of in terms of traditional psychoanalysis. Rather, the patient and the therapist are actively engaged in one form of problem solving or another.

Take interpersonal psychotherapy as an example. Here we're very often dealing with issues related to bereavement, such as the loss of a spouse, or transitions in major social roles, such as can be seen in the wake of retirement.

We might also be dealing with interpersonal conflicts. Let's suppose an older person with depression is becoming increasingly frail or dependent upon a caregiver, and that relationship [has] become somewhat conflictual. One of the important focuses of IPT (interpersonal therapy) in a situation like that is to help improve communication with the caregiver in order to lower the amount of tension or stress that's in that relationship.

GROSS: Now, I know while you were doing your residency at the University of Pittsburgh one of your grandparents committed suicide at the age of 89, and I understand that that helped lead you to study geriatric psychiatry. What happened? What do you know about why your grandparent committed suicide?

REYNOLDS: Yeah, this was my grandfather, Mr. Charlie, as he was called. I'm actually named for him. He was a very successful Mississippi farmer. He raised cotton. He was a—really a great guy, very vital and, as far as I know, had never experienced any depression in his life until he reached very old age. And in his mid- to late-80s, Mr. Charlie suffered a stroke. He also developed a very painful case of herpes, which is common in older people who are frail or whose immune systems are compromised.

And my speculation, Terry, is that in the wake of these medical insults, which were very disabling for him so that he couldn't really practice farming anymore, I think he came to feel that his life was pointless. He became pessimistic. …

So I think he made the decision that he had no more, in a sense, windmills to tilt at. ... He had a gun in his house and, as is the case with many older men who die by suicide, he shot himself in the head. I found out about that after the fact. And, as your question suggested, it had really a profound impact on me, both as his grandson but also as a budding young psychiatrist at that point. And so for the last really 25 years, this has been the focus of a lot of the scientific and clinical work that I've done, and I think we've made a lot of progress [in] trying to prevent the sort of thing that happened to my grandfather.

GROSS: Did people in your family feel that if they had intervened in some way that they might have prevented him from killing himself?

REYNOLDS: Oh yes. I think this is always, Terry, the emotional legacy of suicide within a family. You always have to ask yourself if it was preventable. And yet the science, I think, tells us two things here that are very important to take note of. A lot of suicide in old age is preventable because it's the product of depression, which is a treatable illness. My colleagues and I have shown that if you appropriately treat depression in old age, you greatly lower or reduce the amount of suicidal ideation. At the same time, it's important to remember that mental illnesses, like other illnesses, are sometimes fatal. They can be terminal, and it's not possible in fact to prevent all cases of suicide, even under the best of circumstances.

GROSS: Let me raise a question—and this gets to an issue that I think a lot of people talk about with people that they're comfortable with. … A lot of people feel now that we are able to be kept alive medically past the point where anybody would really want to be alive. …

WOODS AND UNDERGROWTH, 1887, VINCENT VAN GOGH, THE BRIDGEMAN ARCHIVE/GETTY IMAGES

And, I mean, people are living in ways that they just never did before. I'm sorry for stammering here, but it's a very uncomfortable subject to discuss. But there's just a lot of people who say, "If I get to that point, I don't want to live that way."

REYNOLDS: I'm glad that you asked the question, because it's a conversation that we need to have as a nation—isn't it?—as well as within our own families and with our primary care physicians. The fastest-growing segment of the population in the U.S. is actually people above the age of 85. That is to say, the frail elderly. … It's very important for all of us to have discussions with family members, caregivers, ministers, physicians, about what our core values and preferences are, about the extent of treatment and support that we want at the end of life. So often we don't have those conversations. They aren't reflected in living wills, for example. And yet, if we do have those conversations with significant others and with our physicians, I think the chances are that we'll have a greater sense of control at the end of life and prevent the kind of scenario that you described.

GROSS: Of course, you know, living wills never say, "I have a gun, and, at a certain point, let me use it." Do you know what I mean? And without sounding cold, I'm wondering if there was anybody in your family who said about your grandfather after he killed himself, "God bless him. He knew what he wanted. He got to a point where he no longer wanted to live. He had a gun. He made a rational choice, and, you know, who can argue with it? Maybe he knew what his limits were and, by his standards, he did the right thing."

REYNOLDS: You know, I think that's a very understandable point of view, and I struggle with that myself. And at times I think, Terry, I've comforted myself as a grandson with that point of view. You know, at the same time, though, the science tells us something that may be slightly different from that interpretation. … If you provide appropriate clinical management or treatment to [older adults] living with depression or with emotional or spiritual or psychological pain, very often their desire to end their lives may actually go away. And they may decide that it's worth sticking around for a little bit longer.

GROSS: What advice would you have for people who have an elderly parent or grandparent or spouse who they really feel is depressed and could benefit from … psychiatric help, but the person who is depressed doesn't comprehend that they're depressed? They refuse to do anything about it, to see anybody about it, and, in fact, even accept it as an insult that somebody would think that they are depressed and that they need help.

REYNOLDS: Your question is so very important because, as you've just said, many older people simply don't, or won't, recognize clinical depression in themselves.

Also, it's very difficult to be the family member or caregiver of an older person with depression. Depression is almost like a contagious illness, and many of the caregivers of our depressed patients are themselves suffering from mild forms of depression.

There [are] some practical things that a family member or caregiver can do. First of all, it may be better not to use the D word, the depression word, which may be so stigmatized for older Americans that it represents an absolute barrier to help-seeking. Instead of depression, they hear "crazy." So it may actually be better to use terms that are out of the everyday vocabulary or experience of an older depressed person. Perhaps they're tired day in and day out or not enjoying most of their usual activities. Maybe they're worried. Maybe they're not sleeping well. So a family member can talk to the older person in terms of their actual lived experience of depression. Under those circumstances, it's often possible to persuade an older family member to get help.

Now, the help may be from a trusted professional. Perhaps that is going to be a minister or a priest or a rabbi. Maybe it's going to be a primary care doc with whom they've worked for many years. The important point is that they're beginning to get help from some appropriate source, and then, if the primary care doc, for example, feels that he or she needs a second opinion, they can call in a mental health specialist to give that opinion about managing a tricky situation, for example.

"It may be better not to use the D word, the depression word, which may be so stigmatized for older Americans."

GROSS: Dr. Reynolds, thank you so much for talking with us. ■