Depression in Older Adulthood

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Prevalence

Depression is not an inevitable part of the aging process. The Center for Disease Control reports the prevalence for depression is 5.4% in adults 60 years and older, significantly lower than rates in middle-aged (9.8%) and younger adults (7.4%). Although prevalence rates of depression in older adults are relatively low, research suggests symptoms of depression that do not meet diagnostic criteria are experienced by 19-39% of older adults. Additionally, prevalence rates for older adults residing in nursing homes are 49%. This may be due to the high comorbidity, or coexistence, of depression and physical illnesses such as diabetes, stroke, cancer, and cardiovascular disease.

Although women are twice as likely to be diagnosed with depression, men have significantly higher suicide rates across the lifespan. Men 75 years and older have the highest suicide rate. This suggests that current methods of assessing depression in men, particularly older men, may be fundamentally flawed.

Diagnostic Criteria

There are notable differences in how depression commonly presents in older adults versus younger adults. Younger adults are more likely to experience guilt, suicide ideation, and

dysphoria. Older adults are more likely to report somatic symptoms, hopelessness, helplessness, slowed movement, weight loss, memory issues, and loss of appetite. Additionally, age intersects with other identities (i.e., gender, race, culture) to affect the expression of depression. For example, Black women are more likely to report somatic complaints and men are more likely to report anger and irritability.

Missed Diagnosis

Unrecognized and undertreated depression in older adults may be due to a variety of reasons: older adults not reporting symptoms, clinicians attributing somatic complaints to physical rather than psychological concerns, and stigma associated with mental disorders. Thus, it is important for physicians to ask follow-up questions when an older client presents with somatic complaints such as insomnia or fatigue to determine if depression is a concern. The DSM IV mentioned that older clients may present as irritable and angry rather than sad and advised clinicians to probe for depressive symptoms when clients present with somatic complaints such as bodily aches and pains. However, those recommendations were omitted from the DSM V, increasing the likelihood of a missed diagnosis in older adults.

Complaints such as memory loss can be a sign of depression (psuedodementia) but is often misdiagnosed as dementia without conducting a thorough differential diagnosis to rule out other causes. Further, clinicians may over attribute depressive symptomology to the expected feelings associated with bereavement, loss, and health concerns that increase in prevalence with age.

Treatment

Although antidepressants medications are often the to-go treatment for depression in older adults, caution is recommended due to the increased risk of side effects (e.g., drug interactions, sexual dysfunction, cardiovascular and osteoporotic fracture risks) because of older adult's natural biological, psychological, and social changes. Thus, non-drug-based treatments are more desirable. Studies on the efficacy of cognitive behavioral therapy (CBT), reminisce therapy or life review therapy, electroconvulsive therapy (ECT), and problem-solving therapy (PST) are promising with older adults. However, the extent of their effectiveness is inconclusive because there is not enough research data to yield concrete results. Further research with larger sample sizes and control groups are needed to confirm what type of therapy is the most beneficial.

Therapy outcomes for depression vary depending on an individual's comorbid chronic condition and cognitive functioning. For example, PST has been recommended as an efficacious treatment in a sample of older adults diagnosed with both major depression and cognitive impairment or functional disabilities. PST is based on the belief that helping clients handle their lives better by identifying problems and designing and implementing problem-solving plans will reduce stress and as a result, depression. This therapy is modified for individuals with executive function impairments, such that the therapist is more directive to assist clients with initiating action plans, sequencing actions, and recognizing when goals have been accomplished to terminate action. PST is simpler than life review therapy and CBT; this makes it easy to use with older adults who may have certain cognitive deficits as an effect of aging.

Using efficacious treatment is important because depression can negatively influence the course, complicate the treatment, and influence the outcomes of chronic diseases (e.g., diabetes, cancer,

asthma, cardiovascular disease, and arthritis) which is an issue for older adults since they have higher rates, and often multiple, chronic conditions.

Further Reading

Jonsson, U., Bertilsson, G., Allard, P., Gyllensvärd, H., Söderlund, A., Tham, A., & Andersson, G. (2016). Psychological treatment of depression in people aged 65 years and over: A systematic review of efficacy, safety, and cost-effectiveness. *Plos ONE*, *11*(8), 1-20. doi:10.1371/journal.pone.0160859

Lane Valiengo, L. C., Stella, F., & Vicente Forlenza, O. (2016). Mood disorders in the elderly: Prevalence, functional impact, and management challenges. *Neuropsychiatric Disease & Treatment*, *12*2105-2114. doi:10.2147/NDT.S94643