

Depressed Older Adults

Education and Screening

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SPRINGER PUBLISHING COMPANY
NEW YORK

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Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Sheri W. Sussman
Senior Editor: Rose Mary Piscitelli
Cover design: Mimi Flow
Project Manager: Gil Rafanan
Composition: Absolute Service, Inc.

ISBN: 978-0-8261-7102-3
E-book ISBN: 978-0-8261-7103-0

10 11 12 13/5 4 3 2 1

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Library of Congress Cataloging-in-Publication Data

Berman, Jacquelin.

Depressed older adults : education and screening / Jacquelin Berman, Lisa M. Furst.
p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-8261-7102-3 — ISBN 978-0-8261-7103-0 (e-book)

1. Depression in old age. I. Furst, Lisa M. II. Title.

[DNLM: 1. Depression—diagnosis. 2. Aged. 3. Community Mental Health Services. WM 171]
RC537.5.B47 2011

618.97'68527—dc22

2010026047

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Printed in the United States of America by Hamilton Printing Company.

This book is dedicated to the special people in our lives.

*Jason Horowitz, Dylan Horowitz, Jesse Horowitz,
Samantha Horowitz, Jeri Berman, and David Berman,*

and

*Eli Brown, Jennifer Furst, Michael Wagner, Jennifer Wagner,
Sara Murphy, Christian Burgess, and Asha Sanaker
for their ongoing encouragement and love throughout
the entire process of writing this book.*

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Preface

Depression, a serious illness, prevents older adults from maintaining optimal functioning and interferes with successful aging. Older adults with undiagnosed and untreated depression often struggle with poorer health, increased disability, increased social isolation, disengagement in occupational and civic pursuits, and decreased ability to engage in the routine activities of daily living.

Increasingly, aging service professionals are aware of the importance of addressing the mental health needs of older adults. From their vantage points as providers of essential services to older people, they are witness to the challenges older adults face as they struggle with the symptoms of unaddressed depression. They also experience their own challenges as they try to serve these older adults, who may be more difficult to support and engage successfully in services.

Aging service and mental health providers, working in their own silos, may be unaware of opportunities for collaboration in addressing the needs of older adults with depression. Aging service providers often lack methods to identify depression and to connect at-risk older adults to treatment resources. Mental health professionals are not usually available, within aging service programs, to address the mental health needs of older adults. Additionally, they might not regularly reach out to aging service programs to identify older adults with mental health needs and may not know about local aging service programs to which they can refer their older adult clients for socialization and support.

Although there are evidence-based models of mental health service provision for older adults with depression, they were not initially focused on serving older adults within community-based aging services settings. Only recently have they begun to be evaluated for their viability in settings such as senior or community centers. In addition, these models have not primarily focused on supporting older adults at risk for depression to make the initial connection to mental health treatment. Might there be a way for both systems to work in partnership to address the unmet needs of older adults with depression?

Depressed Older Adults: Education and Screening describes a collaborative model of outreach and intervention for older adults at risk for depression. This two-time award-winning model, entitled *Educating About and Screening Elders for Depression*, or EASE-D, offers a practical, flexible,

and culturally sensitive approach to mental health education, which can be adapted by service programs seeking to identify clinical depression among their older adult clientele. In addition, this model provides a framework for incorporating depression screening to identify older adults at risk for depression, and includes a supportive service to link them to treatment resources within the community.

Older adults who participate in EASE-D are able to (a) increase their awareness of the role of mental health in successful aging, (b) increase their knowledge about the symptoms of depression and about effective treatment options, (c) learn if they are at risk for depression, and (d) receive supportive services to help them connect to community resources for evaluation and treatment for depression.

Aging service programs implementing EASE-D are able to (a) address the stigma associated with depression among older adults; (b) incorporate depression screening, an evidence-based practice, into their complement of services; and (c) create long-standing collaborative relationships across the professional disciplines of aging, mental health, and health care services to address the mental health needs of older adults.

Acknowledgments

The authors are grateful to the Mental Health Association of New York City, the New York City Department for the Aging, and the New York City Department of Health and Mental Hygiene. Without the generous support and guidance from these agencies, this project would not have been possible. The authors would also like to thank the senior centers and the older adults who have participated in the workshops and programming over the years. Their enthusiastic participation in this program has been invaluable. Lastly, the authors would like to thank their families and friends for their unwavering support and understanding throughout this process.

1

Depression Among Older Adults

The senior center where we are having our meeting could be any other we have visited in the last several years. Like many others, it is located in a nondescript building in an urban residential neighborhood. When we speak with the senior center director, we describe our project, a special citywide program of mental health education and depression screening designed to identify older adults at risk for depression and to help them connect to treatment services. We would like to include this particular center in our project, we explain, to help address the stigma many older adults experience about mental illness, particularly depression.

We are prepared to justify our reasons for wanting to implement this program. We are ready to explain the risk factors for depression faced by many older adults; the terrible toll depression takes on their health, self-esteem, and well-being; the stigma associated with acknowledging emotional difficulties; and the challenges many older adults face when they recognize that they need help and do not know where to go. As we begin to provide all of these reasons for conducting our project, the director stops us in midconversation.

“I’m so glad you chose to come to my center,” she says. “I already know which older adults here need this kind of help.”

WHY FOCUS ON DEPRESSION?

In our society, we are confronted with two very distinct notions of older age. Now, more than ever before, we are exposed, through the media, to images of healthy and lively older adults—people enjoying the fruits of their labor in their retirement or continuing to have success in their careers, possessing robust health, enjoying their families, and having close and satisfying relationships with friends and intimate partners. Aging successfully—even happily—seems to be an ever-realistic and achievable goal. At the same time, we live in an ageist society that equates older age with decline in every aspect of life. Older people, according to this view, are or will become physically frail, psychologically fragile, isolated, and lonely as the inevitable consequences of reaching late life. Either picture begs the questions: Why focus on depression in older age? If successful aging is being achieved by

so many, is depression really a problem? Alternatively, if emotional difficulties and loneliness are simply the natural and ordinary outcomes of having a long life, is there any point in trying to do something about them?

Most people would agree that sound physical health is a critical component of healthy aging. However, many do not realize that without good mental health, successful aging is not achievable. Clinical depression, a serious mental illness, can interfere with the capacity to live a rewarding life in older age. When depression develops, it severely affects an older adult's ability to maintain good physical health, to stay active occupationally and socially, and to maintain optimal functioning at home and in the community. Depression also negatively affects those who are close to older adults who have it. Family members and friends who may have counted on that older adult for emotional support and companionship or concrete support may find that they are no longer able to do so once depression becomes significant. Providers who work with older adults may find, too, that they are unable to serve older adults with depression as well as they would wish, because these older adults may withdraw from services, become more irritable, and have more difficulty following through with the programs and services with which they are engaged. The good news is that depression is very treatable and older adults can benefit from interventions to help them achieve a higher quality of life.

This chapter will review the symptoms, prevalence, and common risk factors for depression in older adults. The most common types of clinical treatments and other supportive interventions for depression will also be considered, as will the challenges of identifying and treating older adults with depression. Finally, this chapter will introduce a model for aging services providers to conduct their own outreach to at-risk older adults called Educating About and Screening Elders for Depression (EASE-D). This model illustrates the ways in which providers of aging services, mental health providers, and health care professionals can collaborate successfully to identify at-risk older adults and link them to evaluation and treatment for depression.

DEFINING DEPRESSION

Most of us use the word *depression* on a regular basis in ordinary speech; when we do, we are usually not referring to clinical depression. More often than not, we speak of depression in everyday language referring to feelings of sadness that come and go in response to particular life circumstances. Although sadness is a normal human emotion, which everyone experiences from time to time, clinical depression is not normal at any age, including in later life.

Clinical depression is a treatable mood disorder. Also known as affective disorders, mood disorders are mental illnesses that cause a disturbance in a

person's emotional state. Mood disorders include various forms of clinical depression, as well as bipolar disorder, otherwise known as manic–depressive illness. Depression is characterized by emotional, physical, cognitive, and behavioral symptoms. The most common types of clinical depression affecting older adults include *major depressive disorder*, *dysthymia*, and *minor* or *subsyndromal depression*. Although these are related conditions, they differ in the number of symptoms they cause and in the severity and duration of the symptoms that older adults experience.

Major Depression

Major depression can be experienced as a single episode, a series of recurrent episodes, or a chronic problem spanning many years of someone's life. To diagnose major depression, at least five out of a total of nine symptoms must be present for a minimum of 2 weeks and must cause significant distress or impairment in daily functioning. Major depression is characterized by the presence of at least one of two primary or cardinal emotional symptoms, which are:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in activities one formerly enjoyed (American Psychiatric Association [APA], 2000)

It is important to note that when we think about major depression, we most commonly associate it with having a sad mood most of the time. However, it is possible to have major depression without having a persistently depressed mood. Having a prolonged lack of interest or pleasure in activities, plus four of the following symptoms described, is also considered major depression, even if depressed mood is not an identified symptom. Major depression of this type has been called “depression without sadness” and is considered more common among older adults than among other age groups (Blazer, 2009).

In addition to at least one of the primary or cardinal symptoms, a minimum of four of the following symptoms must also be present in major depression (APA, 2000):

- Diminished or increased appetite, often leading to weight loss or gain;
- Sleeping difficulties, such as insomnia or sleeping too much;
- Psychomotor agitation or psychomotor retardation (noticeable restlessness or noticeable slowness of movement stemming from mental tension or mood);
- Fatigue and/or loss of energy;
- Feelings of worthlessness or excessive or inappropriate guilt;
- Difficulty thinking, concentrating, or focusing; or
- Recurrent thoughts of death or suicide (not including fear of dying or thinking about mortality as a result of growing older).

The following vignette provides an illustration of some ways in which the symptoms of major depression might affect an older adult.

Case Vignette: Ms. A.

Ms. A., a woman in her early 70s, has plans to meet a friend for lunch at her local senior center. She did not sleep well the night before because she was troubled, as she is most nights, by intense feelings of sadness and despair, accompanied by crying spells, lasting long into the night. She spends the morning lying in bed exhausted but unable to drift off. About an hour before she is supposed to have lunch, she slowly rises to dress and make her way to the senior center. She is very slow moving and finds it difficult to muster the energy to select clothes to wear and put them on. As she starts to dress, she decides not to visit with her friend at the senior center, after all. It seems like too much effort to get to the senior center. Their usual weekly plan to have lunch together and then play bingo has not been very appealing to her in the last several weeks. She also realizes that she is not very hungry and does not feel like eating lunch. After deciding not to leave her home, she tries to distract herself by reading a book but is unable to concentrate well enough to do so. It even seems like watching television requires too much effort. She returns to her bed, where she remains for the rest of the day.

Dysthymia

Dysthymia is a form of depression in which a fewer number of depression symptoms are experienced over a relatively long period. Despite the presence of fewer symptoms than in major depression, dysthymia can be quite a distressing problem. Unlike in major depression, for which depressed mood does not have to be present, the criteria for diagnosis of dysthymia always includes having a persistently depressed mood, most of the day, nearly every day, for a period of at least 2 years. Remission of symptoms, if it arises, does not occur for more than 2 months at a time.

In addition to a continually depressed mood, at least two to four of the following symptoms must also be present for a period of at least 2 years (APA, 2000):

- Diminished appetite or overeating;
- Difficulty sleeping or oversleeping;

- Fatigue and/or low energy;
- Poor self-esteem;
- Difficulty concentrating or making decisions; or
- Hopelessness.

The following vignette provides an illustration of some of the ways in which the symptoms of dysthymia might affect an older adult.

Case Vignette: Mr. B.

Mr. B., a man in his late 60s, has been retired for 3 years. Although he initially enjoyed the first 6 months following his retirement, he finds that most of the time since then, he feels generally down in the dumps, even though nothing in his life seems particularly troubling or difficult to manage. He feels especially sad when he has thoughts about not having much to show for his life, or to accomplish, now that he is retired. As he thinks back, he finds he cannot remember the last time he was in a good mood for more than a day or two at a time. Even though he seems to be in generally good health, he has gained nearly 20 lb over the last 2 years and is usually fatigued during the day, even when he gets enough hours of sleep at night. He still manages to do volunteer work at his local senior center once a week and spends time with his family and friends, but he just does not feel like his old self.

Minor or Subsyndromal Depression

Minor depression, also known as subsyndromal depression, is thought to occur at least as often in the general population as major depression. At the time of this writing, subsyndromal depression is not a category of depression with which one can be formally diagnosed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the diagnostic guide used by medical and mental health professionals. However, it is increasingly recognized in research as a subtype of depression.

Subsyndromal depression presents with at least two, but fewer than five, symptoms of depression for a minimum of 2 weeks and is generally more episodic, and less chronic, than dysthymia (APA, 2000; Kroenke, 2006; Williams et al., 2000). As in both major depression and dysthymia, subsyndromal depression usually includes either a persistently sad mood or a loss of interest or pleasure in activities. Like major depression or dysthymia, subsyndromal depression can cause significant impairment in daily

functioning. Like dysthymia, this encompasses fewer distinct symptoms than in major depression. However, the duration of subsyndromal depression is generally less than in dysthymia.

Subsyndromal depression can be a precursor to major depression. Research suggests that depressive disorders occur on a continuum of less to more severe and that people who develop subsyndromal depression are more likely to also develop major depression over time if the earlier stage of the illness is not addressed (Kroenke, 2006; Lyness et al., 2006).

The following vignette demonstrates the ways in which symptoms of subsyndromal depression might affect an older adult.

Case Vignette: Ms. C.

Ms. C., an 80-year-old woman, describes her concerns about her health to her doctor for the third time this month, this time reporting having frequent headaches. She currently takes medications for high blood pressure, diabetes, and a thyroid condition. Upon examination, all of her chronic health problems appear to be well controlled and her medications do not need adjustment. When Ms. C. hears, once again, that she is fine and has nothing to worry about, she does not feel any better. She hesitantly explains to her doctor her real reasons for the visit, which are that she feels sad most of the time, has trouble sleeping at night, and is often fatigued during the day. These problems bother her tremendously, although she takes pains to hide her unhappiness and discomfort from her family, because she does not want to sound like a “complainer.” She also tries her best to “put on a happy face,” particularly when she is socializing with her friends during the classes and trips she takes at her local senior center. She does not understand why she feels this way, is tired of pretending that nothing is wrong, and does not really know what to do about it.

EPIDEMIOLOGY OF DEPRESSION AMONG OLDER ADULTS

As the baby boom generation ages over the next quarter century, the United States will see significant growth in the number of people 65 years old and older, from approximately 39 million in 2010 to 69 million by 2030. In addition, the percentage of older adults will increase from 13–20% of the country's total population (Bartels, Blow, Brockmann, & Van Citters, 2005; Day, 1996). As a result, projections indicate that the number of older adults with

any mental illness will double from 7 million to 14 million between 2000 and 2030 (U.S. Department of Health and Human Services [DHHS], 1999; Bartels et al., 2005).

Despite the estimated growth in the number of older adults with mental illness, older people do not have clinical depression more often than younger people do. In fact, there is considerable evidence that they have a lower rate of major depression than other age groups (Chapman & Perry, 2008; Kessler et al., 2005). According to the data from the Epidemiologic Catchment Area (ECA) survey, the prevalence of all affective disorders (including depression as well as other mood disorders) among community-dwelling adults aged 65 and older is 2.5%; the highest prevalence of depression, 3%, was observed among adults 25–44 years of age (Hybels & Blazer, 2003). For major depression, older adults were found to have a lifetime prevalence rate of 2%, and a 1-year prevalence rate of 1.4%, compared to 3.7% for younger individuals (Kohn, Gum, & King-Kallimanis, 2009). In another study examining data from the National Household Survey on Drug Abuse (NHSDA), the point prevalence of depression symptoms for community-dwelling older adults was found to be only 1.9% for older women and 1% for older men (Wu & Anthony, 2000).

Other sources document the prevalence of major depression to range between 1 and 4% (Alexopolous, 2005). Despite the generally lower prevalence of diagnosable major depression, 15–20% of older adults experience clinically meaningful symptoms of depression, without necessarily warranting a diagnosis (Kohn et al., 2009). Older adults are more likely than other age groups to experience subsyndromal depressive symptoms that, although not enough to correspond to a diagnosis of major depression or dysthymia, are significant enough to cause distress and impair functioning. Prevalence studies for subsyndromal depression in late life yield an estimated range of 3–26% (Hybels & Blazer, 2003). Additional evidence for higher rates of subsyndromal depression among older adults comes from the Established Populations for Epidemiological Studies of the Elderly (EPESE). Data from this study indicates that although the prevalence of diagnosable depression among older adults is 8.4%, the prevalence of subsyndromal depression is 9.3% (Hybels, Blazer, & Pieper, 2001).

Women have been shown generally to have a higher prevalence of depression than men do across age groups, including in later life (Kessler et al., 2005). One study of older adults living in the community found that women older than age 60 are twice as likely to experience depressed mood as men in the same age demographic (Harwood, Barker, Ownby, Mullan, & Duara, 1999). This trend has been confirmed by other studies. For example, both ECA and NHSDA studies found elevated risk for depressive symptoms for older women, compared with older men. In particular,

the NHSDA researchers found that older women's risk of developing depressive symptoms was 5.93 times that of older men (Wu & Anthony, 2000). Furthermore, a study conducted in 2006 among community dwelling older women indicates that women between the ages of 65 and 74 were more likely to report both current and past episodes of depression than men in the same cohort (McGuire, Strine, Vachirasudlekha, Mokdad, & Anderson, 2008).

The literature examining the role of race and ethnicity on depression has been mixed, with some studies indicating that certain ethnic minorities are less likely to have depression than Caucasians, whereas others indicate that these same ethnic minorities are more likely to have depression. Although some studies indicate that mental disorders are as prevalent among ethnic minorities as among Caucasians, others challenge this assumption. In several large community-based samples, race or ethnicity does not appear to be significantly associated with depression prevalence (Chapman & Perry, 2008; Hybels & Blazer, 2003).

Other studies find an association between race/ethnicity and depression. In a study of preretirement-age adults (aged 54–65), symptoms of major depression were found to occur more frequently among members of minority groups than among Caucasians (Dunlop, Song, Lyons, Manheim, & Chang, 2003). The implications of this study include the possibility that older adults from minority groups may be more likely to have depressive disorders in later life, because they may have past histories of depression, which could recur or become exacerbated as age-related risk factors are encountered in older age. There has been some evidence of greater frequency of depressive symptoms among individuals of Hispanic descent, notably among Mexican Americans (Hybels & Blazer, 2003; Dunlop et al.), although data from the National Comorbidity Survey Replication study indicate that the Hispanic community has a lower risk of mood disorders than Caucasians (Kessler et al., 2005). African Americans appear to have similar rates of depression as Caucasians (Blazer, Hybels, Simonsick, & Hanlon, 2000; Coleman & Ahmed, 2009), although some studies document that African American older adults experience fewer symptoms of depression, compared to Caucasian older adults (Kessler et al., 2005). Among Asian Americans, the rates of major depression appear to be lower than other ethnic groups, with a lifetime prevalence of 3.4%, compared to the general population's rate of 5.28% (Coleman & Ahmed). The 1-year prevalence rate of major depression has been documented to be approximately 5% among Asian older adults living in the community; however, as with other ethnic groups, depressive symptoms that did not warrant a diagnosis of major depression were more prevalent for Asian older adults, estimated to range between 8 and 20% (Mui, 2003).

Poor health status is associated with a higher incidence of depression. Indeed, the estimated prevalence of depression among older adults is higher in primary care settings than among older adults surveyed in the community and has been documented to range from 5–10% (Unützer et al., 2003). The prevalence of depressive symptoms is also higher among older adults who are homebound, receive health care in the home, or are being treated in hospitals, nursing homes, or other institutional settings. As much as 10–12% of older adults seen in hospital settings are estimated to have major depression (Alexopolous, 2005). Additionally, a study of the medical records of nursing home residents found a depression prevalence rate of 20.3%, and a study of older adult recipients of home health care found a depression prevalence rate of 13.5%, compared to the 1-year prevalence rate of 0.9% for community-dwelling older adults found in the ECA study (Chapman & Perry, 2008; Hybels & Blazer, 2003).

Depression does not manifest uniformly among all generations of older adults. Some experts believe that clinical depression may be a more significant problem for the baby boom generation as it ages, compared to the current cohorts of older adults. Baby boomers have been found to have a higher lifetime prevalence of depression than both people in younger age groups and the current group of adults aged 65 years and older (Hasin, Goodwin, Stinson, & Grant, 2005). There are also prevalence differences for depression among subgroups of older adults throughout later life. Most studies tend to classify older adults into a single cohort of those aged 65 years or older; however, there are significant differences within subgroups of older adults. Although research indicates that older adults are less likely than adults in midlife to have depression, the distribution of depression changes with very old age. The incidence, or development of new cases, of major depression has been shown to double in any given year for older adults aged 70–85 years (Alexopolous, 2005). Additionally, a study of German older adults yielded similar findings, because depression prevalence appeared to increase with advancing age; those who are 85 years old or older had a 70% higher risk of developing depression than those aged 74–79 (Weyerer et al., 2008).

RISK FACTORS FOR LATE-LIFE DEPRESSION

Although depression affects people across all age groups, older adults may possess an increased number of risk factors for depression, compared to people of other ages. The risk factors associated with late-life depressive disorders are numerous, and, for many older adults, depression may arise from a confluence of biologic, psychosocial, and socioeconomic factors.

Biologic Factors

Although age in and of itself does not cause depression, age-related biologic risk factors have been implicated in its onset. Common biologic risk factors include comorbid chronic illness, sensory or mobility impairment, cognitive impairment, and the presence of vascular lesions in the brain (Chapman & Perry, 2008; Hybels et al., 2001; Weyerer et al., 2008). Increased rates of depression have been found among older adults diagnosed with chronic illnesses such as cardiovascular disease, diabetes, arthritis, and other disorders that may decrease physical functioning, increase disability, and contribute to social isolation (Blazer & Hybels, 2005). Additionally, physiological changes associated with aging, such as decreased neurotransmitter activity in the brain and lowered functioning of the endocrine system, are also associated with depression (Blazer & Hybels).

The correlation between depression and medical comorbidities among older adults is complex. For reasons not yet entirely understood, the outcomes of physical illness dramatically worsen when depression is present, particularly in the case of cardiovascular disease (Alexopolous, 2005). Older adults who have histories of chronic illness, but no past histories of clinical depression, have been shown to have an increased incidence of depression over time. At the same time, older adults diagnosed with clinical depression who do not initially have comorbid medical illnesses are more likely to develop such diseases over time compared to their peers who are not depressed (Krishnan et al., 2002).

The burden of comorbid health conditions is a particularly significant predictor of depressive symptoms in older age, especially if disease impairs an older adult's ability to perform activities of daily living or connect with sources of social support (Hybels et al., 2001). For example, a study of Asian American older adults found a depression prevalence of 24.2% for those with chronic illness, compared to 13.7% for those without such medical problems (Chapman & Perry, 2008). The role of physical illness may also be particularly significant for older women with depression, who appear to incur greater risk of developing a first-time occurrence of clinical depression when suffering from poor physical health than do older men (Sneed, Kasen, & Cohen, 2007). Depressive illness has also been associated with dementia and other forms of cognitive decline; it is also associated with increased risk for the onset of Alzheimer's disease (Alexopolous, 2005).

The Role of Functional Disability

Worsening health problems may encourage the development of additional psychosocial risk factors for depression. Functional disability, or the loss of the ability to maintain activities of daily living because of illness or injury,

may play as critical a role in the development of depression among older adults as medical comorbidities. This is particularly the case if the medical illness or resultant physical frailty compromises an older adult's ability to sustain social support networks.

Research suggests that poor health status may precipitate the loss of social networks and support by decreasing an older adult's ability to engage in meaningful social contact outside of the home, in addition to preventing them from performing the usual activities of daily living. In addition, an older adult's personal experience of disability may be an important factor in the development of depression. One recent study indicates that when older adults with impaired physical functioning are able to engage in what they perceive as meaningful social activity, the likelihood of depression is decreased, even if the level of disability does not improve (Yang, 2006).

Psychosocial Risk Factors

Psychosocial risk factors common to this age group include relationship loss, caused by either death of a loved one or more prolonged periods of separation as friends or family members move to other, more distant communities, loss of social role functioning, and loss of social status (e.g., after retirement), which accompanies aging in a culture that does not respect older adults (Bartels et al., 2005; Blazer & Hybels, 2005). Other significant psychosocial risk factors for older adults include past or current traumatic experiences, as well as the lack of actual or perceived emotional or social support (Bruce, 2002).

Depending on the exposure to other precipitating psychosocial factors, older adults may exhibit differing patterns of depression onset. Some older adults may have prior histories of psychological dysfunction that are associated with the development or exacerbation of depression in older age (Vink, Aarsten, & Schoevers, 2008); in fact, most older adults who experience depression have had at least one episode of depression earlier in life (Kohn et al., 2009). Others develop depression for the first time late in life, often in conjunction with the emergence of new psychosocial stressors. For example, a study of older adult women indicated that those who have depression for the first time as older adults struggled with stressors that did not exist earlier in their lives, particularly physical illness and resultant disabilities that contributed to social isolation. Those who had an early onset of depression, on the other hand, were found to have experienced psychosocial difficulties throughout their lives, including having more episodes of depression or anxiety, as well as family histories of depression (Sneed et al., 2007).

Socioeconomic Risk Factors

Having a lower income status, economic hardship relative to income, and lower overall educational attainment, most notably among those who have received fewer than 12 years of education, are all associated with an elevated risk for depression (Kim & Durden, 2007). Both planned retirement and involuntary job loss have also been identified as socioeconomic risk factors for depression, particularly when accompanied by a relative lack of financial assets and economic hardship following the change in employment status (Mojtabai & Olfson, 2004).

DEPRESSION AND SUICIDE

Depression has been shown to increase older adults' risk of mortality, particularly when symptoms are severe and protracted. Data from the ECA study indicates that the risk of death was four times greater for older adults with depression than for those without a mood disorder (Blazer, 2009). Not only does depression increase the risk of mortality among older adults who are medically ill, but it also is a major risk factor for death by suicide, particularly when medical illness and depression are comorbid (Abrams, Marzuk, Tardiff, & Leon, 2005).

Estimates suggest that the rates of suicide among older adults will double between 2000 and 2040 (Kennedy, 2000). Thoughts about suicide—otherwise known as suicidal ideation—are estimated to occur among 5–10% of the general population of older adults. Older adults with depression are more at risk of dying by suicide than either their nondepressed peers or the general population (Butler, Cohen, Lewis, Simmons-Clemmons, & Sunderland, 1997). Although they currently comprise just fewer than 13% of the total population, adults aged 65 and older complete 16% of all suicides. The national rate of suicide among older adults is five times higher among older Caucasian men, particularly among those aged 85 years old or older (Bharucha, 2009), than among other groups. Older adults who make suicide attempts are more likely to have experienced the death of a spouse, to live alone, to have poor perceptions of their health, to have sleep disturbances, to be socially isolated, and to experience stressors such as financial hardship and relationship difficulties (Blazer, 2009).

Older adults complete suicide through various means, the most common of which is by using firearms. Although older men are more likely to complete suicide using firearms, older women are increasingly at risk of using this method to complete suicide (Bharucha, 2009). Other common means older adults use to complete suicide include the lethal ingestion of

drugs (Blazer, 2009), suffocation, hanging, self-injury by stabbing, jumping from a significant height (buildings, bridges), and carbon monoxide poisoning, among others (Kennedy, 2000).

Most older adults who complete suicide experience a period of depression prior to their deaths, and up to 20% of these older adults were seen by their doctors within the 24 hours prior to their suicides. A tragic statistic such as this indicates the many missed opportunities by health care providers to identify depression among older adults by health care providers, many of whom did not recognize the presence of depressive symptoms in their older patients (Kennedy, 2000). The lack of a systematic way to identify depression and other suicide risk factors remains a continuing challenge for health care and other providers who work with older adults.

TREATMENT OPTIONS FOR OLDER ADULTS

Depression can become a chronic disorder for older adults if it is not identified and treated. A study of older adults diagnosed with major depression found that without clinical treatment, 90% of older adults experienced recurrent depressive episodes, compared to recurrence rates of 20% for older adults treated with medication and psychotherapy and 43% for older adults receiving medication alone (Alexopolous, 2005).

Fortunately, both psychotherapy and psychotropic medications are effective treatments for depressive disorders among older adults. There is general agreement that the optimal treatment of major depression and dysthymia in older adults is a combination of medication and psychotherapy, whereas subsyndromal depression may be responsive to psychotherapeutic or other supportive interventions alone (Alexopolous, 2005). Antidepressant medications are effective treatments for older adults who have depression, with more than half of all older adults treated with antidepressants experiencing a minimum of a 50% reduction in symptoms (Bartels et al., 2004).

The most effective forms of psychotherapy for older adults with depression include cognitive, behavioral, and combined cognitive-behavioral therapeutic approaches (Bartels et al., 2004; Blow, Bartels, Brockmann, & Van Citters, 2005), such as problem-solving therapy (PST). Other helpful psychotherapeutic modalities include supportive psychotherapy and interpersonal psychotherapy (Alexopolous, 2005). Additional nonpharmacologic interventions, which are beneficial, include regular physical exercise, involvement in stimulating social and intellectual activities, engaging older adults about their mental health through education (Center for Mental

Health Services [CMHS], Substance Abuse and Mental Health Services Administration [SAMHSA], 2005) and early intervention, such as screening for depression.

DETECTING DEPRESSION IN OLDER ADULTS

Many older adults who receive treatment for depression do so within the context of their primary care physician's office, rather than in specialty mental health treatment programs (Wang et al., 2005). In the United States, of the 7 million older adults with mental illness, only half, or approximately 3.5 million, receive any treatment. Of those who do, just more than 1.9 million receive treatment from their primary care physicians (U.S. DHHS, 2001) rather than mental health specialists. Despite the significant prevalence of depression and medical comorbidities within the general older adult population, and in spite of the documented higher risk of suicide among older adults, depressive disorders remain inadequately diagnosed and treated by primary care physicians.

There are several challenges to identifying depression in older adults. Although there are many tools available to help screen for depression (for more information about depression screening instruments, refer to chapter 4 ["What Depression Screening Tools Exist?"]), these have not yet been universally incorporated into the health care and other sectors commonly serving older adults. As a result, most older adults with depression do not receive appropriate clinical assessment or treatment. Physicians' insufficient recognition of depressive disorders also may be influenced by attitudinal factors endemic to both doctors and patients. These include the belief among older adult patients that depression is a natural function of the aging process. For example, one study indicated that more than 50% of women aged 65 or older believe that depression is a normal part of growing older (McGuire et al., 2008) and might be unlikely to report depressive symptoms because of misconstruing them as an expected part of aging. Physicians may miss the opportunity to identify depressive disorders in their older adult patients if they, too, believe that depression is a normal part of the aging process because of expected losses coinciding with aging (e.g., bereavement or diminished physical capacities). Such attitudes among both primary care physicians and older adults may lead inadvertently to a "don't ask/don't tell" policy about depression, decreasing the likelihood of treatment.

In addition to the barriers associated with ageism and lack of awareness about depression, the diagnostic factors contributing to the challenge of recognizing late-life depression may be significant. A review study indicates older adults have a higher "threshold for reporting symptoms of depression" than

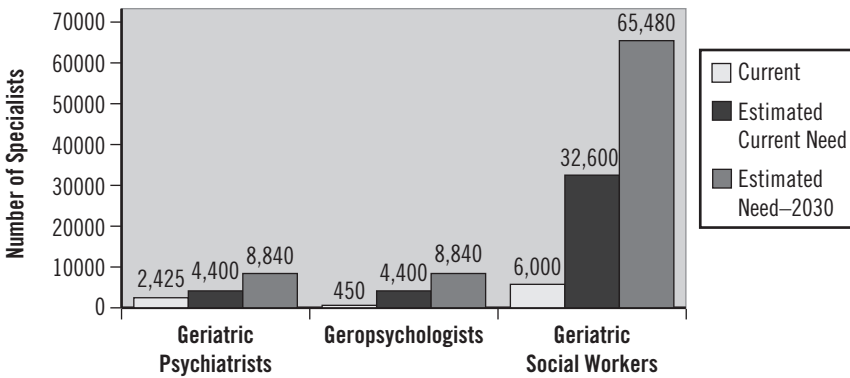
middle-aged adults and might suffer for a significant period before addressing the problem (Jeste, Blazer, & First, 2005) with a health care professional or other service provider. Moreover, there are notable differences in the clinical presentation of depressive symptoms among older adults compared to younger adults. Older adults may visit their health care providers complaining of specific somatic symptoms, such as frequent headaches, fatigue, difficulty sleeping, appetite or weight changes, and increased pain, none of which may initially be associated with depression, particularly if emotional symptoms are not disclosed or if persistently sad mood is not present.

Many of these somatic complaints are characteristic of subsyndromal depression, which rises in prevalence among older adults. Subsyndromal depression among older adults is often accompanied by depressed mood, lowered ability to concentrate, psychomotor retardation, lowered perception of good health, and increased anxiety about health in general. Except for depressed mood, these symptoms are not seen as often in younger adults with depression and may be assessed incorrectly as functions of the natural aging process rather than as indicators of depressive illness (Jeste et al., 2005; VanItallie, 2005). The difficulty of detecting subsyndromal depression is of particular significance to health care providers, because there is evidence that subsyndromal depression is a predictive risk factor for the development of major depressive illness among older adults (Lyness et al., 2006). An older adult experiencing minor depression has a much higher risk of developing a more serious form of depression over time; failure to identify subsyndromal depression is another missed opportunity to prevent the exacerbation of the disorder and its attendant complications.

Even when primary care providers identify depression, treatment is not uniformly available and adequate. Some groups of older adults seem less likely to receive treatment than others. For example, a study of Medicare enrollees in primary care found that nearly one third (32.3%) of older adults diagnosed with depression did not receive any treatment. These older adults were primarily those who were 75 years old or older, had low income, lacked supplemental insurance or drug coverage, and were a race other than Caucasian (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003). Similarly, in a study of 1,801 older adults with depression in primary care, those found to be most at risk of not receiving treatment were those who were Latino, African American, male, and who stated a preference for nonpharmacological treatment (Unützer et al., 2003).

Finally, another challenge to the successful identification and treatment of depression in older adults is the general lack of geriatric medical and mental health specialists (Bartels et al., 2005), particularly those who are bilingual and bicultural. Figure 1.1 illustrates the current lack of specialty geriatric mental health providers and the widening of the gap that is

SHORTAGE OF GERIATRIC MENTAL HEALTH PROFESSIONALS



Halpain, Maureen C. et al. (1999). Training in Geriatric Mental Health: Needs and Strategies. *Psychiatric Services*, 50:9, 1205–1208.

Jeste, Dilip V. et al. (1999). Consensus Statement on the Upcoming Crisis in Geriatric Mental Health. *Archives of General Psychiatry*, 56, 848–853.

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FIGURE 1.1 Geriatric mental health providers 2000–2030. *Source:* Copyright Michael B. Friedman, 2009.

estimated to occur by 2030. The growing lack of geriatric mental health providers is particularly troubling as the demand for mental health treatment among older adults is likely to increase in the coming decades, including among older adults whose first language is not English. Increased demand will be driven by baby boomers, a group that has been shown to have less stigma about depression and may be more likely to seek mental health treatment (Bartels et al., 2005). Without adequate means of ascertaining depression in older adults seeking health care and social services, older adults who have depression will be at a disadvantage, unless alternative methods of connecting at-risk older adults are made available.

HOW CAN PROVIDERS OF AGING SERVICES HELP?

Without help, older adults who have depression symptoms are at risk for a poorer quality of life. They are less likely to connect with community resources, including aging services agencies, such as senior and community centers, as well as other programs, which support their optimal functioning

and civic engagement. They are more likely to experience worsening medical outcomes, increased levels of disability, social isolation, and increased mortality. Despite the generally lowered prevalence of major depression in older adults, compared to midlife and younger adults, the prevalence of depression symptoms increases with age, particularly in the face of age-associated risk factors. Although there is some evidence for generally enhanced emotional well-being among senior center participants than among older adults who are not involved in such programming (Choi & McDougall, 2007), the demographics of senior center attendees points to the potential risk for depression among this population. For example, research indicates that many older adults who routinely attend senior centers are more likely to be female, to live alone, to have experienced the death of a spouse, and to have incomes in the middle-to-low range (Calsyn, Burger & Roades, 1996; Calsyn & Winter, 1999; Krout, Cutler & Coward, 1990; Pardasani, 2004; Turner, 2004). All of these are risk factors for depression.

In addition, senior centers and other aging services programs are increasingly focusing on health and wellness promotion as central aspects of service provision (Beisgen & Kraitchman, 2003; Pardasani, Sporre, & Thompson, 2009; Ryzin, 2005). What, then, can aging services providers do to engage older adults in a meaningful discussion about mental health as a component of overall health and well-being? How can these providers, who are often not located within medical or mental health settings, identify older adults who may be at risk for depression? In what ways can they support older adults with depression to ensure that they receive the treatment they need?

If we are to promote successful aging among older adults, their mental health needs must be addressed from multiple service sectors, including aging services programs. Professionals who work in senior centers, community centers, case management agencies, and area agencies on aging may be aware of depression's devastating effects on older adults but often do not have the internal resources to routinely identify at-risk older adults and connect them to treatment resources. Many providers also know firsthand that it can be difficult to enter into a productive conversation with the older adults they serve about mental health, partly because of the stigma associated with mental illness and partly because they are not sure what to do if an older adult acknowledges that he or she is depressed.

To provide increased opportunities to identify older adults at risk for depression, the Mental Health Association of New York City, the New York City Department for the Aging, and the New York City Department of Health and Mental Hygiene have developed a collaborative model of outreach to older adults that providers of aging services can replicate in their own communities. This model, entitled EASE-D, is an approach that emphasizes the partnership between providers of aging services,

mental health agencies, and, where possible, health care practitioners to identify older adults who are at risk for depression and connect them to treatment.

EASE-D consists of three main components, including (a) mental health education, (b) screening for depression, and (c) linkage to treatment.

MENTAL HEALTH EDUCATION

The first component of the model, mental health education, provides a means of outreach to older adults who may be at risk for depression. Education is instrumental in helping older adults overcome the stigma associated with depression and other mental disorders and is a recommended strategy for engaging older adults about the role of mental health in aging successfully (CMHS, SAMHSA, 2005). Education addresses stigma by providing useful information about the signs and symptoms of depression, the benefits of treatment and self-care, and resources older adults can use to obtain treatment services.

In this book, you will learn about several approaches to engage older adults in an educational discussion about depression. In particular, chapter 3 (“Educating About Depression: Approaches for Older Adults, Their Service Providers, and Community Members”) addresses ways to recruit older adults to participate in mental health education, how to create an environment conducive to learning about mental health, and how to go beyond the topic of depression to address additional mental health topics. In addition, this chapter also addresses the provision of mental health education about depression for health care practitioners and providers of aging services. This book will also provide principles for developing engaging and easy to understand educational and outreach information for older adults and for other service providers in the community. Chapter 6 (“Developing Program Materials for Outreach and Education”) includes useful guidelines for creating these materials and provides a set of exercises that can help you design your own program resources.

EARLY INTERVENTION AND DEPRESSION SCREENING

Chapter 2 (“Evidence-Based Models...”) will introduce you to different models of early intervention for depression with older adults, including evidence-based models in nontraditional settings, such as aging services organizations. This chapter will also review the pros and cons of using these

models within community settings and explain how to use EASE-D as a complement to or in place of these models to provide early intervention for at-risk older adults.

The second component of EASE-D, screening for depression, involves creating the opportunity for older adults to voluntarily screen for depression risk. Depression screening is recognized as a useful early intervention to help identify at-risk older adults to link them to treatment. Depression screening following mental health education provides a nonstigmatizing way of engaging at-risk older adults about their personal experience of symptoms and help to initiate a discussion about seeking help. In chapter 4 (“Implementing Depression Screening”), you will learn about the advantages of incorporating depression screening as a part of a mental health education program in an aging services setting, even when implemented outside of the structure of an evidence-based program. This chapter will also present information about the different depression screening tools available for use with older adults. In addition, it will underscore the advantages of partnering with mental health and health care services to ensure that depression screening helps older adults connect with qualified treatment providers.

LINKAGE TO TREATMENT

In addition to mental health education and depression screening, EASE-D includes a method of helping at-risk older adults to connect with treatment services in their communities. Chapter 5 (“Connecting Older Adults to Treatment: Pretreatment Care Management”) outlines a method of supportive intervention, called *pretreatment care management*, which providers of aging services can use to help older adults navigate successfully through the health care or mental health service system as they seek out a qualified clinical evaluation and treatment for depression.

WHO CAN USE EASE-D?

EASE-D may be conducted in various types of programs serving older adults, but is particularly applicable in community-based settings such as senior or community centers. Certain components of the model, such as depression screening and linkage to treatment, also may be conducted easily within the context of providing case management or other services to homebound adults.

Although providers in the aging services field can choose to offer the program components on their own, this model is particularly well-suited to and intended for collaborative partnerships between providers of aging services, mental health agencies, and, where possible, health care practitioners. In chapter 7 (“How to Implement EASE-D in Your Community”), you will learn more about how to build EASE-D into your community through partnerships with these other stakeholders. Additionally, chapter 8 (“The Benefits and Challenges of Program Implementation”) will review the advantages of implementing this model and will address some of the more common technical challenges encountered when using EASE-D.

EASE-D can pave the way for providers of aging services to open a dialogue with older adults about their mental health, to identify those who may be at risk for depression, and to provide worthwhile information, referral, and linkage services to help the older adults in their community continue to live satisfying and meaningful lives.

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