

## Chapter 4

### Depression in Older Adults – Is It Worthy of Recognition & Treatment?

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#### **1. Introduction**

The scientific and academic community is split on the question of the inevitability of depression in older age. Findings by researchers such Blazer (1996a), Blazer & Koenig (1996), Popkin, Mackensie, and Callies (1984), Mather (1997) and Collins, Katona, and Orrell (1995) suggest that, on the one hand, there are those who argue that depression is a predetermined consequence of ageing. There are, however, also those who view it as a specific clinical condition that can respond to appropriate treatment interventions (Baldwin, 1997a, 1997b, 1998; Blazer & Koenig, 1996; Gerson, Belin, Kaufman, Mintz, & Jarvik, 1999; Karel & Hinrichsen, 2000; Pearson & Brown, 2000). Studies (such as Baldwin, 1997b; Blazer, 1996a; Geiselman, Linden, & Helmchen, 2001; Gurland, 1976; Jorm, 2000; Lindesay, Briggs, & Murphy, 1989) on the prevalence rates of Major Depressive Disorder (MDD) in an elderly population have tended to vary in outcome, and authors such as Copeland et al. (1987) Geiselman, Linden, and Helmchen (2001), Blazer & Williams (1980), and Blazer (1996a) have emphasised the discrepancy in rates between those diagnosed with MDD and those with some degree of depressive symptomatology.

In order to define the context of this review a working definition of depression is required and its prevalence in an older adult population. An overview of the theories of why depression can occur in later life will be provided, as well as an evaluation of the assessment of depression and the efficacy of current psychological treatment modalities on offer.

#### **2. Definition**

The most widely accepted classification systems for determining a case of depression are the DSM (American Psychiatric Association) and ICD (World Health Organisation) diagnostic manuals. The definition of depression and the terminology used to describe the state of it appears to have found greater clarity, and precision of definition and categorisation, as a result of the extensive work carried

out in order to produce the DSM-IV (APA, 1994) and the ICD-10 (WHO, 1994) (Geiselman et al., 2001). Kaplan, Sadock, and Grebb (1994, p. 303) define depression as ‘a psychopathological feeling of sadness’. This definition is somewhat broad and therefore lacks precision and specificity, though it does give a general sense of what the condition implies. In order to give a precise diagnosis of this psychiatric disorder one needs to look to the various symptoms of it, as it presents itself as a syndrome rather than as one specific symptom.

According to the DSM-IV (APA, 1994) and ICD-10 (WHO, 1994) depression is a syndrome that includes depressed mood, loss of interest and enjoyment, reduced energy leading to increased tiredness and a decrease in activity, reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness, ideas of acts of self-harm or suicide, disturbed sleep and diminished appetite. In older adults, it may be more difficult to establish whether the presence of such symptoms, for example reduced energy, concentration, and confidence, are due to depression, changes in circumstances or to the ageing process (Blazer & Koenig, 1996; DSM-IV, 1994; Siegler, Poon, Madden, & Welsh, 1996).

### **3. Prevalence**

There have been a number of attempts to establish the prevalence of depression in the elderly. The main difficulty in comparing these studies is the differences in methodology. Zarit and Zarit (1984) and Blazer (1996a) suggest that the method of gathering information and the case identification process used to determine estimates of prevalence of depression (or other disorders) is what tends to account for discrepancies in the statistics reported. Greater variation occurs between studies drawn from community dwelling populations compared with those from psychiatric facilities or nursing homes for the elderly (Blazer, 1996a; Jorm, 2000; Zarit & Zarit, 1984). Arèan, Hegel, and Reynolds (2001) note that recent research by Demmler (1998) shows that as people get older there is a decrease in their use of mental health services, and Badger (1998) found that depressed older adults compensate for this by seeking help from primary care services, and that this section of the population would not, therefore, be represented in studies taken from mental health services.

A further difficulty is that the instruments used to measure symptoms of depression tend to vary across studies. For example, Steffens et al. (2000) used a modified version of the Diagnostic Interview Schedule and not a clinical interview. The use of such a schedule may lead to the under diagnosing of disorders as the symptoms and their severity cannot be teased out (Steffens et al., 2000). In contrast, Geiselman et al. (2001) carried out their study with the use of an intensive interview schedule over an extensive 14 session period allowing them to be more specific and detailed in their findings, and possibly more accurate. Knauper and Wittchen (1994) found an important factor in the use of standardised questions or statements in that older people have difficulty in understanding or interpreting the language of such methods, and that this may influence the clinician’s decision regarding a diagnosis of depression.

The Guy’s/Age Concern Survey (Lindesay, et al., 1989) of older adults living in a socially deprived inner city community in London found that the prevalence of depression steadily increases from 65 years of age upwards. Gurland’s study (1976) found that severe depression tends to have a peak time between the ages of 45 and 55, though there are factors that often prevent the true prevalence of it in later life being measured. One factor is the reticence of professionals to admit older adults to psychiatric units for treatment, as there is a more pessimistic view regarding their recovery. A second factor is that depression tends to be under-diagnosed as it is more often present with somatic complaints in the elderly than in younger age groups (Kaplan et al., 1994), and older people are referred less frequently for treatment compared with younger people (Gurland, 1976). In addition,

Geiselman et al. (2001) cite Gallo and colleagues (Gallo, Rabins, Lyketsos, Tien, & Anthony, 1997) who found that older individuals have a reduced tendency to complain and are more prone to deny their depressed mood, or they may conceal or refute the presence of symptoms (Blazer & Koenig, 1996).

The community prevalence of Major Depressive Disorder (MDD) in older adults ranges from between 1.8% to 3% (Baldwin, 1997b; Blazer, 1997), though Lindsay, Briggs, and Murphy (1989) found a prevalence of it in older adults to be as high as 4.3%. Helmchen, Linden, Reischies, and Wernicke (1999) refer to studies that have reported prevalence rates of moderate and severe depression to vary between 0.07% and 5.4%, and all forms and degrees of clinically relevant depressive symptoms to range from 11.5% to 26.2%. The Guy's/Age Concern Survey (Lindsay et al., 1989) found that 13.5% of the sample suffered from a depressive illness, and Copeland et al. (1987) found that 11.2% of their elderly population in Liverpool suffered from depression.

Steffens et al. (2000) suggest that a more complex picture emerges if adults over the age of 65 are not viewed as homogenous. They cite a large number of epidemiological studies that suggest that the prevalence of MDD decreases compared to the general population after the age of 65. On closer examination, the demographic profiles of these studies under-represent individuals over the age of 80. Studies that have been sensitive to this 'within group' variation have suggested that MDD increases again after 80 years of age (Steffens et al., 2000). Helmchen et al. (1999) note that people over the age of 80, or even 90, are no longer rare exceptions, and that epidemiological estimates of prevalence rates and investigation into the age-dependence of a disorder require people over the age of 85, and a higher proportion of men, to be included. They also state that cross-sectional assessments of prevalence rates ought to be enhanced by longitudinal studies if accurate statements are to be produced on the relationship between ageing and mental disorders.

Studies (Blazer, 1996a; Blazer & Williams, 1980; Copeland et al., 1987; Kaplan et al., 1994) of elderly populations consistently demonstrate that the prevalence of depressive symptoms far exceeds that of depressive illness. Between 10% and 15% of elderly people in the community have some degree of depressive symptomatology at a given point in time, but only about 3% will be found to have a depressive illness (Copeland et al., 1987).

This discrepancy, between depression as a symptom and as a psychiatric diagnosis, was investigated by Blazer and Williams (1980). They found a prevalence of depression of 14.7% with only 3.7% of these cases being regarded as a Major Depressive Disorder. The rest were subdivided into dysphoric disorders secondary to health problems, simple dysphoria, or cognitive impairment, resulting in depressive symptoms that fall short of an actual psychiatric diagnosis of MDD being common in older age. More recently, Geiselman et al. (2001), in a community-based random sample of 516 subjects aged between 70 and 90, found MDD to be present in only 4.5% of subjects but 16.5% to have subthreshold depression. Blazer, Hughes, and George's (1987) community survey of 1,306 adults over the age of 60 found that 27% of the population experienced depressive symptomatology that did not always fit the DSM-III categories (the relevant classification system at the time). Even amongst institutionalised care, such as long-term care homes and acute-care hospitals, where the prevalence rates for MDD in both is estimated at 12%, significant depressive symptomatology (not MDD) was found in 31% of those in long-term care and 23% in acute-care (Allen & Blazer, 1991).

In the general adult population, lifetime risk for major depression remains around 16% (DSM-IV, 1994; Sturt, Kumarakura, & Der, 1984). At any one time, there are some 5% of the adult population who are suffering from depression (Williams, 1997), and 9% - 20% of the population suffering from significant symptoms of depression (Bradley, 1995; Paykel, 1984). In older adults, studies

(Baldwin, 1997b; Blazer, 1997; Blazer & Williams, 1980; Copeland et al., 1987; Geiselman et al., 2001; Helmchen et al., 1999) have suggested that the prevalence of MDD ranges from 1.8% – 5.4%, and from 10% – 16.5% for depressive symptomatology. When comparisons are made, there does not appear to be a greater prevalence of depression in older adults compared to the general adult population. There is a suggestion that the prevalence is greater in younger adults (Roth & Fonagy, 1996), but that the elderly kill themselves more often (Butler & Lewis, 1982).

A number of studies (Osgood, 2001; Pearson & Brown, 2000; Pitt, 1997) have found that older adults are at greater risk from completed suicide than younger adults. Pearson and Conwell (1995) report that statistics from industrialised countries reveal that suicide rates rise progressively with age, with the highest rates for men of 75 years and older. Pearson and Brown (2000) refer to the most current rates in the US (Peters, Kochanek, & Murphy, 1998) that report the highest rates are amongst older white males (65 per 100 000) and not amongst adolescent males aged 15 – 19 (16.6 per 100 000), and that older adults commit one out of every five suicides in America. In the UK, similar results have been found. Baldwin (1998) notes that those over the age of 65 account for 15% of the population but for 20% – 25% of all completed suicides. One of the difficulties in establishing precise figures on suicide is that it is often under-reported or misclassified, particularly if the individual used alcohol (Pearson & Brown, 2000). Another difficulty is that in the US, different states have different registry systems as well as a variety of people from diverse backgrounds who are responsible for completing death certificates.

Psychiatric disorder and/or substance use was found to be present in approximately 90% of all suicides, and affective disorders were the most common psychopathology found when the Psychological Autopsy method was used (Conwell & Brent, 1995). This method assesses mental and physical disorders, health service use, personality and life events from all sources including interviews with knowledgeable informants, clinical records and case formulations from mental health professionals with expertise in post-mortem studies (Pearson & Brown, 2000). However, the results thus far using this method for older adults, has only yielded findings on age-based comparisons and has not as yet been applied to control groups. Pearson and Brown (2000) note the work of Conwell (1994) and Conwell and Brent (1995) that suggest older suicide victims had a physical illness and suffered from depression that was not co-morbid with a substance disorder. The type of depression found in the majority of cases was an uncomplicated first episode, which they state is the most treatable of late-life depressions.

Pitt (1997) states that epidemiological research has also shown that suicide increases with age, bereavement, isolation, deteriorating health and pain, but Angst (1999) argues that suicide risk in affective disorders is linear and thus constant over the lifetime. However, it is not clear whether Angst's (1999) conclusion excludes the factors stated by Pitt (1997), and his argument is specific to affective disorders and therefore not necessarily generalisable to other disorders or to the population in general. Blazer (1996a) argues that the trend over the past 100 years for suicide rates to increase with age has flattened due to age, generational or cohort effects and period effects. He cites an example of a marked period effect postulated by Murphy, Lindesay, and Grundy (1986) in their study of suicides in England and Wales. In their cohort analysis of recorded suicides from 1921 – 1980, successively older cohorts were found to show a fall in suicide rates that contradicted findings in the US. Murphy et al. (1986) postulated that the decline was due to the detoxification of domestic gas in the 1960's. The rate of gas poisoning in the more elderly group decreased dramatically and this decrease, they suggest, was not offset by an increase in other methods of suicide. However, there does appear to be stronger evidence for suicide rates to increase in those over 65 rather than the curve to flatten (Baldwin, 1998; Center for Disease Control and Prevention [CDC], 2000; Osgood, 2001; Pearson & Brown, 2000).

Regarding the prognosis of depression in later life, Pitt (1997) notes that 30% of older patients are still depressed after 3 years, and Livingston and Hinchliffe (1993) found complete recovery in only 20% of cases. Burvill (1993) found that a significant proportion of participants made a partial recovery (24%) or relapsed within one year (18%), and he also found a high mortality rate of 11% in his study. Angst (1999) cites a recent UK study that supports the literature showing prognosis to be no worse in late-onset depression than in the early-onset variety. However, the majority of the epidemiological studies on prognosis cited above refer to cases in which there was very limited psychotherapeutic input, as the emphasis in treatment was predominantly pharmacological.

#### **4. Theories of Depression**

Different schools of thought have produced different theories on why older adults may become depressed. Biological theorists propose that ageing critically alters the levels of neurotransmitters and the body's response to stress (Finch, 1977; Lipton, 1976), which implies an increased vulnerability to depression in the elderly. Seligman (1975) proposed the learned helplessness theory, wherein individuals perceive themselves as having no control over events, and thus feel helpless and unable to actively re-organise or alter their circumstances. Behavioural theorists view depression as a state when there has been a withdrawal from positive activities and reinforcement, and cognitive theorists, such as Beck (1967, 1976) emphasise negative beliefs about oneself, events and experiences, and the future, resulting in negative thinking and distortions of reality. The multidimensional model of depression of Akiskal and McKinney (1973) combines many factors, such as stress, biochemistry, recent losses and so forth, and perhaps offers the most holistic and interactional conceptualisation of depression in older adults.

Psychoanalytic theorists link depression to traumatic early childhood experiences that are rekindled and exacerbated by more recent events (Freud, 1905). Others (Ardern, 1997; Butler & Lewis, 1982) emphasise the extent of the losses that occur in later life, and how the individual adapts to them, as being a component of depression. Loss and the events that occur in one's life impact on individuals in different and idiosyncratic ways. Life changes and the onset of depression have a close link in that significant life changes were found to be widely reported by depressed elderly people as having preceded a depressive episode (Post, 1967, 1972). The elderly are commonly bereaved of their loved ones, and bereavement has often been hypothesised to be a common precipitating factor for depression that hospitalises elderly patients (Turner & Sternberg, 1978). Yet, longitudinal studies have found relatively low rates of depression in the bereaved, and that symptoms of depression in bereaved individuals are generally less severe and fewer than those in individuals institutionalised for depression (Gallagher, Breckenridge, Thompson, Dessonville, & Amaral, 1982). Retirement has also been assumed to have a negative consequence for the person, but research does not generally support this assumption (George, 1980). The ill effects found by studies may have much to do with the poor health and low income of the retired rather than with the retirement itself (Wilson, Chen, Taylor, McCracken, & Copeland, 1999). Physical illness too appears to play a prominent part in late-life depression (Kim, Braun, & Kunik, 2001).

However, Ariskel and McKinney (1973), Butler and Lewis (1982) and Ardern (1997) emphasise that as unique entities, each older person brings to late life a developmental history, a set of coping skills and a personality style all of which combine in order to determine how he or she will react to common problems and new life events. Therefore, one should be cautious not to assume that depression, rather than adaptation, is the common reaction to loss and stress in later life (Ardern, 1997; Butler and Lewis, 1982). Nevertheless, should depressive symptoms be present, the next task would be to assess them with a view to accurate diagnosis and appropriate intervention.

## **5. Assessment of Depression in Later Life**

### **5.1 Symptomatology**

Depression may have similar clinical presentations across age groups, but research (Mithani & Ancill, 1997; Pulska et al., 2000) appears to be showing that there may be factors that can modify the expression of it in the elderly. Some of these arise out of the ageing process itself, whereas others are due to generational differences in the perception of psychological and physical health, or differences occurring because of the frequent overlap of depressive symptoms and physical illness (Karel & Hinrichsen, 2000; Mithani & Ancill, 1997; Pulska et al., 2000). Some factors may accentuate certain aspects of the clinical picture, whilst others may obscure the diagnosis. Therefore, problems associated with old age, such as cognitive impairment, memory loss, physical illness, and functional disability, rather than old age per se, may contribute to differences in presentation (Baldwin, 1998).

The symptomatology of older age depression was generally thought to differ qualitatively from that seen in the general adult population in that there are certain aspects of depressive illness that are thought to be more common in, or typical of, old age. They include more frequent delusions, an increased likelihood of presentations coloured by confusion (Horden, Holt, Burt, & Gordon, 1963), and a more 'endogenous' picture (Blazer, George, & Landermark, 1986). These findings, however, have tended to create a stereotypic picture of depressive illness in old age, and Baldwin (1997b) states that surprisingly few of the 'typical' features of later-life depression have withstood the rigours of modern research; this view is increasingly being born out in current research (Baldwin, 1997b; Gallo et al., 1997; Geiselman et al., 2001; Mithani & Ancill, 1997).

Mithani and Ancill (1997) emphasise that older adults present with a much higher weighting of neuro-vegetative symptoms in depressive illness than in a younger population. Gurland (1976) found that older adults tend to report more somatic symptoms, or a higher level of anxiety (Winokur, Morrison, & Clancy, 1973), than younger individuals, but fewer thoughts of suicide (Gallagher, Breckenridge, Thompson, Dessonville & Amaral, 1982; Winokur, Behan, & Schelesser, 1980). However, it has been noted that suicidal threats by the elderly are a rarity: older adults simply kill themselves (Butler & Lewis, 1982). Baldwin (1998) notes that older adults also present with an increased incidence of somatic preoccupation, agitation, forgetfulness and delusions, though he does warn that these features may arise out of an over-emphasis on the severe end of the depressive spectrum, as is seen in in-patient settings. Penninx et al. (1998) found that the reporting of depressive symptoms by older adults resulted in them being at a higher risk for later physical decline. Neiderehe and Schneider (1998) state that symptoms such as lack of interest in normal pursuits, deterioration in self-care and actual or perceived problems with memory or attention may frequently predominate in older depressed adults.

### **5.2 Memory & Dementia**

Prevalence estimates for the presence of dementia in those of 65 years of age and over are at least 5% of this population, and if analysed even further, it amounts to 1% of those who are 65 years old and the percentage then doubles approximately every 5 years to reach a figure around 30 % for those who are over 90 years of age (Helmchen et al., 1999).

It seems that older adults who complain of memory loss should also be evaluated for differential diagnoses of dementia and depression. Helchem et al. (1999) found, in line with other international studies, that the Berlin Ageing Study [BASE] reported a steep increase in the age-related prevalence

rates of dementia from 1% in the age group 70 – 74 to 43% in those aged 90+. Memory problems may be a product of depression or anxiety (Watts, 1995) rather than Alzheimer's disease or another form of dementia.

Whereas there is some overlap of symptoms between depression and dementia, in that depressed people often report loss of memory and other intellectual impairment, and dementia patients may have depressive symptoms especially in the early stages, there are differences. Depressed persons do not necessarily have an obvious memory loss, though they may complain of it, and they very seldom make errors on mental status tests (Kahn, Zarit, Hilbert, & Neiderehe, 1975; Raskin & Rae, 1981; Sinclair, Lyness, King, Cox, & Caine, 2001). Subtle intellectual impairments may occur in depressed persons, but seem to be less global or profound as one would find in cases of dementia (Kahn et al., 1975; Raskin & Rae, 1981). Gurland (1976) notes that depression is typically episodic, but with dementia the onset is mostly insidious and there is a gradual progression of symptoms, and Woods (1995) remarks that patients, particularly in the early stages of dementia, are aware of cognitive decline and feel depressed about it.

The term 'depressive pseudodementia' is a controversial one that is used in a number of ways (Baldwin, 1998). Its usefulness lies in facilitating the recognition that evidence of cognitive impairments in elderly patients can be misleading if these occur within the context of a mood disorder. As mood disorders are amenable to treatment, an exclusive focus on cognitive impairments at the exclusion of the influence of the depressive component can suggest an unnecessarily poor prognosis.

### **5.3 Physical & Medical Conditions**

Mithani and Ancill (1997), Kim, Braun, and Kunik (2001), and Salzman and Shader (1978b) cite the most common factor complicating the identification of a depressive illness as the co-morbid presence of a physical illness. They list many conditions that can give rise to depressive illness, such as cardio-vascular diseases, various carcinomas, endocrine and metabolic disorders, infections, brain disease, intercranial aneurysms and Parkinson's disease. Adverse side effects from medications such as antiparkinsonian, antihypertensive and neuroleptic drugs have been found to cause depressive symptoms in their own right (Salzman & Shader, 1978b) and should be taken into account. Kim et al. (2001) suggest that an assessment should involve a comprehensive diagnostic interview, including a complete medical history, and a careful examination. Teasing out the effects of the physical disease in order to differentiate the secondary depressive illness can be a difficult task. Baldwin (1998) suggests that appropriate sensitivity to anhedonia and cognitive features, such as guilt and self-deprecation, and changes in symptoms when physical health status is static may be useful.

Pulska and colleagues (Pulska, Pahkala, Laippala, & Kivela, 2000) carried out a study on 169 depressed (DSM-III criteria) elderly subjects drawn from an older adult population of 1, 225 from a municipality in Finland over a six-year period. They found that the emotional symptom of dissatisfaction (confirming Blazer's 1982 study) was common and pervasive amongst the elderly. When age, sex, smoking, physical health and functional abilities were taken into account, they found that dissatisfaction, weight loss and gastrointestinal symptoms (namely anorexia and constipation) predicted mortality together with high age and physical health. They also state that people with depression have poorer compliance concerning disease and their treatments than do those who are not depressed. At the other end of the spectrum, dismissing or under-estimating physical complaints through focussing on the features of depression can have fatal consequences. The results of this study are in line with those found in a nation-wide (n=29, 173) Finnish project spanning a 20 year follow-up period of adults aged 18-64 at the start of it who were unselected for mental health status

(Koivumaa-Honkanen et al., 2001). They found that life dissatisfaction had a long-term effect on the risk of suicide and that this appeared to be mediated, in part, through poor health behaviour (e.g. smoking and drinking levels) and social situation.

#### **5.4 Environmental & Social Factors**

Factors such as social environment, living conditions, family support, family background, family psychiatric history, premorbid functioning, finances, mobility, community support and coping resources have also been found to be important and contributing issues (Akiskal & McKinney, 1973; Butler & Lewis, 1982; Kim et al., 2001; Wilson et al., 1999)

#### **5.5 Late Onset of Other Psychiatric or Behavioural Disturbances**

If depression can occur later in life, then perhaps so can other psychiatric or behavioural disturbances. Baldwin (1998) refers to this as ‘neurotic symptoms’ of recent onset. He notes that it is extremely rare to have obsessive-compulsive, hypochondriacal and dissociative disorders begin for the first time in late adulthood, and for this not to be part of a larger clinical picture that can frequently include a depressive disorder. Similarly, anxiety can be the most prominent symptom of distress but can co-occur with a depressive illness (Baldwin, 1998; Niederehe & Schneider, 1998). Baldwin (1998) also notes that recent onset of alcohol abuse or shoplifting, food refusal and aggression in more institutional settings, can be important markers of depression, and that behavioural problems may also arise out of the exacerbation of pre-morbid personality features in the context of a mood disorder. However, if the difficulties are simply attributed to the person’s ‘temperament’ or age, then the mood component may be missed (Baldwin, 1998).

#### **5.6 Assessment Tools**

Assessment instruments developed for the diagnosis of psychiatric disorders, such as the Structured Clinical Interview for DSM-III-R (SCID), the Research Diagnostic Criteria (RDC) and the Diagnostic Interview Schedule (DIS) are the more commonly used tools for the use in an older population (Blazer, 1996b). In general, the scales used to assist in the assessment of depression in older adults have proven to be both valid and reliable, such as the Beck Depression Inventory, the Hamilton Anxiety and Depression Scale, and the Center for Epidemiologic Studies-Depression Scale (Karel & Hinrichsen, 2000). However, such scales were not specifically developed for use with this population, though they appear to be proving reliable and valid with older adults who have a high level of education (Kazniak & Christenson, 1994; Pachana et al., 1994 in Karel & Hinrichsen, 2000). The Geriatric Depression Scale (GDS) (Yesavage et al., 1983) which has been recommended by the Royal College of Physicians and the British Geriatric Society (1992), and the adapted version of the Brief Assessment Schedule (BASDEC) (Adshead, Cody, & Pitt, 1992) were developed specifically for use with older adults, and both have shown acceptable levels of sensitivity and specificity (Rait & Burns, 1998). Hammond, O’Keeffe, and Barer (2000) have developed and validated a brief observer-rated screening scale for depression in elderly medical patients where prevalence rates of depression have been found to be as high as 50% (Hammond, O’Keeffe, & Barer, 2000), and was devised in order to facilitate a non-verbal assessment tool that could be used by nurses. The Camberwell Assessment of Need for the Elderly (CANE), although not specifically focussing on depression, can determine the presence of psychological distress which would allow for further investigation (Walters, Iliffe, Tai, & Orrell, 2000). Walters, Iliffe, Tai, and Orrell (2000) have also validated this tool for use in a primary care setting.

Rait and Burns’s (1998) commentary on the screening for depression and cognitive impairment

in older adults from ethnic minority groups raises the issue of many current assessment tools not necessarily being applicable for use with people from ethnic minorities. They note that the detection and management of depression in older adults from these groups has received little attention, which may, in part, be due to the difficulties and complexities inherent in cross-cultural research. However, they cite examples of the GDS being adapted for use in India with a rural illiterate population (Kohli, Banerjee, & Verma, 1991) and with Chinese immigrants in the USA (Mui, 1996). The BASDEC has been translated into South Asian languages, but not as yet validated in these groups, the Hospital Anxiety and Depression Scale has been translated into Urdu, and an instrument for detecting emotional distress in older African-Caribbeans has been developed by Abas (Rait & Burns, 1998).

## **6. Professional Beliefs and its Impact on the Detection and Treatment of Depression in Later Life**

Professional pessimism regarding old age, i.e. a belief that illness is a natural consequence of old age, will affect assessment and treatment provided (Blazer, 1996b; Blazer & Koenig, 1996; Mather, 1997). Karel & Hinrichsen (2000) are of the opinion that inadequate recognition is the biggest barrier to effective treatment of depression in older adults. However, they note that this poor level of recognition is not only by physicians, but also by older adults and their families. Waxman, Carner, and Klein (1984) state that older adults have had less exposure to information on mental health issues than younger adults, and therefore, this older cohort may not view depressive symptoms as a mental health problem and seek help. Elderly people with even mild symptoms of depression may frequently present themselves to the physician and express more physical complaints than the elderly without such symptoms (Allen & Blazer, 1991; Niederehe & Schneider, 1998; Pearson & Brown, 2000; Waxman et al., 1984). Karel & Hinrichsen (2000) note that a different picture may emerge when more 'psychologically-minded' younger cohorts fall into the category of 'older adults'.

It appears that depression in the elderly is often 'missed' both in the hospital setting and in the community. Elderly people occupy nearly half of all hospital beds, and during a hospital admission for assessment or treatment of medical or surgical illness, between a third and a half of these patients will have, or will develop, a psychiatric disorder that can significantly influence the outcome of the associated physical illness, and approximately a quarter of these patients will suffer from a depressive disorder (Cooper, 1987; O'Riordan, et al., 1989; Burn, Davies, McKenzie, Brothwell, & Wattis, 1993). Both Baldwin (1998) and Pitt (1997) suggest that older people tend not to report their mood or to show a reduced expression of sadness, and this has been attributed to the shame of being depressed, the cultural attitude towards expression of emotion, the stigma attached to mental illness and a tendency to stress bodily symptoms rather than emotional distress.

Despite the high numbers of old people in general hospitals, the rates of referral to consultation liaison psychiatric services for the elderly are relatively low. Popkin et al. (1984) found that there were one third fewer psychiatric referrals amongst the elderly medically ill, than for those less than 60 years of age. There may be many reasons for this low referral rate of elderly people with depression for psychiatric assessment. First, there may be a failure to recognise psychiatric illness, or the depressed mood may be masked by a presentation of somatic symptoms (Kim et al., 2001; Mithani & Ancill, 1997). There may be a belief that certain symptoms are part of the ageing process, which involves depressed mood, apathy and impaired cognitive functioning (Pearson & Brown, 2000), and thus be viewed as normal due to losses and life changes, and therefore not identify those needing mental health treatment (Blazer, 1996b; Blazer & Koenig, 1996; Gurland, 1976). Collins et al. (1995) found this to be particularly true for older practitioners. Apart from the failure to detect potentially treatable psychiatric conditions, there may also be more general reasons

for failing to refer for psychiatric assessment, which has been analysed by Steinberg, Torem, and Saravay (1980). These may be particularly pertinent for the elderly population where the physician's difficulties in assessing psychological issues may be compounded by the attitudes and beliefs of the elderly person and his or her family. The physician may have difficulty in discussing the reason for psychiatric referral; he or she may believe that it will upset the patient, that it may prolong the hospital stay, or that physical treatment for depression will be too dangerous and complicated. Furthermore, physicians may be ignorant of other effective interventions for the elderly (Steinberg et al., 1980).

The tendency to under-diagnose depression in later life was highlighted in a major cross-national study by Mather (1997) who found that the rate of detection of depression by doctors and nurses was low, that most cases went unnoticed, untreated or were inappropriately managed, and that this affected subsequent morbidity and mortality. Zarit and Zarit (1984) found that American psychiatrists made fewer diagnoses of depression than British psychiatrists, and that they were more likely to diagnose depressive symptoms as organic brain damage. Woods (1995) notes DesRosiers' finding that across 18 studies, 10% of cases initially diagnosed as organic dementia were later rediagnosed as depression. However, Rao's (2001) prospective study, albeit much smaller in sample size, found that 10 out of 12 people referred by physicians in a hospital setting to an old age psychiatric service were correctly diagnosed with dementia, and 13 out of 16 with depression.

Blazer, Hybels, Simonsick, and Hanlon (2000) cite the USA Epidemiologic Catchment Area Study by Weissman, Bruce, Leaf, Florio, and Holder (1991) who found that the frequency of MDD between African Americans and White USA groups appear to be similar. However, Blazer et al.'s (2000) community-based cohort study of older adults over a 10 year period reveal that African Americans were significantly less likely to be prescribed SSRI antidepressants, as opposed to tricyclic ones (in spite of their reduced side-effects) than Whites. They explain this as being a consequence of relative under-diagnosis of depression as a treatable condition in elderly African Americans coupled with prescribing practices of physicians being partly determined by the race of the individual.

Twining (1998) suggests that there is almost always a psychodynamic factor that can be identified in the histories of patients presenting with depression and that a detailed history is a crucial component. He (Twining, 1998) states that care should be taken not to stereotype older people and so leave certain problems unconsidered such as substance abuse, sexual difficulties, neglect or abuse by others. These facets of assessment focus on what is frequently not addressed and that is the salient uncomfortableness (or counter-transference) that working with older adults can present for the younger clinician (Ardern, 1997; Porter, 1997).

An issue that is frequently overlooked in the elderly is that of substance abuse (Atkinson, 1999; Blazer, 1996c; Phillips & Katz, 2001; Stewart & Oslin, 2001; Twining, 1998). Phillips and Katz (2001) cite the United Nations International Drug Control Programme of 1997 wherein the increase in prevalence of substance misuse in the elderly over time is already established. Even when substance abuse is diagnosed, which is seldom (Atkinson, 1999; Phillips & Katz, 2001; Stewart & Oslin, 2001), it may not be addressed. Estimates of the prevalence of alcoholism, drug addiction, problematic use and heavy use among older adults appear to vary from 2% to 25%, with significantly higher representation among medical and psychiatric patients as well as nursing home residents (Phillips & Katz, 2001; Stewart & Oslin, 2001). Stewart & Oslin (2001) cite figures of around 10% for gambling as an addiction, and Phillip and Katz (2001) cite the UK Department of Health's figures that 19% of men and 23% of women between the ages of 65 and

74 smoke, and that 10% of men and 9% of women over the age of 75 are smokers. They also note that smoking has been found to be a risk factor in 8 of the top 16 causes of death for those who are 65 years of age and older.

Atkinson (1999) emphasises the links between depression, alcoholism and ageing, and he cites the largest US household survey (in Grant and Harford, 1995) on the assessment of syndromal depression and alcoholism for people aged 65 or more. The survey found that amongst those with lifetime DSM-IV Major Depressive Disorder 13.3% also met criteria for a lifetime alcohol use disorder, whilst only 4.5% without a history of MDD had an alcohol use disorder. Phillips and Katz (2001) and Stewart and Oslin (2001) note that the reluctance of professionals to consider the possibility of substance misuse and addiction in older adults as real problems, and to believe that individuals may be motivated to change, are still barriers that result in the condition being under-diagnosed and treatment interventions under-utilised.

An even more difficult issue to acknowledge and assess is abuse. Osgood and Manetta (2001) review the literature in this area. They cite a number of studies that confirm that adult women survivors of childhood physical or sexual abuse, rape, and battering have an increased risk of depression and of suicidal behaviour. They refer to the US Department of Justice's 1991 study that places the incidence of rape of women 65 and older at 10 per 100 000 in the US. Their own study (Osgood & Manetta, 2001) found that women with suicidal ideation had significantly more victimisation (such as sexual abuse, rape and battering) than women without suicidal ideation, but no significant difference was found between the subtypes of abuse. Many of these women, both in their study and in the others, stated that they had never mentioned the abuse or received support around it. They note that the distress around the incident(s) may still be present once they move into later life. They also mention that many of these women have turned to drugs or alcohol as a means of coping with the distress. In addition, Osgood and Manetta (2001) cite a study by Raymonds (1994) wherein it is estimated that each year in the US between 700 000 and 1.5 million older adults are victims of abuse by another elder.

Thus far, this review has aimed to discuss the incidence of clinical depression in an older adult population, the possible causes of it, and the complex nature of making an accurate diagnosis of it in the light of confusing clinical presentations and professional pessimism. What remains to be explored is whether psychological intervention is an appropriate form of treatment for this population.

## **7. Psychological Treatment Interventions**

A conclusion of the 1992 National Institutes of Health [NIH] Consensus Development Conference on Diagnosis and Treatment of Depression in Late Life (Washington, DC) that psychological interventions for older adults experiencing depressive symptoms were only moderately effective and were listed third in a hierarchy of recommended treatments, behind pharmacotherapy and electroconvulsive therapy. It is uncertain on what grounds such a conclusion was drawn, though in part it appears that it may have been due to the very limited research available for scrutiny at the time. Now, a decade later, research findings (Bortz & O'Brien, 1997; Gerson et al., 1999; Karel & Hinrichsen, 2000; Knight, 1999; Niederehe & Schneider, 1998) are providing sufficient evidence to contest this view.

On the whole, psychological treatment for depression seems to be offered less often to older adults than to younger adults (Woods, 1995). The efficacy of antidepressant medication in older adults has been proven but there are difficulties in their long-term use with some patients with specific physical problems (Blazer, 1996b, Kim et al., 2001), and there is an increased risk for adverse side effects in this population, particularly with tricyclic antidepressants (Karel & Hinrichsen, 2000;

Gerson et al., 1999; Niederehe & Schneider, 1998). Relapse rates are relatively high: a significant number of patients recover only partially (Burvill, 1993; Livingston & Hinchliffe, 1993; Murphy, 1982; Pitt, 1997) with some being left with disabling symptoms; almost a fifth relapse within a year (Burvill, 1993); and as many as a tenth do not improve at all (Murphy, 1982), though Gerson, Belin, Kaufman, Mintz, and Jarvik (1999) place this at a lower estimate of a third who do not show any improvement. The scope, therefore, for psychological approaches to supplement or substitute pharmacological treatment seems apparent, particularly as this population tend to have multiple medical conditions, they are more sensitive to adverse drug effects, and they may be exposed to a number of psychological stressors such as loss of status (Gerson et al., 1999).

The reluctance to use psychological approaches in large is part of a legacy of the Freudian view that older adults are not suitable for therapy. Freud, in 1905 (p. 264) wrote that older individuals were not fit for psychoanalytic treatment because "... near or above the age of 50 the elasticity of the mental processes, on which treatment depends, is as a rule lacking - old people are no longer educable ...". Although this needs to be seen within the context of his era, Porter (1997) expresses the view that this attitude lingered for years and has often been the excuse for not treating depression in later life with psychological methods. Though age-related changes in mental functioning do necessitate modifications of the psychological techniques used for treating depression (Bortz & O'Brien, 1997; Karel & Hinrichsen, 2000; Knight, 1999) it is becoming increasingly evident that they do not exclude older adults benefiting from treatment (Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990; Karel & Hinrichsen, 2000; Katona, 1994; Knight, 1999; Niederehe & Schneider, 1998; Scogin & McElreath, 1994; Steur et al., 1984; Thompson, Gallagher, & Steinmetz-Breckenbridge, 1987).

Scogin & McElreath (1994) found comparable effect sizes when comparing the overall effect size ( $d=.78$ ) established in their meta-analysis of psychological interventions with older adults with that found in such interventions with adults of all ages ( $d=.73$ ) and psychotherapy efficacy in general ( $d=.85$ ). A study by Meats, Timol, and Jolley (1991) of in-patients found a better outcome for an older compared to a younger group, and Roth and Fonagy (1996) also identify older subjects to be as responsive to psychotherapeutic interventions as younger patients but that they may require a longer period of treatment in order to show the same gains. Weiss and Lazarus (1993) point out that high drop-out rates in outcome studies are frequently attributable to transportation and physical health problems. Ardern (1997) and Twining (1998) therefore suggest that therapy be taken to the client in order to work around such difficulties and assist compliance. They also suggest that session lengths require flexibility so as to accommodate the likelihood of potential difficulties with concentration and fatigue, and that sensory impairments need to be accommodated, such as failing eyesight or hearing.

Various forms of brief, structured psychotherapeutic input have been developed in recent years for the treatment of depression in older adults. Behavioural therapy (Lewinsohn, Munoz, Youngren, & Zeiss, 1978), Beck's cognitive-behavioural therapy (Beck, 1967), Klerman and associates' (1984) interpersonal psychotherapy, a psychoanalytic approach (Ardern, 1997), and family therapy (Benhow & Marriott, 1997; Herr & Weakland, 1984) have emerged.

An overview of review studies (Bortz & O'Brien, 1997; Karel & Hinrichsen, 2000; Gerson et al., 1999; Niederehe & Schneider, 1998; Scogin & McElreath, 1994) of the efficacy of psychotherapy with older adults appears to reach similar conclusions, regardless of the differences in inclusion criteria. Gerson et al.'s (1999) meta-analysis included double blind (for the drug trials), randomised controlled studies with a quantitative documentation of depressive symptoms (MDD) utilising observer pre- and post-treatment rating scales. Niederehe and Schneider's (1998) review incorporated eight randomised controlled studies with participants diagnosed with Major Depressive Disorder, and ten controlled studies including mixtures of depressive subtypes. Scogin and McElreath's

meta-analysis (1994) included seventeen studies of psychosocial treatment interventions, each of which included either a comparative control group or a second psychosocial intervention. Bortz and O'Brien (1997) and Karel and Hinrichsen (2000) studies reviewed the available literature but did not state exclusion criteria.

Across the board, any psychological intervention appeared to yield more positive results than no therapy or placebo (Gerson et al., 1999; Niederehe & Schneider, 1998; Scogin & McElreath, 1994). The comparative efficacy of one modality over another was not found, nor was there any advantage of individual therapy over group therapy, or vice versa (Gallagher-Thompson et al., 1990; Gallagher & Steffens, 1994; Gerson et al., 1999; Niederehe & Schneider, 1998; Roth & Fonagy, 1996; Scogin & McElreath, 1994; Steur et al., 1984).

The comparisons of intervention efficacy appear to be mainly between studies that utilise cognitive, behavioural, and psychodynamic modalities, with only a few studies on interpersonal therapy being included (Bortz & O'Brien, 1997; Karel & Hinrichsen, 2000; Niederehe & Schneider, 1998; Scogin & McElreath, 1994) and even fewer on reminiscence therapy or review therapy (Bortz & O'Brien, 1997; Karel & Hinrichsen, 2000; Niederehe & Schneider, 1998). A marked absence of research with depressed older adults in the modality of family therapy was noted. Karel and Hinrichsen (2000) make reference to this and state that of the nine studies they found all except one was on the efficacy of treatment with caregivers of older adults. They cite Teri, Logsdon, Uomoto, and McCurry's (1997) study that involved two behavioural interventions taught to the family caregivers of depressed dementia patients on techniques to help reduce the patients' depressive symptoms. There does, however, appear to be a growing body of literature on the use of family therapy with older adults (Benbow & Marriot, 1997; Carpenter, 1994; Gilleard, 1996; Herr & Weakland, 1984; Qualls, 1999) but few empirical studies appear to be available.

In a systematic review on treatments (both drug and psychotherapy) for late life depression in primary care Freudenstein, Jagger, Arthur, and Donner-Banzhoff (2001) used literature searches from electronic databases for articles in French, English and German, and quality criteria for inclusion based on Cochrane Effective Practice and Organisation of Care Group. Their inclusion criteria were controlled clinical trials, randomised controlled trials, controlled before and after studies, and time series studies on cognitive/cognitive behavioural therapy, interpersonal therapy, counselling, social support, and drug treatment. The subjects needed to have been recruited from a sample of the general population or from primary care attenders, and to be 60 years of age or over. Studies that were based on those of adult age but included those of 60+ were also used. The outcome was that no studies on psychological treatment were found. Only five studies were applicable in the area of drug or other treatment, two of which were specifically with adults over the age of 60 whilst the others only included participants of that age group. The authors emphasise how research into depression has tended to be carried out exclusively on those with severe, uncomplicated Major Depressive Disorder as there are reliable methods to identify and categorise it (such as the DSM and ICD), but that symptoms below the diagnostic level are more difficult to classify and are therefore mostly excluded. However, they note that milder forms of depression are more commonly found in primary care than MDD, and that research on MDD may only be applicable to <15% of depressed primary care patients. In addition, the findings on efficacy can therefore only be applied to this minority and not to all older patients who are depressed, and particularly not to those who are only seen in primary care settings.

Arèan et al. (2001) discuss three ongoing research programmes that are utilising specifically modified forms of psychotherapeutic modes (namely, CBT, IPT and Problem Solving therapy).

These intervention models have been modified to suit their use in a primary care setting specifically with older adults. Preliminary results suggest that all three modified models are showing some level of efficacy, though a precise analysis of their efficacy can only be carried out once the results are more fully available.

Gerson et al. (1999) note that the literature comparing psychological and pharmacological treatments for depression across the age groups suggests that psychological interventions may be comparably effective as medication in milder to moderate depression as well as severe depression. Niederehe and Schneider's (1998) meta-analysis of ten psychosocial treatments with previous meta-analyses by Schneider (1994) on imipramine and nortriptyline, respectively, for the treatment of depression in late-life found comparable mean effect sizes between psychosocial interventions ( $d=.74$ ), imipramine ( $d=.60$ ) and nortriptyline ( $d=.62$ ). Combined treatment (i.e. psychotherapy and medication) has been found to be more effective than only drugs or psychotherapy when treating and preventing relapse in severe depression (Gallagher & Thompson, 1983; Gerson et al., 1999; Reynolds, 1997; Thase et al., 1997; Thompson, Gallagher, Hanser, Gantz & Steffens, 1991).

The main limitations stated in the studies are, firstly, the limited number of psychological treatment studies available, particularly in modalities other than cognitive-behavioural therapy (Freudenstein et al., 2001; Gerson et al., 1999; Karel & Hinrichsen, 2000; Niederehe & Schneider, 1998; Roth & Fonagy, 1996; Scogin & McElreath, 1994). However, there appear to be numerous studies available on the use of different antidepressant medications. Gerson et al. (1999) comment that this may be due to funding issues rather than to any reluctance to undertake research. Secondly, many of the psychological treatment studies have used participants with mixed depressive disorders whereas the drug studies have focussed predominantly on MDD making comparisons more difficult (Gerson et al., 1999; Niederehe & Schneider, 1998; Roth & Fonagy, 1996). Lastly, the generalisability of the psychological treatment studies is limited as the majority of participants were either relatively well-functioning, or came from predominantly white populations (Gerson et al., 1999; Karel & Hinrichsen, 2000). Furthermore, those of 80 years and older were seldom included in such studies, as were older adults with multiple co-morbid medical conditions, neurobiological and/or chronic psychiatric disorders (Karel & Hinrichsen, 2000).

## **8. Conclusion**

This review has discussed and challenged what appears to be the simplistic view that depression in older adults is a predetermined reaction to the ageing process and thus does not require accurate assessment or treatment priority. It appears plain that when comparing prevalence rates, symptoms, treatment efficacy, and the implications of loss and life events in the older depressed population with that of the adult population, there were no significant differences between the age groups. These findings led to a discussion and analysis of issues around the understanding and treatment of depression in older adults and how it is frequently 'missed' and at worst, dismissed. Whether this is a reflection of an unwillingness to treat the disorder or a lack of understanding is uncertain. What appears to be evident is that health care specialists may benefit from a greater understanding of its assessment, treatment and management. Professionals are adjusting and altering present methods, and developing new assessment and treatment strategies that are specific to older adults and not to all age groups, and different antidepressant and psychological interventions have proven to be successful as individual and combined treatment modalities. It is anticipated that the implementation of the National Service Framework for Older Adults (Department of Health, 2000) will raise the profile of the needs of older adults and establish age-appropriate facilities, both physical and interventional, for this important and ever-increasing population.

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