Recognizing Depression in the Older Adult

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Mrs. Jones, an 82-year-old with Parkinson's disease, is being treated for multiple falls that occurred during the night while she was trying to get out of bed. The primary medical concerns are dementia or a urinary tract infection. Her urinalysis is clear and her mini mental score is 25. Her geriatric depression scale score is 12 (i.e., severe depression). So, do you really know when your elderly patient is depressed?

Depression can complicate the recovery process and keep the patient from making gains in rehabilitation. It can be a preexisting and possibly exacerbated condition or a new onset. To some, depression may be considered commonplace and even expected in the elderly, but that does not make it acceptable. The research has shown that depression is a serious issue for older adults, which makes recognizing it crucial for practitioners. By overcoming barriers and using a simple 15-question Geriatric Depression Scale, recognition and treatment can be made easier.

Why Is Geriatric Depression an Issue?

According to the National Institutes of Health (1991), depressive symptoms occur in approximately 15% of community residents over the age of 65, and the rates of major and minor depression vary from 5% in primary care to 25% in long-term care settings. It is estimated that only 10% of elderly who require treatment ever receive it. Mortality rates for depressed elderly are higher compared to nondepressed elderly. Much of this may be due, in part, to the presentation of depression in the elderly. Symptoms may vary from the typical depression observed in younger adults and may not meet all the criteria listed in the *American Psychiatric Association DSM-IV-TR*. These criteria and the atypical symptoms of the older adult are shown in **Table 1**.

Often barriers, either on the part of the patient or the healthcare provider, cause difficulties in diagnosing depression. These potential barriers are listed in **Table 2**. The barriers discussed by Corrigan et al. (2003) must be overcome in order to recognize and treat the depression.

According to Schwenk (2002), there is also a priority issue for both the patient and the provider. Depression does not compete well for time and attention with other medical problems that require more urgent care. However, the profound negative effect of depression on overall health, function, medical comorbidity, healthcare outcomes, and cost may be more significant than that of other medical illnesses. Also, depression has been shown to increase the risk for the development of coronary artery disease and leads to poorer outcomes for patients with existing coronary artery disease.

The Geriatric Depression Scale

Depression screening tools were reviewed by Watson and Pignone (2003). This systematic review of instruments used to screen for late-life depression looked at 18 articles pertaining to screening tools that are specifically used for older adults in primary care. This study found that there are accurate screening tools available for late life and recommends the 15-item Geriatric Depression Scale because it is easy to use, has a yes/no format, and an easy-to-understand scoring method. The mini mental status exam can easily be used in conjunction with this and performing both tests can be done in approximately 20–30 minutes.

Table 1. Presentation

American Psychiatric Association DSM-IV-TR criteria

- Five or more of the following symptoms present for a minimum of 2 weeks:
  - Depressed mood
  - Loss of interest or pleasure in activities
  - Changes in weight or appetite
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Low energy
  - Feelings of worthlessness
  - Poor concentration
  - Recurrent suicidal ideation or suicide attempt

From Lapid, M. I., & Rummans, T. A. (2003). Evaluation and management of geriatric depression in primary care. Mayo Clinic Proceedings, 78, *1423–1429.*

Atypical presentation of depressed older adult

- Deny sadness or depressed mood
- May exhibit other symptoms of depression
- Unexplained somatic complaints
- Hopelessness
- Helplessness
- Anxiety and worries
- Memory complaints (may or may not have objective signs of cognitive impairment)
- Anhedonia
- Slowed movement
- Irritability
- General lack of interest in personal care

From Gallo, J. J., & Rabins, P. V. (1999). Depression without sadness: alternative presentations of depression in late life. American Family Physician, 60*(8), 820–826.*

Table 2. Barriers

The Patient

- Concerns about perceptions or stigma related to mental illness
- Perception of support system
- Concern about disapproval by family or other members of support system
- Financial concerns regarding cost of treatment, Medicare coverage, etc.
- Knowledge and ability to recognize signs of depression
- Concern regarding other medical conditions, such as chronic illness, take priority

The Practitioner

- Ageist attitudes: unwillingness to listen
- Belief that depression is a normal part of aging
- Lack of knowledge or recognition of symptoms
- Search for other physical reason for depressive symptoms versus assessment for a depressive syndrome
- Other chronic and medical conditions take priority

The Importance of Recognition

Depression is a serious issue at any age; however, it is especially deleterious to the elderly. Symptoms are often left unreported by the patient or unrecognized by the practitioner. Suicide rates and overall mortality are higher in elderly who suffer from depression. For more information about depression in older adults, the John A. Hartford Foundation

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Institute for Geriatric Nursing has published guidelines that are available at www.guidelines.gov. Other sites on the internet that are helpful include the National Institutes of Health (www.NIH.gov) and the American Association of Retired Persons (www.aarp.org).

The studies that have been briefly reviewed above include a variety of subtopics regarding depression. A common theme among these studies is that although a significant amount of research has been conducted, diagnosis, treatment, and outcomes still need to be improved. Possible reasons for this include the barriers discussed by Corrigan et al. (2003), a lack of public education, vague complaints and symptoms that are difficult for practitioners to pinpoint as depression, and recurrence in the elderly population after treatment.

The research regarding depression is abundant; however, the education of both practitioners and patients is still deficient. As practitioners, we are responsible for educating ourselves about geriatric depression and the impact it has on treatment and recovery. By properly educating ourselves, we pass this knowledge on to patients and families. We must understand the subtle signs that are often confused with other problems and overcome the barriers that stand in the way of proper diagnosis and treatment. ARN

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