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Depression in Older Adults

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Introduction

Depression in older adults is associated with an increased risk of cardiac disease and death from illness, and it can exacerbate memory loss and suicidal thoughts and lead to sleep and appetite disturbances. In addition, depression reduces an older adult's ability to function in a healthy and productive manner. Early recognition, diagnosis, and treatment can help counteract and prevent the emotional and physical consequences of depression among older adults.

Depression affects 15/100 adults over the age of 65. During the first year, over half of residents of long-term care facilities experience depression (54.1%). Furthermore, depression can have grave consequences for older adults. Those who suffer from depression have poor physical and cognitive functioning, poorer perceptions of their own health status, lower health utilization rates, and they experience increased healthcare costs. A particularly devastating outcome of depression in older adults is suicide. For a variety of reasons, older adults, especially older men, have high suicide rates. In the United States, suicide rates for males are the highest for those over the age of 75, with a rate of 36 per 100,000 individuals (Kropf & Cummings, 2017).

Characteristics of the older adult population

Many older adults face physical, emotional, and social challenges as they experience numerous life changes. Although older adults may have characteristics and circumstances in common, they also have many diverse attributes and needs. This age group includes five decades of individuals, and the differences among older adults are greater than those seen in other age groups (APA, 2021).

Over the last decades, life expectancy has increased substantially. The increasing number of individuals who reach over 80 years of age has led to higher rates of multimorbidity, frailty, and disability in the older population (Urtamo et al., 2019).

The Administration for Community Living (ACL), who releases an annual report on the Profile of Older Americans, found the following statistics and characteristics for older Americans in 2020 (ACL, 2021).

- In the U.S., the population aged 65 and older numbered 54.1 million in 2019. They represented 16% of the population, more than one in every seven

Americans. The number of older Americans has increased by 14.4 million (or 36%) since 2009, compared to 3% for the under-65 population.

- In 2019, persons reaching age 65 had an average life expectancy of an added 19.6 years (20.8 years for women and 18.2 years for men). A child born in 2019 could expect to live 78.8 years, more than 30 years longer than a child born in 1900 (47.3 years).
- Between 1980 and 2019, the centenarian population experienced a larger percentage increase than the total population. There were 100,322 persons aged 100 and older in 2019—more than triple the 1980 figure of 32,194.
- The population aged 65 and older increased from 39.6 million in 2009 to 54.1 million in 2019 (a 36% increase) and is projected to reach 94.7 million in 2060. By 2040, there will be about 80.8 million older persons, more than twice as many as in 2000.
- Marital Status: In 2020, more older men (70%) than older women (48%) were married. Widows accounted for 30% of all older women in 2020. There were more than three times as many widows (8.8 million) as widowers (2.6 million).
- Living Arrangements: Of the older adults living in the community, more than half (61%) of persons age 65 and older lived with their spouse (including partner) in 2020. About 27% (14.7 million) of all older adults living in the community in 2020 lived alone. A relatively small number of people (1.2 million) aged 65 and older lived in nursing homes in 2019. However, the percentage increases with age, ranging from 1% for persons ages 65-74 to 2% for persons ages 75-84 and 8% for persons over age 85.
- Racial & Ethnic Composition: In 2019, 24% of persons age 65 and older were members of racial or ethnic minority populations—9% were African American (not Hispanic), 5% were Asian American (not Hispanic), 0.6% were American Indian and Alaska Native (not Hispanic), 0.1% were Native Hawaiian/Pacific Islander (not Hispanic), and 0.8% of persons age 65 and older identified themselves as being of two or more races. Racial and ethnic minority populations increased from 7.8 million in 2009 (20% of older Americans) to 12.9 million in 2019 (24% of older Americans) and are projected to increase to 27.7 million in 2040 (34% of older adults).

- Income: The median income of older persons in 2019 was $27,398. Men had a higher median income overall: $36,921 compared to $21,815 for women.
- Poverty: In 2019, nearly 1 in 10 people age 65 and older (8.9% or 4.9 million) lived below the poverty level.
- Employment: In 2020, 9.8 million (18%) Americans age 65 and older were in the labor force (working or actively seeking work).
- Education: The educational level of the older population is increasing. Between 1970 and 2020, the percentage of older persons who had completed high school rose from 28% to 89%. Approximately one-third (33%) in 2020 had a bachelor's degree or higher. The education level of older adults varied considerably by race and ethnic origin.
- Health & Health Care: In 2019, 22.3% of the population aged 65 to 74 assessed their health as fair or poor compared to 29.3% of the population aged 75 and over. Leading chronic conditions among adults age 65 and older in 2019 include arthritis (48%); coronary heart disease (14%); myocardial infarction (9%); angina (4%); any cancer (25%); COPD, emphysema, or chronic bronchitis (10%); stroke (9% in 2017- 2018); and physician-diagnosed and undiagnosed diabetes (29% in 2015-2018).
- Disability & Physical Functioning: In 2019, 19% of adults age 65 and older reported they could not function at all or had a lot of difficulty with at least one of six functional domains. Domains were broken down as follows: 22% reported trouble seeing (even if wearing glasses), 31% reported difficulty hearing (even if wearing hearing aids), 40% reported trouble with mobility (walking or climbing stairs), 8% reported difficulty with communication (understanding or being understood by others), 27% reported trouble with cognition (remembering or concentrating), and 9% reported difficulty with self-care (such as washing all over or dressing).
- Caregiving: Older adults often provide care to younger family members. For example, approximately 1.1 million grandparents age 60 and older were responsible for the basic needs of one or more grandchildren under age 18 living with them in 2019. Of these caregivers, 60% were grandmothers and 40% were grandfathers.

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Factors for achieving successful aging

Successful aging may be viewed as how to expand functional years in later life span, but what that entails can have a variety of definitions. Successful aging is a multidimensional concept encompassing physical, functional, social, and psychological health domains. These dimensions should be taken into account, both with objective and subjective conditions.

Different domains that can be reviewed to describe successful aging may include: avoiding disease and disability, having high cognitive, mental, and physical function, being actively engaged in life, being psychologically well adapted in later life, positive domains of health and activities of daily living, physical and cognitive functioning, social participation and engagement, and positive affect and control. It is essential to acknowledge that many older adults are aging successfully, but the combinations of successful indicators and definitions of successful aging vary between individuals (Urtamo et al., 2019).

Urtoma et al. (2019) explored the following categories when assessing successful aging:

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Biomedical Factors

- Physiological Function: The concept of successful and healthy aging has been generally associated with longevity and the absence of disease and disability. However, recent studies have suggested that the absence of disease and disability is not the most crucial element in the concept of successful aging, and people with chronic disease can also age successfully. Adaptive psychological and social mechanisms can compensate for limitations of physiological health.
- Cognitive Function: Maintaining cognitive abilities and preventing memory disorders are key aims in old age. Cognitive functioning comprises perception, attention, memory, and higher functions.
- Physical Function: Maintaining physical function is an important component of successful aging. Regular physical activity during the life span is a strong predictor of healthy aging. Decreases in muscle mass and strength are related to aging processes, chronic diseases, and lifestyle (nutrition, physical inactivity). Chronic pain is a common condition in older adults and contributes to functional decline and limitation of activity.

Psychosocial Factors

Psychosocial conditions contribute to aging processes. Successful aging includes people's capacity to adapt to aging deficits with successful psychological and behavioral processes that best suit their individual resources. Older adults can age successfully if they are socially active and psychologically well-adapted, even though they encounter a decline in physical and cognitive function.

- Actively Engaged in Life: Good social functioning is often determined as an important factor in successful aging, especially by older adults themselves. It reflects a wish to retain a role in society and be involved with people. Social functioning includes indicators of loneliness, social activity, and emotional and instrumental support given to others. Examples of social engagement might include involvement in voluntary work, participating in a sport, social or other kinds of clubs.

- Psychological Well Adapted Later in Life: Life satisfaction, purpose in life, and perception of the aging process contributed to aging successfully, and therefore the psychological domain of adaptation in later life is an important component in successful aging. Emotional functioning could be assessed by depressive symptoms and life satisfaction, and subjective feelings could be assessed with questions, e.g., "describe how successfully you have aged".

Older adults who rate their health as good are twice as satisfied with life as older adults who rate their health as poor. Older adults can increase their chances of aging well by taking the following steps (APA, 2021):

- Exercise. Even a moderate amount each day can help one stay active, independent and maintain a positive mood. It can make even the frailest older person stronger and more fit.

- Continue to maintain a healthy lifestyle and make adjustments for any changes in function (e.g., hearing, vision, flexibility, or strength).

- Continue to engage in routine preventive health behaviors (e.g., get immunizations for flu and pneumonia).

- Advocate for self and family in health care settings or bring a knowledgeable representative to appointments. Do not be afraid to ask questions or get a second opinion.

- If feeling anxious, depressed, or using alcohol or drugs to manage mood, seek assistance. Untreated mental health problems are associated with poor physical health outcomes, including increased disability and illness as well as decreased quality of life.
- Be an interested person. Remain aware of new developments in the arts, sciences, politics, and other cultural and social interest areas.
- Be an interesting person. Engage in something meaningful or that one is passionate about

Types of depression in older adults

There are several types of depression that older adults may experience, including:

- **Major Depressive Disorder** causes severe symptoms that affect how one feels, thinks, and handles daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.
- **Persistent Depressive Disorder (Dysthymia)** is a depressed mood that lasts for at least two years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for two years to be considered persistent depressive disorder.
- **Seasonal Affective Disorder** is characterized by the onset of depression during the winter months when there is less natural sunlight. This depression generally lifts during spring and summer. Winter depression, typically accompanied by social withdrawal, increased sleep, and weight gain, predictably returns every year in seasonal affective disorder.
- **Post-Menopausal Depression:** Women appear to be particularly vulnerable to depression during the perimenopause years and in the years immediately after menopause. Some studies have found that women have double the rate of depression during the perimenopause through post-menopause years. Some women are more sensitive to the hormone shifts that occur during perimenopause, which puts them at greater risk for depression. In addition,

women at greatest risk are those with a history of depressed mood earlier in life (NAMS, 2022).

- **Bipolar Disorder** is different from depression, but it is included in this list because someone with bipolar disorder experiences episodes of extremely low moods that meet the criteria for major depression (called "bipolar depression"). But a person with bipolar disorder also experiences extreme high – euphoric or irritable – moods called "mania" or a less severe form called "hypomania."
- **Psychotic Depression** occurs when a person has severe depression plus some form of psychosis, such as having disturbing false fixed beliefs (delusions) or hearing or seeing upsetting things that others cannot hear or see (hallucinations). The psychotic symptoms typically have a depressive "theme," such as delusions of guilt, poverty, or illness.
- **Substance/Medication-Induced Depressive Disorder:** depression related to the use of substances, like alcohol or pain medication
- **Depressive Disorder Due to A Medical Condition:** depression related to a separate illness, like heart disease or multiple sclerosis (NIMH, 2022).

Symptoms of depression in older adults

Depression in older adults may be difficult to recognize because older people frequently have different symptoms than younger people. For some older adults with depression, sadness is not their main symptom. Instead, they could feel more of a numbness or a lack of interest in activities. They may not be as willing to talk about their feelings.

The following is a list of common symptoms. Still, because people experience depression differently, there may be symptoms that are not on this list (NIA, 2022).

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, guilt, worthlessness, or helplessness
- Irritability, restlessness, or having trouble sitting still
- Loss of interest in once pleasurable activities, including sex
- Decreased energy or fatigue

- Moving or talking more slowly
- Difficulty concentrating, remembering, or making decisions
- Difficulty sleeping, waking up too early in the morning or oversleeping
- Eating more or less than usual, usually with unplanned weight gain or loss
- Thoughts of death or suicide, or suicide attempts.

The APA Guidelines for Psychological Practice with Older Adults (2022) recognizes that this population often has concurrent health and mental health problems. Mental disorders may coexist in older adults (for example, those with a mood disorder who also manifest concurrent substance abuse or personality pathology). Likewise, older adults who have dementia often have coexistent psychological symptoms, which may include depression, anxiety, paranoia, and behavioral disturbances. Because chronic diseases are more prevalent in old age than in younger age, mental disorders are often comorbid and coincide with physical illness. Therefore, being alert to co-occurring physical and mental health problems is key in evaluating older adults.

Further complicating the clinical picture, many older adults receive multiple medications and have sensory or motor impairments. All of these factors may interact in ways that are difficult to disentangle diagnostically. For example, sometimes depressive symptoms in older adults are caused by physical illnesses. At other times, depression is a response to the experience of physical illness. Depression may increase the risk that physical illness will recur and reduce treatment adherence or otherwise dampen the outcomes of medical care. Growing evidence links depression in older adults to increased mortality, not attributable to suicide (APA, 2022).

Some mental disorders such as depression and anxiety may have unique presentations in older adults and are frequently comorbid with other mental disorders. For example, late-life depression may coexist with cognitive impairment and other symptoms of dementia or may be expressed in forms that lack overt manifestations of sadness. It may thus be difficult to determine whether symptoms such as apathy and withdrawal are due to a primary mood disorder, a primary neurocognitive disorder, or a combination of disorders. Furthermore, depressive symptoms may at times reflect older adults' confrontation with developmentally challenging aspects of aging, coming to terms with the existential reality of physical decline and death, or spiritual crises (APA, 2022).

Depression is not a normal part of aging. However, older adults are at an increased risk of experiencing depression, as demonstrated by the following (CDC, 2022):

- Older adults are at increased risk. About 80% of older adults have at least one chronic health condition, and 50% have two or more. Depression is more common in people with other illnesses (such as heart disease or cancer) or whose function becomes limited.
- Older adults are often misdiagnosed and undertreated. Healthcare providers may mistake an older adult's symptoms of depression as just a natural reaction to illness or the life changes that may occur with aging and therefore not see the depression as something to be treated. Older adults often share this belief and do not seek help because they are unaware that they could feel better with appropriate treatment.

Risk factors of depression in older adults

Many factors may contribute to depression in older adults. For some people, changes in the brain can affect mood and result in depression. Others may experience depression after a major life event, like a medical diagnosis or a loved one's death. Sometimes, those under a lot of stress — especially people who care for loved ones with a serious illness or disability — can feel depressed. Others may become depressed for no clear reason.

Research has shown that these factors are related to the risk of depression but do not necessarily cause depression (NIA, 2022):

- Medical conditions, such as stroke or cancer, diabetes, heart disease, or Parkinson's
- Genes – people who have a family history of depression may be at higher risk
- Stress, including caregiver stress
- Sleep problems
- Social isolation and loneliness
- Lack of exercise or physical activity
- Functional limitations that make engaging in activities of daily living difficult
- Addiction and/or alcoholism —included in Substance-Induced Depressive Disorder

Suicide is a serious public health concern among older adults. The rate of suicide is particularly high among older men. In 2019, it was highest for men aged 85 and older (49.3 per 100,000) compared to a rate of 13.9 per 100,000 in the general population. Older adults are also more likely than other age groups to use more lethal means such as firearms (men) and medications (women). While many factors may contribute to a person thinking about or attempting suicide, certain diagnoses, such as bipolar disorder, are associated with higher rates of suicide compared to the general population (SAMHSA, 2021).

Assessment of Depression in Older Adults

Screening and assessing older adults for mental illness can be challenging. Along with difficulties related to accurate diagnosis, many older adults experience stigma in seeking mental health treatment, such as a reluctance to seek treatment because they hold a negative attitude toward themselves for having a mental illness. As a result of this stigma, they are more likely to visit their primary care physician for both mental and physical health needs, even though these providers may lack specialized training in the assessment of or evidence-based interventions (SAMHSA, 2021).

The Geriatric Depression Scale is a tool used to assess depression in older adults. While it originally comprised 30 questions, it has since been condensed to 15 questions while maintaining a high validity. The GDS is sometimes simply labeled as a Mood Scale to reduce the stigma of completing the screening. The Geriatric Depression Scale - Short Form with scoring instructions can be found in Appendix A.

Evidence-based practices for treating older adults with depression

Late-life depression is one of the most prevalent mental disorders in older age. It is associated with various adverse outcomes and frequent use of health care services, thereby remaining a serious public health concern. Psychotherapy may be particularly beneficial for late-life depression due to specific psychological conditions in old age and a low risk of side effects (Dafsari et al., 2019).

Older adults respond well to various forms of psychotherapy and can benefit from psychological interventions to a degree comparable to younger adults. Both individual

and group psychotherapies have demonstrated efficacy in older adults (APA, 2022). Cognitive-behavioral, problem-solving, reminiscence, or life review therapy and other approaches have shown utility in treating depression among older adults. Psychotherapies delivered as part of integrated care models have also been effective in treating depression in primary care settings. As with other age groups, practitioners are encouraged to use evidence-based practices with older adults. No single modality of psychological intervention is preferable for all older adults. The selection of the most appropriate treatments and modes of delivery depends on the nature of the problem(s) involved, clinical goals, the immediate situation, and the individual patient's characteristics, preferences, gender, cultural background, place on the continuum of care and availability of evidence-based practice. (APA, 2022).

Using Evidence-Based Practices to treat depression in older adults can (APA, 2022):

- Reduce or eliminate the symptoms of depression
- Lower the risk for suicide
- Improve physical health
- Reduce functional disability.

The following Evidence-Based Practices have been specifically developed or adapted to treat older adults.

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Cognitive Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for various problems, including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness. In addition, CBT is an approach for which there is ample scientific evidence, in research and clinical practice, that the methods that have been developed actually produce change.

CBT is based on several core principles, including (APA, 2017):

1. Psychological problems are based, in part, on faulty or unhelpful ways of thinking.
2. Psychological problems are based, in part, on learned patterns of unhelpful behavior.

3. People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

By focusing on changing thinking patterns and behavioral patterns, individuals will learn to address their depression symptoms (APA, 2017).

Kropf & Cummings (2017) explore the following key components of cognitive-behavioral therapy. At the core, CBT helps clients understand the relationship between thoughts, feelings, and behaviors; identify the distorted cognitions they possess that negatively influence their feelings and behaviors; and change their disruptive thought patterns to healthier and more adaptive ones. CBT is a problem-oriented therapy focused on helping clients deal with a specific problem in the here and now as well as learning how to handle troublesome future symptoms. The treatment process is a collaborative approach in which the client and therapist work together to investigate and discover automatic thoughts and test the truthfulness or reality of these thoughts. Based on the Socratic method, the therapist asks the client questions to assist in the investigative process. The therapist does not try to persuade or convince the client or engage in interpretations. Instead, the clinician asks questions to help the client gather evidence from his or her own life that either supports or disputes the disruptive thought. If there is limited evidence to support the distorted thought, the therapist will ask the client what other possible interpretations might exist .

When employing CBT with older clients, it is necessary to pay special attention to age-related events and contextual factors. Events that occur as one ages, such as loss of loved ones, transitions in employment status and living environment, and the emergence of medical and functional difficulties, may not only represent current challenges, but also trigger the operation of dormant schema, especially those involving self-worth, competence, and security. Such assaults can hamper the individual's ability to effectively perceive and respond to events and manifest as dysfunctional behaviors such as withdrawal, excess dependence, and substance misuse (Kropf & Cummings, 2017).

CBT actively engages older adults in a non-threatening process that seeks to address and reformulate problematic thoughts and behaviors. One of CBT's basic tenets is that the meaning of the events is what matters, not the actual event itself. Many events that occur in later life do require practical and, at times, complex responses. Part of the clinician's assessment includes the older clients' thoughts and beliefs about the situations they are confronting. For example, the loss of the ability to drive results in the

need to secure alternative transportation. However, older adults also experience a loss of independence and a threat to perceived competence (Kropf & Cummings, 2017).

Research indicates that CBT is effective with older adults; however, adaptations to the CBT process may be necessary due to age-related cognitive and sensory changes. Normal cognitive changes do occur as part of the aging process. Older adults experience a decline in cognitive speed, spontaneous recall of newly learned material, selective attention, and fluid intelligence. Cognitive changes in older adults may require that material be presented more slowly, with more frequent repetition and summaries, and the use of aids to help retention of information from session to session. Sensory changes, such as decreased hearing and vision loss, may also impact the older client's ability to grasp the information presented and may necessitate the use of special aids. Although modifications may be required for some older clients, it is important not to assume that adaptations must be made just because of the client's age. Adjustments should be made based upon client assessment and learning about the client's needs and abilities (Kropf & Cummings, 2017).

Cognitive-behavioral therapy is a flexible psychosocial intervention that can be used in various contexts and with diverse older populations. Individual and group-based cognitive-behavioral treatments with older adults most frequently occur in community-based settings such as out-patient clinics, private practice offices, and community mental health centers. Treatment duration commonly extends from 12 to 16 weeks (Kropf & Cummings, 2017).

Problem-Solving Therapy

Problem-solving therapy (PST), as noted by Kropf & Cummings (2017), is a psychological intervention that assists individuals by enhancing coping abilities to decrease the stresses of negative physical and mental health conditions. A person's problem-solving ability is understood as a moderator of the relationship between challenges and emotional stress responses. Therefore, effective problem-solving skills mitigate the probability of experiencing negative health and mental health outcomes when confronted with challenging events. The process involves identifying the particular problems experienced, generating solutions to the problem, implementing selected options, and evaluating the outcome. The goal of PST is to help clients engage in resolving problems they are currently experiencing. Effective problem-solving involves the ability to develop adaptively and match solutions to life problems while considering the specific internal and external factors that are present. Since later life often involves

stresses from managing health and mental conditions, decreased functional abilities, and residential and social transition, PST is an appropriate treatment choice to assist older clients with these and related issues (Kropf & Cummings, 2017).

Clients are taught problem-solving skills through verbal instruction, written materials, participating in exercises, and completing assigned homework. The Socratic method is also employed to elicit clients' ideas and suggestions for problem solutions. PST therapists do not provide solutions, instead, they engage in discussions and formulate questions that encourage clients to come to their own conclusions. Two overarching treatment goals exist for those involved in PST. First is acquiring a positive orientation toward problems that arise in one's life. Second is the development of the ability to employ specific problem-solving behaviors effectively (Kropf & Cummings, 2017).

PST can be a very useful therapy for older clients and those who have mild cognitive impairment because the steps involved in PST are structured, concrete, and clearly laid out. In addition, older adults who are uncomfortable with psychotherapy are often more open to the skills-training approach employed in PST. Some adaptations of this intervention are recommended when using PST with older adults. Older adults are more likely to grasp and retain information when presented in multiple formats. Therefore, the therapist should explain information verbally, present written materials that highlight key concepts, and practice PST skills in session with the client. Some older clients may not have the cognitive ability or the independence to address complicated problems. However, tackling smaller and more manageable problems can lead to early success. As appropriate, the therapist should involve family members. Family caregivers can play crucial roles as sources of information and active participants in some aspects of PST, with client approval (Kropf & Cummings, 2017).

PST is a flexible approach that can be implemented in numerous settings with older adults. Often used as a treatment approach in geriatric depression, PST has been successfully implemented in long-term care settings and with community-based samples in individuals' home environment and community agencies. Outcomes studies have reported that PST is effective when delivered in face-to-face formats and over the telephone. This approach can be offered as an individual treatment or within a group setting (Kropf & Cummings, 2017).

Reminiscence and Life Review

Kropf & Cummings (2017) state that the act of reminiscing is a natural part of human interaction and occurs across the life course. Older adults use event recall to integrate their past with present-day functioning with age. Older adults' unique life stories are a mingling of their distinct and individual experiences. Reminiscence is a phenomenological process of recalling the past that provides people with both pleasure and pain. It has healing qualities and provides a vehicle for socializing with others. With age, reminiscing becomes more prominent, as older adults use this process to create meaning and integration for events across their life course, have a heightened awareness of the finiteness of life, and work to create meaningful roles in a society that limits experiences in later adulthood. For these reasons, reminiscence and life review have been used as therapeutic processes to address challenges experienced during late life (Kropf & Cummings, 2017).

Finding personal meaning is associated with positive outcomes for older adults. Life review and reminiscence interventions have been associated with improvements in meaning-making activities for older adults. The meaning systems across different experiences in later life suggest that meaning is important in dealing with challenges associated with later life, including illness, caregiving, and approaching death (Kropf & Cummings, 2017).

The reminiscence process occurs naturally, so practitioners and clinicians can implement the interventions in several contexts, with various types of administration and different populations. One method to use reminiscence work is to have a structured approach, such as offering group sessions. This type is frequently used within congregate settings such as senior centers or long-term care residences (Kropf & Cummings, 2017).

As part of this process, it is important to provide stimulation to help older adults retrieve memories. For example, music or pictures of the era when the participants were adolescents or young adults can be included. Couples can also participate in reminiscence or life review work together. This intervention can be used when there is an impending juncture, such as deteriorating health or cognitive functioning. The process of reminiscence or life review can expand the range of memories that are shared within a couple or caregiving dyad and can facilitate a richer and deeper relationship between the individuals. Reminiscence and life review work can also be individual interventions. For example, transitions that occur in later life can be facilitated by these interventions as older adults access coping and resilience that can benefit their current life situation (Kropf & Cummings, 2017).

Depression can compromise treatment for other health challenges, and interventions such as life review and reminiscence therapy may be introduced within acute care settings. As an adjunct to medical treatment, these interventions have the potential to address psychosocial functioning, which is often a comorbid condition to the physiological challenges of later life. Long-term care settings are frequent settings for these interventions. Transitions to long-term care settings may be difficult for new residents, and these interventions can help with coping with the new environment and structure. Rates of geriatric depression are higher in these settings than in the community-dwelling population, with an estimate of up to 50% of residents suffering from depression. Interventions such as reminiscence and life review are treatments to deal with the high rates of geriatric depression within nursing homes. In addition, bonds between residents can be strengthened through these protocols, as reminiscence groups can bring residents together and increase interactions (Kropf & Cummings, 2017).

As a naturally occurring process, reminiscence work has several positive functions for older adults. As older adults face mental health challenges, such as geriatric depression or anxiety, reminiscence and life review can help foster positive aspects such as coping and resilience. In addition, the therapeutic process of life review can address past wounds or unfinished issues that are brought into later life. Additionally, these interventions can facilitate engagement among participants within-group interventions and promote pleasant memories that increase life satisfaction. In this way, the interventions have utility for multiple populations of older adults. Reminiscence and life review have been used in multiple settings and contexts. Studies have reported effectiveness in community-dwelling populations, those in acute-care settings, and residents of long-term care facilities. These approaches have been used with individuals and in group formats, as well as through technology-based applications (Kropf & Cummings, 2017).

Cultural Considerations

Since some older adults (including those in certain cultural groups) may view mental health services as stigmatizing, case practitioners should make active efforts to engage them and discuss their concerns. In addition, culturally sensitive psychotherapy may incorporate aspects of the older adult's (in some cultures, "elder" is the preferred term) indigenous spiritual beliefs or cultural practices and customs (APA, 2021).

Culturally and linguistically appropriate treatment is respectful of and responsive to the individual's health beliefs, practices, and cultural, linguistic, and other social and environmental needs. Services that recognize the cultural and other needs of the individual can decrease disparities in access to behavioral health services, as well as improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes (SAMHSA, 2021).

Older Black, Indigenous, and other people of color are underrepresented in most of the current research on interventions for older adults with serious mental illness, limiting the generalizability of findings to an ethnically diverse population (SAMHSA, 2021).

Research pertaining to depression in older adults

Given the rapid growth of the older adult population, there is a need for more large-scale studies to better understand how to improve quality of life, functioning, and clinical outcomes for older adults with depression and other mental illnesses, including for those with comorbid physical illness. The growing number of older adults with mental health concerns will require a workforce specifically trained to address the special needs of this high-risk group. In addition, research is needed on interventions that leverage the use of technology, peer support, community-based outreach, and integrated psychiatric and medical care for older adults with mental illness to extend the reach of geriatric specialty providers. A critical priority for future research is identifying optimal strategies that successfully implement, scale, and sustain these interventions in diverse community settings (SAMHSA, 2021).

Conclusion

Depression in older adults is one of the most prevalent mental disorders for those over 65. As the older adult population grows, those in the mental health and healthcare fields need to understand how depression impacts this population. Practitioners must be aware of how to assess depression and recognize the different types of depression their clients may experience. Providing evidence-based treatments for depression will reduce or eliminate depression, improving mental and physical health and allowing clients to manage their symptoms and live more meaningful and healthy lives.

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Appendix A

Geriatric Depression Scale - Short Form

Retrieved April 2022: https://web.stanford.edu/~yesavage/GDS.html

MOOD SCALE

(short form)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**

2. Have you dropped many of your activities and interests? **YES** / NO

3. Do you feel that your life is empty? **YES** / NO

4. Do you often get bored? **YES** / NO

5. Are you in good spirits most of the time? YES / **NO**

6. Are you afraid that something bad is going to happen to you? **YES** / NO

7. Do you feel happy most of the time? YES / **NO**

8. Do you often feel helpless? **YES** / NO

9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO

10. Do you feel you have more problems with memory than most? **YES** / NO

11. Do you think it is wonderful to be alive now? YES / **NO**

12. Do you feel pretty worthless the way you are now? **YES** / NO

13. Do you feel full of energy? YES / **NO**

14. Do you feel that your situation is hopeless? **YES** / NO

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15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes, a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

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