

Chapter 12

Psychological Problems at Late Life: Holistic Care with Treatment Modules

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Below is a typical case for later-life patients. This particular man is best seen as one with multiple problems and needs. He has depression, anxiety, cognitive issues, somatic/sleep problems, as well as life adjustment concerns. He needs a coordinator who can assist him in his psychological, social, health, and practical problems/needs. This entails a holistic view of his situation and a considered approach to his plight. The answer then is not in a *Diagnostic and Statistical Manual (DSM)* diagnosis, not just in a medication for psychiatric care, and not in a private therapy session. It is in holistic care and case based on empirically supported therapies and social realities, as well as general health. This is not easily done.

Mr. B was referred by PCP for depression and complaints of memory disturbances. He is a 72-year-old African American man who lives with his wife. He has been married for 38 years and has two adult children. He has worked for the same ball-bearing company for 45 years and retired at age 65. In recent days, he is more retiring as he previously enjoyed socializing with neighbors and church group. He is also unsure of why he is here; “My wife told me I needed to come.” He presents with vagueness regarding details of early and mid-life; he acknowledges “tough” experiences but does not elaborate; and he relates his life story apathetically with a general paucity of content. He also denies feeling depressed, and shows no enthusiasm for what his wife has described as “prime interests.”

On the initial patient assessment, he was accompanied to the office visit by his wife. He demonstrates chronic pain from knee-related osteoarthritis and walks slowly with a cane, sits hunched over in chair. He complains frequently about pain. He is casually dressed as his clothing is not well arranged. He is, however, cooperative and communicative. His speech is clear but slow and

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of low volume, fluent without paraphasic errors. He is distractible with some unfocused effort. There is some evidence of psychomotor retardation.

He also has lost weight and has a decreased appetite. He has a history of smoking but quit 6 years ago; he has hypertension which is treated with hydrochlorothiazide; he has type 2 diabetes which is treated with glipizide; he has hypercholesterolemia which is treated with atorvastatin. His osteoarthritis is treated with nonsteroidal anti-inflammatory drugs (NSAIDs). He has had few surgeries (hernia repair) and has no allergies. He possesses substantial cardiovascular risk factors in the form of a history of smoking, hypertension, type 2 diabetes, hypercholesterolemia, as well as chronic pain.

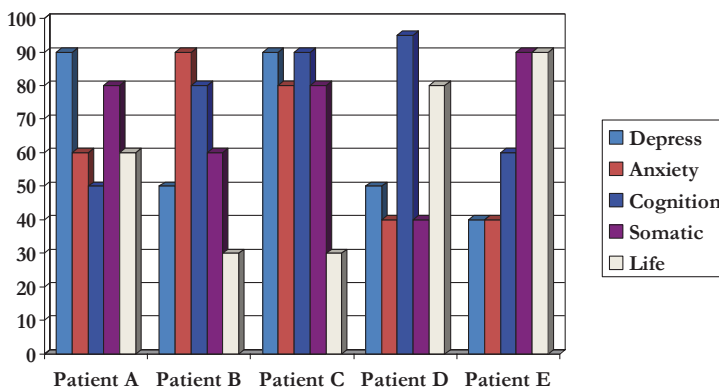
There is no history of depression. Now, the patient denies feeling depressed and has a loss of interest in seeing neighborhood friends and feels “He does” and does not enjoy former pleasures like softball. The patient complains of poor concentration and the wife reports that husband’s memory has become faulty and “disturbed.” He is also considerably more anxious than he has been in the past. He is not sleeping well as he ruminates. His wife reports changes in behavior as he is more irritable and raises voice frequently and is less talkative. He shows no apparent activities of daily living/instrumental activities of daily living (ADL/IADL) difficulties but complains that “everything just takes longer now.”

His symptoms at presentation suggest major depression, as well as anxiety. He scores 20 on the Patient Health Questionnaire (PHQ-9) with no positive endorsement of item 9; he scores 13 on the Generalized Anxiety Disorder 7-item (GAD-7). His Montreal Cognitive Assessment (MoCA) score is 21 suggesting mild cognitive disturbance and some memory recall and executive function impairment. He is also not sleeping (<5 h night) and is in pain (5/10). He is also increasingly anxious as he relates that he cannot tolerate his “poor ways” and is less efficient at everything. Psychiatric issues involve mild psychomotor retardation with some latency in speaking, hearing impaired, with delayed but adequate comprehension at increased volume, thought processes notably slow but otherwise unremarkable, and no delusions or hallucinations. General cognitive profile shows that he is oriented but not fully able to concentrate. He registers 3/3 items, recalls 2/3 after 5 min, and 3/3 with cueing, does name and repetition intact, has normal visuospatial functioning, and has poor insight. His judgment is intact.

Possible Diagnoses

- Major depressive disorder (MDD)
- Dysthymia
- Generalized anxiety disorder (GAD)
- Endocrine-associated depression
- Pain-related depression
- Vascular depression
- Mild cognitive impairment
- Dementia

Patient C below best represents this patient. He has multiple psychological problems, including depression, anxiety, cognitive problems, and some somatic and sleep issues. The task of the health care provider is considerable: Case-base this patient. Assess on all dimensions. Develop a treatment plan (watch and wait method explained below). Establish a “watch and wait” procedure. Develop a plan. Bring in necessary personnel. Monitor the case. Be in for the long hall.



This chapter addresses the psychiatric and psychological components of older adults. What is the best way to address the modal psychosocial problems of late life, taking into account what science has to offer, what seems commonsensical, and what can be done? What are the reasonable concepts and learning required for care of older adults? Like Pascal, we must place our bets. With older adults, we witness a decline in being, a (likely) medically impacted person, a psychologically complex entity who is bothered by anxiety and depression, as well as somatic issues, and who has (probably) less cognitive power and in some cases considerably less. We are also living longer with several adjustment concerns. The translation of simple care at late life with multiple needs is upon us.

In the long run to benefit depressed or anxious elderly patients in the community, personalization of care must employ comprehensive common sense care algorithms targeting both modifiable predictors of poor outcomes and organizational barriers to care. Whether this care can be done on a grand societal level is perhaps unknown. We believe, however, that psychosocial care can evolve and move from intuitive to precision care. The latter has well-defined boundaries that a diagnosis assists and treatments match, but there is more. One does not need an advanced degree to know that if there is a bacterial infection, then an antibiotic is in order. But, we need skills to deal with closing the deal, follow-ups, side effects, messy socialization, personal reactions, iatrogenic nuances, and life. Older adults have side effects.

In the past 10 years, there remains a vacuum as results from trends have been enlightening but disappointing. The importance of medical care, use of selective serotonin reuptake inhibitors (SSRIs) and medication brethren, issues related to suicide, subsyndromal states, and validation of variants of cognitive-behavioral therapy (CBT) have been in play. But treatments work at best only 50% of the time and most often not permanently. People continue on as both system and self-change failures and patients often wax and wane as they get a little better before they come

to see you and at different times during the treatment. Long-term treatment is still largely an anomaly with little in the way of specific effects in therapies. Dismantling studies have not provided robust findings and it seems that general effects of care are greater than specific effects. We need better models.

Our position is simple: Treating “depressive symptoms” in isolation of the patients’ whole person, especially cognitive and physical limitations, risks slower or less-effective reduction in depressive symptoms. Targeting an organized patchwork of psychological problems, in this case depression, anxiety, cognitive impairment (CI), adjustment, and some disability, provides for a concerted effort to help the patient adapt and cope with their problems, promoting successful outcomes for the prime target, depression. Evidence for such multifaceted approaches to treatment is nascent, and so we must borrow from each problem and look at the efficacy for older adults, as well as what works for younger adults. While this is case based, with older adults it is more—it is a real everyday problem in treatment.

Applied science is not practical and we require a “reparticularization” of scientific knowledge to individual patients (Cassell 1991). This allows the practice of care for older adults not to go from science to practice but from science through patients and expertise, as well as clinical and real-life conditions, back to actual clinical practice. Experimental science is not a sufficient knowledge base for psychological practice.

Model and Process of Care

Algorithms are perhaps brittle and often do not work well in the shadows; skilled decision makers are more sensitive to the context of problems at later life. We need informed and adaptive decision makers. The Sequenced Treatment Alternatives to Relieve Depression (STAR-D) study [20] showed us that only 33% of more patients with difficult to treat depression respond to four alterations in treatment with medications. We need a skilled therapeutic flexibility and response to this. Like schizophrenia, where the treatment of early responders is often found to be more cost effective than the treatment of early nonresponders, we need to know where and to whom we can best devote energies to. And for those who are not responsive, we need common sense care and reasonable treatment rubrics. In the cost-effectiveness vernacular, the early responder is considered a dominant choice over the early nonresponder, but beyond clinical acumen for matching patients with treatments, a clinician cannot choose which individuals will be early responders to a specific antipsychotic medication. We need clinical acumen for older adults so that these parameters can be available and known and the clinician can respond accordingly.

We do not need or require a crystal ball for what works with whom for older adults. Andreescu et al. [3] identified predictors of full response both at baseline and on change in depressive symptoms after treatment is under way. The authors used signal detection theory on pooled data from three acute treatment trials of either nortriptyline or paroxetine. They found that response by the fourth week of treatment was a critical factor in determining the probability of response by 12 weeks. Of course, a strong treatment response by the fourth week suggests that the treatment should continue. However, if only a moderate response has occurred

by that time, the clinician has to choose whether to continue the same treatment or do something different—switch to another treatment, for example, or augment the first treatment with another drug or a nonbiological intervention. Interestingly, in this study patients who had low levels of anxiety at baseline had a 61% chance of full response, whereas those with moderate or severe anxiety at baseline had a 39% chance of response. The probability of full response was even lower (33%) in patients who had experienced depressive episodes from early life. Using the probability of full response in treatment, then, decisions can spare patients from long exposure to treatments that have a low likelihood of success as well as from premature discontinuation of treatments that would likely be helpful.

Psychotherapy groups have been applying these ideas for many years (e.g., [46]). The score on the Outcome Questionnaire 45 (OQ-45) over three sessions affects outcomes. The American Association of Geriatric Psychiatry (AAGP) also has advocated for clinical prudence when there is no or a partial response early on in the treatment. So far, however, the empirical basis for personalizing treatment principally consists of post hoc analyses of unitary treatments (e.g., a course of an antidepressant or psychotherapy). While this knowledge is necessary, it is insufficient for two reasons. First, a one-disorder patient, like a depressed elder, faces a bewildering constellation of other health threats and social constraints and thus has many different contributors to poor treatment outcomes. Second, the skills available in various treatment settings and sectors can promote or inhibit treatment success.

We need an all encompassing-based model for change. We have argued for a “Watch and Wait” model [35]. This model posits that there are five areas of concern that are just sufficient for care. They include, cognition, depression, anxiety, health issues, and life problems. This last factor involves SES, caregiving, needs for living, and even long term care. Knowledge of these five domains, we believe, allows for the best grouping of variables for care. Importantly, they provide a profile where all influence care. We shall discuss these modules later in this chapter.

We need models of care then that encompass more than one diagnosis. Clinical and psychosocial predictors of response to single antidepressants or comprehensive interventions have been identified. These include anxiety, hopelessness, executive dysfunction, limitations in physical and emotional functions, chronicity of the current episode, and low income [11]. Such predictors can help in personalizing the first step of treatment for a given patient. Accordingly, a patient with one or more predictors of poor outcome may receive interventions targeting each modifiable predictor, as well as more vigilant follow-up. For example, a low-income depressed elderly patient whose symptoms did not respond to an adequate trial of an antidepressant and who is experiencing hopelessness may benefit from a trial of psychotherapy focusing on hopelessness as well as case management connecting him or her with social services.

Backdrop

We are in the midst of a revolution in science, especially neuroscience, that is fast replacing usual care for all, but especially older adults. We of course do not yet know what causes aging and how we can prevent the harmful aspects of old age

[48]. We also have the limitations of our sciences; there is a 33% upper limit of any psychiatric therapy. Public health models suggest that we target “indicated or high-risk individuals” as most appropriate [35]. We also know that even small changes in core capacities of older adults can lead to large changes in complex behavior [71]. In psychiatry, it is reasonable to expect that only 38–46% get better (show a response) and that 1/2–2/3 will not remit [57]. We also know from the National Institutes of Health (NIH) conference on Alzheimer’s disease (AD) and cognitive decline in 2010 that very little is firm. Several “obvious” predictors are now wavering—adequate folic acid, low-fat diet, ETOH, vitamins, statins, cognitive rehabilitation, education, leisure, physical activity, metabolic syndrome, low social support, never married, homocysteine, obesity, and nonsteroidal anti-inflammatory drugs (NSAIDs). Maybe *Apolipoprotein E* (Apo-E), diabetes, smoking, and depression will prove eventful but even these “surefire” predictors possess noise. There are no firm biomarkers for AD and the diagnoses themselves are suspect [56].

In fact, we are in a taxonomy crisis where dementia, anxiety, and depression are concerned, especially at late life. The focus should be on identifying items that place a person on the continuum, not whether he or she is or is not in the group. The additive effect where many risk factors of genes and environment accumulate represents a better model of care. It is an aggregate effect. We have a poor recent history of efficacy in psychiatry and psychology.

Over 50 years of research has suggested that the following are more true than not:

1. The differential effectiveness of competing therapeutic approaches does not exist.
2. The superiority of psychopharmacological over psychological approaches is untrue.
3. The utility of psychiatric classification as determining the course of prescription medication is poor.
4. The short and effective treatments for older adults have weak effect sizes and large numbers needed to treat (NNT)

We do have reasonable facts, however. Prevention works [76] and about 25% remit with no treatment. With time, things can get better. Psychiatry clinics as they have been designed (set apart and medication driven) are becoming anachronistic where older adults are concerned. The “placebo effect” is strong in most treatments, certainly those relevant to psychiatry. In fact, a better statement for the efficacy of psychotherapy is that the real effect–placebo effect = a substantive effect. This is likely to be in single digits. Depression itself, except for the very impaired, is probably a placebo disease. The treatment response to depression is probably a placebo reaction. The NNT necessary for remission is quite high for most psychiatric disorders at late life. Most often, when change occurs, there is a response but no remission. “Omics” (genomics) too is not ready for prime time. There is now a firm belief that the careful look at the brain and body is necessary. Medically unexplained symptoms (MUPS)

are now the norm. Further, we know that the old-old (>85) are a distinct problem; treatment is generally less effective. Finally, as clinicians, we are constantly in the battle for the “best fit” for adaptation—the assimilation and accommodation dance whether through selective optimization and compensation (SOC) or other models. The exact match for this fit takes time and prudence.

What can health care providers do? We believe that prudence and data dictate that we should pay less attention to the nuanced differences in treatment (one antidepressant vs. another, one psychotherapy vs. another, medications vs. psychotherapy). While we should be aware of these, they help providers of older adults less than other age groups. Published reports suggest that attending to novel “significantly better,” or “evidenced based,” will result in better patient outcomes but doing so with older adults often diverts attention from the real-world issues and has only marginal evidence of benefit. Instead of presenting a comprehensive algorithm, then, for treating depression in older adults, or offering a canonical framework for describing or incorporating the complex interplay of medical, psychological, and social services into treatment planning, perhaps attention to the basics is more important [81].

The belief here is that the basics of care for older adults require some change. There is a need to march carefully over the case, proceeding from the real world, targeting issues, and entering mental health treatment. This requires assessment and monitoring as well as flexibility. There is no desire here to usurp the scientist–practitioner model as we need to do formal assessments and attend to the input of science. But, as noted before, we need more. Mast [52] argues for a “whole person” approach where “the person” of the diagnostic category becomes as important as the process of the diagnosis and treatment plan. We agree, but add that we need to apply

Basics of care for the older adult

- Assuring social reality is in place (home, no alcohol, social care, etc.).
- Assure that the dosage is appropriate (not just medications). About 28% of older adults do not adhere to medication recommendations, and this is associated with poorer outcomes. Most patients do not seek a change in treatment if they are faltering.
- Consider non-pharmaceutical treatment first. It is true that these forms of treatment are not so much better than medications or the combo, *but* they have equal efficacy and are the least noxious. Efficacious treatment always involves some aspect of non-pharmaceutical treatment.
- Make sure a mental health professional is involved. The Healthcare Effectiveness Data and Information Set (HEDIS) study showed that they made a difference in only half the cases but this modality is always involved in the change in outcomes.
- Think about “watch and wait.” Monitor and wait for issues to confess themselves. The lack of clinically significant differences between treatment and placebo applies to mildly depressed patients.
- Frequent monitoring of patients’ symptoms and the frequent reconsideration of treatments may produce as much benefit for patients as a medication or psychotherapy and may fit better with the patient’s desires.

- Track outcomes. Use these as you would use laboratory values. Do not accept “Fine” as an outcome or marker of depression. If you are not measuring something, it has not occurred. Patients who just receive monitoring get better.
- Since remission rates are low, change treatments if patients do not remit for 6–8 weeks. Both longer time intervals and tinkering are the keys. Depression/anxiety/cognitive problems impact life downstream.

the better-known canons of our sciences to the person and formulate real plans that are titrated to tangible outcomes.

When dealing with older adults, we are often doing some application of translational research because few psychotherapy interventions have been designed expressly for elders. The translational component involves focusing on the time span of the problem, the nature and scope of hypothesis, dose adjustments, and patient population characteristics. Early on in therapy with older individuals, treatment is titrated. This includes a time frame that is short, hypotheses that are narrow in scope, small doses of the intervention, close monitoring of coping/potential, and choosing narrow treatment targets. In later phases of treatment, there is the requisite alteration in goals, which are simplified for reality’s sake. Psychotherapies are never just pure techniques to be used off the shelf. As this process has unfolded over the years, however, efforts to document the applicability of all-purpose psychotherapy research data appear to be relevant to older adults only if practiced in an aging-informed manner [32]. Both context and outcomes matter. With older adults, both are complex. For outcomes, the issue is never just symptom abatement. Rather, therapy should aim at symptom relief *and* improving overall quality of life (QoL).

Some good news The good news is that most psychotherapies developed for younger patients appear useful for older adults when applied in an age-informed and age-sensitive manner. [32]

Best Predictors

We identify and briefly discuss the best predictors of our science for our modal psychosocial problems at late life, cognition, depression, anxiety, medical/somatic problems, and adjustment. We start with age.

Age

Aging is complex and variable. The phenomenon of aging is itself a problem from most perspectives. We do not know well what cell senescence is, what causes the

allostatic load to not be processed well. We do not know the true savings in number of years lived for most of our treatment efforts. Just the idea of an 85-year-old who is optimally healthy coming for care is most probably problematic. Within 5 years, 80% will develop considerable medical problems. Variability itself is not an optimal sign at older ages. While this can be a nonevent for younger age groups and inherent within and between all biological systems, this is a problem at late life. Intraindividual variability (IIV) is associated with problems in cognition, especially working memory (WM), volumetric decline, demyelination, blood flow, vascular injury, and many neurological conditions.

Where age is concerned, we have had a culture change. In 1959, older people had the highest poverty rate (35%) followed by children (27%); by 2007, the proportion of older adults in poverty was 10%. In fact, in 2007, older people in the middle income group made up the largest share of older people by category (33%) with those in the high income group up to 31% (*Older Americans 2010: Key Indicators of Well-Being* [21]). Health ratings also were up. In 2008, 75% of people 65 or older rated their health as good, very good, or excellent; for 85 and older, these rates were still respectable at 66%. Life expectancy (the average number of years lived by a group of people born in the same year) along with a growing burden of chronic diseases also keeps rising ([83] Chap. 4 Case Based).

Percentages of lifestyle problems are also noteworthy. For starters, if you are a male in the USA and 65 years of age, you can expect to live an average 18.5 years; if you are 85, you can expect 6.8 more years. While life expectancy has increased by a year in the past decade, the time spent seriously sick is 1.5 years and time disabled has accrued by 2 years. For people 65 or above, diseases of the heart, followed by malignant neoplasms, and then stroke lead the way for death. Older men and women have hypertension and arthritis at rates over 50%. In 2008, 32% of people 65 or older are considered obese, 11% smoke, 25% spend time in leisure, and watching TV occupied the most leisure time (>50%): [81].

Related, we have a special problem with the old-old group, those >84. Interestingly, it is only at about age 80 that the vagaries of living become more apparent—the percentage of people with no disability rises, the percentage of people going into long-term care facilities increases, and the percentage of people married is lower. Older adults seek mental health at 3–6% levels (of all actual visits) as they see little connection between symptom and mental problems. Problematically, cognitive decline or depressive symptoms are actually more frequent in the old-old, but this is generally due to aging-specific variables. Not surprisingly, older adults seek mental health through somatic problems [39]. It is also true that the number of medications/person, number of medial visits, and number of falls, to name a few, are highest in this group.

Though professional, policy, and other recent developments portend an increase in service use, there has been scant empirical attention devoted to the current or recent utilization of mental health treatment by the elderly, and almost nothing is known about the correlates of mental health need and service use among older adults. Karlin and Fuller [38] examined patterns of serious mental illness, specific mental health syndromes, and service use among older (65+) and younger (18–64) adults throughout the USA, and the extent to which various factors predict mental

health need and the use and magnitude of mental health treatment. In addition, the study examined factors related to unmet need, as well as age group differences in perceived benefit from treatment. The findings reveal that older adults were three times less likely than their younger counterparts to receive any outpatient mental health treatment. Only 2.5% of older individuals utilized any outpatient mental health service in the past year, versus 7.0% of younger adults. These results indicate that the low rate of utilization by older adults may be partly a function of limited subjective mental health need. Importantly, though mental health problems appear to be significantly undertreated in older and younger age groups, Karlin and Fuller [38] also noted that those older adults who make it into services typically benefit considerably from treatment.

Common problems run the gamut from basic risk and safety issues to reasonable prevention. Major areas of focus would include polypharmacy, adverse drug events, medication compliance, fall prevention, continence care, and caregiver management of problem behaviors. These areas are problematic and can significantly impact the quality of everyday life.

Special older adult concerns *Common conditions go undiagnosed and untreated:* Too often, common and treatable conditions, such as CI, nutrition problems, sleep disorders, fall risk, overactive bladder and incontinence, mobility disorders, and depression, are undiagnosed.

Health and care needs of the oldest old: Included in this frail population are many minority and rural elders. The population of 85+ is the fastest-growing population and places the most demands on the health care system.

Minority/disadvantaged: African American and Hispanic elders especially are at greater risk of health problems and often receive less treatment for their conditions.

Health literacy: The Institute of Medicine has stated that “90 million people have difficulty understanding and acting upon health information.” The prevalence of limited health literacy is highest among older adults, minority populations, those who are poor, and medically underserved people. Training of health care professionals to improve their ability to communicate with their older patients is critical.

Older adults face many challenges as society’s view of their role transforms once they enter their sixth and seventh decades of life. The attitudes, values, and norms that have previously been constructed by society regarding aging are constantly evolving to accommodate the growing older adult population. However, a large segment of our culture adheres to negative stereotypes and prejudices associated with the process of aging. The practice of expressing prejudice and holding undesirable views towards a person due to their age—particularly older adults—is known as ageism. Ageism can be a significant problem as it can affect the perceived

functioning, cognition, and emotional health of an older adult. Coudin and Alexopolous [16] determined that older adults who were presented with an narrative-focused cognitive task after having read materials imbued with negative stereotyping towards older adults reported lower levels of subjective health and extraversion, higher feelings of loneliness, and more frequent help-seeking. These findings can be extrapolated indicating that older to the notion that older adults who internalize negative messages that they receive from society regarding aging may experience problems in maintaining a positive self-image and developing suitable coping skills to adjust to biopsychosocial changes they encounter as they age.

Aging is then replete with disease and impairment, often unrecognized or inadequately treated. But there are problems. Health confounds the results of age all the time. Health is based on self-reports and many studies simply overestimate the effect of age because they do not know about health. Ignorance of health in the study of morbidity does aging no favor. We have come to know that aging is a factor in people at risk across the life span, but it is really only a marker for other more important issues like cognition (brain at risk) in the identification process of persons at high risk for end-stage problems like AD. Once a mild cognitive impairment (MCI) or dementia diagnosis is given, all is probably lost in the long-term preventative sense. Age, at this point, reduces its value as a causal variable and cannot be viewed usefully as a basis for understanding cognitive changes.

Brain Issues

We have passed the decade of the brain (1990s) and are now firmly entrenched in the neuroscience era. At late life, this applies in spades. Older adults lose brain power and eventually lose functioning. Most often, they are correlated [69]. Denise Park [61] noted that the older brain presents with a symphony of degenerative expressions and develops scaffolding to address these, sometimes done well and sometimes not. All speed of processing and fluid tasks decompensate, while the person tries to adapt and assimilate/accommodate with skill training and coping. Increasingly too, we are seeing that cognitive training may make a difference. For cognitively healthy people, we know that mnemonic strategies work, that they improve but less than younger groups, that they can maintain skilled memory performance for 6 months, that they show little transfer, and that affect, attitude, and effort, as well as stress, matter. For cognitively less healthy individuals, we are now seeing that several studies are showing some promise [6, 49, 84, 88], that caregivers really can help with compensation strategies [35], and that multi-method packages with caregivers help (Hyer et al. in press).

It is now over two decades in which there was reasonably documentation that depression was a function of frontal-striatal problems [15]. Other studies through the years documented that more than 50% of patients with late-onset major depressive disorder (MDD) had such problems [23]. The influence of white and gray matter hyperintensities, as well as subcortical infarcts or hyperintensities, is

being associated with more severe symptoms, more hospital admissions for depression, longer hospitalizations for depression, resistance to medications, and executive function problems.

Late-life depression has been a special problem as far as brain issues are concerned. Knowledge of brain problems in the context of depression is informative in two ways. First, identifying persisting abnormalities during remission may indicate a high risk for relapse or persistent CI. Second, finding brain abnormalities predictive of poor outcomes of depression may initiate a search for their clinical correlates, which then can be used to personalize treatment. Wang et al. [86] used functional magnetic resonance imaging (fMRI) to compare activation and deactivation of brain regions in currently depressed elderly patients, elderly patients in remission from depression, and healthy elderly comparison subjects. The stimulus was an emotional oddball task, which activates or deactivates distributed brain networks and structures relevant to depression. The study documented activation changes that were limited to the depressive state as well as persistent changes occurring in both depressed patients and patients in remission from depression. Depressed patients showed attenuated activation of the right middle frontal gyrus and greater deactivation of the posterior part of the posterior cingulate relative to remitted patients and comparison subjects. The middle frontal gyrus exerts inhibitory control on emotional structures, and the posterior cingulate is connected to the hippocampus and the posterior cortex and participates in memory retrieval and self-consciousness [74].

Reduced activation of structures that participate in executive function (the supramarginal gyrus bilaterally, the left anterior cingulate, and the anterior part of the posterior cingulate) occurred both in depressed and remitted patients relative to comparison subjects. Executive dysfunction [1] and microstructural abnormalities in white matter-connecting structures that subserve executive functions [2] have been associated with poor or slow response of geriatric depression to antidepressant treatment. Taken together, then, these findings suggest that functional and structural abnormalities of networks relevant to executive dysfunction characterize a subgroup of depressed elderly patients who experience poor outcomes. This subgroup is quite large (>50%) and, even if these problems do not impact other older adults with depression at late life, these symptoms represent a prodrome for other problems downstream.

In the following text box, we outline how the brain is important in therapy with older adults. We start from the position that reregulation of neuronal networks parallels symptomatic changes in psychotherapy. Older brains confess their problems with symptoms, both cognitive and affective. Adjustment also suffers. Utmost, the psychologist is the manager of the therapy and, as such, he/she uses the brain as the explanatory mechanism for the dialogue. The mind and brain are indivisible; problems in life are reflected in or caused by brain input; and the use of the brain model can assist in the understanding of this. The therapist as neuroscientist can utilize and foster these issues.

Psychotherapist as neuroscientist

- Mind and brain are indivisible.
- Reregulation of neuronal networks parallels symptomatic changes in psychotherapy.
- Narratives re-sculpture neuronal networks throughout life.
- Activation of the left hemisphere assists in top-down or placebo effect.
- Strategies of cognitive retraining assist in the treatment of depression and anxiety.
- Lower hippocampus-related anxiety and hypometabolism in temporal lobes create real brain-related memory problems and resistance to therapy.
- Placebo effect depends on the prefrontal lobes in a top-down cortical modulation of mood, emotion, and immune activity. Placebo effect is one of the core conditions of treatment—necessary and at times sufficient for change.
- Appreciate the centrality of stress: Early stress impairs! [17]

When it comes to the worst aspect of cognition at late life, dementia, the focus may be poorly targeted. The focus should be on a continuum of CI connected to health risk factors, lifestyle habits, and reasonable preventative targets. We need to see a “brain-at-risk” stance where we can learn that disease occurs long before symptoms are present. The vascular hypothesis and information from preventative cardiology make this point clear and convincing. It should be clear now that research on a variety of disciplines shows that cognition and mental health are intertwined across the life course.

We can add one more feature of age and brain: The idea of considering dementia without age is a nonstarter as the type of symptoms, the number of neuritic plaques, and the phenomenology of problems are different for differing older ages. There is then variability in the whole older group that is best reflected in the category of young-old and old-old. Cognition especially is the harbinger of problems of all sorts, both physical and mental, across the later years of life.

“The concept of dementia is obsolete.” [29, p. 2172]

Anxiety

The forgotten problem in the psychological care of older adults is the phenomenology of anxiety and what to do about it. Anxiety disorders are the most common psychiatric illnesses in the USA with approximately 30% of the population experiencing anxiety-related symptoms in their lifetime (Kessler et al. 2005). Current rates of anxiety extend to 10% with its symptoms actually doubling that number.

Most anxiety problems occur in early life (50–97%). In general, the fact that anxiety may attack in early or late life is unremarkable except for medical problems:

Late onset has more medical symptoms. In general too, early onset was most characterized by obsessive–compulsive disorder (OCD), panic disorder (PD), and specific phobias; late onset is most characteristic of post-traumatic stress disorder (PTSD), agoraphobia, adjustment with anxiety, and GAD.

While GAD levels (e.g., [58]), as well as depression and anxiety in general, are lower in older age than other ages (e.g., [28]), only 33% of older GAD patients reported using mental health resources (Blazer 2000). Older adults with GAD are more disabled, have worse QoL, demand a greater health care utilization than non-anxious groups [65]. Also, 90% of older adults with GAD report dissatisfaction with sleep and the majority report depression; however, problems with anxiety show first at primary care clinic (PCC)—both medication use and numbers are up. Younger ages also do better in terms of assessment and treatment where anxiety is concerned.

Anxiety is both brain based and unique at late life. As implied, the most common type of anxiety at late life is GAD. This type of worry is best connected to depression and often to medical problems. Worry and nervous tension (as opposed to specific anxiety syndromes, such as PD) are common presentations of depression in older people. Unfortunately, many physicians tend to focus on the symptoms of depression or anxiety alone, thus failing to consider the possibility of comorbidity. Often, patients who have both anxiety and depressive symptoms are more likely to be given a benzodiazepine rather than treatment for depression [60, 81]. Older adults with depression too often may worry about memory loss without showing objective evidence of memory impairment in simple tests of memory. These patients should be evaluated for symptoms of depression, with careful follow-up to watch for the development of dementia [17].

Anxiety facts

GAD levels (e.g., [57]) and anxiety in general are lower at older age (e.g., [28]).

Research on subthreshold disorders with nonclinical older samples indicates that mental health is not better in older age.

Literature on the dimensional approach suggests that this is a better model of psychopathology.

Older individuals provide responses significantly different from those of younger adults, potentially requiring special attention in psychiatric care.

Depression

Depression has changed the face of confidence regarding the canons of established psychiatry. Yes, it exists and is prevalent, but its phenomenology is complex and varied. Older persons with significant depression may have fewer symptoms than the number required by the *DSM-IV* criteria for major depression. In one study [26], older adults who expressed feelings of hopelessness or worthlessness admitted to

thoughts of death or suicide and had at least two other symptoms of depression, were at increased risk for functional disability, CI, and psychological distress and death even if they did not display symptoms such as sadness or loss of interest or pleasure in activities that were formerly enjoyed (nondysphoric depression). Depressive symptoms are also associated with the development of functional impairment as measured by performance tests (avoiding reliance on self-report of function) in a similar study [62].

Depression issues at late life

- “There is increasing evidence that symptoms of elderly depression may be etiologically distinct (e.g., more psychomotor retardation and anhedonia in vascular depression) and that focusing on subclusters of depressive symptoms, rather than relying on general depression assessment tools, may help enhance construct validity...” (p. 379)
- At the least, “It is apparent that the ‘oldest old’ (>75) present different from the ‘young old.’” (p. 379)
- At the least, “...the development of depression and cardiovascular dysfunction share molecular mechanisms, such as stress induced changes in inflammatory markers and neurotransmitter signaling, all related to common genetic elements.” ([50], p. 380)
- “The heterogeneity in symptom presentation among older adults diagnosed with MDD can potentially inform the development of the DSM-V.” [34, p. 387]

Older patients with depression may present with somatic complaints for which a medical etiology cannot be found or that are disproportionate to the extent of medical illness. Patients who express somatic symptoms as a manifestation of depression seem to be less willing to mention psychological symptoms to their physician [10]. Certainly, illnesses, such as pancreatic carcinoma or hypothyroidism, might cause symptoms that mimic depression. Therefore, addressing the patient’s psychological distress while appropriately evaluating the possible diagnoses is important. Clinical experience also suggests that physicians are less likely to move from recognition to treatment of the illness in older patients than in younger patients. Physicians, like patients and their families, are usually able to find a “reason” for depression in the older person. That said, treatment is often delayed or not pursued at all [12]. Physicians may believe that a medical illness is a contraindication to treatment with antidepressants, but older patients with physical illness seem just as likely to respond to selective serotonin-specific reuptake inhibitors (SSRIs) as older patients without physical illness [72]. Now, we know that psychotherapy can be as effective as antidepressants if not more so [35].

At late life too, several varieties of depression can exist. As intimated above, there are varieties of the phenomenology of depression. There are shades of grayness, as well. Major, minor, and mixed depression exist at late life. Annoyingly,

subsyndromal depression (often defined as >16 on Center for Epidemiological Studies-Depression (CES-D) but full MDD criteria are not met) is also a pervasive problem. All of these states are prevalent, all assert an influence on QoL, and all segue to MDD at some point, if not handled when the symptoms are first noted. These states are highly prevalent and have a propensity to convert to MDD, especially when there is a history of MDD [14]. Most patients do not solicit treatment.

Of interest too is that there are no clear biomarkers of depression. This is said despite the fact that there are MRI changes in late-life depression, that twin studies show that 16% of variance is attributed to CES-D, that 5HT2A and 5HT1A receptor-binding decreases with an increased incidence of homozygous “short” alleles in promoter region of 5-HT transporter, that corticotropin-releasing factor hypersecretes (in low-level doses, and that the HAM-D factors correlate with distinct brain regions). In addition, there is comorbid weight loss, cardiovascular disease, increased platelet activation, lower T cell response, poor blastogenic response to mitogens, high level of cytokine interleukin 6, as well as elevated homocysteine levels. Despite this, depression is generally not measured by biomarkers. That said, this state is best viewed as an epigenetic disease where nature and nurture dance for dominance.

Depression is often the driving force in the panoply of symptom domains discussed. In fact, anxiety seems to lead the pack in time to disorder, but depression is the core substance. Depression is comorbid with everything bad. On the one side of the coin, depression can be punishing. Styron [80] noted: “The gray drizzle of horrors induced by depression takes on the quality of physical pain.” But there is another side: Depression may be overrated. It is common as a sign and symptom. But its true prevalence may be considerably less than 12%, closer to 2%. If we mark depression as a true disorder that is debilitating, not episodic and marginal in intensity, it may be less serious a disorder and more a universal annoyance that peaks on occasion to cause some problems.

Medical/Somatic Issues

Older adults have historically utilized health services at higher rates than anyone and mental health services at substantially low rates. If they do seek help for mental problems, it is in primary care. We also know that medical care is directly related to mental health. It is estimated that more than 70% of medical problems, especially unexplained ones, are attributed to mental health issues. Modal problems for older adults regarding cognitive decline, depressive symptoms, anxiety issues, or unexplained somatic concerns are more than 50%. Patients with depression and significant comorbidities are especially costly to the health care system. Depressed patients with diabetes, for example, have more trouble adhering to their diet and checking blood glucose levels, and they exercise less, smoke more, and die at about twice the rate as those without depression. It is costly not to treat these people, to develop preventative programs for them, and have educative targets around diabetic problems.

The pathways leading to comorbidity of mental and medical disorders are complex and bidirectional [43]. Medical disorders may lead to mental disorders, mental conditions may place a person at risk for medical disorders, and mental and medical disorders may share common risk factors. Comorbidity between medical and mental conditions is the rule rather than the exception. In the 2001–2003 National Comorbidity Survey Replication (NCS-R), a nationally representative epidemiological survey, more than 68% of adults with a mental disorder (diagnosed with a structured clinical interview) reported having at least one general medical disorder and 29% of those with a medical disorder had a comorbid mental health condition [11, 25]. In addition to the high prevalence of these conditions, there is also evidence that having each type of disorder is a risk factor for developing the other. For example, among respondents to the 1999 National Health Interview Survey, another nationally representative epidemiological survey, the likelihood of having major depression diagnosed via a screening instrument increases with each additional reported comorbid chronic medical disorder.

Worse, medical conditions are most often grouped into “triads” (i.e., common co-occurrences of three diseases together). Psychiatric disorders were among seven of the top ten most frequent diagnostic comorbidity triads in the most expensive 5% of Medicaid beneficiaries with disabilities. The most common triad was comorbid psychiatric conditions, cardiovascular disease, and central nervous system disorders, which affected 9.5% of all beneficiaries and 24% of the most expensive group of beneficiaries. One of the most important drivers of the high costs is the high prevalence of mental disorders and chronic conditions in the USA (RWJ Report). The 2001–2003 National Comorbidity Survey Replication, an epidemiological survey, found that approximately 25% of American adults meet criteria for at least one diagnosable mental disorder in any given year [27], and more than half report one or more chronic general medical conditions [72].

When mental and medical conditions co-occur, the combination is associated with elevated symptom burden, functional impairment, decreased length and QoL, and increased costs [8, 73, 78]. The impact of having comorbid conditions is at least additive and at times may be synergistic, with the cumulative burden greater than the sum of the individual conditions. Comorbid mental and medical conditions are associated with substantial individual and societal costs [18, 88]. Melek and Norris [53] analyzed the expenditures for comorbid medical conditions and mental disorders using the 2005 Medstat MarketScan national claims database. They looked at the medical expenditures, mental health expenditures, and total expenditures of individuals with one of ten common chronic conditions with and without comorbid depression or anxiety. They found that the presence of comorbid depression or anxiety significantly increased medical and mental health care expenditures, with more than 80% of the increase occurring in medical expenditures.

We also note that other medical/somatic issues infect the QoL for older adults. Two that are prevalent are sleep and pain. Sleep problems become more common with age, affect QoL for individuals and their families, and can increase health care costs. Older people are often prescribed a range of drugs for their health problems (including with sleep), many of which have side effects. Total sleep duration

appears to show a modest improvement post treatment, which declines with time. Pain also is prevalent and asserts an influence over care programs. In fact, the more the person suffers from pain, the more each is resistant to treatment for any psychiatric disorder.

There is no easy summary here. Chances are that, if you have a mental problem and if you desire to seek help, you are probably depressed, anxious, have some cognitive issue, or are in pain and sleep deprived. Additionally, the thrust of care is towards more medications and a reduced adjustment. If you are treated, it occurs in PCCs and you are prescribed medication. Often, you are misdiagnosed as either a false positive or negative. If accurately diagnosed, you are not followed up well or the medications do not prove effective. Depression care invariably means antidepressant treatment (40%) or being tabbed as a false positive (45% false positives). You are also treated by primary care providers (PCPs; 50%; [7]). If you have anxiety, medical utilization increases with the number of anxiety diagnoses [44]. Also, if you say that your problem is somatic, your PCP misses psychiatric diagnosis (85%; [41]).

Adjustment

The evidence is that adjustment suffers as these issues percolate at late life more than other ages. Adjustment problems are always salient but become a big issue if one of the following components is present. First, adjustment suffers just by getting older; at age 80, 60% of adults start having problems with instrumental activities of daily living (IADLs). This increases as spousal loss occurs and presence in long-term care facilities (LTC) expands. Second, adjustment is at issue when there are activities of daily living (ADL) or IADL functional problems. A 75-year-old male with one ADL problem has the rough life expectancy of an 85-year-old without one. QoL is also equated.

Third, cognition and function cohabit with ~40% of common variance [70]. Adjustment has an equal chance of predicting dementia and related problems as do neuropsychological or medical predictions. This is especially the case when IADLs are assessed. But, adjustment is often the forgotten component in care as the focus is on medical and psychiatric/psychological problems. Once one is in an LTC facility, adjustment becomes even more important.

Fourth, QoL is critical for reasonable living; QoL is adjustment. How the person lives, with whom, with what supports, money, options, and with the ability to act as they would like, become central to well-being. What is involved in happiness is complex but clearly involves the desire to be ambulatory, to have some resources, to be social, to feel some self-efficacy, and to live where the person desires. Some decades ago, Rowe and Kahn set the bar for successful aging very high. Only about 8% of older adults have this as a designation because most have medical maladies and limits on function. For our purposes, the presence of anxiety, depression, cognition problems, or medical concerns affects adjustment. Measuring and targeting common living/adjustment account for as much of the variance of change as any of the variables by themselves.

Psychotherapy Works, Even at Late life

In the main, psychotherapy does work. It is reasonably enduring as well but also not as effective as possible as many (most) patients do not fully remit. We start from the position that psychological problems at late life are best dealt with by the therapeutic response based on modular interventions, that the modal problems at late life, anxiety, depression, somatization (pain), and cognitive decline are joined at the hip, that emotional disorders have a similar underlying structure, that the components of core therapies, like CBT, problem-solving therapy (PST), and interpersonal therapy (IPT), incorporate the best modules for change. This then represents a unified approach to treating problems at late life. At base, this involves core psychotherapeutic responses of experiencing the emotion, changing the cognition, and behaviorally acting. In fact, psychotherapy in the twenty-first century is one in which there is a melding of theories and borrowing of techniques, making pure models of care (e.g., CBT) difficult to find.

The intervention of change for an older adult in turmoil is a beginning. The careful therapist will know that the chances of recurrence are high. The antidotes to this are awareness of its existence, a focus on relapse, an educational gathering of social resources, a team approach, and a loose monitoring over time. Good science can inform practice, and good practice is good policy. That said, there are many variables in the dance of therapy and the health care provider must act on clinical common sense before best practice when the two collide. There must then be an “epistemological politics” that can supplant one knowledge system for another.

“Advances in knowledge in the psychopathology of mood disorders seem to make it clear that the wrong target has been addressed. . . major depressive episodes will respond to most reasonable treatments in the short term or will remit on their own, but they will *almost always recur*. To be truly effective, treatments, whether psychological or pharmacological, must prevent recurrence of future depressive episodes.” Barlow, [5, p. 873]

When dealing with older adults, we are often doing some application of translational research because few psychotherapy interventions have been designed expressly for elders. The translational component involves focusing on the time span of the problem, the nature and scope of hypotheses, dose adjustments, and patient population characteristics. Early on in therapy with older individuals, treatment is titrated. This includes a time frame that is short, hypotheses that are narrow in scope, small doses of the intervention, close monitoring of coping/potential, and choosing narrow treatment targets. In later phases of treatment, there is the requisite alteration in goals, which are simplified for reality’s sake. Psychotherapies are never just pure techniques to be used off the shelf. As this process has unfolded over the years, however, efforts to document the applicability of all-purpose psychotherapy research data appear to be relevant to older adults if practiced in an aging-informed manner [32].

From this position, we can see that psychiatric treatment with medications is really a *psychological intervention*. We argue this for many reasons, including the fact that there are no specific effects of the antidepressants, that more caring and empathic physicians get better results, and that there is little relationship between dosage and plasma levels of antidepressant and outcome. In our experience, successful doctors get better results with a range of psychotropic medications, whatever is applied.

Both context and outcomes matter. With older adults, both are complex. For outcomes, the issue is never just symptom abatement. Rather, therapy should aim at symptom relief *and* improving overall QoL. Residual symptoms portend relapse or a lower QoL. But a careful and caring focus for the long term will assist. Reality constraints on outcome cannot be easily captured by research. These include the client's readiness to change, acceptability of the treatment and preferences of the client, caregiver acceptance, availability of desired or needed services, probability of third-party payer approval, tolerance of incongruous recommendations, prior treatment failures or successes, and side effects. Hence, with older adults, the big three components of therapy—research, clinical experience, and client characteristics—are added to by these generic background and living markers for adequate outcome coverage.

Although evaluation questions necessarily focus on the reasons why an elder is seeking treatment, such a narrow focus is not helpful for understanding process changes over time or other longer-term and broader concerns. In translating evidence-supported treatments to older adults and in targeting this to the most researched psychotherapy, CBT, we must concentrate on more general outcomes (not just diagnosis), as well as specific markers associated with the identified problem. For the treatment of depression, for example, CBT will involve the alteration of cognitions to reduce depressive symptomatology, as well as alterations within the context. As noted above, with older adults too, the therapy also demands a scientific attitude, a skillful and flexible delivery of services, quantitative monitoring of the client's progress, and an awareness of the personologic, interpersonal, and cultural characteristics of the client as well as QoL themes. The efficacy of change also resides in common factor details, the context of therapy.

Psychotherapy does not work as medicine; nonspecific factors are integral to both but prepotent for mental health care. This allows the patient to generate change, spontaneous recovery, self-generated change, placebo effects, resilience, post-traumatic growth, corrective effects of disclosure, and feedback. Always, there is a need to take into account the context of practice; evidence-based practice may not be practical. In addition, the therapist effects are at least equal to treatment effects. At late life too, the realities of practice that science cannot address well, such as socioeconomic status, medical comorbidities, and patient attitudes, are prevalent. In general, when clinical experience and science butt heads, the best advice is to opt for clinical experience. At late life but across the board, psychotherapy is both an art and a science.

Rubrics of psychotherapy

- Psychotherapy is effective; effect size is ~ 0.8 , indicating that the average treated person is better off than 80% of not in treatment [47].
- The apparent existence of specific psychological treatments for specific disorders is suspect [54].
- People are increasingly accepting mental health programs as a normal mode of treatment [31]. Also, most people will admit to emotional or life-style problems in the last year.
- The quality of the patient's participation is most determinant of outcome [59].
- Change as a result of psychotherapy derives from key ingredients or elements that transcend all approaches.
- Nonspecific components of the alliance, the placebo and the person of the therapist, are critical for change in mental health. Allegiance effects by the therapist are also substantial.
- The comparative effectiveness of drug studies versus psychosocial therapies is virtually equal. In fact, placebo closely approximates the effect size of both. The combined use of both types of therapies is more helpful only to some (e.g., treatment resistant or in acute phase only).
- Up to 10% deteriorate in psychotherapy and another 25% do not benefit at all [44].
- Monitoring or tracking patient outcome alone has an effect size of at least 0.4 [45].
- Between 6 and 9 weeks seems to be an initial marker for change; if there is no change by then, problems will likely continue.
- Clinicians practicing in multidisciplinary settings do better than sole practice models.
- Dropout rates in outpatient clinics total as high as 47%.
- How one copes with problems over time to prevent relapse is more critical than initial changes. Change then is not just managing symptoms.
- Particular treatments work because the patient is motivated, the therapist is likeable and competent, the alliance is firm, and feedback is applied.
- The psychiatric treatment with medications is really a *psychological intervention*.
- There are no specific effects of any of the psychiatric medications, especially the antidepressants.
- Most people with mental disorders remain untreated or poorly treated [85].
- Patients given "usual care" have a very high likelihood of remaining depressed.

Social Reality/Cost

The issue for providers, health care administrators, and policy makers is to balance the essential tension between good care and cost. This is not easy as it requires a thoughtful program of preventative self-care and reasoned medical service utilization based on patient-centered input by the older adult and his/her caregiver/family. In the Institute of Medicine report, *Retooling for an Aging America* [36], a vision of health in America is laid out. First, the health care needs of the older population will be best served by a patient-centered, preference-sensitive approach. Patient centeredness includes taking into account the increasing sociodemographic and cultural diversity of older Americans. Second, services will need to be efficient so that wasteful and ineffective care is reduced. Third, interdisciplinary teams will provide comprehensive, seamless care across various delivery sites and be supported by easily accessible health information systems fitted to emerging care needs and delivery modalities. Last, older adults will be active partners in their own care until they no longer have the capacity for competent decision making. Ideally, there will be a partnership between provider and patient that includes: (1) clear information, (2) adoption of healthy lifestyles, (3) informed self-management of chronic conditions, and (4) increased participation in one's own care.

We do not do a good job of health care in this country. We spend twice the amount of other countries and end up in the middle of the pack on just about every outcome marker of health. Only 25% of people with a *DSM* diagnosis actually get treatment; only 10% of people with lifestyle problems (smoking, poor diets) ever seek professional help. Mental health is costly—really costly, more so than most medical problems. We have already established that unmet mental health needs lead to problems downstream. The pharmaceuticals have not changed this. We need a better model of care.

Socioeconomic status has long been viewed as a strong marker of QoL. Recent studies have illustrated the fact that socioeconomic status and our living environment begin to play an even more significant role in our QoL as we age, particularly with respect to the development of chronic diseases. Freedman et al. [22] utilized subject data from the 2002 Health and Retirement Study to postulate that a correlation exists between the characteristics of the neighborhood in which an older adult inhabits and his or her late-life morbidity. It was found that for women aged 55 and older, living in an economically disadvantaged neighborhood predicted the onset of critical heart problems. In addition, Freedman et al. demonstrated that older adults—both men and women—living in more highly segregated, higher-crime areas were at greater risks of developing cancer. Socioeconomic status determines more profoundly and predicts QoL and general health than perhaps any other researched factor. Lack of monetary resources, restricted access to quality health care, and environmental stressors add to the deterioration of older adults living in low-income environments. The practice of negative habits such as lack of physical activity, poor diet, and smoking also influences the onset of other chronic disorders such as hypertension and diabetes.

Gender and race should also be examined with regard to the aging process and the utilization of health care services to promote overall well-being. Income and wealth certainly influence health care resources available to older adults, especially considering the availability and costs of health maintenance (HMO) enrollment plans, Medicare, Medicaid, private insurance, and government assistance. According to Cameron et al. [13], women report more health needs and disability in terms of functional limitations and report fewer economic resources in terms of income. Davitt and Kaye [19] also investigated differences that exist with regard to quality of home health care offered to minority groups and other vulnerable populations due to current national health care policies. These are all factors considered when evaluating gender and racial disparities that may exist in older adults seeking preventative care, physician visits, hospital admissions, and home health care.

Caregiving

It has been estimated that 65.7 million Americans served as caregivers in the past year. This is 28% of the population. Nearly one third of American households reported at least one person serving in an unpaid caregiving role. The typical caregiver is a female, taking care of one person on an unpaid basis. But more than one third (34%) report taking care of two or more people. Most are providing care for a relative (86%) and more than 1/3 are taking care of a patient. On average, caregivers have been on the job for 4.6 years and 31% have been doing this for 5 or more years. The typical person receiving the unpaid care is a female (62%) who is 61 years old and gets about 20.4 h per week of active care. Burden was rated as medium-high by 51% of respondents with 35% relying on paid caregiving and 66% on other unpaid caregiving. Stress of caregiving is notable [30, 33, 73].

Throughout the life span, levels of caregiver burden increase as the physical health and mental capacity of the care recipient deteriorate. Caregivers are often confronted with issues of frailty, cognitive deficits, and behavior problems at the hands of their ailing spouses. Lack of adequate coping skills and a positive support system can lead to caregivers experiencing depressive symptoms, problems with anxiety, and other emotional disorders. In addition, older adult caregivers who expend all of their time and energy into taking care of their loved ones often neglect their own personal health, resulting in a myriad of physical ailments.

The responsibility of caring for a spouse inherently holds an overall increase in burden. Pinquart and Sorenson [63] ascertained that spouse caregivers report high levels of physical burden, financial burden, and relationship strain between themselves and the care recipient. As a result, physicians, social workers, and mental health professionals who encounter older adults living in a caregiver dyad should extend resources that help improve the overall well-being of the spouse caregiver. Resources should include psychoeducational and support groups for couples living with a particular disorder (i.e., Parkinson's Disease, AD, stroke, etc.), skill-training programs focused on behavior management, depression, and anger management,

and psychotherapy of the CBT [24]. The physical and emotional well-being of the caregiver directly impacts those reciprocal aspects of the care recipient; therefore, health care professionals should promote increased self-awareness and self-care for the caregiver.

Not enough emphasis can be placed on how greatly impacted a spouse caregiver may be from exposure to the psychological, physical, and spiritual distress that their care recipient endures in their presence. According to Monin and Schulz [55], the nature of caregiving exposes caregivers to increased cognitive empathy, prolonged bereavement, and extended observations of physical pain in the care recipients. The emotional toll resulting from witnessing the decline of a spouse can also manifest itself as physiological distress such as fatigue and somatic symptoms. In addition, taking on the caregiver role causes some spouses to experience existential crises of their own regarding their legacy, personal values, and meaning in life.

The Domain Dance

We have advocated for a holistic approach for the assessment and treatment of older adults. This is anything but linear and clean. The older adult is waiting to be parsed apart and better understood, but holistically. The most assessed targets involve cognition and depression. Cognitive compromise associated with late-life depression can present anywhere along a continuum from MCI to a frank dementia. A mood disturbance in an older adult can initially present as a subjective cognitive complaint. Likewise, the existence of depression can exacerbate previously existing cognitive difficulties. In community-dwelling residents, the combination of impaired cognition and depressive symptoms doubles in frequency at 5-year intervals beyond age 70; combined depression and cognitive dysfunction are present in 25% of individuals aged 85 years or older [4]. There is ample evidence that the presence of comorbid cognitive deficits is associated with reduced treatment responsiveness in late-life depression [37, 66, 75, 77, 79].

This applies to the other problem domains, anxiety, somatic/pain/sleep, and adjustment. Most psychosocial interventions for the acute treatment of geriatric major depression focus on “young-old” (average age of 65–70 years), cognitively intact, ambulatory older adults who can follow outpatient treatment [51]. Clearly, this is only a subsample of the population who are in need. Additionally, homebound, rural, and low-income older adults may not have the same access to effective interventions for depression as those living in situations more conducive to receiving traditional psychotherapeutic treatment [51]. Furthermore, interventions may not be available or appropriate for ethnically and culturally diverse populations.

We have also noted above that factors such as comorbid illness can also serve as a barrier for treatment. Evidence suggests, for example, that depressed older adults with comorbid physical illness and CI experience reduced intervention effectiveness which argues for a strong need for new evidence-based psychosocial interventions to help depressed older adults with CI and disability [64]. Studies

have not indicated significant treatment remission differences between early-onset and late-onset depression [42] although older adults who had an early-onset depression may be slower to remit [68]. This is because they have more “other” problems, principally cognition, anxiety, and pain/sleep.

What can providers do? We believe that the core treatment involves non-pharmaceutical interventions. This form of treatment is not so much better than medications or the combo, but they almost never cause harm and always lead to better results. As indicated, we believe that the “watch and wait” strategy is most important here. The judicious application of monitoring and waiting for success or failure to be expressed is suggested, where an observation period as a part of the treatment plan is considered good care.

The recent studies in primary care regarding depression (IMPACT) made one important contribution; the idea of a step care model with a watch-and-wait background. Mistakes are made in the care of mental health problems when decisions are made too quickly, empirical science is suspect, or commitment (of the patient) is not certain. Step care establishes a slow pattern of treatment in which the problem is assessed, monitored, and problem-solving interventions are slowly but deliberately introduced. Problems confess themselves. Recall that the social reality of the patient is of equal concern to the psychiatric problems and requires intervention. Frequently, the monitoring of patients’ symptoms and the reconsideration of treatments may produce as much benefit for patients as a medication or psychotherapy and may fit better with the patient’s desires.

Reality constraints for outcomes that cannot be easily captured by research include the client’s readiness to change, acceptability of the treatment and preferences of the client, caregiver acceptance, availability of desired or needed services, probability of third-party payer approval, tolerance of incongruous recommendations, prior treatment failures or successes, and side effects. Boyd et al. [9] in 2005 noted that best practice for an older adult who has high blood pressure, diabetes, arthritis, and depression involves more than 14 medications and as many non-pharmacological interventions resulting in excessive costs and many practical problems. Coordinated care is necessary for help and change.

Conclusion

Psychological problems at late life are best dealt with by the watch and wait scaffold using modular interventions. The modal problems at late life, anxiety, depression, somatization (pain), and cognitive decline, as well as adjustment, are interactive. Dealing with these issues requires much of the health care provider. It is fortunate that emotional disorders have a similar underlying structure, and that the components of CBT, including PST and IPT, have modules that can be effective in care.

Something more than standard care is required. In a review of long-term care and the value of psychiatric medication, Reichman and Conn [67] noted that the

evidence in support of various models of psychogeriatric services in nursing homes liaison-style services that employed educational approaches, treatment guidelines, and ongoing involvement of mental health staff are more effective than the purely case-based consultation model. This latter model almost exclusively involved medication.

- “The narrow emphasis is not serving the nursing home population adequately. We continue to rely nearly exclusively on medication management in our clinical nursing home practices, even though our confidence in the efficacy and safety of the historically most treasured psychotropic agents has been seriously eroded.... We must acknowledge that the newer generation medication therapies have no been delivered substantial enough gains over their predecessors.”
- “What are the specific contributors to the display of mental illness in the nursing home? In this milieu, they are the physical environment, the processes of care, and the behavior of people (care providers and other residents).”
- “...it is time to shed our overreliance on biological determinants and the disease models of mental illness. It is time for a reappraisal.” [67, pp. 1050–1052].

We agree.

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