Assessment of Depression and Anxiety in Older Adults

4

Dimitris N. Kiosses and Patricia Marino

Epidemiology of Late-Life Depression

The prevalence of late-life depression increases as we move from the community to medical settings, home care, and nursing homes. Three percent of older adults in the community, 5–8% of medical outpatients, 11% of medical inpatients, approximately 12% of nursing home residents, and 14% of home-care recipients have major depression [1–3]. The percentages are even greater in milder forms of depression including dysthymia.

Despite its detrimental consequences, late-life depression is underdiagnosed and undertreated. Factors which contribute to underdiagnosis and undertreatment of geriatric depression likely include the following:

(a) Similarities of depression symptoms with those of medical illnesses.
(b) Many older depressed adults do not report depressed mood but rather lack of interest or pleasure in activities.
(c) Aging stereotypes.
(d) Primary care settings, where most of the depressed older adults are treated, are busy and emphasize medical rather than mental health problems [4]. In primary care, almost half of high utilizers receive no antidepressant treatment, and 1/3 receive inadequate treatment [4, 5]. Even when antidepressants are prescribed, adherence rates are discouraging, ranging from 25% to 60% [5].

Suicide

Suicide is devastating for the victim's families, friends, and communities. Suicide rates have increased in the past 10 years, with white older men (85 year old or older) at greatest risk. Although there has been a decrease in suicide rates in older adults in recent years, rates may significantly rise again because of the aging of baby boomers, a cohort with increased suicide rates [6]. When compared with suicide attempts of young adults, attempts of older adults are more determined and use more lethal means, including the use of firearms or hanging. Psychiatric illnesses in general, but mood disorders and major depression in particular, are the most prominent risk factors for suicide. Other risk factors include poor physical health, disability, recent loss, and lack of social connectedness [7–9]. Assessment of these risk factors is important during the assessment of depression.

D. N. Kiosses (✉) · P. Marino
Department of Psychiatry, Weill-Cornell Institute of Geriatric Psychiatry, Weill Cornell Medicine, White Plains, New York, NY, USA
e-mail: dkiosses@med.cornell.edu; pam2029@med.cornell.edu

© Springer Nature Switzerland AG 2019

L. D. Ravdin, H. L. Katzen (eds.), *Handbook on the Neuropsychology of Aging and Dementia*, Clinical Handbooks in Neuropsychology, https://doi.org/10.1007/978-3-319-93497-6_4

Epidemiology of Late-Life Anxiety

Late-life anxiety contributes to decreased sense of well-being, reduced satisfaction, and increased disability [10]. Even though reported prevalence rates of diagnosable anxiety in older adults vary greatly in the community (2–19%), the best estimate is about 10%, while this rate increases in medically ill populations [10]. Comorbid anxiety is common in late-life depression, with reports estimating its prevalence up to 65% [10], and it is associated with lower response to antidepressant medication treatment, longer time to response or remission, and shorter time to recurrence once remission is achieved [11–15].

Diagnosis of Clinical Depression and Anxiety

Diagnosis of Clinical Depression

There are different types of clinical depression highlighted in the DSM-5 [16], some of them are updated from the DSM-4. Major depressive disorder (MDD), dysthymic disorder, depressive disorder NOS, and adjustment disorder of depressed mood and anxiety are the most common diagnoses of clinical unipolar depression. Differential diagnosis is based on the severity and duration of symptoms as well as on the precipitants of the onset of depression. As we review the symptoms of different types of depression, it is evident that MDD is the most severe. In the following section, the most common depressive and anxiety disorders will be described, and certain diagnostic considerations will be highlighted. Updates with reference to the DSM-5 (released in May 2013) are provided.

Major Depressive Disorder

MDD is characterized by the presence of one or more major depressive episodes (MDEs) and the absence of any hypomanic or manic episode. A MDE is diagnosed when either depressed mood or loss of interest or pleasure (anhedonia) is present for at least 2 weeks, every day, most of the day [16]. In addition, the patient may experience five or more of the following symptoms: (a) depressed mood, (b) lack of interest or pleasure in activities, (c) significant weight loss or weight gain or appetite disturbances (in older adults, most commonly weight loss and decreased appetite), (d) sleep disturbances, i.e., insomnia or hypersomnia, (e) psychomotor agitation or retardation, (f) fatigue or loss of energy, (g) feelings of worthlessness or excessive or inappropriate guilt, (h) concentration difficulties or indecisiveness, and (i) recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt or a specific plan for committing suicide (DSM-5) [16]. To diagnose an episode of major depression, clinically significant distress or impairment in social, occupational, or other important areas of functioning is required [16]. Within the diagnosis of MDD, there are different degrees of severity denoted in the last digit of the DSM-5 diagnosis [16]. Specifically, (1) refers to mild severity, (2) to moderate, (3) to severe without psychotic features, (4) to severe with psychotic features, whereas (5) and (6) refer to partial or full remission. The DSM 5 [16] now indicates two additional specifiers. The coexistence within a major depressive episode of at least three manic symptoms (insufficient to meet criteria for a manic episode) is now acknowledged by a specifier "with mixed features." Additionally a new specifier of "with anxious distress" has been added to rate the severity of anxious distress in all individuals with depressive disorders (DSM 5). Bereavement is no longer an exclusion in the DSM 5 for a major depressive disorder.

Psychotic Depression

Major depression with psychotic features is a severe disorder, which is characterized by delusions or hallucinations and is associated with slow recovery, poor outcomes, and increased disability and mortality [17–19]. Delusions are more frequent than hallucinations, and compared to delusions in dementia, delusions in psychotic depression are systematized and mood congruent [4]. Usual delusional themes include guilt, persecution, hypochondriasis, nihilism, and jealousy.

Persistent Depressive Disorder or Dysthymia

Dysthymic disorder is a chronic depression of milder intensity than major depression. Specifically, depressed mood is present for most of the day, not every day but for most days than not, for at least 2 years and should not be absent for longer than 2 months [16]. Contrary to the diagnosis of major depression, lack of interest or pleasure is not a cardinal symptom of dysthymia. In addition to depressed mood, the patient may experience two or more of the following symptoms: (a) poor appetite or overeating (in older adults, most commonly poor appetite), (b) insomnia or hypersomnia, (c) low energy or fatigue, (d) low self-esteem, (e) poor concentration or difficulty making decisions, and (f) feelings of hopelessness [16]. Once again, clinically significant distress or impairment in social, occupational, or other important areas of functioning is required for diagnosis [16].

A close examination of the symptoms of major depression and dysthymia may explain why late-life depression is underdiagnosed. First, fatigue, loss of energy, concentration difficulties, weight loss, and sleep disturbances may be symptoms of other medical illnesses. As older adults frequently suffer from medical illnesses, it may be difficult to differentiate whether these symptoms are features of depression or other medical illnesses. Second, due to aging stereotypes, lack of interest or pleasure may be incorrectly perceived as a normal part of aging. This is a very critical issue as many depressed older adults do not exhibit or report depressed mood, but rather lack of interest or pleasure.

Adjustment Disorder with Anxiety and/or Depressed Mood

Adjustment disorder refers to the development of emotional and behavioral symptoms as a response to a stressor occurring within 3 months of the onset of the symptoms [16]. Usual stressors of adjustment disorder in older adults include poor physical health and disability, socioeconomic deprivation, and placement to a long-term care facility [4, 20]. Based on DSM-5 [16], the symptoms are clinically significant and may cause marked distress (more than expected from the exposure to that stressor) and significant impairment in social or occupational functioning. Adjustment disorder may occur with anxiety, depressed mood, or both.

Cognitive Deficits Associated with Depression

As mentioned above, late-life depression may be accompanied by cognitive difficulties. Poor concentration is a common symptom of depression. Moreover, nondemented depressed elders may present with disturbances in processing speed and executive functioning [21, 22]. To evaluate the etiology of cognitive difficulties in late-life depression, a thorough neuropsychological examination is strongly recommended.

Some older adults display symptoms of dementia that are due to depression. As soon as depression remits, their cognitive functioning may reach their premorbid functioning. This clinical picture is referred as "pseudodementia" or "reversible dementia." The causes of "pseudodementia" are not clearly understood; in some cases, depression may contribute to cognitive impairment, whereas in others, cognitive deficits may be the result of a progressive subclinical dementia that is exacerbated by depression [4, 23]. Despite their return to almost normal cognitive functioning, older adults with "pseudodementia" may develop irreversible dementia at a rate of 9–25% per year (approximately 40% within 3 years) [4, 23]. Further research is needed to understand "pseudodementia" and its consequences.

Depression in Alzheimer's Disease

Some depressive symptoms may be similar to symptoms of Alzheimer's disease (AD). For example, diminished social activity and lack of interest, which are symptoms of depression, are prevalent in AD. The overlap of symptoms

between depression and AD may complicate the diagnosis of depression in AD [24]. Further, research suggests that depression in AD may be different from other depressive disorders [24].

In 2002, the NIMH organized a workshop with a group of investigators of depression and AD to facilitate the development of provisional diagnostic criteria for depression of AD [24, 25]. The goals of the development of these criteria were to assist clinicians in diagnosing depression in AD and to provide a target for research on the mechanism and treatment of depression and AD [25]. The criteria required three (or more) of the following symptoms to be present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) decreased positive affect or pleasure. The symptoms were (a) clinically significant depressed mood; (b) decreased positive affect or pleasure; (c) social isolation or withdrawal; (d) disruption in appetite; (e) disruption in sleep; (f) psychomotor changes (agitation or retardation); (g) irritability; (h) fatigue or loss of energy; (i) feelings of worthlessness, hopelessness, or excessive or inappropriate guilt; and (j) recurrent thoughts of death, suicidal ideation, and plan or attempt [24, 25]. These criteria must be present in an individual diagnosed with dementia of the Alzheimer's type, and the symptoms are believed to cause clinically significant distress or disruption in functioning [25].

The provisional diagnostic criteria for depression of AD mainly differ from DSM-5 criteria of MDD in the following ways: (a) the duration of cardinal symptoms (in DSM-5, the symptoms must be there nearly every day, most of the day, while in provisional criteria, the symptoms may have shorter duration), (b) the number of symptoms required for the diagnosis (five in DSM-5 vs. three in provisional criteria), and (c) description of anhedonia ("lack of pleasure in DSM-5" vs. "decreased positive affect or pleasure in response to social contacts or activities" in provisional criteria) [24, 25].

Diagnosis of Anxiety

In a review of cognitive therapy of anxiety disorders, Clark and Beck highlight the following definitions of fear and anxiety: "Fear is a primitive automatic neuropsychological state of alarm involving the cognitive appraisal of imminent threat or danger to the safety and security of an individual," whereas "Anxiety is a complex cognitive, affective, physiological, and behavioral response system (i.e., threat mode) that is activated when anticipated events or circumstances are deemed to be highly aversive because they are perceived to be unpredictable, uncontrollable events that could potentially threaten the vital interests of an individual" [26]. Therefore, fear and anxiety have a protective value of helping us deal with actual threats. However, in anxiety disorders, the patient's perceived threats may not be accurate, last longer than expected, while the threshold for perceived threats is lowered, and, therefore, the patient becomes hypersensitive to external stimuli. As a result, the response could be excessive compared to the severity of the perceived threat, while anxiety feels uncontrollable and significantly impairs functioning. Therefore, in the assessment of anxiety, the clinician has to evaluate the evidence for a realistic threat and the appropriateness and excessiveness of the patient's response to the perceived threat.

Generalized anxiety disorder (GAD) and phobias are the most common anxiety disorders in older adults [10, 27, 28], even though a number of older adults may experience clinically significant anxiety without any specific diagnosis [10]. The following section highlights the diagnoses of GAD, phobias, and panic disorder.

Generalized Anxiety Disorder

The critical features of GAD as described in DSM-5 [16] are (a) excessive and difficult to control anxiety or worry (apprehensive expectation), for more days than not, for at least 6 months, and (b) at least three or more of the following symptoms: (1) restlessness, (2) being

easily fatigued, (3) concentration difficulties, (4) irritability, (5) muscle tension, and (6) sleep disturbances [16]. Similar to other diagnoses in DSM-5, the symptoms must be severe enough to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning [16].

Specific Phobia

Specific phobia is characterized by “marked and persistent fear that is excessive and unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood)” [16]. The patient recognizes that his or her fear is excessive and unreasonable and avoids the phobic situation, as the exposure of the stimulus “almost invariably provokes an immediate anxiety response” [16].

Panic Disorder

As described in DSM-5, panic disorder is characterized by recurrent unexpected panic attacks; one of the attacks has been followed by at least 1 month of persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks [16]. Panic attacks are defined as “an intense period of fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 min: (a) palpitations, pounding heart, or accelerated heart rate; (b) sweating, (c) trembling or shaking, (d) sensations of shortness of breath or smothering, (e) feeling of choking, (f) chest pain or discomfort, (g) nausea or abdominal stress, (h) feeling dizzy, unsteady, lightheaded, or faint, (i) derealization (feelings of unreality) or depersonalization (being detached from oneself), (j) fear of losing control or going crazy, (k) fear of dying, (l) paresthesias (numbness or tingling sensations), and (m) chills or hot flushes” [16].

Agoraphobia

The DSM 5 now has separate diagnosis of panic disorder and agoraphobia, each with separate criteria. Agoraphobia is characterized by a fear of open spaces and avoidance of places or situations. The core symptoms require fear about multiple situations from across at least two distinct domains in which escape might be difficult (DSM 5) [16].

Diagnostic Considerations

Rule Out Other Diagnoses

The clinician needs to evaluate whether other mental disorders exist. For example, ruling out bipolar I and II disorders is critical because the pharmacological or psychological treatment of bipolar depression differs from that of unipolar depression. Geriatric bipolar disorder is relatively rare in the community, and its point prevalence rate is less than 0.5% [29]. However, 17% of older adults in psychiatric emergency rooms have bipolar disorder [29, 30]. Compared to young adults, fewer older bipolar patients have a diagnosis of substance abuse, and more have a cognitive disorder diagnosis (i.e., dementia, amnesia, and cognitive disorder NOS) [28].

Bipolar I is characterized by the occurrence of manic episodes, with or without MDEs [16]. However, bipolar I older patients usually have had one or more MDEs. Manic episode is defined as “a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)” [16]. During this period, the patient experiences three or more of the following symptoms (four if mood is only irritable): (a) inflated self-esteem or grandiosity, (b) decreased need for sleep (e.g., patient feels rested after only 3 h of sleep), (c) more talkative than usual or pressured speech, (d) flights of ideas or racing thoughts, (e) distractibility, (f) psychomotor agitation or increase in goal-directed activities, and (g) excessive involvement in pleasurable activities that

have a high potential for painful consequences (e.g., buying sprees, sexual indiscretions, or foolish business investments) [16]. The patient has significant impairment in occupational, interpersonal, or social functioning [16] that may require hospitalization. Because of the severity of the manic episodes, early-onset bipolar I disorder has been usually diagnosed before an older adult presents with psychiatric problems, while late-onset bipolar I disorder occurs only in a small minority of geriatric bipolar cases [31].

Bipolar II is characterized by the occurrence of MDEs and at least one hypomanic episode [16]. Hypomanic episode is of lesser severity and duration than a manic episode and is defined as "a distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood" [16]. During this period, the patient experiences three or more of the same symptoms described in the manic episode (four if mood is only irritable) [16]. According to the DSM-5 criteria, the hypomanic episode does not include psychotic features and is not severe enough to cause significant impairment in occupational, interpersonal, or social functioning or to necessitate hospitalization [16].

Substance Abuse

The use of alcohol, drug, or prescription medication needs to be evaluated. The clinician shall evaluate the amount and frequency of alcohol consumption and the use of possible illicit drugs and prescription medication. Special attention must be placed on the possible abuse of prescription medications as some of them may be addictive (e.g., medications for the treatment of anxiety or pain).

Evaluation of Medical Conditions and Medications

Certain medical conditions and medications may cause depression. Specifically, medical conditions, including thyroid abnormalities, deficiency of vitamin B12, lymphomas, and pancreatic cancer, are often associated with depression [4]. Moreover, steroids, anti-Parkinsonian drugs, and benzodiazepines may cause depression [4]. As noted in DSM-5, the symptoms of depression must not be "due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)." Treatment recommendations highlight that the medical condition may need to be treated first; however, there are cases that depression may not remit unless antidepressant medication treatment is prescribed [4].

Assessment of Depression and Anxiety

Accurate Diagnosis of Depression

During the first interview with the depressed older adult, the clinician must obtain the following information: present history of depression, onset of the current episode, precipitants of the current episode, past history of depression, current or past suicidal ideation, family history of depression and suicide attempts, history of antidepressant medication and psychotherapeutic treatments and outcomes, medical history, and list of psychiatric and nonpsychiatric medications.

The clinician needs to evaluate the onset of current and past depression episodes, explore any events that preceded these episodes, and evaluate the coping mechanisms that the patient used to deal with potential stressors. Helpful questions include: What were the precipitants of the episodes of depression? What were the most critical stressors that the patient experienced before the onset of depression? What were the coping mechanisms that the patient utilized? Which coping mechanisms were successful or unsuccessful?

As the clinician explores past and current depressive episodes, he or she needs to evaluate the patient's previous response to antidepressants or psychotherapies. The patient should also be asked to produce a list of all antidepressant medi-

cations (i.e., highest dosages, duration, and treatment response for each medication), a list of previous and current psychotherapeutic treatment (i.e., type of treatment, e.g., cognitive behavioral therapy, behavioral therapy, or problem-solving therapy; frequency and duration of treatment; and treatment response), and a list of any other treatments (e.g., electroconvulsive therapy). These lists may help the clinician to determine adequacy and response to antidepressant treatment. Finally, psychiatric hospitalizations, reasons for admissions, inpatient psychiatric treatments, and follow-up treatments should be discussed in detail.

Sometimes the patient's depression may not be easily recognized. Loss of interest and pleasure or depressed mood is cardinal symptoms of clinical depression. At least one of these two symptoms is required for the diagnosis of major depression. Therefore, a patient may suffer from depression even though he or she does not report depressed mood. In fact, many older adults report loss of interest or pleasure, as well as physical symptoms, in the absence of depressed mood. It is also important to recognize that depressed older adults may not necessarily use the words "depressed" or "sad," but rather "blue," "helpless," "hopeless," "apathetic," "disinterested," or "unmotivated." The clinician needs to evaluate the patient's words carefully and assess whether these words reflect clinical depression.

Assessment of Past or Present Suicide Ideation

The assessment of suicide ideation in older adults is critical as older adults have high suicide rates and use more lethal means to attempt suicide than younger adults. Older adults also suffer from increased disability, physical and functional impairment, pain, and interpersonal losses, all of which are risk factors for suicide. Because some older adults may not readily report psychiatric symptoms, the clinician needs to ask thorough questions to evaluate suicide risk.

Suicide ideation may be expressed in different ways, including passive (e.g., I wish I were dead) or active (e.g., I have thoughts of killing myself). Suicidal ideation usually covers a wide spectrum of thoughts and feeling, such as feelings that life is not worth living, wishes of being dead, thoughts of killing oneself but without intent or plan, thoughts of killing oneself with intent or plan, and thoughts of killing oneself with intent and plan. The stronger the degree of suicidal ideation, the higher the risk of suicide is.

Since hopelessness is associated with suicide ideation, the clinician should evaluate the degree of hopelessness and suicide ideation in past and current episodes of depression. Important questions include: What makes you feel hopeless? Have you recently felt (or have you ever felt) that life is not worth living? What parts of life are not worth living? What parts of life are worth living? How strong is your wish to live? Have you ever wished you were dead? Describe recent events that made you feel that life was not worth living or that you wished you were dead? Any specific event or stressor that precipitated these feelings? What went through your mind? Have you ever thought of hurting or killing yourself? If yes, have you thought about a specific plan? What kept you from doing anything to harm or kill yourself? Has there been a family history of suicide attempts?

The clinician needs to gather detailed information about past and recent suicide attempts. The patient may describe the sequence of events, as well as severity and duration of the suicide ideation that contributed to the suicide attempt. The goal of the clinician is to understand risky situations, to illuminate the hopeless thoughts that contributed to suicide ideation or suicide attempts, and to explore potential positive thoughts that have prevented the patient from harming or killing himself or herself. Access to firearms or to other potential lethal means (e.g., lethal doses of medication) must be evaluated during the interview of a patient at risk of suicide. In certain cases, to avoid risky access to firearms, the clinician may propose that firearms be removed from the patient's residence. Finally, the clinician may decide to hospitalize the patient if, after the evaluation, the clinician believes that the patient is a threat to himself or herself. In addition to suicide ideation, the clinician should also

evaluate whether the patient is a threat to hurt others or whether there is a history of violent outbursts and physical abuse.

Depression Versus Normal Fluctuation of Mood

Clinical depression is different from the normal "ups and downs" of everyday life in severity, duration, and its effect on the patient's functioning. Normal fluctuation of mood is usually not prolonged, is not as severe, and does not significantly impair functioning. Impairment in functioning is required for the diagnosis of clinical depression. Signs and symptoms of hopelessness, worthlessness, or excessive guilt are associated with clinical depression and are not typically part of normal mood fluctuations.

Complicated Grief

One of the most difficult situations in assessing depression and recommending treatment is when the sadness is associated with grief. In general, if the older adult's functioning is significantly impaired, psychotherapeutic or medication treatment is recommended. Because of the stigma attached to mental illness, the clinician needs to address the issue tactfully, recognizing that it is expected to experience sadness after the loss of a loved one. Grief-stricken patients may also experience an exaggerated sense of guilt when they feel pleasure, which may reinforce the vicious cycle of depression.

Accurate Diagnosis of Anxiety Disorders: Productive Anxiety Versus Unnecessary Worrying

Patients with anxiety disorders often present for the treatment of anxiety with the expectation of complete elimination of their anxiety symptoms. The clinician needs to discuss the potential benefit of anxiety to help the patient recognize that the goal of treatment may not be the elimination of anxiety per se, but rather learning techniques to effectively deal with excessive and uncontrollable anxiety or worrying. Moderate levels of anxiety may also be a motivating factor and become a productive force.

The interview may illuminate areas of worrying, degree and duration of worrying, and its impact on the patient's functioning. It is important for the clinician to understand the patient's fears and explore his or her "catastrophic" predictions that are the basis for their anxiety or worrying. Finally, patients with anxiety may either avoid situations that produce anxiety (e.g., a patient may avoid going out because he is concerned that he may have an anxiety attack) or focus extensively (obsess) on situations that trigger anxiety (e.g., a patient is obsessively worried about her health).

Differentiating Obsessive Anxiety and Overvalued Ideas from Delusions

The clinician needs to assess whether the patient's obsessive concerns, anxiety, or overvalued ideas are reaching psychotic proportions. For example, a patient believes that she has cancer in the absence of any medical data to support her conviction. Questions that may help the clinician make the differential diagnosis include: (a) How convinced are you that you have cancer? (b) Do you feel relieved that the physicians have confirmed that there is no evidence of cancer? (c) Do you see any alternative explanation for your pain other than cancer? Nondelusional depressed patients usually recognize that their thoughts are exaggerated, but they may not be able to reduce its effect [4]. In addition to astute questioning, the Delusional Assessment Scale for psychotic depression may help the clinician measure the intensity of delusional beliefs [32].

The Use of Formal Measures in the Assessment of Depression and Anxiety

Certain questionnaires may be helpful in identifying symptoms of depression and anxiety. These measures are not necessarily used to diagnose

clinical depression but rather help the clinician identify symptoms of depression and assess their severity. Both clinician-administered and self-report measures may be administered. Clinician-administered rating scales include Hamilton Rating Scale for Depression and Montgomery-Asberg Depression Rating Scale [33]; both may be used for patients with mild cognitive impairment. Depression in patients with dementia may be evaluated with the Cornell Scale for Depression in Dementia [34], a measure which calculates a composite score based on reports from both the patients and their caregivers. Self-report questionnaires include the Beck Depression Inventory [35] and Geriatric Depression Scale [36]. Measures that may capture anxiety symptoms also include self-report (e.g., Beck Anxiety Inventory [37]) or clinician administered (e.g., Hamilton Scale for Anxiety [38]).

Involvement of Caregiver

The clinician should encourage the participation of an available and willing caregiver in the assessment process. The caregiver may be a spouse, partner, child, sibling, other family member, or an aide. If the patient does not think that the involvement of caregiver is necessary or helpful, the therapist may try to understand the reasons for the patient's reluctance (e.g., beliefs that this may be burdensome to the caregiver, tension between the patient and the caregiver, caregiver is not involved significantly in the patient's care, etc.). The clinician may explore whether these reasons may contribute to or affect patient's depression.

Caregiver participation in the assessment process may prove to be important and at times necessary. The caregiver may help in identifying periods of depression, illuminate the patient's behavior when he or she is depressed, and highlight patient's cognitive, physical, and functional limitations. This is particularly important in patients with cognitive impairment, as obtaining information from a collateral source is necessary when patients are not good historians, have advanced cognitive impairment, or may lack insight into their difficulties.

Assessment of Disability

Depression may contribute to disability, and disability may precipitate the onset of depression. Furthermore, improving functioning and reducing disability may mediate reduction in depression [39]. Because of the reciprocal relationship of depression and disability, a careful assessment of patient's depression, disability, and everyday functioning is strongly recommended. Specifically, the clinician needs to evaluate the patient's physical and functional limitations and assess their performance in activities of daily living. Activities of daily living may be divided into instrumental activities of daily living (e.g., taking medication, walking a short distance, shopping for groceries, using the telephone, paying bills, doing housework and handyman work, doing laundry, preparing meals) or basic activities of daily living (e.g., bathing, eating, combing hair). The clinician may explore whether the patient was performing these activities before the onset of their depression, whether depression has affected the patient's performance in activities of daily living, or whether the patient *is able* to perform these activities with or without help. In addition to careful questioning, the clinician may administer instruments that evaluate a patient's functioning and disability such as the Philadelphia Multiphasic Assessment Instrument (MAI) [40] or the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) [41].

Clinical Pearls

- Clinical depression is different from the normal fluctuation of depressed mood in the severity of symptoms, their duration, and most importantly, the patient's impairment in his or her everyday functioning.
- Depressed older adults may exhibit lack of interest or pleasure and physical symptoms rather than depressed mood. This is one of the reasons late-life depression is underrecognized.
- The clinician should be aware that the patient may not report sadness or depression per se, but

may report “discouragement,” “lack of energy,” “blue feeling,” or “lack of motivation.”

- Depressed elders may display “dementing” symptoms during their depression; sometimes, these symptoms subside when the depression remits. This phenomenon is called “pseudodementia” or “reversible dementia.” Depression may also be a prodromal state of dementia.
- A thorough neuropsychological examination is recommended for depressed elders who present with cognitive difficulties.
- Treatment for complicated grief is recommended when the patient’s functioning is significantly impaired.
- The clinician needs to thoroughly evaluate hopelessness given its strong correlation with suicide risk, past and present suicide ideation and attempts, and family history of suicide. Risky access to firearms or to other potential lethal means must be evaluated during the interview of a patient at risk of suicide.
- In the assessment of anxiety, the clinician has to evaluate the evidence for a realistic threat and the appropriateness and excessiveness of the patient’s response to the perceived threat.

References

1. Katon W, Schulberg H. Epidemiology of depression in primary care. Gen Hosp Psychiatry. 1992; 14(4):237–47.
2. Bruce ML, McAvay GJ, Raue PJ, Brown EL, Meyers BS, Keohane DJ, Jagoda DR, Weber C. Major depression in elderly home health care patients. Am J Psychiatry. 2002;159(8):1367–74.
3. Katz IR. On the inseparability of mental and physical health in aged persons: lessons from depression and medical comorbidity. Am J Geriatr Psychiatry. 1996;4:1–6.
4. Alexopoulos GS, Kelly RE Jr. Research advances in geriatric depression. World Psychiatry. 2009;8:140–9.
5. Pampallona S, Bollini P, Tibaldi G, Kupelnick B, Munizza C. Patient adherence in the treatment of depression. Br J Psychiatry. 2002;180:104–9.
6. Conwell Y, Van Orden K, Caine E. Suicide in older adults. Psychiatr Clin North Am. 2011;34(2):451–68.
7. Rubenowitz E, Waern M, Wilhelmson K, Allebeck P. Life events and psychosocial factors in elderly suicides—a case-control study. Psychol Med. 2001;31(7):1193–202.
8. Duberstein PR, Conwell Y, Conner KR, Eberly S, Caine ED. Suicide at 50 years of age and older: perceived physical illness, family discord and financial strain. Psychol Med. 2004;34(1):137–46.
9. Conwell Y, Duberstein PR, Hirsch JK, Conner KR, Eberly S, Caine ED. Health status and suicide in the second half of life. Int J Geriatr Psychiatry. 2009;25(4):371–9.
10. Ayers CR, Sorrell JT, Thorp SR, Wetherell JL. Evidence-based psychological treatments for late-life anxiety. Psychol Aging. 2007;22:8–17.
11. Lenze EJ. Comorbidity of depression and anxiety in the elderly. Curr Psychiatry Rep. 2003;5:62–7.
12. Driscoll HC, Karp JF, Dew MA, et al. Getting better, getting well: understanding and managing partial and non-response to pharmacological treatment of non-psychotic major depression in old age. Drugs Aging. 2007;24:801–14.
13. Andreescu C, Lenze EJ, Dew MA, et al. Effect of comorbid anxiety on treatment response and relapse risk in late-life depression: controlled study. Br J Psychiatry. 2007;190:344–9.
14. Greenlee A, Karp JF, Dew MA, et al. Anxiety impairs depression remission in partial responders during extended treatment in late-life. Depress Anxiety. 2010;27:451–6.
15. Andreescu C, Lenze E, Mulsant B, et al. High worry severity is associated with poorer acute and maintenance efficacy of antidepressants in late-life depression. Depress Anxiety. 2009;26:266–72.
16. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition(DSM-5). Washington, DC: American Psychiatric Association; 2013.
17. Meyers BS, Klimstra SA, Gabriele M, Hamilton M, Kakuma T, Tirumalasetti F, Alexopoulos GS. Continuation treatment of delusional depression of older adults. Am J Geriatr Psychiatry. 2001;9:415–22.
18. Maj M, Pirozzi R, Magliano L, Fiorillo A, Bartoli L. Phenomenology and prognostic significance of delusions in major depressive disorder: a 10-year prospective follow-up study. J Clin Psychiatry. 2007;68(9):1411–7.
19. Vythilingam M, Chen J, Bremner JD, Mazure CM, Maciejewski PK, Nelson JC. Psychotic depression and mortality. Am J Psychiatry. 2003;160(3):574–6.
20. Wilson KC, Chen R, Taylor S, McCracken CF, Copeland JR. Socio-economic deprivation and the prevalence and prediction of depression in older community residents. The MRC-ALPHA study. Br J Psychiatry. 1999;175:549–53.
21. Lockwood KA, Alexopoulos GS, Kakuma T, van Gorp WG. Subtypes of cognitive impairment in depressed older adults. Am J Geriatr Psychiatry. 2000;8:201–8.
22. Kindermann SS, Kalayam B, Brown GG, Burdick KE, Alexopoulos GS. Executive functions and P300 latency in elderly depressed patients and control subjects. Am J Geriatr Psychiatry. 2000;8:57–65.
23. Alexopoulos GS, Meyers BS, Young RC, Mattis S, Kakuma T. The course of geriatric depression

with "reversible dementia": a controlled study. Am J Psychiatry. 1993;150:1693–9.
24. Olin JT, Katz IR, Meyers BS, Schneider LS, Lebowitz BD. Provisional diagnostic criteria for depression of Alzheimer disease: rationale and background. Am J Geriatr Psychiatry. 2002;10(2):129–41. Review. Erratum in: Am J Geriatr Psychiatry 2002 May–Jun;10(3):264
25. Olin JT, Schneider LS, Katz IR, Meyers BS, Alexopoulos GS, Breitner JC, Bruce ML, Caine ED, Cummings JL, Devanand DP, Krishnan KR, Lyketsos CG, Lyness JM, Rabins PV, Reynolds CF 3rd, Rovner BW, Steffens DC, Tariot PN, Lebowitz BD. Provisional diagnostic criteria for depression of Alzheimer disease. Am J Geriatr Psychiatry. 2002;10(2):125–8.
26. Clark DA, Beck A. Cognitive therapy of anxiety disorders. New York: The Guilford Press; 2010.
27. Beekman AT, Bremmer MA, Deeg DH, Van Balkom AM, Snut JH, De Beurs E, et al. Anxiety disorders in later life: a report from the longitudinal aging study Amsterdam. Int J Geriatr Psychiatry. 1998;13:717–26.
28. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62:593–602.
29. Sajatovic M, Chen P. Geriatric bipolar disorder. Psychiatr Clin North Am. 2011;34(2):319–33.
30. Depp CA, Lindamer LA, Folsom DP, et al. Differences in clinical features and mental health service use in bipolar disorder across the lifespan. Am J Geriatr Psychiatry. 2005;13(4):290–8.
31. Sajatovic M, Blow FC, Ignacio RV, et al. New-onset bipolar disorder in later life. Am J Geriatr Psychiatry. 2005;13(4):282–9.
32. Meyers BS, English J, Gabriele M, Peasley-Miklus C, Heo M, Flint AJ, Mulsant BH, Rothschild AJ. STOP-PD study group. A delusion assessment scale for psychotic major depression: reliability, validity, and utility. Biol Psychiatry. 2006;60(12): 1336–42.
33. Montgomery SA, Asberg M. A new depression scale designed to be sensitive to change. Br J Psychiatry. 1979;134:382–9.
34. Alexopoulos GS, Abrams RC, Young RC, Shamoian CA. Cornell Scale for depression in dementia. Biol Psychiatry. 1988;23(3):271–84.
35. Beck AT, Steer RA, Brown GK. Manual for Beck Depression Inventory II (BDI-II). San Antonio, TX: Psychology Corporation; 1996.
36. Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. In: Brink TL, editor. Clinical gerontology: a guide to assessment and intervention. New York: The Haworth Press; 1986. p. 165–73.
37. Beck AT, Steer RA. Beck anxiety inventory manual. San Antonio, TX: The Psychological Corporation Harcourt Brace & Company; 1993.
38. Hamilton M. The assessment of anxiety states by rating. Br J Med Psychol. 1959;32:50–5.
39. Alexopoulos GS, Raue PJ, Kiosses DN, Mackin RS, Kanellopoulos D, McCulloch C, Areán PA. Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction: effect on disability. Arch Gen Psychiatry. 2011;68(1):33–41.
40. Lawton MP, Moss M, Fulcomer M, Kleban MH. A research and service oriented multilevel assessment instrument. J Gerontol. 1982;37(1):91–9.
41. Ustun B, Kostnjesek N, Chatterji S, Rehm J & World Health Organization. Measuring health and disability: manual for WHO Disability Assessment Schedule (WHODAS 2.0)/edited by Üstün, N. Kostanjsek, S. Chatterji, J. Rehm. Geneva: World Health Organization (2010).