Silent Battles: The Reality of Depression and Anxiety in Older Adults

Understanding prevalence, comorbidities, & intervention strategies

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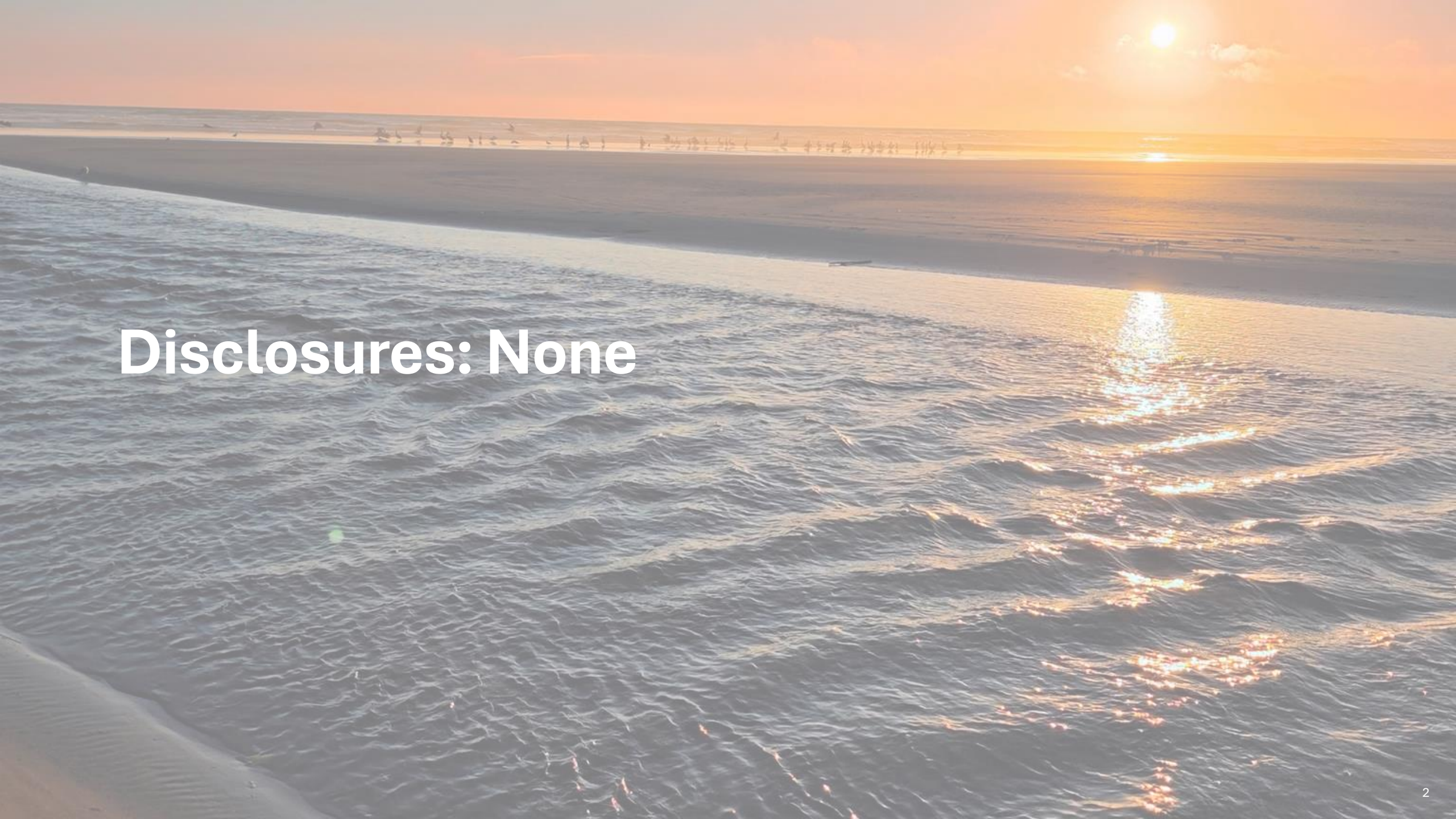
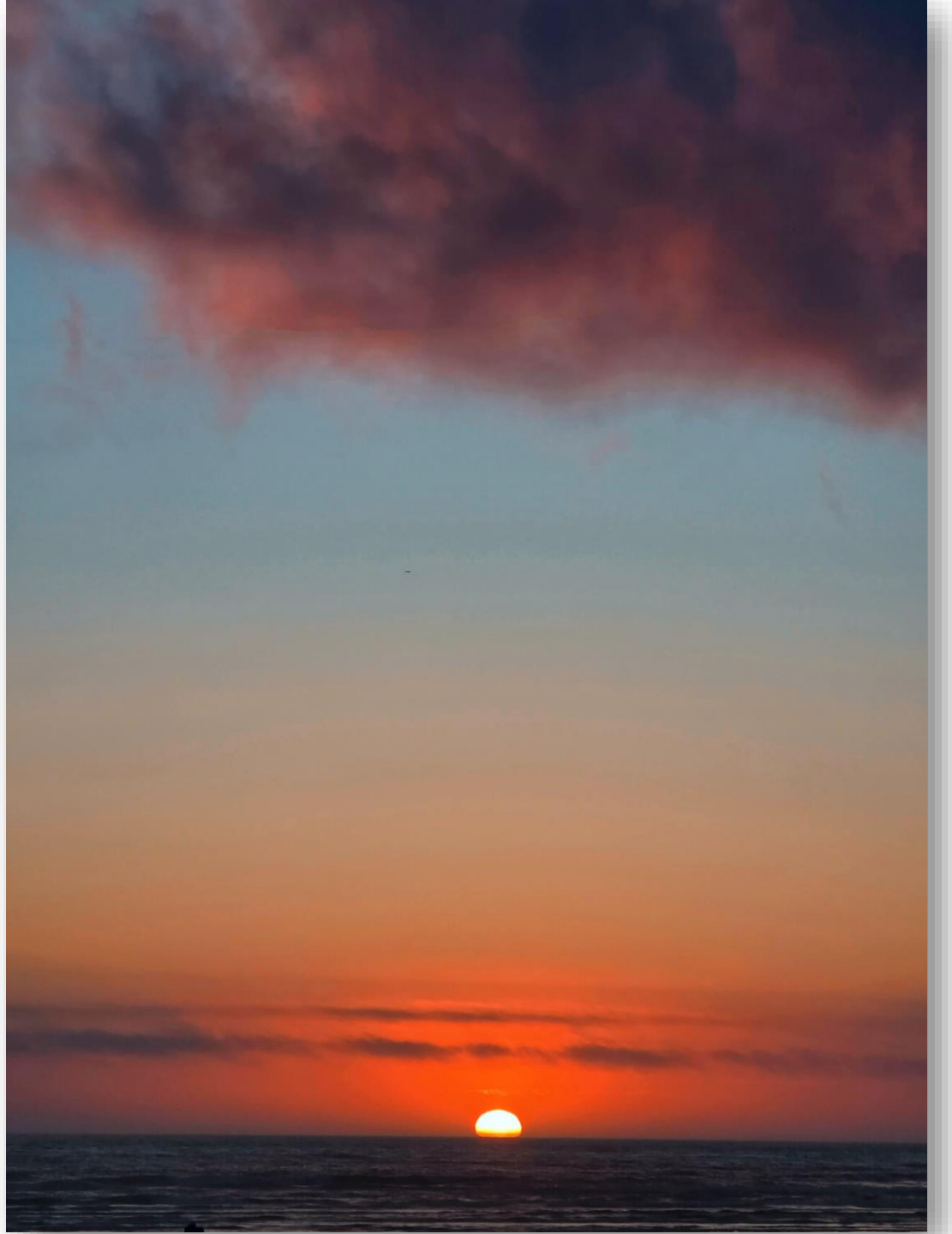


Disclosures: None



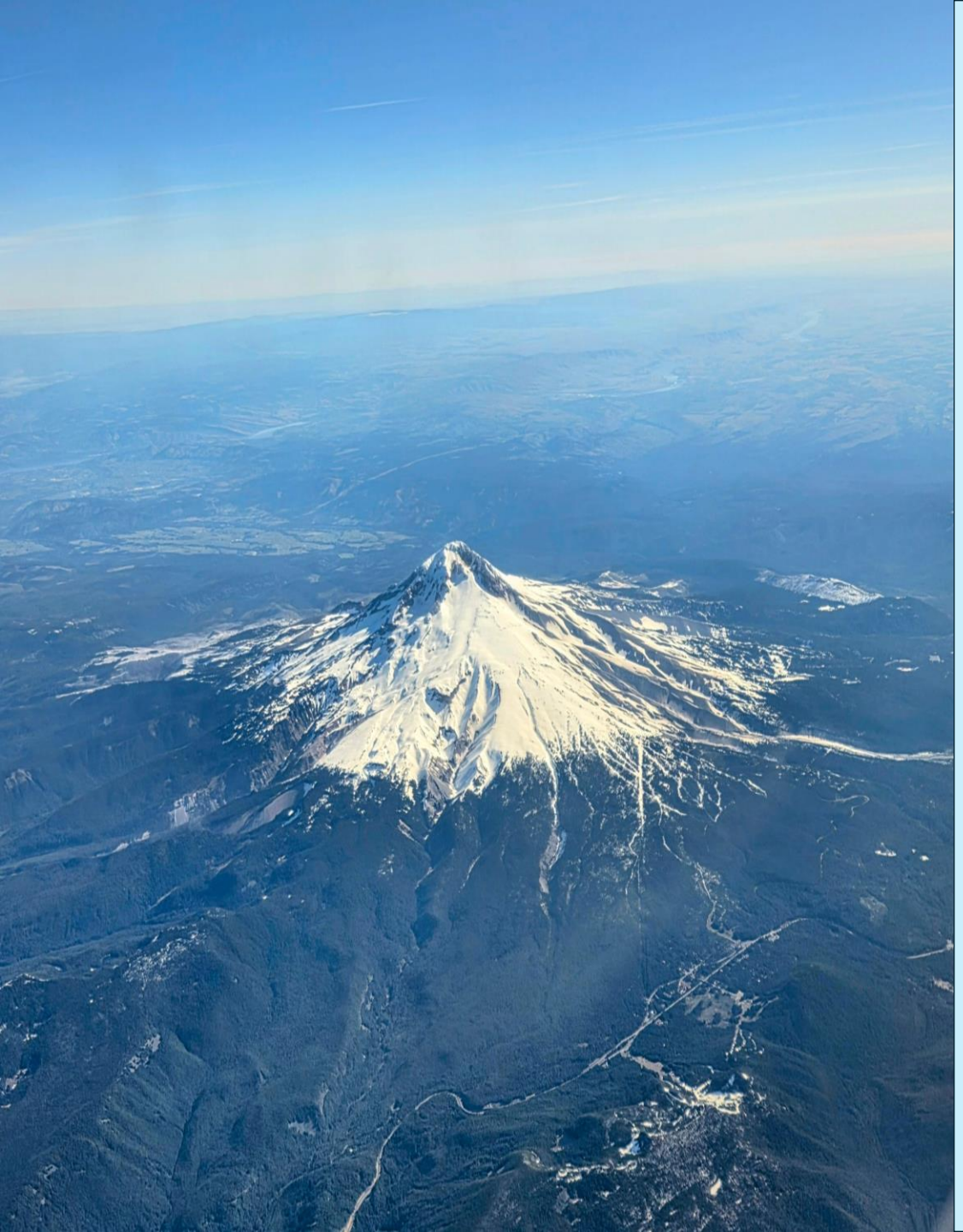
Learning Objectives:

1) Highlight the prevalence and impact of depression and anxiety among older adults.
2) Describe common signs and symptoms associated with depression and anxiety caused by substance abuse in older adults.
3) Discuss evidence-based strategies and interventions for managing and treating depression and anxiety in older adults related to social isolation.

Jesse: An unseen struggle

Patient Profile:

- 76-year-old male, retired widower
- Found on the floor of his home by daughter (unsure how long down)
- Brought to clinic for evaluation after the fall
- Lives alone; daughter visits weekly



"Usual" Approach to a Fall in Primary Care

Jesse and his daughter sit in waiting area ~ 30 min before they are roomed

Hallway is ~50 feet long – Jesse is a bit winded by the time he enters the room, "drops" into chair

Routine seated vitals done by MA within 2 min of Jesse sitting down, BP 155/80, P 76

He & daughter attest "no med changes since last visit;" MA exits to get PCP

Exam unremarkable, no injuries from fall noted beyond mildly sore R shoulder but ROM grossly intact

Jesse's lisinopril *increased* slightly for his not-at-goal BP

He's asked to keep a BP log (*he isn't sure what this means*) and call nurse in 2 weeks

Outpatient PT ordered for sore R shoulder

Visit wrapped up in 20 min., daughter can view full note in patient facing chart by the time they return to their car

???

Let’s Try A Different Approach...

Initial Clinical Findings

Medical History:

- Hypertension, osteoarthritis
- No major cognitive complaints
- Vitals and neuro exam normal

Clinical Clues:

- Mild dehydration
- Flat affect, disheveled appearance
- No clear fall mechanism
- Daughter unaware of any issues

Social History & Psychosocial Clues

Key Findings:

- Lives alone since wife died 3 years ago
- “Not much going on” socially; little engagement since pandemic (*5 years ago*)
- Admits to nightly alcohol use: ~½ bottle of whiskey
- Increasing isolation and poor sleep

Daughter’s Input:

- “He’s always been very independent”
- Notes withdrawal and “slowing down” over past year, was never really the outgoing type

NOW What are You Going to Do?????

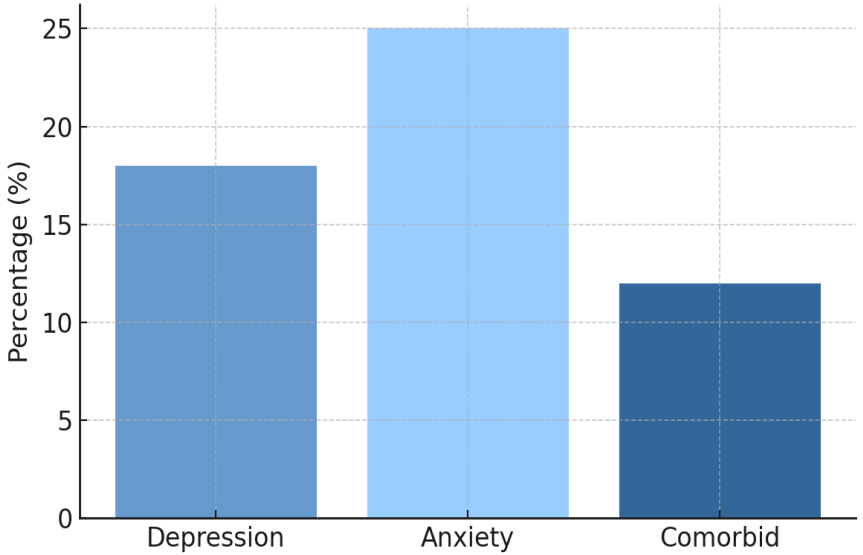
Scope of the Problem

- Depression is leading cause of disability-adjusted life years lost across lifespan.
- 15–20% of older adults experience depression; 15–40% report anxiety.
- **47–50% of older adults with depression have comorbid anxiety**.
- Mixed anxiety-depression is common but often overlooked:
  - Stigma
  - Misdiagnosis
  - Normalization of symptoms

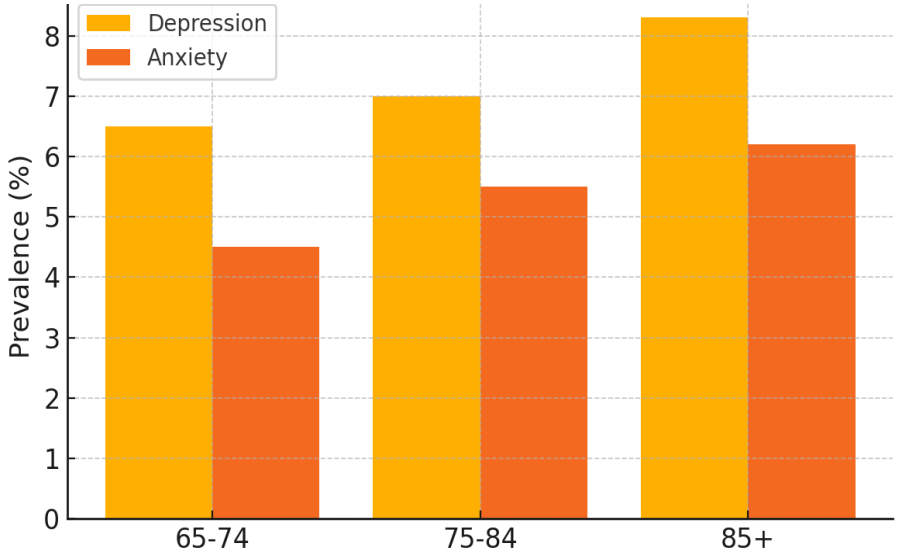
Prevalence of Depression & Anxiety in Older Adults

- Isolated depression: ~14-18% prevalence
- Isolated anxiety: ~11-24% prevalence
- Half of all cases depression diagnosed > 60 yrs are index cases; prevalence ↑ w/ age
- Highest prevalence in those with chronic illness, functional decline or recent loss

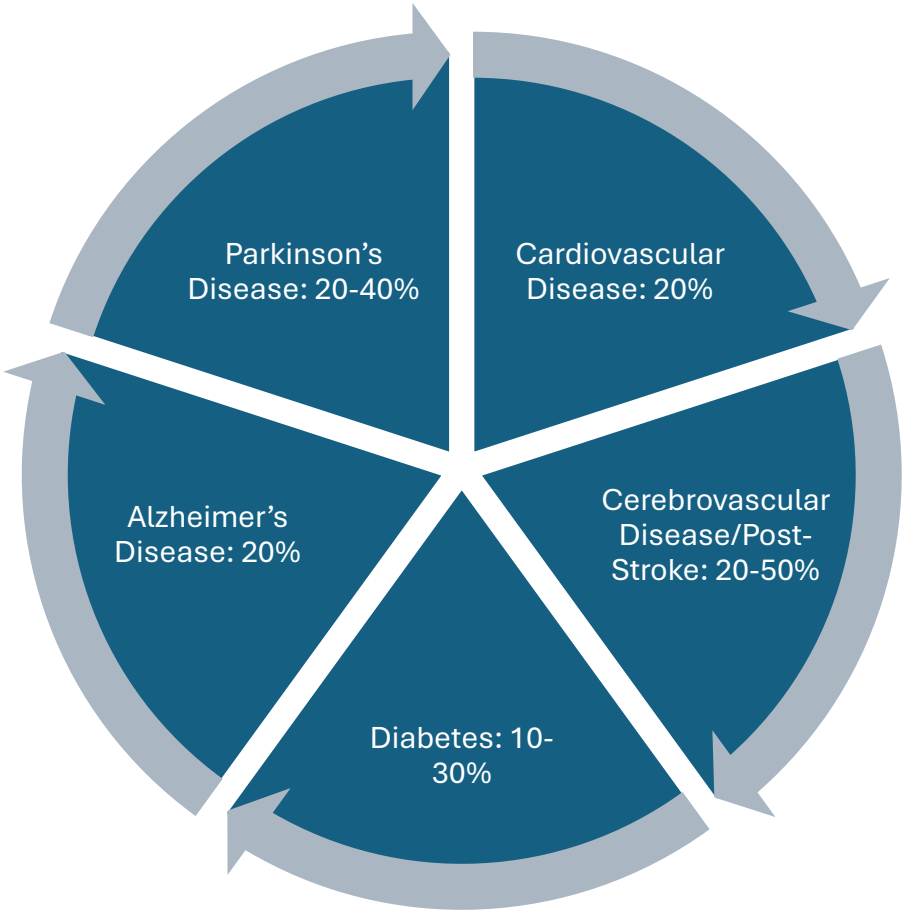
Prevalence Depression and Anxiety in Older Adults



Prevalence Depression and Anxiety by Age Group



Depression Prevalence in Comorbid Conditions



Risk Factors for Later-Life Depression

Past history of depression

Family history

Medical comorbidities/burden of illnesses

Psychosocial

- Physical loss
- Environmental Challenges
- Financial Worries
- Loss/lack of social support

Caregiver burden

Impacts on Health and Functioning

Minor depression ("other specified depressive disorder" in *DSM-5*): presence of **depressed mood with 2 or 3 additional symptoms** of major depressive disorder

- **15%** of older people (range 8% to >40%)
- **Associated with ↑ use of health care costs** (25%), **excess suffering & disability, poor health outcomes, including ↑ mortality** (30%)

Major depressive disorder: presence of depressed mood or anhedonia with 4 additional symptoms for 2+ weeks

- **1-2%** in community at large, but…
  - **6%–10%** of older adults in primary care clinics
  - **12%–20%** of nursing home residents
  - **11%–45%** of hospitalized older adults

- Older adults more apt to endorse somatic symptoms than "depressed mood."
- Prevalence increases with medical complexity & functional decline.
- Increased rates of depression found among older adults in health care facilities and inpatient settings.

Somatic Symptoms

- 50% will DENY sadness
- Many will exhibit only anxiety, anhedonia or irritability
- Nearly 2/3 will present only with exacerbated somatic & pain symptoms
- Social withdrawal leading to overt neglect of self +/- home
- Psychotic depression*


Change in appetite or weight


Sleep alterations


Low/decreased energy


Psychomotor agitation or retardation


Inability to concentrate or make decisions

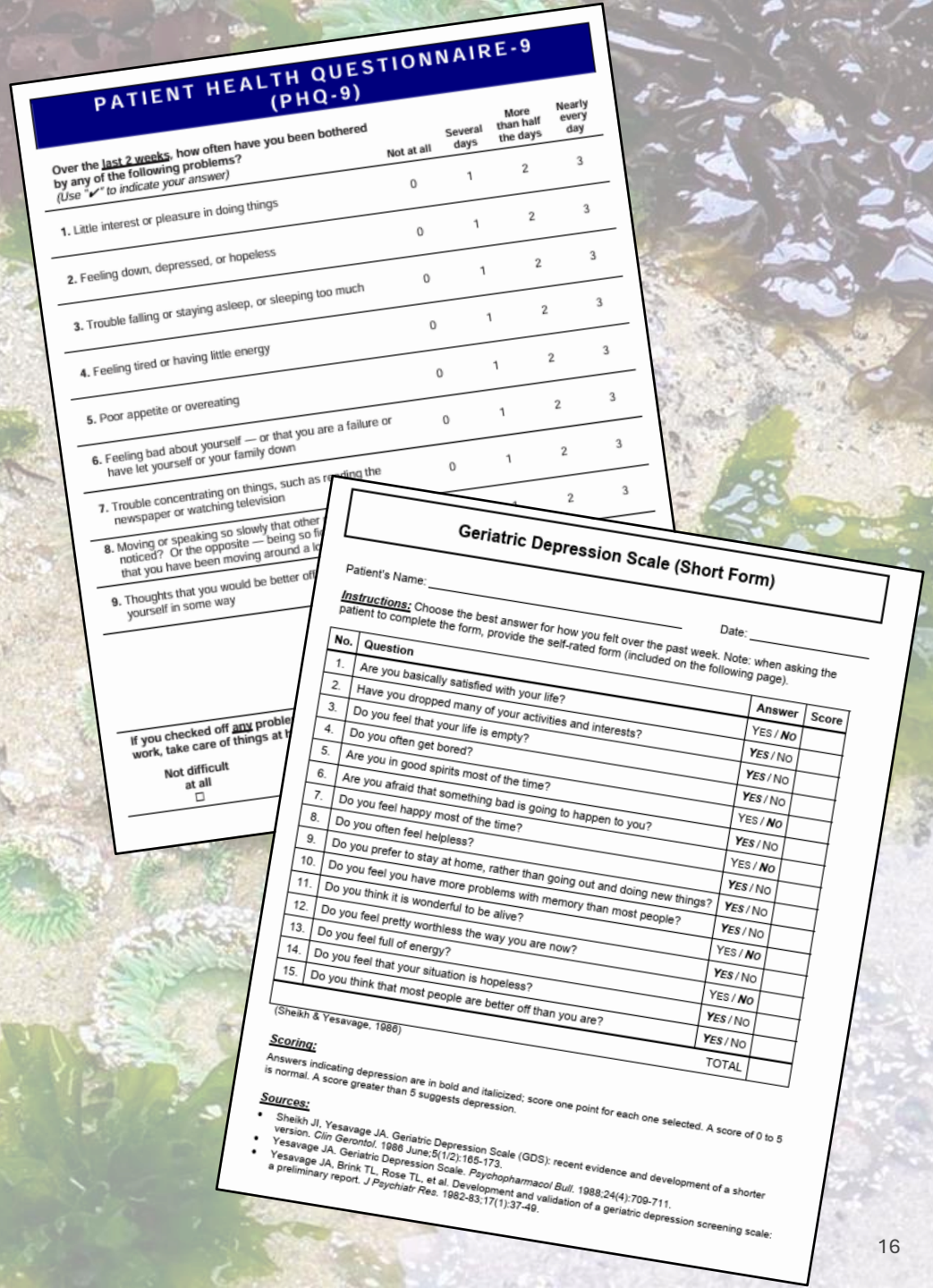

Feelings of guilt, worthlessness, helplessness


Suicidal ideation

Depression Screening

- **9-Item Patient Health Questionnaire (PHQ-9)**
  - Covers MDD diagnostic criteria
  - Initial 2 questions (PHQ-2) can be used for quick screening
  - Any endorsement of “would be better off dead” or “thoughts of self harm” → ask about firearms!
  - Can be done serially to assess treatment response

- **15-Item Geriatric Depression Scale (GDS)**
  - Does not inquire about sleep or somatic symptoms
  - Lacks question(s) about suicidal ideations
  - Not used for assessing downstream response



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other noticed? Or the opposite — being so fi that you have been moving around a lo				
9. Thoughts that you would be better off yourself in some way				

If you checked off any proble work, take care of things at h

Not difficult at all ☐

Geriatric Depression Scale (Short Form)

Patient's Name: Date:

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / ***NO***	
2.	Have you dropped many of your activities and interests?	***YES*** / NO	
3.	Do you feel that your life is empty?	***YES*** / NO	
4.	Do you often get bored?	YES / ***NO***	
5.	Are you in good spirits most of the time?	***YES*** / NO	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	
8.	Do you often feel helpless?	***YES*** / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / ***NO***	
10.	Do you feel you have more problems with memory than most people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	***YES*** / NO	
12.	Do you feel pretty worthless the way you are now?	YES / ***NO***	
13.	Do you feel full of energy?	***YES*** / NO	
14.	Do you feel that your situation is hopeless?	YES / ***NO***	
15.	Do you think that most people are better off than you are?	***YES*** / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)

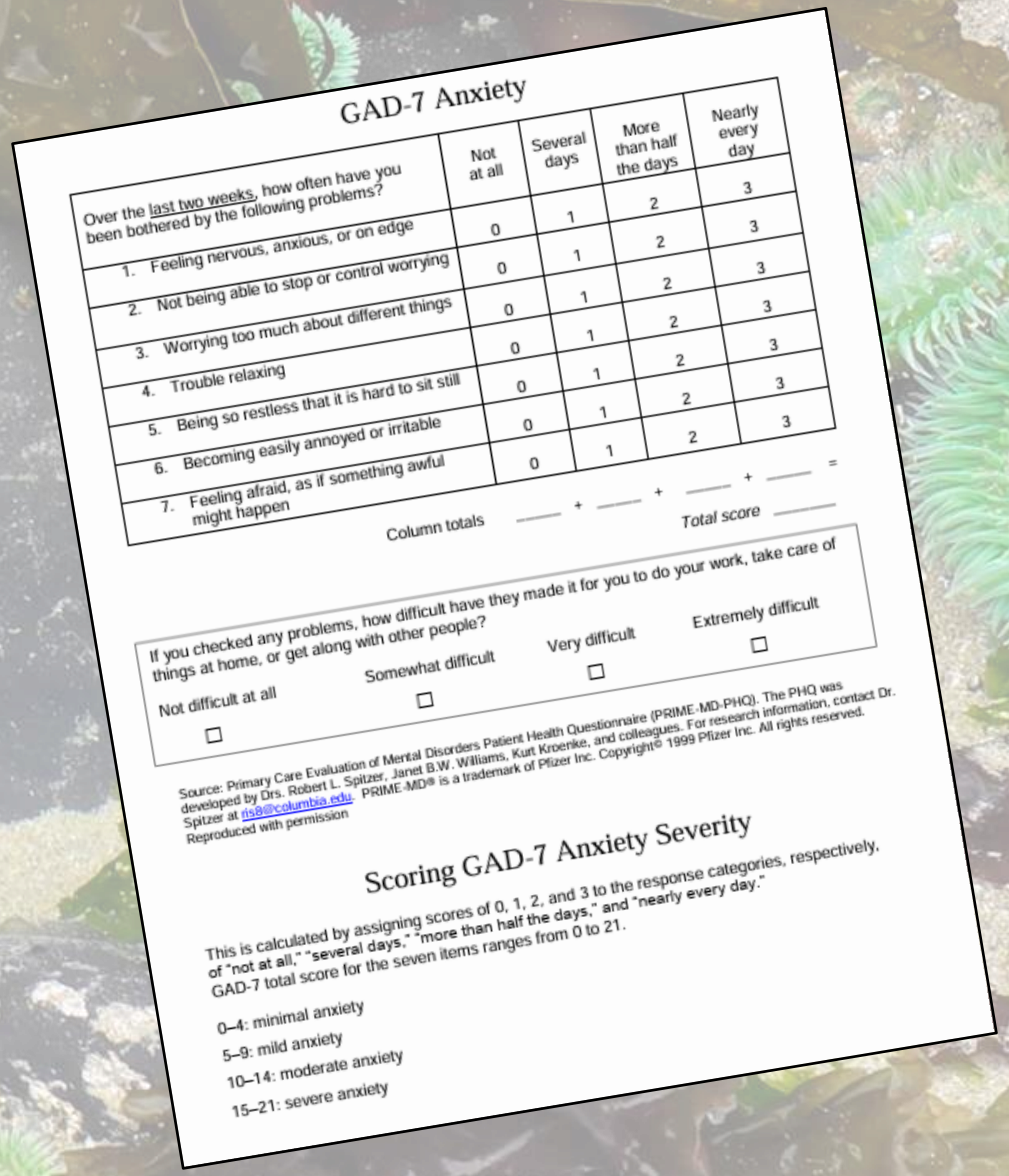
Scoring:

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

Sources:

- Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. *Clin Gerontol*. 1986 June;5(1/2):165-173.
- Yesavage JA. Geriatric Depression Scale. *Psychopharmacol Bull*. 1988;24(4):709-711.
- Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res*. 1982-83;17(1):37-49.

Anxiety Screening



GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Column totals	____ +	____ +	____ +	____ =
				Total score ____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety
5–9: mild anxiety
10–14: moderate anxiety
15–21: severe anxiety

- **7-Item Generalized Anxiety Disorder (GAD-7)**
  - Covers generalized anxiety diagnostic criteria
  - Measures anxiety severity
  - Most appropriate in outpatient setting
  - GAD = most prevalent anxiety disorder in primary care

Mental Health and Cognition

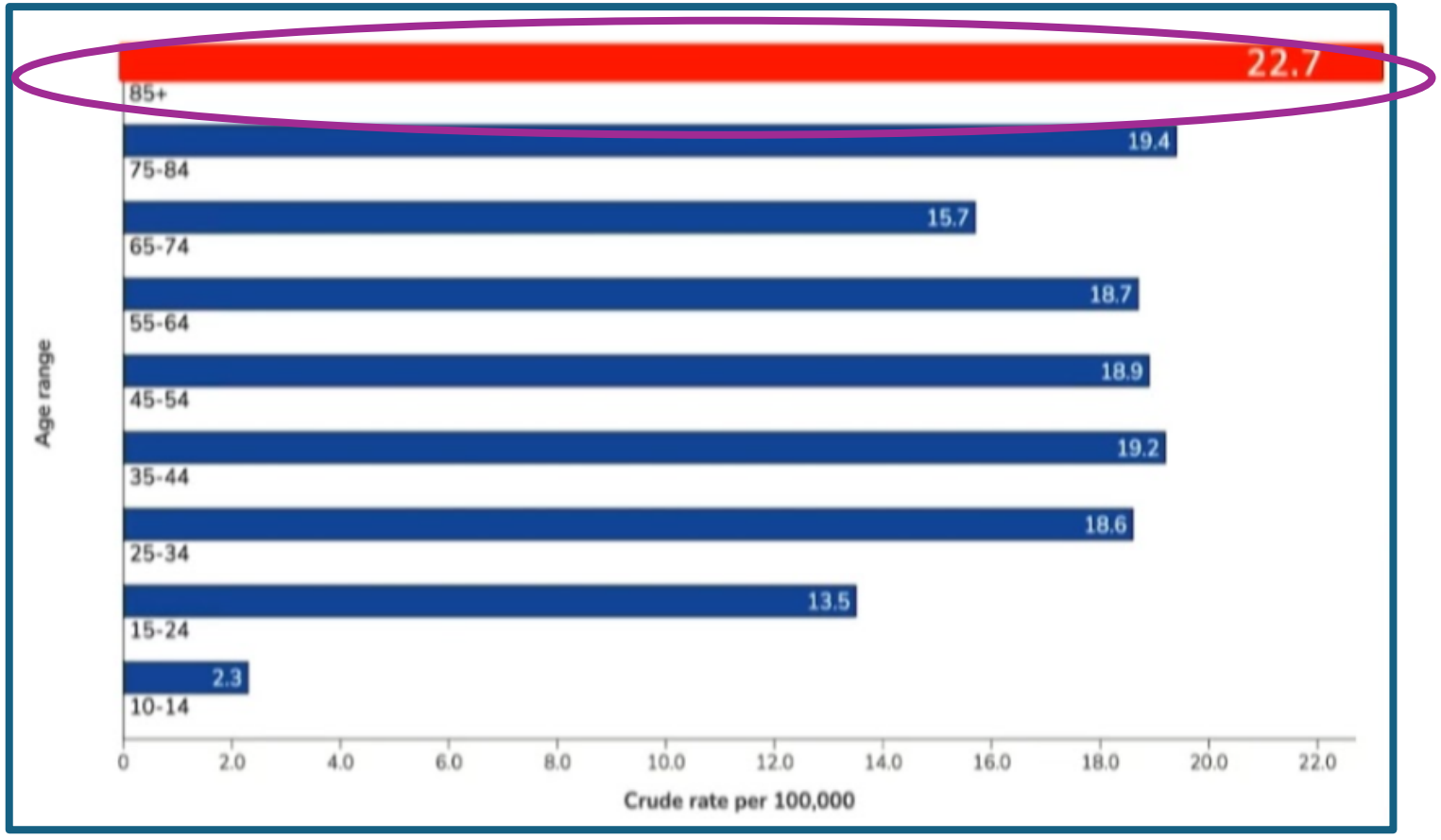
Untreated depression can:

- Impair cognition & increase risk for dementia (1.5-4X risk dementia)
- Lead to a dementia misdiagnosis / reversible cause of dementia
- Decrease medication adherence, worsening comorbid disease outcomes
- Lead to tricky diagnosis, as depression & anxiety symptoms often overlap with comorbid conditions
- Be a risk factor for suicide…highest rates men > 85 yrs

Suicide

- Most catastrophic complication
- Many common risk factors:
  - **Depression**/prior attempts
  - **Substance abuse/dependence**
  - Physical illness
  - Functional decline + loss of independence
  - Uncontrolled pain
  - Terminal illness
  - Economic problems
  - **Social isolation & loneliness**
  - Loss of life partner
  - **Anxiety**

Suicide Rates by Age in 2023



Suicide Statistics in Late Life Depression (65+)

Over 10,000 die by suicide **every year.**

Approximately 28 die by suicide **every day.**

More than 1 die by suicide **every hour.**

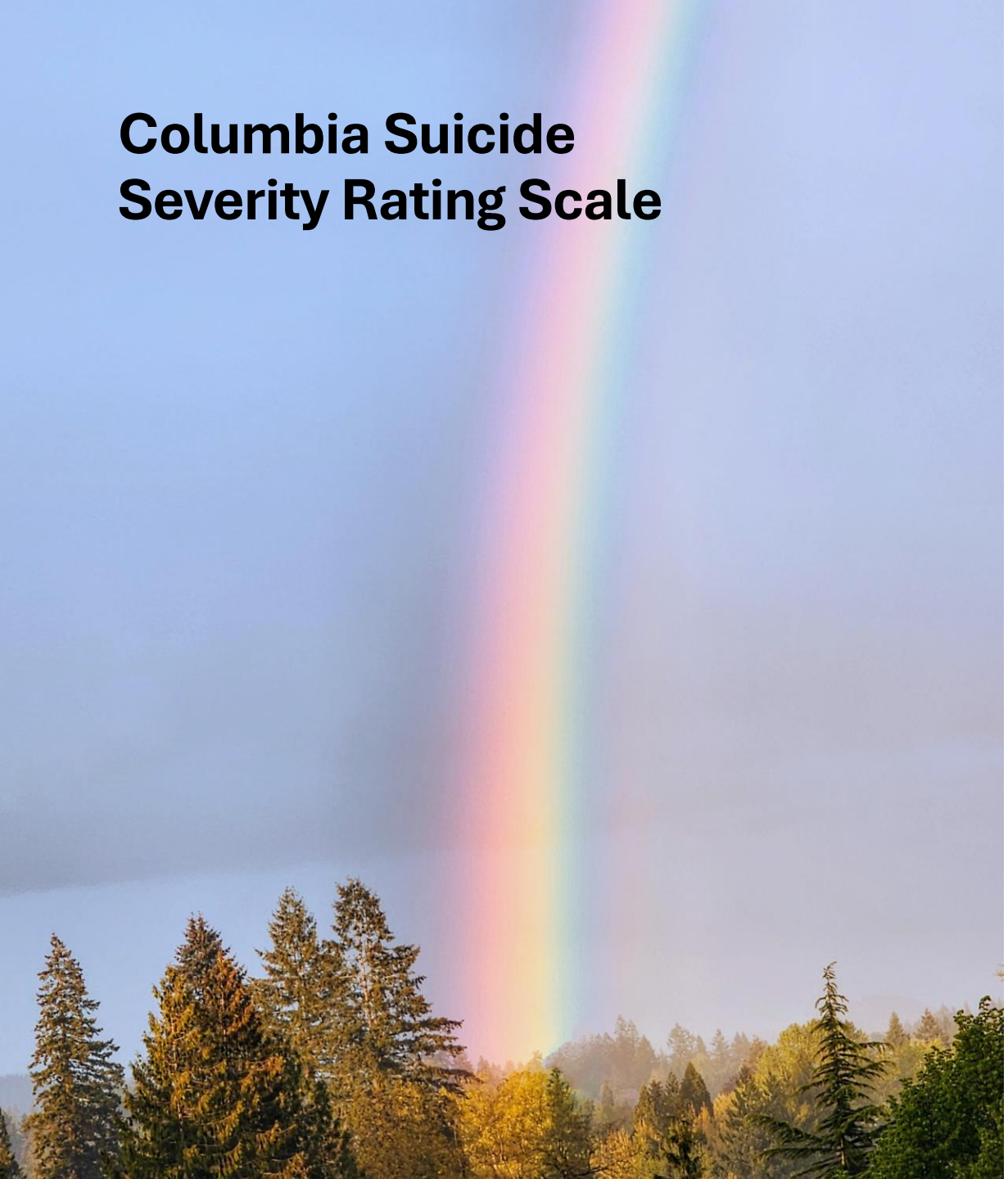
2/3 had seen PCP in the **last month.**

1/2 had seen PCP in the **last week.**

WE CAN, AND MUST, DO BETTER.

CDC 2023 suicide rates
National Council on Aging 2022 suicide statistics
Conwell Y & Thompson C PCNA 2008.

Columbia Suicide Severity Rating Scale



Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		High Risk

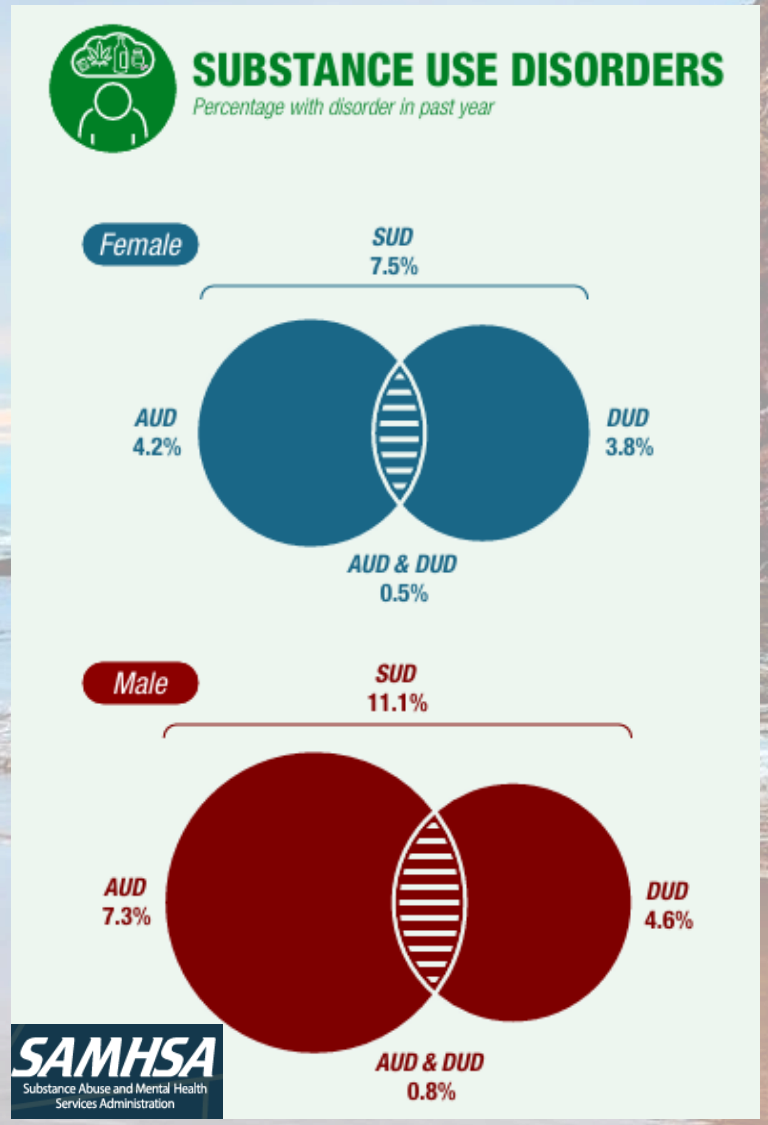
988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Substance Use Disorders (SUD) & Mental Health in Older Adults



7.1 million older adults with SUD in 2022 (9.1%)

- 4.4 million AUD (5.6%)
- 3.2 million DUD (4.1%)
- Males 1.5 X as likely than female counterparts for SUD

Associated with prescription drug misuse (e.g., benzodiazepines, opioids):

- 1 in 50 with OUD
- 1 in 25 with DUD

Often used as an attempt at self-medication for sleep, pain, or emotional distress

Dual diagnosis often missed!

Rising trend due to aging baby boomer generation

Alcohol Use in Older Adults: *One Month's Data* in 2022

10 million engaged in binge drinking (12.8%)

- 1 in 7 males
- 1 in 10 females

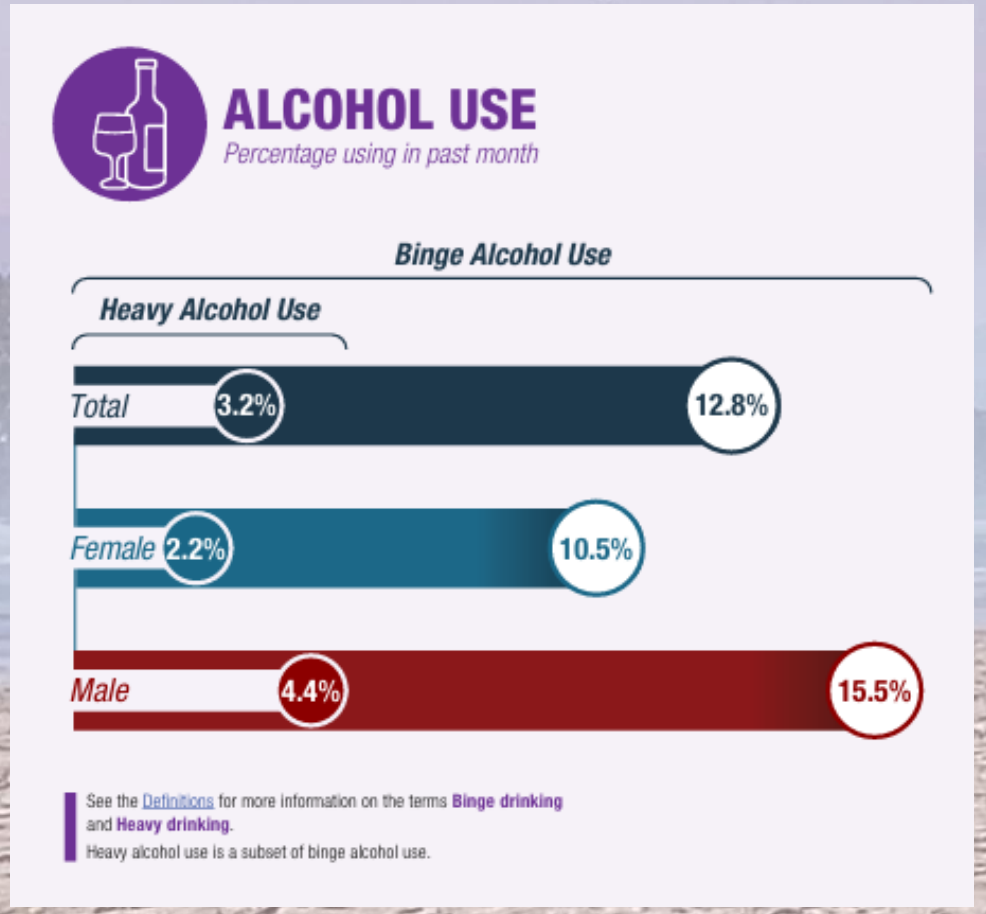
2.5 million engaged in heavy drinking (3.2%)

- Males 2x more likely than females

Most frequently misused substance

Hospitalizations and deaths on the rise

- **18.2% rise alcohol-related deaths between 2019-2020**

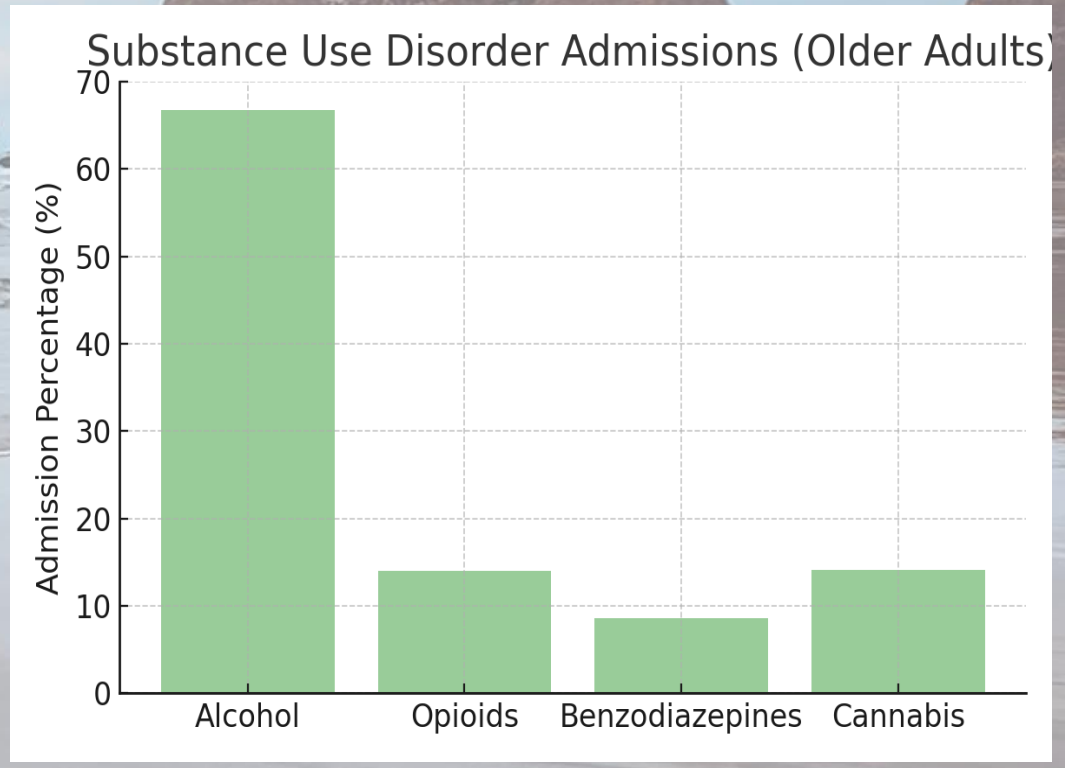


Symptoms of Substance-Linked Depression & Anxiety

- Anxiety prominent symptom of depression in many older adults, especially in SUD/AUD
- Perhaps more culturally acceptable to express anxiety than depression
- Many with social anxiety use substances to cope
- Older patients with anxiety always need evaluation for depression

Presentation is often Atypical:

- Difficulty concentrating/subj. memory loss
- Cognitive decline
- Somnolence/lethargy
- Irritability/restlessness
- Somatic complaints/muscle tension
- Social withdrawal
- Excessive worry, often about health
- In hospital: Delirium & Falls!!!



Comorbidity in Anxiety and Depression

Medical illnesses can mimic or exacerbate anxiety disorders & vice versa

Adverse effects of medications

Cardiovascular conditions: angina, atrial fibrillation, congestive heart failure

Endocrine: hyperthyroidism

Infectious: Viral illnesses *(remember COVID???)*

Pulmonary: COPD, asthma

Essentials(!!!):

1) Thorough **history** to know what you are treating!

2) **Medication** review!

3) **Collateral** information from caregivers/family when able!

Alcohol

Rx/drugs

Screening Tools for Substance Abuse in Older Adults

Tool	Length / Format	Focus	Strengths in Elderly	Limitations in Elderly
SMAST-G (Short Michigan Alcoholism Screening Test – Geriatric)	10 yes/no questions	Alcohol use	Tailored for older adults; asks about health/social consequences relevant to aging	Only covers alcohol; no prescription/illicit drug screening
MAST-G (Michigan Alcoholism Screening Test – Geriatric, full)	24 yes/no questions	Alcohol use	Comprehensive, geriatric-focused	Longer; may feel burdensome in busy clinics
AUDIT-C	3 questions (frequency/quantity)	Alcohol use	Quick, validated in elderly, good sensitivity	May miss social/medical consequences (focuses mainly on amount/frequency)
AUDIT (full version)	10 items, score-based	Alcohol use disorders	Widely used, good for risky/harmful drinking	Less specific to elderly; may overemphasize quantity
CAGE	4 yes/no questions	Alcohol use	Very brief, easy to remember	Misses prescription misuse and low-level but risky use common in elderly
DAST-10 (Drug Abuse Screening Test)	10 yes/no questions	Non-alcohol drug misuse (incl. prescriptions)	Captures prescription/illicit drug misuse	Not geriatric-specific; wording sometimes confusing for older adults
ASSIST (WHO)	~8–10 min structured interview	Alcohol, tobacco, prescription, illicit drugs	Comprehensive, covers all substances	Time-consuming; not always feasible in primary care
NIDA Quick Screen	1 item, follow-up if positive	Any drug misuse (illicit or prescription)	Extremely quick; good first step in busy settings	If positive, requires longer tool (ASSIST) for full assessment

Whatever assessment tool you employ: **always use age-sensitive, non-judgmental language.**

Social Isolation: A Critical Factor

1 in 3 older adults experiences loneliness.

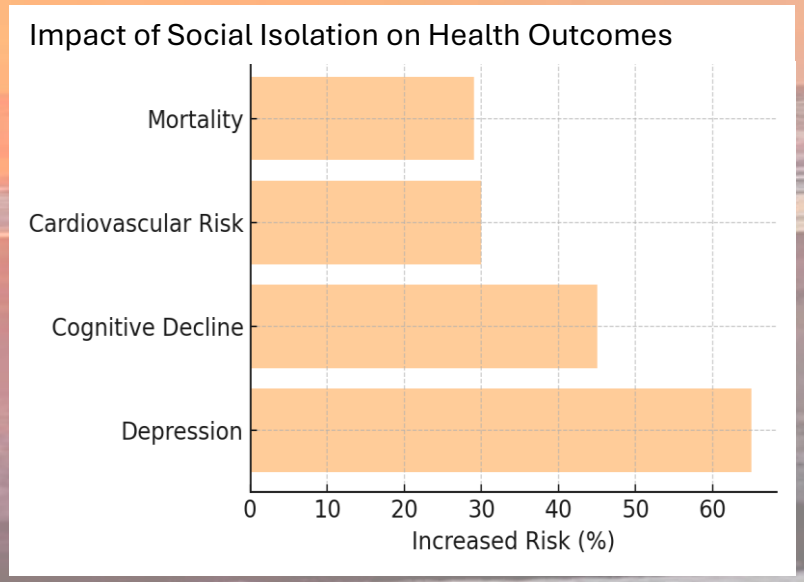
Loss of spouse, friends, independence.

Limited mobility or transportation.

COVID-19 pandemic worsened isolation effects!

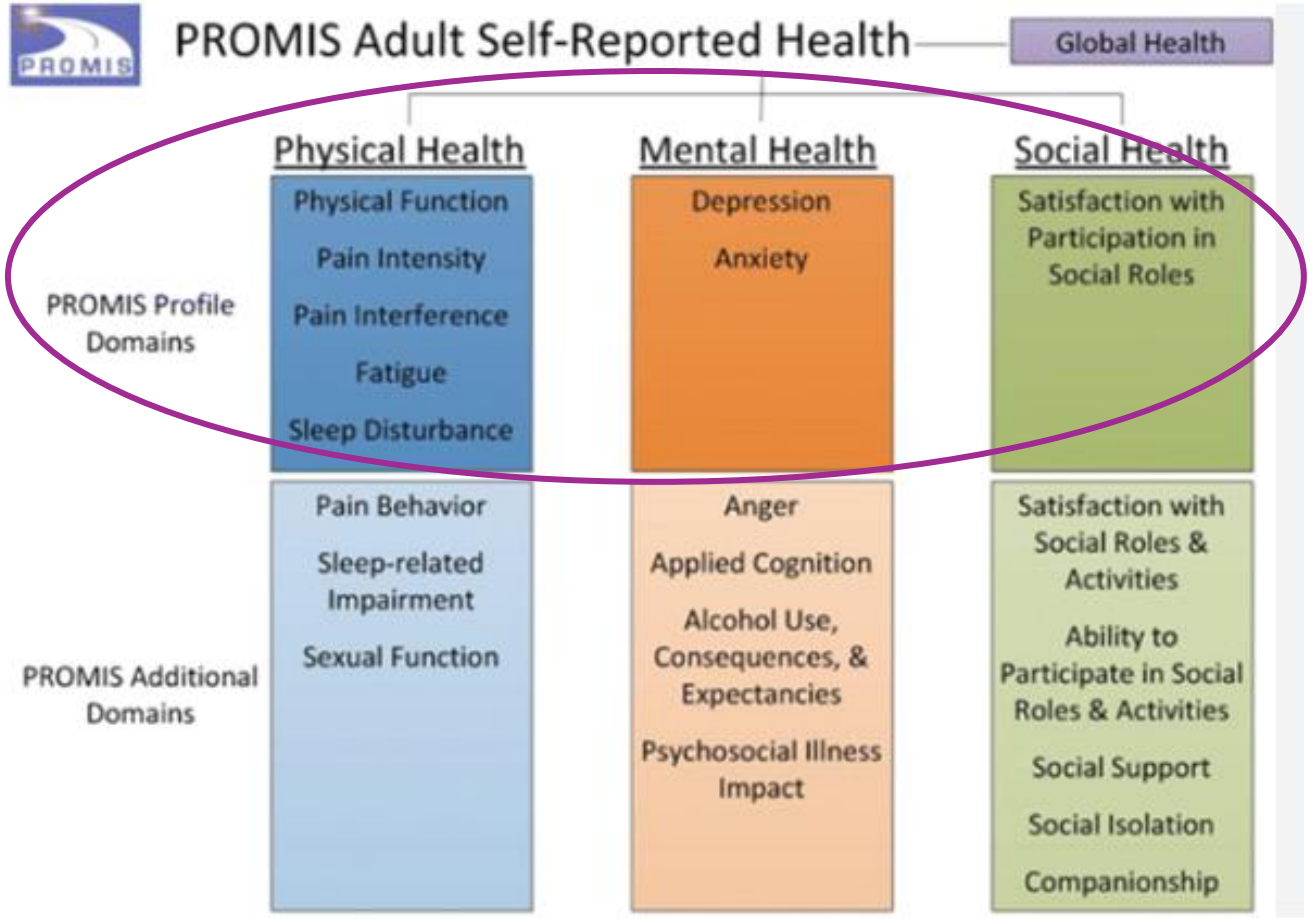
Social Isolation/Loneliness and Mental Health

- Strongly linked to depression, anxiety, ***mortality risk***.
- Also increases risk for cognitive decline.
- Bidirectional relationship: mental illness ⟷ isolation.
- ***Comparable impact to smoking or hypertension***.



Isolation → Depression/Anxiety → Withdrawal → **Increased Isolation**

Loneliness and Social Isolation



Associated with worse mental health outcomes:

suicidal ideation	self-harming behaviors	completed suicides	greater risk of depression

Assessment: 8-item Patient Reported Outcomes Measurement Information System, Social Isolation Scale (PROMIS-L)

PROMIS-L scale: http://www.healthmeasures.net/images/PROMIS/manuals/PROMIS_Social_Isolation_Scoring_Manual.pdf

Managing depression & anxiety:

Evidence-based strategies and interventions

- **Pharmacologic**
- **Nonpharmacologic**

Pharmacologic:

Mainstay of treatment = antidepressants

Mechanism: enhance monoamine function via either blocking reuptake or stimulating receptors for serotonin, dopamine, or norepinephrine

Selective Serotonin Reuptake Inhibitors (SRIs) preferred/effective

Avoid benzodiazepines!

Other options:

- **Selective Serotonergic and Noradrenergic Reuptake Inhibitors (SNRIs)**
- **Tricyclic Antidepressants (TCAs)**
- **Augmentation (Using any of the above with antipsychotic)**

Some Pharmacologic Considerations:

Symptom/Condition	Ideal Option	Try To Avoid
Apathy & Fatigue	SNRIs (Buproprion)	Mirtazapine, TCAs
Cardiovascular Issues	Sertraline (minimal QTc)	Citalopram, Venlafaxine, TCAs
Chronic Pain	SNRIs, TCAs	---
Cognitive Impairment	Escitalopram, Sertraline	Paroxetine, TCAs
Hyponatremia	Bupropion, Mirtazapine	SSRIs
Insomnia	Mirtazapine	Bupropion, SNRIs
Polypharmacy	Escitalopram, Sertraline	Fluoxetine, Paroxetine
Unintended Weight Loss	Mirtazapine	Bupropion, SNRIs
Substance abuse	*Always refer to SUD counseling in addition to any medication/therapy*	---

Non-Pharmacologic & Interventional Psychiatry:

Electroconvulsive therapy (ECT): *since 1938; up to 60-80% remission after series of 6-12 acute sessions*

Repetitive Transcranial Magnetic Stimulation (RTMS): *approved 2008; uses magnetic pulses over 25-30 short sessions*

Ketamine infusions and intranasal: *especially with treatment resistant depression; since early 2000s – approved as monotherapy in 2025*

Integrated Care/Relaxation Training: aromatherapy, *massage, music, relaxation techniques, visual imagery, yoga*

Psychotherapy: *CBT, problem-solving therapy, ideally with medication*

Psychosocial: ***especially for those suffering loneliness and social isolation***

Examples of Psychosocial Interventions

Intensive psychosocial

- **Cognitive-behavioral therapy:** most rigorously tested, with in-person, telephonic, and telemedicine capability!
- Restructures negative thinking, identifies triggers, activates behavioral change via coping strategies
- Less successful in those with significant cognitive impairment

Aerobic exercise

- Faster results when used in combination with medications than either approach alone
- Reduces depressive symptoms

Behavioral health manager

- Disease management model
- *large-scale multisite studies demonstrate greater rates of response + remission with lower suicidality vs routine care*

Additional support

- Social connections
- Religion
- Spirituality
- Volunteerism

Addressing Social Isolation: Role of the Community

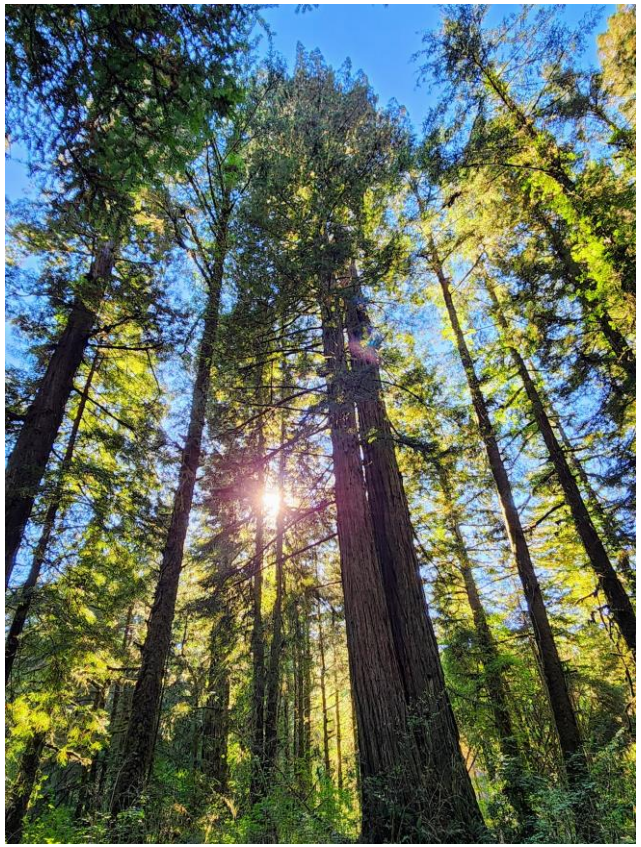
Senior centers, Adult Day Programs

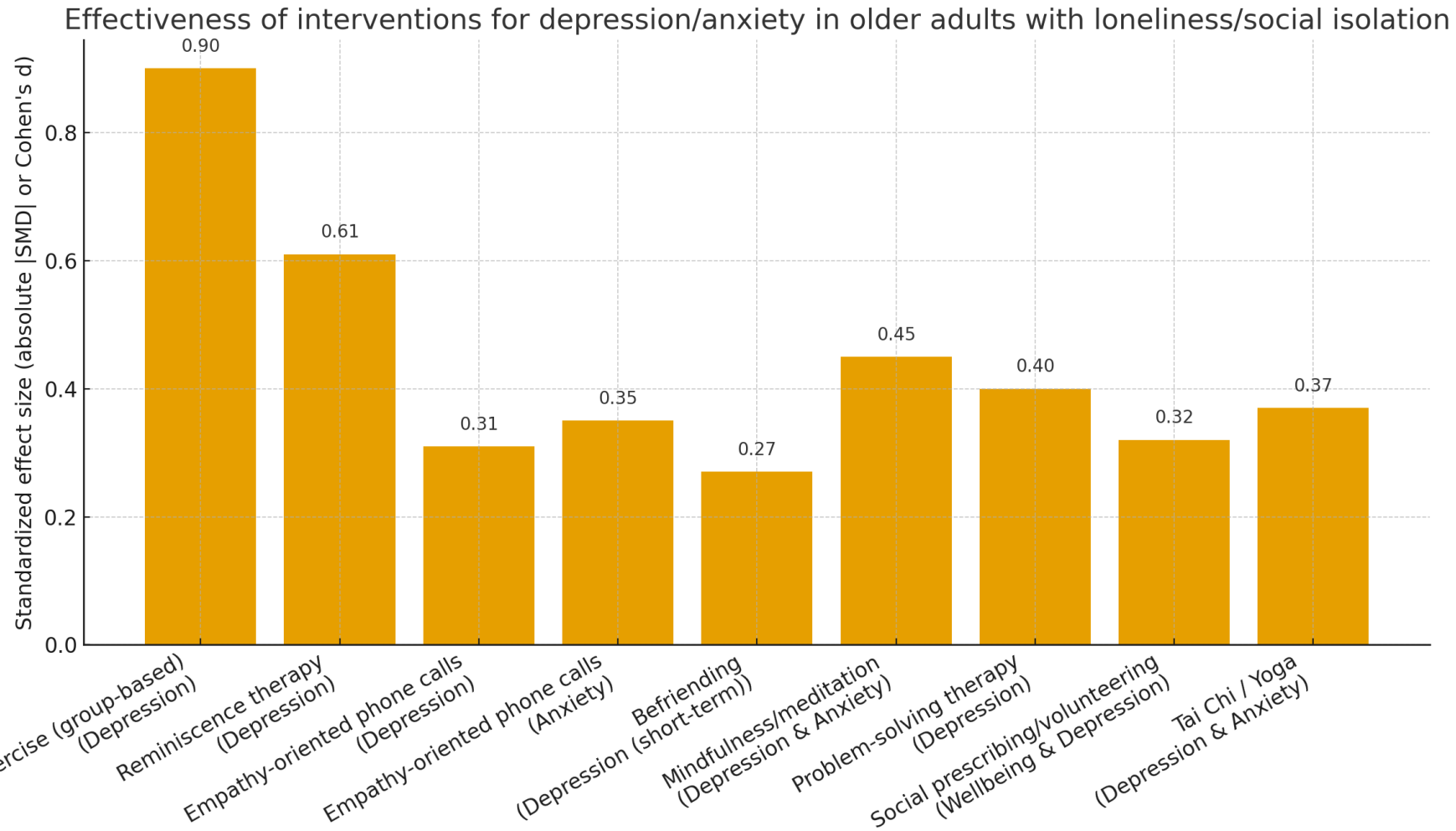
Transportation services

Tech Support: Digital Literacy Programs, Virtual Connection

Pet Therapy, Volunteer engagement

Effectiveness of Interventions





Additional Resources for Clinicians

- National Council on Aging
- American Geriatrics Society
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Local Aging Services & Mental Health Helplines

Remembering Jesse…

76 yo found down by daughter after presumed fall & brought to clinic for evaluation

Mental Health & Substance Use Assessment

Geriatric Depression Scale (GDS):

- 10/15 (positive for depression)

Generalized Anxiety Disorder 7-Item Scale (GAD-7):

- 11/21 (positive for moderate anxiety)

Further Interview:

- Low mood, poor sleep, hopelessness, worries all the time about money (unnecessarily), always on edge
- Denies suicidal ideation but expresses passive death wishes
- Alcohol used to "numb the evenings“

Labs:

- Mild hyponatremia
- Elevated liver enzymes

Problem List

Fall, likely multifactorial	• (alcohol use, deconditioning, poor nutrition)
Undiagnosed late-life depression	
Undiagnosed generalized anxiety	
Alcohol use disorder	• (daily intake with functional impact)
Social isolation	• (compounded by death of wife)
Limited caregiver awareness of mental health decline	• (and who admits she is overwhelmed)

Your Management Plan for Jesse

Interventions:

Initiate SSRI at geriatric-appropriate dose

Gradual alcohol taper + substance abuse counseling

Connect with senior support group / social work

Engage daughter in psychoeducation and follow-up planning

Follow-Up:

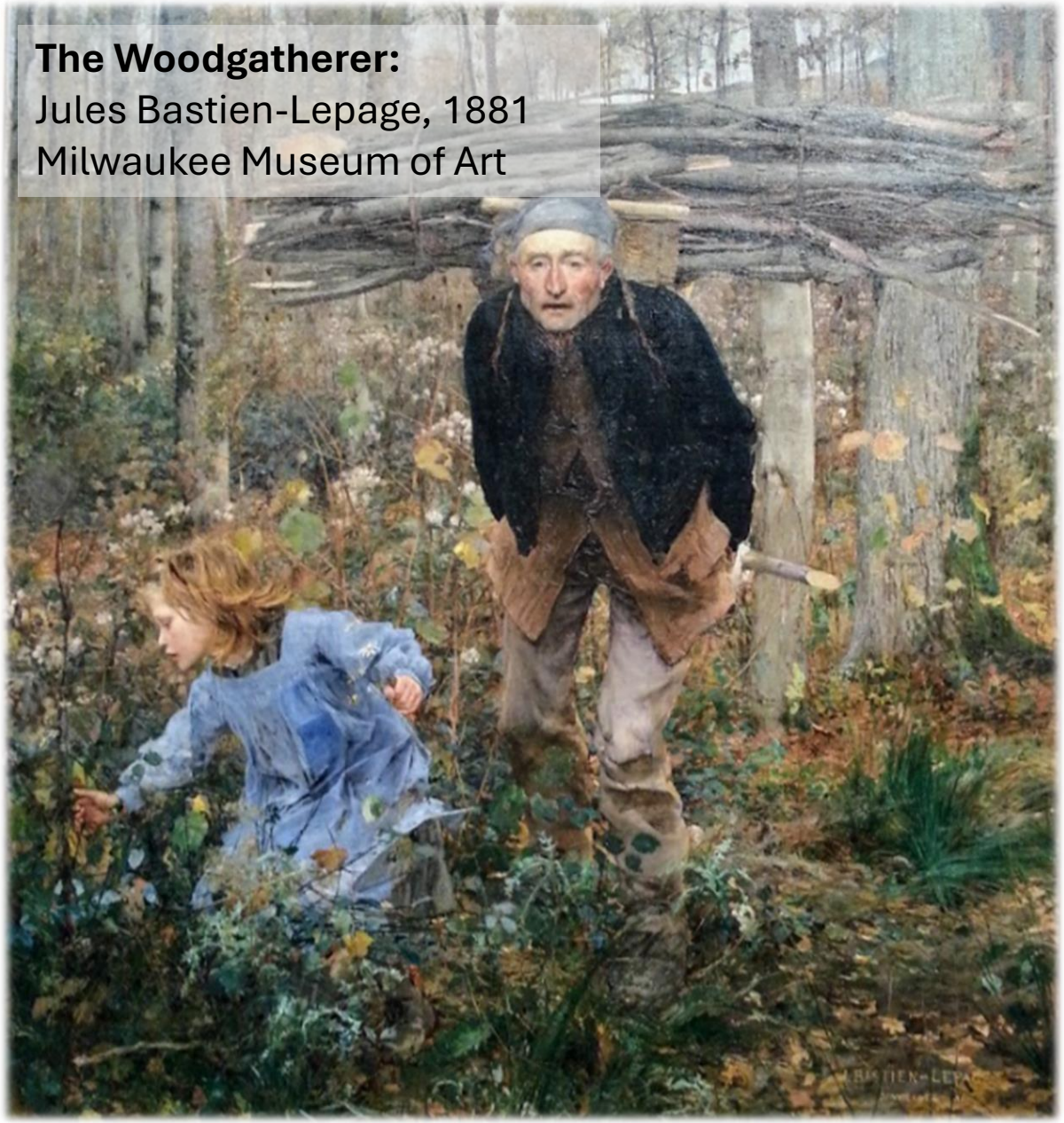
Weekly check-ins for first month

Fall risk and home safety evaluation

Monitor liver function and mood response

Summary:

- Mental health disorders in older adults are underrecognized.
- Late-life depression can present subtly (fatigue, apathy, withdrawal).
- Anxiety often occurs in conjunction with depression.
- Substance use is often underrecognized in older adults, can represent undiagnosed mood disorder as well as exacerbate it, & complicate the diagnosis and treatment.
- Falls may be the first presenting sign of underlying mood or substance disorder.
- Social isolation/loneliness = major risk factor for mental health decline.
- Caregivers may normalize or miss warning signs.
- Integrated, multimodal strategies are crucial. Exercise for those who are able helps reduce symptoms of depression and anxiety and should always be part of the plan.



The Woodgatherer:
Jules Bastien-Lepage, 1881
Milwaukee Museum of Art

Acknowledgement:
Dr. Michael Malone
“The Geriatrics Gatherer”

References:

https://onedrive.live.com/personal/e46c7d450ef3b2d9/_layouts/15/Doc.aspx?sourcedoc=%7B7ECA1E8C-242F-47F3-B269-5F9AB7045ABB%7D&file=References%20-%20Silent%20Battles_E%20H%20Bowman.docx&action=default&mobileredirect=true

Thank you! / Discussion Time

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