Depression and Suicide in Older Adults
Resource Guide

Introduction

Depression and suicide are significant public health issues for older adults. Depression is one of the most common mental disorders experienced by elders, but fortunately is treatable by a variety of means. Current cohorts of older adults in the United States evidence lower rates of major depression than younger cohorts, but experience minor depression or significant subsyndromal depressive symptoms at rates equal to or greater than younger groups. Adults soon to enter later adulthood, most notably the so-called Baby Boom cohort, seem to be evidencing depressive disorders at significantly higher rates than previous groups; this trend towards greater incidence of depression in subsequent cohorts seems steady. The reasons for these changes are the subject of much debate and not clearly understood. Because depression tends to be a recurrent disorder, this means that many older adults will have experienced previous bouts of depression and will be at increased risk.

Depression is not only a prevalent disorder but is also a pervasive problem. Depressed older adults, like younger persons, tend to use health services at high rates, engage in poorer health behaviors, and evidence what is known as "excess disability." Depression is also associated with suicide. Older adults have the highest rates of suicide of any age group, and this is particularly pronounced among men.

Several efficacious treatments are available for geriatric depression but seem to be underused. Pharmacotherapy and several versions of psychotherapy, including interpersonal, brief psychodynamic, problem-solving, and cognitive-behavioral, significantly reduce depressive symptoms. Interestingly, when given thorough descriptions of these treatments, older adults state a preference for receiving psychologically based treatments rather than medication.

Geriatric depression will continue to be a topic worthy of much scientific and applied interest in the years to come. This resource guide provides some current information we hope will be useful as you learn more about this important health issue.

Forrest Scogin, PhD
Department of Psychology
University of Alabama at Tuscaloosa
Updated: September 2009

Journal Articles

Clinical determinants of suicidal ideation and behavior in geriatric depression
Most older adults who commit suicide see their physicians within a few months of their death and more than a third within the week of their suicide. Therefore, reliable assessment of suicide risk is critical; protective measures may avert suicide. The principal aim of this study was to determine which clinical characteristics could be used to assess suicidality in 354 61-93 yr old patients with depression who were studied for a mean of 1.8 yrs. Results demonstrate that elderly patients with severe depression, poor social support, and history of serious suicide attempts have high suicide potential.

The "vascular depression" hypothesis

Proposes the "vascular depression hypothesis" which suggests that cerebrovascular disease can predispose, precipitate, or perpetuate a depressive syndrome in many elderly patients with underlying neurologic brain disorders. This article reviews findings relevant to the vascular depression hypothesis and discusses their clinical and heuristic implications. The vascular depression hypothesis is supported by the high frequency of depression in patients with hypertension, diabetes, coronary artery disease, and stroke; the frequency occurrence of silent stroke and white matter hyperintensities in geriatric depression; and the association of depression with lesions impairing the integrity or regulation of the circuits linking basal ganglia and prefrontal cortex.

Effectiveness of problem solving therapy for older, primary care patients with depression: Results from the IMPACT project

The study compares a primary-care-based psychotherapy, that is, problem-solving therapy for primary care (PST-PC), to community-based psychotherapy in treating late-life major depression and dysthymia. Older adults who received PST-PC had more depression-free days at both 12 and between 12 and 24 months and they had fewer depressive symptoms and better functioning at 12 months than those who received community-based psychotherapy. Results suggest that PST-PC as delivered in primary care settings is an effective method for treating late-life depression.

Assessment and treatment of depressed older adults in primary care

The purpose of this paper is to describe and discuss both assessment and psychotherapeutic techniques that can be applied in primary-care medicine for older adults seeking mental health services in these settings. Assessment techniques that are amenable to primary-care settings include the Center for Epidemiological Studies Depression Scale, Revised; the Geriatric Depression Scale-15; two and nine-symptom Patient Health Questionnaire; the General Health Questionnaire; the Beck Depression Inventory-II; and the Beck Depression Inventory for Primary Care. Psychotherapeutic interventions that have been created and/or modified for primary-care settings are Problem
solving therapy (PST-PC) and interpersonal therapy (IPT-PC). These detection tools and treatments are discussed in the context of primary-care medicine.

**Comparative effectiveness of social problem-solving therapy and reminiscence therapy as treatments for depression in older adults**

Compared the effects of 2 psychotherapies based on divergent conceptualizations of depression in later life. 75 older adults diagnosed with major depressive disorder were assigned randomly to problem-solving therapy (PST), reminiscence therapy (RT), or a waiting-list control (WLC) condition. Participants in PST and RT were provided with 12 weekly sessions of group treatment. Dependent measures, taken at baseline, post-treatment, and 3-mo follow-up, included self-report and observer-based assessments of depressive symptomatology. At post-treatment, both the PST and the RT conditions produced significant reductions in depressive symptoms, compared with the WLC group, and PST Ss experienced significantly less depression than RT Ss. Moreover, a significantly greater proportion of Ss in PST vs. RT demonstrated sufficient positive change to warrant classification of their depression as improved or in remission at the post-treatment and follow-up evaluations.

**Improving access to geriatric mental health services: A randomized trial comparing integrated and enhanced referral care for depression, anxiety disorders, and at-risk alcohol use**

The authors sought to determine whether integrated mental health services or enhanced referral to specialty mental health clinics results in greater engagement in mental health/substance abuse services by older primary care patients. This multisite randomized trial included 10 sites consisting of primary care and specialty mental health/substance abuse clinics. Seventy-one percent of patients engaged in treatment in the integrated model compared with 49% in the enhanced referral model. Integrated care was associated with more mental health and substance abuse visits per patient (mean=3.04) relative to enhanced referral (mean=1.91). Overall, greater engagement was predicted by integrated care and higher mental distress. For depression, greater engagement was predicted by integrated care and more severe depression. For at-risk alcohol users, greater engagement was predicted by integrated care and more severe problem drinking. For all conditions, greater engagement was associated with closer proximity of mental health/substance abuse services to primary care. Older primary care patients are more likely to accept collaborative mental health treatment within primary care than in mental health/substance abuse clinics. These results suggest that integrated service arrangements improve access to mental health and substance abuse services for older adults who underuse these services.

**The association of anxiety and depressive symptoms with cognitive performance in community-dwelling older adults.**
Examines the association of anxiety, depressive symptoms, and their co-occurrence on cognitive processes in 102 community-dwelling older adults. Participants completed anxiety and depression questionnaires, and measures of episodic and semantic memory, word fluency, processing speed/shifting attention, and inhibition. Participants with only increased anxiety had poorer processing speed/shifting attention, and inhibition, but depressive symptoms alone were not associated with any cognitive deficits. Although co-existing anxiety and depressive symptoms was associated with deficits in 3 cognitive domains, reductions in inhibition were solely attributed to anxiety. Findings suggest an excess cognitive load on inhibitory ability in normal older adults reporting mild anxiety.

**Depression in late life: Review and commentary**


Depression is perhaps the most frequent cause of emotional suffering in later life and significantly decreases quality of life in older adults. In recent years, the literature on late-life depression has exploded. Many gaps in our understanding of the outcome of late-life depression have been filled. Intriguing findings have emerged regarding the etiology of late-onset depression. The number of studies documenting the evidence base for therapy has increased dramatically. This article reviews: the case definition; current community and clinic based epidemiological studies; the outcome of late-life depression, including morbidity and mortality studies; extant evidence regarding the etiology of depression in late life from a biopsychosocial perspective; and evidence for the current therapies prescribed for depressed elders, ranging from medications to group therapy.

**Suicide in the elderly**


Suicide is a major public health problem, with rates rising to their highest levels in many countries and cultures during the second half of life. The risk factors that contribute to later-life suicide are distinctive from those in younger populations. This paper reviews a variety of potential approaches for effective suicide prevention among elders, and considers as well both age-specific and general barriers that impede such efforts. It proposes that future effective measures will need to integrate public health and individual-oriented therapeutic approaches to intervention, and that specific efforts will need to be developed to address the natural history of suicidal processes.

**Life regrets and pride among low-income older adults: Relationships with depressive symptoms, current life stressors and coping resources.**


We examined the contents and intensities of both life regrets and pride among a convenience sample of 213 low-income older adults and the associations between the contents and intensities of life regrets and pride, on the one hand, and the older adults’ current life stressors, coping resources and depressive symptoms, on the other. Regrets about education, career and marriage were common, but intensities of regrets were higher for issues related to finance/money, family conflict and children’s problems, loss and grief, and health. Common sources of pride were related to children and parenting, career, volunteering/informal caregiving, long/strong marriage and personal growth/self. Controlling for current life stressors of disability, money worries, loneliness and overdependence on
others for management of daily life, and coping resources of social support and religiosity, the intensities of loss-and-grief related regrets and the pride in long/strong marriage were significant predictors of the Geriatric Depression Scale (GDS) scores. However, the regrets and pride explained a small amount of the variance in the GDS scores, while the current life stressors explained a large portion of the variance.

Low-income older adults’ acceptance of depression treatments: Examination of within-group differences.

Using the 11-item Treatment Evaluation Inventory (TEI), a community sample of 79 homebound and 127 ambulatory older adults rated their acceptance of four depression treatments for two hypothetical cases with mild-to-moderate or severe levels of depressive symptoms. The four treatments were clinic-based cognitive therapy (CT), in-home cognitive bibliotherapy (CB), antidepressant medication (AM), and regimented physical exercise (PE). Older adults had significantly less favorable attitudes toward AM than CT as a treatment for mild-to-moderate symptoms, and they were less accepting of CB than CT for severe symptoms. Concerns about becoming dependent on medication and about its side effects as well as the understanding of loneliness and isolation as causes of depression appear to have affected their scores. African American and Hispanic older adults showed attitudes that were as favorable as those of their non-Hispanic white peers toward all four types of depression treatments. Homebound older adults had less favorable attitudes toward CB than did their ambulatory peers.

Depression care need among low-income older adults: Views from aging service providers and family caregivers.

This study reports findings from focus group discussions with aging service providers and family caregivers about low-income ambulatory or homebound older adults’ depressive symptoms and barriers to seeking treatment. It also reports the participants’ suggestions about interventions for depression that can be integrated into existing aging service settings or implemented in older adults’ homes, as well as the type of training the aging service providers need if they are to provide services for depression. Participants identified social isolation, loneliness, and loss and grief as major correlates of depression in older adults. Barriers to seeking treatment included older adults’ denial of or lack of understanding about depression, a sense of stigma, financial worries, and lack of mobility. Suggested depression treatments included brief cognitive behavioral interventions, friendly visitors, and physical exercise. Bachelor’s-level service providers expressed their need and desire for training in mental health assessment and brief psychotherapy.

Minority and cultural issues in late-life depression

Disparities in the identification and treatment of behavioral health problems such as depression have only recently come to the attention of policymakers, researchers, and practitioners. This paper reviews currently available information on critical elements of cultural competence for clinical practice, including not only organizational
standards but also the standards recommended for individual providers. Factors that may distinguish a minority elder from non-Hispanic white clients are discussed, as well as potential problems with psychosocial assessment tools.

**Suicidal Behaviors in Older Adults, Theme Issue**


This issue of the American Journal of Geriatric Psychiatry contains five articles related to suicide in older adults: Risk Factors for Late-Life Suicide: A Prospective, Community-Based Study; Access to Firearms and Risk for Suicide in Middle-Aged and Older Adults; Suicidal and Death Ideation in Older Primary Care Patients With Depression, Anxiety, and At-Risk Alcohol Use; Cognitive Functioning and Geriatric Suicide Ideation: Testing a Mediational Model; and, Suicidality in Older African Americans: Findings From the EPOCH Study.

**Is psychotherapy for depression equally effective in younger and older adults? A meta-regression analysis.**


It is well established that psychotherapy is effective in the treatment of depression in younger as well as in older adults. Whether these psychotherapies are equally effective in younger and older age groups has not been examined in meta-analytic research. Methods: We conducted a systematic literature search and included 112 studies with 170 comparisons between a psychotherapy and a control group (with a total of 7,845 participants). Twenty studies with 26 comparisons were aimed at older adults. Results: We found no indication that psychotherapies were more or less effective for older adults compared to younger adults. The effect sizes of both groups of comparisons did not differ significantly from each other (older adults: d = 0.74; 95% CI: 0.49 ~ 0.99; younger adults: d = 0.67; 95% CI: 0.58 ~ 0.76). In a multivariate meta-regression analysis, in which we controlled for major characteristics of the participants, the interventions and the study designs, no indication of a difference between psychotherapy in younger and older adults was found. Conclusions: There appears to be no significant difference between psychotherapy in younger and older adults, although it is not clear whether this is also true for clinical samples, patients with more severe depression, and the older old.

**Late-life depression: Detection, risk reduction, and somatic intervention**


In light of recent statistics suggesting that geriatric depression is highly prevalent, complicates and promotes medical illness, and strongly impacts quality of life, this paper explores numerous aspects of depression in late life, including proper detection and treatment barriers, risk reduction, and somatic intervention. Additionally, the relationship between depression and morbidity is highlighted given that the prevalence of depressive symptoms increases in older adults with medical disorders and greatly impacts outcome. Finally, empirically supported somatic treatments and their side effects are discussed with emphasis on the efficacy and effectiveness of pharmacotherapy, electroconvulsive therapy (ECT), exercise, and phototherapy (bright light therapy).

**Depression in Older Adults**

Depression is less prevalent among older adults than among younger adults, but it can have serious consequences. More than half of cases represent a first onset in later life. Although suicide rates in the elderly are declining, they are still higher than in younger adults and are more closely associated with depression. Depressed older adults are less likely to endorse affective symptoms and more likely to display cognitive changes, somatic symptoms, and loss of interest than are depressed younger adults. Risk factors leading to the development of late-life depression likely comprise complex interactions among genetic vulnerabilities, cognitive diathesis, age-associated neurobiological changes, and stressful events. Insomnia is an often overlooked risk factor for late-life depression. We suggest that a common pathway to depression in older adults, regardless of which predisposing risks are most prominent, may be curtailment of daily activities. Accompanying self-critical thinking may exacerbate and maintain a depressed state. Offsetting the increasing prevalence of certain risk factors in late life are age-related increases in psychological resilience. Other protective factors include higher education and socioeconomic status, engagement in valued activities, and religious or spiritual involvement. Treatments including behavioral therapy, cognitive-behavioral therapy, cognitive bibliotherapy, problem-solving therapy, brief psychodynamic therapy, and life review/reminiscence therapy are effective but are too infrequently used with older adults. Preventive interventions including education for individuals with chronic illness, behavioral activation, cognitive restructuring, problem-solving skills training, group support, and life review have also received support.

The epidemiology of common late-life mental disorders in the community: Themes for the new century

The prevalence and incidence of the major mental disorders of late life that are common in the community and in primary health care are reviewed. As the population ages, dementia, depression, and other mental conditions of the aged will demand more attention from clinicians and investigators to minimize their effects on disability, the use of health care services, and the quality of life for older adults and caregivers. Up to 15 to 20 percent of older adults have significant depressive symptoms, and it is estimated that as many as 45 percent of persons age 85 years and older have significant cognitive impairment and dementia. Other mental-health-related conditions, such as anxiety disorders, alcohol abuse, and prescription medicine misuse, are also important considerations but have not been as well studied as depression and dementia. Because an increasing proportion of older adults are members of minority groups, clinicians need to increase their awareness of how cultural factors relate to risk for mental disorders in late life.

Comparative Effects of Cognitive-Behavioral and Brief Psychodynamic Psychotherapies for Depressed Family Caregivers

Clinically depressed family caregivers of frail, elderly relatives were randomly assigned to 20 sessions of either cognitive-behavioral or brief psychodynamic individual psychotherapy. At post treatment, 71% of the caregivers were no longer clinically depressed according to research diagnostic criteria, with no differences found between the two outpatient's treatments. The results suggested therapy specificity; there was an interaction between treatment modality and length of caregiving on symptom-oriented measures. Clients who had been caregivers for at least 44
months improved with CB therapy. These findings suggest that patient-specific variables should be considered when choosing treatment for clinically depressed family caregivers.

**Suicide in later life**

This paper addresses a number of issues related to suicide among older persons in the United States. A presentation of the epidemiology of late life suicide is followed by a discussion of known risk factors for both suicide attempts and completed suicides. Other issues discussed include the assessment of suicidality among older men and women, and the highly controversial topic of "rational" suicide. The article concludes with suggestions for intervention in order to reduce suicide ideation and improve the individual's quality of life.

**Empirically Validated Psychological Treatments for Older Adults**

Psychological treatments with older adults were evaluated against criteria developed by the Division of Clinical Psychology of the American Psychological Association for documenting effective psychosocial interventions. To be included as evidence, the studies must exclude dual or ambiguous diagnoses and must adhere to standardized treatment manuals. Demonstrated efficacy compared to waiting list control groups qualifies an intervention as "probably efficacious", whereas being categorized as "well established" requires superiority to a psychological placebo group or control treatment (or equivalence to another well-established treatment). Major findings included: use of behavioral and environmental treatments for behavior problems in dementia patients met criteria for "well established"; cognitive, behavioral, and brief psychodynamic therapy for the treatment of depression in older adults met criteria for "probably efficacious"; life review and reminiscence met the criteria for "probably efficacious" for both cognitively intact and demented individuals with symptoms of depression and those living in settings that restrict independence; cognitive behavioral treatment of sleep disorders, support groups for caregivers based on a psychoeducational model, and memory and cognitive retraining with dementia patients all met the criteria for "probably efficacious."

**Predictors of change in caregiver burden and depressive symptoms following nursing home admission.**

Prior research has yielded discrepant findings regarding change in caregiver burden or depressive symptoms after institutionalization of persons with dementia. However, earlier studies often included small postplacement samples. In samples of 1,610 and 1,116 dementia caregivers with up to 6 months' and 12 months' postplacement data, respectively, this study identified predictors of change in caregiver burden and depressive symptoms following nursing home admission. Descriptive analyses found that caregivers reported significant and considerable decreases in burden in the 6- and 12-month postplacement panels. A number of variables predicted increased burden and depressive symptoms in the 6- and 12-month postplacement panels. Preplacement measures of burden and depressive symptoms, site (Florida), overnight hospital use, and spousal relationship appear to result in impaired
caregiver well-being following nursing home admission. Incorporating more specific measures of stress, considering the influence of health-related transitions, and coordinating clinical strategies that balance caregivers' needs for placement with sustainability of at-home care are important challenges for future research.

**Removing the barriers to effective depression treatment in old age**

Notes that although antidepressants and psychotherapy have been shown to be effective in treating older patients with depression, non-treatment or under-treatment for depression is common in this population. The authors argue that there must be further efforts to improve access to and quality of care for depression among older adults. Reasons why diagnosis and treatment of depression among older adults are inadequate are discussed and barriers to effective treatment are explored. Specifically, inability to pay for services and mixed results of previous efforts to improve rates of diagnosis and treatment are cited.

**An impressive step in identifying evidence-based psychotherapies for geriatric depression**

Discusses six treatments that they found to be beneficial for treatments of geriatric depression. The current author states that the substantive contribution identifying six evidence-based psychotherapies for geriatric depression by Scogin, Welsh, Hanson, Stump, and Coates is laudable. Their analysis of studies from the 1980s to the present, which recognizes treatments with clear research support, will likely prove valuable to clinicians, researchers, and political advocates. However, their efforts are an initial step. The scope and depth of the findings are limited as a result of the decision to exclude studies of depression with comorbid medical conditions, particularly field research done in primary-care settings, as well as those that use both medication and psychological strategies. Included in this commentary are some caveats regarding the pragmatics of financial reimbursement for the identified EBTs.

**Suicide prevention in older adults**

Reviews the research on the epidemiology, risk and resiliency, assessment, treatment, and prevention of late-life suicide. Approximately 12/100,000 individuals aged 65 years or over die by suicide in Canada annually. Suicide is most prevalent among older white men; risk is associated with suicidal ideation or behavior, mental illness, personality vulnerability, medical illness, losses and poor social supports, functional impairment, and low resiliency. Novel measures to assess late-life suicide features are under development. Few randomized treatment trials exist with at-risk older adults. Research is needed on risk and resiliency and clinical assessment and interventions for at-risk older adults. Collaborative outreach strategies might aid suicide prevention.

**Hopelessness as a measure of suicidal intent in the depressed elderly**

Suicidal ideation in the elderly has been related to depression, changes in health and anticipation of a limited future.
The present study examined the Hopelessness Scale (HS) and its relation to these factors in a depressed geriatric population. A total of 120 elderly outpatients, who had applied to receive psychotherapy for depression, completed the HS, Beck Depression Inventory (BDI), health ratings, and the Schedule for Affective Disorder and Schizophrenia (SADS) at intake. The HS was found to be internally consistent, and a principal component analysis revealed three distinct factors that were related to hope, feelings of giving up, and future planning. The HS, BDI, and health ratings were predictive of suicidal ideation as measured by specific items in the SADS. The relationship between suicidal ideation, hopelessness, depression, and health perceptions for the depressed aged are discussed.

**Interpersonal psychotherapy as a treatment for depression in later life**


Interpersonal Psychotherapy (IPT) is an empirically-supported treatment for depression and other mental disorders. This article discusses the structure of IPT, its use with older adults, and research that supports its efficacy with depressed older people. Depressed older persons with significant health problems or cognitive impairment present special challenges for those conducting IPT and other psychotherapies. Promising new psychotherapies developed for depressed older adults with cognitive impairment and those living in nursing homes are reviewed. Recommendations are made for use of IPT with older adults in nursing homes.

**Depressive symptoms among older residents in assisted living facilities**


Responding to the dramatic growth in Assisted Living Facilities (ALFs), the present study focused on mental health among older residents in ALFs. We assessed the effects of physical health constraints (chronic conditions, functional disability, and self-rated health) and psychosocial resources (social network, sense of mastery, religiosity, and attitude toward aging) on depressive symptoms. A sample of 150 residents (M age = 82.8, SD = 9.41) from 17 facilities in Florida was used for analyses. Higher levels of depressive symptoms were observed among older residents with a greater level of functional disability, poorer self-rated health, lower sense of mastery, less religiosity, and less positive attitude towards aging. In addition, the linkages between physical and mental health were modified by psychosocial resources. For older residents with more positive beliefs and attitudes (a higher sense of mastery, greater religiosity, and more positive attitudes toward aging), the adverse effects of functional disability or poorer self-rated health on depressive symptoms were attenuated. The protective roles of psychosocial resources against physical health constraints yield important implications for designing prevention and intervention strategies for the mental health of older populations in ALF settings.

**Assessment and psychological treatment of depression in older adults with terminal or life-threatening illness**


Depression decreases the quality of life and hinders efforts to palliate symptoms of adults with terminal or life-threatening illness. Nevertheless, depression often may go undetected and untreated in palliative care and hospice
settings due to a number of factors, including the overlap of depressive symptoms with those of serious medical illness and concern that frail elderly patients cannot tolerate psychotherapy or antidepressant treatment. In this paper we review the available research regarding assessment and treatment of depression in older adults with terminal or life-threatening illness, focusing on patients who are seen in palliative care, cancer treatment, or hospice settings. Although the prevalence of depression is relatively high in these settings in mixed-age adult samples, studies focused exclusively on older adults are rare and there appear to be no randomized controlled trials of psychotherapy conducted to date that specifically address their needs. There are, however, promising psychological approaches featured in case reports and pilot studies that are consistent with empirically supported therapies for the general treatment of depression in older adults. Based on these preliminary findings and reports, we offer tentative recommendations for the assessment and treatment of depression in terminally ill older adults. We conclude that controlled research on psychotherapy for late-life depression is both feasible and urgently needed in palliative care, cancer care, and hospice settings.

The prevention of depression in nursing home residents: A randomized clinical trial of cognitive-behavioral therapy.


The prevention of depression in individuals who are at risk is important for affected individuals, their family members, and for society at large. This study presents the results of a randomized clinical trial aimed at the prevention of depression in nursing home residents. Residents were screened with the Geriatric Depression Scale (GDS) and a diagnostic interview. Those with elevated GDS scores who did not meet diagnostic criteria for depression were randomly assigned to a treatment or control (treatment as usual, TAU) condition. The treatment was an adaptation of the Coping with Stress program developed by Clarke et al. (1995; Journal of the American Academy of Child and Adolescent Psychiatry, 34, 312–321), and focused on various components typical of cognitive–behavioral treatment (CBT) programs (e.g. increasing pleasant events, reducing negative cognitions). Both groups were assessed on measures of depression before treatment, after treatment, and at 3- and 6-month follow-up points. Compared with the TAU group, residents receiving the intervention showed considerable improvement over the 6-month follow-up on the GDS. Average scores on the GDS, for example, went from 14.0 to 9.4 in the CBT group over the course of treatment and follow-up, vs. scores from 13.4 to 12.3 for the TAU group over the same time. However, results on the Center for Epidemiological Studies Depression Scale at 3 months were nonsignificant. Overall, the results of this study suggest that a brief, group-based CBT program can have significant benefit in nursing home residents at risk for depression.

Older adults’ acceptance of psychological and pharmacological treatments for depression


Two hundred participants aged 65 and older recruited from 4 different family medicine clinics rated the acceptability of 3 different treatments for geriatric depression: (a) cognitive therapy (CT), (b) cognitive bibliotherapy (CB), and (c) antidepressant medication (AM). Results showed that the acceptability of the treatments is a function of the severity of the symptoms of the depressed patient to whom they would be applied. CT and CB were rated as more acceptable than AM when patient symptoms were mild to moderate. However, CT was more acceptable than both CB and AM.
when patient symptoms were described as severe. Acceptability ratings were not related to the raters’ own depressive symptoms. The practical implications of these results are discussed.

**Depression in long-term care**


The assessment and treatment of depression in long-term care (LTC) settings poses unique challenges to both clinicians and researchers. In this review we discuss the variety of forms depression can take among LTC residents and the influence the LTC environment can play on the development and maintenance of depression. We describe instruments that can be used to assess depressive symptoms, along with their strengths and liabilities. Additionally, we summarize treatment approaches, with an emphasis on the relatively limited number of empirically informed interventions. Throughout, we describe modifications that may improve the accuracy of assessment and the effectiveness of psychological treatments. Depression, while common among LTC residents, appears amenable to psychological intervention, although the field is far from identifying empirically supported treatments in the LTC setting.

**Evidence-Based Psychotherapeutic Interventions for Geriatric Depression**


In 1991, the National Institutes of Health consensus statement on the treatment of late-life depression ranked psychotherapy as third in a line of treatment options, with antidepressant medication first and electroconvulsive therapy second, indicating that there was insufficient evidence to recommend psychotherapy as a first-line treatment for depression in older adults. Since that time, numerous articles have been written reviewing the evidence base for psychotherapy research in older adults and four meta-analyses of existing trials have been conducted. In addition, several randomized clinical trials meeting guideline recommendations for evidence-based interventions have evaluated the efficacy of psychotherapy as a treatment for late-life depression (Table 2). Most of these studies have focused on the evaluation of cognitive-behavioral therapy (CBT), brief dynamic therapy (BDT), interpersonal psychotherapy (IPT), reminiscence therapy (RT), and the combination of these interventions with medication management. This review systematically evaluates the evidence base for psychotherapy as an empirically supported treatment of late-life depression and is an update of the present authors’ recent review of the literature.

**BE-ACTIV: a staff-assisted, behavioral intervention for depression in nursing homes**


This article (a) describes a 10-week, behavioral, activities-based intervention for depression that can be implemented in nursing homes collaboratively with nursing home activities staff and (b) presents data related to its development, feasibility, and preliminary outcomes. Design and Methods: We developed BE-ACTIV, which stands for Behavioral Activities Intervention, in two pilot study phases: a treatment development phase and a feasibility-outcome phase with a small, randomized trial. We first piloted the intervention with five depressed residents in a single nursing home in collaboration with the social services and activities staff. The second phase randomized 20 residents from six nursing homes to receive either the intervention or treatment as usual. Results: The intervention was well received by
residents, family, and staff members. Experience with the intervention and input from staff members resulted in modifications to streamline the intervention and improve implementation. Results suggest that BE-ACTIV reduced institutional barriers to participation in pleasant activities, increased resident control over activity participation, increased overall activity participation, and improved depressive symptoms. Despite low power, statistical and graphical comparisons suggest superiority of the intervention over treatment as usual. Implications: Because depression among nursing home residents is prevalent, heterogeneous, and often treatment resistant, there is a need for effective, low-cost interventions that are ecologically acceptable and efficient. BE-ACTIV is a promising intervention; it is brief, addresses institutional barriers, involves facility staff in treatment, and is acceptable to residents. As such, BE-ACTIV merits further evaluation to establish efficacy and effectiveness.

**Increasing pleasant events in the nursing home: Collaborative behavioral treatment for depression**


Depression is prevalent in nursing homes, but there are many barriers to effective treatment in these settings. This case study describes a successful behavioral treatment of a nursing home resident with recurrent major depression. The 10-session, manualized program involved negotiating a weekly plan to systematically increase pleasant activities, administered collaboratively with nursing home staff. At baseline, the client was socially withdrawn, participated in no regular activities, did not leave her room except for therapies, and was tearful and apathetic. Treatment outcomes included markedly improved positive affect and increased activity level at posttreatment, and absence of depressive symptoms or diagnosis at both posttreatment and after a 12-week follow-up. The case illustrates barriers to successful treatment in nursing homes such as ongoing medical stressors, poor staff follow-through, and difficulty maintaining gains, but it also supports the potential of a theoretically based, behavioral approach to treating depression in long-term care.

**Developing psychosocial interventions for depression in dementia: Beginnings and future directions**


An overview of the current literature on treatment of depression in demented older adults, with particular emphasis on providing guidelines for evidence-based clinical care. The current author states that Teri, McKenzie, and LaFazia's review of outcome studies suggests that a number of psychosocial interventions have shown positive benefits relative to depression in dementia. However, considerably more research will be required to marshal convincing and practice-relevant evidence for the efficacy of particular intervention techniques in producing clinically significant amelioration of depression in older adults with dementia. This commentary discusses risk-benefit considerations surrounding the use of interventions in vulnerable older adults, as well as suggesting issues to be addressed in intervention development studies on this class of interventions.

**Treatment of depression and anxiety in the aged**


Antidepressant medications, ECT, and selected psychosocial interventions have all been shown to be efficacious
treatment approaches for depression in the elderly. Most studies have used drug and psychotherapy protocols specifically tailored for use with older patients. This chapter evaluates the efficacy evidence for these treatments, emphasizing randomized clinical trials with elderly samples in which depression or anxiety have been objectively characterized.

Incidence of depression in long-term care settings

Conducted a 1-yr longitudinal study to examine incidence and persistence of depression among nursing home and congregate apartment residents. Of 868 persons (mean age 83.9 yrs) interviewed at Time 1, 15.7% displayed possible major depression (MD), and 16.5% displayed minor depressive symptoms. A follow-up interview a year later with 448 Ss yielded an incidence rate for possible MD of 6.6% among persons with only minor or no depression in the previous year. For Time 1 nondepressives, the incidence of possible MD was 5.6%, and of minor depression, 6.3%. More than 40% of Time 1 possible major depressives showed no remission of symptoms a year later. In contrast, more than half of Time 1 minor depressives showed no depression at follow-up; however, another 16.2% appeared at follow-up to suffer possible MD. Change in depression was associated with cognitive status, functional disability, and physical health. In general, persistence of depression was associated with greater decline.

How effective are psychotherapeutic and other psychosocial interventions with older adults? A meta analysis

Meta-analysis was used to synthesize the effects of 122 psychosocial and psychotherapeutic intervention studies with older adults. Three research questions were explored: (1) what is the effectiveness of psychotherapeutic and psychosocial treatments (cognitive-behavioral therapy, reminiscence, psychodynamic approaches, relaxation, supportive interventions, control enhancement, psychoeducational treatments, activity treatments and training of cognitive abilities) on self-ratings of depression, clinician-rated depression, and other measures of subjective well-being in older adults; (2) the influences of moderator variables, and (3) whether the effects of psychosocial and psychotherapeutic interventions vary by age. Psychotherapeutic interventions changed self-rated depression and other measures of psychological well-being by about one half standard deviation and clinician-rated depression by more than one standard deviation.

Suicidality in nursing home residents: Part I. Prevalence, risk factors, methods, assessment, and management

Professional psychologists often work in nursing home settings. As the number of older adults in nursing homes increases, the number of psychologists providing care to this population will likely increase as well. Even though literature has suggested that nursing home residents have a high rate of mental disorders, the literature investigating suicidality in this population is scarce. Our discussion includes two articles. This article (Part 1) summarizes types of suicidal behavior, prevalence, risk factors, methods, screening/assessment, and management issues. The second
Suicidality in nursing home residents: Part II. Special issues.

Professional psychologists working with suicidal nursing home residents often deal with a host of special issues that may not be relevant to other populations. This review article (Part 2 of a series) was written to acquaint professionals with the concept of indirect self-destructive behavior and dealing with ethical concerns. This article also summarizes health care systems issues, including how to involve staff and family members in assessment and management, as well as understanding Medicare/Medicaid related concerns and public policy regarding long-term care. The article concludes with information about training and continuing education offerings for psychologists who need more information about working in nursing home settings.

Unmet needs in the diagnosis and treatment of mood disorders in later life.

In this editorial, the authors discuss the diagnosis and treatment of mood disorders among the elderly. They examine risk factors for unipolar and bipolar disorders, discuss the assessment of depression in old age, and look at treatment options for depression. The authors then describe mental health services for older depressed patients. They conclude by discussing the 5 Ds of depression in old age: disability, decline, diminished quality of life, demands on caregivers, and discriminatory reimbursement policies.

Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: A randomized controlled trial in patients older than 59 years

This 7-yr study examined the efficacy of nortriptyline and interpersonal therapy (IPT), either alone or in combination, in the treatment and recurrence prevention of major depression of adults aged older than 59 yrs. 180 elderly patients (mean age 67.6 yrs) with recurrent, nonpsychotic unipolar major depression were treated acutely with nortriptyline and IPT. 107 Ss whose remissions were stable for 16 wks were randomly assigned to 1 of 4 maintenance therapy conditions (1) medication clinic with nortriptyline, (2) medication clinic with placebo, (3) monthly maintenance IPT and nortriptyline, or (4) monthly maintenance IPT with placebo. Survival analysis showed a highly significant effect for active treatment over placebo in preventing recurrence of major depressive episodes. The best outcome was observed in Ss assigned to the combined treatment condition, with 80% remaining depression-free. On pairwise analysis, each of the active treatment conditions was significantly better than placebo in preventing recurrence. Older age was associated with a higher and more rapid rate of recurrence during the 1st year of maintenance with all treatments except combined nortriptyline and IPT.
Life-sustaining treatment and assisted death choices in depressed older patients

Examined the effect of depressed mood in older, medically ill, hospitalized patients on their preferences regarding life sustaining treatments, physician-assisted suicide (PAS), and euthanasia and to determine the degree to which financial constraints affected their choices. 158 hospitalized, nondemented patient's aged 60-94 yrs participated. The sample was divided, into a depressed group and a nondepressed control group. Ss underwent a structured interview evaluating their life-sustaining treatment choices and whether they would accept or refuse PAS or euthanasia under a variety of hypothetical conditions. These choices were reevaluated with the introduction of financial impact. Assessment included measures of depression, suicide, cognition, social support, functioning, and religiosity. Depression was found to be highly associated with acceptance of PAS and euthanasia in most hypothetically clinical scenarios in addition to patients' current condition. The authors found that depressed Ss and even Ss with subtle, passive suicidal ideation were markedly more interested in PAS and euthanasia than nondepressed Ss in hypothetical situations.

Depression and mortality in the elderly

It is well known that depression can be a consequence of medical illness and disability, but a growing literature suggests also that depression can cause biological changes linked to morbidity and mortality. Depression is strongly implicated as a contributor to cardiovascular disease and mortality. Using the cascade-to-death model as a conceptual framework, we explore the complex relations among behavior.

Introduction to the special section on evidence-based psychological treatments

Results of several evidence-based reviews of psychological treatments for older adults are presented which demonstrate that there are a number of EBTs (evidence-based treatments) that can contribute to their care. Identification of appropriate EBTs is fundamental to the provision of suitable psychological treatments for older adults.

Evidence-based psychotherapies for depression in older adults

We conducted an evidence-based review of psychological treatments for geriatric depression using coding criteria, and we identified six treatments to be beneficial: behavioral therapy, cognitive behavioral therapy, cognitive bibliotherapy, problem-solving therapy, brief psychodynamic therapy, and reminiscence therapy. Other interventions were found to be promising but were lacking replication. These findings suggest that (a) there are several treatment choices for consumers and practitioners across a relatively broad range of theoretical orientations and modalities, (b)
there needs to be a recognition of the viability of psychological treatments for depressed elders by other disciplines, and (c) there is an opportunity to provide training in evidence-based treatments for present and future providers to the growing number of older adults.

**Efficacy of psychosocial treatments for geriatric depression: A quantitative review**

A meta-analysis of 17 studies examined the efficacy of psychosocial treatments for depression among older adults. Psychosocial treatment was defined as an intervention, the primary mode of action which was through psychological or social mechanisms such as psychotherapy, bibliotherapy, or behavior therapy. Studies were included only if a comparison was made to a control condition (no treatment, delayed treatment, or placebo treatment) or another psychosocial intervention. Results indicated that treatments were reliably more effective than no treatment on self-rated and clinician-rated measures of depression. Effect sizes for studies involving participants with major depression disorder were also reliably different from zero, as were effect sizes from studies involving participants with less severe levels of depression. These findings compare favorably with several other quantitative reviews of treatments for depression. Results suggest more balanced presentations of the potential benefits of psychosocial interventions are warranted.

**The treatment of depression in older adults in the primary care setting: An evidence-based review**

The objective of this study was to conduct an evidence-based review of treatments for depression in older adults in the primary care setting. A literature search was conducted using PsycINFO and Medline to identify relevant, English language studies published from January 1994 to April 2004 with samples aged 55 and older. Studies were required to be randomized controlled trials that compared psychosocial interventions conducted within the primary care setting with "usual care" conditions. Eight studies with older adult samples met inclusion criteria and were included in the review. Two treatment models were evident: Geriatric Evaluation Management (GEM) clinics and an approach labeled integrated health care models. Support was found for each model, with improvement in depressive symptoms and better outcomes than usual care; however, findings varied by depression severity, and interventions were difficult to compare. Further efforts to improve research and clinical care of depression in the primary care setting for older adults are needed. The authors recommend the use of interdisciplinary teams and more implementation of psychosocial treatments shown to be effective for older adults.

**Psychosocial treatment of depression in older adults with dementia**

Depression and dementia commonly coexist and are associated with higher rates of behavioral and functional problems. Caregivers of these individuals report higher levels of physical and mental distress, as well. Effective treatment, therefore, has the potential to help both the older adult and their caregiver. This article provides an overview of the current literature on treatment of depression in demented older adults, with particular emphasis on providing guidelines for evidence-based clinical care. Eleven randomized controlled clinical trials were identified
following an extensive review of the literature. These studies are reviewed with particular attention to the methodological issues of most relevance to clinicians attempting to use the findings from these studies to guide their practice. Issues of particular relevance when working with this population are also addressed, including (a) for assessment—differential and coexistent diagnosis of depression in dementia, use of collateral informants, self-report and interviewer-obtained information; and b) for treatment—the need for caregiver involvement, individualizing of goals, and planning for future deterioration of cognitive function.

**Behavioral treatment of depression in dementia patients: A controlled clinical trial**

The current study is a controlled clinical investigation of 2 nonpharmacological treatments of depression in patients with Alzheimer’s disease (AD). Two active behavioral treatments, one emphasizing patient pleasant events and one emphasizing caregiver problem solving, were compared to an equal-duration typical care condition and a wait list control. 72 patient-caregiver dyads were randomly assigned to 1 of 4 conditions and assessed pre- and post-treatment, and at 6-mo follow-up. Patients in both behavioral treatment conditions showed significant improvement in depression symptoms and diagnosis as compared with the 2 other conditions. These gains were maintained at follow-up. Caregivers in each behavioral condition also showed significant improvement in their own depressive symptoms, while caregivers in the 2 other conditions did not. Results indicate the importance and effectiveness of behavioral interventions for treatment of depression in AD patients and their caregivers.

**Comparison of desipramine and cognitive/behavioral therapy in the treatment of elderly outpatients with mild-to-moderate depression.**

This study evaluated the efficacy of desipramine alone vs. cognitive/behavioral therapy alone (CBT) vs. a combination of the two, for the treatment of depression in older adult outpatients. 102 patients (mean age 66.8 yrs) meeting criteria for major depressive disorder were randomly assigned to one of the three treatments for 16-20 therapy sessions. All treatments resulted in substantial improvement. In general, the CBT only and combined groups had similar levels of improvement. In most analyses, the combined group showed greater improvement than the desipramine alone group, whereas the CBT alone group showed only marginally better improvement. The combined therapies were most effective in patients who were more severely depressed, particularly when desipramine was at or above recommended stable dosage levels.

**Treatment of dysthymia and minor depression in primary care: A randomized controlled trial in older adults**

Compared the effectiveness of placebo plus clinical management (CM), paroxetine, and problem-solving treatment–primary care (PST-PC), a behaviorally based psychotherapy designed specifically for primary care. 415 older primary care patients (mean age 71 yrs) with minor depression or dysthymia were randomly assigned to receive placebo,
paroxetine, or PST-PC. All patients were scheduled for 6 treatment sessions over 11 wks. The primary outcome measure was the Hopkins Symptom Checklist Depression Scale (HSCL-D-20). All groups showed improvement over the 11-week treatment period. Mean HSCL-D-20 scores decreased by an average of 0.61 points for patients taking placebo plus CM. 338 patients completed at least 4 treatment sessions, which was considered an adequate course of treatment. Patients treated with paroxetine showed greater improvement than patients taking placebo plus CM. Patients treated with PST-PC did not differ overall from placebo plus CM or paroxetine but showed more rapid symptom resolution that those taking placebo during wks 2 through 11. Other results are discussed.

**Development of a curriculum for long term care nurses to improve recognition of depression in dementia**


There is increasing recognition of the severe consequences of depression in long-term care residents with dementia. Most health care providers are unprepared to recognize and to manage the complexity of depression in dementia. Targeted educational initiatives in nursing homes are needed to address this growing problem. This paper describes the development of competencies, learning objectives, and learning outcomes for a curriculum on depression in dementia for nurses working in nursing home settings. This work provides the foundation for a curriculum to improve learning for nurses and, ultimately, to advance health care outcomes for residents with concurring depression and dementia.

**Depression in long-term care: Contrasting a disease model with attention to environmental impact**


Discusses the variety of forms depression can take among LTC residents and the influence the LTC environment can play on the development and maintenance of depression. The current author states this review of depression in long-term care (LTC) settings recognizes the prevalence of depression in LTC, addresses problems in assessment of depression, and examines empirical literature on the effectiveness of psychotherapy for depression. This commentary expands on the preceding review by focusing on a theoretical understanding of depression and how that understanding can inform treatment recommendations. The basic argument presented is that psychologists could best serve older adults in LTC settings by extending beyond traditional approaches to treatment of individuals who are depressed; psychologists can become good observers of the relationship of environmental factors in LTC to the internal emotional experience of depression, and then help to serve as change agents by collaborating in designing and implementing change in LTC environments. Such a radical shift could improve the quality of life for LTC residents. It also offers the possibility of defining theoretical linkages among external environmental variables, cognitive understanding of them, and emotional experience that could inform depression theory generally.

**Books**

**Interpersonal psychotherapy for depressed older adults**

This volume applies interpersonal psychotherapy (IPT), as developed by Gerald Klerman, Myrna Weissman, and their colleagues, to older adults with depression. It also draws on IPT research on late-life depression conducted by Ellen Frank, Charles Reynolds, and their collaborators at the University of Pittsburgh. With cognizance of broader issues that apply to psychotherapeutic work with older adults, the original IPT framework for the treatment of depression in younger adults can be applied to older adults. The volume first reviews relevant gerontology issues that provide the broader context in which older lives are lived. Knowledge of depression and later life are then discussed in Chapter 2 along with general clinical recommendations for the assessment and treatment of older adults. In Chapter 3, we make a clinical and research case for why IPT is especially well-suited for older people. In Chapter 4, the general structure of IPT is reviewed along with a distillation of salient research. In much of the remainder of the book we discuss how to conduct IPT, drawing on our clinical experience with older people. A chapter is devoted to common problems that arise for those who are learning IPT. The final chapter includes a summary of concluding remarks and guidance for those who want to gain further knowledge and experience in the application of IPT. The book concludes with an annotated list of resources.

**Suicide and depression in late life: Critical issues in treatment, research, and public policy**

The authors explore the biology, psychology, epidemiology, and sociology of depression and suicidal behavior in late life as well as ethical principles that underlie clinical research and therapeutic intervention. The range of treatment including environmental manipulations, psychotherapy, family counseling, medications, and ECT is reviewed, and guidelines for effective interventions are provided. The limits of existing scientific data and social policy are detailed. Readers will gain a better understanding of the dilemma presented by the older adult's thoughts of death in relation both to mental illness and rational expectations for the end of the life span.

**Assessing and treating late-life depression: A casebook and resource guide.**

This practice-oriented, research-based casebook draws on extensive clinical and academic data on late-life depression and its treatment as a resource for practitioners and researchers. With a rapidly aging population, depression among the elderly has become a critical issue for the mental health and medical communities. The authors--a practicing psychologist and two clinical geropsychologists among them--provide an interdisciplinary framework for understanding and treating late-life depressive symptoms. The authors elucidate the problems and principles of late-life depression with fourteen extended case studies. Explicating the range of syndromes and strategies for assessing and treating them, they conclude with a guide to medications, screening tools, innovative models, and supplementary resources.

**Elder suicide: Research, theory and treatment**

This volume synthesizes research findings, identifies gaps in our knowledge, and explores current controversies
related to elder suicide. Thoughtful theoretical discussions examine sociological, psychological, biological, and other theories of suicide. While emphasizing the cognitive-behavioral orientation, the book provides an overview of clinical approaches to depressed and suicidal elders, identifying aspects unique to elder suicide, exploring assessment and intervention modalities, and specifying warning signs. Varied case histories illustrate the many complicated aspects of elder suicide. The book also explores sensitive ethical and philosophical issues raised by elder suicide, including the current debate over assisted suicide.

**Physical illness and depression in older adults: A handbook of theory, research, and practice.**

This handbook consists of 3 major sections. The first considers risk factors for the development of depression in older adults. The second section graphically illustrates the need for complex models when studying associations between physical illness and depression. The third section considers critical diagnostic and treatment issues.

**Book Chapters**

**Suicide among ethnic elders**

Statistics on suicide are presented for each group of ethnic elders [African Americans, American Indians and Alaskan Natives, Asian Americans and Pacific Islanders, Hispanic Americans]. The chapter then discusses the attitude toward the completion of suicide by each group of ethnic elders and concludes with a summary of the known information and the areas where further investigation is indicated.

**Openness to experience and completed suicide across the second half of life**

This chapter offers the testable hypotheses that persons low in OTE [openness to experience] are at risk for taking their own lives because their affective dampening, cognitive certainty, diminished behavioral repertoire, and rigidly defined self-concept have decreased their capacity to adapt to the expectable age-associated changes in role, health, and function that accumulate over time. Concrete thinking and excessive focus on proximal, low-level goals place them at risk for descending into states of suicidal meaninglessness in times of stress or crisis. This state of awareness increases the desirability of suicide as an action-oriented solution to the stressors of aging. Other lines of investigation are suggested including research on OTE in attempted suicide, OTE and the neurobiology of suicidal behavior, OTE and gender differences in suicidal behavior; and clinical intervention designed to increase the degree to which one is open to experience.
Interpersonal psychotherapy as a treatment for late-life depression.

This chapter discusses the treatment of late-life depression using interpersonal psychotherapy. Several generations of gerontological researchers have examined how early-life and generational experiences, the onset of health problems in later life, loss and acquisition of new social roles, and the availability of adult children and other social relationships affect emotional well-being of older adults. In view of the large body of research that has documented that interpersonally relevant problems increase risk for late-life depression, Interpersonal psychotherapy (IPT) seems like an especially useful modality. Research documents that IPT successfully treats depression in younger and older adults. Clinically, it has been found that the majority of our older IPT clients show significant improvement in depressive symptoms. Most older IPT clients find the goal-oriented, time-limited format of IPT appealing. My colleagues and I find that, while IPT has a well-delineated structure of goals and strategies, it is a versatile therapy in which 'here and now' issues can be addressed in tandem with expression of feelings and discussion of historical issues that resonate with present problems.

Mood disorders in older adults

Discusses mood disorders in older adults, focusing on depressive disorders, as these are the most prevalent and concerning disorders found in older adults. Although other disorders are addressed, this chapter emphasizes the etiology, diagnosis, and treatment of unipolar major depression in older persons. A case study of a 76-yr-old woman with major depression is used throughout the chapter to highlight key factors and symptoms that facilitate a differential diagnosis of her mood disorder. Other topics discussed include epidemiology and theories of depression. The chapter also reviews various biological, psychological, and social systems approaches to treatment.

Alcoholism, drug abuse, and suicide in the elderly

Discusses the contributions of alcoholism, drug abuse, and depression to suicide in the elderly. Case events are presented that help to understand the suicidal decision in aging substance abusers, but the importance of estimating suicide risk is highlighted. Seven attitudinal risk factors for suicide in substance abusers are presented, followed by discussion of preventing suicide. In addition, the importance of diagnosing and treating major depression in elderly alcoholics and substance abusers is noted.

Suicidal behavior in later life: Research update
Reviews the available research evidence on risk factors and correlates in later-life suicidal behavior, and suggests
opportunities for research. Information is presented from studies on completed suicide, attempted suicide, suicidal ideation, and indirect life-threatening behaviors. The identification and adequate treatment of depression is proposed as the most promising research avenue when preventive interventions in later-life suicide are considered.

Reports


Chapter 5, Older Adults and Mental Health, first reviews the normal developmental milestones of aging, highlighting the adaptive capacities that enable many older people to change, cope with loss, and pursue productive and fulfilling activities. The chapter then considers mental disorders in older people, including their diagnosis and treatment, and the various risk factors that may complicate the course or outcome of treatment. Gains that have been realized in making appropriate mental health services available to older people and the challenges associated with the delivery of services to this population are discussed. The chapter concludes with a review of the supports available for older persons that extent beyond traditional, formal treatment settings.

The Surgeon General’s Call To Action To Prevent Suicide (1999)
U.S. Public Health Service, Washington, DC.

This report outlines more than a dozen steps that can be taken by individuals, communities, organizations, and policymakers to prevent suicide.

Resources for Consumers

Age Page: Depression: A Serious but Treatable Illness (National Institute on Aging)
Discusses causes of depression, symptoms, treatment and helpful resources.

Aging in the Know: Depression (American Geriatrics Society)
Contains a list of important about types of depression and treatment for elders.

At a Glance - Suicide among the Elderly (National Strategy for Suicide Prevention)
Contains helpful links and important statistics on the issues of suicide and aging.

Depression and Older Adults (Mental Health America)

Older Adults: Depression and Suicide Fact Sheet (National Institute on Mental Health)

Psychology and Aging: Addressing Mental Health Needs of Older Adults (American Psychological Association)