Professional Reference Series

Depression and Anxiety, Volume 1

Depression and Anxiety Prevention for Older Adults

OLDER AMERICANS
Substance Abuse & Mental Health
Technical Assistance Center

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TAC MISSION

The mission of the *Older Americans Substance Abuse and Mental Health Technical Assistance Center* is to enhance the quality of life of older adults by providing training and technical assistance to health care agencies and providers regarding health issues common in late life. TAC priorities include the prevention and early intervention of substance abuse, medication misuse and abuse, mental health disorders, and co-occurring disorders.

For more information on this topic or other topics offered in our *Professional Reference Series* please contact the Older Americans Substance Abuse and Mental Health Technical Assistance Center at:

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Depression and Anxiety Prevention for Older Adults

The following information is adapted from the SAMHSA Older Americans Technical Assistance Center "Evidence-Based Practices for Preventing Substance Abuse and Mental Health Problems in Older Adults."

Preventing Depression and Anxiety

Risk factors for late-life depression have been identified through a systematic review of the research literature and a longitudinal study. In a review of 20 studies, Cole and Dendukuri noted that bereavement, sleep disturbance, disability, prior depression and female gender were all significant predictors of depression. Risk factors for depression have also been identified through a survey of older persons living in the community. In a second study of 1,947 older adults, Strawbridge and colleagues noted that older adults who were more likely to be depressed included those:

- With low and medium levels of physical activity,
- Who possess a physical disability or mobility impairment,
- Who have one or more chronic conditions,

- With fewer than three close friends or relatives, and
- Those who were somewhat satisfied or not satisfied with friendships.

Several of these risk factors may be mitigated by preventive efforts, including programs for persons who are currently suffering from depression or have a history of recurrent depression. In addition, undertreated conditions that commonly precipitate depression such as vascular disease, functional impairment, or nutritional deficiencies may be prevented through programs as well.

DID YOU KNOW

- 1 in 5 older adults has a significant mental disorder. This includes more than 16% with a primary psychiatric illness and 3% with dementia complicated by psychiatric symptoms.
- Depression and anxiety disorders are among the most common mental health problems in older persons, affecting approximately 3-7% and 11% of the general older adult population, respectively. The prevalence of anxiety symptoms among older adults may be as high as 20%.
- Estimates suggest that sub-threshold or minor depression is present in 8-16% of older adults **residing in the community,** 15-20% of those **receiving primary care services,** 25-33% of older adults in an acute care hospital, and up to 50% of older adults in **long-term care facilities.**
- The prevalence of other mental health disorders among older adults such as schizophrenia and bipolar disorder is much lower (less than 1%), although these disorders impart significant functional impairments to older persons.

Preventing Depression in Older Adults

Exercise

Findings from at least two programs show that exercise can help prevent depression in older adults. Wallace and colleagues evaluated a multi-component intervention in which participants received a 30- to 60-minute visit at a senior center with a registered nurse to review risk factors for disability, develop a targeted health promotion plan, and introduce a supervised exercise program. This visit focused on current exercise habits, alcohol and tobacco use, dietary habits, and home safety issues. The nurse contacted subjects by telephone to review progress toward goals, motivate continued behavior change, and identify problems with compliance. The exercise program was conducted in groups of up to 10-15 older adults led by a trained exercise instructor. **Positive outcomes included improved health functioning and a reduction in depressive symptoms.**

A second study conducted by Penninx and colleagues evaluated the effectiveness of exercise in preventing depression in older adults with osteoarthritis. They compared a 3-month facility-based aerobic or resistance exercise program to a control group receiving education on arthritis management. The aerobic exercise program consisted of an indoor walking program that was conducted under the supervision of an exercise leader three times per week for one hour. The aerobic and resistance exercise programs were each followed by a 14-month home exercise program with support and supervision from an exercise leader. **Evaluation of these programs found that aerobic exercise, but not resistance exercise, significantly reduced depressive symptoms.** Not only

do these findings support previous research showing that exercise is an effective treatment for late-life depression, but they illustrate the benefits of exercise in preventing depressive symptomatology in non-depressed older adults.

Educational Classes

Several educational programs were evaluated to determine their effectiveness in preventing depression, including two that were directly targeted at increasing knowledge regarding specific medical conditions. A 10-week arthritis education class was associated with significant reductions in depressive symptoms compared to a control group at 1 and 2-year followup evaluations. Similarly, a 6-week diabetes education class combined with a support group was associated with lower incidence of depression at 2-year followup compared to a control group. Finally, classroom and home-based multi-component mind-body wellness courses, including relaxation training, cognitive restructuring, problem solving, communication, behavioral treatment for insomnia, nutrition and exercise, and instruction on mind-body relationships, were associated with a reduction in depression and anxiety symptoms compared to a control group.

Life Review

Zauszniewski and colleagues examined the effectiveness of a focused reflection reminiscence program in reducing negative emotions in older adults living in retirement communities. The program, entitled "Reflections for Seniors," included members of a retirement community who met for two hours per week over a 6-week period. A similar life review program evaluated by Haight and colleagues included nursing home residents who met for

one hour per week over a 6-week period. Both studies found small effects on the reduction of depressive symptoms in older adults. Evidence also suggests that screening alone may be associated with a lowering of depression levels.

A study conducted in urban senior congregate housing settings also used gatekeepers to identify older adults at high-risk of psychiatric problems. The Psychogeriatric Assessment and Treatment in City Housing (PATCH) model incorporates components of the Gatekeeper program and assertive community treatment. The PATCH psychiatric nurse met with the building administrator; an education program was provided to housing personnel to enhance recognition of high-risk residents; and to clarify procedures for making referrals of high-risk residents, and weekly nurse visits included in-home psychiatric evaluation and case management services for residents ages 60 and older. This study of the PATCH model found that outreach services were associated with a decrease in overall psychiatric symptom severity for individuals with a variety of psychiatric disorders.

Problem-Solving Therapy

Two studies have evaluated the effectiveness of problem-solving therapy (PST) for older adults with dysthymia or minor depression. The PEARLS program, evaluated by Ciechanowski and colleagues, was found to be associated with improved depressive symptoms and functional and emotional well-being. In addition, compared to a control group, those receiving PST were more likely to achieve remission of depressive symptoms (36% vs. 12%). In contrast, Williams and colleagues evaluated PST compared to an antidepressant medication (paroxetine) or a placebo.

They found that neither treatment was associated with a difference in rates of remission compared to placebo. However, for those patients with minor depression, both paroxetine and PST improved mental health functioning in patients with initial low functioning. Only paroxetine was associated with improvement for persons with dysthymia.

Interpersonal Therapy

One study found interpersonal therapy (IPT) to be effective at preventing an increase in depressive symptoms. Mossey and colleagues compared IPT to usual care. IPT was associated with improved self-rated health and after 6 months, three-fifths of the intervention group, compared to approximately one-third of the control group, had experienced a reduction in depressive symptoms.

Resistance Training

A study of older persons with pre-existing depressive symptoms (59% with minor depression or dysthymia) found that resistance training was more effective than health education alone in preventing the worsening of depression. Singh and colleagues noted that remission was achieved by six of seven (86%) participants in the resistance exercise group, compared to 4 of 10 (40%) participants in the health education control group.

Interventions for Care Providers

Two studies evaluate whether modifications to the provision of care can affect depressive symptoms. Cuijpers and colleagues evaluated a multifaceted education and support program admin-

istered in a residential care setting, compared to usual care. The intervention included training for caregivers and other employees of the residential home, informational meetings for residents and their relatives, support groups, and discussion and feedback sessions for care providers. The target population included older persons who were incapable of living independently due to physical, psychiatric, or psychosocial constraints, yet who did not require extensive nursing home care. Results indicate that providing education, support and feedback to residential care providers can reduce depressive symptoms and maintain health-related quality of life for older persons. Waterreus and Blanchard evaluated the effectiveness of care delivered through a nurse case management system in which the care plan was developed through coordination of a multidisciplinary psychogeriatric team. Compared to a usual care control group, the intervention group exhibited greater reduction in depression severity, but the intervention was not associated with fewer cases of depression.

Interventions for Family Caregivers

Family caregivers, such as spouses or children caring for loved ones with dementia, are also at risk for developing depressive disorders. In the early 1990s, Mittelman and colleagues developed and tested an intervention consisting of scheduled individual and family counseling sessions, unlimited consultation on request, and continuous support group participation for family caregivers of persons with dementia. This intervention was found to delay nursing home placement by an average of 329 days, prompting researchers to develop, refine, and test similar interventions to support the capacity of natural caregivers to care for their loved one in the home environment.

In addition to improving outcomes for the individual with Alzheimer's disease, this intervention also has been found to reduce stress and psychological symptoms for caregivers. The counseling and support provided to families is associated with greater satisfaction with assistance received from others, as well as decreased caregiver depression. In addition, PST has been successfully used to enhance the ability of caregivers to cope with stress and to decrease the incidence of depression and other adverse outcomes. For example, Teri and colleagues studied the effectiveness of PST as an intervention for reducing depression among individuals with dementia and their caregivers. Caregivers who participated in PST decreased their levels of depression and burden over a 6-month period.

Of note, a recent systematic review evaluated major outcomes in family caregiving interventions for dementia, as published in 43 studies since 1996. Findings indicate that the major impact on caregivers includes decreased incidence and severity of depression, moderate decreases in reported anger, moderate improvement in stress management, positive changes in clinical health indicators such as blood pressure and stress, and small improvements in caregiver burden.

Targeted Outreach for Vulnerable Older Adults: The Gatekeeper Program

The Gatekeeper program was developed to train and encourage non-traditional referral sources to identify and refer older adults living in the community who are at risk for serious substance abuse and mental health problems. Gatekeepers are the employees of local businesses and community organizations who have contact with older adults (e.g., letter carriers, police officers, bank tellers, landlords, meter readers, and many others). The "gatekeeper" model has been compared with traditional referral sources (e.g., medical providers, family members, informal caregivers, or other concerned persons) to determine its efficacy in identifying vulnerable older adults in need of services. Studies of the Gatekeeper program have found differences in individual characteristics between individuals referred by gatekeepers and those referred by medical or other traditional sources. Older adults (age 60+) referred by gatekeepers were significantly more likely to live alone, were more often widowed or divorced, and were significantly more likely to be affected by economic and social isolation. These findings suggest that the gatekeeper model may uniquely provide outreach to individuals who are less likely to access services through conventional referral approaches.

Conclusions

This review highlights the scientific evidence for the prevention and early intervention of depression and anxiety in older adults. As shown, several programs have identified positive effects in preventing depression or reducing depression symptoms. The best evidence exists for the effectiveness of exercise and psychotherapeutic interventions, such as problem-solving therapy and interpersonal therapy. In addition, there is evidence to suggest that targeted outreach to older adults is effective in engaging isolated and vulnerable older persons in treatment for mental health and substance abuse problems. Other potentially effective strategies include life review, reminiscence therapy, educational classes, mind-body wellness, and provider education. Many of these approaches require further evaluation prior to establishing their effectiveness among older adults. Our review also revealed that there is minimal evidence for programs that target the prevention of anxiety among older adults. As one in five older adults experiences symptoms of anxiety, programs are needed in this area.

It is important to acknowledge that several programs developed to prevent depression have not demonstrated effectiveness. For instance, among the brief interventions for older adults with minor depression reviewed by Cole and Dendukuri, several trials showed no effect in the prevention of depression. These studies were primarily focused on bereavement support groups or life review. The lack of effect on the prevention of depression was also noted in a social support network intervention for seniors.

Finally, it is important to remember that late-life depression is often chronic or characterized by a relapse. Although this review focuses on the universal prevention of late-life depression and selective and indicated prevention of the exacerbation of minor depression into major depression, an important area of research addresses the prevention of further disability among older adults who have developed depression. Prevention strategies should focus attention on preventing relapse, recurrence, and residual symptoms among older adults with current or remittent major depression.

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