Sadness and Worry in Older Adults

Differentiating Psychiatric Illness from Normative Distress

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KEYWORDS

• Depression • Anxiety • Suicide • Grief • Bereavement • Social connectedness • Social isolation • Geriatrics

KEY POINTS

- Later life is generally associated with greater emotional well-being.
- However, in certain contexts older adults may be more at risk for bereavement and grief, social isolation and loneliness, and suicide.
- Self-reported symptoms of depression and anxiety may differ for older adults, necessitating developmentally appropriate assessment of symptoms.
- It is critical to consider the balance of risk and resilience factors for depression and anxiety in late life, as well as developmental trajectories, rather than assessing each factor in isolation.

INTRODUCTION, BACKGROUND, AND DEFINITIONS

Although later life is broadly associated with greater emotional well-being,[1] older adults face a number of developmental changes that have the potential to negatively impact their mood and emotional well-being. This dichotomy between emotional well-being and emotional vulnerability in late life may be demonstrated by the relatively low rates of depression in this age group[2] compared with the fact that older men compose the demographic group with the highest risk of suicide in the United States[3] and around the world.[4] Further, older adults may present with a different array of risk factors and symptoms of depression or anxiety than younger adults.[2,5] Additionally, older adults may be at greater risk for changes that may frequently be comorbid with, but do not automatically confer a diagnosis of, depression or anxiety, such as grief, social isolation and/or loneliness, and thoughts of death. The aim of this review is to distinguish these phenomena from each other and from a major depressive disorder or

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anxiety disorder in late life, to clarify normative and non-normative changes in emotional well-being among older adults, and to provide recommendations for assessment and intervention.

There is a common misconception of aging that depression or poor emotional well-being is common, or even normal, in late life.[6,7] This notion likely stems from a societal ageist bias, and beliefs that it is normal for late life to be characterized by poor health and poor functioning and, therefore, poor mental health.[7,8] It additionally stems from a lack of understanding of normative developmental changes throughout adulthood and late life. Emotional experiences can be understood in a developmental context, such that certain experiences are normative at certain times in life, whereas others are not normative in certain contexts. Without an understanding of these contexts, a developmentally normal experience may be mistaken to be pathologic, whereas an experience of suffering may be overlooked owing to an incorrect assumption that it is typical of a certain age. With greater knowledge of the developmental trajectory of emotional well-being in late life, a clinician may more accurately assess whether a patient's experience represents a divergence from a healthy trajectory, and what interventions may support that patient in getting back "on track."

For the purpose of this review, "normative" refers to phenomena appearing in research to be developmentally appropriate, or to occur among a large portion of the population without diagnosable mental illness. "Non-normative" refers to phenomena that are associated with maladaptive coping or adjustment, and possibly (but not necessarily) mental illness, that may be the target of intervention/treatment. The terms "depression" and "anxiety" refer to diagnosable disorders per the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) 5th edition[9] and/or *International Classification of Diseases*, 10th edition,[10] such as major depressive disorder, generalized anxiety disorder, and so on. There will also be some discussion of subthreshold syndromes, in which an older adult may not meet criteria for a disorder, but experiences some symptoms with a significant effect on his or her quality of life.

NORMATIVE EMOTIONAL DEVELOPMENT IN LATE LIFE

Research to date on lifespan development has shown that, generally, later life is associated with greater emotional well-being, including less frequent negative affect and more frequent positive affect, and decreased lability in emotions.[1,11] One prominent theory posited to explain this phenomenon is the socioemotional selectivity theory.[12] The socioemotional selectivity theory posits that, as the end of life is perceived to draw nearer, people shift their goals from the acquisition of knowledge or exploration of new experiences, to the regulation of emotion and enhancement of positive emotional and relational experiences. In other words, as people perceive their time becoming more limited, they focus more on maximizing positive emotional states and minimizing negative emotional states in the present, often via seeking out stable and positive social contexts.

Taking a more expanded view by considering the age-related physiologic factors in emotional experience in addition to the psychological factors, the strength and vulnerability integration theory posits that later life is associated with both psychological enhancements in adaptive emotion regulation strategies (as described in the socioemotional selectivity theory) as well as physiologic vulnerabilities to situations involving higher, more prolonged negative emotional arousal.[13] With age, people build and hone effective psychological strategies for regulating average, common emotional experiences, therefore leading to a decrease in exposure to negative

emotional experiences, improved ability to rebound after minor negative experiences, and a general increase in emotional well-being. However, aging is also associated with decreased physiologic flexibility and resilience, leaving older adults more vulnerable to distress when they experience high levels of physical arousal associated with an unavoidable, prolonged state of stress or negative emotional arousal.

In behavioral and imaging studies of the brain as people age, patterns of resilience to negative emotional experience and reactivity to positive emotional experience are borne out, despite the general reality of physiologic and cognitive decline in later life.[14] Older adults exhibit less reactivity to negative stimuli, and greater memory for positive information. However, older adults who have damage to areas of the prefrontal cortex related to emotion regulation are more likely to experience negative outcomes such as depression.[14]

These results indicate that, contrary to a common misconception that growing older is associated with a decline in emotional well-being,[6] the majority of older adults will experience a general improvement in emotional well-being in late life. However, older adults who are exposed to significant, unavoidable, prolonged stressors may be especially vulnerable to negative outcomes, such as mood or anxiety disorders, or even suicidal thoughts or behaviors.

MOOD AND ANXIETY DISORDERS IN LATE LIFE

Numerous studies have documented that older adults have a lower prevalence of mood and anxiety disorders than younger adults,[15–17] which may be accounted for, in part, by increased levels of emotional well-being in later life. However, many believe that these estimates can be misleading, owing to issues of accurately detecting depression and anxiety in this population.[18] Under-recognition may occur due to underreporting of symptoms by older adults owing to stigma, or internalized ageism whereby older adults—and providers—expect depressed mood to accompany aging and thus do not think it warrants treatment. Physicians and other clinicians are less likely to ask older adults about psychological symptoms, including suicide ideation, than for younger adults.[18,19]

Older adults' presentation of mood or anxiety disorders often differ from younger adults, meaning that the symptoms older adults experience and describe differ from those of younger patients. Older adults are less likely to report sad or depressed mood, but more likely to report anhedonia (lack of pleasure),[5] apathy, and irritability.[20] In addition, older adults are more likely to describe somatic symptoms as their primary concern, such as those related to sleep, fatigue, and psychomotor slowing, as well as cognitive symptoms such as deficits in memory, concentration, processing speed, and executive functioning.[2] Depression in late life commonly co-occurs with gastrointestinal and other somatic symptoms.[20] Older adults may also be more likely to present with a subthreshold depression, meaning that clinically significant depression symptoms are present, but not enough symptoms to meet the criteria for a major depressive episode. The clinical importance of subthreshold syndromes should not be minimized, because this syndrome is associated with a greater odds of lifetime psychiatric disorders and of developing major depressive disorder or an anxiety disorder in the subsequent years.[21] Finally, because older adults are more likely to experience multiple health problems, differentiating a depressive disorder from an underlying medical condition is essential and can be complex. Nonspecific physical symptoms, such as fatigue, loss of appetite, weakness, diffuse physical pain, and sleep problems, can be signs of a depressive illness or symptoms of an underlying medical condition. Depressive disorders and medical illnesses also frequently

co-occur (and share symptoms) and can increase risk in both directions—a depressive disorder is associated with poor health and many medical illnesses are associated with increased risk for a depressive disorder.[2]

Older adults' presentations of anxiety disorders may differ somewhat from those of younger adults, including the topics of worry (eg, more concerns about health and fewer about work or school),[5,22] but there are fewer differences than regarding depression. Older and younger adults report comparable symptoms of anxiety disorders, but they may describe their symptoms differently, using terms such as "stressed" or "tense" rather than "anxious," "worried," or "nervous."[5] Given these differences in the presentation of anxiety in late life, recommendations for future diagnostic classifications have included attention to the heterogeneity of anxiety symptoms and experiences in older adults, the use of language appropriate to the older adult in the assessment of anxiety, consideration of comorbidities (eg, comorbid depression, medical illness, and cognitive impairment), and attention to variants of anxiety that are mostly exclusive to late life (eg, fear of falling).[23]

As clinicians assess for the presence of mood or anxiety disorders among older adults, they should be alert to these possible differences in presentation and use appropriate assessment strategies and instruments. The use of assessment instruments developed and validated specifically for use in older adults (eg, Geriatric Depression Scale,[24] Geriatric Anxiety Inventory[25]) is recommended, because such instruments take into account differences in symptom presentations and measurement in older adults and are designed to be easy to administer, with yes/no response choices. Additionally, best judgment should be used regarding the presence of distressing subthreshold mood symptoms that may merit an intervention, although they may not meet diagnostic criteria.

BEREAVEMENT AND GRIEF

Losses become a normative part of life in older adulthood, including bereavement (death of a loved one) and loss of prior levels of health and physical functioning. However, although loss is a common experience in later life, that does not mean that all grief reactions will resolve on their own or do not warrant intervention. For example, individuals who have experienced bereavement are at greater risk for declines in health and functioning, potentially increased risk of mortality, decline in socioemotional well-being, and increase in loneliness and social isolation.[26] Prolonged grief around decline in health or physical functioning may be associated with greater use of health care services (eg, emergency room visits, hospitalizations).[27] Further, up to 25% of older adults who have experienced a major bereavement may go on to experience complicated grief, which refers specifically to an atypical, maladaptive, and prolonged grief reaction.[28–30] The boundary between what is normal after a loss and what constitutes a disorder is a topic of debate, including regarding the recent change in the fifth version of the DSM released in 2013.[9] In this version, a controversial change was made to remove an exclusion for a major depressive episode for bereavement, which in previous DSM versions had ruled out a diagnosis of major depressive disorder for individuals within 2 months after bereavement except in severe cases.[31] Although there are several arguments both in support and opposition of this change,[31] the implication for clinicians is the critical need to use best judgment in distinguishing a normative grief reaction from complicated grief or a depressive syndrome. Some of the research to date on differences between normal or uncomplicated grief, complicated grief, and depression or anxiety may be useful in making diagnostic decisions.

Common predictors for a greater risk of complicated grief across studies are female gender, older age, lower education, and poorer cognitive functioning.[28,29,32] Anticipation or expectancy around the loss (ie, whether an older widow expected the death of her spouse to occur) has not been shown to be predictive of differences in grief.[33] Among those with complicated grief, up to 10% may experience comorbid depression and 17% comorbid anxiety.[29] Of note, the emotional responses to bereavement may mitigate across time; for example, in 1 study, differences in depressive symptoms and psychopathology between widowed older adults and nonwidowed older adults that had been evident 2 months after a loss faded to nonsignificance within 12 months, although differences in grief-specific symptoms remained to some extent even up to 2.5 years after the loss.[34] Given that the DSM's bereavement exception extended only to 2 months after a loss, these results highlight the more protracted trajectory that recovery from grief and its emotional associates may take.

Research indicates that there is not a consistent, clear definition and boundary between complicated grief and uncomplicated or normal grief and, throughout the literature, symptoms of complicated grief and depression or anxiety significantly overlap.[30] Also, a comprehensive framework of bereavement and grief must take into account preloss factors (eg, preexisting depression), interpersonal and intrapersonal factors (eg, social support, physical health and functioning), and cognitive coping (eg, cognitive appraisal, emotion regulation), all of which influence grief outcomes and resilience.[30] Finally, cultural sensitivity to grief and mourning-related norms and practices is critical, although little is currently known about cultural differences in this area.[30]

Grief may present in many heterogeneous ways among older adults who have experienced bereavement and has the potential to impact risk for depression and anxiety. Clinicians should use their best judgment to distinguish normative grief responses, complicated grief, and depression or anxiety syndromes. Preloss functioning, as well as current functioning and the individual's trajectory of change in grief symptoms over time, may help to distinguish these phenomena.

SOCIAL ISOLATION AND LONELINESS

Aging is associated with changes in the size and composition of social networks, such that, as we age, the size of our social networks tends to decrease, with decreases primarily seen regarding friends and other nonfamily connections.[1] This finding was originally attributed to the many losses that occur in later life, including retirement (and loss of work relationships), declining health, and deaths of friends and family. However, gerontologists have documented that the decreased size of social networks associated with aging is actually due, in large part, to an active process by older adults to "prune" their networks and discard the less meaningful and valued ties to devote more energy and time to the most meaningful relationships.[1] Thus, although social networks tend to be smaller in later life, older adults report greater satisfaction with their social networks. Further, although loneliness and social isolation are often described as a problem of old age in the popular media, loneliness and social isolation are not the norm in later life. In fact, a recent study with a large sample representative of the US population found that the prevalence of loneliness decreases with age.[35] In contrast, up to one-third of community-dwelling older adults report that they expect to become lonely as they grow older or that they agree with the statement, "old age is a time of loneliness."[36] In turn, those who agree with these stereotypes of aging are then more likely to actually experience loneliness in the future, consistent with a "self-fulfilling prophecy."[36] Addressing expectations about aging to be more positive and realistic can be a useful intervention for individuals at all ages, patients, caregivers, and clinicians.

This is not to say that social isolation and loneliness are not relevant issues for older adults. Although social isolation and loneliness are not the norm in later life, when they do occur, they may have even more deleterious effects on health and well-being than at younger ages owing to the body's decreased capacity for managing stress (cf., the strength and vulnerability integration theory discussed in the Introduction). Further, social isolation and loneliness may be key targets of intervention to promote health and well-being in later life because these aspects of our social health remain malleable throughout our lives, whereas some factors, such as sensory impairment or loss of mobility may be less amenable to intervention. Thus, promoting social connectedness and social well-being is a promising intervention strategy in later life. However, the research literature on *how* to promote social connectedness and decrease loneliness is in its infancy for individuals at any age.[37] What is known, however, suggests that, to effectively help an older patient with isolation and/or loneliness, it is useful to understand the context in which these experiences are occurring and what the older adult believes is the primary cause. Research with older adults has confirmed that loneliness is due in part to objective circumstances—increasing disability and frailty, environmental barriers to socialization, and bereavement, whereas other research emphasizes the role of subjective perceptions, such as thinking of oneself as useless, in causing and perpetuating loneliness.[38,39] Each of these potential contributors to loneliness and isolation can be addressed through various interventions, such as care management to address transportation barriers, hearing aids to promote communication, psychotherapy to promote motivation to engage, and access to meaningful social activities, such as volunteering or educational opportunities.

For older adults with moderate to advanced dementia, or other illnesses that impact the ability to understand and communicate one's needs, a lack of social stimulation and loneliness can be one contributor to agitation or aggressive behavior that is distressing to both the patient and caregivers. These types of behaviors that are considered abnormal and problematic can sometimes occur when an older person is not able to communicate a very normal and healthy need, such as social connections and comfort. All humans have an innate need to belong to social relationships and groups.[40] When this need is not met, loneliness and distress emerges at all ages. When working with older adults who may be demonstrating abnormal behaviors, it is useful to consider whether a normal and healthy unmet need is contributing to the behavior.

SUICIDAL IDEATION AND BEHAVIOR

Older adults, specifically older men, have the highest rates of suicide in the United States[3] and around the world,[4] with risk increasing with age through late life. In the United States, white men aged 85 and older have the highest rates of suicide deaths, almost four times the rate in the general population (ie, 47.17 per 100,000 vs 14.21 per 100,000).[3] Among older Americans who reported suicidal ideation in the past year, 12.7% reported at least 1 suicide attempt in the past year.[41] Older adults who attempt suicide are known to be at exponentially greater risk for death, although exact statistics are difficult to find; some estimates state that whereas there are 25 attempts for every suicide death nationally within the United States, among older adults there are only 4 attempts to every suicide death,[42] therefore making nonlethal suicide attempts less common. Therefore, it is critically important to identify suicidal ideation and risk early in this age group, before it escalates into an attempt. Risk factors for suicide among older adults include the "5 Ds": depression and other psychiatric illnesses, disease (physical illness), disability (pain and functional impairment), social disconnectedness, and access to deadly means (such as firearms).[43,44]

Given the importance of identifying suicidal ideation early, understanding the difference between normative thoughts or attitudes about death in late life and maladaptive thoughts that could contribute to risk for suicide is critical. Older adults do demonstrate differences in their attitudes and reactions toward death compared with younger and middle-aged adults, such that they report overall less fear of death and greater acceptance of death,[45] and exhibit less attentional avoidance to death-related information.[46,47] Acceptance of death can be a neutral view of death as natural and inevitable, or even a positive view of death as a gateway to a positive afterlife. However, a lesser fear of death and greater acceptance of death with a particular focus on escaping negative situations or experiences in life are associated with a wish to die.[48] Passive suicidal ideation—going beyond just acceptance of death—refers to thoughts of being better off dead, or a desire to die, without specific thoughts of ending one's own life. (Active) suicidal ideation—refers to thoughts of ending one's own life. One study estimated that 10% to 13% of all adults age 50 and older experience passive suicidal ideation.[49] Despite misconceptions that passive suicidal ideation is less concerning than active suicidal ideation, or even normal among older adults, studies have shown that even passive suicidal ideation is associated with an increased risk for suicidal behavior and should not be considered normative.[50,51] Further, some research has shown that individuals may transition between passive and active suicidal ideation in a given episode.[52] The studies reviewed here suggest that, although older adults may exhibit less avoidance of death-related topics and greater overall acceptance of death, it is problematic when older adults express a desire for their life to end, even without active thoughts of ending one's own life.

Assessment of suicide risk by health care providers is essential, because many older adults who die by suicide have had recent contact with a health care provider, but may not have contact with any mental health provider. More than three-quarters (77%) of adults age 55 and older who die by suicide have had contact with a primary care physician within the past year, with 58% having contact within the past month, compared with 8.5% in the past year and 11.0% in the past month having contact with mental health care.[53] Almost one-third (29%) of adults age 50 and older who die by suicide have contact with a primary health care provider within 1 week of their death.[54] However, general medical providers may be less likely to screen for suicidal ideation and risk and implement important interventions. Among Veterans Affairs patients who attempted suicide, older adults' charts were less likely to show documentation by general medical providers of assessment for certain risk factors for suicide (eg, access to firearms) or interventions to reduce suicide risk (eg, safety planning, mental health care referrals) compared with younger adults.[19]

Although assessment for suicidality should occur for all patients with depression, suicidal ideation can also occur among those without depression, and therefore it is important to use best judgment in screening for suicide risk in a primary care or other medical population.[55,56] Although a clinician may use an assessment instrument to screen for suicidal ideation, such as the Patient Health Questionnaire-9, it is important to follow-up with specific questions about types of suicidal thoughts, plans, access to means, intent, and so on.[55,56] The P4 Screener may be a useful tool, because it was designed as a brief follow-up to the Patient Health Questionnaire-9.[57] Also, relying on assessments of depression may miss older adults who have suicidal ideation but are not reporting symptoms of depression.[55] It is important to have mental health care, implemented within an effective referral and transfer of care system, available for those who do exhibit an increased risk for suicide.[55,56] In addition to referrals to more intensive mental health care, brief interventions such as safety planning[58] may be implemented within medical clinics and emergency departments.

DISCUSSION AND SUMMARY

A common misconception, likely rooted in ageist societal biases, is that emotional turmoil or negative affective experiences are the norm in later life[6–8]; lifespan theory and research demonstrates that this is not true, and can negatively impact diagnosis and treatment by providers as well as expectations and physical and mental health outcomes in patients themselves.[7,8] However, in certain contexts older adults may be vulnerable to experiencing grief, social isolation, and/or loneliness and have a heightened risk of suicide. Although older adults experience greater psychological resilience to negative affect, they also experience age-related physiologic vulnerabilities.[14] **Fig. 1** illustrates the risk and resilience factors for affective well-being commonly experienced in late life, as discussed throughout this review, as weights on a balance scale. Although the majority of older adults benefit in late life from greater positive affect via flexible coping and decreased reactivity to negative affect, as well as

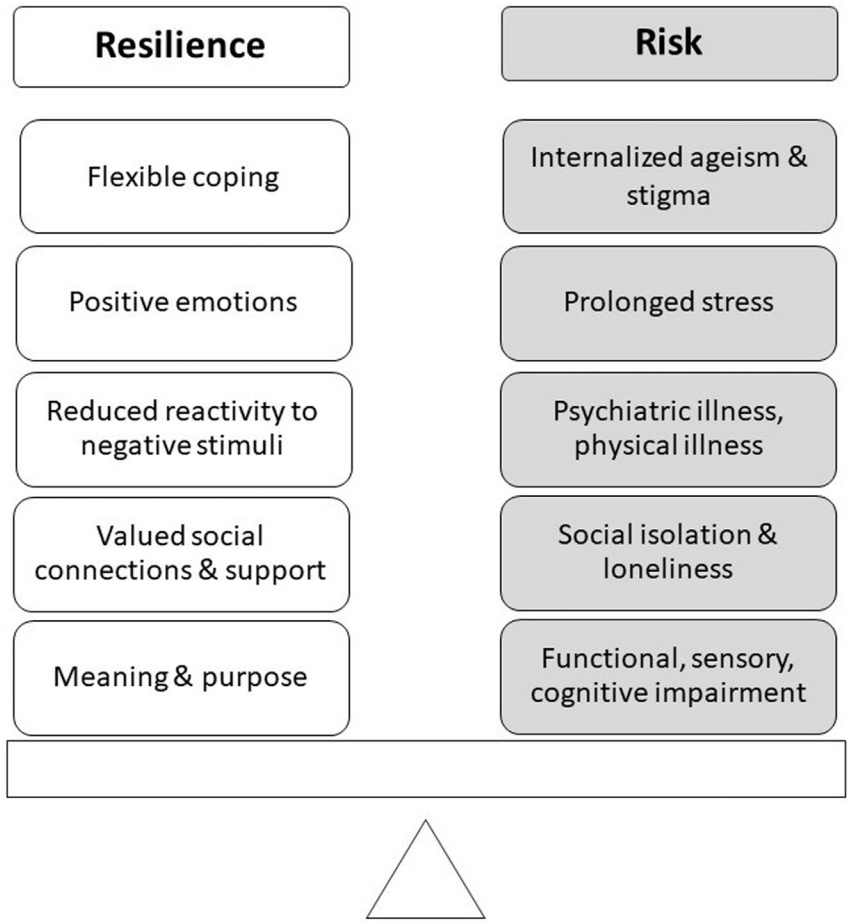

Fig. 1. Late life is associated with a number of both risk and resilience factors for depression and anxiety. Although older adulthood is generally a time of positive affective well-being owing to resilience factors pictured, the presence of the outlined risk factors may contribute to negative affective outcomes.

more meaningful and valued social connections, those who experience prolonged stressors, physiologic risk factors such as illness or impairment and decreased physiologic resilience to stress, as well as social isolation or loneliness, along with internalized ageist views of late life may be at elevated risk for depression, anxiety, or other negative outcomes. Viewing risk and resilience factors this way highlights the usefulness of considering the combination of factors (eg, if multiple risk factors are "piling up" for a given patient, in the absence of some resilience factors) rather than assessing each factor in isolation. Additionally, strengthening protective factors, even when risk factors are currently minimal, can serve as a valuable prevention tool against future risks.

Affective problems such as depression and anxiety may be more difficult to diagnose in older adults, owing to unclear differentiation between normative experiences (eg, bereavement and uncomplicated grief) and maladaptive syndromes (eg, complicated grief), differences in symptom presentation in this age group, and comorbid physical and cognitive conditions. It is critical for those working with older adults to use criteria and assessment instruments that are tailored to the unique needs and presentations of older adults, rather than depending on criteria and instruments that do not reflect this age group. The most important factor in determining diagnosis and the need for treatment is the impact on the individual's everyday functioning. If treatment is needed, implementation of or referral for appropriate treatments that are evidence based in older adults (eg, cognitive behavioral therapy,[59] problem solving therapy,[59,60] antidepressant treatment[61]) may significantly improve mood and quality of life.

CLINICS CARE POINTS

- Use of criteria and assessment instruments validated in older adults is necessary. The Geriatric Depression Scale (https://consultgeri.org/try-this/general-assessment/issue-4.pdf) and Geriatric Anxiety Inventory are examples of such instruments.
- The Patient Health Questionnaire-9 and P4 screener (https://gerocentral.org/wp-content/uploads/2013/04/P4-Suicide-Risk-Screener.pdf), in conjunction with a detailed clinical interview, may be used to assess risk for suicide.
- Safety planning (https://www.mirecc.va.gov/visn16/collaborative-safety-planning-manual.asp) is a brief, effective intervention that can help to manage suicide risk in a clinical setting.

DISCLOSURE

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