Diagnosing Depression in Older Adults in Primary Care
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The prevalence of diagnosed depression in U.S. adults 65 years of age or older doubled from 3% to 6% between 1992 and 2005. A majority of patients with diagnosed depression were treated with antidepressant medications by primary care and other general medical clinicians. Several factors probably contributed to this trend, including publicity regarding the extent of underdiagnosis and undertreatment of depression in older adults, aggressive pharmaceutical marketing efforts targeting providers and consumers, and the introduction of new antidepressants. A majority of the people diagnosed with depression in primary care settings, however, do not meet the diagnostic criteria for major depressive disorder.

This conclusion is supported by data from two sets of national surveys conducted between 2005 and 2010 examining the prevalence of major depressive episodes (as defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition [DSM-IV]) at any time in the previous year, clinicians’ diagnoses of depression in the previous year, and current use of antidepressants (see graphs). Like other epidemiologic studies, these data indicate that depression is significantly less prevalent among older adults than in other age groups. The number of antidepressant prescriptions, however, does not match this trend. Although antidepressants are prescribed for various diagnoses, research indicates that almost two thirds of prescriptions are for a clinician-diagnosed mood disorder. The correspondence between clinicians’ diagnoses and diagnoses based on structured interviews is significantly poorer in older adults than in younger adults (see graph, Panel B). Only 18% of older adults with a clinician’s diagnosis of depression meet the diagnostic criteria for a major depressive episode on the basis of a structured interview. Clinical studies have similarly shown that less than one third of older adults with major depression diagnosed by primary care clinicians also meet the diagnosis of major depression according to structured interviews or rating scales.

It’s difficult to diagnose depression in primary care settings, especially in older adults. Sleep problems, fatigue, and low energy levels associated with medical conditions often mimic depressive symptoms. Furthermore, losses of friends and loved ones and a shrinking social network in old age result in diminished social involvement, which is a common feature of depression. These problems of old age are sometimes difficult to distinguish from depressive symptoms.

The challenge of correctly identifying depression in primary care is compounded by the fact that depressed patients seen in these settings have less-clear-cut symptom profiles than those seen in specialty mental health settings, mainly because their symptoms are less severe or disabling. Some patients diagnosed with depression in primary care may meet the criteria for dysthymia or adjustment disorder with mood symptoms. Others may have mild depressive symptoms that don’t reach the threshold for diagnosis of major depressive disorder. Many such patients would benefit from supportive counseling or lifestyle modification. In some cases, watchful
Diagnosing Depression in Older Adults

Waiting with regular follow-up may be appropriate. Yet the majority of primary care patients diagnosed with depression are simply prescribed antidepressants.2 Although there is good evidence for antidepressants’ efficacy in major depressive disorder — especially when it’s severe — the evidence for efficacy in less-severe cases and for “subthreshold” depressive symptoms is much less robust. Exposing older adults to antidepressants in the absence of evidence for benefit raises safety and ethical concerns.

Nonetheless, many patients with depression and other common mental disorders are treated in general medical settings, and there’s some evidence that treating depression in patients with physical health conditions might positively affect both mental and physical health. To maximize benefit from treatments, however, the accuracy of depression diagnosis in these settings must be improved, especially as applied to older adults. Over the years, various approaches to improving primary care diagnosis and treatment of depression have been proposed, including use of screening measures, implementation of integrated care models, and stepped-care approaches.4,5

Routine use of screening instruments is controversial. In 2009, the U.S. Preventive Services Task Force recommended screening for depression when “staff-assisted depression care supports” — staff who can provide care coordination, follow-up planning, mental health referrals, psychoeducation, and sometimes psychotherapy — are in place. More recently, the Canadian Task Force on Preventive Health Care advised against routine screening because of the lack of high-quality data supporting its benefits and concerns about increased rates of false positive diagnoses and unnecessary treatment. Staff-assisted depression care supports are also essential to integrated models of depression care, which require greater access to mental health specialists than is available in many primary care settings.

Stepped-care models represent a nuanced approach to diagnosis and treatment of depression in which symptoms of varying severity and duration are matched with appropriate intervention options. The 2009 guidelines issued by the U.K. National Institute for Health and Clinical Excellence (NICE) (www.nice.org.uk/nicemedia/live/12329/45888/45888.pdf) represent one such approach. As a first step, these guidelines recommend assessment, support,
and psychoeducation for patients with all “known and suspected presentations of depression.” Clinicians are advised to be alert to possible depression in patients with a history of the illness or chronic physical health problems associated with functional impairment. Clinicians are to consider asking patients with possible depression whether they’ve had depressed mood or loss of interest in daily activities in the past month. A positive response on either count should be followed by a fuller assessment of the severity and duration of symptoms and functioning, if the clinician is competent in conducting such an assessment (see the Supplementary Appendix, available with the full text of this article at NEJM.org). The guidelines also advise clinicians to consider using validated measures of symptoms and functioning; the Patient Health Questionnaire 9 is one such validated and widely used measure that captures the DSM-IV criteria for a major depressive episode (http://phqscreeners.com/pdfs/02_PHQ-9-English.pdf). If the clinician is not competent to conduct such an assessment, the patient may be referred to a mental health professional for assessment.

Step 2 involves management of persistent subthreshold depressive symptoms and mild-to-moderate depression (see the Supplementary Appendix for definitions of levels of depression). NICE recommends active monitoring, including psychoeducation and follow-up in 2 weeks for subthreshold depressive symptoms that may remit without formal treatment. Active monitoring may also be appropriate for patients with mild depression who aren’t interested in more intensive treatment. For these patients, NICE also recommends “low-intensity psychosocial interventions,” which include individual guided self-help based on the principles of cognitive behavioral therapy, computerized cognitive behavioral therapy, and structured group physical activity (see the Supplementary Appendix).

The guidelines discourage routine use of antidepressants for persistent subthreshold depressive symptoms or mild depression. However, clinicians may consider these medications for patients with a history of moderate or severe depression, subthreshold symptoms lasting 2 years or longer, and subthreshold symptoms or mild depression that persists after low-intensity psychosocial interventions. Medications (typically selective serotonin-reuptake inhibitors) or high-intensity psychosocial interventions, such as individual cognitive behavioral therapy or interpersonal therapy, alone or combined with medications, may be considered as a third step for patients with no response to low-intensity psychosocial interventions and those with moderate-to-severe depression. When medication has been started, the guidelines recommend continuing it at a therapeutic dose for at least 6 months after remission of an episode.

The fourth step involves mental health referral for patients with high risk of suicide, psychotic symptoms, or complex, severe depression whose management requires expert knowledge. There is some evidence that when it’s coupled with organizational changes such as the addition of support staff, training of clinicians in using practice guidelines such as NICE’s can improve outcomes of depression care in general. Implementing these guidelines, however, may require extended and more frequent visits, which may be difficult to accommodate in many primary care settings.

With the looming shortage of geriatric mental health care providers, general medical clinicians’ role in managing older adults’ mental health problems will probably increase. A nuanced approach to depression diagnosis and treatment may improve the management and outcome of geriatric depression in primary care settings. Incorporating the stepped-care approaches into generalists’ training and making low-intensity psychosocial interventions more widely available may help prepare clinicians to more effectively meet future needs.

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