Assessment of Depression in Aging Contexts:
General Considerations When Working With Older Adults

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Popular assertions portray depression as an inevitable outcome of aging, a widespread image embraced by many health professionals. Although epidemiological data contradict the prevalent image that depressive syndromes increase with age, the prognosis becomes more negative as one grows older. An early thorough assessment is vital to identify depressive symptoms in older adults, thus promoting the development of tailored interventions and improved recovery rates. The main problems associated with the assessment of depressive symptoms in older adults include a lack of knowledge about changes in the pattern of symptoms, the inadequacy of techniques developed for other age cohorts, the misuse of psychometric instruments, and deficits in additional areas of assessment. The underlying goal of this article is to analyze the obstacles to a successful assessment of depression symptoms in older adults, suggesting strategies to overcome them.

Keywords: older adults, depression, assessment

The consequences of depression in older adults are vast, including reduced quality of life and increased medical morbidity and mortality. In addition, the individual’s family may be affected, for example, through an increased caregiver burden. In a broader sense, there are societal consequences with the loss of a potentially active member but also due to the expenditure of resources to compensate for the individual’s functional decline and consequent needs. Epidemiological studies show a prevalence of between 1% and 5% in older adults living independently (Blazer, 2002b; Pfaff et al., 2009). However, numbers are considerably higher within institutional contexts (Pope, Watkins, Evans, & Hess, 2006).

Contrary to popular and persistent assertions and current stereotypes, which often depict depressive symptoms as being a normative part of aging, depressive disturbance is an avoidable feature of growing old, and older age is not generally a precipitating factor. Epidemiological studies indicate that the prevalence of mental disorders is lower in late life when compared with other age groups (Hybels & Blazer, 2003), which might be partially explained by full recovery from previous depressive episodes, selective survival, and diagnosis limitations (Zarit & Zarit, 2007). Although the frequency of depressive symptoms and syndromes is equal to or even lower in older adults when compared to young and middle aged adults, the prognosis seems to become increasingly negative as age increases (Subramanian & Mitchell, 2005), which can be explained by several reasons, from a micro to a macro perspective.

First, older adults have more general medical problems than younger people, hence taking more medications. Simultaneously, older adults are at an increased risk of experiencing medication side effects, due to decrease in body weight and liver size as well as changes in homeostatic processes (Berra & Torta, 2007). Furthermore, in older adults there is an increased probability that medications for depression will interact with other prescribed medications and that patients experience difficulties in understanding their prescriptions (Lotrich & Pollock, 2005). A second contributing factor for the worsened prognosis is the commonly held stereotype that depression is unavoidable in old age. Stereotypes
present in older adults might be explained by cohort effects, in that current older cohorts show a greater reluctance to look for help for mental health issues than younger cohorts, and often hold biased beliefs and misconceptions about mood states (Segal, Coolidge, Mincie, & O’Riley, 2005), whereas beliefs held by health professionals involve ideas of deterioration of cognitive and functional performance (Lee, Volans, & Gregory, 2003). This combination of factors may lead to failure to recognize depression or failure to treat even when it is recognized. Finally, the inaccessibility of health facilities, due to economic or geographical constraints, constitutes a major obstacle for the adequate treatment of older adults. The use of mental health services by older adults is conditioned by their existence, accessibility, and acceptance. In this way, specific services for older adults are scarce and older adults tend to stigmatize their role (Murphy, 2000).

On a positive note, research has suggested that dysthymia and minor depression respond in a very favorable way to psychological interventions (Pinquart, Duberstein, & Lyness, 2006). Furthermore, it is also highly significant to bear in mind that existing data support the hypothesis of an increase in emotional regulation capacity with age, thus making older adults more capable of dealing with negative affect (Turk-Charles, Mather, & Carstensen, 2003). There is not a precise answer to the question “how much adaptation is required to work with older adults?”—as the idiosyncrasies of each patient will dictate a large part of the psychotherapeutic process. Older adult is a broad definition, which congregates under the same label a heterogeneous group of humans, with social, economic, cultural, educational, physical, and cognitive disparities. The cutoff point to define old age is arbitrary and differs according to the adopted criteria (APA Working Group on the Older Adult, 1998). In the present work, we adopted the World Health Organization’s (WHO; 2007) definition of older adult as someone aged 60 years or older.

General Domains To Consider

Clinical assessment of older adults requires knowledge of the potentially complex interplay between medical and psychiatric presentations, which can affect diagnosis, formulation, and subsequent treatment. In the therapeutic work developed for older adults, the complexity inherent to assessment in mental health increases once we consider interpersonal factors such as low reading ability, mild cognitive decline, and sensory deficits (Knight, 2004). These dimensions, combined with older adults’ lack of familiarity with mental health practitioners, are likely to interfere with the establishment of therapy, resulting in unsuccessful therapeutic efforts. The main difficulties therapists face when assessing older adults are lack of knowledge about changes in the pattern of symptoms, inadequacy of general techniques, misuse of psychometric instruments, and deficits in additional areas of assessment. Table 1 summarizes the main challenges related to the assessment of older adults.

Recognizing Changes in the Pattern of Symptoms

In older adults depression can present itself as what Gallo and Rabins (1999) called “depression without sadness,” which according to the authors is characterized by unexplained somatic complaints, hopelessness, helplessness, anxiety symptoms, memory complaints, loss of pleasure, slowed movements, irritability, and loss of interest in personal care. Older people often present with fewer complaints of sadness and a higher propensity for vegetative symptoms, especially lack of energy, sleep, and pleasure with usual activities (Katona et al., 1997). Ruminative thoughts and lack of motivation are also common, as are symptomatic worries or hypochondria (Katona & Shankar, 2004). The pattern of depressive symptoms in older adults is in fact complex, varying according to the etiology of the illness (Naarding et al., 2005). Frequently, the signs are attributed by the clinician or the patient, or both, to other physical illnesses, possibly resulting in underdiagnosis. The converse is also possible and it is not uncommon for a medical illness to underlie depressive symptoms (Krishnan et al., 2002). As a consequence, the mental health professional should possess a working knowledge of the symptoms and emotional and behavioral sequelae of common general medical conditions, as well as potential medication side effects (American Psychological Association, [APA], 2004), and referrals to either the primary care provider or a psychiatrist should be made when necessary (APA Working Group on the Older Adult, 1998).

When faced with direct questioning regarding mood, the depressed older adult may respond with worries about his or her health, relationships with family members, domestic isolation, or economic difficulties and not present direct complaints about feeling depressed or sad (Blazer, 2002a). The absence of direct complaints about mood symptoms might be intentional, as older adults are often uncomfortable with the idea of sharing emotional issues or unintentional as they may have misconceptions about the source of their symptoms, or may have fears about the consequences of their symptoms being labeled as depression. Older people may be concerned that the diagnosis of depression will lead to institutionalization or to other types of loss of autonomy and independence.

Older adults are often less familiar than younger adults with the role of the psychotherapist and with standard assessment techniques, which may lead to undesirable outcomes, such as increased anxiety or reduced attention or motivation (Edelstein, Northrop, & MacDonald, 2009), requiring more psychoeducation. As in some cases older adults do not recognize their current symptoms as potential psychiatric problems, and may be unaware of the relation between present and past problems, both present and past history should be assessed (Blazer, 2007). A first interview should be as comprehensive as possible, comprising a mixture of allowing the person to tell their story in their own words, coupled with questions designed to elicit details (e.g., current and past medical and psychiatric history). Some authors (e.g., Scogin, 2000) suggested use of largely directive questions to avoid frustration or inhibition by open questions about mood or memory problems. In practice, as older adults are quite heterogeneous, the clinician must make judgments about the best strategy of how to gather data from that individual. In this way, the clinical interview allows the clinician not only to gather information but also to build rapport and briefly assess cognitive function (Zarit & Zarit, 2007). In some cases, cognitive decline might interfere with the ability of the older adult to report mood symptoms, in which case the use of alternative methods of assessment is very useful, such as behavioral observation or informants’ reports about recent changes in mood and activities of daily living (ADL) or instrumental activities of daily
Table 1
Key Considerations About Assessment of Depression in Older Adults

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
<th>Dealing with the problem</th>
<th>Further reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td></td>
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<tr>
<td>Pattern of symptoms</td>
<td>Absence or low presence of subjective mood complaints</td>
<td>Awareness of changes in symptoms</td>
<td>Gallo &amp; Rabins, 1999</td>
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<td></td>
<td>Predominance of somatic symptoms</td>
<td>Be up-to-date with current literature and recent findings</td>
<td>Katona &amp; Shankar, 2004</td>
</tr>
<tr>
<td>Mood problems</td>
<td>Lower probability of the older adult to openly address mood problems</td>
<td>Pose directive and concrete questions</td>
<td>Scogin, 2000</td>
</tr>
<tr>
<td>Stereotypes</td>
<td>Tendency for clinicians to normalize depressive states in older adults</td>
<td>Assess possible related dimensions, for example, change in daily habits</td>
<td>Blazer, 2007</td>
</tr>
<tr>
<td>Adaptations</td>
<td></td>
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<tr>
<td>Language</td>
<td>Lack of familiarity with complex terminology and elaborated sentence construction</td>
<td>Avoid use of psychological jargon</td>
<td>Kim, Goldstein, Hasher, &amp; Zacks, 2005</td>
</tr>
<tr>
<td>Sensory decline</td>
<td>Hearing and vision impairment, which interfere with performance</td>
<td>Use short and explicit sentences</td>
<td>Knight, 2004</td>
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<td>Psychometric concerns</td>
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<tr>
<td>Inaccurate norms</td>
<td>Use of classification systems normalized to other cohorts, biasing assessment</td>
<td>Select instruments with specific age norms</td>
<td>Blazer, 2007</td>
</tr>
<tr>
<td>Erroneous test choice</td>
<td>Selection of inadequate questionnaires, for example, length or performance demanding</td>
<td>Use additional sources of information, for example, observation and caregivers’ reports</td>
<td>Pachana, Helmes, &amp; Koder, 2006</td>
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<tr>
<td>Test anxiety</td>
<td>Lack of familiarity with psychological therapy settings, leading to anxiety and low test performance</td>
<td>Consider patient’s characteristics and whether this additional assessment material is necessary</td>
<td>Arean &amp; Ayalon, 2005</td>
</tr>
<tr>
<td>Additional considerations</td>
<td></td>
<td></td>
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<tr>
<td>Cognitive</td>
<td>Late-life depression is often associated with cognitive decline</td>
<td>Explain carefully underlying goals of information gathering</td>
<td>Zarit &amp; Zarit, 2007</td>
</tr>
<tr>
<td>Physical</td>
<td>High probability of comorbid physical illnesses, for example, cardiovascular and neurological</td>
<td>When possible, assess during the morning</td>
<td></td>
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<tr>
<td>Sociodemography</td>
<td>Life setting and social support, among others, contribute to the prognosis</td>
<td>Start with basic questions and proceed to a more complete assessment if detecting problems</td>
<td>Ashla, 2000</td>
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<td></td>
<td></td>
<td>Ask directly about medical problems</td>
<td>Potter &amp; Steffens, 2007</td>
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<td></td>
<td></td>
<td>Assess impact in ADLs and IADLs</td>
<td>Alexopoulos et al., 2002</td>
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<td></td>
<td></td>
<td>Understand as thoroughly as possible all the details surrounding the older person</td>
<td>Edelstein, Northrop, &amp; MacDonald, 2009</td>
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| Note. ADL = activities of daily living; IADL = instrumental activities of daily living.
living (IADL). This topic will be discussed later, when talking about additional areas of assessment.

Finally, questioning about the presence of mood disturbance in older adults by medical professionals is often insufficient, due to the normalization of depressive states in older cohorts (Delano-Wood & Abeles, 2005) or to the discomfort that some professionals feel when assessing mood states in older adults. Many health professionals possess reasonable knowledge about the myths and the misconceptions of aging but feel uncomfortable when dealing with depressed older adults, avoiding assessment of depressive symptoms and not referring the patients to treatment (Waller & Hillam, 2000). To avoid bias in assessment, a list of common symptoms should be used as an adjunct to the broader clinical assessment, inquiring directly about symptoms such as excessive fatigue, mood, memory, difficulty concentrating, helplessness, isolation, suspicion, anxiety, and also what triggers these symptoms, in which context are they more frequent, and if they appear together, isolated, or in clusters (Blazer, 2007).

A particularly important area of assessment is suicidal ideation, as older adults are the age group at the highest suicide risk (Conwell, Duberstein, & Caime, 2002). Asking about suicidal thoughts, plans, and intents, rarely causes offense and often gives the older person “permission” to talk about a subject often considered taboo (for a review, see Reiss & Tishler, 2008). Nevertheless, it is possible that the questions are not sincerely answered (Alexopoulos et al., 2002), and behavioral and nonverbal signs of mood symptoms should be monitored (Gallo & Rabins, 1999). It is important that questioning about suicidal ideation is not dependent on depression severity or degree of functional impairment but rather always considered (Duberstein et al., 1999).

One of the major problems when considering depressive states in older adults is the existence of subclinical syndromes, defined by the presence of depressive symptoms that do not fulfill all formal diagnostic criteria. However, not only does the presence of depressive symptoms decrease functioning and increase morbidity, but also they can lead to major depression (Alexopoulos et al., 2002). Thus, such subsyndromal states are of high importance, making them a strategic stage at which to intervene with older adults. Anxiety symptoms should also be carefully considered in the course of depression, as comorbidity interferes with the course of depressive illness and decreases treatment response (Lenze et al., 2001). In addition, consideration should be given to the distinctions between depression, grief, and demoralization. Grief is often confused with depression in older people and the diagnostic boundaries between these states are not particularly distinct. Demoralization is often seen in the context of general medical disorders, particularly in hospitalized older people and may sometimes be confused with depression (Clarke, Kissane, Trauer, & Smith, 2005).

Adapting Standard Assessment Techniques

When assessing older adults by oral questioning, the professional needs to be sure that the patient understands the question, not only to collect accurate information but also to avoid misjudgments. All the terms employed by the patient should be specified and never taken for granted, specifically when clinical terms are used. The professional should explore and define all the described states, clarify possible doubts and avoid vague or abstract descriptions (Zarit & Zarit, 2007). It is not only the tone and pace of speech that are relevant. Older adults are more prone to framing effects, which means that posing a question in a specific way can greatly affect the answer that will be given (Kim, Goldstein, Hasher, & Zacks, 2005). To examine the impact of different instructions on the answers provided by older adults, Chodosh, Buckwalter, Blazer, and Seeman (2004) assessed 699 highly functional older adults (M age = 74.6 years, SD = 2.7) using two depression scales. Both scales required the adults to rate the depressive symptoms experienced in the previous week. One of the questionnaires assessed the frequency of the symptoms and the other the impact they had or the suffering they provoked. Results indicated that although some items such as poor appetite or feelings of inferiority were rated equally in both scales, older adults scored higher in feelings of “blueness,” loneliness, hopelessness, sleep disturbances, and crying, when they assessed the impact of the symptoms, as opposed to their frequency (Chodosh et al., 2004).

Developing an awareness of the age related difficulties in assessment is the first step to overcome them. Starting with a careful observation of the older adult, the next step is to adapt materials used in the assessment to increase ease of use and minimize perceptual difficulties, for example by using instruments with larger letters and higher contrast and rooms with better lighting (Knight, 2004). Utilization of external resources may also be useful to aid the older patient in following the session, such as a blackboard presenting the main goals and steps for the session, as well as outlines, to guide the patient through the session and to employ at home (Scogin, 2000). Furthermore, external resources brought by the patient, for example photographs or reports from previously consulted professionals, can also be quite useful to boost additional information (Edelstein, Martin, & Goodie, 2000).

Accurate Use of Psychometric Instruments

Although specific age norms are often provided with assessment scales, the use of classification systems normalized for other age groups often leads to misdiagnosis, either false positives or false negatives, resulting in a biased and less effective intervention plan (Knight & Satre, 1999; Pachana, Helmes, & Koder, 2006). In the specific case of depression in older adults, some symptoms can be misinterpreted as depressed states even being normative conditions of aging. For example, older adults are more prone to insomnia and reduction in appetite in the absence of depression (Delano-Wood & Abeles, 2005), which may lead to the occurrence of false positives. Thus, it is important for the clinician to ask about changes in neurovegetative symptoms in relation to the development of affective symptoms rather than simply asking about whether they are present or absent.

There are several screening instruments that were either developed targeting depression in older adults or validated for this population (for a review, see Edelstein et al., 2007). Probably the most used screening instrument for depression in geriatric settings is the Geriatric Depression Scale (GDS; Yesavage et al., 1982), which assesses the presence or absence of depressive symptoms in the past week. Some instruments were developed to assess depression in the context of cognitive decline, such as the Cornell Scale for Depression in Dementia (Alexopoulos, Abrams, Young, & Shamoian, 1988). Notwithstanding the utility of screening instru-
ments and the information they provide, the ultimate decision regarding diagnosis should be based on a systematic and thoughtful clinical judgment (Kane, 2000).

Scales and questionnaires should be complemented through direct observation or reports from caregivers (Hyer, Carpenter, Bishmann, & Wu, 2005). However, when considering the use of other sources, one should always bear in mind that all questions should be addressed to the patient directly if possible. If necessary, the clinician can obtain consent to interview an informant and then interview that other person together with the older adult. An exception to this rule can be made in cases of confusion or marked psychosis, in which the patient is unable to follow an entire session, in that case the health professional should focus only on the symptoms with the patient, and later collect additional information with the family or other caregivers (for a review, see Blazer, 2007).

In addition, one should consider carefully whether it is worth using numerous scales, because frequently the similarity of their objectives and items does not offer additional information and renders the assessment redundant for the specialist and exhausting for the older adult (Coleman, Philp, & Mullee, 1995). Many instruments, although having norms adapted to older cohorts were developed for younger samples and require an additional effort for the older adult. At times, professionals may rely on a predefined battery aimed at assessing distinct functions, such as mood, memory, and general health. Despite being complete and informative, the use of such a battery might pose a considerable burden for the older adult, decreasing performance and subsequent results.

Therefore, when choosing a questionnaire for screening depression symptoms, one should attend to psychometric features, required procedures, and clinical content (Arean & Ayalon, 2005). In this way, the ideal questionnaire should be short, avoid items related to somatic symptoms, have an easy response choice, and be available in larger print, to avoid vision impairment problems (Hyer et al., 2005). Finally, when assessing older adults through a battery of tests, the mental health practitioner should consider the effects of fatigue, time of the day and test anxiety (Zarit & Zarit, 1995), as all of these variables can interfere with performance, biasing results and decreasing motivation to subsequent treatment. Also, the practitioner should remember that older adults are more cautious and prefer not to respond than to respond incorrectly, and therefore allow them enough time to answer questionnaires (Blazer, 2007).

**Additional Areas of Assessment**

To properly assess and understand mood states in older adults, additional information is essential, such as cognitive functioning, health status, and sociodemographic and family characteristics. In a first session with an older patient, some explicit cognitive symptoms, such as difficulty in remembering very recent events, can be briefly assessed through basic tests or questions, later followed by an objective psychometric assessment (Potter & Steffens, 2007). If some deficit is indicated during the general assessment, a complete evaluation of cognitive functioning is made, including: (a) arousal and orientation, (b) psychomotor speed, (c) attention, (d) language, (e) memory, (f) perceptual skills, and (g) executive concepts (for a review, see Ashla, 2000). When the therapist lacks sufficient skills to perform a thorough assessment, a referral to a clinical neuro-psychologist or neurologist should be made (APA, 2004). When a formal diagnosis of cognitive impairment is already made, the mental health professional should tailor assessment accordingly to overcome additional obstacles. Some of the specific challenges that may arise when assessing depression with cognitively impaired older adults include apathy in Alzheimer’s disease, emotional lability in Parkinson’s disease, and aphasia in stroke (Strober & Arnett, 2009). Comorbid depression and dementia might conduct to a phenomenological distinct pattern of symptoms, including the presence of irritability and social isolation (Olin, Katz, Meyers, Schneider, & Lebowitz, 2002).

There is also a strong probability of existing physical or functional comorbidity (Pfaff et al., 2009). Depression is often comorbid with medical diseases, such as cardiac disease, cancer, and neurological disorders, all of them more common in older adults than in younger adults (Krishnan et al., 2002). These problems can mimic, interfere with, or even cause depressive symptoms (Hyer et al., 2005). As Fiske, Wetherell, and Gatz (2009) hypothesized, comorbid medical illnesses can lead both to underdiagnosis, if the depressive symptoms are misattributed to the physical pathology or to overdiagnosis, if the organic source of the symptoms is not identified.

Every aspect of the older person’s functional status should be contemplated, such as well-being, behavior, and daily routines, ADLs, IADLs, and recent shifts in these (Edelstein et al., 2009). The ability to live independently is related to self-rated depression (Baird, Podell, Lovell, & McGinty, 2001) and, as such, early identification of depressive symptoms might delay the likelihood of institutionalization. The quality and nature of social interactions and thoughts about the future should also be ascertained.

Although negative life events may occur at any stage of a person’s life, these are particularly important to consider during the assessment of older adults, as not only they are more probable after the sixth decade of life (Molinari et al., 2003), but also their potential impact on the person’s functioning increases with age (Fiske, Gatz, & Pedersen, 2003). In addition, assessment must consider the characteristics of the person’s life setting (Satre, Knight, & David, 2006), particularly, for example, whether the person lives in an institutional setting or remote area. The assessment of older adults living in long-term care settings entails specific parameters, including institutional dynamics, existence of a multidisciplinary team, likelihood of comorbid illnesses, and sensorial and physical limitations (Edelstein et al., 2009). Family and additional caregivers play an important role in the course of depression in old age. To better understand if caregivers are a source of the problem or a plausible resource to solve it, the professional should gather information about the availability, frequency of contacts, services provided, perception of support satisfaction manifested by the patient and tolerance held by caregivers to different types of behaviors (Blazer, 2007).

Finally, although not being restricted to older adults, ethnic, racial, and gender issues are also significant. The language used in the instrument, including idiomatic or metaphorical expressions, might render instruments inappropriate to work with ethnic and racial minorities (for a review, see Hinrichsen, 2006). In addition, background experiences and historical and cultural characteristics might interfere with instruments’ meaning or even psychometric properties. Due to the life expectancy disparity between men and women in most countries there is a higher likelihood of having
female older patients, who in turn might be in a vulnerable position as many of them were economically dependent on their partners. To know community’s social, medical, or legal resources is an essential skill for the psychologist working with older adults.

One final remark should be made regarding countertransference, not as a therapeutic tool but rather as a universal dimension of psychotherapeutic work with an older patient, who might evoke in therapists reminiscences concerning aging parents, their own aging and death (Knight, 2004). Being aware of these reactions is crucial, as they will not only have the potential to interfere with therapy and the likelihood of success, but also may place the therapist under constant strain (Knight, 2004).

Implications for Practice

Whatever the chosen diagnostic system, scales or instruments used, one should keep in mind that assessment is the starting point of the entire intervention program, and thus requires careful consideration and execution so that it does not constrain the subsequent efficacy of therapy. Intervention success rates are highly correlated with professionals’ skills and abilities to conduct the assessment, as a thorough assessment allows the clinician to establish the biological and psychosocial causes for the current clinical condition, and therefore tailor appropriate treatment strategies (Alexopoulos, Schultz, & Lebowitz, 2005). A well-conducted assessment will also educate the patient about their disorder and will often provide a sound basis to the introduction of the patient to the treatment plan.

As the aging of the population gains status as a worldwide issue, researchers and professionals will experience growing demands for enhanced and adapted techniques of assessment of depressive syndromes for older adults. At present, lacunae in this area exist not only in relation to the availability of appropriate techniques and instruments for assessing depression, but also regarding adequate clinician knowledge and training to recognize the distinct issues that are particularly pertinent to the assessment of older adults.

Notwithstanding the exponential growth observed in aging research, with more adapted and efficient techniques and instruments for use with older adults quickly proliferating, there still exist considerable gaps. These limitations concern not only assessment instruments and methods but also and perhaps even more serious, practitioners’ knowledge and training. The use of assessment techniques requires knowledge by the psychotherapist about the types of psychotherapy available, their effectiveness, and their likelihood to match well with patient’s characteristics. Although the body of adapted methods to assess older adults is growing, the truth is that they are not accessible to all older adults. This happens for several reasons. Insufficient detection by clinicians, due to lack of knowledge about late-life depression, seems to be one of the most common explanations. Along with a shortage of knowledge by practicing clinicians is the absence of information provided to older adults about existing services, and misconceptions and biased beliefs about mental health (Segal et al., 2005).

The mental health professionals’ shortfall in identifying signs indicative of depression in older adults, which many times are distinct from depressive symptoms in other age groups, as well as the older adults’ reluctance in acknowledging their distress or asking for help, render diagnosis and consequent intervention difficult. It is estimated that around one third of older adults with depression are not identified (Bergdahl et al., 2005), and only a small percentage of psychotherapists consider older adults as their primary professional target (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). In addition, the theoretical body of knowledge on adult and old age development is growing but with an emphasis on biological and organic perspectives, which overshadow social and psychological factors. These factors notably complicate the establishment of specific diagnostic guidelines for depression and other pathologies in old age, as several psychosocial variables contribute to this process.

All professionals who work with older people need to be aware of these and other aspects of depression, to increase the probability of detecting psychopathological states. Faced with several problems or unusual issues in functioning, the mental health professional should be able to specify each case’s priorities. Acquiring knowledge about aging processes is crucial for the adequate delivery of mental health services to older adults (Hinrichsen & McMenamin, 2002). The following two publications are essential readings for all practitioners who deliver services to older patients: “What Practitioners Should Know About Working With Older Adults” (APA Working Group on the Older Adult, 1998) and “Guidelines for Psychological Practice With Older Adults” (APA, 2004). Also valuable is the Council of Professional Geropsychology Training Programs website (http://www.ucss.edu/~/cpgtp/), which offers practitioners a self-rating inventory to assess their competencies in geropsychology. Finally, the “Pikes Peak Model Competencies” (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) provides a resourceful model for training in geropsychology.

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