LIVING WELL

Why Depression in Older People Slips Past Us

Depression later in life may resemble pain, memory trouble or withdrawal, but noticing the pattern can open the door to effective care.

The quiet change in the room

The phone calls become shorter. The weekly lunch is quietly dropped. Someone who once followed every family story now says they cannot concentrate, then insists they are simply getting older. Nothing looks dramatic enough to name. That is exactly how depression can remain in the room without being recognised.

Depression does not always announce itself as sadness. In an older person, it may appear as a lack of emotion, fading interest, exhaustion, disturbed sleep, appetite changes, physical pain, irritability or withdrawal. Memory and thinking problems can become prominent in severe cases. The clues may look disconnected until somebody notices the pattern.

That pattern matters because depression is not a brief low mood. It can change how you think, feel and manage ordinary life, making sleeping, eating, working or keeping up with responsibilities difficult. Major depression involves depressed mood or loss of interest most of the time for at least two weeks, alongside disruption to daily activities.

Age does not place anyone beyond depression, or beyond help. But later life can provide unusually convincing alternative explanations for what is happening. Pain may look like the whole story. Forgetfulness may seem to explain withdrawal. A shrinking routine may conceal the loss of pleasure that would be more visible in a busier life.

Sadness is only one disguise

If you are waiting to hear the words "I feel depressed," you may wait a long time. Older adults may describe sadness or grief, but they can also report having no feelings rather than feeling low. A blankness where enjoyment used to be can be easier to dismiss than obvious distress.

Depression can also speak through the body. Aches, headaches, cramps and digestive problems can accompany it, as can fatigue and changes in sleep or appetite. Older adults are more likely to have medical conditions or pain that can cause or contribute to depression, so emotional and physical problems may overlap rather than arriving in separate boxes.

The behavioural shifts can be just as revealing. A person may isolate themselves from family

and friends, stop meeting responsibilities, become irritable or negative, or use more alcohol or drugs. None of those changes proves depression. Together, especially when they persist and interfere with everyday life, they deserve a proper conversation.

Loss of interest is particularly easy to underestimate. It can sound like a preference: no longer wanting visitors, hobbies or outings. Yet loss of interest or pleasure is one of the two central features used when assessing major depression. The other is depressed mood. Sadness is therefore not the only doorway into recognising the illness.

Depression in an older person may hide behind pain, silence or forgetfulness, but you do not have to solve that puzzle alone.

Other explanations crowd the picture

Depression can occur alongside diabetes, cancer, heart disease, chronic pain and other mental disorders. Each can worsen the other. When several problems are competing for attention, the most visible physical condition can dominate an appointment while changes in mood, interest and thinking stay in the background.

Some medicines can contribute to depressive symptoms. Medical conditions, including viruses and thyroid disorders, may produce symptoms that resemble depression. That uncertainty is not a reason to dismiss a change as inevitable. It is a reason for a clinician to look at the whole picture rather than deciding from a single complaint.

Memory trouble creates another trap. In severe depression, problems with thinking and remembering can be prominent enough to resemble dementia, sometimes called pseudodementia. That does not mean every memory lapse is depression. It means new cognitive difficulties and changes in mood, interest or daily functioning should not automatically be treated as one simple story.

A proper assessment may include questions about when the changes began, how long they last, how often they occur and whether they prevent usual activities. A clinician may also review medical history, perform a physical examination and order tests to rule out other explanations. The uncertainty is part of the work, not evidence that nothing is wrong.

Recognition changes what happens next

Depression often needs continuing care, but it can be treated. Usual approaches include psychotherapy, antidepressant medicine or both. If these do not reduce symptoms sufficiently, brain stimulation therapy may be considered. Choosing among them belongs in a conversation

with a health care or mental health professional, particularly when other illnesses and medicines are involved.

Antidepressants may take time to work, can have side effects and sometimes require trying more than one medicine. They should not be stopped without first speaking to the prescriber. Psychotherapy can help a person recognise and change troubling thoughts, emotions and behaviours while offering skills, education, coping strategies and support.

Movement may have a supporting role, but the evidence should not be oversold. A 2022 systematic review of 21 studies involving 1,610 adults aged 60 or older found that resistance training improved depression scores, strength and several areas of quality of life. The authors called the evidence preliminary and said more research was needed for firm conclusions.

This stops being a matter of observation when thoughts of death, suicide or self-harm appear. In the United States, call or text the 988 Suicide and Crisis Lifeline at 988; in a life-threatening emergency, call 911. Persistent changes that interfere with daily life also warrant professional help, even when nobody is certain that depression is the explanation.

Bring the pattern to Monday

A vague concern is difficult to carry into an appointment. A short record is easier. Before Monday, use a notebook and pen to write down the changes you have noticed: less interest, altered sleep or appetite, pain, irritability, withdrawal, low energy, memory trouble or difficulty managing normal activities.

Add when each change began, whether it happens most days and what it now prevents. Include current medicines and medical conditions because both can matter when depression-like symptoms are assessed. Do not try to turn the notes into your own diagnosis. Their job is to preserve details that can disappear once a conversation starts.

If the notes concern someone close to you, use them to open the door rather than win an argument. Say what you have observed in plain language: "You have stopped coming to lunch, you are sleeping differently, and you do not seem to enjoy the things you used to." Then encourage an appointment with a health care or mental health professional.

Depression in an older person may hide behind pain, silence or forgetfulness, but you do not have to solve that puzzle alone. This week, take the notebook and pen to the appointment-or hand the notes to the person who is going. A visible pattern gives the conversation somewhere concrete to begin.

Where this comes from

- Depression

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/depression.html
- Postpartum Depression

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/postpartumdepression.html
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