

Geriatric Mental Health Training Series: Revised

When You Are More Than Just “Down in the Dumps”

Depression in Older Adults

Lecturer’s Script

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When You Are More Than Just "Down in the Dumps": Depression in the Elderly

INTRODUCTION AND OVERVIEW

>>Title Slide

Today we're going to talk about another cause of problem behaviors among our residents: DEPRESSION. Although we may use the word "depression" or "depressed" in our everyday language, it's important to *recognize all the various psychological and behavioral symptoms* that can occur as a result of depression, including irritability, anxiety or agitation!!

>>Facts about depression: Most common psychiatric disorder for people of all ages

**Refer to handout: Facts about depression

We all talk about being "depressed" when we are really just "down in the dumps." What we mean is that we are sad, or blue, or disappointed somehow. But we aren't really depressed. But the way that we use the word can affect the way that we think about things -- in this case a serious illness.

And depression is an *ILLNESS* -- one that is believed to be due to changes in neurotransmitters (chemicals) in the brain. And like other illnesses, depression is often very treatable -- both by medications and by talking therapies.

Depression is an important topic because *it is associated with high rates of disability*. In fact, the National Institute of Mental Health¹ reports that Major Depression is *the leading cause of disability* in the U.S. and the world!!

>>Facts about depression: 7 of 35 million older adults have depression

Depression is the most common psychiatric illness *among people of all ages*, including older adults. Of the 35 million Americans aged 65 years and older, 2 million have major depression, dysthymia or bipolar disorder. Another 5 million have Minor depression¹ – depression that does not meet the full criteria for major depression, but causes considerable suffering and loss of quality of life.

Considerable evidence supports the fact that certain characteristics can put older adults *at higher risk for becoming depressed*, including those listed on the slide: being female, disabling or chronic illness, lack of social support, recent bereavement, and prior history (or family history) of depression.

¹ Rates reported by the National Institute of Mental Health are from their publications "The Invisible Disease: Depression (2001) and "Older Adults: Depression and Suicide Facts" (2003).

Of importance, these risk factors are quite common in older adults who require nursing home care. In fact, some report that as many as 40% of nursing home residents have undiagnosed depression!² Rates of depression in assisted living are not as well studied, but early reports suggest that a substantial number of older adults living in this care setting also experience depression.

>>Diagnosis is difficult

Although depression is pretty common among the older adults, it is often missed or overlooked. Depression in older adults *may mask, or be masked by other physical disorders*. That means that we may not recognize the psychological or behavioral symptoms *as being the result of depression*. But as we said before, the RISK of depression INCREASES with the occurrence of physical illness – which means that lots of older adults living in long-term care settings at risk!

>>Is it natural to be old and sad?

Another reason that depression is overlooked is that the symptoms are frequently viewed as a *"natural part"* of growing older. That is, many people think that it's "normal" to be OLD AND SAD. As a result, we may not distinguish between this *"expected behavior"* (e.g., *Who wouldn't feel that way?!?*) and a treatable illness!

>>Suicide in older adults

The idea that depression is a big problem among elderly folks is highlighted by the SUICIDE RATE among older adults. Although we often hear about the problems of suicide among children and young people, the truth is that the suicide rate in this country is the *highest among older adults!*

Older adults make fewer ATTEMPTS but are more likely to die when the attempts suicide (compared to younger adults). Suicide ranks among the *top ten causes of death* in the 65 plus age group. People over the age of 65 *make up about 13% of the population, but they commit 20% of all reported suicides!* And even at that, the rates are believed to be *more under-reported* than for any other age group.

>>Passive suicide

These rates also don't include passive suicide. PASSIVE SUICIDE includes starvation, alcohol abuse, mixing and or abusing or overdosing on medications, or stopping needed medications. We might add "giving up the will to live" to that list, too. That is not well documented in the literature but it certainly is observed in real life settings. People who "give up" often die soon after.

>>Poor Outcomes

² Risk factors and rates of depression in nursing homes are reported a publication of the American Geriatrics Association, "Compendium on Issues in Geriatric Depression," *Clinical Geriatrics*, December, 2000.

Although depression is *highly treatable*, problems that tend to cluster in late life can put some older adults at risk for poor outcomes (e.g., not recovering fully). As noted on the slide, people who have comorbid health conditions like anxiety, medical problems, and cognitive impairment are all at higher risk of poor outcomes.

Likewise, concurrent problems like having impaired social support and stressful life events are also important factors in determining outcomes. In addition, if the person has psychotic symptoms (e.g., hallucinations or delusions) as part of their depression, or has recurrent episodes of depression, their chances of recovering fully are reduced.

In summary, depression is a big problem for older adults – one that has lots of important implications for their health and well-being! By being aware of depression, and by being *able to recognize the warning signs and symptoms*, we may be able to help identify older adults who are suffering from depression. And recognizing the "real problem" is the first step in helping the person become healthy again.

SYMPTOMS OF DEPRESSION

>>Disturbed mood

****Refer to handout: Signs & symptoms of depression**

There are many types of depression. In late life, we often see both “Major Depression” and “Minor Depression” – which we will talk about in a few minutes. First, let’s just think about the signs and symptoms of depression in a general way.

The most common changes in *mood* include feelings of sadness, discouragement, and crying spells. Other common descriptions for depressed mood include feeling “down in the dumps” or “having the blues.” Older adults may say that “nothing is fun” or that they “just don’t care anymore.” They may feel deep sadness and despair, and some may say they are “depressed.”

But depression can include changes in mood that are not directly related to sadness. Some people may also experience anxiety, irritability, brooding and worry, and panic attacks. As before, anxiety AND depression are more difficult to treat – making it very important for us to recognize when the person has both symptoms!

>>Disturbed perceptions

Another cluster of symptoms involved disturbed perceptions – including the person’s view of him or herself, the environment and future. The person’s on life becomes pretty badly skewed. *They often don't feel pleasure anymore. They can't see the "bright side." They lose hope that it will ever get any better. We may hear them complain of "not caring." And we may see them doing, or *not doing things* for themselves that represent that feeling of "Who cares? What difference does it make?"*

Some of the more common signs and symptoms include things like

- ✓ Loss of ability to experience pleasure;
- ✓ Withdrawal from usual activities (often related to fatigue, loss of concentration, or inability to feel pleasure);
- ✓ Feelings of worthlessness;
- ✓ Unreasonable fears (that are often associated with anxiety and excessive worry);
- ✓ Feelings of guilt, including self reproach for minor failings (e.g., being excessively critical of oneself over something that is “not a big deal”)
- ✓ Delusions (false fixed beliefs that are characteristic of “psychotic” depression)
- ✓ Hallucinations (false sensory experiences that characteristic of “psychotic” depression).

In many ways, depression “robs” the person of having any quality of life by reducing his/her ability to experience PLEASURE in things that normally feel good.

>>Changes in behavior

Another group of symptoms is behavioral. These are the things that caregivers often “pick up on” as part of providing care. For example, the older person may complain about feeling PHYSICALLY ILL – when actually the physical problems are the result of being depressed! Some of important “red flags” include the following:

- ✓ Increased or decreased body movements (e.g., psychomotor agitation or retardation);
- ✓ Pacing, wringing their hands; pulling or rubbing their hair, body, or clothing;
- ✓ Sleep disturbance: difficulty getting to sleep, staying asleep or especially waking up early;
- ✓ Changes in appetite: usually loss of appetite but sometimes increased appetite;
- ✓ Weight loss, but occasionally weight gain;
- ✓ Fatigue, decreased energy;
- ✓ Preoccupation with physical health;
- ✓ Believing they have cancer or some other serious illness when they don't (called somatic delusions);
- ✓ Difficulty concentrating, thinking or making decisions;
- ✓ Slowed speech, slowed responses with pauses before answering, decreased amounts of speech, low or monotonous tones of voice;
- ✓ Thoughts of death or suicide or suicide attempts;
- ✓ Constipation;
- ✓ Unusually fast heart rate (tachycardia).

We need to remember that the symptoms that accompany a severe depression can be *challenging to understand and respond to* from the caregiver's perspective. The person with depression may

seem to be *unmotivated, passive, or uncaring*. They may seem to be "complainers," griping about their physical aches and pains – *aches and pains that we can't find a cause for!* Depression can cause them to feel tired all the time (fatigue) and slow them down physically. They may "resist" even simple activities, like eating, bathing, or dressing, because the "just don't care." Impaired concentration can make us think they are ignoring us, or "not paying attention," or even having "memory problems."

>>Depression or ???

We may think that the person is "putting us on" or "manipulating" when we are actually seeing the effects of depression. We need to return to the idea of looking at the symptoms as a signal of an underlying problem. We need to look for the CHAIN OF EVENTS that may cause or contribute to the symptoms! And we certainly need to remember that *the depressed resident is not behaving this way intentionally or purposefully to cause us dismay or to "manipulate!!"* We need to think about the depression as an illness, an illness that has a treatment.

And we need to adjust our expectations accordingly. We sometimes want people to stop "feeling sorry for themselves" or "see the bright side" when they just aren't able to. But the depressed person can't just "cheer up" -- like we do when we're having a hard time. Their viewpoint is *colored by the depression* -- like a dark and gloomy cloud between them and the rest of the world.

>>Major Depression

**Refer to handout: Types of Depression

The clustering of particular signs and symptoms can signal MAJOR DEPRESSION. Major depression is a diagnosis that includes EITHER

- ✓ depressed mood most of the day, every day, OR
- ✓ loss of ability to experience pleasure nearly every day over a two-week period, AND
- ✓ four additional symptoms.

>>Major Depression, cont.: Four Additional Symptoms

As you can see on the slide, the additional signs and symptoms that are used to make the diagnosis of depression include changes in perception and behavior.

- ✓ Significant weight loss or gain, or increase or decrease in appetite
- ✓ Insomnia or hypersomnia
- ✓ Psychomotor agitation or retardation
- ✓ Fatigue or loss of energy

- ✓ Feelings of worthlessness, or inappropriate guilt
- ✓ Loss of ability to think, concentrate, or make decisions
- ✓ Recurrent thoughts of death, or suicidal ideation

As before, these changes occur *nearly every day* over at least a 2 week period of time and represent a change from the person's previous level of functioning. Of importance, the changes are **OBSERVABLE** by others. We can **SEE** the changes if we are paying good attention! As a result, we have the ability to document those changes and help the person get needed assistance!

>>Minor Depression

We also want to watch for MINOR DEPRESSION, which is also called “subclinical” or “subsyndromal” depression because it does not meet the full “criteria” for MAJOR depression. For example, “Sally” complains that “nothing is enjoyable anymore” and doesn't want to participate in any activities, including coming to meals (e.g., has lost the ability to experience pleasure in nearly all activities). She wakes up early every morning and cannot return to sleep (e.g., sleep disturbance). She has lost 5 pounds in a month because she is not eating right (e.g., appetite change, weight loss), and complains of being tired all the time (e.g., fatigue) – which is another reason she doesn't want to attend activities. These are all changes for Sally; all occur nearly every day; and all have persisted for 2 weeks. *But Sally has four, but not five of the targeted signs and symptoms, so does have “major depression.”*

Is Sally's quality of life compromised by these changes? YES! Will supportive therapy, talking therapy (e.g., individual or group psychotherapy) or even antidepressant medication therapy help relieve Sally's symptoms? YES!! In short, identifying ALL people with significant symptoms of depression is important to restoring quality of life!

CAUSES OF DEPRESSION

>>Common Causes of Depression: Chain of events

****Refer to handout: Causes of depression**

Let's go back to the "CHAIN OF EVENTS" way of thinking about the person now. We've reviewed the signs and symptoms of depression, and can see how they might become a real problem for the person. Now let's think about the things that might CAUSE depression. And as we look at the causes, we are better able to see the things that we may be able to do with and for the resident to treat the underlying problem!!

Like many other illnesses, it is often difficult to say exactly what causes depression. Typically it's not one specific thing, but a combination of things that leads to depression. We're going to review some of the more important underlying causes so that we can recognize those residents who are most at risk!

>>Stress and Loss in Late Life

The very first thing that we need to realize is that stress, and particularly loss, are clearly related to depression. Just by growing older many people experience some degree of loss because of *changing abilities and roles*.

- ✓ Decreased sensory capacity: vision, hearing
- ✓ Changes in social status, responsibility to others
- ✓ Loss of family, friends
- ✓ Relocation due to changing abilities
- ✓ Declining social contacts due to health limitations
- ✓ Dwindling financial resources

Stop and think about our residents. Most of them are living here *because of physical illness and loss of ability that makes it impossible for them to live on their own*. They aren't able to do lots of the things that they used to enjoy – things that "made life worth living." For example, sensory changes, like not being able to see and hear well, interfere with being able to socialize with friends, and increase the risk of isolation.

In addition, lots of residents have lost long-time friends and family members, which can cause loneliness and sad feelings. Even the process of moving here, and leaving behind valued neighbors, and *the house that was your HOME* can be very stressful.

>>Stress and Loss in Late Life: Loss of self-esteem

The other kinds of loss that we don't often think about related to the MEANING of these life changes to the older person. For example, changes in physical health often interfere with participating in activities and roles that have been meaningful throughout life. The sense of not being a "PRODUCTIVE" person, or of doing something "MEANINGFUL" – that *somehow "makes a difference" to someone or something*, can be difficult for lots of people.

In addition, unwanted DEPENDENCY – having to rely on others for help and assistance – can contribute to loss of self worth. In turn, feelings of helplessness and powerlessness can occur. Changes in physical and mental abilities can also interfere with the person's ability to use their typical "coping methods." For example, a person who managed stress through physical activities may have difficulty "working it off" because of limitations

And with each additional stress or loss, the person becomes *more at risk for giving up hope and feeling that life isn't really worth living*. And THAT puts them one step closer to DEPRESSION! Remember, it is rarely "one thing or another" – it all ADDS UP.

>>Biological depression

It's also important to realize that some depressions seem to just "*come out of nowhere.*" This type of depression is often called "biological" depression because it isn't related to anything in the environment. So the resident may become depressed "for no reason." By that, I mean that we can't identify any recent loss or stress that seems to set it off. That does not mean that "medication alone" will be effective! We still need to think carefully about the effects of the environment and physical illness on the person!

>>Physical Illnesses & Depression: Illness can directly cause symptom of depression

**Refer to handout: Physical illnesses associated with depression

As mentioned before, there is a strong relationship between physical illness and depression among older adults. In fact, there are five different ways that illness and depression are connected.

FIRST, some physical illnesses can directly cause the symptoms of depression. As listed on the slide and in the handout, lots of different types of medical conditions that can "mimic" symptoms of depression.

- ✓ Metabolic
- ✓ Endocrine
- ✓ Neurological
- ✓ Pulmonary
- ✓ Cardiovascular
- ✓ Musculoskeletal
- ✓ Others like cancer and anemia

>>Physical Illness & Depression: Illness can trigger a reaction of depression

SECOND, lots of physical illnesses can trigger a reaction of depression. This is especially true of illnesses that

- ✓ cause *fear of pain* or *cause chronic pain*;
- ✓ *cause disability*, or *loss of function*;
- ✓ *affect self esteem*;
- ✓ *increase dependence*; or
- ✓ *cause fear of death* that accompanies a severe illness.

Think about that for a moment in relationship to our residents. Think about the number of people that have physical illnesses, illnesses that may cause *pain or fear of pain, disability, loss of function, dependency, loss of self worth, or fear of death*. Illness, disability and dependency

are common reasons for living in residential care settings. That's important to remember as we think about the potential for depression among residents!

>>Physical Illness & Depression: Depressed older adults may present with somatic complaints

A THIRD factor that we need to consider is the fact that *many depressed older adults present with somatic complaints*. Somatic is just another word for physical so that means that they complain primarily about their physical ailments rather than about their mood! We can miss the depression because their focus is on being constipated, or feeling like their heart is giving them trouble, or that they have no energy -- or even that they think that they have cancer or some other dread disease that is making them feel bad physically!

>>Physical Illness & Depression: Medications can cause symptoms of depression

****Refer to handout: Medications that can cause symptoms of depression**

A FOURTH way that physical illness is related to depression is the fact that *lots of medications used to treat physical illnesses* can cause the symptoms of depression. When the medication is stopped, the symptoms go away! Just think of the number of people in our facility that are on multiple medications!! Note that nearly every class of medicine has one or more type that can cause *side-effects that look like depression!*

- ✓ Antihypertensive (high blood pressure medicines)
- ✓ Psychotropics (sedatives, hypnotics, antidepressants, antipsychotics)
- ✓ Analgesics (pain medicines)
- ✓ Cardiovascular (heart disease)
- ✓ Antimicrobials
- ✓ Steroids

>>Physical Illness & Depression: Environment can contribute to depression

And FINALLY, *the environment* in which physical illnesses are treated *can contribute to the development of depression* because of such factors as

- ✓ isolation,
- ✓ sensory deprivation, and
- ✓ enforced dependency.

Stop and think about our facility and the reasons that older adults live here. Typically it's because they are in *frail health and not able to do for themselves*. Many have suffered losses: of cherished friends, family, or possessions. Most have given up a way of life that was valued.

And at the same time, WE might be adding to their problems! Even simple things like not providing enough light to see or meaningful thing to do can complicate matters.

Revised by M. Smith (2006) from K.C. Buckwalter & M. Smith (1993), "When You Are More Than 'Down in the Dumps': Depression in the Elderly," *The Geriatric Mental Health Training Series*, for the Hartford Center of Geriatric Nursing Excellence, College of Nursing, University of Iowa.

Likewise, when we are in a hurry, we may “take over” and do things for them – instead of giving them time and assistance to do things on their own – which makes them feel even more worth-LESS! We need to remember that what we do and how we do it does make a difference!!

IN SUMMARY, lots of different things cause and contribute to depression in late life. Of important, feeling sad, blue, or depressed may be “overlooked” because it seem “natural” or “easy to understand.” After all, who wouldn’t be depressed, given the situation?!? But depression is NOT a “normal” reaction – it is an illness! So let’s think about how we can help assess symptoms to help people get the assistance they need.

ASSESSMENT

>>Assessment

****Refer to handout: Factors to Consider in Assessment**

As this review emphasizes, there are a lot of things to consider!! How much and what type of information we look for will largely *depend on the person and the situation*. However, there are several main areas that we definitely want to consider in our assessments:

- ✓ Depression symptoms
- ✓ Suicidal thoughts
- ✓ Psychiatric history
- ✓ Physical conditions
- ✓ Medications
- ✓ Recent loss and stress and
- ✓ Resources and abilities

Perhaps most important, we need to think about all the various signs and symptoms of depression that we might observe. One option is to use the handout that lists common signs and symptoms of depression as a "cheat sheet" (a reference). Ask: What are you seeing? What has changed?

>>Geriatric Depression Rating Scale

****Refer to handout: Geriatric Depression Scale**

Another choice is to use the Geriatric Depression Rating Scale to screen the person for depression. This scale has two versions, a short and a long form. This is the long form. We can read the questions to the resident or ask them to fill it out by themselves.

Ask the person to think about how they've been feeling for the last 2 or 3 weeks and then answer the questions "*mostly yes*" and "*mostly no*." That is, *most* of the time they feel that way or they

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don't. A score of 0 to 9 is considered “normal,” a score of 10 to 19 is considered “mild” depression and a score of 20 or more is considered “severe.” In most cases, anyone who scores higher than 10 should probably be evaluated further. Remember: this is only a *screening tool!*

Also, notice that there aren't any questions about their physical health on this scale. The people who developed it *left out physical symptoms like appetite, weight, and sleep changes* so that there wasn't any confusion between physical problems caused by physical illness and the physical complaints caused by depression. At the same time, *we need to assess those physical or behavioral symptoms as well!*

>>Suicide Assessment

But before we look for physical illness, check out any thoughts of death, or feeling that life is not worth living. Listening carefully to what the person says, and thinking carefully about their behavior can help identify people who may be having suicidal thoughts. Remember: older adults are the age group who are MOST LIKELY to complete suicide. And while it may be difficult to imagine, even a frail person living in a “protected” care setting can find a means to kill themselves if they are motivated to do so!

If you have any concerns about suicidal behavior, ASK. Asking will NOT put the “thought in their head” and make them start thinking about it! Start with a “neutral” question:

Have you thought that life is not worth living?

In a few cases, the answer is “no” – and we stop. But in many cases the answer is “yes.” They HAVE thought that life is not worth living. So ask the next level of question:

Have you thought about harming yourself?

As before, if the answer is “no”, we stop. But if the answer is “yes” then we need to know if they have a plan, and if so, what that plan involves. *Anyone who has been thinking about harming themselves – whether or not they have a plan – should be carefully monitored and referred for further evaluation.*

>>Psychiatric History

Another important area of assessment that caregivers are often able to help with is psychiatric history. In some cases, there may be a diagnosis or other information about having depression in the person’s medical file. So be sure to check the record to see if the person has a history of being depressed. This is important since *recurrent depressions, ones that come back over and over again, are often more severe and more difficult to treat* – so knowing that this is not the first episode can be very important.

In lots of cases, there is no record of depression – *but that doesn't mean that the person has NOT been depressed at some other point in their life!!* Because of the stigma associated with mental illness, lots of people DID NOT get help. Even if they saw a doctor, they called their problem “bad nerves” – not depression. But in lots of cases, *there is a history of having had an emotional*

reaction, often in relationship to major life changes – after the birth of a child, when children leave home, after the death of loved one, or even after retirement. The point is that caregivers who know the person well often can ask questions about whether this kind of difficulty has ever occurred before.

>>Physical Health/Illness

As we discussed earlier, there are many different ways that physical illness can mimic and cause symptoms of depression! Take time to think about the person’s health history and current health conditions. Take time to think about how physical illness can cause isolation, fear, hopelessness and worry that contributes to depression AND how illness and its’ treatment can directly cause depression!! Be sure to consider,

- ✓ Loss of mobility that increases the risk of isolation and interferes with participation in usual and enjoyable activities;
- ✓ Level of disability and impact on daily function, self worth, and involvement in meaningful activities;
- ✓ Pain associated with physical illness that may have “depressing effects” and interfere with participation in activities and quality of living;
- ✓ Worry about declining abilities, new health problems, and fear of death that may be contributing to emotional distress.
- ✓ Medications use, particularly any change in medications
- ✓ New onset of physical health problem, like the development of flu or some new acute condition, and
- ✓ Changes in the status of ongoing, chronic health problems like diabetes, heart disease, cancer or others.

Use the lists of medications and physical health problems that are associated with depression as a reference as you think about the person. Remember, depression overlaps on many health conditions – including heart disease, diabetes, Parkinson’s disease and all types of dementia.

>>Recent Loss

As we discussed earlier, loss and life change are important triggers to depression. *Understanding the type of loss, and the meaning of the loss to the person, is important.* As noted on the slide, there are lots of different possibilities to consider.

- ✓ Recent relocation
- ✓ Change in relationships
- ✓ Change in health
- ✓ Change in functional status
- ✓ Change in financial status
- ✓ Death of a loved one (even a pet)

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- ✓ Loss of control over daily routines
- ✓ Loss of a significant role

>>Resources and abilities

We also need to be thinking about the person's STRENGTHS AND RESOURCES!!! In addition to thinking about the problems and challenges the person is having, we need to know WHO and WHAT may help them become well again!!! Think carefully about THIS PERSON. What abilities and resources can we "BUILD ON" as we think about interventions?

- ✓ Family support
- ✓ Community support
- ✓ Social network
- ✓ Physical abilities
- ✓ Functional abilities
- ✓ Cognitive abilities
- ✓ Financial resources
- ✓ Personality traits; personal history
- ✓ Experiences, beliefs, convictions

>>Person-Centered

Before we move on to discuss interventions, let's take another moment to appreciate the importance of person-centered care. We need to withhold our OWN values about the person and his/her situation. Instead, we need to try to view things from *the person's perspective – from his or her unique point of view.*

The MEANING of changes to the PERSON is important to understand. Our ability to HELP the person really depends on our understanding of the "problem." So think about all the ways the person may be feeling "helpless" or "hopeless" – and what opportunities may exist to change what WE do to help them feel in control of their lives or less dependent on us! What activities can we offer or encourage that helps put the meaning back in living?

INTERVENTIONS

>>Interventions: Depression is highly treatable

Once the depression is recognized we can offer the person assistance to recover. And it's important to know that recovery is, in fact, quite possible. Although the person may FEEL like they will never get better, they can!

Remember, LOSS OF HOPE is part of the depression. *It's part of the illness.* And as we discussed earlier, many people think that it is natural to be "old and sad" – so they may not think there is any hope of getting better.

We need to reassure them that *depression is an illness and that it has a treatment!!* In fact, treatment is so successful that depression has even been called "*a reason for hope!!*"

The treatments for depression often include talking therapy and use of medication. But we need to remember that **EVERY INTERACTION WITH THE RESIDENT HAS THE POTENTIAL TO BE THERAPEUTIC!!**

>>Interventions: Every interaction has “therapeutic potential”

****Refer to handout: Interventions for Depression**

Remember: *Every conversation with the resident, with every person in his or her environment, can make a difference in how they feel!* That means the housekeeping staff, the maintenance people, the dietary aides, you, me, the administrator, volunteers -- **EVERYONE!** We all have an opportunity to help the person grow, to encourage socialization, and to create a climate that fosters health and healthy relationships.

The social environment (which is also called the “milieu”) can make a **BIG** difference in how people feel and function. Caregivers can promote **HEALTH** and **WELL-BEING**

- ✓ through our support and encouragement (to get through it or to try new things),
- ✓ by providing structure in their daily activities (which provides safety and security),
- ✓ by encouraging interaction and involvement (which adds meaning and purpose to life),
and
- ✓ by validating their worth as a person by the way that we treat them!!

>>Interventions: First-line interventions

Although the treatments offered by professionals **ARE VERY** important, we also need to remember *what WE can do to comfort the resident and help them return to health!* We can think about these things as "first line" interventions since we are the **FIRST** people that the resident will come into contact with. There are four main groups of "first line" interventions that we may want to use

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- ✓ letting the person know that we care about them,
- ✓ helping them to see that they are unusually sad or blue,
- ✓ providing accurate information about depression, and
- ✓ creating a healthy physical and social environment.

>>Interventions: Communicate caring

It's important to remember that the resident may feel like "they should be able to take care of themselves" -- and feel "crazy" if they accept help. We need to be sensitive to their feelings and realize that there is a STIGMA about "mental anything!!" So we will need to provide them with *lots of encouragement and accurate information!!*

Likewise, we need to let them know that WE DO CARE! For example,

- ✓ Tell them directly that we care about them;
- ✓ Remind them that WE VALUE THEM *even if they don't seem to care about themselves right now;*
- ✓ Ask them about how they feel or what they think. Let them talk about what's happened that has upset or hurt them, and/or what their fears are;
- ✓ Try to understand the situation *from their point of view;* and
- ✓ Accept their feelings and perspectives as "real to them," by being nonjudgmental, nonpunitive, conveying interest, talking and listening to the resident, and permitting the resident to *express strong emotions* – whether that is anger, crying, or saying that they wish they were dead!

//Trainer: You might want to offer an illustration of how to talk to a resident:
 "Mrs. Smith, I know that you feeling pretty down these days, and that you wish God would just 'take you.' But I have to say that I would sure miss you, and so would a lot of other people! You haven't told me what is causing you to feel so sad, but I'd sure be glad to listen if you want to talk. Can you tell me what you think about? That makes you feel so bad inside?"

>>Interventions: Help to realize they are unusually sad or blue

At the same time, we may want to assist them to realize that they are UNUSUALLY SAD OR BLUE! To do that, we may want to

- ✓ suggest that they are more than just "down in the dumps";
- ✓ ask questions that may help them to identify the things that they feel sad about, that they have lost, or that they are grieving over;
- ✓ recall past positive events (their enjoyment with family visits, hobbies or activities, contributions to others) that you know about to help them see that things haven't always been this bad; or simply

- ✓ point out the positive things that you see in them to help them see that they do still have worth.

//Trainer: You might want to offer an illustration of how to talk to a resident:

"Mrs. Smith, we all have 'good days and bad days' but it sure seems like you're having more than *just a bad day*... It's like there's a big black cloud hanging over you that makes everything look worse! You're so hard on yourself! And you just don't seem to be able to have fun anymore. But I know from talking to your family and friends that you haven't always been that way! And that things haven't always been this bad for you! In fact, you were telling me yourself about when you used to make ice cream out of the first snow, and how much you enjoyed it, and now I can't get you to eat even one bite! It just doesn't go together!"

>>Interventions: Provide information about depression

We also want to give them accurate INFORMATION about depression!

- ✓ Remind them that *depression is an illness* and, just like many physical illnesses, *it has a treatment* that can help them feel better;
- ✓ Tell them that their *symptoms are part of this illness*, that feeling like nothing is fun, that they have no energy, that food doesn't even taste good will go away when the depression lifts;
- ✓ Let them know how common depression is, in all age groups! Help them *feel more "normal"* and less alone;
- ✓ Encourage them that *medications and talking about their feelings* can help reduce or eliminate the symptoms of depression.
- ✓ And finally, we need to remind them that they have lived a LONG LIFE and SURVIVED many difficulties. They have *many valuable experiences* that can help them cope with this problem, and they will live through this too!!

//Trainer: You might want to offer an illustration of how to talk to a resident:

"You know, Mrs. Smith, the doctor says that you are suffering from depression. And depression is an illness that is caused by a chemical imbalance in your body, just like other physical illnesses like diabetes. Do you know anyone with diabetes? Often they have to take pills or injections to REPLACE the chemical that their body can't make. And that's the same thing that happens with depression. That's why it's so important to take the medication that the doctor prescribed. When we get your medication adjusted properly, *you'll feel so much better, you won't even believe it!* And in the meantime, I want you to keep telling yourself that you've lived through things *even worse than this!* Stop and think about all the things that you've survived in your life time! The Great Depression, and World War! Let alone the death of your husband! So hang in there! You're a survivor! You can handle this, too!"

>>Promote Mental Health

In addition to helping the person understand that they are “more than down in the dumps,” caregivers are often able to *adjust what they do* to help PROMOTE MENTAL HEALTH. As we said before, the ENVIRONMENT often has “depressing” effects that can be altered!

Granted, caregivers cannot change the physical environment – but they most certainly can change the SOCIAL ENVIRONMENT. In mental health treatment, “milieu therapy” is a powerful intervention. The milieu is just the social climate, and by changing the social climate we can promote positive experiences and positive HEALTH OUTCOMES!

Considerable research supports the fact that activities that promote MASTERY or CONTROL often increase a sense of EMPOWERMENT that is associated with POSITIVE HEALTH OUTCOMES (by promoting positive immune system function). Likewise, involvement in physical activity has been shown to be a potent “antidepressant!! Caregivers make a BIG difference in WHAT TYPE of activities residents are offered (and encouraged or helped to attend!!) and HOW day-to-day care is provided. *So let’s think more about those factors!!*

>>Monitor Physical Health

Remember: Many “physical” health problems are part of the depression. *If the person does not feel physically well, they are unlikely to engage in activities that might help them feel better!!*

Being more attention to factors that are PART of depression, AND that can contribute to either feeling better OR feeling worse, is important! Key areas of concern include:

- ✓ Nutrition: Is the person eating enough to maintain weight? Would offering snacks or favorite foods help?
- ✓ Elimination: Is constipation a problem? If so, what can be done to help the person restore his/her usual habits and be comfortable again?
- ✓ Sleep/rest patterns: Is the person getting enough rest? What sleep hygiene measures³ might be used to help increase hours and quality of sleep?
- ✓ Physical comfort: What can you do to promote comfort?
- ✓ Pain management: Is the person getting appropriate relief? If not, what adjustments can be made?

>>Encourage Physical Activity

Another incredibly important area that caregivers can influence is how MUCH and what TYPE of physical activity the person gets. In too many situations, depression robs the person of their motivation to “get up and get going.” When fatigue combines with loss of interest, the person too often just stays in their room – alone, feeling bad.

However, physical activity, ALL BY ITSELF, is associated with relief from depression!! So getting the person up, out, and moving is very important. Encourage the person that “getting moving” can help them feel better – physically and emotionally!!

³ Refer to the program “Lullaby and Goodnight, or Not: Understanding and Managing Sleep Disturbance in Older Adults with Dementia” for additional information on sleep hygiene methods.

- ✓ Exercise programs are a great way to assure that older adults are helped to maintain physical activities. Lots of choices exist today – so it doesn't get boring and exercises can be done by even frail older people.
- ✓ Referrals for physical therapy, occupational therapy, recreational therapy may be needed to increase mobility, strength, function and enjoyment.
- ✓ Develop a daily activity schedule to assure that the person is not allowed to “just sit.”
- ✓ Involvement in meaningful activity is as important as physical exercise!! Encourage involvement in hobbies or pastimes that promote feeling good (self worth).

>>Promote Autonomy

Because depression is often accompanied by a sense of hopelessness and helplessness, *your approach to care becomes very important*. People with depression may resist bathing, grooming or other activities of daily living *because they “just don't care.”* It is easy to “step in” and start doing things for and to them. However, increasing their dependency can decrease their self worth by giving them the message that they aren't very capable. So slow down and take time to “get them going.”

We can create MASTERY experiences (which another word for “being successful”), by breaking tasks into easy-to-accomplish steps, cueing the person to keep going, and giving lots of positive praise for efforts. By doing this, you increase the likelihood that the person will be successful *doing things for themselves* (autonomously), which in turn promotes their self worth and builds confidence. Do things for the person *only when they really can't do it for themselves*.

We can also encourage their sense of personal CONTROL and POWER (which is tied to self worth) by making “simple” changes in our routines.⁴ As before, we can encourage independent activity – doing things *for themselves* whenever possible, *followed with lots of praise for their efforts*. We can also promote self worth by encouraging decision-making – which is another way of “making a difference.” Try using close-ended choices that are easier to make. For example, instead of asking “What do you want to wear?” try asking “Do you want to wear the blue dress or the pink one?” Even simple decisions can increase a sense of involvement in their care!

>>Focus on Positive

Assessment information about the person's STRENGTHS and RESOURCES can be used to *develop interventions that build on the individual's abilities and lifelong interests*. For example, knowing about the person's interests and past experiences can help caregivers draw the person into conversation. And in conversation, much may be learned about attitudes and beliefs – like believing it is natural to be “old and sad” or that they “have nothing left to live for.”

⁴ The importance of personal power and control over daily decisions is better explained in the module “Help, Hope, and Power: Issues of Control and Power in Long-term Care.”

Conversation may also lead to REMINISCENCE about past, positive experiences that help the person see that things have not ALWAYS been this bad. Remembering “the good times” can help restore self worth by strengthening the person’s tie to their “former self” – the things they have done in the past. It may also help them see that *they have lived through some very difficult times*, and will survive “this” too.

We may also be able to identify MEANINGFUL activities – things that the person has valued and are enjoyable. By knowing the person well, we can develop an INDIVIDUALIZED plan of care.

>>Encourage Group Activities

In addition to talking one-to-one with you and others, group interventions can also be very helpful to older adults who have depression. Many types of groups are possible. Groups that

- ✓ focus on activity, movement, or music;
- ✓ encourage reminiscing about times gone by or that help remotivate people;
- ✓ teach about health or stress management;
- ✓ stimulate the senses, like pleasant aromas or beautiful views.

There are lots of possibilities! No matter what the format, bringing people together has the opportunity to promote social interaction and relationships. Groups that are activity-oriented can increase self worth by providing an opportunity to "master" an activity or project, and feel a sense of accomplishment. Groups also increase a sense of "shared experiences," that is, the feeling that "I'm not alone in this!"

>>Employ Alternative Therapies

As we said before, involvement in MEANINGFUL ACTIVITIES often has positive health outcomes. Too often, living in residential care means “giving up” activities that gave the person a “*reason*” to get up in the morning. We forget that “chores” like cooking or cleaning, “hobbies” like gardening, or having “animal friends” (e.g., pets) were a big part of the person’s life BEFORE living here.

As noted on the slide, offering alternatives that are meaningful to the PERSON can promote self worth in a variety of ways.

- ✓ Pet therapy: unconditional positive regard, sensory stimulation, sense of responsibility, meaningful role
- ✓ Horticultural therapy: lifespan simulation; aroma therapy benefits (e.g., herbs smell good); maintain mobility

Remember! This is only a small sample of things that might be offered!! Be creative! What did the person like to do *before they came to live here*? How did they spend their time?

>>Promote Creativity

Research supporting the *positive effects of social and productive activities* for older adults also includes use of CREATIVE ACTIVITIES – like painting, drawing, making jewelry, singing, playing a musical instrument, writing, and story-telling (like Time Slips⁵), along with lots of others.

For many older adults, EXPERIMENTING WITH SOMETHING NEW is a gratifying and positive experience that is associated with positive health outcomes. Preliminary results indicate that older adults who engage in creative activities on a regular basis experience less depression and loneliness, fewer visits to the doctor and less use of medication. They reported better overall physical health, higher morale, greater life satisfaction, and higher levels of activity.⁶

Of importance, the activity might involve trying something NEW, or pursuing some lifelong interest that was neglected because of other obligations – like work and family. Again, talking with the person about past interests and positive experiences may provide clues to helping the person “take up” something new, or explore something that was fun in the past.

>>Enhance Social Support

For many people, being with people is another important way to experience enjoyment in living. Social isolation is a real risk in residential care. When the person moves away from their life-long neighborhood and friends, daily social contacts with *significant others* may decrease dramatically.

In some cases, residential and nursing facility care providers become “like family” – providing needed support, assistance, and caring. At the same time, helping the person with depression remain involved with family, friends, and others who can spend time talking, socializing, or in activities, is also very important!

One of the best things caregivers can do is identify a “point person” who will help mobilize social contact with people from outside the care setting. Often this is a family member, but it can also be a good friend. The point is that this person understands the risks associated with loneliness and isolation, and makes a special effort to get other people involved. That might include visits, telephone calls, or written messages from a variety of people: family members, friends or neighbors; church members or clergy; volunteer visitors, or peer counselors (e.g., older adults who are specially trained to listen and interact as lay counselors).

⁵ TimeSlips is “an innovative and effective method of creative storytelling that celebrates the creativity of people with dementia.” Visit the website <http://www.timeslips.org/> for information about training, support, and models for community outreach.

⁶ Research described here is conducted by Gene D. Cohen, MD, PhD. The three-year study, “Creativity and Aging: The Impact of Professionally Conducted Cultural Programs on Older Adults,” was initiated in 2001 with support from the National Endowment for the Arts (lead sponsor), SAMHA, NIMH, AARP, and others. Initial results provided by Dr. Cohen are described here.

>>Professional Interventions

In addition to changing how we interact with the person, adjusting what we do to promote a more positive social climate or milieu, and adding activities that are associated with positive health outcomes, interventions offered by mental health professionals may also be needed.

Some of the most common professional interventions for depression include:

Talking therapy: Also known as counseling or psychotherapy; cognitive-behavioral approaches are often used to help the person with depression examine feelings and perceptions that may be distorted and substitute more realistic views;

Supportive therapy: Provides support for positive coping mechanisms, encouragement and praise for efforts to perform daily activities;

Medication therapy: Antidepressant medications are commonly used to treat both Major and Minor depression. However, medication “alone” is rarely effective! Changing *daily routines and habits that contribute to feelings of depression* are also critically important!!

SUMMARY

In summary, depression is common among people of ALL ages. However, older adults who live in residential care and nursing home settings are at an even higher risk for becoming depressed than others. Our residents often have experienced many losses and have physical illnesses that cause pain and unwanted dependence. In addition, the social climate of the facility may add to their troubles by contributing to social isolation, reinforcing dependency, and failing to offer activities that promote positive health outcomes.

At the same time, depression is the *most treatable of all mental illnesses* – and is sometimes called “a reason for hope!” But first we have to *recognize the symptoms* for what they are! Only when we understand that the behaviors are part of depression can we change what WE DO and HOW WE DO IT to help restore and maintain the person’s sense of well-being, purpose in living, and self worth. The assessments that daily caregivers conduct make a difference – both in the care that is provided AND in making referrals for needed health and mental health services.

Take time to listen to the person, observe possible changes in their behavior, ask them about feelings and problems, discuss those issues with team members, and make an individualized plan that builds on the person’s strengths and abilities, creates mastery experiences, and encourages meaningful activity that promotes health and well-being.