

Geriatric Mental Health Training Series: Revised

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

Depression in Older Adults

Supportive Materials

Revised by Marianne Smith, A.R.N.P., B.C., Ph.D.(c)

From original content by

Kathleen Buckwalter, R.N., Ph.D., F.A.A.N

Marianne Smith, R.N., M.S.

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When You Are More Than Just "Down In The Dumps": Depression in Older Adults

CONTENTS

The revised version of this training module includes the following components. To facilitate use, some components are combined in a file, others are located in independent files, and all are provided in at least two formats – the electronic processing format in which they were created (Microsoft Word or PowerPoint) and a PDF version. A brief description of each is provided to enhance overall use of these training materials.

- Statement of Intended Use: Contained in this file. Provides guidelines for use of the training materials.
- Statement of Purpose, Learning Objectives, Content Outline: Contained in this file. Provides guidance about both content discussed in the module and provides the basis for applying for continuing education credits for teaching the module to a group of people. The program is about an hour long.
- Notes for the Instructor: Contained in this file. Provides an overview of the goals of the module, along with suggestions to personalize the content and make the training more individualized to the audience.
- Handouts, Bibliography: Contained in this file. Handouts that address program content are provided. These may be used independently, or in conjunction with handouts made from PowerPoint. The bibliography is provided for your reference and consideration. As before, these materials are provided in two formats to best accommodate all users.
- PowerPoint Program: Separate file, provided in both PowerPoint format and in PDF (slides only). The module contains 49 slides. If opened using PowerPoint, they may be viewed and used in a variety of ways: 1) slides may be shown in Presentation View using a projector, 2) lecture content is provided in Notes View, and may be printed for use to lecture, 3) slide content may be printed as handouts. Because some users may not have PowerPoint, the slides have also been converted into a PDF file which allows you to print a hard copy and make overheads or 35mm slides if desired to accompany the training program.
- Lecturer's Script: Separate file, provided in Microsoft Word and PDF format. This content provides the narrative to accompany and explain the slides and is also found in Notes View in the PowerPoint program.

Supportive Materials: List

The following materials are found in this file:

- Statement of Intended Use (1 page)
- Purpose, Objectives, & Content Outline (2 pages)
- Notes for the Instructors (6 pages)
- Handouts
 - ✓ Facts about depression (1 page)
 - ✓ Signs and symptoms of depression (1 page)
 - ✓ Types of depression (1 page)
 - ✓ Causes of depression (1 page)
 - ✓ Physical illnesses associated with depression (1 page)
 - ✓ Medications that can cause symptoms of depression (1 page)
 - ✓ Factors to consider in assessment (2 pages)
 - ✓ Geriatric depression scale (1 page)
 - ✓ Interventions for depression (5 pages)
- Bibliography (6 pages)
- Links to Resources (2 pages)

Statement of Intended Use

This training module is provided by the Hartford Center of Geriatric Nursing Excellence (HCGNE), College of Nursing, University of Iowa, as a free service. The training program, “Back to the A-B-C’s: Understanding and Responding to Behaviors in Dementia” is revised and updated from a module titled “Acting Up and Acting Out: Assessment and Management of Aggressive and Acting Out Behaviors” that was first published in *The Geriatric Mental Health Training Series (GMHTS)*. The GMHTS was developed and evaluated during a five year grant from The Division of Nursing, Bureau of Health Professions, Department of Health and Human Services, Grant # D10NU2711801, between 1989 and 1994. Other titles in the GMHTS include:

- Whose Problem Is It? Mental Health and Illness in Long-term Care
- Getting the Facts: Effective Communication with the Elderly
- Help, Hope, and Power: Issues of Control and Power in Long-term Care
- When You Are More Than Just Down in the Dumps: Depression in the Elderly
- When You Forget that You Forgot: Recognizing and Managing Alzheimer’s Type Dementia, Part I (Introduction and Overview)
- When You Forget that You Forgot: Recognizing and Managing Alzheimer’s Type Dementia, Part II (Interventions)

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Attn: Marianne Smith

HCGNE

College of Nursing

Iowa City, Iowa 52242

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

Purpose:

Depression is more common in older people than is often realized. The failure to recognize this treatable illness may lead to unnecessary suffering. This lecture provides participants with an overview of the signs and symptoms of depression, common problems that cause or mimic depression, and ways to assist elderly who may be depressed.

Objectives:

1. List signs and symptoms of depression in the elderly.
2. Discuss some of the causes of depression.
3. Give an example of factors that should be included in assessment.
4. Administer the Geriatric Depression Rating scale.
5. Give an example of “front line” interventions.
6. Discuss interventions that promote mental health for residents with depression.

Content Outline:

Introduction and overview

- Significant public health problem
- Factors that put some at higher risk
- Diagnosis difficult, underestimated
- Suicide and passive suicide in elderly
- Risk for poor outcomes

Symptoms of depression

- Change in mood
- Disturbed perceptions
- Changes in behavior
- Symptom are blamed on other factors
- Major depression criteria
- Minor depression criteria

Causes of Depression

- Chain of events
- Stress and loss associated with aging
- Biological depression
- Physical illness

Assessment

- The Geriatric Depression Rating Scale
- Psychiatric history
- Suicide assessment
- Recent loss
- Resources and abilities
- Person-centered

Interventions

- Importance of daily care/social environment
- First line interventions
 - Communicate caring
 - Unusually sad/blue
 - Provide information
 - Environment
- Support mental health
 - Monitor physical health
 - Encourage physical activity
 - Promote autonomy
 - Focus on positive
 - Encourage group activities
 - Employ alternative therapies
 - Promote creativity
 - Enhance social support
- Professional interventions

Summary

Notes for the Instructor

Depression is a significant health problem for people of *all ages*, but is particularly troublesome among older adults. Although the “difficult” behaviors associated with depression may be less frustrating to staff than those associated with dementia, older adults with depression may present a number of challenges to staff providing patient care.

Common Behavioral Challenges: The depressed person may easily become so apathetic, lethargic, and uncaring (about their personal hygiene, eating, activity, etc.) that they require an increased amount of staff time to execute their daily cares. Many depressed elderly are mistaken for someone with dementia (or delirium) because their concentration is so impaired that it seems their memory has failed. The person may become psychotic, hearing voices or believing things that aren't real, leading staff to think that they are schizophrenic. Agitated depression (with increased irritability, brooding, pacing, and worry) can create many problems for the staff and other residents. Here the person may become either verbally or physically threatening.

As you can see, these "variations" can cause all kinds of care problems, *particularly when no one has recognized depression as the cause!* Like so many other types of difficult-to-understand-behavior, understanding the cause of the “problem” is critical to helping the person be comfortable and functional. Consequently, the main goals of this program are to:

- 1) introduce caregiving staff (particularly nursing assistants, universal workers, and other paraprofessionals) to the various signs and symptoms of depression *among older adults* so that they can respond empathetically when the resident “resists” personal care, or behaves in ways that they do not understand;
- 2) sensitive staff to the wide range of loss and life changes (including medical problems) that *most* of older adults living in long-term care settings have experienced, and how that can contribute to depression;
- 3) encourage caregivers that you *don't* have to be a *physician or a mental health professional* to identify depression or to implement supportive interventions!

The health care providers who are on the "front line" (the nurses and nursing assistants) are in the *very best position* to recognize behaviors that suggest depression, as well as other emotional or mental disorders. Likewise, their participation in the treatment plan is critically important. The "front line" provides 24 hour care, 7 days a week. *They CREATE the social environment, or milieu, in which the older adult lives.* They have both the ability and the opportunity to promote health by intervening directly with the resident, and by insuring that the professional's treatment plan is followed (e.g. monitoring medication effectiveness and side-effects, getting the person out of their room to activities, meals, group therapy, etc.).

Emphasis in Revisions. In this revision (2006), we have chosen to emphasize content that is relevant to direct care providers, focusing on things that they have control to do in daily practices to assure better quality of care for older adults with depression. We recognize that nurses and nursing assistants (as well as other paraprofessional staff that they supervise) have different responsibilities in identifying, assessing and intervening with older adults who are depressed. At the same time, all workers benefit from having a base of knowledge about depression. We leave it to you, the trainer, to decide how much and what type of emphasis is placed on various points in the module and use of handouts. Adjust the program to best

Because we anticipate that the majority of nursing care staff in long-term care settings are nursing assistants (or other nonprofessionals), rather than nurses, we have tried to keep the program content fairly simple. Unfortunately, this means omitting information that nurses in your facility may find meaningful. In specific, we have omitted content that relates to antidepressant medication use in order to spend more time discussing psychosocial interventions that may be used by all staff in daily practice. We encourage you seek additional information on medication use via links provided in the last handout.

Please be aware that handout on medications and physical illnesses that are associated with depression are targeted to nurses (who are most likely to review and critique medications). At the same time, users of the GMHTS provided feedback that ALL STAFF appreciated having this level of information (e.g., detailed list contributed to a sense of involvement in assessment and care plan development). We recommend that you review all handouts in advance, think of your audience, and make decisions about how best to approach this training program to meet the needs of different members of all participants.

In this revision, we continue to use “resident” to refer to older adults who are being provided care. We also assume that care is provided in a protected environment, like a nursing home, assisted living facility or residential care center. However, content in this module may also easily be applied to older adults who are living at home and are receiving home care or attending adult day health care programs or other structured community-based program (e.g., senior centers). We encourage you to adapt the content taught, and language used, to meet the needs of your care setting and audience (following terms in Statement of Intended Use).

Review Other Modules. This module builds on issues and ideas presented in the first program, “Whose Problem Is It?” Be sure to review ideas and concepts related to looking at the “chain of events” that are causing the behaviors observed. Think again about the importance of assessments, and figuring out what the “underlying problem” might be. In addition, reviewing content on the relationship between control, power, and self worth and the role of loss in the program “Help, Hope, and Power: Issues of Control and Power in Long-Term Care” may be useful.

Content in this Module. As in other programs, we ask that you consider the residents of your facility and be prepared to give real life examples. This is especially important to do in the discussion of stress and loss that residents have endured (part of the section on Causes of Depression). The handout has a list of illustrations that expands on the actual script to help you think of examples.

Remember that staff may easily become "immune" to the experience of stress and loss among your residents because it has become so much a part of their day-to-day work life. Assist them to see life from the resident's perspective.

Remember that there is a very close relationship between depression and grief. Although we don't address this directly in the program, it's important to know that grief can look like depression, and visa versa!! That means that we may KNOW that the person suffered a recent loss and just "write it off" as grief. Sometimes IT IS JUST THAT: a normal, healthy grief reaction. It's called "Uncomplicated Bereavement" by the psychiatric community. But we also need to remember that the person who is grieving may BECOME DEPRESSED!

A full depressive syndrome is often a normal reaction to loss: they cry, they feel sad, they feel lost, and lonely, out of sorts, or like there's no point in going on. They may even lose their appetite, lose weight, and develop insomnia. But they don't have severe feelings of worthlessness, psychomotor retardation (slowing of movements), psychotic symptoms (e.g., delusions or hallucinations) or impairment in their ability to function. If they do, they have likely become depressed as a result of their loss and should be professionally assessed.

Another point that we don't explore "in depth" is the difference between "biological" and "reactive" depression. In fact, the distinction between endogenous and exogenous depression is rarely made today. Instead, *most people believe that all depression is a medical, or biological, condition.* We understand that different factors may serve as antecedents or triggers to developing depression. We also understand that early onset of depression (before age 30 years) tends to result in recurrent depression that is more severe. As a result, we emphasize the importance of *identifying if the person has a history of depression – including a depression that was not labeled as such and may have not been treated.*

Depression is nearly twice as common in women as in men. And many women (particularly in this cohort of older adults) may have experienced post-partum or "empty nest" depression that was not recognized or treated. Because of the stigma associated with mental illness in this cohort, the depression may have been labeled as having "bad nerves" or a "nervous breakdown" or "going to bed sick" after some traumatic life experience. As a result, there may be no record of depression in the medical or psychiatric history. However, staff who know the person well may be able to identify these problems by gently probing, asking, and problem-solving with the person about their past experiences.

We know that a wide variety of factors are highly associated with depression – and that many of those same factors are the very same ones that older adults require various types of residential, nursing home, or structured daytime care. In other words, the same problems that interfere with the older adult being able to live independently in the community may cause or contribute to depression. As we emphasize in the module, the combination of chronic health problems and psychosocial stress can place older adults at much higher risk for developing depression – and for having poorer outcomes even when the depression is identified and treated!

As you will see in the lecturer's script and handouts, we spend considerable time reviewing the array of emotional and behavioral symptoms that older adults with depression may

experience. We urge you to emphasize that a wide variety of behavioral changes can signal depression. For example, depression overlapping on dementia may cause additional behavioral symptoms that are attributed to the dementia. Those with anxious depression may be worried, apprehensive, and irritable instead of sad and blue. As we said in the introduction to these notes, depression may appear as a wide variety of challenges in daily care.

We also spend time differentiating between major and minor depression. The primary aim here is to help caregivers understand that “subclinical” or minor depression is just as important to address as major depression. *This is particularly important in term of developing care plans that use psychosocial interventions to promote mental health.*

The section on assessment introduces the Geriatric Depression Scale (GDS), which is commonly used in LTC settings today. Although we do not address this in text, examining MDS data related to depression may also be useful to help staff. The assessment section reviews information on symptoms and causes, and hopefully helps staff see that “assessment is everyone’s job” – a theme that runs throughout all modules.

Finally, we provide two main types of psychosocial interventions. We labeled the first group “First Line Interventions.” These strategies are designed to help caregivers talk to the older person with depression and help that person see that he/she is “more than down in the dumps.” We believe that caregivers too often believe that information sharing and discussion like this is “not their job.” However, much time is spent with residents during the provision of daily cares. That time can be used effectively to demonstrate caring, show interest and concern for the person’s current worries and feelings, and offer perspectives that may help reduce negative feelings. However, many caregivers need “permission” to do those things. Your job is to assist them to “find the right words” and then support them to have the conversations. In the Lecturer’s Script, you will find boxed information offering specific examples of how to talk to residents. Please take time to review these and be prepared to discuss ideas with staff.

The second group of interventions is labeled “Mental Health Promotion.” Here we address psychosocial factors in the SOCIAL ENVIRONMENT, or MILIEU. Here we build on the theme that the environment in which physical health care is provided often has depressing effects. Take time to review that idea and emphasize that caregivers can do MUCH to reduce or change things that contribute to feelings of depression. Several principles underlie much of the content provided here.

FIRST, *depression often distorts people’s perceptions of their self worth.* They feel helpless, hopeless and powerless; they think they have no value and that life is not worth living. Too often care routines contribute to those feelings by creating unwanted and unneeded dependency. Caregivers “hurry people along,” doing things “to” them and “for” them in a way that reinforces their sense of being worthless and incapable. Saying, “Here, let me just do that for you!” may be experienced as “You aren’t doing it fast enough or well enough! You are no good!” Help caregivers appreciate that doing things FOR the person who is depressed may NOT be helpful at all!! Instead, taking time to cue the person, break tasks into steps, giving lots of praise for all efforts, and even offering “rewards” may be more effective!

Staff can create “MASTERY” experiences – ones in which the person “masters the task” and is successful. In turn, these experiences contribute to self worth.

A SECOND important point is that personal POWER and CONTROL (which in simple terms is a sense of being able to affect the outcome of what happens to you in daily life) *is intimately linked to SELF WORTH and self esteem.* (Note that we use self worth and self esteem interchangeably throughout the program.) In other words, feeling “good about oneself” (self worth/esteem) is often tied to factors that enhance feeling like what you do “makes a difference” in life (power, control). We don’t use the term EMPOWERMENT, but that is what we are talking about. Staff can empower residents by changing what they do and how they do it! Offering simple choices about daily care can have a powerful effect. Likewise, involving residents in activities can be very potent form of empowerment!

The THIRD important area is the “ANTIDEPRESSANT” EFFECT that is associated with various activities. As we discuss, there are a wide variety of choices. Therapeutic benefits of activities tend to revolve around

- mobilizing the person, helping them to be more physically active, which is associated with reduced depression symptoms;
- engaging the person in social interactions, which reduces loneliness and increases a sense of “not being alone with this problem” (whatever that problem may be); and
- promoting involvement in meaningful activities (not just things that “pass the time”), which in turn contribute to a sense of productivity, creativity, mastery, and self worth.

Although the frequency with which we use “meaningful” in association with “activities” may seem redundant. However, the choices offered in too many LTC settings often do NOT reflect the diversity of the population being served. A handful of options are offered in rotation with a nearly “take or leave it” attitude. Activities are not individualized to the person and his/her lifelong interests, habits, or current abilities. Activities are also NOT seen as a means by which to promote positive HEALTH outcomes. Instead, they are offered to “fill the calendar” in order to meet licensing requirements, because a volunteer group offers to conduct it (e.g., bingo), or for some other reason that is NOT based in “evidence” about promoting health and well-being for residents.

The LAST point, which relates to activities for residents, is the need to address the UNHEALTHY “SPLIT” between the “Nursing” and “Activity” departments. In too many care situations, caregivers who provide “personal care” (e.g., nurses, nursing assistants) are not “responsible” for “activities.” Instead, an activity, recreation, or even occupational therapy person (usually an “assistant”), organizes and provides psychosocial activities. Instead of “pairing” members of the two departments, they each “do their own thing,” often with vigor (e.g., Not my job!). Regrettably, each team member often knows part – but not all – of the information that may be needed to facilitate the best possible outcomes. We strongly encourage collaboration between all departments, cross-training of staff, and shared responsibility – particularly for psychosocial activities.

The suggestions and ideas provided in this module are the “tip” of the proverbial “iceberg” of knowledge about depression and activity-based care. We urge you to explore the literature about interventions for depression (and other mental disorders) that are research-based, and that target health promotion – not just “filling time.”

As we noted in our "General Instructions," we ask that you "try out" the concepts and interventions in advance of teaching the program so that you can relate, from your own personal experience, how they may work out in a real life setting with a real, live resident! After reviewing the program materials, think about the following questions and suggestions and make some notes to yourself in the margin of the lecturer's script or the handouts.

1. Can you think of a resident who has (or had) a "classic" depression? That is, they have some of the more common symptoms of depression: sad and blue, anorexia, insomnia, psychomotor retardation, etc.? What do you know about this person? About their history? About their medication use (either for physical illness or psychotropic medications)? About their current treatment plan? What additions might you make, given the suggestions provided in the lecture? Think carefully about the ideas described and try out the techniques ahead of time. What can you learn about the person? What problems did you encounter using interventions? Was the approach or method effective? If not, why not? What will it take to make things “work well” in this environment? Can you offer staff some concrete suggestions?
2. Who in your facility has (or had) a depression in which they actually became psychotic (hallucinations and delusions)? Can you remember the details to illustrate how a psychotically depressed person may think, talk, or act? Some real life examples from my practice (M.S) include: thinking that they have cancer, that their body has turned to wood, that they can't breath but have no symptoms of respiratory distress, that they can't walk but do get up and walk, that they are dying in the absence of physical illness, that their food is poisoned, that the sun is artificial, that their husband is calling them from the other side. However, real life examples from your residents will be more meaningful than any others!!
3. What kind of depression assessment methods are currently in use in the facility/organization, if any? Who administers the tool(s)? How does that person share information with day-to-day care providers? How is information used in practice? Or is it just “filed for future reference”? What adjustments can be made to assure that direct care staff participate in the assessment of depression (and other mental disorders)? What changes might be needed to promote information-sharing AMONG staff?
4. If you are not fully acquainted with the Geriatric Depression Scale (GDS), but sure to use it with several older adults to become familiar with common questions or issues that may arise with its use. Be ready to tell staff WHAT to say to residents to introduce the scale, how to score it, and what should be done with the results if it is used (e.g., report to supervisor, place in chart, etc.).
5. Some trainers like to have staff complete the GDS for themselves (e.g., score it during the training program for experience in reading the questions and summing the score). If you use it in this way, recognize that some staff may score above the "cut-off score" (10

points). This may create a feeling of alarm or dismay, or it may promote a defensive reaction (e.g. "This scale is obviously worthless if it says that I'm depressed!").

Be prepared to respond to questions or concerns. Reassure staff that this scale is only a SCREENING TOOL, not a diagnostic tool. It is designed to identify a cluster of symptoms that commonly occur in depression, but does not necessarily indicate that the person is, in fact, depressed. However, the cluster of symptoms does say that the person is feeling some subjective distress and they may want to pursue that with someone (e.g. talking to a good friend or confidant, mental health professional, pastoral counselor, etc.).

6. We also encourage you to inventory the type of activities, conducted with individuals and in groups, that are routinely provided in the facility or setting. Take time to evaluate how these programs may "fit" with concepts being taught. We recognize that being openly critical of existing program is not useful. Instead, try to think creatively about how programming might be enhanced, who is in charge of these decisions, what type of additional resources might be needed, and how changes might be undertaken.
7. Take time to review the boxed illustrations that related to "First Line Interventions." Personalize those examples if possible. Be sure to help staff "find the right words" and give them "permission" to talk openly with residents. At the same time, you may also want to emphasize that STAFF self-disclosure (e.g., staff talking about their own feelings, issues, and problems) should be limited. The focus needs to remain on the older adult and his/her problems and issues, not the staff person's.
8. Note that bulleted lists in the Lecturer's Script (✓key point) are also on the Powerpoint slide (often in an abbreviated format) and in the handout (often in an expanded format).

To enhance your working knowledge of depression in the elderly, we have provided a number of articles for you to review. We suggest that you read as many as possible and utilize any examples or illustrations that you think will be meaningful to the staff that you are training. Although some references are dated (e.g., from the first edition of this module), they are still some of the best reading on the topic. For example, Billig's 1987 book *To Be Old and Sad* is an excellent and yet easy-to-read books on depression. A newer book by Miller and Reynolds, *Living longer depression free: A family guide to recognizing, treating and preventing depression in later life*, is another good resource for family and staff.

In addition, we have provided a number of links to other resources in the handouts. These may be helpful to review as you prepare to teach the module. You may want to refer family members or friends to these online resources to help them better understand problems experienced by their loved one.

These resources may also be helpful to your staff, in terms of understanding depression as an illness. As we said in the lecture, too often depression in older adults is dismissed as a "natural" part of aging which unnecessarily deprives the person of quality living. Depression can, and does, occur at any point during the life span. Knowing about depression and its treatment may be helpful for your staff in their personal lives, as well as on the job!

Facts About Depression¹

Depression: Common Illness

- Depression is a *serious medical condition*.
- Unlike passing mood states, depression is *persistent* and *interferes with ability to function*.
- Depression is the *most common mental illness* among people of all ages.
- Depression is the *leading cause of disability* in the U.S. and worldwide.
- Of the 35 million Americans age 65 and older, *2 million have depressive illness* and another *5 million suffer from minor depression*.

Comorbid Condition/Groups at Risk

- Depression is often *missed or misdiagnosed* in older adults because the symptoms are mistaken for the "everyday problems of the aged."
- Depression can *mask or be masked by physical illnesses* that are common among older adults.
- Heart disease, stroke, diabetes, cancer and Parkinson's disease often *co-occur with depression*.
- An estimated 30% of those with *Alzheimer's disease* and related disorders also develop depression.
- *Family caregivers*, who are often older adults, are at particularly high risk for depression.

High Suicide Risk

- The *suicide rate* is higher among older adults than any other age group.
- Older adults are less like to *attempt* suicide, but are more likely *use more lethal methods that result in death* (compared to younger adults).
- People over the age of 65 make up 13% of the population but commit *20% of all reported suicides*.
- White men aged 80 years and over are at highest risk of suicide.

Highly Treatable

- Depression is a *very treatable illness*, and is sometimes called "a reason for hope."
- Negative societal attitudes and inaccurate beliefs (e.g., symptoms are "not real"; person should just "shake off symptoms") *interfere with seeking treatment, or staying on treatment* because of shame and stigma (e.g., "should be able to manage on my own").
- Almost 80% of all people with serious depression are *successfully treated and returned to health*.
- Day-to-day experiences and contacts in the *social environment (milieu)* have a powerful effect on mental *health* and *reducing depression symptoms*.
- Anti-depressant medications and talking therapies are the most *common forms of professional treatment*. Combination therapy is *more successful than either alone*.
- Family and friends also provide *much needed support, love, and encouragement*.

1. Source: National Institute of Mental Health (NIMH), "The Invisible Disease: Depression (2001) and "Older Adults: Depression and Suicide Facts" (2003).

Signs and Symptoms of Depression

Disturbed Mood

- ✓ Sadness, discouragement, crying
- ✓ Anxiety, panic attacks, brooding, irritability
- ✓ Say they feel sad, blue, depressed, low, nothing is fun, down in the dumps

Disturbed Perception

- ✓ 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).

Behavioral Changes

- ✓ 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).

Types of Depression¹

Major Depression: 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:

- 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

These OBSERVABLE 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.

Minor Depression: also called "subclinical" or "subsyndromal" depression because it does not meet the full criteria for major depression. For example, the person has 4 of 5 symptoms. Like major depression, minor depression is associated with disability and reduced quality of life, and responds well to the same treatments that are used with major depression.

Dysthymic Disorder: a chronic but less severe form of depression that includes depressed mood and at least 2 additional symptoms that persist for at least 2 years. People with dysthymia may also develop major depression.

Bipolar Disorder: episodes of depression may alternate with mania, which is characterized by elevated mood or irritability and other symptoms. Bipolar disorder requires different treatments than major depression; professional diagnosis and treatment is essential.

Other disorders that cause depressed mood include:

Adjustment Disorder with Depressed Mood: signs and symptoms of depression that occur in response to a significant psychosocial stressor, but do not meet the full criteria for Major Depression. Symptoms occur within 3 months of the stressor and subside within 6 months after the stressor (or its consequences) have resolved.

Bereavement: signs and symptoms of depression that occur following the loss of a loved one are considered bereavement unless they "persist for more than 2 months, or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation." (DSM-IV-TR, p. 355)

1. Source: DSM-IV-TR (2000).

Depression in Older Adults

Causes of Depression

Stress and loss associated with aging

- ✓ Physical illness or disability
- ✓ Decreased sensory capacities
- ✓ Changes in social status and responsibilities to others
- ✓ Decreased self esteem due to role loss or change
- ✓ Loss of friends and family
- ✓ Relocation due to changing abilities
- ✓ Loss of financial resources due to retirement
- ✓ Social isolation
- ✓ Diminished capacity to adapt to change

Biological depression

- ✓ Comes "out of nowhere"
- ✓ Tends to be more severe than "reactive" type
- ✓ Person more likely to have had other episodes earlier in life

Physical illnesses

- ✓ Physical illness can directly cause the symptoms of depression
- ✓ Physical illness can cause a reaction of depression by causing
 - chronic pain or fear of pain
 - disability or loss of function
 - loss of self esteem
 - increased dependence
 - fear of death
- ✓ Depressed elderly may present with somatic (physical) complaints
- ✓ Medications can cause the symptoms of depression
- ✓ The environment in which physical illnesses are treated may contribute to
 - isolation
 - sensory deprivation
 - enforced dependency

Physical Illnesses That Are Associated With Depression

Metabolic Disturbances

Acid-base disturbance
Azotemia, uremia
Dehydration
Hypo- and hypercalcemia
Hypo- and hyperglycemia
Hypo- and hyperkalemia
Hypo- and hypernatremia
Hypoxia

Endocrine

Addison's disease,
Cushing's disease
Diabetes mellitus
Hyper- or hypoparathyroidism
Hypo- and hyperthyroid

Neurological Disease

Aneurysms
Brain tumors
Cerebral arteriosclerosis
Cerebral infarct
Cerebrovascular disease (stroke;
transient ischemic attacks)
Dementia: all types
Intracranial tumors (malignant
or benign)
Meningitis
Neurosyphilis
Normal pressure hydrocephalus
Parkinson's disease
Subarachnoid hemorrhage
Temporal lobe epilepsy

Respiratory Infections

Brucellosis
Hepatitis
Influenza
Pneumonia
Tuberculosis

Cancer

Occult carcinomas
Pancreatic

Cardiovascular Disorders

Congestive heart failure
Endocarditis
Myocardial infarction

Pulmonary Disorders

Chronic obstructive lung disease
Malignancy

Gastrointestinal Disorders

Hepatitis
Irritable bowel
Malignancy
Other organic causes of chronic
abdominal pain, ulcer, diverticulosis

Genitourinary

Urinary incontinence
Urinary tract infections

Musculoskeletal Disorders

Degenerative arthritis
Osteoporosis with vertebral
compression or hip fracture
Paget's Disease
Polymyalgia rheumatica
Rheumatoid arthritis

Collagen Vascular Disease

Systemic Lupus Erythmatosis

Anemias

Folate and iron deficiencies
Megaloblastic anemia
Pernicious anemia

Metal Intoxications

Thallium
Mercury

Medications That Can Cause Symptoms of Depression

Analgesics

Morphine
Codeine
Morphine (Demerol)
Pentazocine (Talwin)
Propoxyphene (Darvon)
Indomethacin (Indocin)

Antiparkinsonian

Amantadine (Symmetrel)
Bromocriptine (Parlodel)
Levodopa (Larodopa)

Anticonvulsant

Carbamazepine (Tegretol)
Ethosuximide (Zarontin)
Phenobarbital
Phenytoin (Dilantin)
Primidone (Mysoline)

Anti-inflammatory/Anti-infective

Ampicillin
Cycloserine (Seromycin)
Dapsone
Ethambutol (Myambutol)
Griseofulvin (Grisactin)
Isoniazid (INH)
Methoclopramide (Reglan)
Metronidazole (Flagyl)
Nalidixic acid (NegGram)
Nitrofurantoin (Furadantin)
Non-steroidal anti-inflammatory agents
Penicillin G procaine
Streptomycin
Sulfonamides
Tetracycline

Cardiovascular

Clonidine (Catapres)
Digitalis
Guanethidine (Ismelin)
Hydralazine (Aspresoline)
Methyldopa (Aldomet)
Procainamide (Pronestyl)
Propranolol (Inderal)
Reserpine (Serpasil)
Thiazide diuretics

Cancer chemotherapies

6-Azauridine
Asparaginase (Elspar)
Azathioprine (Imuran)
Bleomycin (Blenoxane)
Cisplatin ((Platinol)
Cyclophosphamide (Cytoxan)
Doxorubicin (Adriamycin)
Mithramycin (Mithracin)
Vinblastine (Velban)
Vincristine (Oncovin)

Hormones

Adrenocorticotrophic
Anabolic steroids
Estrogen
Glucocorticoids
Oral contraceptives

Hypoglycemic agents*

Cocaine**
Methylphenidate (Ritalin)

Psychotropics

Barbiturates
Benzodiazepines
Chloral hydrate
Meprobamate
Chlorpromazine (Thorazine)
Haloperidol (Haldol)
Thiothixene (Navane)
Fluphenazine (Prolixin)

Steroids

Corticosteroids

Stimulants

Amphetamines**
Caffeine

Others

Alcohol
Choline
Cimetidine (Tagamet)
Disulfiram (Antabuse)
Lecithin
Methysergide (Sansert)
Phenylephrine (Neo-Synephrine)
Physostigmine (Antilirium)
Ranitidine (Zantac)

Factors to Consider in Assessment

Signs & Symptoms of Depression

- Review signs and symptoms; look for changes in mood, perceptions, and behaviors. Consider number, type, intensity of signs and symptoms.
- Think about diagnostic criteria: What are the key features of depression?
- Consider changes over time. Is this “baseline” for the person (e.g., personality traits, usual coping; person has legitimate complaints)? Or are behaviors a change from their usual level of function?
- Apply a standardized rating scale, like the Geriatric Depression Scale.

Suicidal Ideation (Thoughts)

- Take all thoughts of death seriously.
- Ask: “Have you thought that life isn’t worth living?” If YES, proceed.
- “Have you thought about harming yourself? If YES, proceed.
- “Do you have a plan?” If YES, examine lethality.
- Is the plan viable? Can they execute it? Are means deadly, available?
- REPORT all information to your supervisor or other appropriate personnel!

Psychiatric History

- Look in the chart for diagnosis of depression.
- Ask the person about having had problems “like this” earlier in life.
- Inquire about problems with “nerves,” “nervous breakdowns” or difficulties “adjusting” after major life events like child birth, children leaving home, loss of a loved one, or retirement.

Physical Health/Illness

Consider factors that increase the risk that depression will develop or get worse, AND factors that directly contribute to the development of depression symptoms, including but not limited to the following:

- 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 and medication interactions; getting assistance from the pharmacy may help.
- New onset of physical health problem, like the development of flu or some new acute condition that causes or contributes to depression.
- Changes in the status of ongoing, chronic health problems like diabetes, heart disease, cancer or others.

Recent Loss/Stress

- Recent relocation
- Change in relationships
- Change in health
- Change in functional status
- Change in financial status
- Death of a loved one (even a pet)
- Loss of control over daily routines
- Loss of a significant role

Resources & Abilities

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

Geriatric Depression Scale

		<u>YES</u>	<u>NO</u>
1.	Are you basically satisfied with your life?	___ 0	1
2.	Have you dropped many of your activities and interests?	___ 1	0
3.	Do you feel your life is empty?	___ 1	0
4.	Do you get bored often?	___ 1	0
5.	Are you hopeful about the future?	___ 0	1
6.	Are you bothered by thoughts you can't get out of your head?	___ 1	0
7.	Are you in good spirits most of the time?	___ 0	1
8.	Are you afraid that something bad is going to happen to you?	___ 1	0
9.	Do you feel happy most of the time?	___ 0	1
10.	Do you often feel helpless?	___ 1	0
11.	Do you often get restless and fidgety?	___ 1	0
12.	Do you prefer to stay at home, rather than going out and doing new things?	___ 1	0
13.	Do you frequently worry about the future?	___ 1	0
14.	Do you feel you have more problems with memory than most?	___ 1	0
15.	Do you think it is wonderful to be alive now?	___ 0	1
16.	Do you often feel downhearted and blue?	___ 1	0
17.	Do you feel pretty worthless the way you are now?	___ 1	0
18.	Do you worry a lot about the past?	___ 1	0
19.	Do you find life very exciting?	___ 0	1
20.	Is it hard for you to get started on new projects?	___ 1	0
21.	Do you feel full of energy?	___ 0	1
22.	Do you feel that your situation is hopeless?	___ 1	0
23.	Do you think that most people are better off than you are?	___ 1	0
24.	Do you frequently get upset over little things?	___ 1	0
25.	Do you frequently feel like crying?	___ 1	0
26.	Do you have trouble concentrating?	___ 1	0
27.	Do you enjoy getting up in the morning?	___ 0	1
28.	Do you prefer to avoid social gatherings?	___ 1	0
29.	Is it easy for you to make decisions?	___ 0	1
30.	Is your mind as clear as it used to be?	___ 0	1

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Interventions for Depression

First-line interventions

Remember! *Every interaction with the resident has the potential to be therapeutic.* That is, our interactions can be either hurtful or HEALING! We can make a big difference in how our residents get along by offering them safety and comfort

- ✓ through our support and encouragement (to get through it or to try new things);
- ✓ by providing them with structure (information about "who" is doing "what" and "when" to reduce anxiety);
- ✓ by encouraging them to interact and be involved with others (which adds meaning and purpose to life);
- ✓ by changing how we approach and interact with them to assure that we don't contribute to feelings of being helpless, hopeless, and "no good to anyone"; and
- ✓ by facilitating involvement in activities that promote feelings of mastery, control, power, and self worth that act as potent "anti-depressants" and contribute to health.

Communicate that you care about the person.

Tell them directly that you care about them.

Remind them that you 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 bothering them.

Try to understand the situation from their point of view.

Validate, that is, recognize and accept that they are feeling great sadness.

Demonstrate acceptance by being nonjudgmental and nonpunitive, conveying interest, listening, and permitting them to express strong emotions.

Assist them to see that they are unusually sad or blue.

Suggest that they are more than "down in the dumps."

Ask questions that may help them identify the things that they feel sad about, that they have lost, or that they are grieving over.

Recall past positive events to help them see that things haven't always been this bad.

Remind them that they do still have worth by telling them about positive things that you see in them, or know about them.

Provide accurate information about depression.

Tell them that depression is an illness, an illness that has a treatment.

Tell them that their symptoms are part of the illness and will go away when the depression lifts.

Let them know how common depression is.

Encourage them that both medication and talking about their feelings can reduce or eliminate the depression.

Remind them that they have lived a long life and have survived many difficulties; suggest that they draw on past experiences to help "get through this."

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. By changing factors in the SOCIAL ENVIRONMENT, caregivers are able to reduce “depressing” effects, and promote positive health outcomes, by

- ✓ paying close attention to health care needs

Monitor physical health

Nutrition: Keep track of intake and weight. Offer snacks or favorite foods to increase intake to sustain weight.

Elimination: Monitor elimination assure constipation is not causing additional discomfort. Take steps to help the person restore his/her usual habits and be comfortable again.

Sleep/rest patterns: Evaluate if the person getting enough rest. Add sleep hygiene measures¹ to help increase hours and quality of sleep.

Physical comfort: Offer personalized comfort measures: soft clothing, use of touch, relaxation methods, other strategies.

Pain management: Evaluate if pain is contributing to emotional distress and behavioral changes. Adjust pain medication schedules to accommodate needs (e.g., give prn dose before bath to reduce risk of discomfort during movement).

¹ 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.

Encourage physical activity

Encourage exercise: Scheduled exercise is a great way to assure that older adults are helped to maintain physical activity. Lots of choices exist today – so it doesn't get boring and exercises can be done by even frail older people.

Suggest referrals: Involving physical therapy, occupational therapy, recreational therapy may be needed to increase mobility, strength, function and enjoyment.

Set a daily schedule: Developing a daily activity schedule helps assure that the person is not allowed to “just sit.”

Involve in meaningful activity: Encourage involvement in hobbies or pastimes that promote activity and movement, as well as feeling good about oneself (self worth).

Promote autonomy (independent activity)

Understand resistance: Depression may create an “I don't care” attitude, slow people down and reduce interest in bathing, grooming, hygiene and other personal cares.

Adjust approaches: Slow down and give the person time to perform self-care activities on their own. Avoid helping the person unless they cannot do the task on their own.

Create “mastery” experiences: Break tasks into easy-to-do steps that better assure success. Cue, encourage the person to do as much for themselves as possible, and praise all efforts.

Encourage personal control, power: A sense of “making a difference” is enhanced by independent activity, decision-making, and involvement in care. Offer choices whenever possible, using close-ended questions (e.g. This or that? Now or later?)

Remember: Being successful in even “simple” activities promotes a sense mastery (being capable) and control and power (e.g., making a difference) that is tied to self worth. *Helping people engage in self care and other activities successfully has “anti-depressant” effects!!*

Focus on the positive: What the person can DO

Identify strengths: Talking to the person while providing other care can provide considerable information about past experiences, attitudes, beliefs, and interests.

Build on strengths: Starting conversations about known interests or past experiences can promote positive feelings. Information can also be used to shape activity programs.

Reminisce about past positive times: Talking about the “old days” can help the person “rediscover” positive thoughts and feelings that are counter to the sense of being “worthless,” and “helpless.”

Encourage group activities

Promote socialization: Groups of all kinds have value. Both informal and “formal” groups encourage interaction and often encourage the sense that “*I am not alone in this!*”

Start a group: Lots of possibilities themes may be used in groups – reminiscence, remotivation, health teaching, sensory stimulation, exercise, or creative projects.

Get the person to group: Take time to get the person to attend scheduled activities, by encouraging, cueing, reminding, helping to “get ready” and offering rewards.

Employ alternative therapies

Think “outside the box”: Remember that lots of enjoyable activities also have therapeutic value!! (e.g., promote self worth, increase mobility, reduce loneliness, etc.)

Pet therapy: Cats, dogs and other animals often provide unconditional positive regard (loving attitudes) and sensory stimulation (soft, warm). Caring for a facility animal can provide a sense of responsibility and a meaningful role.

Horticultural therapy: Gardening or tending to plant are familiar activities for many people, but also offer aroma therapy benefits (e.g., herbs smell good) and help maintain mobility and fine motor movements.

Music therapy: Listening to music, playing instruments and singing are all associated with positive outcomes. However, using “personally preferred” music is usually most successful.

Promote creativity!

Stretch YOUR imagination: New evidence indicates that the use of creative activities with older adults has many positive outcomes.

Try something new: Lots of options are available – painting, drawing, making jewelry, singing, playing a musical instrument, writing stories or poetry, and story-telling (like Time Slips²)

Offer evidence if needed: Creative activities are associated with less depression and loneliness, fewer visits to the doctor and less use of medication; better overall physical health, higher morale, greater life satisfaction, and higher levels of activity.

² 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.

Enhance social support

Identify a point person: Ask a family member or close friend to help mobilize the person's outside social circle, including letters, telephone calls, and personal visits if possible.

Look broadly for support: Both informal and formal social support may help reduce isolation and loneliness that contribute to depression. Consider lots of resources – family members, friends, or neighbors; church members or clergy; volunteer visitors, or peer counselors.

Professional Interventions

In addition to providing the resident with lots of "TLC" we also want to be supportive of other therapies (provided by the physician or a mental health professional) that are part of the care plan.

Talking therapy

- ✓ Also known as counseling or psychotherapy
- ✓ Can be provided in one-to-one sessions or in groups
- ✓ Focus on talking about recent events, reactions, feelings; may also review earlier life events that contribute to present distress
- ✓ Cognitive-behavioral approaches (linking thoughts and feelings) are often used in depression treatment
- ✓ Focus is often on changing the person's methods of think about problems and introducing new coping methods

Supportive therapy

- ✓ Can be provided in one-to-one sessions or groups; focuses on talking about recent events.
- ✓ Provides support for positive coping mechanisms, but does not try to change habits.
- ✓ Offers encouragement and praise for efforts to perform daily activities.

Medication therapy

- ✓ Antidepressant medications are commonly used to treat both Major and Minor depression.
- ✓ All medications have side-effects; monitoring side-effects is an important role for caregivers.
- ✓ Monitoring if the person is getting better – and reporting that to those who prescribe the medication – is important. (e.g., want person to recover, not just “get better”)
- ✓ Medication “alone” is not as effective as combining talking medication therapy.
- ✓ Changing *daily routines and habits that contribute to feelings of depression* are critically important.

Bibliography

- American Geriatric Society (AGS). (2002). Compendium of Issues in Geriatric Depression. *Clinical Geriatrics*, (December), 1-22.
- Alexopoulos, G. S. (1996). The treatment of depressed demented patients. *Journal of Clinical Psychiatry*, 57(Suppl 14), 14-20.
- Alexopoulos, G. S., Katz, I. R., Reynolds, C. F., 3rd, Carpenter, D., & Docherty, J. P. (2001). The expert consensus guidelines series: Pharmacotherapy of depressive disorders in older patients. *Postgraduate Medicine: A Special Report*, (October), 1-86.
- Alexopoulos, G. S., Meyers, B. S., Young, R. C., Campbell, S., Silbersweig, D., & Charlson, M. (1997). 'Vascular depression' hypothesis. *Archives of General Psychiatry*, 54(10), 915-922.
- Alexopoulos, G. S., Meyers, B. S., Young, R. C., Kakuma, T., Feder, M., Einhorn, A., et al. (1996). Recovery in geriatric depression. *Archives of General Psychiatry*, 53(4), 305-312.
- Alexopoulos, G. S., Meyers, B. S., Young, R. C., Kakuma, T., Silbersweig, D., & Charlson, M. (1997). Clinically defined vascular depression. *American Journal of Psychiatry*, 154(4), 562-565.
- Alexopoulos, G. S., Vrontou, C., Kakuma, T., Meyers, B. S., Young, R. C., Klausner, E., et al. (1996). Disability in geriatric depression. *American Journal of Psychiatry*, 153(7), 877-885.
- APA. (2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Association.
- Baldwin, R. C. (2000). Poor prognosis of depression in elderly people: Causes and actions. *Annals of Medicine*, 32(4), 252-256.
- Bartels, S. J., Horn, S. D., Smout, R. J., Dums, A. R., Flaherty, E., Jones, J. K., et al. (2003). Agitation and depression in frail nursing home elderly patients with dementia: Treatment characteristics and service use. *American Journal of Geriatric Psychiatry*, 11(2), 231-238.
- Benazzi, F. (2000). Late-life chronic depression: a 399-case study in private practice. *International Journal of Geriatric Psychiatry*, 15(1), 1-6.
- Bierman, E. J. M., Comijs, H. C., Jonker, C., & Beekman, A. T. F. (2005). Effects of anxiety versus depression on cognition in later life. *American Journal of Geriatric Psychiatry*, 13(8), 686-693.
- Billig, N. (1987). *To be old and sad: Understanding depression in the elderly*. Lexington, MA: Lexington Books.
- Birrer, R. B., & Vemuri, S. P. (2004). Depression in later life: a diagnostic and therapeutic challenge. *American Family Physician*, 69(10), 2375-2382.
- Blazer, D. (1990). *Emotional Problems in Later Life*. New York: Springer Publishing Company.
- Blazer, D. G. (1982). The epidemiology of late life depressions. *Journal of the American Geriatrics Society*, 30(9): 587-592.
- Blazer, D. G., Bachar, J. R., and Manton, K. G. (1986). Suicide in late life: Review and commentary. *Journal of the American Geriatric Society*, 34(7): 519-525.
- Blazer, D.G. (1986). Depression: Paradoxically, a cause for hope. *Generations*, Spring: 21-23.

- Bogner, H. R., Cary, M. S., Bruce, M. L., Reynolds, C. F., III, Mulsant, B., Have, T. T., et al. (2005). The role of medical comorbidity in outcome of major depression in primary care: The PROSPECT Study. *American Journal of Geriatric Psychiatry*, 13(10), 861-868.
- Boyle, V. L., Roychoudhury, C., Beniak, R., Cohn, L., Bayer, A., & Katz, I. (2004). Recognition and management of depression in skilled-nursing and long-term care settings: Evolving targets for quality improvement. *American Journal of Geriatric Psychiatry*, 12(3), 288-295.
- Brink, T.L., Yesavage, J.A., Lum, O., Heersema, P.H., Adey, M., and Rose, T.L. (1992). *Clinical Gerontologist*, 1(1):37-40.
- Brodaty, H., Cullen, B., Thompson, C., Mitchell, P., Parker, G., Wilhelm, K., et al. (2005). Age and gender in the phenomenology of depression. *American Journal of Geriatric Psychiatry*, 13(7), 589-596.
- Bruce, M. L. (1999). The association between depression and disability. *American Journal of Geriatric Psychiatry*, 7(1), 8-11.
- Bruce, M. L. (2001). Depression and disability in late life: Directions for future research. *American Journal of Geriatric Psychiatry*, 9(2), 102-112.
- Bruce, M. L., McAvay, G. J., Raue, P. J., Brown, E. L., Meyers, B. S., Keohane, D. J., et al. (2002). Major depression in elderly home health care patients. *American Journal of Psychiatry*, 159(8), 1367-1374.
- Buckwalter, K. C., Smith, M., & Mitchell, S. (1993). When you are more than down in the dumps: Depression in the elderly. In K. C. Buckwalter, M. Smith & S. Mitchell (Eds.), *The Geriatric Mental Health Training Series*. Iowa City, Iowa: Hartford Center for Geriatric Nursing Excellence.
- Buckwalter, K.C. (1990). How to unmask depression. *Geriatric Nursing*, (July/August): 179-182.
- Chaisson, M., Beutler, L., Yost, E., & Allender, J. (1984). Treating the depressed elderly. *Journal of Psychosocial Nursing*, 22(5): 25-30.
- Chopra, M. P., Zubritsky, C., Knott, K., Have, T. T., Hadley, T., Coyne, J. C., et al. (2005). Importance of subsyndromal symptoms of depression in elderly patients. *American Journal of Geriatric Psychiatry*, 13(7), 597-606.
- Cole, M. G., Bellavance, F., & Mansour, A. (1999). Prognosis of depression in elderly community and primary care populations: A systematic review and meta-analysis. *American Journal of Psychiatry*, 156(8), 1182-1189.
- Colenda, C. C., Wagenaar, D. B., Mickus, M., Marcus, S. C., Tanielian, T., & Pincus, H. A. (2003). Comparing clinical practice with guideline recommendations for the treatment of depression in geriatric patients: Findings from the APA Practice Research Network. *American Journal of Geriatric Psychiatry*, 11(4), 448-457.
- Doraiswamy, P. M. (2001). Contemporary management of comorbid anxiety and depression in geriatric patients. *Journal of Clinical Psychiatry*, 12, 30-35.
- Doraiswamy, P. M., Khan, Z. M., Donahue, R. M., & Richard, N. E. (2002). The spectrum of quality-of-life impairments in recurrent geriatric depression. *Journals of Gerontology Series A Biological Sciences & Medical Sciences*, 57(2).
- Essex, M. J. (1987). Depression associated with lack of intimacy in older women. *Geriatric Medicine Today*, 6(3), 50-66.

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- Gallo, J. J., Ryan, S. D., & Ford, D. E. (1999). Attitudes, knowledge, and behavior of family physicians regarding depression in late life. *Archives of Family Medicine*, 8(3), 249-256.
- Hammond, M. F. (2004). Doctors' and nurses' observations on the Geriatric Depression Rating Scale. *Age and Ageing*, 33, 189-192.
- Husain, M. M., Rush, A. J., Sackeim, H. A., Wisniewski, S. R., McClintock, S. M., Craven, N., et al. (2005). Age-related characteristics of depression: A preliminary STAR*D report. *American Journal of Geriatric Psychiatry*, 13(10), 852-860.
- Janzing, J., Teunisse, R., Bouwens, P., van 't Hof, M., & Zitman, F. (2000). The course of depression in elderly subjects with and without dementia. *Journal of Affective Disorders*, 57(1-3), 49-54.
- Johnson, C. D. (1999). Therapeutic recreation treats depression in the elderly. *Home Health Care Services Quarterly*, 18(2), 79-90.
- Kales, H. C., Chen, P., Blow, F. C., Welsh, D. E., & Mellow, A. M. (2005). Rates of clinical depression diagnosis, functional impairment, and nursing home placement in coexisting dementia and depression. *American Journal of Geriatric Psychiatry*, 13(6), 441-449.
- Kennedy, G. J. (2001). The dynamics of depression and disability. *American Journal of Geriatric Psychiatry*, 9(2), 99-101.
- Kivela, S. L., Viramo, P., & Pakkala, K. (2000). Factors predicting chronicity of depression in elderly primary care patients. *International Psychogeriatrics*, 12(2), 183-194.
- Klausner, E. J., Clarkin, J. F., Spielman, L., Pupo, C., Abrams, R., & Alexopoulos, G. S. (1998). Late-life depression and functional disability: The role of goal-focused group psychotherapy. *International Journal of Geriatric Psychiatry*, 13(10), 707-716.
- Koenig, H. G., & Blazer, D. (2004). Mood disorders. In D. Blazer, D. C. Steffens & E. W. Busse (Eds.), *Textbook of Geriatric Psychiatry, 3rd Edition*. Washington, DC: American Psychiatric Publishing Company.
- Koenig, H. G., & George, L. K. (1998). Depression and Physical Disability Outcomes in Depressed Medically Ill Hospitalized Older Adults. *American Journal of Geriatric Psychiatry*, 6(3), 230-247.
- Kraaij, V., Arensman, E., & Spinhoven, P. (2002). Negative life events and depression in elderly persons: A meta-analysis. *Journals of Gerontology Series B Psychological Sciences & Social Sciences*, 57(1), 87-94.
- Kurlowitz, L. H. (1997). Nursing standard of practice protocol: Depression in elderly patients. *Geriatric Nursing*, 18(5), 192-200.
- Kurlowitz, L. H. (1999). Depression in elderly patients. In I. Abraham, M. M. Bottrell, T. Fulmer & M. D. Mazy (Eds.), *Geriatric Nursing Protocols for Best Practice* (pp. 111-130). New York: Springer Publishing Company.
- Lapid, M. I., & Rummans, T. A. (2003). Evaluation and management of geriatric depression in primary care. *Mayo Clinic Proceedings*, 78(11), 1423-1429.
- Lavretsky, H., & Kumar, A. (2002). Clinically significant non-major depression: Old concepts, new insights. *American Journal of Geriatric Psychiatry*, 10(3), 239-255.
- Lavretsky, H., Bastani, R., Gould, R., Huang, D., Llorente, M., Maxwell, A., et al. (2002). Predictors of two-year mortality in a prospective "UPBEAT" study of elderly veterans with comorbid medical and psychiatric symptoms. *American Journal of Geriatric Psychiatry*, 10(4), 458-468.

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.

- Lazarus, L. W., Davis, J. M., & Dysken, M. W. (1985). Geriatric depression: A guide to successful therapy. *Geriatrics*, 40(6): 43-53.
- Lebowitz, B. D., Pearson, J. L., Schneider, L. S., Reynolds, C. F., 3rd, Alexopoulos, G. S., Bruce, M. L., et al. (1997). Diagnosis and treatment of depression in late life. Consensus statement update. *Journal of the American Medical Association*, 278(14), 1186-1190.
- Linka, E., Bartko, G., Agardi, T., & Kemeny, K. (2000). Dementia and depression in elderly medical inpatients. *International Psychogeriatrics*, 12(1), 67-75.
- Lo, T., & Bhanji, N. H. (2005). Beyond sad mood: Alternate presentations of major depression in late life. *Geriatrics & Aging*, 8(8), 12-17.
- Manderino, M. A. & Bzdek, V.M. (1986). Mobilizing depressed clients. *Journal of Psychosocial and Mental Health Nursing*, 24(5): 23-27.
- McMordie, W. R. & Blom, S. (1979). Life review therapy: Psychotherapy for the elderly. *Perspectives in Psychiatric Care*, 17,(4): 162-166.
- Miller, M. D., & Reynolds, C. F., 3rd. (2002). *Living longer depression free: A family guide to recognizing, treating and preventing depression in later life*. Baltimore: The John Hopkins University Press.
- Miller, M. D., Cornes, C., Frank, E., Ehrenpreis, L., Silberman, R., Schlernitzauer, M. A., et al. (2001). Interpersonal psychotherapy for late-life depression: past, present, and future. *Journal of Psychotherapy Practice & Research*, 10(4), 231-238.
- Miller, M. D., Frank, E., Cornes, C., Houck, P. R., & Reynolds, C. F., 3rd. (2003). The value of maintenance interpersonal psychotherapy (IPT) in older adults with different IPT foci. *American Journal of Geriatric Psychiatry*, 11(1), 97-102.
- Montano, C. B. (1999). Primary care issues related to the treatment of depression in elderly patients. *Journal of Clinical Psychiatry*, 20, 45-51.
- Mueller, T. I., Kohn, R., Leventhal, N., Leon, A. C., Solomon, D., Coryell, W., et al. (2004). The course of depression in elderly patients. *American Journal of Geriatric Psychiatry*, 12(1), 22-29.
- Nelson, J. C., Clary, C. M., Leon, A. C., & Schneider, L. S. (2005). Symptoms of late-life depression: frequency and change during treatment. *American Journal of Geriatric Psychiatry*, 13(6), 520-526.
- National Institute of Mental Health (NIMH). (2001). *The Invisible Disease: Depression*. National Institute of Mental Health: <http://www.nimh.nih.gov/publicat/invisible.cfm>.
- National Institute of Mental Health (NIMH), (2003). *Older Adults: Depression and Suicide Facts*. National Institute of Mental Health: <http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm>.
- Norris, J.T., Gallagher, D., Wison, A., & Wiongrad, C.H. (1987). Assessment of depression in geriatric medical outpatients: The validity of two screening measures. *Journal of the American Geriatric Society*, 35: 989-995.
- O'Connor, D. W., Rosewarne, R., & Bruce, A. (2001). Depression in primary care: General practitioners' recognition of major depression in elderly patients. *International Psychogeriatrics*, 13(3), 367-374.
- Osgood, N.J. (1988). Suicide in the elderly: Clues and prevention. *Carrier Foundation Letter*, #133, April, 1-3.
- Ouslander, J. G. (1982). Physical illness and depression in the elderly. *Journal of the American Geriatrics Society*, 30(9), 593-599.
- 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.

- Papassotiropoulos, A., Heun, R., & Maier, W. (1999). The impact of dementia on the detection of depression in elderly subjects from the general population. *Psychological Medicine*, 29(1), 113-120.
- Pike, C. (1983). The 'broken heart syndrome' and the elderly patient. *Nursing Times*, (March 2), 50-53.
- Proctor, E. K., Morrow-Howell, N. L., Dore, P., Wentz, J., Rubin, E. H., Thompson, S., et al. (2003). Comorbid medical conditions among depressed elderly patients discharged home after acute psychiatric care. *American Journal of Geriatric Psychiatry*, 11(3), 329-338.
- Rozzini, R., Bianchetti, A., Carabellese, C., Inzoli, M., & Trabucchi, M. (1988). Depression, life events and somatic symptoms. *The Gerontologist*, 28(2), 229-232.
- Rubin, E.H., Zorumski, C.F., & Burke, W.J. (1988). Overlapping symptoms of geriatric depression and Alzheimer-Type Dementia. *Hospital and Community Psychiatry*, 39(10), 1074-1079.
- Ruckdeschel, K., Thompson, R., Datto, C. J., Streim, J. E., & Katz, I. R. (2004). Using the Minimum Data Set 2.0: Mood disturbance items as a self-report screening instrument for depression in nursing home residents. *American Journal of Geriatric Psychiatry*, 12(1), 43-49.
- Rush, A. J., Crisman, M. L., Toprac, M. G., Trivedi, M. H., Rago, W. V., Shon, S., et al. (1998). Consensus guidelines in the treatment of major depression. *Journal of Clinical Psychiatry*, 59(suppl 20), 73-84.
- Salzman, C. (1999). Practical considerations for the treatment of depression in elderly and very elderly long-term care patients. *Journal of Clinical Psychiatry*, 20, 30-33.
- Salzman, C. (2000). Mood disorders. In C. E. Coffey & J. L. Cummings (Eds.), *Textbook of Geriatric Neuropsychiatry*. Washington, DC: American Psychiatric Press, Inc.
- Schoevers, R., Beekman, A., Deeg, D., Hooijer, C., Jonker, C., & van Tilburg, W. (2003). The natural history of late-life depression: results from the Amsterdam Study of the Elderly (AMSTEL). *Journal of Affective Disorders*, 76, 5-14.
- Schoevers, R., Deeg, D., van Tilburg, W., & Beekman, A. (2005). Depression and Generalized Anxiety Disorder: Co-Occurrence and Longitudinal Patterns in Elderly Patients. *American Journal of Geriatric Psychiatry*, 13(1), 31-39.
- Seaburn, D. B., Lyness, J. M., Eberly, S., & King, D. A. (2005). Depression, perceived family criticism, and functional status among older, primary-care patients. *American Journal of Geriatric Psychiatry*, 13(9), 766-772.
- Sheikh, J. I. & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS) Recent evidence and development of a shorter version. *Clinical Gerontologist*, 5(1/2), 165-173.
- Singh, N. A., Clements, K. M., & Singh, M. A. (2001). The efficacy of exercise as a long-term antidepressant in elderly subjects: a randomized, controlled trial. *Journals of Gerontology Series A Biological Sciences & Medical Sciences*, 56(8).
- Spikes, J. (1980). Grief, death, and dying. In E. W. Busse and D. G. Blazer (Eds.), *Handbook of Geriatric Psychiatry* (pp. 415-426). New York: Van Nostrand Reinhold Co.
- Starkstein, S. E., Mizrahi, R., & Garau, L. (2005). Specificity of symptoms of depression in Alzheimer Disease: A longitudinal analysis. *American Journal of Geriatric Psychiatry*, 13(9), 802-807.
- Steffens, D. C., & McQuoid, D. R. (2005). Impact of symptoms of generalized anxiety disorder on the course of late-life depression. *American Journal of Geriatric Psychiatry*, 13(1), 40-47.

- Steffens, D. C., Levy, R. M., Wagner, R., McQuoid, D. R., Krishnan, K. R. R., & Carroll, B. J. (2002). Sociodemographic and clinical predictors of mortality in geriatric depression. *American Journal of Geriatric Psychiatry, 10*(5), 531-540.
- Steffens, D. C., McQuoid, D. R., & Krishnan, K. R. R. (2003). Partial response as a predictor of outcome in geriatric depression. *American Journal of Geriatric Psychiatry, 11*(3), 340-348.
- Sullivan, M. D. (2003). Hope and hopelessness at the end of life. *American Journal of Geriatric Psychiatry, 11*(4), 393-405.
- Thompson, L. W. & Gallagher, D. (1986). Psychotherapy for late-life depression. *Generations, (Spring)*, 38-41.
- Travis, L. A., Lyness, J. M., Shields, C. G., King, D. A., & Cox, C. (2004). Social support, depression, and functional disability in older adult primary-care patients. *American Journal of Geriatric Psychiatry, 12*(3), 265-271.
- Unutzer, J., Patrick, D. L., Marmon, T., Simon, G. E., & Katon, W. J. (2002). Depressive symptoms and mortality in a prospective study of 2,558 older adults. *American Journal of Geriatric Psychiatry, 10*(5), 521-530.
- Waller, M. & Giffin, M. (1984). Group therapy for depressed elders. *Geriatric Nursing, (September/October)*, 309-311.
- Watson, L. C., Garrett, J. M., Sloane, P. D., Gruber-Baldini, A. L., & Zimmerman, S. (2003). Depression in assisted living: Results from a four-state study. *American Journal of Geriatric Psychiatry, 11*(5), 534-542.
- Waxman, H. M. & Carner, E. A. (1984). Physicians' recognition, diagnosis, and treatment of mental disorders in elderly medical patients. *The Gerontologist, 6*: 593-597.
- Whall, A. L., & Hoes-Gurevich, M. L. (1999). Missed depression in elderly individuals. Why is this a problem? *Journal of Gerontological Nursing, 25*(6), 44-46.
- Whall, A.L. (1991). Using the environment to improve the mental health of the elderly. *Journal of Gerontological Nursing, 17*(7): 39.
- Wiener, P., Alexopoulos, G. S., Kakuma, T., Meyers, B. S., Rosenthal, E., & Chester, J. (1997). The limits of history-taking in geriatric depression. *American Journal of Geriatric Psychiatry, 5*(2), 116-125.
- Yaffe, K., Edwards, E. R., Covinsky, K. E., Lui, L.-Y., & Eng, C. (2003). Depressive Symptoms and risk of mortality in frail, community-living elderly persons. *American Journal of Geriatric Psychiatry, 11*(5), 561-567.
- Yesavage, J.A., Brink, T.L., Rose, T.L., & Adey, M. (1983). The geriatric depression rating scale: Comparison with other self-report and psychiatric rating scales. In T. Crook, S. Ferris, and R. Bartus, (Eds.), *Assessment in geriatric psychopharmacology*. New Canaan, CT: Mark Powley Associates, Inc.
- Yesavage, J.A., Brink, T.L., Rose, T.L., Lum O., Huang, V., Adey, M., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17*(1):37-49.
- Yohannes, A. M., Baldwin, R. C., & Connolly, M. J. (2003). Prevalence of sub-threshold depression in elderly patients with chronic obstructive pulmonary disease. *International Journal of Geriatric Psychiatry, 18*(5), 412-416.

Links to Resources

A considerable amount of information about depression and its treatment is now available on the worldwide web. A simple “Google” search will assist you in locating additional sources of information and assistance. We believe the following sites may be of interest as you plan depression training. Online learning may also be useful in educating families and friends, both those who live outside the community and are not available to meet with you, as well as those who live nearby but prefer this format of education. All sites are subject to change without notice, so we can only endorse the quality of content at the time of this writing (January, 2006).

<http://www.stanford.edu/~yesavage/index.html> Describes Jerome Yesavage, Director of Aging Clinical Research, Stanford, California. Yesavage and Brink developed the Geriatric Depression Scale, and the link to the GSS site originates on this page.

<http://www.stanford.edu/~yesavage/GDS.html> Describes the Geriatric Depression Scale (GDS), including access to both short and long versions with coding. As the site notes, the scale is considered PUBLIC DOMAIN. The pages provide additional information about the translation of the GDS to other languages and its use in practice settings.

<http://www.neurotransmitter.net/depressionscales.html> Provides a list of scales with which to assess depression in people of all ages (e.g., is not specific to older adults). Links to scales are provided. The page is a service of The Medical Algorithms Project
<http://www.medal.org/visitor/>

http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm? Clinical Practice Guidelines developed by the American Psychiatric Association are provided on this page. Links include viewing guidelines in HTML or PDF formats and purchasing the published versions through APA. The guideline for depression, *Practice Guidelines for the Treatment of Patients with Major Depression, 2nd Edition*, includes information about older adults.

<http://www.webmd.com> Provides a search tool that may be used to locate recent articles and features related to depression in late life, along with other topics of interest. An article posted there, “Depression in the Elderly,” provides a brief but high quality review of key issues. See www.webmd.com/content/Article/45/1663_51234.htm

<http://healthyplace.com/communities/depression/elderly.asp> The website “HealthPlace.com,” a website related to mental health and illness issues, maintains a page devoted to late life depression. Like WebMD, the information provided is very good quality and easy-to-read. Of importance, this site provides links to specialty issues related to aging; for example, How Family and Friends Can Help, Where to Get Help, In Older Blacks, Depression Often Goes Untreated, Exercise Works in Treating Elderly Depression and Geriatric Depression Scale (Short form), among other topics. This site may be particularly helpful for families and friends, particularly those who live at a distance.

<http://www.nimh.nih.gov/publicat/publisting.cfm?dID=6> The website of National Institute of Mental Health (NIMH) Publication Materials includes a variety of brochures about depression, including the two that were used as references in this module. Many fact sheets are available in both English and Spanish.

http://www.pplusic.com/uploads/media/DepressionCGL_092104final.pdf This is PDF file for the document “Treating Depression in Adults in Primary Care: Clinical Practice Guidelines.” The header indicates the paper is co-sponsored by UW Health, Physicians Plus Insurance Corporation, and Unity Health Insurance. The 18 page document offers an algorithm for treating depression, information about medication use and selection, and other issues relevant to depression treatment. It is not specific to older adults, but provides a good quality, easy-to-read review of key issues.