Real Problems with Real Solutions:
A Practice Approach to Geriatric Depression

Sponsored by the Finger Lakes Geriatric Education Center
Ithaca College Gerontology Institute and CNY Area Health Education Center.

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Introduction
Welcome to the interactive learning module on geriatric depression. Throughout this session, we will be exploring some of the common myths about depression in older adults, and learning the facts about the causes of depression, how it is diagnosed, and treatment approaches. We will be asking you to think about this information as it may relate to your personal interaction with older adults, whether in a nursing home, home care agency, doctor's office, or in your own neighborhood or family.

Course Objectives
- *Learn about the causes of depression and depressive symptoms in older adults*
- *Learn about three major approaches to treating geriatric depression*
- *Understand the difference between screening and diagnosing depression*
- *Identify barriers to diagnosing and treating depression in older adults*
- *Consider strategies for engaging clients in treatment in your practice*

Chapters
- *Definition*
- *Causes of Depression*
- *Symptoms*
- *Depression and Chemical Dependence*
- *Screening vs Diagnosis*
- *Suicide*
- *Treatment*
- *Barriers*
- *Caregiving and Depression*
- *Resources*

TRUE/FALSE QUIZ

1. **What Is Depression?**
   Depression is a group of symptoms that occur when there is a chemical imbalance in the brain.
   True False

2. **What Causes Depression?**
   Depression can be associated with physical illness.
   True False

3. **What Are The Symptoms of Depression?**
   Depressed seniors are more likely to report emotional rather than physical symptoms.
   True False

4. **Geriatric Depression and Chemical Dependence**
   Very few hospitalizations of the elderly for injury or illness are alcohol-related.
   True False

5. **Screening and Diagnosing Depression**
   Depression is a normal part of growing older.
   True False

6. **Geriatric Depression and Suicide**
   The best way to determine if someone is having thoughts of suicide is to ask them.
   True False

7. **Treating Depression**
   There is usually no reason to treat depressed seniors.
   True False

8. **Barriers to Treatment**
   A feeling of shame sometimes keeps seniors from seeking treatment for depression
   True False

9. **Caregiving and Depression.**
   Family caregivers of elderly relatives have very low rates of depression.
   True False

10. **Geriatric Depression Resources**
    A multidisciplinary approach is the most effective way to treat seniors with depression.
    True False

Chapter 1: What is Depression?
True or False: Depression is a group of symptoms that occur when there is a chemical imbalance in the brain (True)

Serotonin is a neurotransmitter found in the brain. A decreased level of serotonin and norepinephrin in the synaptic cleft is associated with the disorder, depression. Serotonin affects sleep, mood, attention, and learning. We'll see how decreased levels of serotonin are linked to the common symptoms of depression, including sleep disorders, attention problems, irritability, and lack of energy among others. We'll talk about the causes of depression in Chapter two, and about symptoms in Chapter Three.

More information can be found on the National Institute of Mental Health website: http://www.nimh.nih.gov/
Information on depression can be found at: http://www.nimh.nih.gov/publicat/depressionmenu.cfm
Information on depression and older adults: http://www.nimh.nih.gov/publicat/depoldermenu.cfm

Chapter 2: What Causes Depression?
True or False: Depression can be associated with physical illness (True)

Causes of Depression
- Depression is common in elders with medical problems
- Chronicity of disease is not as important as level of disability
- Depression can run in families
- Depression is associated with major life changes
- Loss may trigger depression

- *List some of the losses of aging:*
  Note that in some ways loss is a normal part of aging -- bereavement symptoms may be similar to depression, including sadness, loss of appetite, trouble sleeping, and/or passive thoughts of suicide or death. If preoccupation with the loss continues beyond 2 – 3 months, then a major depression may have occurred. Major depression -- whatever the cause -- requires evaluation and treatment by a mental health professional. An evaluation by a health care practitioner or family physician may help determine if the problem is also caused by something physical (medical disorder).

NOTE: Those with negative life events in childhood AND late adulthood are most at risk for Depression.

Chapter 2: Case Scenario
Ruth is an 80-year-old woman who had a bout with painful shingles six months ago. About that same time, she moved from her long-time home into a senior apartment, because her eyesight is failing.

- What are Ruth's risk factors for depression?
- What losses can we identify in Ruth's life?

Chapter 2: Questions for Further Consideration

- Ruth's risk factors include painful shingles, possible interactions with medications, and major life changes, including her move and eyesight problems. Did you think of others?
- Ruth's losses include her home and her eyesight. Did you think of others?

Remember that we know very little about Ruth at this point, so we don't know about other physical problems she may be having, the strength of her support system, other losses in her life, or what her strengths are or how she views her situation. All are important aspects of assessing Ruth's situation!

For more information on the causes of depression in older adults, please refer to the bibliography.

For more information on depression and other illnesses, please see:
http://www.nimh.nih.gov/publicat/cooccurmenu.cfm

Chapter 3: What are the Symptoms of Depression?
True or False: Depressed seniors are more likely to report emotional rather than physical symptoms (False)

FACT: *Depressed seniors are more likely to report PHYSICAL or somatic symptoms, than EMOTIONAL or affective symptoms, such as feelings of sadness.*

What are the Symptoms of Depression?

- depressed or irritable mood
- loss of interest or pleasure in daily activities
- change in appetite
- insomnia or hypersomnia
- fatigue
- difficulty concentrating
- feelings of worthlessness or sadness
- abnormal thoughts about death
- excessively irresponsible behavior pattern

Symptoms differ in the elderly in that they are more likely to exhibit irritability, anxiety, conduct and cognitive disorders than pessimism, or guilt. They are likely to have more somatic symptoms vs subjective sadness, such as head or stomach ache.

Remember that Depression may be masked by substance abuse, which can also lead to misinterpretation of somatic symptoms.

Chapter 3: Case Scenario

Since moving into the senior apartment, Ruth has complained of headaches, and she's had cold symptoms for about a month. She denies feeling sad, but she hasn't been interested in attending any of the activities offered in her housing complex, other than the regular meals in the dining room. In fact, she has gained about five pounds in six months!

- What symptoms of depression might Ruth be experiencing?
- What else might account for these symptoms?

Chapter 3: Questions for Further Consideration

The symptoms of depression that Ruth is experiencing include loss of interest or pleasure in daily activities, a change in appetite (weight gain), and headache.

Other things to consider when looking at these symptoms include sinus infection or a head cold, the change in how she eats (is there more food available now?), and social factors. Does she know anyone in her new home?

We still don't know enough about Ruth to determine whether or not she really has a depression. In our next chapter, we'll discuss how drugs and alcohol can interact with depression in the elderly, then in Chapter Five we'll talk about how depression is actually diagnosed.

Chapter 4: Geriatric Depression and Chemical Dependence

True or False: Very few hospitalizations of the elderly for injury or illness are alcohol-related (False)

Older Adults and Chemical Dependence

- About 70% of hospitalized elders have alcohol-related problems
- Women are at higher risk than men
  - More shame
  - Increased isolation
  - Different metabolism
- Easy to deny or dismiss
- Difficult to separate from depression or other physical problems

Warning signs of substance abuse in seniors

- drinking alone
- drinking despite warning labels on prescription drugs
- showing signs of depression
- neglecting personal appearance
- attitude change when drinking
- chronic physical complaints with no apparent physical causes
- malnutrition
- bruises or cuts from accidents and falls
- excessive napping

Additional symptoms that might affect anyone with a drinking problem:

- Drinking to calm nerves, forget worries, or reduce depression
- Losing interest in food
- Gulping drinks fast

- Lying or try to hide drinking habits
- Drinking alone more often
- Hurting yourself or someone else, while drinking
- Being drunk more than three or four times last year
- Needing more alcohol to get high
- Feeling irritable, resentful, or unreasonable when not drinking
- Having medical, social or financial problems caused by drinking

Symptoms of long term chemical dependency

- Anemia
- Forgetfulness
- Depression
- Paranoia
- Withdrawal from usual activities, people and situations.

Interventions for Seniors

- Don't talk to the older person when he or she is drinking.
- Remain non-judgmental.
- Seek an intervention specialist
- Be direct but gentle.
- Avoid using words like "alcoholic" or "drug addict"
- Focus on current effects of the drug use
- Take time to build trust

The good news is that older problem drinkers have a very good chance for recovery because once they decide to seek help, they usually stay with treatment programs.

The best way to intervene in the substance abuse of an older woman is with patience, care and respect. A Hazelden pamphlet, "How to Talk to an Older Person Who Has a Problem With Alcohol or Medications," offers some guidelines for intervention.

Chapter 4: Case Scenario

Herbert went to his doctor after falling in his mobile home. He didn’t tell the doctor that he was intoxicated when he fell, or that he usually drinks about a quart of vodka every day. Herbert’s children live at a distance, and while they know that Herbert drinks, they feel it doesn’t really do him any harm, and that taking his alcohol away would deprive him of one of his few pleasures.

- How can Herbert’s doctor learn more about his patient’s drinking?

- What are the risks of Herbert’s continued use of alcohol?

Chapter 4: Questions for Further Consideration

Herbert’s doctor can learn more about his patient’s drinking by asking him, and all patients, routine questions about alcohol and other drug use.
The risks of Herbert’s continued use of alcohol include more falls, physical illness, and untreated depression.

Consider the opportunities to intervene in the lives of elders you know. How can you become more aware of substance use and abuse in seniors? Do you know where to call for more information and help?

IDEAS: Check out these national resources, and make a note of the local names and phone numbers of providers in your community. Arrange an inservice training at your workplace on this issue!

For a free copy of the Hazelden pamphlet, call 1-800-257-7810.
The Hazelden Report is a chemical health column that addresses the prevention and treatment of chemical dependency and related addictive behaviors. This Report was originally published August 24, 1993 in the Star Tribune newspaper. It is available online at:
http://www.hazelden.org/NEWSLETTER_DETAIL.dbm?ID=117 (eff. 3/26/2002)

Chapter 5: Screening and Diagnosing Depression

True or False: Depression is a normal part of growing older (False!)

Screening for depression

- Hopelessness Scale
- University of Iowa - Geriatric Depression Scale: Mood Scale (short form)

Diagnosing Depression

- Medical exam
- Evaluation by a mental health professional

The following screening tool will help identify the presence of risk factors for depression.

University of Iowa - Geriatric Depression Scale: Mood Scale (short form)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO

2. Have you dropped many of your activities and interests? YES / NO

3. Do you feel that your life is empty? YES / NO

4. Do you often get bored? YES / NO

5. Are you in good spirits most of the time? YES / NO

6. Are you afraid that something bad is going to happen to you? YES / NO

7. Do you feel happy most of the time? YES / NO

8. Do you often feel helpless? YES / NO

9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO

10. Do you feel you have more problems with memory than most? YES / NO

11. Do you think it is wonderful to be alive now? YES / NO

12. Do you feel pretty worthless the way you are now? YES / NO

13. Do you feel full of energy? YES / NO

14. Do you feel that your situation is hopeless? YES / NO

15. Do you think that most people are better off than you are? YES / NO

Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

This screening tool can be found at http://stanford.edu/-yesavage/GDS.html as well as updated information, citations and a video on assessing suicide.

Chapter 5: Case Scenario
Laura is an aide at a local assisted living facility. She noticed that Mrs. Brown seemed “down,” that her appetite seemed poor and her face seemed sad. Mrs. Brown was usually very cheerful, so when Laura asked Mrs. Brown if anything was wrong, she was puzzled when Mrs. Brown just shrugged her shoulders and said “No, I guess not.”

- Is Laura screening for depression or making a diagnosis?
- What should Laura do next?
- What would you do?

Chapter 5: Questions for Further Consideration

- Laura is screening for depression, not making a diagnosis. Remember that a diagnosis can only be made after a medical examination, and should include consultation with a mental health professional.
- Laura should notify her supervisor about her concerns.
- What would you do? Discuss the procedures for getting help for a senior who seems under the weather, and who may be depressed.
- What would you do for a neighbor, family member, or friend?

<u>Chapter 6: Geriatric Depression and Suicide</u>
True or False: The best way to determine if someone is having thoughts of suicide is to ask them (True)

Suicide in the Elderly: Many older adults who commit suicide have visited a primary care physician very close to the time of the suicide: *20 percent on the same day, 40 percent within one week, and 70 percent within one month of the suicide*. The highest rates of suicide are in white males 85 years of age and older.

Chapter 6: Case Scenario
Bernard is a white man in his 80’s whose wife died last year after a long and painful struggle with cancer. His own health is poor – he takes pain medication for a back problem, and it’s getting harder for him to get out and get groceries for himself. Bernard doesn’t see his old friends any more – many of them have died or are too ill to socialize. He’s been thinking that life isn’t worth living any more, and sometimes wishes he could die.

- What are Bernard's risk factors for depression?
- How can you find out if Bernard is thinking about killing himself?
- How can you help Bernard?

Chapter 6: Questions for Further Consideration

- Bernard's risk factors for depression include grief, social isolation, pain and pain medication, the extended stress of providing care for an ill spouse, increasing difficulty with ambulation, transportation problems, age and race.
- You can find out if Bernard is thinking about killing himself by asking him, and you can help Bernard by making sure he is safe. Get his promise not to hurt himself, and call for help.

For More Information
National Institute of Mental Health (NIMH), Office of Communications and Public Liaison
Public Inquiries: (301) 443-4513
E-mail: nimhinfo@nih.gov
Web site: http://www.nimh.nih.gov

Streaming video information on assessing suicidality, and a number of other topics of interest to those working with the elderly can be found at: http://mirecc.stanford.edu/

Please also refer to the bibliography at the end of the web course, and located at the end of this workbook.

Chapter 7: Treating Depression
True or False: There is usually no reason to treat depressed seniors (False)

Why Treat Geriatric Depression? It is common to believe that depression can't be treated in the elderly, but depression can lead to morbidity and mortality – disease and death, and treatment works, and can improve quality of life and medical outcomes for older adults.

Treatment Goals are not to fix *problems*, but to reduce major depression, chemical dependence, pain or symptoms.

Major approaches to Treating Depression include:

- Pharmacotherapy (medication)
- Psychotherapy (counseling)
- Electro-convulsive Therapy (ECT)
- Social support

Pharmacotherapy

- Treats depression by modulating the serotonin and norepinephrine levels.
- Reduces symptoms in 80% of people with depression.
- Selective Serotonin Reuptake Inhibitors (SSRI's), Tricyclic Antidepressants, and Monoamineoxidase (MAO) inhibitors.

Pharmacotherapy treats depression by modulating the serotonin and norepinephrine levels, and reduces symptoms in 80% of people with depression.

The use of SSRI's should be assessed on a case-by-case basis. They are a widely prescribed class of drugs, and include Prozac and Paxil.

***Tricyclic Antidepressants should be used with great caution, if at all, due to the likelihood of overdose (they are more toxic and have a smaller therapeutic window).*

MAO inhibitors such as Parnate block the destruction of norepinephrine and serotonin by the MAO enzyme at the synapse. Foods such as chocolate, aged cheese, beer, and wine must be avoided as they interfere with the inhibition of MAO.

Refer to bibliography for articles related to the efficacy of pharmacotherapy for seniors.

Psychotherapy Tasks:
- Ongoing re-assessment
- Monitoring
- Manage stress
- Insight into psychodynamics
- Increase self-esteem
- Increase social support
- Teach and practice problem-solving skills
- Decrease negative cognitive patterns
- Reframe perceptions
- Learn new responses
- Recall past coping skills
- Address grief
- Support in finding meaning (Life Review – helps elders craft a meaningful narrative of life)
- Humor
- Vent anger, frustration, and guilt
- Cognitive Behavioral Therapy

Electroconvulsive Therapy (ECT or Shock Therapy)
- Increases norepinephrine activity
- Usually 6-12 treatments

ECT is used when:
- Medication is contraindicated or ineffective
- Depression is unremitting
- Suicide risk is high

Be cautious when:
- Elder is confused (ECT may interfere with memory)
- Elder lives alone (must be supervised post ECT)

Side effects, Contraindications, and Concerns about ECT (Note that Improved administration has reduced side effects):
- Mild acute confusional states
- Memory loss
- Cardiovascular complications
- Headache
- Anterograde & retrograde amnesia
- Outpatients should be supervised at home due to confusion & memory loss

Social Supports
- Support network provides some protection from Depression
- Support groups can be therapeutic

Chapter 7: Case Scenario
Ethel is a 75-year-old woman who cares for her husband, who has advanced Parkinson's Disease. In seeking extra in-home help, she confided in a social worker that she was sleeping poorly and crying a lot. After asking some other questions, the social worker suggested that she should get a complete physical, and ask her physician about depression. After two months on an anti-depressant medication, getting extra in-home help, and seeing the social worker on a regular basis for supportive counseling, Ethel reported great relief from her symptoms.

- What interventions were made for Ethel?

- Who are the members of Ethel's health care team?

Chapter 7: Questions for Further Consideration
- The interventions made for Ethel included assessment by a social worker, provision of in-home services, counseling, medication, and a complete physical.
- The members of Ethel's health care team include a social worker, home health worker, and Ethel's physician.

There is a great deal of information on the efficacy of antidepressant medication, electroconvulsive therapy, and psychotherapy for seniors. See the bibliography for many resources.

The greatest success in treating depression has been in combining medication with counseling. *Of course, the most severe forms of depression may require ECT. It is also shown that a multi-disciplinary approach to treatment is the most effective. We'll continue to talk about this through the rest of the chapters.*

What are the treatment resources available in your work setting or community?

Chapter 8: Barriers to Treatment
True or False: A feeling of shame sometimes keeps seniors from seeking treatment for depression (True)

Barriers to treatment may include:
- Patient/family attitudes & behavior
- Belief that depression is a sign of weakness of character; a feeling of shame
- Non-compliance with treatment (may be related to finances, side effects, difficulty remembering medication, or many other reasons)
- Cultural, cohort, gender, and/or religious bias against naming depression
- Primary care provider attitudes
- Belief that depression is a "normal" response to aging and loss
- Difficulty sorting out symptoms from medical problems or substance abuse

Chapter 8: Case Scenario
Floyd lives on a limited income in a rural community. He is a very private person, and is not likely to go to the doctor except in extreme cases. As a WWII veteran, Floyd saw a lot of death that he's never talked about. Now he finds he has very low energy, is increasingly forgetful, and is impatient and irritable with his dog, Hector.

- What are possible barriers to Floyd getting the medical assessment he needs?

- What barriers might exist for Floyd in getting Mental Health services?

Chapter 8: Questions for Further Consideration

- Barriers to Floyd getting the medical assessment he needs may include financial difficulties, transportation, or his own personality: he doesn't like going to a doctor, is unlikely to report his symptoms, and doesn't talk about trauma.
- All these factors may also keep Floyd from getting Mental Health services, as well as the question of whether his physician make a referral, and if services are even available in Floyd's area.

What can we do to approach depression in the elderly in a more positive way?

- *Greater awareness of disease & responses to the stigma of the disease; education*
- *Increased willingness to diagnose, treat or receive treatment for PTSD, Anxiety, and Mood Disorders such as Depression*
- *Take better care of ourselves, and show more concern for others*
- *Make appropriate referrals*
- *Work with a multidisciplinary team*

Chapter 9: Caregiving and Depression

True or False: Family caregivers of elderly relatives have very low rates of depression (False)

FALSE: Family caregivers have higher rates of depression than other people, with women more likely to be affected than men.

The Physical and Emotional Impact of Caregiving for an older loved one

- *Impact on Physical Health*
  - *A study of elderly spousal caregivers (aged 66-96) found that caregivers who experience mental or emotional strain have a 63% higher risk of dying than noncaregivers.*
  - *31% of those caring for persons aged 65+ describe their own physical health as "fair to poor."*
- *Mental and Emotional Effects*
  - *Caregiving can be an emotional roller coaster. Exhaustion, inadequate resources, and continuous caring can lead to burn out, stress and depression.*
- *Why is caregiving so stressful?*
  - *Unresolved family issues may be re-activated*
  - *Losses for the adult children (parent's illness)*
  - *Caregiving usually falls to one adult child more than others*
  - *Safety issues, high demand for assistance with IADLs or ADL's, around the clock care*
  - *Sandwich generation issues*
  - *Financial strain*
- *This can also be a positive period of reconnecting, recognizing the weaknesses and strengths of the older person, accepting, and letting go. Family support, if at all possible, is important for the aging adult and especially if there is depression. If resentment of the older adult is very strong, then support and counseling may be needed and should be sought by the adult caregiver.*

Chapter 9: Case Scenario

Liz is a 68-year-old woman who is very concerned about her older parents. Her father is caring for her mother, who has severe dementia, and her father shows a number of signs of depression. Even though he is overwhelmed, her father refuses to have any help come into the home, and he will not tell his physician

about his symptoms. Liz is worried, angry, frustrated, and has been sick with bronchitis for two months. She also shows signs of depression, but she is willing to talk with her doctor and seek counseling for her own stress.

- What resources exist in your community for caregivers?
- How can Liz help herself?
- How can Liz help her parents?

Chapter 9: Questions for Further Consideration

- Resources for caregivers vary by community, but you can start with the Office for Aging, which has added caregiver support to its list of services
- Liz can help herself by understanding any disease processes, learning about services for herself and her parents, continuing in counseling to sort out what she can influence and what she has to let go of, and by learning communication strategies and skills.
- Liz can help her parents by sharing information on caregiving, Alzheimer's disease, and depression, and by speaking to parents' doctor about any serious safety and health concerns.

Chapter 10: Geriatric Depression Resources

True or False: A multidisciplinary approach is the most effective way to treat seniors with depression (True)

Resources for Geriatric Depression

Depression Resources for the Elderly & their Caregivers

ElderCare on-line: www.ec-online.net

Chemical Dependency Resources for the Elderly

Alcoholics Anonymous: 212-870-3400
The National Institute on Alcohol Abuse and Alcoholism 301-443-3860
Hazelden Foundation West Palm Beach Florida: 1-800-257-7800

Suicide Intervention Resources

American Association of Suicidology (202) 237-2280 www.suicidology.org email: ajkulp@suicidology.org

American Foundation for Suicide Prevention TOLL-FREE: 888-333-AFSP Phone: (212) 363-3500
www.afsp.org email: inquiry@afsp.org

LivingWorks Education, Inc. Phone: (403) 209-0242 www.livingworks.net e-mail: living@nucleus.com

Suicide Information & Education Centre Phone: 403-245-3900 www.suicideinfo.ca
e-mail SIEC: siec@suicideinfo.ca

Please refer to the bibliography for further information!

Chapter 10: Questions for Further Consideration

- Use your workbook to list local resources in the areas of geriatric mental health, chemical dependency, and suicide.
- Who would you contact with a concern about an older adult?
- How can your practice improve services to seniors? Consider areas such as prevention and education, outreach, accessibility, screening tools, removing barriers to diagnosis and treatment, and multi-disciplinary collaborations.

We value your comments and suggestions.
You can contact us at the Finger Lakes Geriatric Education Center
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