II

Psychopathology of Late Life
Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self—to the mediating intellect—as to verge close to being beyond description. It thus remains nearly incomprensible to those who have not experienced it in its extreme mood, although the gloom, “the blues” which people go through occasionally and associate with the general hassle of everyday existence are of such prevalence that they do give many individuals a hint of the illness in its catastrophic form.


The President’s New Freedom Commission on Mental Health (2003) has recognized that mental health is essential to overall health. The World Health Organization’s (WHO) definition of health, which has not been amended since 1948, is stated in the WHO Constitution as follows: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2006, p. 1). Little more than a decade ago the Department of Health and Human Services (DHHS) Report of the Surgeon General declared that, “The mind and body are inseparable” (1999, p. 5).

Depression is one of the most common, often the most debilitating, yet the most treatable illnesses seen in older adults. The WHO has declared that depression is one of the leading causes of disability. Unipolar depression ranks fourth in the leading causes of disability adjusted life years and it is projected to rise to the second cause of disability and second “most burdensome” worldwide by 2020 (WHO, 2009). According to the Agency for Healthcare Research and Quality (AHRQ, 2007), major depressive disorder is the most common of the depressive disorders. It is estimated that between 1% and 5% of older adults living in the community experience major depression. The percentage increases to 11.5% of elderly hospital patients and 13.5% who require home health care (Hybels & Blazer, 2003). Older adult women are almost twice as likely to suffer from depression as older adult men.

### CONSEQUENCES OF DEPRESSION

There is increasing evidence that depression is associated with other physical illnesses. Many people with chronic diseases suffer from depression and other mental disorders, which worsens their physical condition and hinders their ability to follow a prescribed healthcare regimen (WHO, 2003). Kessler et al. (2003) note that major depressive
disorder is usually associated with “substantial symptom severity and role impairment” (p. 3095). Despite knowledge that depression frequently co-occurs with many other medical illnesses and although there is evidence that more persons with depression are being diagnosed by their primary care providers, most cases remain either untreated or undertreated (Wang et al., 2005).

Untreated depression is associated with poorer quality of life, higher use of medical care, increased medical costs, and increased disability (Centers for Disease Control and Prevention [CDC], 2005; Nemeroff, Musselman, & Evans, 1998). According to the WHO (2003), the burden of disease from mental disorders is expected to increase significantly over the next 20 years. The WHO (2003) reports that depression has a high prevalence–cost ratio and that “investing in mental health today can generate enormous returns in terms of reducing disability . . .” (p. 6). Pearson and colleagues (1999) confirmed a strong association exists between depression and an increased use of general medical services, such as outpatient visits, hospitalizations, and total hospital days.

Depression is not only disabling, but there is increasing evidence that depression is a fatal illness in older adults. Depression is the leading risk factor for suicide. The suicide rate for persons 65 years and older is greater than any other age group. In 2004, just over 12% of the United States population was older adults and older adults accounted for 16% of all suicides (CDC, 2008). The highest frequency is found among white males 75 years and older at 14.7 per 100,000 (CDC).

Depression in older adults costs the nation an estimated $43 billion per year, not including the pain, suffering, and poor quality of life that results from depression (American Association of Geriatric Psychiatry, 2001). Furthermore, in one recent study, older adults with depression were found to incur twice as many Medicare costs than older adults who were not depressed (Unützer et al., 2009). Ours is an aging society and as the average age of the population increases, there will be an increased cost to the American public as a result of unnecessary disability and mortality should late-life depression go undiagnosed and inadequately treated.

### GLOBAL AND NATIONAL INITIATIVES FOR MENTAL HEALTH

Mental health is one of the top 10 leading health indicators of Healthy People 2010 (DHHS, 2000). One of the major goals of Healthy People 2010 is to improve access to mental health treatment. Other Healthy People 2010 objectives for mental health include improving treatment access by increasing mental health screening and assessment in primary care offices, increasing the proportion of adults with mental disorders who receive treatment, and increasing recognition of depression in adults over the age of 18 (DHHS, 2000). As recommended by the WHO in 2007, providing mental health treatment in primary care offers the greatest promise of reducing the mental health global burden of disease. Furthermore, the final July 2003 report issued by the President’s New Freedom Commission on Mental Health creates the vision for the United States as “. . . a future when everyone with mental illness will recover . . ., mental illnesses are detected early . . ., and everyone with a mental illness at any stage of life has access to effective treatment and supports . . .” (p. 1). The six goals of this report are as follows (p. 5):

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

The Mental Health Atlas published by the WHO (2005) notes “geographic disparities in mental health
services delivery” exist, with a shortage of mental health services, especially in rural areas of the United States. The report also recognizes the fact that there is not currently a program in place that regularly provides training to primary care providers on the topic of mental health. Another barrier to mental health services for older adults is the combined stigma associated with being old and having a mental illness. Nurses are in a position to play a significant role in educating their patients and the community, decreasing stigma, and decreasing older adult disability and mortality. However, nurses must first assess their own prejudices toward persons with mental illness. Ageism and the stigma associated with depression are among the underlying reasons for the numerous barriers that older adults encounter in attempting to receive treatment for depression.

Older adults think depression is a normal part of aging. According to Mental Health America (2006), 58% of people 65 years of age and older believe it is normal for persons to get depressed as they get older. American culture and health care delivery perpetuate this belief. For decades Medicare has only reimbursed 50% of the Medicare allowable amount for psychological health services. In October 2008, the Mental Health Parity and Addiction Equity Act was signed into law in the United States, which will help decrease a barrier to mental health treatment. Once fully implemented and mental health services are reimbursed by Medicare at a rate similar to other medical illnesses, the financial burden of receiving mental health services will be lessened and the implication that mental health services are less needed or less worthy of reimbursement will be eliminated.

The Surgeon General’s Report (DHHS, 1999) states that the only way the mental health needs of America will be met is for “nonmental health professionals” to be educated and participate in the mental health care of persons suffering from mental illness. The World Health Report of 2006 (WHO, 2006) recognized that because there is a shortage of mental health providers, a shift needs to occur to include mental health services in community-based care and in primary care. In this report it is noted, “... the new emphasis on multidisciplinary and intersectoral approaches means changing roles for staff as well...” The challenge for health workers is to embrace change as an opportunity for further learning and personal and professional development...” (p. 26). Furthermore, Demyttenaere et al. (2004) note that reallocation of resources could help the unmet need of the treatment of mental disorders.

Nurses must educate themselves regarding depression and its treatments and must recognize that frequently they are the healthcare provider who spends the most time with an older client; therefore, nurses are often in a key position to assess for symptoms of depression. Nurses need to advocate for healthcare services and environments aimed at prevention and early recognition of depression. Finally, nurses must also advocate for adequate treatment. The nurse’s goal in treating an older adult with depression is full remission from the illness.

Depression is insidious. It invades all aspects of the older adult’s life: physical, mental, social, and spiritual. Symptoms of depression, such as loss of interest in activities, social withdrawal, irritability, anxiety, chronic aches and pains that do not respond to treatment, and increased dependency, are often incorrectly explained as a normal part of aging. Older adult women have described depression as “the reexperiencing of a severe personal insult” that results in feelings of worthlessness, increased vulnerability or insecurity, a loss of self-respect, and feelings of inferiority or incompetence (Hedelin & Strandmark, 2001, p. 407). The symptoms of depression are also too often attributed to neurologic or other physical illnesses by both physicians and patients. Neurovegetative symptoms, such as sleep disturbances, loss of appetite, poor concentration, and low energy, are frequently explained as symptoms of a comorbid illness. There is a growing body of evidence that depression not only contributes to poor medical outcomes because of unhealthy behavior but it is also an etiologic factor in such
illnesses as cardiovascular disease, stroke, cancer, and epilepsy (Evans et al., 2003). Depression, the “unwanted cotraveler,” a phrase coined at the March 2001 National Institute of Mental Health Forum, also affects the progression of chronic illnesses, such as cardiovascular, cerebrovascular, and neurological disorders; diabetes; cancer; and HIV–AIDS (Evans et al.). Therefore, a strong case can be made for the development and implementation of depression prevention, early detection, and adequate treatment strategies.

**ETIOLOGY**

Typically, depression is multifactorial in origin and requires a biopsychosocial evaluation. Depression in late life can either be the recurrence of an illness experienced earlier or it can show up for the first time later in life, after the age of 55. Depression in older adults is most frequently associated with physiological changes or abnormalities of the brain (Lebowitz et al., 1997). These changes are thought to be of vascular origin or the result of early changes caused by dementing illnesses, such as Alzheimer’s disease or vascular dementia. These physiological changes affect synaptic activity causing fewer serotonin receptor sites or impaired receptor response (Blazer, 2003).

Despite some contradictory findings, most studies demonstrate the potential for neuroimaging (both structural and functional magnetic resonance imaging) to serve as an important diagnostic biomarker for late-life depression. Steffens argues that neuroimaging should be the gold standard in diagnosing vascular depression (Steffens, 2004). Vascular depression seems to exhibit different clinical characteristics including apathy and psychomotor changes, poorer response to antidepressant therapies, and is associated with a greater risk of cognitive decline and mortality (Alexopoulous et al., 1997; Steffens & Krishnan, 1998; Vaishnavi & Taylor, 2006). Although neuroimaging may be useful in diagnosing vascular depression, the findings do not provide information that will guide treatment and improve treatment outcomes in vascular depression, and thus neuroimaging is not currently used as a diagnostic tool. The ability to quantify with the use of both structural and functional neuroimaging the brain’s function is necessary to provide optimal targeted treatment (Mayberg, 2003).

Hormonal changes have also been associated with depression. Low levels of estrogen and dehydroepiandrosterone in women and low levels of total testosterone in older men have been shown to be associated with depressive symptoms; however, the efficacy of treating either has not been established (Blazer, 2003; Lebowitz et al., 1997; Tweedy, Morrison, & DeMichele, 2002).

In addition to the biological etiology of depression in older adults, there are clearly psychological contributing factors. The older adult’s life events and the interpretation and response to the events contribute to the risk for developing depression. The predominant life events that put an older adult at risk for depression, and contribute to the older adult’s experience and receptiveness to treatment for depression, are medical illness, bereavement or death of a loved one, disability, trauma, and impaired social support (Bruce & Pearson, 1999). These risk factors do not necessarily individually cause depression; rather, it may be the chain of events that results in depression (Bruce & Pearson). Risk factors, coupled with behavioral, psychodynamic, and negative thoughts surrounding life events, seem to contribute to late-life depression (Blazer, 2003). For instance, older adults’ interpretation of their situation may be that no matter what they do, bad things continue to happen or they continue to experience losses, so they assume a helpless position. Older adults also may not adapt to physical changes that occur with aging and may have unrealistic expectations and feel as if they continue to fail (Blazer). The current culture that places value on one’s accomplishments or one’s physical ability to “do,” versus an individual’s contribution to the greater good, may compound the older adult’s feelings of inadequacy. Impaired social support is also associated with depression in older adults (Blazer).
ASSESSMENT AND SCREENING OF LATE-LIFE DEPRESSION

Most older adults fall into one or more at-risk groups for depression. Many, however, do not recognize their symptoms as depression and do not request an evaluation. As previously mentioned, older adults may be resistant to seeking treatment because of the stigma of mental illness. As a result, all older adults should be screened for depression whether they present in a primary care office, hospital, long-term care home, or community senior center. Screening for major depression and other mental health disorders implemented in clinics at the local level is one of the six goals of the President's New Freedom Commission on Mental Health (2003). Likewise, the US Preventive Services Task Force recommends “screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up” (AHRQ, 2002). It has been shown that screening for depression is cost-effective (Nease & Maloin, 2003).

The first two questions of the Patient Health Questionnaire (PHQ)-9 (Figure 7-1) have been shown to be valid in detecting depressive symptoms, with a sensitivity of 83% and a specificity of 92% for major depression with a PHQ-2 score of 3 or greater (Kroenke, Spitzer, & Williams, 2003). This two-item questionnaire (PHQ-2) is a short version of the original nine-item questionnaire, which is comprised of the symptoms of depression listed in the Diagnostic and Statistical Manual of Mental Disorders IV ([DSM-IV] American Psychiatric Association [APA], 2000). A meta-analysis of 22 studies revealed that two to four question tools can accurately detect depression (Mitchell & Coyle, 2007). The two questions on the PHQ-2 are comprised of the two key or hallmark symptoms of depression, which are related to mood (feeling blue, down, or sad) and anhedonia (having little interest or pleasure in doing things).

The need to gather information regarding the patient's symptoms from a caregiver for the purpose of diagnosing an older adult with depression has been accepted for years. There are emerging data that suggest as many as 27% of older adults who are not cognitively impaired and have depression living in residential facilities would go unidentified if collateral information regarding symptoms was not gathered from nursing staff (Davison, McCabe, & Mellor, 2009). Older adults two questions can easily be added to a primary care health history questionnaire. Each question has an answer range of zero to three, with a possible total of six. When a patient answers positively to one (or two) of the questions to obtain a score of three or above, the staff member could then either administer the nine-item questionnaire (the PHQ-9) to complete for a full screening or refer to an outside resource for a full evaluation. If a patient completes the nine-item questionnaire and the score (greater than five) indicates the patient is experiencing symptoms of depression, a more thorough evaluation is indicated.

The Geriatric Depression Screening tool (Yesavage & Brink, 1983) is a valid and useful self-rated screening instrument (Figure 7-2). It is used frequently for detecting depression in older adults who have co-occurring medical illness and in older adults with mild to moderate cognitive impairment. A score of greater than 10 out of 30 yes-or-no questions is considered to be significant for depression and warrants a more thorough evaluation. There is also a 15-item or short form version of this tool. One drawback of the Geriatric Depression Screening is that it does not include a question on suicidal thought or intent.

Another screening instrument recommended for use in persons with dementia is an interviewer-rated scale called the Cornell Scale for Depression in Dementia (Figure 7-3) (Alexopoulos, Abrams, Young, & Shamoian, 1988; Alexopoulos, Katz, Reynolds, Carpenter, & Docherty, 2001). This is a 19-item questionnaire that takes approximately 20 to 30 minutes to administer. A score of 12 or greater indicates depression.
During the last two weeks have you often been bothered:

- By having little interest or pleasure in doing things?  
  - Yes  
  - No
- By feeling down, sad, or hopeless?  
  - Yes  
  - No

If the client answers **YES** to either question, administer the PHQ-9 below.

### FIGURE 7–1a

Two-Question Screen for Depression: Patient Health Questionnaire 2 (PHQ-2).

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**Read each item carefully and circle the client’s response. Use a response card as necessary.**

**Over the last 2 weeks, how often have you been bothered by any of the following problems? (Repeat this as needed.)**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(continues)
### FIGURE 7–1b

**Patient Health Questionnaire (PHQ-9). (continued)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Or the opposite—being so fidgety or restless that you have been moving around more that usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Totals**

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not Difficult at All</th>
<th>Somewhat Difficult</th>
<th>Very Difficult</th>
<th>Extremely Difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Suicide Risk:** For any positive response to #9 above, ask this question and adhere to your agency's suicide protocol:

Do you feel these thoughts are a problem for you or something you might act on?  □ Yes  □ No

**PHQ-9 Scoring:**

- ≤ 4—suggests that the patient may not need depression treatment;
- ≥ 5 to 14—physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment;
- ≥ 15—warrants treatment for depression, using antidepressant, psychotherapy, or combination of treatment. A functional health assessment is reflected in question 10 on the PHQ-9, which asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four (see question 10). A response of very difficult or extremely difficult suggests that the patient's functionality is impaired.

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### FIGURE 7–2
Geriatric Depression Screening Tool.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. X</td>
<td>❑</td>
</tr>
<tr>
<td>2. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>3. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>4. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>5. X ❑</td>
<td>❑</td>
</tr>
<tr>
<td>6. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>7. X ❑</td>
<td>❑</td>
</tr>
<tr>
<td>8. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>9. X ❑</td>
<td>❑</td>
</tr>
<tr>
<td>10. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>11. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>12. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>13. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>14. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>15. X ❑</td>
<td>❑</td>
</tr>
<tr>
<td>16. ❑ X</td>
<td>❑</td>
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<tr>
<td>17. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>18. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>19. X ❑</td>
<td>❑</td>
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<tr>
<td>20. ❑ X</td>
<td>❑</td>
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<tr>
<td>21. X ❑</td>
<td>❑</td>
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<tr>
<td>22. ❑ X</td>
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<tr>
<td>23. ❑ X</td>
<td>❑</td>
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<tr>
<td>24. ❑ X</td>
<td>❑</td>
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<tr>
<td>25. ❑ X</td>
<td>❑</td>
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<tr>
<td>26. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>27. X ❑</td>
<td>❑</td>
</tr>
<tr>
<td>28. ❑ X</td>
<td>❑</td>
</tr>
<tr>
<td>29. X ❑</td>
<td>❑</td>
</tr>
<tr>
<td>30. X ❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

The boxes indicate response indicating depressive symptom and each is equivalent to 1. Score of ≥ 10 indicates an evaluation for depression is indicated.

### Scoring system: a = unable to evaluate; 0 = absent; 1 = mild or intermittent; 2 = severe.

#### A. Mood-Related Signs
1. Anxiety: anxious expression, ruminations, worrying  
   a 0 1 2
2. Sadness: sad expression, sad voice, tearfulness  
   a 0 1 2
3. Lack of reactivity to pleasant events  
   a 0 1 2
4. Irritability: easily annoyed, short-tempered  
   a 0 1 2

#### B. Behavioral Disturbance
5. Agitation: restlessness, hand-wringing, hair-pulling  
   a 0 1 2
6. Retardation: slow movement, slow speech, slow reactions  
   a 0 1 2
7. Multiple physical complaints (score 0 if GI symptoms only)  
   a 0 1 2
8. Loss of interest: less involved in usual activities  
   a 0 1 2 
   (score only if change occurred acutely, i.e., in less than 1 month)

#### C. Physical Signs
9. Appetite loss: eating less than usual  
   a 0 1 2
10. Weight loss (score 2 if greater than 5 lb. in 1 month)  
    a 0 1 2
11. Lack of energy: fatigues easily, unable to sustain activities  
    a 0 1 2  
    (score only if change occurred acutely, i.e., in less than 1 month)

#### D. Cyclic Functions
12. Diurnal variation of mood: symptoms worse in the morning  
    a 0 1 2
13. Difficulty falling asleep: later than usual for this individual  
    a 0 1 2
14. Multiple awakenings during sleep  
    a 0 1 2
15. Early morning awakening: earlier than usual for this individual  
    a 0 1 2

#### E. Ideational Disturbance
16. Suicide: feels life is not worth living, has suicidal wishes, or makes suicide attempt  
    a 0 1 2
17. Poor self-esteem: self-blame, self-depreciation, feelings of failure  
    a 0 1 2
18. Pessimism: anticipation of the worst  
    a 0 1 2
19. Mood congruent delusions: delusions of poverty, illness, or loss  
    a 0 1 2

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness. Scores of 12 or greater indicate probable depression.

typically underreport symptoms of depression. Depressed mood and diminished interest in pleasurable activities (PHQ-2) and appetite disturbance or weight loss, loss of energy, worthlessness, and suicidal ideation are commonly denied by older adults (Davison et al.). Therefore, it should be noted that all of the tools discussed simply serve as screening tools and do not take the place of a full diagnostic evaluation of the older adult, which includes an extensive assessment of symptoms including information gathered from a reliable informant.

## Diagnosis of Mood Disorders

DSM-IV (APA, 2000) outlines the criteria for major depression, dysthymia, and minor depression. A diagnosis of major depression requires that for a 2-week period the individual either exhibits a sad, depressed mood or a loss of interest or pleasure in usual activities, and five or more of the following symptoms: significant weight loss or an increase or decrease in appetite; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation observable by others nearly every day; fatigue or loss of energy nearly every day; feelings of worthlessness or excessive guilt; diminished ability to think or concentrate or make decisions nearly every day; or recurrent thoughts of death (not just fear of dying or developmentally appropriate thoughts of death as a part of growing old); recurrent suicidal ideation without a specific plan or a suicide attempt; or a specific plan for committing suicide (APA, 2000).

The diagnostic criteria for dysthymia is exhibiting a depressed mood for more days than not for 2 years and two or more of the following: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, or feelings of hopelessness (APA, 2000).

In recent years, more attention has been paid to the importance of diagnosing and treating subsyndromal or minor depression. It is diagnosed with the occurrence of one or more periods of depressive symptoms that are identical to major depressive periods in duration, but involve fewer symptoms and less impairment. A minor depressive episode includes either a period of sad or “blue” mood or a loss of interest in activities and at least two additional depressive symptoms (APA, 2000).

There is growing evidence that supports aggressive treatment of minor depressive episodes. Twenty-five percent of persons with minor depression go on to experience a major depression episode (Lyness, King, Cox, Yoediono, & Caine, 1999; Oxman, Barrett, & Gerber, 1990). Parmelee, Katz, and Lawton (1992) demonstrated that over time nursing home residents who exhibited minor depressive symptoms went on to develop major depression at a greater rate than those who did not exhibit depressive symptoms.

The DSM-IV criteria for major depression, dysthymia, and minor depression do not capture symptoms distinctive of geriatric depression. Older adults tend to have more somatic and cognitive complaints (Alexopoulos et al., 2002). They may not report a sad feeling but instead complain of a lack of feeling or emotion, apathy, or fatigue. Anxiety, nervousness, and increased worry are also common complaints of older adults experiencing depression. This presentation may be described as “depression without sadness” (Gallo & Rabins, 1999). For example, the primary complaint of an older adult may be anxiety or difficulty with concentration or memory. When evaluated further, additional symptoms are present, which add up to a diagnosis of depression.

The DSM-IV criteria for depression require that for a diagnosis of major depression, dysthymia, or minor depression, symptoms are not the result of a medical condition (e.g., hypothyroidism or vitamin deficiency) or a substance (e.g., medication or alcohol). Assessing depression in older adults is complicated by the fact that more frequently than not, the older adult is also experiencing the symptoms of chronic illnesses or symptoms of dementia.

Brown, Lapane, and Luisi (2002) found that nursing home residents with several diagnoses,
including cancer, were all less likely to receive pharmacological treatment for depression. The tendency is to attribute symptoms of depression to other physical conditions because of the stigma associated with a depression diagnosis. Residents of nursing homes who were female, black, or cognitively impaired were less likely to receive treatment (Brown et al., 2002).

If an older adult screens positive for depression or if a screening tool is not used and a more “inclusive” approach to diagnosing is used, in which all depressive symptoms are indicative of depression and not disregarded as symptoms of another illness, then a thorough medical psychiatric evaluation is indicated. The medical evaluation for depression includes an extensive medical, psychiatric, and psychosocial history and a thorough evaluation of the causes for the depressive symptoms guided by a review of systems, a physical examination, including a neurologic examination, and laboratory work. The laboratory examination should include, but not be limited to (depending on findings in the review of symptoms), serum electrolytes, complete blood count with platelets, thyroid panel with thyroid-stimulating hormone, vitamin B₁₂, and folate. The evaluation for depression includes an evaluation of medical conditions that contribute to depressive symptoms (Box 7-1) and medications that can cause depressive symptoms (Box 7-2).

**SUICIDE**

Untreated depression is a risk factor for suicide. The National Institute of Mental Health has recognized that suicide is a major but preventable public health problem (2008). The WHO (2003) reported nearly a million people commit suicide each year, and according to the CDC’s National Center for Health Statistics, the number of suicides in the United States in 2005 was nearly 33,000 (CDC, 2008). A person dies by suicide every 16 minutes in the United States, and 90% of those who commit suicide have a diagnosable psychiatric disorder at the time of their death (American Foundation for Suicide Prevention, 2009). Therefore, early recognition and adequate treatment of mental illness will help prevent suicide.

Older adults who are widowed, live alone, have poor sleep quality, lack someone in whom they can confide, are grieving, are experiencing family discord, perceive themselves to be physically ill, suffer from chronic depression, or who have a history of prior suicide attempts are at high risk for suicide (Blazer, 2003; Conwell, Duberstein, & Caine, 2002). The consensus of expert clinicians is that the severity of the depressive illness, the presence of psychosis, alcoholism, a recent loss or bereavement, abuse of sedatives or hypnotics, and the development of disability are the greatest risk factors for suicide in older adults (Alexopoulos et al., 2001). “Older adult suicides give fewer warnings to others of their suicide plans, use more violent and potentially deadly methods to commit suicide, and apply those methods with greater planning and resolve” (Conwell et al., p. 194). It is imperative that nurses assess for suicidal ideation or intent, keeping in mind that noncompliance with medical recommendations may be suicidal behavior (Conwell et al.). A patient who speaks of wanting to die, who states they would be better off dead, or who exhibits behavior that indicates they are preparing for their imminent death, including not following medical treatment, must be further assessed by asking poignant questions that determine the older adult’s intentions. The nurse must be open to hearing and seeing this behavior among older adults, because there is great reluctance among nurses to ask patients if they are suicidal. As health care providers, nurses must assess their own beliefs and prejudices surrounding suicide because these can interfere with the ability to provide a complete assessment of a patient suffering from a potentially life-threatening illness. Furthermore, it is a myth that asking someone if they have thoughts of suicide is condoning the behavior or encouraging the persons to carry out his or her thoughts. In fact, asking with genuine concern if someone has suicidal thoughts or intent can instill hope during a time of crisis.
Metabolic disturbances
- Dehydration
- Azotemia, uremia
- Acid–base disturbances
- Hypoxia
- Hyponatremia and hypernatremia
- Hypoglycemia and hyperglycemia
- Hypocalcemia and hypercalcemia

Endocrine disorders
- Hypothyroidism and hyperthyroidism
- Hyperparathyroidism
- Diabetes mellitus
- Cushing’s disease
- Addison’s disease

Infections
- Viral: pneumonia, encephalitis
- Bacterial: pneumonia, urinary tract, meningitis, endocarditis
- Other: tuberculosis, brucellosis, fungal, neurosyphilis

Cardiovascular disorders
- Congestive heart failure
- Myocardial infarction, angina

Pulmonary disorders
- Chronic obstructive lung disease
- Malignancy

Gastrointestinal disorders
- Malignancy (especially pancreatic)
- Irritable bowel
- Other organic causes of chronic abdominal pain, ulcer, diverticulosis, hepatitis

Genitourinary disorders
- Urinary incontinence

Musculoskeletal disorders
- Degenerative arthritis
- Osteoporosis with vertebral compression or hip fractures
- Polymyalgia rheumatica
- Paget’s disease

Neurologic disorders
- Cerebrovascular disease
- Transient ischemic attacks
- Stroke
- Dementia (all types)
- Intracranial mass: primary or metastatic tumors
- Parkinson’s disease

Other illnesses
- Anemia (of any cause)
- Vitamin deficiencies
- Hematologic or other systemic malignancy

BOX 7–2 DRUGS THAT CAUSE SYMPTOMS OF DEPRESSION IN OLDER ADULTS

Antihypertensives
- Reserpine
- Methyldopa
- Propranolol
- Clonidine
- Hydralazine
- Guanethidine
- Diuretics (by causing dehydration or electrolyte imbalance)

Analgesics
- Narcotics
  - Morphine
  - Codeine
  - Meperidine
  - Pentazocine
  - Propoxyphene
- Nonnarcotic
  - Indomethacin

Antiparkinsonian agents
- L-Dopa

Antimicrobials
- Sulfonamides
- Isoniazid

Cardiovascular agents
- Digitalis
- Lidocaine (toxicity)

Hypoglycemic agents (by causing hypoglycemia)

Steroids
- Corticosteroids
- Estrogens

Others
- Cimetidine
- Cancer chemotherapeutic agents

Having a suicide protocol in place that clearly defines how the nurse will intervene should the nurse receive an affirmative response to the questions “Do you have thoughts of ending your life?” or “Do you have a plan and intend to carry it out?” will increase the nurse’s comfort in completing a full assessment of the depressed patient. The protocol must include the involvement of others responsible for the care of the patient, such as the physician, nursing supervisor, family members, and others with whom the patient has a trusting relationship, such as a clergy person. If the patient has the intent to commit suicide and a plan to carry it out, then he or she must undergo constant supervision until hospitalization and the potential for carrying out the intent has been eliminated. If there is suicidal thought or ideation, then the nurse must, in conjunction with other healthcare providers, including a psychiatrist, develop a plan for keeping the patient safe. Involving someone in whom the patient feels comfortable confiding is important. The plan should include removing all lethal weapons or other means of suicide; consistent companionship or day treatment, if hospitalization is not possible; and close monitoring of the depression by a mental health specialist or the healthcare provider.

TREATMENT OPTIONS

Kessler et al. (2003), who examined the results of the National Comorbidity Survey Replication, recommended that “emphasis on screening and expansion of treatment needs to be accompanied by a parallel emphasis on treatment quality improvement” (p. 3095). The treatment options for depression are pharmacological, psychotherapeutic, and psychosocial interventions, and electroconvulsive therapy (ECT). Novel treatment options, such as transcranial magnetic stimulation and deep brain stimulation, are currently being investigated. The most effective treatment to date is a combination of pharmacological therapy and psychotherapy (DHHS, 1999). The goal of treatment is for the patient to return to his or her baseline before the depression episode or to where the residual physiological symptoms are clearly related to a chronic illness.

The AHRQ’s National Guideline Clearinghouse (2008, Section I, para. 1) offers the following evidence-based recommendations: “For patients with mild to moderate Major Depressive Disorder (MDD), use either antidepressant medication or psychotherapy (Interpersonal Therapy, Cognitive Behavioral Therapy, or Problem-Solving Therapy) as first-line treatment.” For the antidepressant medication strategy, the AHRQ’s National Guideline Clearinghouse (2008, Recommendations section, para. 3) also recommends “Frequent initial visits. Patients require frequent visits early in treatment to assess response to intervention, suicidal ideation, side effects, and psychosocial support systems; Continuation therapy. Continuation therapy (9-12 months after acute symptoms resolve) decreases the incidence of relapse of major depression.”

Recovery or obtaining a remission is not immediate. It may take longer for older adults to respond to treatment (Nelson, 2001). Generally, medications take 4 to 6 weeks to be effective and frequently 8 to 10 weeks in older adults and several additional months once a therapeutic dosage is reached to eliminate residual symptoms. The treatment of depression may require several different medication trials where the therapeutic dosage is prescribed for 8 to 10 weeks. A combination of medications (e.g., selective serotonin reuptake inhibitor and bupropion) aimed at relieving all symptoms or achieving the individual’s baseline may be indicated only when a therapeutic trial of the initially started medication results in significant symptom reduction with residual symptoms of depression that are not responding to the initial medication. Frequently, patients are the last to recognize their gradual improvement despite family members being able to see positive changes; therefore, reassurance and identification and discussion of areas of improvement with the older adult may be beneficial and facilitate continuation of treatment. Older adults may blame a relapse or the recurrence of symptoms on other physical illnesses or life situations, continuing to deny their psychiatric illness. On the other hand, because of the pain and disability experienced when depressed, some patients become hypersensitive to their mood.
by becoming concerned that they are becoming depressed again whenever they have a “down” day or two as the result of normal life experiences. Patients need to be taught and reminded of the signs and symptoms of depression and their own presentation. They also may need to be reminded of the self-care strategies they have learned and when to seek professional care. Depression is a recurring illness and the use of a combination of treatments, such as medications, psychotherapy, and the adoption of positive psychosocial behaviors, helps prevent relapse and assists the client and his or her family to detect relapse early.

**PHARMACOLOGIC TREATMENT OPTIONS**

Recommendations for pharmacotherapy in older adults are based on expert consensus because most clinical trials are conducted in younger patients (Alexopoulos et al., 2001). Clinicians treating older adults must apply what is known from clinical trials to a population of patients who generally have a number of coexisting medical conditions, metabolize medications more slowly, and are taking other medications that contribute to their depressive symptoms (Alexopoulos et al., 2001). Antidepressant medications most frequently used in older adults include the selective serotonin reuptake inhibitors (SSRIs); serotonin and norepinephrine reuptake inhibitors or modulators (SNRIs); and unicyclic aminoketone (e.g., bupropion). Medications used less frequently in older adults include piperazine (e.g., trazodone and nefazodone); tricyclic antidepressants (TCAs); and monoamine oxidase inhibitors (MAOIs). Although individuals respond differently to medications, all of the medications are 60% to 80% effective (McDonald, 2000).

The Expert Consensus Guideline Series (Alexopoulos et al., 2001) supports the use of SSRIs or venlafaxine XR (Cymbalta was not on the market at the time) in combination with psychotherapy as the first line of treatment for unipolar nonpsychotic major depression (Table 7-1). This is largely because of the presumed low side-effect profile of the SSRIs.

**TABLE 7-1**

Medication and Treatment Selection Strategies for Unipolar Nonpsychotic Major Depression (Mild and Severe) and Unipolar Psychotic Major Depression

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Alternate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild Depression</strong></td>
<td></td>
</tr>
<tr>
<td>Antidepressant medication and psychotherapy</td>
<td>Antidepressant medication alone or psychotherapy alone</td>
</tr>
<tr>
<td>SSRI</td>
<td>Bupropion</td>
</tr>
<tr>
<td>Venlafaxine XR</td>
<td>Mirtazapine</td>
</tr>
<tr>
<td><strong>Severe Depression</strong></td>
<td></td>
</tr>
<tr>
<td>Antidepressant medication and psychotherapy</td>
<td>ECT</td>
</tr>
<tr>
<td>Antidepressant medication alone</td>
<td></td>
</tr>
<tr>
<td><strong>Psychotic Depression</strong></td>
<td></td>
</tr>
<tr>
<td>Antidepressant (SSRI or venlafaxine XR) plus antipsychotic (risperidone, olanzapine, quetiapine) or electroconvulsive therapy</td>
<td>Medication plus psychotherapy</td>
</tr>
<tr>
<td>Antidepressant: TCA</td>
<td>Antipsychotics: ziprasidone or aripiprazole*</td>
</tr>
</tbody>
</table>

* Ziprasidone had just been released at the time of the Expert Consensus Guidelines survey and aripiprazole had not yet been released.

The currently available data, particularly that which pertain to older adults, do not support the use of hypericum perforatum (St. John’s wort) or other herbals and botanicals over standard clinical care for the treatment of depression (Alexopoulos et al., 2001; Desai & Grossberg, 2003; Davidson et al., 2002). Table 7-2 provides an overview of the antidepressants and dosing most commonly recommended for older adults.

The familiar geriatric axiom “start low, go slow” holds true when prescribing antidepressants. However, a common mistake is to undertreat by not titrating to the recommended therapeutic dosage or not raising the dosage to its higher limits to eliminate all depressive symptoms and obtain full remission. Anxiety is a common residual symptom of depression, and it is recommended that the dose of antidepressant medication, other than TCAs, be raised to its highest therapeutic level to treat the anxiety (Alexopoulos et al., 2001). The patient should be maintained on the dose of the medication that adequately treated the depressive illness for at least 1 year if it is their first episode of depression (Alexopoulos et al.). Experts vary in

<table>
<thead>
<tr>
<th>TABLE 7–2</th>
<th>Dosing and Duration of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressant</strong></td>
<td><strong>Average Starting Dose (mg/day)</strong></td>
</tr>
<tr>
<td><strong>SSRIs</strong></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>10–20</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>10</td>
</tr>
<tr>
<td>Escitalopram*</td>
<td>5–10</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>10–20</td>
</tr>
<tr>
<td>Paroxetine CR</td>
<td>12.5</td>
</tr>
<tr>
<td>Sertraline</td>
<td>25–50</td>
</tr>
<tr>
<td><strong>SNRI</strong></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine XR</td>
<td>25–75</td>
</tr>
<tr>
<td>Cymbalta</td>
<td></td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
</tr>
<tr>
<td>Bupropion SR</td>
<td>100</td>
</tr>
<tr>
<td>Bupropion XR</td>
<td>150</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>7.5–15</td>
</tr>
<tr>
<td><strong>TCA</strong></td>
<td></td>
</tr>
<tr>
<td>Nortriptyline†</td>
<td>10–30</td>
</tr>
<tr>
<td>Desipramine†</td>
<td>10–40</td>
</tr>
</tbody>
</table>

Dosages given are based on pharmaceutical recommendations.

*Was not on the market at the time of the Expert Consensus Survey. Dosages given are based on pharmaceutical recommendations.

† Recommended target blood levels:
Nortriptyline: 50–150 ng/ml
Desipramine: 115–200 ng/ml

their recommendations as to how long a patient should be maintained on the antidepressant if it is their second or third depressive episode. Alexopoulos et al. note that in addition to the number of depressive episodes, other factors, such as severity of the illness and how well the illness responded to treatment, play a role in the decision to continue treatment for 3 years or longer.

For patients with symptoms of minor depression or dysthymia, which have persisted for 2 to 3 months, the first line of treatment is medication with psychotherapy or medication or psychotherapy alone (Alexopoulos et al., 2001). Watchful waiting and psychoeducation or psychotherapy is recommended for patients who exhibit dysthymia or minor depressive symptoms for a few weeks or more.

The most common side effects of the SSRIs are mild nausea, stomach upset, and a slight jittery feeling similar to what caffeine may cause. These common but mild side effects usually go away in 7 to 10 days and are minimized by slow titration of dosage. Serotonergic drugs can cause a “serotonin syndrome,” which can be mild to severe nausea, tremor, difficulty sleeping, and anxiety. This occurs most frequently when a medication is started, possibly at too high of a dose, or when added to another serotonergic medication, such as L-tryptophan, hypericum (St. John’s wort), MAOIs, or lithium (McDonald, 2000). This should be addressed by decreasing or eliminating a serotonergic medication. More notable side effects indicating a need to discontinue the medication include rash, agitation, headaches, insomnia, and loss of appetite. The SSRIs are not associated with cardiac effects and they do not potentiate medications that are central nervous system depressants. SSRIs should not be abruptly discontinued. When stopped abruptly, the patient can experience flu-like symptoms.

The SNRI venlafaxine (Effexor) does not have any effect on seizure threshold or cardiac side effects. It has a low incidence of sexual dysfunction and drug-induced anxiety that is sometimes seen when starting a SSRI, and it has a more rapid onset of effectiveness (McDonald, 2000). Similar to the SSRIs, such side effects as nausea, difficulty sleeping, or mild headaches can be minimized by starting the medication at a low dose and titrating up slowly. In some patients, SSRIs and venlafaxine are stimulating and therefore should be given in the morning. If a patient finds the medications to be a little sedating, then they should be dosed in the evening. Venlafaxine should be used with caution in persons with uncontrolled hypertension, because it is associated with dose-related hypertension. The patient’s blood pressure should be monitored each time the dose is increased. Duloxetine (Cymbalta) is also an SNRI and indicated for diabetic peripheral neuropathy (Goldstein, Detke, Lee, & Iyengar, 2005; Raskin, Pritchett, Wang, D’Souza, Waninger, Iyengar, & Wernicke, 2005).

Bupropion and mirtazapine are considered high second-line alternatives (Alexopoulos et al., 2001). Bupropion (Wellbutrin), a unicyclic aminoketone, has a side-effect profile similar to the SSRIs. Unlike the SSRIs, it does not cause sexual dysfunction. The medication can be somewhat activating or stimulating; therefore, it should not be dosed in the evening because it could interfere with sleep. Bupropion is associated with an increased risk of seizure. The risk of seizure has been significantly decreased with the newer sustained-release and extended-release formulas.

Mirtazapine (Remeron), a piperazinoazepine or serotonin and norepinephrine reuptake modulator, also does not have significant sexual or cardiac side effects. Mirtazapine can cause weight gain. It also is sedating at lower doses. Dosing is counterintuitive with Remeron in that it is more sedating at lower starting doses than at target doses. Remeron is often selected as a treatment because of its side effects of weight gain and sedation, which can be helpful in an older adult with a poor appetite, weight loss, and difficulty sleeping.

Although more difficult to use in older adults because of their side-effect profile, TCAs may be considered an option when treating depression that is unresponsive to the newer antidepressants.
(e.g., SSRIs and SNRIs) that have a more favorable side-effect profile and are better tolerated in older adults (Alexopoulos et al., 2001). The Expert Consensus agrees with research showing the SSRIs are as effective as the TCAs with a better side-effect profile (Alexopoulos et al., 2001). TCAs are associated with anticholinergic side effects, including dry mouth, tachycardia, increased or decreased sweating, impaired visual accommodation or blurred vision, constipation and urine retention, orthostatic hypotension, and sedation (McDonald, 2000). Older adults are at risk of an anticholinergic-induced delirium in which the patient becomes confused, agitated, or more withdrawn. This could be confused with a worsening of their depression. Most importantly, TCAs can cause heart block and arrhythmias. A TCA overdose is likely to be fatal.

MAOIs are effective antidepressants but are not used often in older adults because of the risk of severe drug interactions. As with TCAs, close monitoring for drug interaction is recommended when prescribing MAOIs (Alexopoulos et al., 2001). Hypertensive crisis can occur when MAOIs are taken with foods that contain tyramine, sympathomimetic medications, narcotics, TCAs, nefazodone (Serzone), and SSRIs.

Finally, piperazines, nefazodone, and trazodone (Desyrel) are not frequently used with older adults because they cause orthostatic hypotension and sedation at doses that are needed to have an antidepressant effect. Trazodone, however, may be used as a treatment for insomnia (Alexopoulos et al., 2001) and can be helpful in decreasing agitation in older adults (McDonald, 2000). When these medications are used, the patient needs to be carefully assessed for hypotension and instructed regarding the risk of falls. Neither medication is associated with cardiotoxicity or sexual dysfunction.

There is considerable evidence that supports augmentation using low doses of atypical antipsychotics in treatment-resistant depression (Thase, 2002; Blier & Szabo, 2005). However, Expert Consensus Guidelines for Using Antipsychotic Agents in Older Patients does not support the use of antipsychotic agents in the treatment of nonpsychotic major depression (Alexopoulos et al., 2005). The reason for this opinion is the unfavorable risk–benefit ratio; the high risk of adverse effects primarily caused by disease–drug and drug–drug interactions outweighs the limited documented benefit of use of atypical antipsychotics in the treatment of depression in older adults (Alexopoulos et al.). Expert consensus does recommend the use of atypical antipsychotics in the treatment of psychotic major depression in an older adult. Based on the evidence of the effectiveness of antipsychotics in treatment-resistant depression, the clinician must consider the risk–benefit in the use of atypical antipsychotics in the treatment of an older adult who is treatment resistant.

**PSYCHOTHERAPY**

The Expert Consensus Guidelines (Alexopoulos et al., 2001) consider cognitive–behavioral therapy, supportive psychotherapy, problem-solving psychotherapy, and interpersonal therapy to be first-line psychotherapy options for older adults. The two forms of psychotherapy that have been studied the most and have been shown to be the most effective in treating depression are cognitive–behavioral therapy and interpersonal therapy (Arean & Cook, 2002; Blazer, 2003). There is some evidence that brief dynamic therapy and reminiscence therapy are somewhat effective in treating late-life depression (Arean & Cook). Cognitive–behavioral therapy has also been shown to help prevent relapse and improve psychosocial functioning in younger patients (Fava, Grandi, Zienlenzy, Canestraari, & Morphy, 1994; Paykel et al., 1999; Scott et al., 2000). Psychotherapy is effective for individuals or in groups. Group therapy is one way of providing a peer group for older adults who have lost their social network or support.

The skilled psychotherapist can treat almost all of the symptoms of depression and the resulting behaviors associated with depression (i.e., hopelessness, anhedonia, anxiety, interpersonal problems, treatment compliance, poor energy, and negative thoughts). However, a moderate to severe
Depressive episode, which may include sleep disturbance, change in appetite, suicidal thoughts, or psychosis, almost always requires pharmacotherapy. Licensed therapists, such as clinical nurse specialists, psychiatric nurse practitioners, psychologists, licensed clinical social workers, licensed marriage and family counselors, pastoral counselors, and psychiatrists, are all psychotherapists. However, not all specialize in the therapies proven to be effective in treating depression and not all are skilled at working with older adults.

All advanced practice nurses treating older adults with depression can use cognitive–behavioral therapy techniques (when a therapist is not available or in collaboration with a therapist) with the goal of altering negative behaviors and thought patterns. The basic premise of behavioral therapy is to influence or change behavior that contributes negatively to an individual’s depression. Someone who suffers from depression for any length of time adopts behaviors that exacerbate or perpetuate the symptoms of depression. A hallmark symptom of depression is loss of interest in activities that were pleasurable (anhedonia). Clearly, the depressed person who no longer enjoys things over time loses social contacts and becomes less physically active. Being separated from others socially and becoming less physically active contribute to depressive symptoms. Persons who have been cut off from family and friends and who are inactive because of their depression frequently need to be provided guidance and support to change behaviors. Chronically depressed persons or older adults who are transitioning from work to retirement, or from living independently to assisted living, may need assistance in identifying activities they enjoy and that provide them with a sense of satisfaction. Likewise, the changing of roles that is the result of retirement, loss of a spouse or friend, or a change in lifestyle can be facilitated with cognitive therapy by assisting with thoughts or perceptions of changing roles and contributions.

One behavioral therapy strategy is activity scheduling (France & Robson, 1997). Activity scheduling requires the patient keep a diary of the activities they were involved in over the week (e.g., watching television, bathing, and grocery shopping). Once the nurse has a clear picture of the patient’s level of activity, the patient should be asked to evaluate the activities, as to whether they are considered an achievement or a pleasurable experience. This information, in addition to the patient’s psychosocial history, is used to help the patient identify which activities affect mood positively and to set goals for increasing those activities. During this process, the older adult might identify numerous barriers to assuming an active lifestyle (e.g., immobility, pain, or lack of transportation). Here lies the challenge to the nurse. These barriers should be discussed and the nurse can provide valuable guidance to the older adult in identifying ways to overcome the barriers or alternative activities that will be enjoyable to that individual. The nurse must make certain that the goals for changing behavior are the patient’s and not the nurse’s goals. Identification of the patient’s goals is a key in problem solving therapy and behavioral activation, both psychotherapeutic strategies shown to be effective in changing behaviors and decreasing depressive symptoms in older adults.

While implementing the “activity scheduling” technique, the nurse is certain to identify the depressed patient’s negative or fatalistic attitudes. These negative thoughts are a hallmark of depression. Frequently, depression contributes negatively to the patient’s self-esteem and the negativity becomes a conditioned or an automatic response. Cognitive therapy helps the depressed person recognize his or her negative thoughts and challenges those thoughts with a positive response (France & Robson, 1997). What one thinks about or how one interprets life’s events affects mood. France and Robson suggest that even though a thought may be fleeting, the mood it creates may linger. The same is true with a negative interpretation of events.

One cognitive therapy strategy is a “negative automatic thoughts record” (France & Robson, 1997). The patient is instructed to keep a record of
negative thoughts, including the negative meaning they have assigned to events and images and their mood during that day. The nurse can help the patient evaluate how their thoughts correlate with their moods. The patient is challenged to think about their automatic thoughts regarding an event, if their response (thought) is rational, and if not what is a rational response. A plan to carry out the more positive rational response is developed.

ELECTROCONVULSIVE THERAPY

ECT is a highly effective treatment for major depression. Published research and expert clinicians support the safety and efficacy of ECT in older adults (Salzman, Wong, & Wright, 2002; Alexopoulos et al., 2001). ECT is most appropriate in psychotic depression when depression has failed to respond to an antidepressant and antipsychotic medication or in a severe depression that has failed to respond to adequate trials of two antidepressants (Alexopoulos et al.). It is also appropriate for severe depression with acute suicidal risk that may include refusing medication and food (Alexopoulos et al.). Unfortunately, ECT is postponed or not considered a viable treatment option by many patients, families, and clinicians because of its historical negative depiction. Likewise, there are persons who have had negative experiences with ECT and are opposed to the use of ECT. However, similar to many medical procedures, ECT has been developed over past years such that side effects are minimized. The most common side effect of ECT is disturbance of memory around the time of the course of treatment and possibly loss of memory of isolated events. Cognition is closely monitored during the course of treatment.

Before being treated with ECT, the patient undergoes a full medical evaluation including laboratory work, electrocardiogram, and a CT scan of the brain. A recent stroke is a contraindication for ECT. With close monitoring, persons with severe cardiovascular disease can be treated successfully with ECT (Zielinski, Roose, Devanand, Woodring, & Sackeim, 1993).

ECT is administered while the patient is asleep and their muscles are totally relaxed using medication. An electrical stimulus that causes a seizure is administered through the electrodes placed on the depressed person’s head. The patient does not feel any pain. The patient awakes approximately 5 to 10 minutes following the seizure. The patient is closely monitored for confusion, agitation, headache, and changes in cognition or memory. Any changes are addressed medically as indicated.

NURSING INTERVENTIONS

In 1999, the Report of the Surgeon General noted there will never be enough mental health clinicians to treat the vast numbers with a mental illness. Thus, it proves essential that mental health become an integral part of primary care and of other specialties. Nurses can be instrumental in arranging for comprehensive and more effective treatment of depression. In addition to pharmacotherapy and psychotherapy, psychosocial interventions need to be considered and included in the treatment plan as appropriate. Psychosocial interventions, such as psychoeducation, family counseling, visiting nursing services, bereavement groups, and senior citizen center activities, are all strongly recommended as first-line intervention options (Alexopoulos et al., 2001). Kurlowicz and NICHE faculty (1997) provides a comprehensive list of nursing interventions for the management of depression (Box 7-3).

Depressed older adults need an advocate and someone to provide ongoing supportive counseling that reinforces what they have been taught about the illness. They also need assistance in combating the stigma of the illness, problem solving and setting goals, and ongoing reassurance. Just knowing that there is someone to talk to who understands their illness and is available to answer questions and provide reassurance is extremely therapeutic for both the patient and their caregiver.
For all levels of depression, develop an individualized plan integrating the following nursing interventions:

1. Institute safety precautions for suicide risk as per institutional policy (in outpatient settings, ensure continuous surveillance of the patient while obtaining an emergency psychiatric evaluation and disposition).
2. Remove or control etiologic agents.
   a. Avoid, remove, or change depressogenic medications.
   b. Correct or treat metabolic and systemic disturbances.
3. Monitor and promote nutrition, elimination, sleep-rest patterns, physical comfort (especially pain control).
4. Enhance physical function (i.e., structure regular exercise or activity, refer to physical, occupational, recreational therapies); develop a daily activity schedule.
5. Enhance social support (i.e., identify or mobilize support persons [e.g., family, confidante, friends, hospital resources, support groups, patient visitors]); ascertain need for spiritual support and contact appropriate clergy.
6. Maximize autonomy or personal control and self-efficacy (e.g., include patient in active participation in making daily schedules, short-term goals).
7. Identify and reinforce strengths and capabilities.
8. Structure and encourage daily participation in relaxation therapies, pleasant activities.
9. Monitor and document response to medication and other therapies; readminister depression screening tool.
10. Provide practical assistance; assist with problem solving.
11. Provide emotional support (i.e., empathic, supportive listening, encourage expression of feelings, instill hope), support adaptive coping, encourage pleasant reminiscences but do not “force” happiness.
12. Provide information about the physical illness and treatments and about depression (i.e., that depression is common, treatable, and not the person’s fault).
13. Educate about the importance of adherence to prescribed treatment regimen for depression (especially medication) to prevent recurrence; educate about specific antidepressant side effects and any dietary restrictions.
14. Ensure mental health community link-up; consider psychiatric nursing home care intervention.

EVIDENCE-BASED MODELS OF CARE DELIVERY

There are many evidence-based programs on mental health promotion recognized by the United States Substance Abuse Mental Health Services Administration’s National Registry of Evidence-based Programs and Practice (NREPP) (http://nrepp.samhsa.gov) and the National Council on Aging’s Center for Healthy Aging (http://healthyagingprograms.org) that can be implemented in primary care clinics and other settings where older adults live and congregate. Numerous efforts, including the recommendation that all primary care providers screen for depression and the advent of antidepressant medications with fewer side effects, have increased the number of older adults receiving treatment for depression. However, the “expertise gap” (primary clinicians are unable to be experts in all areas) has been cited as the primary reason for older adults not receiving adequate treatment for depression (Bartels et al., 2002). Studies have shown that older adults whose primary care practitioners collaborate with a specialist, as opposed to simply consulting a specialist, such as a psychiatrist, psychologist, psychiatric clinical nurse specialist, or other mental health provider, are more adequately treated (Katon et al., 1995; Unutzer, 2002). Studies have shown that older adults whose primary care practitioners collaborate with a specialist, as opposed to simply consulting a specialist, such as a psychiatrist, psychologist, psychiatric clinical nurse specialist, or other mental health provider, are more adequately treated (Katon et al., 1995; Unutzer, 2002). This growing need for mental health specialists in primary care and medical specialties provides great opportunity for the registered nurse and advanced practice nurse who have developed expertise in treating persons, particularly older adults, with mental illness.

Studies have shown that it is cost-effective to have a depression care manager on an ongoing basis in primary care settings to help persons with depression receive the care they need. Wang and colleagues (2006) noted that “how service sectors share responsibility for people’s mental health is changing . . .” (p. 1187). One study found that hiring a care manager may initially be costly, but has been shown to be cost-effective in the long-term compared to usual care (Rost, Pyne, Dickinson, & LoSasso, 2005). This study by Rost et al. found that implementing depression case management resulted in an incremental cost-effective ratio ranging from $9,592 to $14,306 per quality-adjusted life-year. Furthermore, adding a depression care manager significantly decreases the number of days with depression. Collaborative models of care, such as Prevention of Suicide in the Primary Care Older Adults Collaborative Trial (PROSPECT), Improving Mood: Promoting Access to Collaborative Treatment for Late-Life Depression (IMPACT), and Healthy IDEAS: Identifying Depression, Empowering Activities for Seniors, have been effective by using specially trained nurses and other social service providers within primary care or aging service programs (Bruce & Pearson, 1999; Unutzer et al., 2002; Quijano et al., 2007). Important components of these models of care are screening persons for depression, patient education regarding the illness and treatment options and education regarding support services, collaboration with or referral to a mental health specialist in more severe cases, and ongoing supportive counseling or therapy that focuses on problem-solving therapy and behavioral activation. Similar models of care that use specially trained nurses to assess for depression, provide care management, liaison with primary care and mental health specialists, and train residential community staff to recognize depression have been shown to be effective in decreasing depressive symptoms among older adults in older adult residential communities (Blanchard, 1995; Llewellyn-Jones et al., 1999; Rabins et al., 2000). “Question, persuade, refer” is a gatekeeper training designed to train non–mental health professionals on how to prevent suicide by asking patients if they are thinking of harming themselves, persuading them to get help, and referring them to appropriate resources (Quinnett, 1995).

An important component of nursing care of older adults with depression that should not be
overlooked is the care of the primary caregiver of the depressed person. Caregivers, particularly those caring for a person with a mental illness, are themselves at risk for depression (Horton-Deutsch, Farran, Choi, & Fogg, 2002). Caregivers must be included in the treatment plan and assessed for symptoms of depression. The PLUS intervention, which provides education, assistance in identification, and strengthening of resources and supportive counseling for caregivers, was shown to benefit the depressed patient by improving their personal activities of daily living while decreasing the amount of time the caregiver spent in direct caregiving activities (Horton-Deutsch et al.). By decreasing caregiver burden, the nurse has taken steps to prevent disability in both the caregiver and the depressed older adult.

CASE EXAMPLE

Ms. Smith is a 79-year-old black woman. She has lived with her daughter since her husband died 3 years ago. She is a retired school teacher. During an office visit, her daughter says that for approximately 9 months her mother has not been herself. When Ms. Smith is asked how she is doing and why she is here today, she says “my daughter brought me. I am doing just fine—just getting old and don’t have the energy I once had.” Her daughter says she frequently misses church and would rather be waited on. Ms. Smith’s daughter says “My Mom was always busy doing something—she no longer even reads.” Ms. Smith denies feeling sad or down. When asked, she does say that she often feels nervous, more so in the morning when she wakes up. She reports waking up at night, worrying, with the inability to get back to sleep. She states, “There is a lot to worry about these days. I worry a lot about my grandchildren. My daughter works too hard. I feel sick and my knees are always hurting. No sense in going to my doctor, nothing he can do for me.” When asked, Ms. Smith says her appetite is fair and she has lost a few pounds recently. She denies feelings of worthlessness or thoughts of wanting to die, but does state she has lived a long life and sometimes thinks it would be best if she died in her sleep.

Ms. Smith scores a 9 on the PHQ-9 and a 2 on the PHQ-2 with a normal clock drawing test.

1. Ms. Smith has not been to her primary care provider for 6 months or more. What laboratory testing should she have done and why?

All of Ms. Smith’s laboratory work is normal.

2. What are the possible diagnoses for Ms. Smith? Discuss your rationale for choosing her diagnosis.

Ms. Smith’s family medical and psychiatric history reveals that Ms. Smith’s other daughter has been treated for depression with sertraline and has done very well since being treated.

3. Describe the specific strategies you would use for promoting Ms. Smith’s mental health. Describe the treatment plan and follow-up you would recommend.
REFERENCES


