CARE FOR ELDERS

Depression and Grief in the Older Adult

• Pre-reading •
Acknowledgments:

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For information on other modules please contact:

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Depression and Grief in the Older Adult:
(2003)

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Welcome to the Care for Elders Modules!

The Care for Elders modules have been written for and by interdisciplinary teams. These modules are unique in that they are interactive and participatory. The goal is for you to learn about elders and also about you – exploring your role and attitudes; other disciplines; your team and how to work as part of a team caring for elders.

The Care for Elders learning experience is comprised of two parts:

1) Pre-reading - this is a general comprehensive overview of one topic
2) A 2 to 3 hour small group session with case study discussion.

- To get the most out of this module it is strongly recommended that you read the pre-reading package. Information in the pre-reading is reviewed during the small group discussions.
- Small groups will consist of 6-10 participants from various disciplines, and a facilitator.
- The facilitators will not ‘teach’; rather your small group will discuss one fictional case using the information you possess, and the information you acquired from the pre-reading. The learning is accomplished if your team fully discusses the questions asked in the case study.
- The facilitator’s role is to guide discussion and ensure that all learning points are covered during the session. Your facilitator is NOT expected to provide information!

We hope that this experience will be a rewarding one for you!
Depression and Grief in the Older Adult  
Goals and Learning Objectives

At the end of the Depression and Grief in the Older Adult module, you will be able to:

🌟 Create a person centered care plan for Mrs. Lowmood.

1. discuss the key reasons that depression and grief are important to recognize in the older adult population,

2. determine the presence of risk factors for depression in Mrs. Lowmood,

3. assess Mrs. Lowmood for the presence of grief related symptoms and a depressive illness,

4. describe three assessment tools used to assess depression in older adults,

5. create a strategy for dealing with grief in Mrs. Lowmood, using the principles of grief counselling described by Worden,

6. identify other physical and psychiatric syndromes that can mimic the appearance of depression,

7. outline the experience of depression from the perspective of the older person,

8. involve Mrs. Lowmood and her family in all decisions regarding her care, and

9. plan follow-up for Mrs. Lowmood.
Psychiatric interview of the geriatric patient

### History
- **Symptoms**
  - Present episode including onset, duration, and change in symptoms over time
  - Past history of medical and psychiatric disorders
  - Family history of depression, alcohol abuse/dependence, psychoses, and suicide

### Physical Examination
- Evaluation of neurologic deficits, possible endocrine disorders, occult malignancy, cardiac dysfunction, and infections

### Mental Status Examination
- Disturbance of level of consciousness
- Disturbance of mood and affect
- Disturbance of motor behaviour and speech
- Disturbance of perception (hallucinations, illusions)
- Disturbance of thought (delusions)
- Disturbance of self-esteem and guilt
- Suicidal ideation
- Disturbance of cognition (memory, abstraction, calculation, aphasia, and knowledge)

### Assessment Tools (see appendix)
- Geriatric Depression Scale – short form 15 items (>5 probable depression, >10 very high chance of major depressive episode)
- Cornell Scale for Depression in Dementia (>10 probable, >18 very high chance of major depressive episode)

### Four Key Tasks of Grieving
- To accept the reality of the loss
- To work through the pain of grief
- To adjust to an environment in which the deceased is missing
- To emotionally relocate the deceased and move on with life

### Differences Between Grief and Depression

<table>
<thead>
<tr>
<th>Uncomplicated Grief</th>
<th>Abnormal Grief</th>
</tr>
</thead>
<tbody>
<tr>
<td>focus of attention or treatment is a normal reaction to the death of a loved one</td>
<td>morbid preoccupation with worthlessness</td>
</tr>
<tr>
<td>poor appetite</td>
<td>prolonged and marked functional impairment</td>
</tr>
<tr>
<td>weight loss</td>
<td>marked psychomotor retardation</td>
</tr>
<tr>
<td>insomnia</td>
<td></td>
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</tbody>
</table>
Recognizing Depression in the Older Adult – A Must!
Depression in the older adult is a common and debilitating illness. The following factors make depression in the older adult important to address:

- Major depression is a significant predictor of suicide in older adults. Many of those who commit suicide have recently visited a primary care physician: 20% on the same day, 40% within one week, and 70 percent within one month of the suicide.¹

- Functional decline secondary to depression necessitates a great deal of assistance from caregivers (both paid and unpaid) and in extreme cases may precipitate unnecessary placement into a care facility.

- Many depressed persons in this age group respond to treatment.

- Depressive symptoms may be a marker for an underlying pathophysiologic process that is not yet diagnosed.²

- The social stigma surrounding diagnosed depression is substantial and often prevents the optimal use of current knowledge and treatments. The burden of illness in terms of pain, suffering, disability, and death is high.³

Estimated Prevalence and Incidence Rates of Depression

- Up to 35% of residents in long term care and acute care facilities over the age of 65 suffer from depression.⁴

- Approximately 15 - 20% of community residents over 65 years of age experience depression.⁴

- Older adults are often inadequately assessed for depression. It is estimated that only one out of six depressed older adults will be appropriately diagnosed and treated.⁵

Recovery and Relapse Rate Trends
Recurrence of depression is high.
In the adult population, > 50% of those who have depression will suffer a recurrence after one episode. In older adults, the statistics are similar. The successful long-term treatment of depression rests on addressing both recovery from the initial episode of depression as well as preventing recurrence. The number of chronic illnesses and an external locus of control predict persistence of depression.

What is Depression?
- Depression exists on a continuum from experiencing the ‘blues’ to experiencing ‘major depression’. At points along the continuum, ‘depression’ has diagnostic categories including dysthymia (symptoms are less severe from day to day but persist for longer periods than in major depressions), bipolar mood disorder (where periods of mania are also experienced), organic mood disorder (where depression is caused by an organic problem), and major depression. A depressed mood that occurs in the context of a significant stressor is often referred to as Adjustment Disorder with Depressed Mood. It is less severe and usually self limited.
- Bereavement is the term used for depressed mood that occurs in the context of the death of a loved one. (See Grief)

Common Risk Factors for Depression
- Personal or family history of depressive disorder
- Prior suicide attempts
- Female gender
- Lack of social supports
- Stressful life events, particularly related to Losses (retirement, social role, significant others, health, independence, decline in cognition, alterations in self image)
- Current substance abuse
- Chronic medical illness

Key Symptoms of Depression
In the DSM-IV TR, diagnosis of major depression is based on identifying the following symptoms during a two week period:
1. A change from previous functioning,
2. Depressed mood or loss of interest or pleasure
3. At least four of the following: anorexia or significant weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished concentration, or recurrent thoughts of death.

The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. General medical conditions and/or the effects of substances have been ruled out in order to make the diagnosis of major affective disorder depression.

The “SIGECAPS” mnemonic has been used to identify symptoms of depression.

- **S**: sleep is disturbed
- **I**: interest is decreased
- **G**: guilt
- **E**: energy is lower
- **C**: concentration is poor and memory problems may appear
- **A**: appetite is disturbed, usually a loss of appetite
- **P**: psychomotor retardation or agitation (Agitation may be misconstrued as anxiety)
- **S**: suicidal ideation (or a passive wish to die)

**How Can Depression Present Differently in Older Adults?**

- Depressed older persons often do not report feelings of ‘sadness’. Rather, they present with loss of pleasure, irritability, social withdrawal, hypochondriasis, and somatic symptoms.

- Somatic symptoms of late life depression typically include insomnia, loss of appetite, and lack of energy. Memory loss may affect the ability of the client to describe changes. The level of medical burden in older adults makes it difficult to ascribe somatic symptoms only to depression. Chronic pain and bowel preoccupation can often be the presenting complaint of an older person’s depression.

- Older people with depression may present with cognitive impairment as their most prominent symptom. Complaints of memory problems and self neglect may be the result of depression rather than dementia, and it is important to distinguish between the two (see below). Older people with dementia may also develop depression. In the middle to late stages of dementia, behavioral disturbances are sometimes due to depression.

**Components of Assessment**

- Identify symptom complex, identify co-morbid medical conditions, assess suicide risk, establish a therapeutic alliance and consider treatments.
Medical conditions which may mimic depression
- Malignancies (Lung, Pancreatic, Hematologic etc.)
- Endocrine (Hypothyroidism, Cushing’s Syndrome, Diabetes etc)
- Metabolic (Conditions creating Hypoxia, Electrolyte Imbalance, Hepatic and Renal Failure, etc)
- Infection (Encephalitis, TB, AIDS)
- Neurologic (Parkinson’s Disease, Huntingdon’s Disease, Dementia)
- Vitamin Deficiency (B12 Deficiency, B12)
- Medications and Substance Abuse (Polypharmacy, Benzodiazepines, Beta Blockers, Steroids, Cimetidine, Barbiturates, Alcohol etc.)

- Major depression is rarely considered as a diagnosis in a bereaved person until at least 8 weeks after the loved one’s death.12

Ten Principles of Grief Counseling16
1. Help the survivor actualize the loss
2. Help the survivor to identify and express feelings including anger, guilt, anxiety and helplessness
3. Assist living without the deceased
4. Facilitate emotional relocation of the deceased
5. Provide time to grieve
6. Interpret “normal” behaviour
7. Allow for individual differences
8. Provide continuing support
9. Examine defenses and coping styles
10. Identify pathology and refer

Key Differences Between the Presentation of Depression and Dementia17

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Depression</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Relatively rapid progressing from weeks to months.</td>
<td>Usually insidious and gradual.</td>
</tr>
<tr>
<td>Course</td>
<td>Generally self-limiting, recurrent or chronic without treatment. Often has periods of improvement.</td>
<td>Usually slow and continuous decline.</td>
</tr>
<tr>
<td>Behaviour</td>
<td>May be apathetic, anxious, fatigued. Patient often complains more than family.</td>
<td>May be agitated, aggressive or apathetic. Wandering. Family more concerned than patient.</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Depression</td>
<td>Dementia</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>Insight</td>
<td>Person with depression complains a lot about symptoms</td>
<td>Person’s family is generally much more concerned than elder.</td>
</tr>
<tr>
<td>Sleep</td>
<td>Trouble falling asleep or early morning awakening. Either excess sleeping or insomnia. Complain of feeling tired despite sleep.</td>
<td>Normal early in illness. Later there are repeated wakenings and night time wandering.</td>
</tr>
<tr>
<td>Attention</td>
<td>Problems concentrating.</td>
<td>Generally intact initially. May focus on one idea for a long time.</td>
</tr>
<tr>
<td>Perception</td>
<td>Intact except for possible mood congruent hallucinations or delusions in severe depressive disorder.</td>
<td>Misperceives people and events as threatening. Paranoia re: lost objects common early in illness</td>
</tr>
<tr>
<td>History</td>
<td>Often has previous psychiatric history. Undiagnosed depressive episodes not uncommon.</td>
<td>First episode depression late in life may be prelude to dementia.</td>
</tr>
<tr>
<td>Mental Status</td>
<td>Able to follow directions although may refuse to do so. Frequently answers ‘I don’t know’ or ‘I don’t feel like it’ when asked to perform a task.</td>
<td>Worsens as disease progresses. Denial of memory problems. Frequent confabulation.</td>
</tr>
</tbody>
</table>

**Laboratory investigations**

<table>
<thead>
<tr>
<th>Test</th>
<th>To Rule Out</th>
</tr>
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<tbody>
<tr>
<td>Glucose</td>
<td>Diabetes</td>
</tr>
<tr>
<td>B12 and folate levels</td>
<td>Deficiencies</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid dysfunction</td>
</tr>
<tr>
<td>Electrolytes, Urea, Creatinine, Calcium</td>
<td>Metabolic disorders</td>
</tr>
<tr>
<td>CBC and Differential</td>
<td>Anemias, infection, cancer</td>
</tr>
<tr>
<td>ESR, ANA Titer, RF Titer (depends on sx)</td>
<td>Small blood vessel disease</td>
</tr>
<tr>
<td>VDRL</td>
<td>Neurosyphilis</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>Cardiac disorders</td>
</tr>
<tr>
<td>Chest x-ray (depends on sx)</td>
<td>Heart or lung disorders</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Infection, renal or systemic disease</td>
</tr>
<tr>
<td>CT Scan of Head (depends on sx)</td>
<td>Normal pressure hydrocephalus, tumor, strokes, atrophy, vascular changes</td>
</tr>
</tbody>
</table>
Contributions of Interdisciplinary Team Members
1. The difference between a team and a group is that the team has a common goal for its members to embrace. A true interdisciplinary team is one that requires each member of the team to understand, acknowledge, and address the contributions of its other members.
2. Communication and collaboration are identified as key features and attention to the process of decision making is just as important as the actual content of the decisions.
3. Further information regarding interdisciplinary team functioning can be found in “Interprofessional Team Work Module” – Care for Elders Project.

Care Interventions for Depression in Older Persons
Involvement of mental health professionals is appropriate when:
1. Unclear diagnosis
2. Management problem due to concomitant illness
3. High suicidal risk
4. Inadequate response to treatment

The treatment of depression in late life includes:
- Psychotherapy
- Pharmacotherapy
- ECT
- Psychoeducation and family support
- Social and functional support

1. Psychotherapy
   a) Cognitive-behavioural therapy:
      i) directive and time limited (usually requiring between 10 and 25 sessions)
      ii) goal: to change behaviour and modes of thinking
      iii) accomplished by: restructuring negative cognitions or automatic thoughts and generating new ways of viewing one’s life
   b) Brief dynamic psychotherapy
      i) stresses the importance of the patient-therapist relationship
      ii) emphasizes realistic collaborative aspects of the therapeutic alliance
      iii) studies have shown that 16-25 sessions are effective in older adults
   c) Interpersonal Therapy:

      The success of psychotherapy alone depends on the severity of the depression and the psychological mindedness/commitment of the elder. Studies demonstrate the combination of psychotherapy and pharmacotherapy is most helpful for moderate to severe depression in younger populations and clinically this appears to stand for elders also.

2. Pharmacotherapy
   In moderate to severe depression, pharmacotherapy is usually the mainstay of treatment. Placebo controlled studies have documented the effectiveness of antidepressant medication in treating depressive illness. At the same time, it is
recognized that the therapeutic effect of antidepressants is significantly increased through a strong therapeutic alliance and psychoeducation. Thus medication on its own is an inadequate approach to the treatment of depression.

Challenges of treating geriatric clients with medications:

i) Coexistence of medical illness that can complicate treatment
ii) There is a greater potential for drug-drug interactions due to the use of multiple medications and having multiple illnesses.
iii) Biological changes in older persons increase their sensitivities to medication usage
iv) Most psychotropic drugs are fat soluble and because there is an increase in total body fat in older people, the drugs stay in the body longer
v) Many drugs bind to protein in the blood. A decrease in these proteins will increase free drug concentrations and can increase the drug’s effect
vi) Kidney and liver function decrease normally with age and can affect the excretion and metabolism of drugs
viii) Altered pharmacokinetics result in higher concentration of psychotropic drugs at CNS receptor sites

For more information on the challenges of prescribing for older adults, refer to “Medications and the Older Adult Module” – Care for Elders Project

<table>
<thead>
<tr>
<th>Classification</th>
<th>Example of Medication</th>
<th>Dosing</th>
<th>Advantages</th>
<th>Disadvantages/ Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selective Serotonin-Reuptake Inhibitors (SSRI)</td>
<td>Paroxetine (Paxil)</td>
<td>10-40 mg. daily</td>
<td>Anxiolytic effect; once daily dosing; little</td>
<td>Gl upset; altered sodium levels; can</td>
</tr>
<tr>
<td></td>
<td>Sertraline (Zoloft)</td>
<td>25-200mg. daily</td>
<td>anticholinergic effect; low CVs effects</td>
<td>impair balance; Potential drug interactions -</td>
</tr>
<tr>
<td></td>
<td>Fluvoxamine (Luvox)</td>
<td>25-250 mg. daily</td>
<td></td>
<td>(Citalopram, Escitalapram, and Sertraline</td>
</tr>
<tr>
<td></td>
<td>Citalopram (Celexa)</td>
<td>10-40 mg. daily</td>
<td></td>
<td>least)</td>
</tr>
<tr>
<td></td>
<td>Escitalapram (cipralex)</td>
<td>10-30 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)</td>
<td>Venlafaxine XR (Effexor)</td>
<td>37.5-75 mg. qam (max 225mg daily)</td>
<td>Broad spectrum; effective in Parkinson’s with depression, anxiolytic</td>
<td>Anticholinergic effects; Increased BP with higher doses; occasional hypotension; Gl side effects</td>
</tr>
<tr>
<td>Reversible MAOI-A Inhibitor (RIMA)</td>
<td>Moclobemide (Manerix)</td>
<td>75-300 mg. bid</td>
<td>No food interactions, compared with the old MAOIs,</td>
<td>Nausea; agitation; insomnia</td>
</tr>
</tbody>
</table>
### Classification

| Non-Selective Cyclic Agents (Mixed Reuptake Inhibitor/Receptor Blocker) | Trazodone | 25-300 mg hs. | Trazodone used for hs. Sedation Decreases anxiety | Sedation, orthostatic hypotension, nausea, anticholinergic side effects, confusion |
| Norepinephrine Dopamine Reuptake Inhibitor (NDRI) | Bupropion SR (Wellbutrin) XL | 100-150 mg. bid Or 150-300 mg. qam | Fewer sexual side effects, nonsedating, no weight gain | Orthostatic hypotox or dizziness; Seizure risk |
| Secondary Tricyclic (TCA) antidepressants | Nortriptyline Desipramine | 10-50 mg. daily | Monitored with serum level; used for augmentation | anticholinergic side effects, orthostatic hypotension; CV side effects |
| Noradrenergic/Specific Antidepressants (NaSSA) | Mirtazapine (Remeron) | 15-45mg qhs | ?faster onset of antidepressant action, decreased sleep latency, anxiolytic | Sedation; hypotension; anticholinergic effects, weight gain and increased triglycerides |

- an adequate trial is therapeutic dose for at least 4-6 weeks
- refractory depression is generally described as 2 failed trials of meds and failed trial of augmentation strategies
- drug-drug interactions are key in the choice of an appropriate medication (those with the fewest drug drug interactions include: Citalopram, Sertraline, Venlafaxine, and Mirtazapine)

3. Electroconvulsive Therapy (ECT)
ECT is a treatment which occurs through the induction of generalized seizures, by means of an externally applied electric stimulus. Its main indication is for Major Depression especially when associated with a high suicide risk, refusal to eat & drink, psychosis, or nonresponse to pharmacotherapy. ECT has also been helpful for the treatment of catatonia, severe mania, and refractory delirium. The exact mechanism of action is unknown. ECT remains the most effective treatment for severe depression in that a substantial proportion of non-responders to antidepressants do recover with ECT. Its onset of action is often more rapid than with antidepressants.

Adverse Effects include:
Depression and Grief in the Older Adult - pre-reading

- Memory loss occurs to some degree during all courses of ECT usually related to time around the time of ECT.
- Memory impairment may persist 3-6 months – new learning not usually affected in the long term.
- Delirium uncommon in people without preexisting cognitive impairment.
- Tachycardia and hypertension may be pronounced lasting several minutes post-treatment.
- Mortality rate 2-4/100,000 treatments
- No absolute contraindications

4. Psychoeducation and family support
   a) Assess overall family atmosphere, family values regarding psychiatric disorders, and family support and tolerance of symptoms.
   b) With permission of client: family should be instructed as to:
      i. the nature of the depressive disorder
      ii. potential risks resulting from depression in late life
      iii. observing changes in behaviour
      iv. means by which they can communicate with the elderly depressed client
      v. methods of responding to expressions of low self-esteem and pessimism
      vi. behavioural techniques for dealing with depressed relatives who, because of their depression appear demanding or overly dependent.

5. Social and Functional Support
   It is increasingly recognized that older adults need comprehensive support in their community as part of their recovery. During periods of depression, the older adult often benefits from increased levels of support for self care, including homemaking, shopping, cooking, bathing etc. If these supports are not reviewed and increased, the older person will often decline despite the use of medications.

Follow-up and Maintenance Therapy
1. Combined pharmacotherapy and psychotherapy in maintenance treatment for late life depression is associated with better preservation in social adjustment than is the use of monotherapy.
2. Older adults with a moderate to severe first depression, require maintenance for roughly 2 years after resolution of symptoms. This is due to the high rate of occurrence of depression in older people.21
3. Some older adults with mild depression may remain well with monthly interpersonal psychotherapy and do not need antidepressant medication to prevent relapse and recurrence of major depressive episodes.22

Strategies to Create a Plan of Action
For a Master's Thesis completed in 1999, Unsworth23 interviewed older adults who had recovered from depression and their process of recovery described using grounded theory. Four phases identified in the process of recovery from depression included: 1) Spiraling Down, 2) Changing Direction, 3) Working the Way Out, and 4) Staying Out. One of the central themes of the phase 'working the way out' was the hard work.
required. Work included active involvement and active engagement, participation and support.

1. WORK: Older adults had to put a lot of energy into their recovery and because of the very nature of depression they didn’t have much energy to expend. The work of recovery consists of organizing and performing necessary tasks and actions that shape the recovery process. In addition to the daily struggle to manage depression and its symptoms, older adults must try to achieve a sense of control and normalcy in their lives. The work they do to pace activities, follow prescribed treatment, and carry on with their activities of daily living to maintain their household is often devalued, invisible, and unacknowledged by society. The invisibility of the work that individuals do and the extent to which it is not acknowledged or appreciated add to the burden of living with depression. Health Care Professionals often regard participation and involvement as cooperation rather than work.

2. INVOLVEMENT AND ACTIVE ENGAGEMENT: In the study, participants describe the relationships they developed with others and the value of encouragement and reciprocity in maintaining relationships. Having a confidant was valued, as was having people available who ‘care.’ Older adults followed doctors’ advice and accepted rather passively the care that was provided as they were too ill to do otherwise. However, this type of relationship did not last long. As they worked their way out of depression, they actively engaged in the recovery process. They no longer passively followed doctors’ orders without question. They described communicating with and guiding their physicians.

3. PARTICIPATION: Central to involvement and active engagement was the idea of participation which emphasized the establishment of reciprocal relationships. Van Ryn and Heaney said, “helping relationships based on social influence processes that reinforce or enhance client self-esteem, feelings of control, and sense of personal mastery are more likely to help clients achieve their behavioural and health-related goals”. These processes are consistent with many definitions of personal empowerment and therefore the degree to which helping relationships are effective is at least partially determined by the degree to which these relationships are empowering.

4. PARTICIPATORY CONTROL: Reid and Stirling presented a reconceptualization of control that they described as participatory control. The strategies of recovery are central to the concept of participatory control. One of the components of participatory control is the understanding and acceptance of people that there are others who have more expertise or resources to respond to a situation than has the person. Following this, the people must accept that they need to depend on others. This may be difficult because it requires an acknowledgement by the person that he or she is not able to act on his or her own. For this to occur, the person must feel a sense of trust that others will be acting in their best interest. One of the underlying dynamics is the understanding that by giving over such powers to others, the person is negotiating better control over their condition than would otherwise be achieved. With participatory control, the other becomes an agent of the person. By striking a
partnership with a more competent other, the person responds to the situation and takes control by doing something about the situation. Participatory control is of particular interest in understanding how health care professionals can work with older adults because it explains how older adults can “maintain the experience of being in control in situations where changes in health would otherwise erode the patient’s control.” 31 The experience of control is the perceived balance between the actual outcome of a response to stress, and the expected outcome of response to stress. When there is imbalance, there is potential for crisis. People want to know why the situation of depression arose because they may feel that if the cause of the crisis was determined, action could be taken to regain balance and regain a sense of control.

5. SUPPORT: Support from others was required to facilitate the work out of depression. Supports included services offered by programs, family, friends, community services, transportation, and health care professionals. Older adults in the study described relying on others (including health care providers) whom they believed had the expertise needed to help them. There was an element of trust involved as these older adults accepted the help offered. Having someone in whom to ‘confide’ was described as essential in regaining control. People described the development of their ability to regulate the balance between relying on internal strengths and external supports as they worked their way out of depression.
References:


20. Illing, M. Depression in Geriatric Clients. Paper presented at Geriatric Services: Building resources for the interdisciplinary team, Richmond, BC. 2003 (March)


Other References:


Conn D, Herman N, Kaye A, Rewilak D, Schogt B. Practical Psychiatry in the Long-Term Care Facility, Toronto: Hogefe & Huber Publishers. 2001


Date: ___________________200____

**GERIATRIC DEPRESSION SCALE (GDS)**

*Patient Name: ____________________________, ___________________________
  (Surname)     (Given Name)*

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

<table>
<thead>
<tr>
<th></th>
<th>Yes or No</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you basically satisfied with your life?</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. Have you dropped many of your activities and interests?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Do you feel that your life empty?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Do you often get bored?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. Are you in good spirits most of the time?</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6. Are you afraid that something bad is going to happen to you?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Do you feel happy most of the time?</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8. Do you often feel helpless?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Do you prefer to stay at home, rather than going out and doing new things?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Do you feel you have more problems with memory than most?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Do you think it is wonderful to be alive?</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>12. Do you feel pretty worthless the way you are now?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Do you feel full of energy?</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14. Do you feel that your situation is hopeless?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. Do you think that most people are better off than you are?</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*This is the Yesavage et al. short form - 1983/86

**Total Score __________**

Procedure: read the questions to the client, and record their responses. If appropriate, allow the client to complete the form on his/her own.

A score greater than 5 is suggestive of depression, however, full scoring information for the GDS is available at: [http://standford.edu/~yesavage/gds.english.long.html](http://standford.edu/~yesavage/gds.english.long.html)

Depression and Grief in the Older Adult
**Cornell Depression Scale For Depression in Dementia (CSDD)**

**Publisher:** Biological Psychiatry

**Copyright:** Elsevier Science

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PO Box 800
Oxford, OX5 1DX
United Kingdom

**Bibliography:**


**Population:** Patients with depression and/or dementia

**Rater:** Psychiatrist, psychologist, or other clinician

**Time to administer:** Approximately 30 minutes (interviews with both patient and informant)

**Description:** Although the initial ‘gold standard’ in outcome measures for treatment studies of depression has been the Hamilton Depression Rating Scale (HRSD, Ham-D), its applicability in patients with dementia is somewhat limited. It was developed for use in nondemented subjects, raising concerns about reliability of impaired cognition as well as overlap between the signs and symptoms of dementia and depression. The Cornell Scale for Depression in Dementia (CSDD) was developed specifically to assess signs and symptoms of major depression in dementia on the basis of a semistructured interview of a qualified informant. The 19 items were selected on the basis of a review of the existing literature regarding depressive signs and symptoms in patients with and without dementia, and were validated by a consensus among a panel of experts.

The CSDD evaluated a broad spectrum of depressive signs and symptoms and includes items from other depression scales, notably the HRSD. Information is derived from an interview of a caregiver as well as from direct observation and interview of the patient. Special attention has been given to assist the rater in making a distinction between features of cognitive dysfunction and features of depression. Inter-rater reliability and internal consistency are high in subjects with dementia (alpha=0.84, kappa=0.67) (Alexopoulos et al. *Biol Psychiatry*, 1988). Content, construct, and convergent and external validity have been demonstrated.¹

The CSDD requires approximately 20 minutes to administer and typically survey signs and symptoms during the prior week. The informant interview should be conducted first, during which preliminary ratings should be made; these rating should then be confirmed during the patient interview. The interviewer should ensure that the informant is considering change in function over the prior week. For example, loss of interest should not be mistaken for persistent apathy that has been present for months. When disagreements between the patient and informant data occur, it is best to re-
interview the informant for clarification. Each item is rated for severity on a scale of 0-2 (0=absent, 1=mild or intermittent, 2=severe). The item scores are added, and the total score is used for rating. Scores above 10 indicate probable major depressive episode, and scores above 18 indicate a definite major depressive episode. Items may also be divided into 5 subscales: mood-relates signs (eg. sadness, anxiety), behavioural disturbance (eg. agitation, retardation), physical signs (eg. weight loss), cyclic functions (eg. early morning awakening), and ideational disturbances (eg. pessimism).

Frequency and caregiver impact are not assessed. The CSDD has been applied to dementias of varying severity. Although there is a smaller body of evidence in the most severely impaired patients. The scale is generally regarded as an excellent tool for quantifying depression in patients with dementia, although its role in patients with severe dementia is unclear.

The CSDD has been used as an outcome measure in clinical trials, including one of selegiline and vitamin E.²

References:


CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Name_____________________________________  Date_________________

**Scoring System:**  
a = unable to evaluate   1 = mild or intermittent  
0 = absent   2 = severe  

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.

### 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, handwringing, hairpulling  
a 0 1 2

6. **Retardation**  
slow movements, 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 (score only if change occurred acutely, i.e., in less than 1 month)  
a 0 1 2

### 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**  
a 0 1 2

Depression and Grief in the Older Adult
fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)

### D. Cyclic Functions

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>12.</td>
<td>Diurnal variation of mood symptoms worse in the morning</td>
<td>a 0 1 2</td>
</tr>
<tr>
<td>13.</td>
<td>Difficulty falling asleep later than usual for this individual</td>
<td>a 0 1 2</td>
</tr>
<tr>
<td>14.</td>
<td>Multiple awakenings during sleep</td>
<td>a 0 1 2</td>
</tr>
<tr>
<td>15.</td>
<td>Early morning awakening earlier than usual for this individual</td>
<td>a 0 1 2</td>
</tr>
</tbody>
</table>

### E. Ideational Disturbance

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<table>
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</thead>
<tbody>
<tr>
<td>16.</td>
<td>Suicide feels life is not worth living, has suicidal wishes, or makes suicide attempt</td>
<td>a 0 1 2</td>
</tr>
<tr>
<td>17.</td>
<td>Poor self-esteem self-blame, self-depreciation, feelings of failure</td>
<td>a 0 1 2</td>
</tr>
<tr>
<td>18.</td>
<td>Pessimism anticipation of the worst</td>
<td>a 0 1 2</td>
</tr>
<tr>
<td>19.</td>
<td>Mood-congruent delusions delusions of poverty, illness, or loss</td>
<td>a 0 1 2</td>
</tr>
</tbody>
</table>

TOTAL: ""
**STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE)**

**NAME OF PATIENT**

**DATE**

### Directions for administration of the SMMSE:

1. **Before the questionnaire is administered, try to get the person to sit down facing you.** Assess the person’s ability to hear and understand very simple conversation, e.g. *What is your name?* If the person uses hearing or visual aids, provide these before starting.

2. **Introduce yourself and try to get the person’s confidence.** Before you begin, get the person’s permission to ask questions, e.g. *Would it be alright to ask you the same questions about your memory?* This helps to avoid catastrophic reactions.

3. **Ask each question a maximum of three times. If the subject does not respond, score 0.**

4. **If the person answers incorrectly, score 0. Accept that answer and do not ask the question again, hint, or provide any physical clues such as head shaking, etc.**

5. **The following equipment is required to administer the instrument:** A watch, a pencil, Page 3 of this SMMSE with CLOSE YOUR EYES written in large letters and two five-sided figures intersecting to make a four-sided figure, and Page 4, a blank piece of paper.

6. **If the person answers: What did you say?, do not explain or engage in conversation. Merely repeat the same directions a maximum of three times.**

7. **If the person interrupts (e.g. What is this for?), reply: *I will explain in a few minutes, when we are finished. Now if we could proceed please…we are almost finished.***

---

I am going to ask you some questions and give you some problems to solve. Please try to answer as best as you can.

<table>
<thead>
<tr>
<th>Question Type</th>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Time: 10 seconds for each reply</td>
<td>a) <em>What year is this?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>b) <em>What season is this?</em> (accept either: last week of the old season or first week of a new season)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>c) <em>What month is this?</em> (accept either: the first day of a new month or the last day of the previous month)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>d) <em>What is today’s date</em> (accept the previous or next date)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>e) <em>What day of the week is this?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Type</th>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Time: 10 seconds for each reply</td>
<td>a) <em>What country are we in?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>b) <em>What province are we in?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>c) <em>What city/town are we in?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>d) (In home) <em>What is the street address of this house?</em> (accept street name and house number or equivalent in rural areas)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>(In facility) <em>What is the name of this building?</em> (accept exact name of institution only)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>e) (In home) <em>What room are we in?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
<tr>
<td></td>
<td>(In facility) <em>What floor of the building are we on?</em> (accept exact answer only)</td>
<td>/1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Type</th>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Time: 20 seconds</td>
<td>Say: <em>I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.</em> (Say the following words slowly at approximately one-second intervals): Ball/Car/Man.</td>
<td>/3</td>
</tr>
</tbody>
</table>

For repeated use: Bell, jar, fan, Bill, tar, can; Bull bar, pan

*Please repeat the three items for me.* (Score one point for each correct reply on the first attempt.)

If the person did not repeat all three, repeat until they are learned or up to a maximum of five times (but only score first attempts).

---

Depression and Grief in the Older Adult
4. **Time: 30 seconds**
   
   Spell the word WORLD. (you may help the person to spell the word correctly) **Say:** Now spell it backwards please. If the subject cannot spell world even with assistance, score 0. Refer to Page 3 for scoring instructions.

   [Score: /5]

5. **Time: 10 seconds**
   
   **Say:** Now what were the three objects I asked you to remember?
   (score one point for each correct answer regardless of order)

   [Score: /3]

6. **Time: 10 seconds**
   
   **Show wristwatch: Ask:** What is this called?
   (score one point for correct response: accept ‘wristwatch’ or ‘watch’; do not accept ‘clock’ or ‘time’ etc.)

   [Score: /1]

7. **Time: 10 seconds**
   
   **Show pencil : Ask:** What is this called?
   (score one point for correct response: accept ‘pencil’ only; score 0 for pen.)

   [Score: /1]

8. **Time: 10 seconds**
   
   **Say:** I would like you to repeat a phrase after me: No ifs, ands or buts
   (score one point for correct repetition. Must be exact, e.g. no ifs or buts, score 0)

   [Score: /1]

9. **Time: 10 seconds**
   
   **Say:** Read the words on this page and then do what it says. Then, hand the person the sheet with CLOSE YOUR EYES on it. If the subject just reads and does not close eyes, you may repeat: Read the words on the this page and then do what it says, (a maximum of three times. Score one point only if the subject closes eyes. The subject does not have to read aloud)

   [Score: /1]

10. **Time: 30 seconds**
    
    **Hand** the person a pencil and paper (Page 3). **Say:** Write any complete sentence on that piece of paper.
    (score one point. The sentence must make sense. Ignore spelling errors)

    [Score: /1]

11. **Time: 1 minute maximum**
    
    **Place** design, eraser and pencil in front of the person. **Say:** Copy this design please. Allow multiple tries. Wait until the person is finished and hands it back. Score one point for a correctly copied diagram. The person must have drawn a four-sided figure between two five-sided figures.

    [Score: /1]

12. **Time: 30 seconds**
    
    **Ask** the person is he is right or left handed. Take a piece of paper, hold it up in front of the person and say: Take this paper in your right/left hand (whichever is non-dominant), fold the paper in half once with both hands and put the paper down on the floor. (score one point for each instruction executed correctly)

    - Takes paper in correct hand /1
    - Folds it in half /1
    - Puts it on the floor /1

    **Total Test Score** /30
    **Adjusted Score** /

Please note: This tool is provided for use in British Columbia with permission by Dr. D. William Molloy. This questionnaire should not be further modified or reproduced without written consent of Dr. D. William Molloy. Molloy DW, Alemayehu E, Roberts R. Reliability of a standardized Mini-Mental State Examination compared with traditional Mini-Mental State Examination. American Journal of Psychiatry, 1991;148(1):102-105.

Depression and Grief in the Older Adult
Scoring WORLD backwards (instructions for item #4)

Write the person’s response below the correct response.
Draw lines matching the same letters in the correct response and the response given.
These lines MUST NOT cross each other.
The person’s score is the maximum number of line that can be drawn without crossing any.

Examples:

- \[
\begin{array}{c|c|c|c|c|c}
D & L & R & O & W \\
D & L & R & O & W \\
\end{array}
\]
  = Score 5

- \[
\begin{array}{c|c|c|c|c|c}
D & L & R & O & W \\
L & O & W & R & O \\
\end{array}
\]
  = Score 3

- \[
\begin{array}{c|c|c|c|c|c}
D & L & R & O & W \\
L & R & R & W & O \\
\end{array}
\]
  = Score 3

- \[
\begin{array}{c|c|c|c|c|c}
D & L & R & O & W \\
D & R & W & O & D \\
\end{array}
\]
  = Score 3

- \[
\begin{array}{c|c|c|c|c|c}
D & L & R & O & W \\
L & \\
\end{array}
\]
  = Score 1

- \[
\begin{array}{c|c|c|c|c|c}
D & L & R & O & W \\
D & L & R & O & W \\
\end{array}
\]
  = ________

Fold along this line and show instructions to person

Item 9

Close your eyes

Depression and Grief in the Older Adult
The Gardener’s Grief

Part I

Mrs. Lowmood is an 82-year-old recently widowed German woman who now lives alone in the family home. She has two married daughters, Clara and Mary, who live with their respective families in the city which is about an hour’s drive from their mother.

Mrs. Lowmood and her family immigrated to Canada after WWII to have a “better life” and have lived in the same community until the present time. Neither she nor her husband spoke much about the past, except to say that they endured much hardship during the war years. Once in Canada, Mr. Lowmood worked his way up in the timber trade and Mrs. Lowmood ran an efficient household. The Lowmoods regularly attended the local Lutheran Church, and her daughters recall that their mother had one or two close friendships within that circle. Her greatest hobby has been her garden, which is well known and loved throughout the neighbourhood.

Mrs. Lowmood is a rather stoic woman who has a history of minimizing her health problems. When Mrs. Lowmood first experienced chest pains, she was working in her garden with her elder daughter, Clara, who had come for a visit. Her daughter recalled that her mother played down the pain and had to be convinced to visit the doctor.

About five years ago Mrs. Lowmood’s husband was diagnosed with Alzheimer’s type dementia. Honoring her husband’s wish to remain home as long as possible, she became his primary caregiver. As her husband became more dependent on her, she had less and less time to tend her garden as she liked and fewer friends came to visit. Marion, a social work case manager from the local health center, arranged for home support services to assist with Mr. Lowmood’s personal care. Marion also arranged for Mrs. Lowmood, three hours a week of respite care which she used to try to catch up on her sleep. Clara became more involved by visiting and helping with the care of her father on weekends.

As time went on, Clara noticed that Mrs. Lowmood became more negative about her life and began to complain more often about chest pains. Mrs. Lowmood had difficulty accepting the changes in her husband, as the dementia progressed. They had had a relationship built on mutual respect and had survived difficult life events together. Clara heard her mother sound impatient and reprimands her husband as his communication abilities deteriorated. Clara herself began to feel stressed by her added responsibilities. Her mother appeared to become more dependent on her help and Clara felt that her mother tried to make her feel guilty as a way to keep her daughter involved. Clara also resented her younger sister’s lack of involvement in her father’s care.

Eight months ago, Mrs. Lowmood could no longer take care of her husband at home and with Marion’s help she very reluctantly, and with a great deal of guilt, consented to his being placed in a long term care facility.
Mr. Lowmood died two months ago, having lived in the nursing home for 6 months. Mrs. Lowmood has had a difficult time adjusting to her husband’s loss. Clara convinces her mother to allow her to attend an appointment with her family physician, Dr. Kerring, who has known her for 25 years. Clara informs the health center where the doctor practices, that she will be attending and requests a longer appointment.

In preparation for the visit the physician reviews Mrs. Lowmood’s chart noting that she has:

1. Osteoporosis
2. Mild osteoarthritis
3. History of angina with recurrent chest pain
4. Hypertension that has been well controlled

She is currently taking the following medications which are reordered ever three months:

1. Hydrochlorothiazide 50 mg. OD
2. Atenolol 50 mg. OD
3. Nitroglycerin patch
4. Acetaminophen 500 mg. tid

The physician sees Mrs. Lowmood and Clara. Clara tells Dr. Kerring that her mother does not seem to be herself. She says that she has never seen her so sad, but does note that she is able to be cheered up substantially by visits and doing things she enjoys. She notes that her mother complains that she is not sleeping well.

He then interviews Mrs. Lowmood privately.

**Questions:**
1. What questions would Dr. Kerring use to distinguish between normal grief and depression?

2. What tests would assist to rule out physical causes of Mrs. Lowmoods symptoms?
**Care for Elders Module Evaluation**

<table>
<thead>
<tr>
<th>Module Title:</th>
<th>Date:</th>
<th>Location:</th>
</tr>
</thead>
</table>

Please rate the following statements (√):  

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organization, room, and timing of the session was adequate</td>
<td></td>
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<tr>
<td>2. The pre-reading package covered information that was new to me</td>
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<tr>
<td>3. The pre-reading package was well organized and easy to read</td>
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<tr>
<td>4. Today’s session DID improve my knowledge of interdisciplinary roles, responsibilities and team dynamics</td>
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<td>5. The facilitator was effective in keeping discussion moving forward</td>
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<td>6. The facilitator provided new, critical information as needed</td>
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<td>7. The case complexity or difficulty was appropriate for my level</td>
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<tr>
<td>8. The discussion in my group was helpful for my learning</td>
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</tbody>
</table>

1. Please name **two** changes in your own practice that you will implement as a result of what you learned today.

   1. ______________________________________________________________________________________________

   2. ______________________________________________________________________________________________

2. Please name **two** ways in which this session could be improved.

   1. ______________________________________________________________________________________________

   2. ______________________________________________________________________________________________

Please return evaluation forms to: Division of Community Geriatrics, Department of Family Practice, UBC  
c/o GPOT-CP5D, 855 West 12th Ave., Vancouver, B.C. V5Z 1M9

Depression and Grief in the Older Adult