

Practical approaches in treating depression

Alleviating the debilitating symptoms of depression in LTC

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Depression is a significant problem that often remains undetected in Canadian nursing homes (Ostybe, et al., 2005). Between 12% and 16% of older adults living in long-term care facilities have major depressive disorder, 50% may have a minor depressive disorder, and up to 70% may at one time experience depressed, sad, or blue mood (AMDA, 2003); and yet, as many as 20 out of 100 residents may not receive formal treatment interventions (Jones et al., 2003).

Prevalence

Depression is not a normal function of aging (Anderson, 2002). In fact, the incidence of depression is higher in a younger demographic. For example, the lifetime prevalence rate of major depression is higher in a younger demographic. For example, the lifetime prevalence rate of major depression in individuals over age 60 was 10.6%. This compares to 19.8% in individuals aged 30-44 years (Kesler et al., 2005), which is almost double that of their elderly counterparts.

The Canadian Task Force on Preventative Health Care (MacMillan, et al., 2005), the U.S. Preventative Services Task Force (U.S.P.S, T.F., 2002), the Registered Nurses Association of Ontario (RNAO, 2003), and the National Advisory Council on Aging (McCourt, et al., 2002) all recommend screening and treating for depression. Instruments such as the Geriatric Depression Scale (GDS) and the Minimum Data Set (MDS) are able to identify residents with depression (Koehler, et al., 2005).

Educational resources for assessing and treating psychiatric problems in long-term care facilities are available (Conn, et al., 2001). Further, treatment approaches such as supportive

psychotherapy, anti-depressants and, in some cases, electroconvulsive therapy (ECT) are considered appropriate for geriatric patients (Birrer and Vemuri, 2004).

Five Reminders

However, despite recognizing the reality that depression is prevalent among nursing home residents, that it is **not** a normal function of aging, and that professional groups have created a number of best practice guidelines to address the problem, practical responses to the issue remain elusive in the long-term care environment.

This article presents five brief reminders to help assess and alleviate the debilitating depression so many residents experience. These reminders, itemized in the box below, will be discussed at length.

Assessment and alleviation of depression (Five Reminders)

1. Document the presence of depression using the Diagnostic and Statistical Manual of Mental Disorders, the DSM-IV-TR (APA, 2000).
2. Question whether a physical cause or trigger is present.
3. Question whether an emotional cause or trigger is present.
4. Alleviate symptoms by listening actively, encouraging structured activities and monitoring responses to anti-depressant or electroconvulsive therapy.
5. Care for the care-giver must not be neglected.

1. Documenting the presence of depression

Document the presence of depression using the DSM-IV-TR criteria (APA, 2000). Confirm whether any of the following symptoms have been present for two or more weeks, and if they interfere with daily functioning:

- Depressed mood;
- Anhedonia (decreased attention to, and enjoyment from, previously pleasurable activities);
- Unintentional weight change of five percent or more in a month;
- Change in sleep pattern;
- Agitation and psychomotor retardation;
- Tiredness;
- Worthlessness or guilt inappropriate to the situation (possibly delusional);
- Difficulty thinking, focusing or making decisions;
- Hopelessness, helplessness and/or suicidal ideation.

It is important to note that depression in older adults can manifest differently than in other populations. Since a depressed mood may be difficult to determine, anhedonia is a critical consideration.

Denial

Often, residents will deny feelings of depression and emphasize somatic complaints and non-specific complaints instead. Cognitive difficulties may become apparent and behavioural changes, such as apathy and irritability, may be more accurate indications of depression.

Depression is frequently present in residents diagnosed with Alzheimer's disease. Early morning awakening, while normal for many older adults, is also a symptom of depression.

Alexopoulos (2004) emphasized that depression is markedly increased when elders are medically ill, that psychotic features, such as delusions, are often present and that suicide is a significant risk. Therefore, always ask about suicidal ideation.

2. Presence of a physical trigger

Question whether a physical cause or trigger is present. Although some people experience an endogenous (or metabolic) depression which occurs for no apparent reason, others may have depressive reaction in response to a particular health-related event. Question and confirm whether any of the following have occurred recently:

Changes in current health status:

Some conditions are more of a trigger for depression than others. Conditions such as strokes, certain types of cancer, myocardial infarction, diabetes, Parkinson's disease, early stage dementia and hormonal disorders such as hypothyroidism are examples of illnesses that may be related to depressive disorders. Any condition that produces chronic pain, disability, or dependence, can be depressogenic

Medications/substances causing symptoms of depression

- Certain antihypertensives
- Benzodiazepines
- Anti-neoplastics (interferons)
- Anti-inflammatories (corticosteroids)
- H2 antagonists
- Antibiotics
- Antipsychotics
- Alcohol

(Adopted from Tariot, 1996)

Changes in medication regime:

Corticosteroids or interferons often cause depressive symptoms as side effects; also, many other drugs can interact or react in unforeseen ways when taken together or singularly and which can cause symptoms of depressions. (See box above)

Changes in sensory abilities:

Loss of sight and hearing can isolate individuals from others and lead to withdrawal and decreased interactions.

Inadequate diet:

Deficiencies in foods rich in omega 3 fatty acids, in folate and the B vitamins can precipitate depressive symptoms. Omega-3 fatty acids are present in fish and fish oil supplements; folate is present in leafy green vegetables and citrus fruits. The B vitamins – perhaps most importantly, vitamin B12 – are present in liver, other meats, dairy products and eggs.

Since older adults have difficulty absorbing B12 through digestion, regular B12 injections may be necessary; and, since symptoms of dehydration can be similar to those of depression, fluid intake must also be adequate.

Limited exposure to sunlight:

Winter months and extended periods of cloudy, rainy weather can cause some individuals to experience seasonal affective

disorder (or SAD). Limited opportunities to spend time outdoors, or even beside windows during the daylight hours, can lead to minor depressive episodes due to the lack of sunshine.

Limited exercise:

Although mobility is clearly an issue for many residents, lack of exercise depletes the body of endorphins, a brain chemical that reduces pain and stimulates a sense of well-being. Other anti-depression benefits can accrue from exercise.

3. Emotional triggers

Question whether an emotional cause or trigger is present. Loss, loneliness and feelings of abandonment can seem more pronounced at certain times. Death or other traumatic events are clear and easily understood examples. Anniversaries of the death of a loved one or other significant occasion can spark a depressive episode. Holidays, a missed visit from a family member, learning of bad news, experiencing any deprivation and even reminiscing about missed opportunities in one's past life can heighten feelings of sadness as well.

Dysthymia

For individuals who suffer with dysthymia, where the depression is more chronic than acute, low self-esteem and hopelessness can appear more debilitating during the daytime. Knowing that this depressing condition can improve markedly during the evening hours, having limited opportunities to socialize and engage in meaningful activities during this time can give rise to inexorable dejection.

For individuals suffering anxiety-related depression, difficulty falling asleep can be troubling. Feelings of worry can seem disproportionate to the perceived cause. Crying may be either prolonged or strikingly absent.

4. Alleviating the symptoms

Alleviate symptoms of depression by listening actively, encouraging structured activities and monitoring responses from anti-depressant or electroconvulsive therapy. When residents do express feelings of sadness or worry, having someone listen and validate feelings is appreciated.

While a natural response to an individual expressing negative emotions may be to offer solutions, advice and good cheer, simply listening actively can offer invaluable comfort. The opportunity to talk and vent feelings without being cut off is

affirming. Reflecting back what has been stated acknowledges the hurt and difficulties being experienced by the resident.

Structured activities promote a sense of self worth and adequacy. Setting small attainable goals for residents prone to depression, such as just spending short periods of time in an activity, rather than not attending at all, can support immediate successes. Providing opportunities for residents themselves to maintain control over their daily activities strengthens their ability for self-coping with depression.

If anti-depressant medications have been prescribed, tracking the start-dates and individual responses is crucial. Given that the therapeutic effect of most anti-depressants can be expected around two or three weeks, or longer, after the first dose, this time period is significant.

Award-winning research established link between depression in the elderly and poor blood flow

Beyond a certain point of plaque accumulation in the arteries (atherosclerosis), the flow of blood in the body is restricted and may cause a number of forms of physical decline. Atherosclerosis, and other forms of vascular disease, also increase the risk for depression in the elderly, according to a study by psychologist Benjamin Mast, of the University of Louisville.

Using data from the National Institute on Aging, Mast investigated over 2,100 elderly subjects aged 70 to 79 - with no evidence of depression. They were followed for a couple of years to see if some of them who had vascular disease or related risk factors demonstrated a higher risk for depression.

He found that vascular disease was associated with a 50% to 90% increased risk of depression after three years.

Mast pointed out that the link between vascular disease and depression has broad implications for caregivers and researchers: "There is some suggestion that older adults who have depression are at greater risk for developing dementia syndromes - for example Alzheimer's disease and vascular dementia."

Mast presented his findings at the annual (spring, 2005) meeting of the American Geriatrics Society, where he received the Society's New Investigator Award in recognition of his studies in vascular-depression research.

"Feeling better" – be wary

Paradoxically, when an individual resident's mood begins to lift in response to anti-depressant therapy, they are most in

danger of acting on suicidal ideation. In other words, "feeling better" can actually give residents the energy they need to act on their feelings of wanting to die. Thus, observing vigilantly for behaviours, such as hoarding pills once medications have been initiated, is critical.

If electro-convulsive therapy has been prescribed, re-orienting the resident is helpful when short term memory loss, one of the side effects, occurs. Frequently, forgetting recent events is experienced in the hours immediately following treatment. Thus, prompts and cues are appreciated during these times.

5. Care for the care-giver

Care for the care-giver must not be neglected. Supporting residents through their bouts with depression can lead to compassion fatigue and burn-out for staff and family members.

Might any of the DSM-IV TR criteria be present with members of the health care team?

Could the stigma of depression prevent employees from reaching out for help?

Are services readily available for care-givers who need counseling?

Do family members have respite and relief?

When the physical and emotional triggers that can cause depression emerge for care-givers, is there support for creating strategies to cope with these personal feelings of depression?

Is adequate time away from the facility available so care-givers can experience a sense of renewal?

Balancing efforts to ease depression in long-term care residents, and still maintain self-care is not easy. However, implicit within the process of assessing and alleviating depression in others is the reminder that effective caregivers must also look after their own physical and mental health.

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The most important message

"Behavioural interventions decrease depressive symptoms in patients with mild-to-moderate dementia. For clinicians/caregivers treating or caring for patients with dementia, the most important message is to routinely assess for depression and treat it, because successful treatment can improve many dementia-related outcomes."

(From: Boustani, M. and Watson, L., *The interface of depression and dementia*, *Psychiatric Times*; 21(3); March, 2004).

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