

Determining Depression in the Elderly

Depression in older adults not only causes distress and suffering but also leads to impairments in physical, mental, and social functioning. Depression often goes undiagnosed and untreated. One of the problems in trying to diagnose depression in older adults is that it is hard to disentangle it from the many other disorders that affect older people, and its symptom profile is somewhat different from that in other adults.

Depression can and frequently does amplify physical symptoms, distracting the resident's and staffs attention from the underlying depression. Depressive symptoms are far more common than full fledged major depression. According to a 1991 study by the National Institute of Health thirty to forty percent of older adults in primary care settings (nursing facilities included) suffer from depressive symptoms. In the elderly, the signs and symptoms of depression are frequently attributed to "normal aging," atherosclerosis, Alzheimer's disease, or any of a host of other age associated afflictions. Older adults are less likely to report symptoms of restlessness, malaise, hopelessness and worthlessness, which are often considered hallmarks of the diagnosis of depression.

The most serious consequence of depression in later life especially untreated or inadequately treated depression, is the increased mortality from either suicide or a somatic illness. In nursing facility residents, major depression increases the likelihood of mortality by 59 percent, independent of health measures.

Since underdiagnosis and undertreatment represents a serious public health problem this best practice will focus on educating all staff license and non-licensed on what are signs of depression in older adults. It is recommended to develop a standard of practice for assessing for signs of depression. An example would be to assess residents at the time of admission to the facility, quarterly, annually, when a significant change in status occurs and, as needed based on observation. This information will also assist the facility in accurately completing the MDS.

It is also important not to say someone is depressed when they are not and many times residents are classified via the MDS as being depressed when they are not. One example is a resident may facially appear sad when in actuality they are not, but due to loss of facial muscle they appear to have a sad affect.

The MDS is a screening tool and does not diagnose depression, but alerts the clinician to possible symptoms of depression, which requires further investigation. It is important to recognize the signs of depression through accurately assessing the nursing facility resident. This involves not only observing but also interacting verbally with the resident.

Screening For Depression in Older Adults

- Change in appetite and weight (increased or decreased "when not dieting")
- Disturbed sleep (change in sleeping pattern, example: excessive sleeping)
- Fatigue and loss of energy
- Motor agitation or retardation (restlessness)
- Loss of interest or pleasure in usual activities
- Feelings of worthlessness, self-reproach, excessive guilt
- Depressed or irritable mood
- Difficulty with thinking or concentrating (memory loss, dementia like behaviors)
- Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide gestures or thoughts

NOTE: If four of the above are checked, then according to the American Psychiatric Assoc. Diagnostic and Statistical Manual (DSM-IV) the resident has a Major Depressive Disorder. Reports all results to attending physician.

Other Signs of Depression Specific to Older Adults

- Passive suicidal behavior, such as self neglect, passively refusing meds or food, refusing medical care
- Refusal to make decisions, even if in their best interest
- Hints of their ideas about wishing to die but minimizing them when questioned about it
- Noticeable change in ADL's, i.e., bathing, grooming and dressing
- Lack of interest in activities they previously enjoyed or found pleasurable
- Excessive concern with bodily functions, which could be delusional, i.e., overly concerned with elimination, headaches, low back pain, stomach pain, or disability
- Irritability, low frustration tolerance or suspiciousness
- A change in sleep, patterns, i.e., difficulty falling asleep, staying asleep or premature awakening
- Anxiety, agitation and or excessive crying
- Isolative, withdrawn behavior or staying in bed for long periods
- Fearful/overwhelmed by social occasions or usual activities
- Tendency to ruminate about current and past events; regrets
- Attention-seeking for reassurance and support, unable to do what they normally can manage independently

Resident Name: _____ Room #: _____

Physician's Name: _____