University of North Dakota

UND Scholarly Commons

Theses and Dissertations

Theses, Dissertations, and Senior Projects

5-2008

Depression in the Elderly

Jan R. Lynch

How does access to this work benefit you? Let us know!

Follow this and additional works at: https://commons.und.edu/theses

Recommended Citation

Lynch, Jan R., "Depression in the Elderly" (2008). *Theses and Dissertations*. 4986.
https://commons.und.edu/theses/4986

This Independent Study is brought to you for free and open access by the Theses, Dissertations, and Senior Projects at UND Scholarly Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of UND Scholarly Commons. For more information, please contact und.commons@library.und.edu.

SP.COL.
T2008
L9874

Depression in the Elderly

Jan R. Lynch

An Educational Project

Submitted in partial fulfillment of the requirements

for the degree of

Master of Science in Nursing

Education Specialization

University of North Dakota

May 2008

TABLE OF CONTENTS

ABSTRACT 3
INTRODUCTION 4
PURPOSE AND RATIONALE 6
THEORETICAL FRAMEWORK 7
DEFINITIONS 10
REVIEW OF LITERATURE 12
PROCEDURE 30
SUMMARY 31
IMPLICATIONS FOR NURSING 35
RECOMMENDATIONS 36
APPENDIX A: GERIATRIC DEPRESSION SCALE 37
APPENDIX B: CORNELL SCALE 39
APPENDIX C: PRE AND POST TESTS 40
APPENDIX D: POWER POINT PRESENTATION 45
REFERENCES 46

Abstract

Who does depression hurt? The slogan from an advertisement on television described depression in a most effective way. Depression not only hurts a person as a whole, it affects those around him as well. Co-workers, friends, spouses and children all suffer from this prevalent disease, although it may be a loved one with the actual diagnosis. This project explored current literature for treatment and care of elderly persons with depression as well as educated the staff, residents, and families of one long term care facility in an attempt to increase quality of life for those residents.

Introduction

Depression and Anxiety in the Long-Term Care Resident

Depression is defined as a condition of general emotional dejection and withdrawal; sadness greater and more prolonged than that warranted by any objective reason (Dictionary.com; 2007). Some key signs and symptoms of depression include:

*Sadness, tearfulness

*Anhedonia (inability to experience pleasure)

*Unexplained loss of interests

*Social withdrawal

*Rapid decline in functioning unexplained by physical illness

*Appetite, weight loss unexplained by physical illness

*Irritability, pessimism, self-critical attitude

*Persistent passive (or active) suicidal ideation

Anxiety may occur as a secondary symptom to depression. Some key signs and symptoms of anxiety include:

*Restlessness, fearfulness, worries

*Sense of apprehension, dread; feeling that "something bad is going to happen"

*Physical symptoms unexplained by medical condition (i.e., shortness of breath; palpitations; queasiness; dizziness; lightheadedness)

*Excessive need for contact, reassurance, one-to-one attention

(Santulli & Daiello, 2007)

Depression affects people of all ages and race. No one is immune, but the disease is more prevalent in long-term care facilities than those elders in the community. The source cites 46.2%

of all nursing home residents have at least some degree of depression, and 39.6% have at least one degree of anxiety. (Santulli & Daiello, 2007). Why does this occur? The answer is not clear. Several reasons come to mind. A person who has entered a long-term care facility has had to endure several losses. First, their spouse and most of their friends may be deceased, leaving them feeling isolated and very much alone. Second, they have slowly lost physical (and some mental) functioning due to disease and aging thus leading to the third cause, loss of independence. Finally, they have lost their homes and many of their belongings. They have had to give them away or sell them to move to a place with much less room and possibly a roommate they have never met. Their meal times become structured as do their activities and socializing. Life as the resident once knew it no longer exists and he begins to think all hope is lost. These depressed individuals can exhibit the signs and symptoms listed previously, plus they are more likely to die within the first year following admission. Although suicide is rare, it does occur in the Long-Term Care setting. (Santulli & Daiello, 2007).

Depression is misunderstood in the general population as a whole. Many believe depression is part of the normal aging process, when really it is a treatable source of suffering and disability. Others believe depression is a weakness. The affected person may be miserable, but will try and hide his true feelings because he is ashamed. Depression goes unrecognized because in the elderly, grieving, dementia, or some other physical symptom can mask the symptoms of depression. Often those who are depressed themselves don't even recognize their own symptoms (Understanding Geriatric Depression, 2000).

Purpose and Rationale

This project focused on depression in the elderly, although no age group is immune. The goal of the project was to educate staff, residents and families of residents in one long-term care facility on the effects of depression, recognizing, and treating the disease in an attempt to increase the quality of life of those affected individuals.

Theoretical Framework

Sister Callista Roy's Adaptation Model was chosen for the theoretical/conceptual framework for this project. This theory views humans as biopsychosocial adaptive systems who use adaptation to cope with environmental changes. It recognizes four subsystems within the whole human system: physiologic needs, self-concept, role function, and interdependence. Nursing's role is to intervene and promote client adaptation through regulating internal and external stimuli (Polit & Beck, 2004).

Roy's Adaptation Model made several assumptions based on science and philosophy. The scientific assumptions included:

- Systems of matter and energy progress to higher levels of complex self-organization
- Consciousness and meaning are constitutive of person and environment integration
- Awareness of self and environment is rooted in thinking and feeling
- Humans by their decisions are accountable for the integration of creative processes
- Thinking and feeling mediate human action
- System relationships include acceptance, protection, and fostering of interdependence
- Persons and the earth have common patterns and integral relationships
- Persons and environment transformations are created in human consciousness
- Integration of human and environment meanings results in adaptation

The philosophical assumptions included:

- Persons have mutual relationships with the world and God
- Human meaning is rooted in an omega point convergence of the universe
- God is intimately revealed in the diversity of creation and is the common destiny of creation
- Persons use human creative abilities of awareness, enlightenment, and faith
- Persons are accountable for the processes of deriving, sustaining, and transforming the universe (Meyers, 2007).

Roy's Model has four adaptive modes which are described below:

1. Physiologic-physical

   Individual: Five needs-oxygenation, nutrition, elimination, activity and rest, protection. Four complex processes-senses; fluid, electrolyte, and acid-base balance; neurologic function; endocrine function.

   Group: Operating resources: participants, capacities, physical facilities, and fiscal resources.

2. Self-concept-group identity

   Individual: Need is psychic and spiritual integrity so that one can be or exist with a sense of unity, meaning, and purposefulness in the universe.

   Group: Need is group identity integrity through shared relations, goals, values, and co responsibility for goal achievement; implies

honest, soundness, and completeness of identifications with the group.

3. Role function

   Individual: Need is social integrity; knowing who one is in relation to others so one can account; role set is the complex of positions individual holds; involves role development, instrumental and expressive behaviors, and role taking process.

   Group: Need is role clarity, understanding and committing to fulfill expected tasks so group can achieve common goals; process of integrating roles in managing different roles and their expectations; complementary roles are regulated.

4. Interdependence

   Individual: Need is to achieve relational integrity using process of affectional adequacy, i.e., the giving and receiving of love, respect, and value through effective relations and communication.

   Group: Need is to achieve relational integrity using processes of developmental and resource adequacy, i.e., learning and maturing in relationships and achieving needs for food, shelter, health, and security through independence with others (Meyers, 2007).

As mentioned earlier, the role of nursing is to regulate stimuli. Roy's theory is comprised of three classes of stimuli: focal stimuli, contextual stimuli, and residual stimuli (Tomey & Alligood, 2002, p. 270). By manipulating or maintaining the stimuli, a nurse is able to promote a positive response from the client, thus accomplishing adaptation.

Definitions

1. *System:* a set of parts connected to function as a whole for some purpose and that does so by virtue of the interdependence of its parts. Systems also have inputs, outputs, and control and feedback processes (Tomey & Alligood, 2002, p. 271).
2. *Adaptation:* the process and outcome whereby thinking and feeling persons as individuals or in groups, use conscious awareness and choice to create human and environmental integration (Tomey & Alligood, 2002, p 274).
3. *Nursing:* a health care profession that focuses on human life processes and patterns and emphasizes promotion of health for individuals, families, groups, and society as a whole. Nursing acts to enhance the interaction of the person with the environment—to promote adaptation (Tomey & Alligood, 2002, p. 274).
4. *Health:* is a state and a process of being and becoming integrated and a whole person. It is a reflection of adaptation, that is, the interaction of the person and the environment. Health is not freedom from the inevitability of death, disease, unhappiness, and stress, but the ability to cope with them in a competent way (Tomey & Alligood, 2002, p. 275-276).
5. *Environment:* all the conditions, circumstances, and influences surrounding and affecting the development and behavior of persons or groups, with particular consideration of the mutuality of person and earth resources that includes focal, contextual, and residual stimuli. It is the changing environment that stimulates the person to make adaptive responses (Tomey & Alligood, 2002, p. 276).
6. *Focal Stimulus:* the internal or external stimulus most immediately confronting the human system (Tomey & Alligood, 2002, p. 272).

7. *Contextual Stimulus:* all other stimuli present in the situation that contribute to the effect of focal stimulus. The environmental factors that present to the person from within or without but which are not the centers of the person's attention and/or energy (Tomey & Alligood, 2002, p. 272).
8. *Residual Stimulus:* environmental factors within or without the human system with effects in the current situation that are unclear (Tomey & Alligood, 2002, p. 272).
9. *Coping Processes:* are innate or acquired ways of interacting with the changing environment (Tomey & Alligood, 2002, p. 272).
10. *Ineffective Responses:* those that do not contribute to integrity in terms of the goals of the human system (Tomey & Alligood, 2002, p. 272).
11. *Older Adult:* a person over age 65 (Hindman, 2006, p. 2).

Review of Literature

"Each year, about 19 million American adults – or 9.5 percent of the population – struggle with depression. (Major Depressive Disorder) is a recurring and chronic illness, frequently returning for two or more episodes, each usually lasting two years or more. Depression is the fourth-most disabling illness worldwide and cost the United States an estimated $83 billion in the year 2000" (UT Southwestern Leads Largest Study on Treatment for Depression, 2006, p. 2). Persons over age 85 reported the most cases of depression partially because they had fewer opportunities for social participation (UT Southwestern…, p17). One source cites twenty percent of residents in nursing homes have depression (Williams, 2006), where a second source cites as many as 50% meet the diagnostic criteria (Ellen, 2001).

Regardless of the staggering statistics, depression remains under diagnosed and under treated in primary care settings. Many elderly can be suffering miserably from depression at home, but are reluctant to bring it up to the physician based on a generational stigma about mental illness. They may also be worried that they have Alzheimer's disease and will be placed in an institution if they bring up psychological concerns (Ellen, 2001). Older patients seldom complain of depressed mood. They are more likely to have somatic complaints (Harper & Johnston, 2007, p1).

Depression is a biological condition. Neurotransmitters in our brains, such as serotonin and norepinephrine, send messages between brain and body. When these brain chemicals get out of balance, depression can emerge. Several factors can cause the imbalance. They are:

a. Medications—beta-blockers, methyldopa, thiazide diuretics, cimetadine, ranitidine, benzodiazepines, anti-cancer drugs and hormones.

b. Alçoholism

c. Chronic conditions—stroke, Parkinson's Disease, diabetes, cancer, cardiovascular diseases and pain

d. Personal loss and death of loved ones

e. Cascade of life changes

f. Social isolation (Understanding Geriatric Depression, 2000).

Suicide

In the United States in 2002:

- Older adults made up 12.3% of the population and accounted for almost 17.5% of all suicides.
- 85% of older adult suicides were male; the number of male suicides in late life was 5.5 times greater than the number of female suicides.
- Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate.
    a. For all ages combined, there is an estimated 1 suicide for every 25 attempts.
    b. Among the young (15-24 years) there is an estimated 1 suicide for every 100-200 attempts.
    c. Over the age of 65, there is 1 estimated suicide for every 4 attempts (Hindman, 2006, p2).

Of utmost importance for health care providers, family and friends to remember is that depression is not a normal part of aging. Of the percentage of people who die by suicide, 90-95% has a diagnosable mental illness, predominately depression. Several possible warning signs can be identified:

- Depressed mood
- Loss of interest in things previously enjoyable
- A marked noticeable change in a person's behavior like lack of attention to grooming
- Breaking medical regimens (not taking prescription medications)
- Stock-piling medications or buying a gun
- Social isolation
- Saying good-byes
- Talking about suicide
- Statements like: "I'm going to go away" or "You won't have to worry about me anymore."
- Reckless behavior like increased substance use (Hindman, 2006, p6).

Older adults who had attempted suicide named two reasons that gave way to a feeling of depression and hopelessness; inadequate finances and social isolation. Other concerns included the recent death of a loved one and physical illness with chronic, uncontrollable pain (Hindman, 2006, p. 7).

Certain antidepressants have been associated with an increased suicidal risk in some patients, especially children. A black-box warning by the Food and Drug Administration is required for suicide risk in children, but not for adults. The only selective serotonin reuptake inhibitor (SSRI) in the USA that is licensed for use in children is Prozac. All others are banned until efficacy and safety are proven (Wikipedia.org, SSRI, p.8).

Treatment Options

Recognizing depression

Depression is often thought of as sadness or a low mood, but it really is more than that low feeling we have all experienced at one time or another. Depression is losing interest in things or people that are important to us; it is the darkest of moods, emptiness. It is a disorder of the whole body, mind, and soul (Understanding Geriatric Depression, 2000). The elderly have many other conditions and changes occurring that can make recognizing depression very difficult. Elderly persons often exhibit somatic complaints such as headaches and stomach pain or lethargy and irritability rather than looking sad (Understanding Geriatric Depression, 2000).

Using an evidenced based depression scale is one way of screening for depression. One common scale is the Geriatric Depression Scale. This scale offers a short form series of five questions. If the resident scores high enough it triggers a longer more detailed, fifteen question screen. The screen is helpful to determine at-risk residents. At the long term care facility where I am employed, it is performed on admission to the facility and then routinely at set intervals determined by the interdisciplinary team. Another scale used in this setting is the Cornell Scale, which is approved for residents that are cognitively impaired. (Appendix A and B).

Interventions

In the long term care setting, some multidisciplinary interventions include:

a. Providing activities that are of interest to the resident. Thinking creatively and trying to find out what the resident enjoyed to do for hobbies prior to moving in to the facility is more desirable than designing certain activities and having the residents conform to them.

b. Providing food choices with an enjoyable dining experience along with offering compatible tablemates and seating.

c. Addressing concerns in a timely manner, visiting frequently, providing educational information to residents and their families, offering support groups and providing ministry services.

d. Providing a clean, odor-free, "home-like" setting.

e. Reviewing medications, assessing for other medical problems, ie. pain, sleeplessness.

f. Watchful waiting; medical evaluation; psych services, anti-depressant therapy.

g. Suicidal Ideation: immediate request for referral to psych services.

(St. Luke's Home Depression Policy, 2006).

Pharmacological

Studies are showing increasing promise for major depressive disorder when treated with selective serotonin reuptake inhibitors (SSRI's) (UT Southwestern, 2006). Other major classes of antidepressants include tricyclics and monoamine oxidase inhibitors (MAOI's). Recommendations suggest lengthening the time of use (at least 9 weeks) in older adults before determining efficacy. Reviewing side effects, pharmacokinetics, previous responses to medications and cost should all be taken in to account when choosing an antidepressant for an individual (Harper & Johnston, 2007, p.3).

1. <u>Selective Serotonin reuptake inhibitors (SSRI's):</u> Is a class of antidepressants used to treat clinical depression, anxiety disorders (social anxiety, panic disorders, obsessive-compulsive disorder, eating disorders and chronic pain. They are also sometimes used to treat irritable bowel syndrome (IBS) and are effective in treating some sexual

dysfunctions. The mechanism of action includes inhibiting the uptake of the neurotransmitter serotonin into the presynaptic cell thus increasing the amount of serotonin available to bind to the postsynaptic receptor. Depression may be linked to a lack of stimulation of the recipient neuron at the synapse according to some theories. When SSRI's inhibit the reuptake of serotonin, the recipient cell is stimulated. This causes a delay in the amount of time serotonin remains in the synaptic gap, thus allowing the receptors of the recipient cell to recognize the serotonin again and again, stimulating it. Several weeks of continuous SSRI use are of utmost importance for full efficacy as the neurophysiologic adaptations of the brain tissue are very slow to proceed. Drugs in this class include:

- Citalopram (*Celexa, Cipramil, Emocal, Sepram, Seropram*)
- Escitalopram oxalate (*Lexapro, Cipralex, Esertia)*
- Fluoxetine (*Prozac, Fontex, Seromex, Seronil, Sarafem, Fluctin (EUR)*
- Fluvoxamine maleate (*Luvox, Faverin)*
- Paroxetine (*Paxil, Seroxat, Aropax, Deroxat, Rexetin, Xetanor, Paroxat)*
- Sertraline (*Zoloft, Lustral, Serlain)*
- Dapoxetine (no known trade name)

(Wikipedia.org, SSRI, 2007, p. 2)

SSRI's are contraindicated with monoamine oxidase inhibitors (MAOI's), Demerol, Dextromethorphan (cough medicine), Ecstasy and LSD (acid). Increased serotonin levels can occur possibly causing a *serotonin syndrome* (Wikipedia.org, SSRI, 2007). Serotonin syndrome is a deadly drug reaction that can happen when the body has too much serotonin. The onset of serotonin syndrome usually occurs when the medication

is first started or with an increase in medication. Symptoms can include restlessness, hallucinations, loss of coordination, tachycardia, rapid blood pressure changes, fever, overactive reflexes, nausea, vomiting and diarrhea. Other signs for health care professionals to look for are: agitation, uncoordinated movements (ataxia), diaphoresis, confusion, myoclonus (spasms), shivering or tremor. Serotonin syndrome symptoms can sometimes mimic symptoms due to an overdose of cocaine, lithium, or an MAOI. Patients deemed to have serotonin syndrome should be hospitalized under close observation for at least 24 hours. Treatment includes withdrawal of the offending medication, IV fluids, Cyproheptadine (Periactin), a drug that blocks serotonin production, Benzodiazepines, such as Valium or Ativan, are used to decrease agitation, muscle stiffness and seizure-like movements. Treatment needs to be prompt and in some cases requires ventilation and IV sedation. Kidney damage can occur with uncontrolled muscle spasms that break down muscle tissue causing build up of toxic products in the blood. Symptoms of serotonin syndrome usually occur within minutes to hours of initiating the drug or dose change. Also of note is that SSRI's or tricyclic antidepressants should not be taken with the atypical opioid analgesic tramadol hydrochloride (or Ultram, Ultracet). Although rare, this can cause seizures (Serotonin Syndrome, 2007).

The benefits of using SSRI's are many. They only affect the reuptake pumps responsible for serotonin, thus the term 'selective'. Earlier antidepressants affect other monoamine neurotransmitters as well. This phenomenon results in SSRI's having fewer and milder side effects than the more general drugs. Another advantage is that SSRI's toxic dose is high, thus making an overdose in an attempt to commit suicide much more difficult.

Side effects generally occur during the first 1-4 weeks while the body is adapting to the drug. Full potential can take 6-8 weeks. Most SSRI's cause one or more of these symptoms:

- Nausea, vomiting, diarrhea
- Drowsiness or somnolence
- Headache
- Clenching of teeth
- Extremely vivid and strange dreams
- Dizziness
- Changes in appetite
- Weight loss or gain
- Risk of bone fractures and injuries
- Changes in sexual behavior
- Increased feelings of depression and anxiety
- Tremors
- Autonomic dysfunction (orthostatic hypotension, increased or reduced sweating
- Akathisia (motor restlessness, inability to sit still)
- Liver or renal impairment
- Thoughts of suicide
- Depersonalization (derealization—feelings of unreality and strangeness)

Side effects generally disappear after the body has adapted and the positive effects begin to show. The dosage of the medications should be started at a small amount and increased over

time. It should be individualized to each person and monitored for maximum efficacy and side effects.

Abruptly discontinuing SSRI's is not recommended, even though they are not considered addictive. Suddenly discontinuing the medication can result in both somatic and psychological withdrawal symptoms. These symptoms can last weeks to months and can be very distressing for the patient (Wikipedia.org, SSRI, 2007, p.7).

2. Monoamine Oxidase Inhibitor (MAOI's): are another class of antidepressants used to treat atypical depression and to help with cessation of smoking. They had been reserved as a last line of defense due to their detrimental dietary and drug interactions; however, newer MAOI's are safer and are being used first at times to treat agoraphobia (fear of crowds or public places) and social anxiety. Parkinson's disease and migraine headaches are two other uses for MAO inhibitors (Wikipedia.org, MAOI, 2007).

   MAOI's increase available stores by inhibiting the activity of monoamine oxidase, preventing the breakdown of monamine neurotransmitters. MAOI's hinder catabolism of dietary amines when consumed orally. When foods containing tyramine (many cheeses) are ingested, a hypertensive crisis can occur and hyperserotonemia (serotonin syndrome) if foods containing tryptofan (poultry, chocolate, oats, cheeses, peanuts) are ingested. Reactions are very individualized and depend on the dosage and selectivity of the medication. Foods containing high levels of tyramine should also be avoided (aged wines and aged cheeses) (Wikipedia.org, MAOI, 2007).

   Several drug interactions can occur with the use of MAOI's and should be followed closely by an expert. Interactions include:

- Sympathomimetics (e.g. pseudoephedrine in cold remedies)
    - Risk of hypertensive crisis
- Reserpine, guanethidine, tricyclic antidepressants
    - Excitement
    - Increase in blood pressure and body temperature
- Levodopa
    - Excitement
    - Hypertension
- Anticholinergics
    - Risk of hallucination
- Antihistamines, barbiturates, ethanol, opioids
    - Action of these drugs prolonged – risk of respiratory depression
- Pethidine (Demerol)
    - Risk of high fever, sweating, excitement, delirium, convulsions, respiratory depression (MAO inhibitors retard metabolism of pethidine, but not its demethylation, therefore excess norpethidine is formed).
- MDMA (Ecstasy)
    - Risk of hypertensive crisis
    - Serotonin syndrome
- DXM (dextromethorphan)
    - Serotonin syndrome (Wikipedia.org, SSRI, 2007)

Monoamine oxidase inhibitors include:

- Isocarboxazid (Marplan)
- Moclobemide (Aurorix, Manerix, Moclodura)
- Phenelzine (Nardil)
- Tranylcypromine (Parnate contents 5mg, Jatrosom contents 10mg)
- Selegiline (Selegiline, Eldepryl), and Emsam
- Nialamide
- Iproniazid (Marsilid, Iprozid, Ipronid, Rivivol, Propilniazida)
- Iproclozide
- Toloxatone

(Wikipedia.org, SSRI, 2007)

3. <u>Tricyclic Antidepressants (TCA):</u> First used in the 1950's, this class of antidepressants is named after three rings of atoms which comprise its molecular structure. Tricyclic antidepressants include:

   - Imipramine (Tofranil)
   - Desipramine (Norpramin, Pertofrane)
   - Trimipramine (Surmontil)
   - Clomipramine (Anafranil)
   - Lofepramine (Gamanil, Lomont)
   - Amitriptyline (Elavil, Endep, Tryptanol, Trepiline)
   - Nortriptyline (Pamelor)
   - Protriptyline (Vivactil)
   - Dothiepin Hydrochloride (Prothiaden, Thaden)

(Wikipedia.org, TCA, 2007)

Tricyclic antidepressants function by inhibiting the reuptake of the neurotransmitters norepinephrine, dopamine, or serotonin by nerve cells. This group is used for clinical depression, neuropathic pain, nocturnal enuresis(bedwetting), ADHD (attention-deficit hyperactivity disorder), headaches, anxiety, insomnia, smoking cessation, bulimia nervosa, irritable bowel syndrome, narcolepsy, pathological crying or laughing, persistent hiccups, interstitial cystitis, and as an adjunct in schizophrenia. They are considered inferior to the SSRI's, but are preferable to the MAOI's (both due to the side effects). They are not considered addictive and can be very effective (Wikipedia.org, TCA, 2007).

Side effects of the TCA drugs are rather common and include:

- ❖ Dry mouth (salivary secretion is affected)
- ❖ Dry nose
- ❖ Blurred vision (accommodation in the eye is affected)
- ❖ Decreased gastro-intestinal motility and secretion. This may lead to constipation
- ❖ Urinary retention or difficulty with urination
- ❖ Hyperthermia

Again, if treatment is begun at a low dose and increased slowly, side effects are less troublesome. Sensitivity is decreased with continued treatment over time. Tricyclic antidepressants interact with:

- o Cimetadine, Methylphenidate, antipsychotics, and calcium channel blockers. These drugs increase tricyclic blood concentrations.

- Quinidine (antiarrhythmics), Astemizole and Terfenadine (antihistamines), and some antipsychotics may increase the chance of ventricular dysrhythmias.
- TCA's may enhance the response to alcohol, barbiturates and other CNS depressants.

Care must be taken to prevent overdose in this group of medications. The morbidity and mortality rate is severe with these drugs and they can cause serious problems with children due to their inherent toxicity. The prescriber must take this into account when deciding to make these drugs available in the home when prescribed for bed-wetting and depression. Symptoms of over dose consist of:

- Drowsiness
- Dry mouth
- Nausea
- Vomiting
- Hypotension
- Cardiac Dysrhythmias
- Hallucinations
- Seizures

Treatment of overdose consists of gastric decontamination of the patient. Activated charcoal is given orally or via nasogastric tube. Generally patients should be monitored in an intensive care unit for a minimum of 12 hours. Sodium Bicarbonate is considered an antidote. This source suggests "TCA drugs may be involved in up to 33% of all fatal poisonings, second only to analgesics" (Wikipedia.org, TCA, 2007).

Medications all cause side-effects and they are usually the most noticeable in the first few weeks of treatment and then diminish. Side effects usually include the anticholinergic effects of dry mouth, constipation or diarrhea, drowsiness, nervousness or sleeplessness, and dizziness. If severe pain, chills, rash, fever, blurred vision or other troublesome symptoms occur, the doctor should be contacted. Medicine should be taken accurately as ordered. The medication should not be stopped abruptly and alcohol should be avoided (Understanding Geriatric Depression, 2000).

Electroconvulsive Therapy

Administration of electric current to the brain through electrodes placed on the head in order to induce seizure activity in the brain, used in the treatment of certain mental disorders, especially severe depression (American Heritage Dictionary, 2006).

Cognitive Behavioral Therapy

A Cognitive Behavioral Therapy (CBT) is a psychotherapy based on modifying everyday thoughts and behaviors, with the aim of positively influencing emotions. The general approach developed out of behavior modification and Cognitive Therapy, and has become widely used to treat mental disorders. The particular therapeutic techniques vary according to the particular kind of client or issue, but commonly include keeping a diary of significant events and associated feelings, thoughts and behaviors; questioning and testing assumptions or habits of thoughts that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation and distraction techniques are also commonly included. CBT is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders. It is sometimes used with groups of people as well as individuals, and the techniques are also commonly adapted for self-help manuals and, increasingly, for self-help software packages (American Psychological Association, CBT, 2007).

Spiritual Renewal

Looking for the meaning in life and rediscovering a person's spiritual sense of self can definitely help overcome the fear and sadness brought on by depression. Speaking with those that share a similar belief system to your own is helpful, reading the Bible or other religious material, drawing from the past experiences of others or yourself and reminiscing about the strength and faith it gave you and doing a kind of life review will produce a stronger sense of satisfaction. The past helps us understand the present (Understanding Geriatric Depression, 2000).

Treatment-Resistant Depression

As mentioned above, it can take several weeks to see the effects of an antidepressant. Patients not responding to one agent will often respond to another agent. Long term therapy may be required to prevent relapses (Harper & Johnston, 2007, p.3); however another source cites, "25-35% of patients show minimal improvement in depressive symptoms with treatment" (Kaldy, 2007). This could be because the medication was not given enough time to work. The article states 6-8weeks as the average length of time to see a response. Sometimes what could be noted as a resistance to a treatment is simply because the dosage was too low, the treatment was too short, the wrong choice of medication was used, or there was a premature discontinuation due to side effects or cost (Kaldy, 2007).

Treatment-resistant depression involves five stages. They are:

- Stage 1 involves failure of one adequate trial of antidepressant monotherapy.
- Stage II involves failure of stage I interventions, plus failure of an adequate trial of another class of antidepressants.

- Stage III involves failure of stage II treatment options, plus failure of an adequate trial of a tricyclic antidepressant.
- Stage IV involves failure of stage III interventions, plus failure of an adequate trial of an MAO inhibitor.
- Stage V involves failure of stage IV treatment options, plus failure of a course of bilateral ECT.

(Kaldy, 2007)

The article suggests bringing psychological services in for consult if no response has been received by stage III. Suicidal risk needs to be assessed and medications need to be evaluated as not all are optimal for use in the elderly (Kaldy, 2007).

Overcoming Depression

Depression is a disease that is very disabling, but with the correct treatment, it can be overcome. Loved ones and caregivers alike need to help, especially with the frail elderly. The road to recovery is often burdensome and difficult to see the light at the end of the tunnel.

We can learn from Maslow's Hierarchy of needs some important basic information when dealing with the elderly with depression. The most basic of needs required to sustain human life include balanced, nutritious meals, exercise and adequate, usual, uninterrupted sleep. Once those needs are attained, the person can move up to the safety and security needs. Because depressed persons are often self-centered or preoccupied with themselves, it can make it difficult to see potential environmental hazards. Persons affected with depression crave a very predictable, orderly and lawful world in which things that are unmanageable or unexpected do not happen. Minimizing outside stressors and creating a safe environment is of benefit.

The next level includes the love and belonging needs. This need has to do with socializing and forming relationships with others. If we are not healthy, we cannot nurture relationships. We have to love ourselves in order to be able to love others. People need other people. Encouraging activities even when a person feels they have no energy to attend will help lift depression.

The fourth need/level is self-esteem. Depressed persons tend to feel inadequate and unworthy. They have negative opinions of themselves and have difficulty finding anything positive about the future. They are afraid of failing and this can lead to withdrawal from activities. Again encouraging activities the person used to attend, complementing the person on something they do well or the way they are dressed a certain day, can help.

The final level in Maslow's hierarchy is self-actualization. Self-actualization is reaching a point where one is satisfied with who they are and the point they have reached in their lives. Depression will keep someone from ever reaching this point.

Some interventions or strategies caregiver's or families can try when dealing with a depressed elderly loved one are:

1. **Listen.** Most importantly, give your full attention and attempt to understand. Don't turn the conversation to stories about you or people you know and don't change the subject if the person pauses. Repeat back to them so they know you have heard them.
2. **Acknowledge the sadness, irritability or withdrawal.** "You seem sad today", is one way of opening conversation and acknowledging a feeling.
3. **Do not judge your loved one's feelings.** Avoid saying, "You shouldn't feel that way". There is no right or wrong way to feel. It is what it is.

4. **Resist giving advice.** This is hard to do! We need to encourage our loved one to think of solutions on his own. Ask him what he thinks would help the situation. He is much more likely to buy in to a solution he thought of on his own.
5. **Praise even minor accomplishments.**
6. **Be honest and promote realistic expectations.** Set goals that can be met. Unrealistic goals lead to further feelings of failure.
7. **Be patient and don't push your loved one to respond.** The depressed person's feelings may be numbed and it may take awhile for them to formulate a response (Overcoming Geriatric Depression, 2007).

Procedure

This educational project involved teaching and presenting current information and literature on depression in the elderly to healthcare workers, family, and residents from one long-term care facility. The project was presented to nurses at a monthly meeting, families at a support group meeting, and residents at a resident council meeting. Verbal consent/permission to present the project at the monthly nurse's meeting was obtained from the Director of Nursing Services at St. Luke's Home, Anne Mallberg. Permission to present the project at the Family Support Group meeting and the Resident Council meeting was verbally granted by the Director of Social Services, Christine Zander. A ten question pre-test was given to each group prior to the presentation and the same test was given a second time after the presentation to measure and evaluate learning. The information was presented using a power point. The slides were adapted to the educational needs of the group being presented to. The objective of the project was to increase knowledge and understanding of the debilitating disease of depression and treatment options in hopes of increasing quality of life for the elderly at one long-term care facility.

Summary

Overall, there was an improvement in the post-test results versus the pre-test results for two of the three groups presented to. The resident council was the hardest group to give information to. Although the residents that attend this meeting are considered to be mentally competent and higher functioning, undoubtedly there were some inappropriate residents in attendance. This made it difficult to present the information as some could not understand and many needed assistance with reading and marking their answers. The Social Services department assisted with marking papers and I read the questions aloud one by one so all could hear. Although this was a weakness, I wanted to present to this group and I felt any learning acquired was beneficial. They all kept their power point handouts and maybe could read them at a later date or discuss them with family.

There were only three questions on the test in which measurable learning occurred. They are bolded below. Otherwise, they answered more questions correctly on the pre-test, before the project was presented. Some reasons this occurred may have been difficulty reading, writing, seeing, hearing or understanding the questions and answers, and most importantly short-term memory problems. The test may have been difficult, but the questions were word-for-word out of the power point presentation in which all were given a copy.

A summary of the pre and post-test answers from the Resident Council are as follows:

1. 90% correct on pretest

   84% correct on posttest

2. 71% pre

   68% post

3. *52% pre*

   58% post

4. 62% pre

   58% post

5. 71%pre

   68% post

6. *48% pre*

   58% post

7. 71% pre

   74% post

8. 86% pre

   84% post

9. 71% pre

   63% post

10. ***76% pre***

    89% post

A summary of the pre and post-test answers from the Nurse's meeting are as follows:

1.5% correct on pretest

78% correct on posttest

2.78% pre

94% post

3.100% pre

94% post

4.33% pre

78% post

5.56% pre

78% post

6.56% pre

89% post

7.83% pre

94% post

8.72% pre

94% post

9.100% pre

100% post

10. 100% pre

100% post

The bolded questions again account for measurable learning. This group did much better than the first group as would be expected.

Lastly were the Family Support Group results.

1. ***80% correct on pretest***

   100% correct on posttest

2. 100% pre

100% post

3. ***40% pre***

60% post

4. ***80% pre***

100% post

5. 80% pre

80% post

6. ***40% pre***

80% post

7. ***80% pre***

100% post

8. 80% pre

80% post

9. ***60% pre***

100% post

10. 100% pre

100% post

This group did well overall also. Most questions showed a percentage of learning. If not, they had already gotten the answer correct on the pretest.

Implications for Nursing

Depression is clearly a problem disease that is more prevalent than one would think. The disease is most likely not more prevalent than in the past, but more of society is aware it exists. That does not mean the disease is more accepted. This project provided information and created awareness in order to help recognize and treat this debilitating disease. The project focused on interventions for the afflicted individual as well as the family and caregivers.

Recommendations

Further research is needed in determining causes and prevention of depression and effective safe treatment for the elderly especially. More education is needed in the communities so that they may understand and recognize depression in a loved one when they see it and to help eliminate any stigma associated with the disease.

Physicians are becoming more aware and starting to screen for depression with clinic visits. Nursing homes are screening for depression in their residents on admission and quarterly. These interventions are hopefully a start to a new beginning with the recognition and acceptance and treatment of depression in the elderly, with the ultimate goal of enhancing quality of life.

Appendix A

The Geriatric Depression Scale (GDS)

By: Lenore Kurlowicz, PhD, RN, CS, FAAN, University of Pennsylvania School of Nursing and Sherry A. Greenberg, MSN, APRN, BC, GNP, Hartford Institute for Geriatric Nursing, NYU College of Nursing

WHY: Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older. Both major and minor depression are reported in 13% of community dwelling older adults, 24% of older medical outpatients, 30% of older acute care patients, and 43% of nursing home dwelling older adults (Blazer, 2002a). Contrary to popular belief, depression is not a natural part of aging. Depression is often reversible with prompt and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive and social impairment, as well as delayed recovery from medical illness and surgery, increased health care utilization, and suicide.

BEST TOOL: While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression.

The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued. It takes about 5 to 7 minutes to complete.

TARGET POPULATION: The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

VALIDITY AND RELIABILITY: The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria.

The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation ($r = .84$, $p < .001$) (Sheikh & Yesavage, 1986).

STRENGTHS AND LIMITATIONS: The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

FOLLOW-UP: The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.GeroNurseOnline.org.
The Stanford/VA/NIA Aging Clinical Resource Center (ACRC) website. Retrieved Jan 9, 2007, from http://www.stanford.edu/~yesavage/ACRC.html.
Information on the GDS. Retrieved Jan 9, 2007, from http://www.stanford.edu/~yesavage/GDS.html
Blazer, D.G. (2002a). *Depression in late life* (3rd ed.). St. Louis: Mosby Year Book.
Koenig, H.G., Meador, K.G., Cohen, J.J., & Blazer, D.G. (1988). Self-rated depression scales and screening for major depression in the older hospitalized

patient with medical illness. *JAGS, 36, 699-706.*
Kurlowicz, L.H., & NICHE Faculty. (1997). Nursing stand or practice protocol: Depression in elderly patients. *Geriatric Nursing, 18*(5), 192-199.
NIH Consensus Development Panel. (1992). Diagnosis and treatment of depression in late life. *JAMA, 268,* 1018-1024.
Sheikh, J.I., & Yesavage, J.A. (1986). Geriatric Depression Scale (GDS). Recent evidence and development of a shorter version. In T.L. Brink (Ed.),
Clinical Gerontology: A Guide to Assessment and Intervention (pp. 165-173). NY: The Haworth Press, Inc.
Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M.B., & Leirer, V.O. (1983). Development and validation of a geriatric depression
screening scale: A preliminary report. *Journal of Psychiatric Research, 17, 37-49.*
Permission is hereby granted to reproduce, post, download, and/or distribute, this material in its entirety only for not-for-profit educational purposes only, provided that
The Hartford Institute for Geriatric Nursing, College of Nursing, New York University is cited as the source. This material may be downloaded and/or distributed in electronic
format, including PDA format. Available on the internet at www.hartfordign.org and/or www.GeroNurseOnline.org. E-mail notification of usage to: hartford.ign@nyu.edu.

Geriatric Depression Scale: Short Form

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

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

Answers in bold indicate depression. Score 1 point for each bolded answer.
A score > 5 points is suggestive of depression.
A score > 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.
Source: http://www.stanford.edu/~yesavage/GDS.html

Appendix B

Cornell Scale for Depression in Dementia

Name________________________________ Age ______ Sex ______ Date ____________

Inpatient Nursing Home Resident Outpatient

Scoring System

A = unable to evaluate 0 = absent 1 = mild or intermittent 2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview.

No score should be given in 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 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, a 0 1 2
    or makes suicide attempt
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

Appendix C

Depression Pre and Post Test

Nurses

1. What percentage of nursing home residents have at least some degree of depression?
    a. >20%
    b. >40%
    c. >60%
    d. >80%

2. Depression is more prevalent in elders in a long-term care facility than those in the community.
    a. True
    b. False

3. Depression is a normal part of aging.
    a. True
    b. False

4. Which of these statements are true?
    a. Older adults account for almost 1/4th of all suicides
    b. Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate.
    c. Greater than 3/4ths of older adult suicides are male.
    d. All of the above
    e. None of the above

5. Which of the following is a benefit of an SSRI (Selective Serotonin Reuptake Inhibitor)?
    a. They can be abruptly discontinued without side effects
    b. They have fewer and milder side effects than the more general drugs
    c. They are used to treat agoraphobia
    d. All of the above

6. Which antidepressant class hinders catabolism of dietary amines when consumed orally?
    a. Monoamine Oxidase Inhibitors
    b. Selective Serotonin Reuptake Inhibitors
    c. Tricyclic Antidepressants
    d. None of the above

7. Tricyclic Antidepressants are considered inferior to the SSRI's, but are preferable to the MAOI's.
    a. True
    b. False

8. Most medications have side effects; however many will subside with continued therapy.
    a. True
    b. False

9. Non-pharmacological treatment options for depression in the long-term care facility include:
    a. Providing activities of interest
    b. Offering food choices
    c. Counseling/support groups
    d. All of the above

10. Depression is a very disabling disease, but it can be overcome.
    a. True
    b. False

Depression Pre and Post Test

Resident Council & Family Support Group

1. Depression includes many signs and symptoms, not just sadness or tearfulness.
   a. True
   b. False

2. Depression only affects the individual with the disease.
   a. True
   b. False

3. Depression is more prevalent in elders in a long-term care facility than those in the community.
   a. True
   b. False

4. Depression is a normal part of aging.
   a. True
   b. False

5. Depression is a sign of weakness.
   a. True
   b. False

6. Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate.
   a. True
   b. False

7. If someone says, "You don't have to worry about me anymore", they don't mean anything by it. They are just trying to get attention.
   a. True
   b. False
8. Treatment options for depression in the long-term care facility include providing activities of interest, food choices, and support groups.
   a. True
   b. False

9. Electroconvulsive therapy, cognitive behavioral therapy and spiritual renewal are all non-pharmacological treatment options.
   a. True
   b. False

10. Depression is a very disabling disease, but it can be overcome.
    a. True
    b. False

Depression Pre and Post Test Answers

Nurses

1.b
2.a
3.b
4.d
5.b
6.a
7.a
8.a
9.d
10.a

Resident Council
&
Family Support Group

1. True
2. False
3. True
4. False
5. False
6. True
7. False
8. True
9. True
10. True

Appendix D

PowerPoint presentations

My project consisted of two power point presentations. The first was aimed at educating the Family Support Group and the Resident Council and the second was geared toward the Nursing Staff.

DEPRESSION
In the Elderly

By Jan Lynch, RN, BSN

What is Depression?

Depression is a condition of general emotional dejection and withdrawal; sadness greater and more prolonged than would be expected by any objective reason (Dictionary.com)

It has also been described as a biological condition that occurs when our brain chemicals get out of balance. (Understanding Geriatric Depression- www.ec-online.net)

Signs and Symptoms

- Sadness, tearfulness
- Anhedonia (inability to experience pleasure)
- Unexplained loss of interests
- Social Withdrawal
- Rapid decline in functioning
- Appetite or weight loss
- Irritability, pessimism, self-critical attitude
- Persistent passive (or active) suicidal ideation

Who does Depression hurt?

- The afflicted individual
- The family
- The friends
- The co-workers
- Anyone who cares about the individual

Depression affects people of all ages and race, but the disease is more prevalent in long-term care facilities than those elders in the community (Identification and Treatment of Depression and Anxiety in Long-Term Care Residents).

Why?

Long term care residents have sometimes suffered many losses.

Several factors can contribute to our brain chemicals becoming unbalanced.

- Medications
- Alcoholism
- Chronic conditions

Depression is often misunderstood in the general population as a whole.

- It is seen as a normal part of the aging process
- It is seen as a sign of weakness

Often those who are depressed themselves fail to recognize their own symptoms

(Understanding Geriatric Depression- www.ec-online.net)

Suicide

In 2002,

- Older adults accounted for 17.5% of all suicides
- Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate.
- 85% of older adult suicides were male

(Colorado Office of Suicide Prevention)

Suicide Warning Signs

- Depressed mood
- Loss of interest in things previously enjoyable
- A marked noticeable change in one's behavior
- Non-compliance with medical regimens
- Stock –piling medications or buying a gun
- Social isolation
- Saying good-byes
- Talking about suicide
- Statements like, "I'm going away" or "You don't have to worry about me anymore."
- Reckless behavior like increased substance abuse

(Colorado Office of Suicide Prevention)

Treatment Options

- Most important is recognizing the disease
- Using a depression scale such as the Geriatric Depression Scale
- In the long-term care setting, providing activities of interest
- Food choices
- Addressing concerns in a timely manner
- Support Groups
- Reviewing medications

Treatment Options continued

- Assessing for other medical problems
- Watchful waiting
- Psych services
- Antidepressant medication

Antidepressant Medications

There are three groups of antidepressant medications:

- Selective Serotonin reuptake inhibitors
- Monoamine Oxidase Inhibitors
- Tricyclic Antidepressants

Side Effects

Most medications can cause side effects. Antidepressants are no different. Many of the side effects will subside with continued therapy. Some of the more common side effects consist of:

- Nausea, vomiting, diarrhea
- Dry mouth
- Blurred vision
- Drowsiness
- Urinary retention

Non-pharmacological Treatment Options

Electroconvulsive Therapy:

Electric current to the brain through electrodes placed on the head in order to induce seizure activity in the brain

Cognitive Behavioral Therapy:

Psychotherapy based on modifying everyday thoughts and behaviors, with the aim of positively influencing emotions.

Non-pharmacological Options continued

Spiritual Renewal:

Speaking with those that share a similar belief system to your own helps overcome fear and sadness brought on by depression.

Overcoming Depression

Depression is a very disabling disease, but it can be overcome.

- The most basic of needs, (nutritious meals, exercise, and adequate sleep), can help.
- Minimizing outside stressors and creating a safe environment is important.
- Forming relationships. Encouraging activities even when a person feels they have no energy to attend will help lift depression.

Caregiver/Family Interventions

- Listen
- Acknowledge the sadness, irritability or withdrawal
- Do not judge your loved one's feelings
- Resist giving advice
- Praise even minor accomplishments
- Be honest and promote realistic expectations
- Be patient and don't push your loved one to respond (Overcoming Geriatric Depression-www.ec-online.net)

As a resident at St. Luke's Home, your nurses and other staff care about you. Please let us know if you are feeling any of the depression signs we talked about or if you have noticed any of your friends or neighbors exhibiting signs of depression. If we all work together, we can improve lives!

This second power-point included the same information as the first one, but also included these next slides, which included more detail on the medications as it was geared toward the nursing staff.

Antidepressant Medications

There are three groups of antidepressant medications:

- Selective Serotonin reuptake inhibitors
- Monoamine Oxidase Inhibitors
- Tricyclic Antidepressants

Selective Serotonin reuptake inhibitors SSRI's

- Used to treat clinical depression, anxiety disorders (social anxiety, panic disorders, obsessive-compulsive disorder, eating disorders and chronic pain).
- When SSRI's inhibit the reuptake of serotonin, the recipient cell is stimulated.
- Several weeks of continuous use are important for full efficacy.

SSRI's continued

Drugs in this class include:

- Citalopram (celexa, cipramil, emocal, sepram, seropram)
- Escitalopram oxalate (lexapro, cipralex, esertia)
- Fluoxetine (prozac, fontex, seromex, seromil, sarafem, fluctin)
- Fluvoxamine maleate (luvox, faverin)
- Paroxetine (paxil, seroxat, aropax, deroxat, rexetin, xetanor, paroxat)
- Sertraline (zoloft, lustral, serlain)

Serotonin Syndrome

- Deadly drug reaction when the body has too much serotonin.
- Onset is usually when the med is first started or with an increase in medication.
- Symptoms include restlessness, hallucinations, loss of coordination, tachycardia, rapid blood pressure changes, fever, overactive reflexes, nausea, vomiting, diarrhea, diaphoresis, confusion, tremors.

Benefits of SSRI's

- They only affect the reuptake pumps responsible for serotonin, thus 'selective'. This results in fewer and milder side effects than the more general drugs.
- Toxic dose is high, thus making an overdose attempt at committing suicide much more difficult.
- *Abruptly discontinuing medication can result in both somatic and psychological withdrawal symptoms. The symptoms can last weeks to months and be very distressing for the patient (http://en.wikipedia.org)*

Monoamine Oxidase Inhibitor (MAOI's)

- Used to treat atypical depression, help with the cessation of smoking, agoraphobia, social anxiety, Parkinson's Disease and migraine headaches.
- MAOI's increase available stores by inhibiting the activity of monoamine oxidase, preventing the breakdown of monoamine neurotransmitters.

Risks of MAOI's

- Hinder catabolism of dietary amines when consumed orally. When foods containing tyramine (many cheeses and wines) are ingested, a hypertensive crisis can occur.
- Serotonin syndrome can occur if foods containing tryptofan (poultry, chocolate, oats, cheeses, peanuts) are ingested.
- *They had been reserved as a last line of defense due to their detrimental dietary and drug interactions; however newer MAOI's are somewhat safer.*

Monoamine Oxidase Inhibitors include:

- Isocarboxazid (Marplan)
- Moclobemide (Aurorix, Manerix, Moclodura)
- Phenelzine (Nardil)
- Tranylcypromine
- Selegiline (Selegiline, Eldepryl), and Emsam
- Nialamide
- Iproniazid (Marsilid, Iprozid, Ipronid, Rivivol, Propilniazida)
- Iproclozide
- Toloxatone

(http://en.wikipedia.org)

Tricyclic Antidepressants (TCA's)

- First used in the1950's, this class of antidepressants is named after three rings of atoms which comprise its molecular structure.
- Used for clinical depression, neuropathic pain, nocturnal enuresis, ADHD, headaches, anxiety, insomnia, smoking cessation, bulimia nervosa, irritable bowel syndrome, narcolepsy, pathological crying or laughing, persistent hiccups, interstitial cystitis, and as an adjunct in schizophrenia.
- Function by inhibiting the reuptake of the neurotransmitters norepinephrine, dopamine or serotonin by nerve cells.

TCA Risks

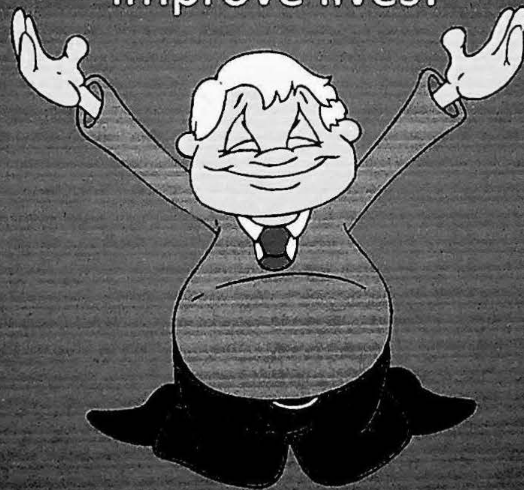
- Considered inferior to the SSRI's, but are preferable to the MAOI's (both due to the side effects).
- *Care must be taken to prevent overdose in this group of medications. The morbidity and mortality rate is severe with these drugs.*

TCA's include:

- Imipramine (Tofranil)
- Desipramine (Norpramin, Pertofrane)
- Trimipramine (Surmontil)
- Clomipramine (Anafranil)
- Lofepramine (Gamanil, Lomont)
- Amitriptyline (Elavil, Endep, Tryptanol, Trepiline)
- Nortriptyline (Pamelor)
- Protriptyline (Vivactil)
- Dothiepin Hydrochloride (Prothiaden, Thaden)

(http://en.wikipedia.org)

If we all work together, we can improve lives!



References

American Heritage Dictionary of the English Language, fourth edition (2006). Houghton Mifflin Company.

American Psychological Association (APA): cognitive_behavioral_therapy. (n.d.) *Wikipedia, the free encyclopedia.* Retrieved July 8, 2007, from Reference.com http://www.reference.com/browse/wiki/Cognitive_behavioral_therapy

American Psychological Association (APA): depression. (n.d.) *Dictionary.com Unabridged (v 1.1).* Retrieved June 11, 2007, from Dictionary.com website: http://dictionary.reference.com/browse/depression

Dictionary.com (2007). http://www.dictionary.com

Ellen, E. LICSW. (2001). Detecting and treating geriatric depression. *Geriatric Times, vol. 2, issue 3.* Retrieved March 4, 2007, from http://www.geriatrictimes.com

Harper, G., MD, & Johnston, C. MD (2007). Depression in elderly. *McGraw-Hill's Access Medicine.* Retrieved April 24, 2007, from http://www.accessmedicine.com

Hindman, J. (2006). *Suicide among older adults.* [teleconference]. Colorado Office of Suicide Prevention, June 1, 2006.

Kaldy, J. (2007). Tackle treatment-resistant depression in elderly residents with patience. *Caring for the Ages, vol.8, no.6,* p.17.

Meyers, K. (2007). *The roy adaptation model.* Retrieved July 8, 2007, from http://www2.bc.edu/~royca/htm/ram.htm

Overcoming Geriatric Depression(2000). *Eldercare skill builders.* Retrieved March 4, 2007, from http://www.ec-online.net/Knowledge/SB/SBdepressionovercoming.html

Polit, D. F., & Beck, C. T. (2004). Developing a Conceptual Context. In M. Zuccarini (Ed.), *Nursing research, principles and methods, seventh edition* (pp. 120-121). Philadelphia, PA: Lippincott Williams & Wilkins.

St. Luke's Home (2006). *Management of depression symptoms.* Policy and Procedure Manual. Obtained June 2007.

Santulli, R. B., MD & Daiello, Lori A. (2007). *Identification and treatment of depression and anxiety in long-term care residents.* Retrieved May 2, 2007, from

http://www.cmecorner.com/depr_anx_06400/topic1/player.html

Serotonin syndrome (2007). *University of Maryland medical center.* Retrieved from http://umm.edu/ency/article/007272.htm

Tomey, A. M., & Alligood, M. R. (2002). Sister Callista Roy, Adaptation Model. In Yvonne Alexopoulos (Ed.), *Nursing theorists and their work, fifth edition* (pp. 269-298). St. Louis, MO: Mosby, Inc.

Understanding geriatric depression (2000). *Eldercare skill builders.* Retrieved March 4, 2007, from http://www.ec-online.net

UT Southwestern Leads Largest Study On Treatment For Depression. (2006). *Directions in Nursing, North Dakota Edition, winter 2006, p. 2.*

Wikipedia.org (2007). http://en.wikipedia.org/wiki/Monoamine_oxidase_inhibitor

Wikipedia.org (2007). http://en.wikipedia.org/wiki/Selective_serotonin_reuptake_inhibitor

Wikipedia.org (2007). http://en.wikipedia.org/wiki/Tricyclic_antidepressant

Williams, P. E. (2006). *Depression quality measure* (Depression in LTC) [teleconference]. January 26, 2006.

Room: LRC 103
Location: Educational Shelf

Thesis or Independent Study paper

LRC10936