Clinical Guidelines

Treating Depression in Older Adults

This guideline presents an overview of depression in older residents with an emphasis on age-related assessment considerations, clinical decision making, and nursing intervention strategies for elders with depression.

Assessment Parameters

Several studies support the use of an interdisciplinary geriatric assessment team for late-life depression with the following being specific parameters of assessment:

A. Identify risk factors/high-risk groups:

1. Current alcohol/substance-use disorder
2. Medical comorbidity: Specific comorbid conditions include dementia, stroke, cancer, arthritis, hip fracture, myocardial infarction, chronic obstructive pulmonary disease, and Parkinson's disease.
3. Functional disability (especially new functional loss). Disability, older age, new medical diagnosis, and poor health status
4. Widow/widowers
5. Older family caregivers, especially those caring for persons with dementia
6. Social isolation/absence of social support
7. Psychosocial causes for depression in older adults include cognitive distortions, stressful life events (especially loss), chronic stress, low self-efficacy expectations.

The Geriatric Depression Scale-Short Form (GDS-SF) is recommended because it takes approximately 5 minutes to administer.

B. Assess all at-risk groups using a standardized depression screening tool and documentation score. The Geriatric Depression Scale-Short Form (GDS-SF) is recommended because it takes approximately 5 minutes to administer, has been validated and extensively used with medically ill older adults, and includes few somatic items that may be confounded with physical illness.

C. Perform a focused depression assessment on all at-risk groups and document results. Note the number of symptoms; onset; frequency/patterns; duration (especially 2 weeks); change from normal mood, behavior, and functioning:

1. Depressive symptoms
2. Depressed or irritable mood, frequent crying
3. Loss of interest, pleasure (in family, friends, hobbies, sex)
4. Weight loss or gain (especially loss)
5. Sleep disturbance (especially insomnia)
6. Fatigue/loss of energy
7. Psychomotor slowing/agitation
8. Diminished concentration
9. Feelings of worthlessness/guilt
10. Suicidal thoughts or attempts, hopelessness
11. Psychosis (ie delusional/paranoid thoughts, hallucinations)
12. History of depression, current substance abuse (especially alcohol), previous coping style
13. Recent losses or crises (eg, death of spouse, friend, pet, retirement; anniversary dates; move to another residence, nursing home); change in physical health status, relationships, roles

D. Obtain/review medical history and physical/neurologic examination.

E. Assess for depressogenic medications (eg, steroids, narcotics, sedative/hypnotics, benzodiazepines, antihypertensives, histamine-2 antagonists, beta-blockers, antipsychotics, immunosuppressives, cytotoxic agents)

F. Assess for related systematic and metabolic processes that may contribute to depression or

might complicate treatment of the depression (eg, infection, anemia, hypothyroidism or hyperthyroidism, hyponatremia, hypercalcemia, hypoglycemia, congestive heart failure, kidney failure).

G. Assess for cognitive dysfunction.

H. Assess level of functional ability.

Care Parameters

A. For severe depression (ie, GDS score 11 or greater, five to nine depressive symptoms [must include depressed mood or loss of pleasure] plus other positive responses on individualized assessment especially suicidal thoughts or psychosis and co-morbid substance abuse), refer for psychiatric evaluation. Treatment options may include medication or cognitive-behavioral, interpersonal, or brief psychodynamic psychotherapy/counseling (individual, group, family); hospitalization; or electroconvulsive therapy.

B. For less severe depression (ie, GDS score 6 or greater, fewer than five depressive symptoms plus other positive responses on individualized assessment), refer to mental-health services for psychotherapy/counseling (see previous types), especially for specific issues identified in individualized assessment and to determine whether medication therapy may be warranted. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community- and institution-specific mental-health services. If suicidal thoughts, psychosis, or comorbid substance abuse is present, a referral for a comprehensive psychiatric evaluation should always be made.

C. For all levels of depression, develop an individualized plan integrating the following nursing interventions:

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

Consider referrals to psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community and institution mental-health services.

Reference

Kurlowicz LH, Harvath TA. Depression. In Capezuti E, Zwicker D, Mezey M, Fulmer T, eds. *Evidence-Based Geriatric Nursing Protocols for Best Practice.* 3rd ed. New York: Springer Publishing; 2008. With permission.