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INTRODUCTION

In this chapter the role of nurses in the care and treatment of older people with depression is described. Reference is made where possible to the growing evidence base on which nurses can base their contemporary practice. Case histories illustrate the common presentations of depression and the settings in which it is especially common are highlighted. Some recent evidence on causative factors is presented. The role of nurses in prevention and detection is emphasized.
Ways to improve management are discussed, including public and professional education and screening. For effective management of depression in older people nurses will work as a member of a multidisciplinary team and are well placed to coordinate the multidimensional approach to assessment and care that is needed. The role that nurses have in the medical, psychological and social aspects of this approach is described. A generic nursing approach is discussed which will be of particular relevance to general nurses. Psychiatric nurses will have roles in more specialist interventions, which are also described. The prognosis for older people with depression depends greatly on the service provided: nurses have important roles in initial care and treatment and in follow-up to maintain improvement and prevent relapse.

Depressive disorder in older people is a major public health problem. It is very common but often goes undetected in primary care, general medical units and in care homes. When it is detected, it is not always treated adequately. When this happens the prognosis is poor with increased mortality rates. Depressive disorder is a cause of disability in its own right and also adds to the disability of physical disorder. It accounts for increased use of health and social services of all kinds and reduces quality of life. However, there is now a substantial evidence base showing how depressive disorder in older people should be treated. This chapter is concerned with depression in older people and the role that nurses have in the process leading to effective care and treatment.

**PRESENTATION OF DEPRESSION IN OLDER PEOPLE**

The following case histories illustrate how depression in older people may present.

**Major depression**

Mary Smith (Case study 25.1) has major depression. She is experiencing a number of key depressive symptoms of depression and as a consequence her usual daily life is adversely affected. In isolation some of the symptoms she is experiencing could be part of a reaction to the difficulties often associated with older age. An older person might feel some sadness or demoralization as health deteriorates and some interests have to be given up. Normal biological ageing might result in reduced vitality. Physical illness might affect sleep and appetite. However, a person will only be considered to be suffering from a depressive disorder when a significant number of key depressive symptoms are experienced, that is, when the depressive syndrome is present. In consequence, the person will usually have difficulty continuing with usual activities, and relationships are likely to be affected.

The key symptoms of depression in a person of any age are described in the World Health Organization International Classification of Diseases, tenth edition, known as ICD-10 (World Health Organization 1992). Box 25.1 shows the ICD-10 guidelines on how a depressive episode can be classified as mild, moderate or severe. The alternative classification system is

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**Case study 25.1**

Mary Smith is 85 years old and lives in her own house, a quarter of a mile from the village shops. Her husband died 3 years ago. He had strokes and suffered from dementia. She has two daughters who live in nearby villages. She has become increasingly depressed over the past 2 months. She experiences considerable pain from her left hip and has been more and more disabled by this for the past 6 months. She is on the waiting list for a hip replacement. She feels miserable and no longer enjoys reading or gardening. She feels irritated and restless when in the company of her family. She has no energy, finds everything an effort and has no interest in household chores. She rarely walks into the village for shopping, relying on family to do this for her. She spends most of the day just sitting on the settee, glancing at the newspaper, but not being able to concentrate on it for long. She has little appetite for food and feels nauseous much of the time. The general practitioner can find no physical cause for this. She sleeps fitfully at night and takes a sleeping tablet occasionally to get a better night’s sleep. She cannot see anything to look forward to in the future and cannot see himself getting better. She feels guilt-ridden about the occasions she became irritated with her husband’s difficult behaviour when she was tired and stressed in looking after him at home. She thinks that life is not worth living but denies any suicidal intent. Mrs Smith had been to see her general practitioner with complaints of poor sleep and nausea but depression was then recognized and she was prescribed an antidepressant and referred to the community mental health team for psychological therapy.
published in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, known as DSM-IV (American Psychiatric Association 1994). In this system major depressive episode is defined by the presence of five or more of the following symptoms: depressed mood, markedly diminished interest or pleasure, decrease or increase in appetite with significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate and recurrent thoughts of death or suicidal ideation. At least one of either depressed mood or loss of interest or pleasure should be present. Severe depressive episode meeting these criteria is commonly referred to as major depression.

In major depression, mood is depressed to a degree that is abnormal for the person and is mainly uninfluenced by circumstances. The depressed mood is present for most of the day, nearly every day. The depressed mood can vary somewhat during the day (diurnal variation) and is characteristically worse in the morning in more severe depression. The person describes not being as interested in usual activities as previously or not being able to experience pleasure (anhedonia). Reduced energy is experienced as sustained fatigue even in the absence of physical exertion. Psychomotor retardation may result, with slowed monotonous speech, increased pauses before answering, slow body movements and decreased amount of speech (poverty of speech) or even muteness. In the most severe cases depressive stupor may develop. The person may complain of memory problems and indecision and may appear distracted.

People have negative thoughts about themselves, saying, for example, ‘I am not as good as other people’ or ‘I am not a very interesting person anymore’. They have distorted beliefs about current or passed failings or blame themselves for some untoward event or for their illness. They may believe that they do not deserve the attention of their family or the concern of the doctor or nurse. Ideas of guilt and unworthiness can be delusional in intensity. They believe that the future will be unpleasant, that something bad will happen or that there is not a future for them. They may believe that the treatment will not help and that they will not recover. They feel hopeless and helpless. Often, they think that they would be better off dead. They may have thoughts of self-harm, with or without a specific plan, or may have attempted suicide.

There may be problems in getting to sleep, waking in the middle of sleep or waking early in the morning. Waking early, 2 h or more before the usual time, is also especially characteristic of severe depression. People no longer enjoy food so eat less and often lose weight. Psychomotor agitation may be prominent instead of diminished activity. They cannot sit still and will pace about, wringing their hands or pulling at their hair or clothes.

The clinical presentation of depression in older people is much the same as in younger adults. In general, similarities in presentation are more important than any differences. However some differences might distract the unwary from the correct identification of depression. Older people may complain less of depressed mood or sadness even when appearing depressed (Baldwin 2002). Note that the presence of depressed mood per se is not needed for a diagnosis of a depressive episode by ICD-10 and DSM-IV criteria; loss of interest and enjoyment have equivalent diagnostic significance. Anxiety may be a dominant feature or the person may have some obsessional symptoms. Hypochondriasis is more common. If depressed older people also have a physical problem, they may complain more about that, especially if their pain threshold has been lowered by the depression.
Complaints of asthenia, headache, palpitations, pain (especially abdominal pain), dizziness and shortness of breath are not uncommon (Rasmussen et al. 1999). Depression presents in a range of severity. The consensus is that most depressive disorders lie on a continuum rather than being discrete categories (Lebowitz et al. 1997). Nonetheless, it is important for nurses to be aware of the terminology currently applicable to different levels of severity.

**Psychotic depression**

A major depression can present with psychotic symptoms, that is, with delusions or hallucinations. Reginald Evans (Case study 25.2) suffered with psychotic depression. Delusions may be paranoid, with individuals believing that they are being poisoned, for example. Others may involve ideas of guilt, sin, poverty or impending disaster. They may believe that their body is rotting away or that they are dead (a nihilistic delusion) or that they have a serious illness such as cancer (a hypochondriacal delusion). They may experience hallucinations such as hearing voices saying derogatory things about them or accusing them of doing evil things (auditory hallucinations). They may perceive an unpleasant smell (an olfactory hallucination), especially if they believe that they are also physically ill.

**Milder depressions**

These are far more common than major depression and will usually be seen in primary care. When a person does not quite fulfil criteria for major depression but has some symptoms and significant functional impairment, the term ‘minor depression’ is being increasingly used. It is suggested that the criteria for minor depression are the presence of at least two (but fewer than five) of the symptoms for a major depressive episode (American Psychiatric Association 1994). It is commonly associated with physical illness.

Betty Watson (Case study 25.3) has a more chronic milder depression. In this disorder the mood disturbance is chronic and variable. Mrs Watson feels well for periods but most of the time she feels depressed and everything is an effort. She tends to brood and complain. She does not fulfil the criteria for a major depression and would be diagnosed as suffering from dysthymia, a chronic mild depression. However, episodes of major depression may develop. The diagnostic criteria for dysthymia are shown in Box 25.2.

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**Case study 25.2**

Reginald Evans, aged 82, lives with his wife and had become increasingly depressed in the past month. He has become convinced that they have no money. He also believes that there is a fault with the power supply to the house and that they should not be using electricity, so will switch off domestic appliances if not supervised by his wife. He believes that something terrible is going to happen to them both so will not let his wife leave the house. He feels upset that he has somehow let his wife down. His condition worsened so that he was neglecting his self-care, was eating little and drinking only with much persuasion. He did not want people visiting him as he thought that he had something wrong with his bowels and that he had a contagious disease and did not want to infect anyone. He was seen by a psychiatrist at home who prescribed an antidepressant and an antipsychotic drug. However, he accepted admission to hospital a week later and consented to having electroconvulsive therapy.

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**Case study 25.3**

Betty Watson is 80 years old. Her husband died 10 years ago. She has arthritis in her knees and hips and has angina. Her mood has been somewhat depressed since her husband died. She gets tearful sometimes, although her mood is brighter for a few days at a time, especially when in company. She no longer enjoys the garden and greenhouse, partly through loss of interest and partly through the pain she gets from her arthritis. She has become particularly anxious about her angina and grumbles that the doctor does not visit often enough. Two months ago she stopped going to the local day centre which she would usually attend one day a week and enjoy. She still walks to the local shops several times a week. Her appetite has remained good and her sleep pattern has not changed. Because of the persistence of her relatively mild depressive symptoms, the general practitioner prescribed an antidepressant and also referred her to the community mental health team for further advice and support.
When depressed mood occurs as part of a period of adjustment to some significant life change, such as moving into a residential home for example, but few other symptoms occur, it would be described as an adjustment disorder with depressed mood. We shall see that depression can sometimes be due to systemic disease or drugs used to treat physical problems; the term 'organic mood (depressive) disorder' is then used.

A new category of vascular depression has been proposed (Baldwin & O'Brien 2002). It is suggested that damage to end-arteries supplying subcortical structures may disrupt neurotransmitter circuitry involved in mood regulation, thus causing or predisposing a person to depression. The presumed basis is of vascular disease, though this is not yet proven. Its features are shown in Box 25.3.

Depressive episodes usually occur as either a single first episode or in the context of previous depressive episodes (recurrent depressive disorder). Experience of a manic episode in the past would be said to be bipolar disorder. Another distinction which is often made is that of late-onset depression, the first episode being in older age, and early-onset, when recurrent depression started in earlier life. Box 25.4 summarizes the types of depressive disorder in later life.

### PREVALENCE AND INCIDENCE

#### Prevalence

An average prevalence in community samples across many European countries has been found to be 12.3%: 14.1% for women and 8.6% for men (Copeland et al. 1999). In an analysis of studies worldwide the average prevalence was 13.3% for all depressive syndromes (major and milder depressions), with rates of major depression averaging 1.8% (Beekman et al. 1999). Although the prevalence of major depression either remains static or perhaps decreases with age, when the whole range of depression is considered, it is likely that overall prevalence rises with age (Baldwin et al. 2002). It appears that ageing per se is not a risk factor for developing major depression (Roberts et al. 1997). Any associations are accounted for by increased health difficulties which, as we shall see, are an important risk factor.

When samples other than community samples have been studied, especially high prevalence rates have been found, as Table 25.1 illustrates.

Also, depression occurs at especially high rates in some physical disorders. Table 25.2 shows the prevalence of depression in older people in the context of a range of physical illnesses or degenerative conditions. The rate of major depression is usually much lower than the overall prevalence. The key message is that nurses working in these settings or with these populations should have a particularly high index of suspicion for depression.

#### Box 25.2 DSM-IV criteria for dysthymia

A. Depressed mood for most of the day, for more days than not, for at least 2 years

B. The presence while depressed of two or more of the following:
   1. poor appetite or overeating
   2. insomnia or hypersomnia
   3. low energy or fatigue
   4. low self-esteem
   5. poor concentration or difficulty making decisions
   6. feelings of hopelessness

C. During the 2-year period the person has never been without the symptoms for more than 2 months at a time

#### Box 25.3 The vascular depression hypothesis: proposed features

- Late-onset depression (but not always)
- Increase in vascular risk factors
- Reduced depressive ideation
- Reduced insight
- Increased apathy and psychomotor retardation
- Cognitive impairment (particularly executive function)
- Neuroimaging abnormalities, notably affecting white matter and subcortical areas.

#### Box 25.4 Types of depressive disorder in later life

- Major depression
- Minor depression
- Dysthymia
- Adjustment disorder with depressed mood
- Mixed anxiety and depressive disorder
- Organic mood (depressive) disorder
- Bipolar disorder
- Vascular depression
Incidence

Incidence refers to the number of new cases that arise within a given population in a given time period. Community studies have found rates of incidence between around 3% and 12% per year (Blanchard et al. 1994, Prince et al. 1998). The lower figure is found in studies of longer follow-up periods and may reflect the finding that those who develop depression are more likely to be lost to follow-up (due to increased physical and other mental health problems and mortality) before the onset can be detected. The study of different populations may also account for some of the differences in rates.

CAUSES OF DEPRESSION IN OLDER PEOPLE

No single theory adequately explains the development of depression. A dynamic stress-vulnerability model is particularly useful for understanding depression in older people (Ormel et al. 2001). This is an integrated model that incorporates evidence from the biological, psychological and social domains. In any individual depression will usually, but not always, result from an interaction of a number of risk factors in one or more of these domains. According to the model, vulnerability factors may influence the risks of onset of depression by the amplification of the effects of acute life events (known as modification). Studies of causation of depression in older people are finding increasing evidence in support of such a model (Schoevers et al. 2000, Ormel et al. 2001). Importantly, these and other recent studies have a prospective design. Much current knowledge has been derived from cross-sectional design studies. These have a number of limitations, most notably concerning temporal relations, so that a characteristic found to be associated with depression may have caused the disorder or it may be a consequence of the depression.

The more important risk factors are briefly described here. For further discussion, readers are referred to Baldwin (2002).

Predisposing factors

Box 25.5 shows risk factors which can be regarded as predisposing or vulnerability factors.

Table 25.1  Studies of prevalence of depression in older people in different settings

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Prevalence of depression (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banerjee &amp; Macdonald 1996</td>
<td>Clients receiving home care from social services</td>
<td>26</td>
</tr>
<tr>
<td>Coope et al. 1995</td>
<td>Carers of dementia sufferers</td>
<td>28</td>
</tr>
<tr>
<td>Burn et al. 1993</td>
<td>Acute medical inpatients</td>
<td>23</td>
</tr>
<tr>
<td>Evans &amp; Katona 1993</td>
<td>General practice attenders</td>
<td>37</td>
</tr>
<tr>
<td>Neville et al. 1995</td>
<td>Residential-home residents</td>
<td>17</td>
</tr>
<tr>
<td>Godlove Mozeley et al. 2000</td>
<td>New admissions to residential and nursing homes</td>
<td>45</td>
</tr>
</tbody>
</table>

Table 25.2  Studies of prevalence of significant depressive symptoms in older people with physical illness or degenerative condition

<table>
<thead>
<tr>
<th>Study</th>
<th>Physical illness/degenerative condition</th>
<th>Prevalence of depression (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cummings &amp; Masterman 1999</td>
<td>Parkinson’s disease</td>
<td>40</td>
</tr>
<tr>
<td>Allen &amp; Burns 1995</td>
<td>Alzheimer’s disease</td>
<td>20</td>
</tr>
<tr>
<td>Burvill et al. 1996</td>
<td>Poststroke</td>
<td>23</td>
</tr>
<tr>
<td>Massie &amp; Holland 1990</td>
<td>Cancer</td>
<td>25</td>
</tr>
<tr>
<td>Holmes &amp; House 2000</td>
<td>Hip fracture</td>
<td>9–47</td>
</tr>
<tr>
<td>Frasure-Smith et al. 2000</td>
<td>After myocardial infarction</td>
<td>31</td>
</tr>
<tr>
<td>Koenig 1998</td>
<td>Congestive heart failure</td>
<td>59</td>
</tr>
<tr>
<td>Yohannes et al. 1998</td>
<td>Chronic obstructive pulmonary disease</td>
<td>40</td>
</tr>
</tbody>
</table>
Depression in older people is consistently found to be more common in women than in men. A number of possible reasons for this have been suggested (Evans 1996):

- loss of the traditional homemaker’s role due to physical disability
- retirement of husband and his ‘intrusion’ into the home
- grief and loneliness following death of husband
- lack of family support, e.g. for spinsters or when children have moved away
- financial constraints or difficulty travelling causing social isolation
- loss of motherhood and role as domestic head of family when the family home is lost in a move to alternative accommodation.

It is generally regarded that genetic factors are less important as age of onset increases (Baldwin 2002). However, older individuals with a previous history of depression are more vulnerable to relapse (Schoevers et al. 2000).

Given that depression has been found to occur at high rates in residential and nursing homes (Neville et al. 1995), living in an institution must be regarded as a risk factor. Although this is likely to be linked to high levels of disability in some homes, the psychosocial environment will have an important impact if choice and control are restricted and there is limited opportunity for meaningful interaction and activity. As can be seen from Table 25.1, people who have recently entered a care home have especially high rates of depressive symptoms (Godlove Mozeley et al. 2000).

Personality and lifestyle can affect the likelihood of developing depression. For example, Ormel et al. (2001) found an association between neuroticism and depression. Also, previous heavy alcohol consumption has been found to be a risk factor for depression in men (Saunders et al. 1991).

Depressive symptoms or a depressive disorder have been reported to be associated with many different drugs (Dhondt et al. 1999). Such organic mood disorders due to drugs are usually caused by antihypertensives, steroids or analgesics.

There is increasing evidence that structural change in the brain increases some older people’s vulnerability to depression. Evidence is often complex and the significance of some changes remains controversial (Baldwin 2002). Brain changes of interest include mild cerebral atrophy, white-matter lesions, reduced regional cerebral blood flow, alteration in brain neurotransmitters and receptors and neuroendocrine disturbance. Interestingly, then, Ormel et al. (2001) in their study of risk factors found that 7.2% of new depressive episodes were not preceded by any of the psychosocial risk factors they were studying. They suggested therefore that vascular and other organic changes might account for such episodes.

Precipitating factors

Risk factors which are best regarded as precipitating factors include a range of acute life events and chronic stressors and are shown in Box 25.6.

Box 25.6 Precipitating factors for depression

<table>
<thead>
<tr>
<th>Acute life events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement and separation</td>
</tr>
<tr>
<td>Medical illness or threat to life of someone close</td>
</tr>
<tr>
<td>Negative interaction with family member or friend</td>
</tr>
<tr>
<td>Financial crisis or theft</td>
</tr>
<tr>
<td>Sudden homelessness or having to move into an institution</td>
</tr>
<tr>
<td>Acute physical illness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chronic stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declining physical health, disability and handicap</td>
</tr>
<tr>
<td>Sensory loss and cognitive decline</td>
</tr>
<tr>
<td>Problems at work; retirement</td>
</tr>
<tr>
<td>Housing problems</td>
</tr>
<tr>
<td>Being a carer</td>
</tr>
<tr>
<td>Major problems affecting family member</td>
</tr>
<tr>
<td>Marital difficulties</td>
</tr>
<tr>
<td>Social isolation and experience of loneliness</td>
</tr>
</tbody>
</table>
The experience of life stress is associated with the onset of depression in older people. Again, in a prospective study, Brilman & Ormel (2001) found that health-related events and difficulties were the most common life stresses, followed by deaths of loved ones and problems in non-partner relationships. Women reported more difficulties, especially health-related, than men. More severe events were strongly associated with onset of a first episode of depression, but milder events only triggered a recurrent episode. Ormel et al. (2001) found that a high level of neuroticism (a vulnerable personality trait) and long-term difficulties (chronic stressors) increased the risk of depression in the presence of an acute life event.

In their prospective study Schoevers et al. (2000) found that spousal bereavement was the strongest predictor of incident depression. Turvey et al. (1999) found the rate of significant depressive symptoms was nearly nine times higher in recently bereaved over-70s than in those still married (15.3% versus 1.9% in men and 13.2% versus 3.4% in women). Such depressive symptoms shortly after a bereavement would usually be seen as part of a normal grieving process. However 12% were still experiencing such symptoms 2 years after bereavement: many of these older people would have developed a depressive disorder.

We have seen that depression is associated with many physical conditions such as chronic obstructive pulmonary disease, heart disease, stroke and cancer. For some conditions, such as myocardial infarction, for example, the depression may be an important cause whereas in others the physical illness causes the depression by changes in body chemistry or by brain damage (Mulley 2001). However, psychological factors such as increased social isolation or embarrassment may also contribute to depression. For example, the depletion of the neurotransmitter serotonin in Parkinson’s disease may be linked to the development of depression (Cummings & Masterman 1999) but psychological factors are also likely to be important. Endocrine and metabolic disturbances such as pernicious anaemia and disorders of thyroid function can also cause organic mood (depressive) disorder.

In another prospective study Prince et al. (1998) found that the strongest predictor for the onset of depression was disablement, especially handicap. Disablement is the long-term consequence of chronic limiting disease resulting in the restriction or lack of ability to perform a particular task. Handicap is the disadvantage for an individual in the performance of a normal role. As we have seen above, certain chronic diseases are associated with depression. Prince et al. (1998) suggest that the aspect of the poor physical health that confers risk of depression is not the type of disease or impairment but the manner in which it disadvantages the performance of normal roles, i.e. handicap. That is, how it disadvantages the individual in mobility, orientation, occupation, social integration, physical independence and economic self-sufficiency. Lack of contact with local friends was the only social support measure that was a risk factor for onset of depression. Conversely, higher levels of social support of this kind acted as a buffer, reducing the risk for depression in the presence of handicap. Also, the subjective experience of loneliness (which is different to living alone) was a strong risk factor. Marriage protected against depression for men but increased the risk for women compared to never-married women. It was low levels of social support and participation, not disablement, that predicted the maintenance of depression. This study therefore points to disablement being an important chronic stressor.

Sensory problems such as visual or hearing impairment often contribute to depression (Evans et al. 1991). There are also factors which may protect or buffer against depression. These include good medical care, positive coping styles and social support (Baldwin et al. 2002). Again, in keeping with the dynamic stress-vulnerability model, Schoevers et al. (2000) found that being married had a protective modifying effect on functional disability as a risk factor for developing depression in the future. Social support had a similar effect in those not married.

Mental health promotion and the prevention of depression

Mental health promotion is any action to enhance the mental well-being of individuals, families, organizations and communities. It is also a set of principles which recognize that how people feel has a significant influence on health (Department of Health 2001a). Mental health promotion clearly has a role in preventing mental health problems. However, by improving mental well-being generally, it has a wider range of health, social and economic benefits.

It is clear from the summary of causative factors above that a wide range of physical, psychological and social factors can be implicated. It can be argued therefore that much physical health promotion activity is likely to impact on the risk of developing depression. Likewise, it can be argued that much health promotion activity that improves the social welfare of older people will impact similarly. The same applies to activities which enhance psychological well-being, for instance in providing bereavement support and encouraging active coping styles.
The UK National Service Framework for Older People (Department of Health 2001b) stresses the importance that maintaining physical health has on general well-being of older people. Older people should have access to mainstream health promotion and disease prevention programmes such as those described in the National Service Framework for Coronary Heart Disease (Department of Health 2000a) and The NHS Cancer Plan (Department of Health 2000b). Older people will benefit from health promotion activities such as increased physical activity (exercise), improved diet and nutrition, immunization and management programmes for influenza and strategies for preventing falls and their consequences and for preventing stroke (Department of Health 2001b).

Nurses have an important role in teaching older people about these interventions and encouraging their participation in them. Older people should be encouraged to consult their general practitioner (GP or family doctor) about physical problems at an early stage. The provision of aids and adaptations in the home to minimize the impact of disabilities will be important. Patients and carers need clear information about physical illnesses such as heart disease or stroke to encourage necessary adaptation and minimize disability and handicap. Carers also need to be helped to access the full range of support services available to maximize their morale.

The financial status of older people should be optimized. In 2000–2001 27% of older people of pensionable age lived on incomes below the poverty line (Help the Aged 2002). Nurses should always think to check a patient’s entitlement to welfare benefits if circumstances suggest a need. Referral to the social services department might be appropriate. Help with form filling will often be needed.

In their public health role nurses can influence developments in the local environment and its amenities. This will involve improvements in housing and transport, access to leisure facilities, libraries and adult education, for example.

It is clear from the evidence above on causes of depression that social support can have an important role in acting as a buffer to the development of depression and might aid recovery in those who are already depressed. Nurses can be involved in the development of local support services for older people, such as befriending services, luncheon clubs or day centres. The social support derived from having a network of friends and other relationships should help to protect an older person from some of the stresses of old age. More specifically there is good evidence of the value of social support in aiding adjustment to bereavement over the long term (Long et al. 2002). This literature review also points to the beneficial effects, certainly in the short term, of individual psychologically based interventions such as bereavement counselling. It is important therefore that the usefulness of such an intervention is explained to an older person and encouragement and help offered to access such services.

### BARRIERS TO EFFECTIVE MANAGEMENT OF DEPRESSION IN OLDER PEOPLE

Community surveys have consistently found that only small proportions of depressed older people are receiving treatment for their depression. For example, Prince et al. (1998) found that only 12% of their depressed community sample were prescribed antidepressants. Wilson et al. (1999) report a figure of 11%, but do note that this had risen from 4% over the 8 years of their follow-up study. Further surveys will inform us if such a trend has continued. Antidepressants are not the only treatment for depression. However, Blanchard et al. (1994) found that only 5% of their London sample were receiving counselling or supportive therapy and above the 14% prescribed antidepressants.

A crucial barrier to treatment is that depression in older people is often not recognized in the first instance. Primary care services have a central role here. GPs and community nurses will see many older people in the GP practice and at home and have the opportunity to detect the presence of mental health problems. Also workers of the social services departments will have many contacts with older people. A study of GPs’ awareness of depressed older people living at home in one electoral ward found that they were aware of 32 out of 62 (51%) older people found to be depressed by a psychiatric screening interview (Crawford et al. 1998). Those not recognized were more likely to be male, married, have high levels of physical handicap, have visual impairment and be less well educated. Banerjee & Macdonald (1996) found low recognition of depression by social services care workers. Also, Mullan et al. (1994) found that only 20% of surgery attenders judged to be depressed by the researcher had a diagnosis of depression recorded currently in their case notes. Junior doctors and general nurses have also been found to have problems detecting depression in older medical patients (Jackson & Baldwin 1993).

Depression in older people may go unrecognized for a number of reasons:

1. Older people may be less likely to present with overt feelings of depression and may present
more often with insomnia or somatic complaints such as pain.

2. Depression may be expressed in an unusual way, as hypochondriasis, complaints of loneliness, or as a behaviour problem such as persistent requests to be helped to the toilet or food refusal.

3. Older people and their relatives may not go to see their doctor or nurse because they do not recognize the problem as depression or know that it is treatable. Only 38% of depressed older people in one community survey said that they had discussed their psychiatric symptoms with their GPs (Blanchard et al. 1994).

4. Many professionals may lack knowledge and confidence in recognizing depression.

5. Some depressive symptoms may be regarded as part of the normal ageing process.

6. Depression may be overlooked when physical illness is also present: depressive symptoms may be considered ‘understandable’ in terms of the person’s physical state.

7. Similarly, depressive symptoms may be considered ‘understandable’ in terms of the person’s psychosocial background.

8. It is possible that some professionals collude with patients in not mentioning depression to avoid the stigma of mental illness.

9. Screening tests are not used routinely. The Audit Commission reports of services nationally for older people with mental health problems found that the majority of GPs do not use screening tests or protocols (Audit Commission 2002).

Nurses need to take note of the above factors so as to ensure that possible depression in older people is detected.

Another key issue militating against effective management is undertreatment of depression. In the Crawford et al. (1998) study, of the 32 known to be depressed, only 12 had active treatment (38%). Why do some older people who are found to be depressed appear not to be receiving treatment? It is possible that a GP has instituted an initial trial of treatment but that inadequate follow-up arrangements were in place to monitor continued compliance and response. Antidepressants may have been stopped too soon after recovery, resulting in relapse which is not reassessed for treatment. Denihan et al. (2000), in a study of prognosis in the community, found older people with more severe depressions to be twice as likely as those with milder depressions to be treated with antidepressants. Perhaps milder depressions were seen not to warrant antidepressant treatment. Recent research is indicating that this widely accepted stance may need reviewing in certain instances (Oxman & Sengupta 2002). Perhaps for an older person seeing the GP for a number of physical and possible mental health problems, the management of serious physical illness is prioritized over possible depression.

Certainly, many GPs report that they need more information and training on how to treat depression in older people (Rothera et al. 2002). Orrell et al. (1995), in a national questionnaire study, found that many GPs would often choose subtherapeutic doses of antidepressants, particularly of the older tricyclics. Also, antidepressants would be stopped too soon after recovery, thereby increasing the risk of relapse, and many would not refer to a psychiatrist or other mental health professional. Many GPs feel they do not have ready access to specialist advice so treatment may be delivered with little confidence (Audit Commission 2002).

**TOWARDS MORE EFFECTIVE MANAGEMENT OF DEPRESSION**

There is a need for more awareness of the nature of depression in older people amongst the public and professionals. Nurses have an important part to play in this mental health education role. Older people need to be made aware that depression is not a normal part of ageing, that there is no stigma attached to developing depression, and that it is an illness that is very treatable. Older people may then be more ready to go to their doctor or nurse to discuss their psychological symptoms. All professionals who come into contact with older people regularly in their work need more education about depression. Clearly, level of knowledge needed will vary depending on professional responsibilities. Nurses in all specialisms and in all settings should have the opportunity to become familiar with the key symptoms of a depressive disorder and with a screening instrument such as the Geriatric Depression Scale (GDS), discussed in the next section. They should also have some understanding of the range of treatment options and an awareness of the role of different professionals in providing comprehensive care.

Screening and education need to influence management and outcome. Routine screening alone, with increased detection, in primary care or on a general medical unit for example, does not necessarily lead to treatment and improved outcome (Iliffe et al. 1994, Weatherall 2000). Education on management generally may improve skills depending on how it is offered. For example, an educational package delivered to GPs...
by old-age psychiatrists has shown improvements in clinical knowledge and attitudes (Butler et al. 1997). However, one delivered by a nurse to GPs failed to generate results due to poor attendance and low return of evaluation questionnaires (Livingstone et al. 2000).

The adoption of a care pathway approach by the whole team, primary care or hospital ward, can be a way forward. The results of initial screening proceed to the next stage of physical screening and mental state examination and diagnosis and then, importantly, to treatment and follow-up. Other factors that should improve overall management are the integration of primary care with the specialist mental health services, the use of care coordinators and the use of liaison psychiatric services in hospital. A number of studies have shown how nurses in the role of care coordinators can positively influence the outcome of depression in older people (Waterreus et al. 1994, McCurren et al. 1999). The linking of a community psychiatric nurse (CPN) to a general practice should provide opportunities for education of primary care staff, ongoing advice and support, and a care coordinator role for certain patients. The importance of such a role for members of the specialist mental health services is emphasized in the National Service Framework for Older People (Department of Health 2001b).

Screening is most efficient when targeted at high-risk populations. Baldwin et al. (2002) recommend screening in primary care in the following instances:

- recent major physical illness
- chronic handicapping illness
- receiving high level of personal care at home
- recent bereavement
- socially isolated
- those who persistently complain of loneliness or sleep difficulties.

Also, patients in acute general hospital wards, people in residential and nursing homes and carers of people with stroke, dementia or depression would be useful targets (Wattis 2001).

As emphasized above, screening is only effective when it leads to appropriate care and treatment by being part of a care pathway approach, for example.

**ASSESSMENT OF DEPRESSION IN OLDER PEOPLE**

**The Geriatric Depression Scale**

Nurses in different settings will be helped in detecting depression by the routine use of the GDS, developed specifically for detecting probable depression in older people.

The GDS consists of 30 questions which concentrate on the thoughts and feelings of depression as they have been experienced over the past week (Stiles & McGarraham 1998). The GDS avoids asking about physical symptoms as these could readily be of physical illness rather than depression. Its simple yes/no answer format is easy to complete and can also be administered by interview for further ease if eyesight or manual dexterity is poor. A cut-off score of 11 or more indicates probable depression. The original validation study was with psychiatric outpatients and inpatients (Yesavage et al. 1983). The GDS adequately detects depression in medical patients (Jackson & Baldwin 1993) and it has been found to be effective in primary care (Evans & Katona 1993).

A short form of the GDS has been developed with just 15 questions (Sheikh & Yesavage 1986) (Box 25.7). This is especially useful when fatigue and poor concentration are problems, with physically ill patients for example. Scores of six or more indicate probable depression. A number of studies now point to its usefulness as a screening instrument for older people living at home (Arthur et al. 1999), for primary care attenders (D’Ath et al. 1994), for psychiatric outpatients (Almeida & Almeida 1999) and for medical patients (Pomeroy et al. 2001). It also remains effective for those over 85 years of age (De Craen et al. 2003). The total score on the 15-item version appears to correlate with severity of depression (Almeida & Almeida 1999).

A 12-item version (GDS-12R) has been developed for use in residential and nursing homes (Sutcliffe et al. 2000). Items 9, 10 and 15 were omitted as they were frequently misunderstood by residents of care homes. The scale’s performance was not affected by moderate to high levels of cognitive impairment. A four-item version (comprising questions 1, 3, 6 and 7) will identify most primary care patients with significant depression (D’Ath et al. 1994). However this is recommended for rapid screening only (Baldwin et al. 2002). There is a website dedicated to the GDS with details of current versions and translations (www.stanford.edu/~yesavage/GDS.html).

**Assessment of depression by nurses**

Nurses will assess older people with depression in a variety of settings. Whether the assessment is taking place in hospital, at home or in a residential or nursing home, the assessment will usually need to involve more than one profession. Effective multidisciplinary working is therefore essential to the process. For
further discussion of nursing assessment readers are referred to Neal et al. (2001).

In addition to using an appropriate screening tool, an assessment should cover the following main areas:

- severity of current episode
- duration, development and maintaining factors
- past history of mood disorder and response to treatment
- previous personality and family history of mood disorder
- current symptom profile
- risk assessment
- main problem areas as seen by the client
- social network
- current and past physical problems
- current medication and compliance

Severity can be judged on ICD-10 diagnostic guidelines (Box 25.1). Possible causative factors in the development of the depression should be noted as these may require specific intervention, in the case of deteriorating physical health or bereavement, for example. The same applies to maintaining factors such as avoidance of going out or abuse of alcohol. Family dynamics should be assessed as inappropriate interactions may have developed during the development of the depression which will now work against the treatment plan. For instance, a carer might have become frustrated and irritated by the lack of interest and motivation of the sufferer. As a result the carer may have withdrawn somewhat, thereby unwittingly intensifying the lack of motivation and withdrawal of the sufferer. Enquiries should be made of any previous depressive or manic episodes and the response to any treatment. Any family history of such problems should be sought as should a description of usual personality.

As we have seen, an older person may not complain of depressed mood as such so it is particularly important to assess for anhedonia (the inability to experience pleasure) and psychological symptoms. This is especially so for patients with physical illness when symptoms of sleep disturbance, appetite change, fatigue and psychomotor retardation may equally be due to a depression or the physical illness. In assessing for the presence of anhedonia it is important to ask about activities the person usually engages in and enjoys, and whether such activities have been dropped, and why. Psychological symptoms include self-perception, how the patient sees the world and how he or she sees the future. Marked negative thinking in any of these areas is indicative of a depressive disorder.

Often we need to assess the significance of depressive symptoms in someone who has been bereaved in recent months. Depressed mood, loss of interest, poor concentration, poor sleep, poor appetite, weight loss and agitation are all common features of normal grieving in older people. However, grief can be complicated by the development of a depressive disorder (Worden 1991). How can we tell when this might be the case? Specifying no particular age group, DSM-IV suggests that even though such symptoms might meet criteria for major depression, they should be considered as bereavement unless they persist for more than
2 months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideas, psychotic symptoms or psychomotor retardation (American Psychiatric Association 1994). Turvey et al. (1999) suggest that, given that widows and widowers in later life have lost a – possibly lifetime – companion, a period longer than 2 months may be expected. The most severe symptoms should normally have improved after 6 months or so.

Some older people who present with depression also have some cognitive impairment. This then should also be assessed, including use of the Mini-Mental State Examination (Folstein et al. 1975). It is possible that some have a dementia and have become depressed. Interestingly, however, it has been suggested that in some patients depression (in association with some cognitive impairment) may be a prodrome to dementia (Schweitzer et al. 2002). In other words, the depressive syndrome is seen as an early manifestation of a developing dementia. In their review Schweitzer et al. (2002) conclude that it is patients with late-onset depression who are more likely to have cognitive impairment and are more likely to progress to dementia. The implication for nurses is that such patients should have close follow-up. Importantly, though, not all patients with late-onset depression will inevitably go on to develop dementia. The link between the depression and the dementia may be due to the sharing of a common aetiological pathway (e.g. via vascular pathology). Alternatively, it has been hypothesized that persistently raised levels of cortisol damage the hippocampus, the brain structure which is central to memory function (Steffens et al. 2000). Raised cortisol levels result from hyperactivity of the hypothalamic–pituitary–adrenal axis which is associated with depression.

A detailed risk assessment must be undertaken. Areas of risk are clearly important to assess as they have implications as to whether the person may need to be treated urgently in hospital, or whether an intensive supportive package needs to be arranged urgently to maintain the person safely in the community. It is essential to assess for thoughts of suicide. Asking about suicidal thoughts does not encourage suicidal acts. ‘Do you ever think that life is not worth living?’ is a useful initial question. Increasing levels of severity of suicidal ideas are indicated by the following thoughts:

‘Life is not worth living’ – without any thoughts of self-harm.

‘I think I would be better off dead’, and the most serious: ‘I can’t go on, I’m going to end it all’ – the means of self-harm is likely to have been considered.

The following factors would indicate higher risk (Baldwin et al. 2002):

- older age (especially over 80), male gender, isolation, recent bereavement
- history of previous suicide attempt(s)
- chronic and painful physical disorder, abuse of alcohol or sedatives
- clinical picture of severe depression with agitation, guilt, hopelessness, insomnia and hypochondriasis

Possible self-neglect is the other main risk area. Neglect of food, and particularly fluids, can soon put an older person in danger. Neglect of self-care and heating of accommodation also need assessment. Risk assessment should be ongoing so that risk is monitored by regular reviews of the patient.

Assessing people’s view of the situation and the main problem areas as seen by them are important in planning care. Their social network should be carefully assessed. Particularly supportive relationships should be noted as these can be used to help in treatment. It is not always the tangible support that is most important; a particular source of support may have more meaning to a person’s situation and problems and be perceived as more supportive. A change in overall pattern of social network may be needed in acute treatment and for relapse prevention. The effect of the current problems on family and other carers should be assessed as they may require support themselves. Carers can also become depressed.

Many physical illnesses can present with symptoms of depression such as fatigue, loss of appetite, psychomotor retardation or depressed mood. Examples are disorders of thyroid function, electrolyte disturbances, anaemia, vitamin deficiencies and malignancy (Wattis & Curran 2001). It is important therefore that medical examination and indicated investigations are carried out in all persons being assessed for depression. Also, the disabling effects of conditions such as arthritis or stroke should be assessed as supportive measures to maximize understanding and independence and counter handicap will contribute to treatment of the depression.

Note should be made of any medication being taken. The person may be taking medication that can contribute to depressive symptoms such as antihypertensives, steroids or analgesics. An antidepressant may have been prescribed but at a subtherapeutic dose. Level of adherence to current medication should be assessed as this will help guide any further prescribing and monitoring.
CARE AND TREATMENT OF DEPRESSION
AND THE ROLE OF THE NURSE

Nurses from different specialisms will see depressed older people in a variety of settings. District nurses and health visitors are likely to have some depressed older people on their caseloads whom they see at home. Practice nurses will see depressed older people in their work in the GP surgery or at home. As hospital inpatients or day patients, depressed older people will be seen by other general nurses. In my own practice as a CPN for older adults, depression accounts for around a third of my caseload at any one time. Older people with the most severe problems will be nursed by mental health nurses in psychiatric units.

Although different nurses will have somewhat different roles and levels of involvement with their depressed older patients, there are a number of important principles to care and treatment which will apply in all settings. There are also some fundamental elements to the nursing approach which can be applied in varying degrees by different nurses in different settings. I will call this the generic nursing approach. It is recognized that in most situations the priorities of the general nurse will be in the more physical aspects of nursing care. However, most general nurses will have sufficient knowledge and skills to implement this generic approach with depressed, physically ill patients. As discussed in the next section, this approach involves relationship building, giving support and information and enabling change in thinking patterns, activity and skills.

Specialist mental health nurses will use the generic approach but will also develop it in terms of:

- more specialist assessment, including risk assessments
- more in-depth and intensive interventions, including psychological therapy and medication management
- care coordination functions
- advice to, and supervision of, other professionals.

Specialist mental health nurses are likely to be involved therefore when reassessment is needed, when depression is more severe with significant risk or psychosis present, or when initial treatment has failed so that more specialist intervention is required.

Principles of care and treatment of an older person with depression

The following important principles apply when nursing any depressed older person:

1. It is a problem-solving exercise based on a thorough assessment
2. It is usually a multidimensional approach with some combination of physical, psychological and social interventions
3. A multidisciplinary approach is therefore usually needed
4. Care needs to be coordinated
5. The timing of interventions is important
6. Physical condition should always be monitored and problems treated
7. Family members and other carers should be involved where appropriate.

Fundamental elements of the nursing approach

The therapeutic relationship

Nurses often form close relationships with their patients. Also, they are usually well aware that the quality of the relationship is an important element in their patient's recovery. Such a close relationship is fundamentally important in nursing people with mental health problems. A key ingredient of the therapeutic relationship is the personal qualities of the nurse. These personal qualities are those described by Carl Rogers in his work on client-centred counselling as the key personal qualities of the 'effective helper' (Rogers 1967). These personal qualities are not simply counselling techniques that can be learnt. They are said to be more of the order of personal convictions and these need to be communicated to the patient at least to some degree.

Key personal qualities

Warmth  Nurses should have a warm, positive and accepting attitude to patients. They should realize that patients have an inherent worth and dignity deserving of respect. This warmth will be conveyed to the patient in general manner, tone of voice and way of phrasing words.

Empathy  Empathy is the ability to see and understand the world as the patient sees it. Nurses need, to some degree, to be able to understand how the patient is feeling and communicate this understanding to the patient.

Genuineness  This refers to the quality of the nurse in having genuine professional interest in patients and their problems. Nurses need at times to be able to share their own feelings with the patient in an open honest manner and not hide behind the professional facade.

The establishment of a therapeutic relationship encompassing the above qualities is the foundation for nursing older people with depression.
The generic nursing approach

Nurses can help depressed older people by being with them and listening to them. Rapport and understanding will only be established by spending time with the person. The overall approach should generally be gentle and accepting. A light-hearted approach aimed at trying to ‘cheer the person up’ is not helpful. It will merely communicate a lack of understanding and lack of respect for the person’s feelings. It may often be necessary to speak more slowly and allow more time for the person to respond. If individuals are severely depressed and say very little then just being with them can be of comfort and communicate a genuine concern for their well-being.

A depressed person should be encouraged to express thoughts and feelings. Clearly, counselling skills are important here. The person is likely to feel some relief from expressing any concerns about the past or present. Also, such expression will allow the nurse to monitor the person’s current mental state. The individual may feel in a hopeless situation with no future. Information-giving is important. The nurse can gently reassure the person that, although recovery from the depression may be slow and possibly take many weeks, improvement will occur. Again such reassurance needs a gentle considered approach so as not to communicate a lack of understanding of the person’s situation. All the above aspects of care detail the supportive role that nurses have.

The generic nursing approach involves care which enables changes in thinking patterns, activity and skills. When depressed, a person often neglects usual interests and activities, including those that were previously enjoyable. People also commonly think that they cannot resume such activities until their depression has lifted. However, it is clear that engaging in enjoyable activity which also gives a sense of achievement is a powerful antidepressant. It is important, therefore, for the nurse gradually to engage the person in potentially enjoyable activity. It will be important to negotiate realistic goals at each stage of treatment. The depressed person should also gradually be encouraged to resume previous social contacts. Family involvement in care is important here.

Nurses should also be aware that there is increasing evidence for the positive effects of exercise on depressive symptoms in older people (Mather et al. 2002, Penninx et al. 2002). Older people can be encouraged to attend established groups as part of their treatment plan or nurses can develop new exercise programmes in hospital and community settings.

Negative thinking very often dominates a depressed person’s perception of reality. Negative evaluations of events and situations may occur automatically so that the person is quite unaware of the process. Negative thinking will perpetuate the depressed mood. The nurse can gently help the person to identify such thoughts and help to examine them so as to see them in a more rational light. Distraction from preoccupation with negative thinking is also important at times so the person can be encouraged to socialize or take part in activities.

Depending on individual circumstances, including the severity of the depression, the following physical aspects of care will need consideration:

- monitoring of fluid and food intake
- offering preferred foods with regular small meals
- monitoring weight
- bowel care
- enhancing sleep by avoiding frequent daytime naps and planning activities according to energy levels
- assisting with personal care and promoting independence by positive reinforcement.

For further discussion of the above aspects of care readers are referred to Stuart (1998).

Physical treatments and the role of the nurse

Antidepressant drugs

The pharmacological treatment of depression is usefully conceptualized as having an acute phase followed by a continuation and a maintenance phase, as illustrated in Figure 25.1. Successful acute treatment should be followed by 12 months of continuation treatment in order to prevent relapse (Anderson et al. 2000). Longer-term maintenance treatment, possibly indefinitely, is recommended for individuals with a history of several depressive episodes, chronic depression or bipolar disorder in order to prevent recurrence.

![Fig. 25.1 Phases in the pharmacological treatment of depression.](image-url)
In summarizing the evidence base for the treatment of depression, Baldwin et al. (2002) offer the following guidance:

- for psychotic depression – antidepressant and antipsychotic drug
- for severe depression – antidepressant plus psychological therapy if possible
- for moderate depression – antidepressant or psychological therapy
- for dysthymia – antidepressant (Williams et al. 2000)
- for recent-onset minor depression – education, support and re-evaluation
- for minor depression when functional impairment is severe or if symptoms persist or worsen after a 4–6-week period of support – antidepressant (Williams et al. 2000)
- for grief or bereavement – as for moderate depression if indicated.

A recent review of the treatment of minor depression showed that the response to active control conditions across all age groups ranges from 35% to 68% (Oxman & Sengupta 2002). These authors suggest therefore that amplification of non-specific treatment factors may be an important strategy for management: these include therapeutic empathy, contact and social support, providing a treatment rationale, talking about one’s problems to an attentive professional and behavioural activation. Interestingly, the generic nursing approach described earlier encompasses all of these factors and so may arguably be very helpful in treating many older people with milder depressions. Many such people will be seen by primary care nurses, and by general nurses in medical and surgical settings where, as we have seen, non-major depression can be very common. Psychological therapy is discussed further in the next section.

Table 25.3 shows some of the antidepressants prescribed for older people. Side-effects and dosages are shown. It is not a comprehensive list but it illustrates the classes of antidepressants that may be prescribed.

In moderate to severe depression up to around 60% of patients significantly improve with antidepressants (Mittman et al. 1997). The response to placebo is often up to 30%. There is no difference in efficacy between different classes of antidepressant. Older people usually take longer to recover. There appear to be no differences between antidepressant drugs in terms of speed of onset. A therapeutic trial may last up to 12 weeks. Older drugs such as the tricyclic antidepressants have more dangerous side-

<table>
<thead>
<tr>
<th>Type of action</th>
<th>Antimuscarinic effect</th>
<th>Antidiurenergic effect</th>
<th>Antihistaminic effect</th>
<th>Starting dosage (mg)</th>
<th>Average daily dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lofepramine</td>
<td>Newer TCA</td>
<td>1</td>
<td>1</td>
<td>70–140</td>
<td>70–210</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>SSRI</td>
<td>0–1</td>
<td>0</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>SSRI</td>
<td>0–1</td>
<td>0</td>
<td>10–20</td>
<td>20–30</td>
</tr>
<tr>
<td>Sertraline</td>
<td>SSRI</td>
<td>0–1</td>
<td>0</td>
<td>25–50</td>
<td>50–100</td>
</tr>
<tr>
<td>Citalopram</td>
<td>SSRI</td>
<td>0–1</td>
<td>0</td>
<td>10–20</td>
<td>20–30</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>SNRI/blocks 5HT</td>
<td>0–1</td>
<td>0</td>
<td>25–75</td>
<td>75–200</td>
</tr>
<tr>
<td>Trazodone</td>
<td>SSRI/blocks 5HT</td>
<td>0</td>
<td>3</td>
<td>100</td>
<td>300</td>
</tr>
<tr>
<td>Nefazodone</td>
<td>SSRI/blocks 5HT</td>
<td>0–1</td>
<td>0</td>
<td>50–100</td>
<td>150–300</td>
</tr>
<tr>
<td>Moclobemide</td>
<td>RIMA</td>
<td>0–1</td>
<td>0</td>
<td>300</td>
<td>300–450</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>NaSSA</td>
<td>0</td>
<td>2</td>
<td>7.5–15</td>
<td>15–30</td>
</tr>
</tbody>
</table>

TCA, tricyclic antidepressant; SSRI, selective serotonin reuptake inhibitor; SNRI, selective serotonin and noradrenaline (norepinephrine) reuptake inhibitor; 5HT, 5-hydroxytryptamine (serotonin); RIMA, reversible inhibitor of monoamine oxidase; NaSSA, noradrenergic and specific serotoninergic antidepressant.

Notes: Effect size on an arbitrary scale from 0 (least effect) to 5 (most effect).
Antimuscarinic effect: dry mouth, blurred vision, constipation, urinary retention, sweating, confusion, worsening of glaucoma.
Antidiurenergic effect: postural hypotension, dizziness, falls.
Antihistaminic effect: oversedation, weight gain.
SSRIs: more common side-effects include: nausea (15%), diarrhoea (10%), insomnia (5–15%), restlessness or anxiety (2–15%), headache, weight gain and hyponatraemia.

Starting and average daily dosages are only a guide; they may vary depending on individual circumstances.
effects. Newer drugs, as listed in Table 25.3, are safer in overdose (Wilson & Curran 2001). For medically ill patients newer drugs have much fewer contraindications. It is therefore not surprising that in primary care selective serotonin reuptake inhibitors (SSRIs) are now favoured as the first line of treatment in many countries (e.g. Rothera et al. 2002).

There are a number of potential strategies for the patient who does not respond to first-line treatment:

- increasing dose if not optimal
- extending the length of treatment
- switching class of antidepressant
- prescribing lithium salts alongside the antidepressant (lithium augmentation)
- using electroconvulsive therapy (ECT) (Baldwin et al. 2002).

Nurses have an important role in caring for someone prescribed an antidepressant. The nurse needs to teach the patient and family about important aspects of antidepressant therapy including the rationale for taking the medication alongside other interventions. Antidepressants can take up to 4–6 weeks to produce any benefit. It is especially important therefore to support patients through these early weeks. They might experience side-effects, making them feel worse, but with little change in depressive symptoms. They then might be tempted to stop taking the medication because 'it was not working'. Adherence can always be a problem. Packaging in drug drawers or Dossett boxes or in blister packs can help adherence, especially if the patient has memory problems. Carers may need to prompt the patient to take medication. The patient should be informed of possible side-effects. These need to be closely monitored by the nurse and reported to the doctor. Patients taking lithium should be warned about the risk of toxicity and told to stop taking the lithium if they become unwell, particularly with diarrhoea, nausea or vomiting, and inform their doctor. Clearly, overall response, or non-response, to medication should be monitored as dosage may need to be gradually increased. The nurse also needs to ensure that the patient does not stop taking the drug when feeling better. As we have seen, the drug should be continued into the continuation phase and possibly a maintenance phase. It is particularly important to monitor a patient with suicidal ideas closely. An antidepressant that is considered to be safer in overdose may be prescribed and it should be prescribed in smaller quantities.

**Electroconvulsive therapy**

The main indication for ECT is severe depression, particularly when antidepressants have failed (Benbow 2001). It may be the treatment of choice for patients who have a history of not responding to antidepressants but responding to ECT. It may also be the first-line treatment for patients whose lives are threatened by high suicide risk or if refusing to eat or drink. It is often considered as the treatment of choice in psychotic depression. The response rate in patients for whom it is indicated is 70–80%. It has been used for people with a range of concurrent physical illnesses and for the very old. Although there are no absolute contraindications, older people with cardiovascular and neurological conditions need particular attention given to management of the physical condition and treatment technique.

The procedure involves passing a small current through the brain, either longitudinally through the non-dominant hemisphere (unilateral ECT) or across the brain through both hemispheres (bilateral ECT). The patient is given a short-acting general anaesthetic and a muscle relaxant. The grand mal-type fit that is induced by the passage of current is then hardly noticeable. It is suggested that bilateral ECT is usually the method of choice, often being more rapidly effective, but that unilateral ECT is preferred in the presence of pre-existing cognitive impairment. ECT is usually administered twice weekly with a course length of between 6 and 12 treatments.

Side-effects of ECT which occur occasionally and are usually only mild include headaches, muscular aches, drowsiness, weakness, nausea and anorexia (Benbow 2001). Cognitive side-effects may occur. ECT can affect memory for events prior to treatment (anterograde amnesia) and which take place after treatment (retrograde amnesia). Acute confusional states may develop between treatments.

The role of the nurse in ECT involves the physical and psychological preparation of the patient, preparation of equipment, safe handling of the patient during administration of treatment and recovery of the unconscious patient afterwards. ECT arouses much anxiety. Nurses particularly have an important role in teaching patients and their relatives about the nature and procedures of ECT.

**Psychosocial interventions**

In the multidimensional approach to treatment a range of psychosocial interventions have an important role either on their own or alongside physical treatments. When social isolation, poor housing or bereavement, for example, have contributed to the development of the depression, a complete and lasting recovery is unlikely unless these psychosocial factors are dealt with in their own right. A person may be able to receive psychological therapy for depression if
indicated or preferred. Nurses have an important role in delivering psychosocial interventions.

**Psychological therapy**
A number of research reviews (Pinquart & Sorensen 2001) have now provided evidence for the efficacy of the following interventions for depression in older people:

- cognitive-behavioural therapy (CBT)
- interpersonal therapy (IPT)
- brief psychodynamic therapy
- problem-solving therapy
- life review

Of these, the strongest evidence of efficacy exists for CBT and IPT (Hepple et al. 2002). These are therefore described in more detail below. There is some evidence that problem-solving therapy may be effective for minor depression (Williams et al. 2000).

**Cognitive-behavioural therapy and interpersonal therapy**
Both are structured forms of psychological therapy aimed at alleviating symptoms and helping the patient to deal more effectively with the problems associated with the depression. They are time-limited problem-solving and focus on the 'here and now'.

In CBT the emphasis is on the negative thinking that is characteristic of depression. The contemporary theoretical view is that negative thinking is part and parcel of the depressive syndrome but is a particularly important symptom. Negative thinking does not cause the depression but it may be important in shaping and maintaining it. Thinking is often distorted in a negative way so that the person has a negative view of self (I’m useless), the world (the world is a terrible place to live in) and the future (I’ll never get better). Underlying such negative automatic thoughts are beliefs, attitudes and assumptions about the self and the world which are, in the case of depressive thinking, ‘dysfunctional’ or unhelpful in that they are fixed, excessive and difficult to change. An example of a dysfunctional belief might be ‘unless I can always be physically well, I cannot be happy’. The cognitive model explains depression at one level without negating biological and sociological elements and cognitive distortions are important entry points into the depressive system for therapy. CBT aims to alleviate depressed mood and other symptoms of depression by changing this pattern of negative thinking and so allow other problems to be tackled. Therapy usually involves a range of behavioural as well as cognitive techniques to achieve this end. Behavioural techniques are often used early in therapy to counteract inactivity and loss of motivation. For example, activity scheduling is a technique which involves the patient and therapist agreeing on tasks to be done (scheduled) on an hour-to-hour basis throughout the day so as to increase general activity levels. The patient is then encouraged to monitor and rate the activities on giving a sense of mastery and pleasure. As well as increasing activity levels the patient is providing evidence that can be used to challenge negative thinking such as ‘I never get anything done’ or ‘I can’t enjoy myself any more’. In graded task assignment, challenging tasks (e.g. walking into town for shopping) are initially broken down into small achievable parts which are practised as homework (e.g. walking to the end of the street) and then the task is gradually built up.

Cognitive techniques involve identifying negative automatic thoughts and the related emotion and recording the situations in which they arose. The aim then is to modify negative thinking by active challenge by, for example, examining the evidence for and against the thought or collecting alternative information through behavioural experiments. It is also important that any unhelpful underlying rigid beliefs are identified and also challenged, not to change them but to add some flexibility to them.

In IPT the emphasis is on the connection between the onset of depressive symptoms and current interpersonal problems. It is based on the research evidence that close interpersonal relationships play a role in preventing depression and that disruption of those relationships can have a causal role in depression. Attention is on current interpersonal relationships as a focus for treatment. Indepth exploring of early life events is avoided. The therapist formulates a proposed focus for treatment in one of four broad areas: (1) grief; (2) role transitions; (3) interpersonal role disputes; and (4) interpersonal deficits. Techniques involve exploration and direct elicitation of the problem area, encouragement and acceptance of painful affect related to this, examining problems in communication in the area and behaviour change techniques. Education is an essential function of IPT in that ultimately all interventions are aimed at teaching patients about their interactions with others. Patients are taught to analyse situations, solve problems for themselves and make their own choices.

**Other psychological approaches**

**Grief work** Grief work is mentioned here separately because in working with depressed older people it is a very common part of therapy. It involves expressing emotions (catharsis) and letting go of lost loved ones. It can be a focus of IPT, as above, and cognitive-
behavioural interventions may be appropriate (Rick-ets 1995). Also, a person may grieve for lost physical functioning due to stroke, for example. However, as Knight (1996: p. 126) succinctly points out, the processes and goals are quite different: 'In brief, lost functioning is often recovered or compensated, but deceased people stay deceased'.

Non-directive client-centred counselling Counselling is an important intervention when a patient needs help in resolving specific problems, making decisions, coping with crises, working through conflict or improving relationships with others (Department of Health 2001c). This will often be needed as part of the multidimensional approach to the treatment of depression. However, research evidence for the effectiveness of non-directive counselling in treating depression in older people is still lacking. Nonetheless, nurses usually spend a lot more time with patients than other professionals and so have opportunities to use their counselling role to help patients in many ways. In relation to depression a counselling approach will probably be most appropriate alongside social and practical interventions in the milder depressive disorders.

Family work Family issues commonly arise in treatment and, although some can be resolved fairly easily, others may require formal family therapy, especially when family discord, for example, is maintaining depression and preventing recovery. Readers are referred to Pearce (2002) for an account of the development of family (or systemic) therapy with older people. However, this approach to depression still requires further evaluation in older people.

Social and practical interventions In the multidimensional approach to depression described here nurses have a role in implementing other psychosocial interventions. These might include: arranging transport to the optician or chiropodist, for example; referral to check on welfare benefit entitlement; referral to a day centre, luncheon club or support group; referral for domiciliary services such as home care and delivery of meals; and help with rehousing. The timing of social interventions such as referral to a day centre needs careful consideration. Severely depressed people will probably need antidepressant or psychological therapy to begin to lift mood and energy levels; only then might they be able to consider changes in their social network.

In the light of the above it is useful to reflect on the case studies presented earlier. Mary Smith (Case study 25.1) had major depression. As there were no signifi-
the home to give advice and support in the development of care planning skills. At the 6-month follow up, the mean decrease in depression scores was significantly larger for residents in the intervention homes than for those in the control homes.

Rabins et al. (2000) studied psychiatric nurses in a mobile outreach programme for residents of three public apartment buildings in the USA: three other buildings formed the control group. In the intervention group, building staff were trained to be case-finders; nurses carried out assessments in residents’ apartments and provided care as indicated. Most frequent interventions were counselling, patient education about their illness and positive health behaviours, and ensuring medication compliance. The mood disorder group showed significant improvement in depressive symptom score compared to the control group.

Kurlowicz (2001) reports on the work of a psychiatric consultation liaison nurse (PCLN) in a US teaching hospital. The nurse was consulted by staff in medical and surgical wards and assessed and developed a joint care plan with ward staff. Interventions by the PCLN were ongoing assessment, supportive and IPT, advice to ward staff, daily review of medications, recommendations for referral to a psychiatrist, family support and nursing care plan modifications. At follow-up before discharge, patients referred with depression showed a significant decrease in mean depression scores, but there was no control group.

Finally, a randomized controlled trial has demonstrated the effectiveness of a multidisciplinary team approach in the UK. Banerjee et al. (1996) examined the approach to depressed older people receiving home care from a local authority in inner London. A management plan was implemented by an assigned team member (including nurses) with a range of interventions being implemented. At 6 months 58% had recovered versus 25% in the control group of usual GP care.

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### The Prognosis of Depression in Older People

What is the outcome for depression in older people in the community if it is not treated? A 5-year follow-up study in Liverpool, UK is worrying (Sharma et al. 1998). Over that period 41 (34%) out of an original 120 cases had died, 33 (28%) dropped out of the study and 46 (38%) had complete follow-up. Of these 46 cases, only 22% had recovered, 24% had been continuously depressed and the remaining 54% had fluctuating levels of symptoms. Importantly, the majority of people with depression were not receiving treatment.

A 3-year follow-up study in Dublin showed the outcome of depressed older people detected in the community when GPs were informed of depressed cases and treatment recommended (Denihan et al. 2000) (Table 25.4). Only just over 10% had fully recovered. Of those still alive at 3 years, 50% were still depressed. Undertreatment appears to be a significant factor in the poor prognosis. Of those who had recovered at 3-year follow-up (i.e. well or subclinical cases), 63% were or had been prescribed antidepressants. Of those still depressed, the figure was only 38%, and 29% of these had received subtherapeutic doses.

The prognosis for older people whose depression has required hospital treatment as an outpatient or inpatient is shown in Table 25.5. These are the results of a meta-analysis of a number of hospital-based studies of major depression (Cole & Bellavance 1997). In the long term it is clear that less than half of those treated will remain well, with relapse and chronic symptoms being common.

Another significant finding of outcome studies is that the death rate in older people who have become depressed is often higher than normally expected at that age (Saz & Dewey 2001). Suicides only account for a small number of deaths at follow-up. Poorer physical health contributes to increased mortality but is not the sole explanation. The main causes of death reported are vascular disease (cardiovascular or cere-

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### Table 25.4 Three-year outcome of depression in older people in a Dublin community sample (expressed as %)

<table>
<thead>
<tr>
<th></th>
<th>Fully recovered</th>
<th>Depressed</th>
<th>Died</th>
<th>Other case</th>
<th>Subclinical case of depression</th>
<th>Other subclinical case</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cases (n = 106)</td>
<td>10.4</td>
<td>34.9</td>
<td>30.2</td>
<td>4.7</td>
<td>8.5</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Subclinical case, some symptoms present but below case-level threshold.
Adapted from Denihan et al. (2000) with permission.
brovascular), carcinoma and respiratory disease. It is not clear why this should be, although it is possible that stressful life events contribute to heart disease and depression and that depression has an adverse effect on the immune system.

A number of factors are associated with a poorer prognosis. These include slower initial recovery, severity and chronicity of the depression, psychotic symptoms, dementia, chronic stress, a new physical illness and poor perceived social support (Baldwin 2002).

**Improving prognosis and the role of the nurse**

The studies reviewed here again emphasize the importance of detecting and comprehensively treating depressions in older people. Otherwise a chronic course will follow or relapses will be common. Nurses have an important role in improving prognosis:

1. The initial episode of depression should be adequately treated whatever the setting. Nurses will have a role in delivering psychological and social interventions as an adjunct or alternative to physical treatments.
2. When antidepressants are used adherence should be carefully monitored in the acute, continuation and maintenance phases of treatment.
3. New physical illness should be promptly treated.
4. Patients with dementia who become depressed should be recognized and treated appropriately.
5. Nurses can be involved in support groups which will be important in preventing relapse.

Nurses can coordinate the plan of care and treatment. A coordinated care plan should ensure that everyone involved in the person’s care knows to report changes in mood and behaviour to the care coordinator so as to detect early signs of possible relapse. Antidepressant medication may need reviewing, the person may need to attend the day hospital again or a new concern over finances or family, for example, may need a psychological or social intervention.

**SUICIDE IN OLDER PEOPLE**

It is beyond the scope of this chapter to give a detailed account of suicide in older people. Readers are referred to Harwood (2002) for a good introduction.

As discussed earlier, it is crucial that suicide risk is assessed in a depressed older person since the majority (up to 87%) of older people who commit suicide will have been suffering from a depressive disorder prior to death (Harwood et al. 2000). Similar rates are found in older people who have attempted suicide. Physical illness and complaint of pain are also strongly related to suicide in older people.

The rate of suicide in older people in England and Wales has been declining in both sexes, with the exception of the 85-year-plus age bands (Shah et al. 2001). In 1998 the annual rate in males aged 65–69 years was 14 per 100 000 population and in females 7 per 100 000. This compares with rates of 21.3 and 6.8 in the 85–89 age groups. Harwood et al. (2000) found the commonest methods of suicide were hanging in men and drug overdose in women. A total of 49.8% had seen their GP in the month before death and 15.4% were under psychiatric care.

In working with depressed older people nurses always need to assess for suicidal thoughts and the risk of a suicide attempt. This is especially so in those depressed patients who are in the higher-risk group: that is, older males, the recently bereaved, the socially isolated, those suffering from a painful physical illness and those who have a history of previous attempts. With high suicide risk a person may be admitted to hospital and be closely supervised. Nurses need to be aware that some changes in behaviour may indicate the possibility of suicidal thoughts: these include altering wills, giving away possessions, changes in religious interest or the hoarding of medications. Depression should be treated. Any physical problems should be reassessed and appropriate care given, with special attention to any painful conditions. If the person is living at home the GP and family need to be educated about risk factors present. The CPN will have a key role here. Any medications should be

<table>
<thead>
<tr>
<th>Table 25.5 The prognosis of major depression in older people following hospital-based treatment</th>
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<tbody>
<tr>
<td>Length of follow-up</td>
</tr>
<tr>
<td>--------------------</td>
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<tr>
<td>&lt; 2 years</td>
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<td>&gt; 2 years</td>
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Data from Cole & Bellavance (1997).
carefully monitored. Prescriptions covering short periods of time, the use of blister packs of medication and avoiding the prescription of particularly toxic drugs will be part of the management plan.

CONCLUSION
This chapter has shown how nurses can make significant contributions to the process leading to the effective care and treatment of depression in older people. Nurses can have a key role in preventing much depression. Nurses see many older people in a variety of settings and are therefore in a unique position to ensure that depression is detected and treated adequately. This chapter has also referred to some of the substantial evidence base that now exists in this field on which nurses can base their contemporary practice.

Recommended reading
This substantial paper reviews the evidence on which to base treatment of mild to moderate depression in adults with antidepressants. The guidelines contain special reference to older people as is needed.
This excellent text provides an overview of current evidence and best practice on the classification, prevalence, causation and management of depressive disorder in older people. Recommendations for practice are made on the basis of the strength of evidence in each of these areas.
This multidisciplinary text is an excellent contemporary overview of practice. The chapter by Graham Mulley on depression in physically ill older patients will be of particular interest to registered nurses in primary care and general hospital settings.
Psychological therapies should be as available to older people as to any other age group. The authors describe the therapies most likely to be useful in a mental health service for older people. It is an important source for all disciplines offering psychological therapy.
This major text includes substantial chapters on topics relevant to depressive disorder. In particular: liaison old age psychiatry in the general hospital by Michael Philpot, Declan Lyons and Tom Reynolds, depressive disorders by R C Baldwin and suicide in older persons by Daniel Harwood.

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