DEPRESSION and ADJUSTMENT IN THE NURSING HOME

A RESOURCE TOOL KIT

2015

Prepared by: University of Pittsburgh, Palliative Care Education Working Group, Geriatric Education Center of Pennsylvania
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Introduction to the Tool Kit

A high percentage of older adults who are temporarily or permanently living in long-term care residences, and nursing homes in particular, experience depression. Their quality of life is diminished, their recovery from illness is negatively impacted and their susceptibility to illness increases as a result. This tool kit was developed to support the efforts of staff members in nursing facilities to prevent, detect, and intervene with depression. It contains tools or links to tools that staff members may use to implement individual, group, or system-wide change.

There is no single practice or approach to depression in later life that fits all older adults or facilities. The tool kit provides you with information about the current state of evidence for addressing depression in long-term care residents. The idea of evidence-based practice is to help bridge the gap between research and practice by utilizing treatments that have been tested to be feasible and have benefits. However, the use of evidence-based practices still requires professional judgment and critical thinking about the individuals with whom you are working and the circumstances of their situations. The reality is that research currently tells us that a number of practices may be promising, but more research needs to be done to verify these practices are effective and feasible for residents in long term care.

While we recognize that most people using this tool kit have had training about depression, the quality and strength of that training may vary by discipline or person. We open the tool kit with a section of Clinical Practice Guidelines for Depression. These guidelines are specifically developed with the older adult in mind and some with nursing facility care settings in mind. The section provides links to several protocols for recognizing and addressing depression. These resources provide information about symptom recognition, diagnosis, and intervening, including with medications. These resources may be of greatest use to physicians and CRNP's; however, other members of the team may find them helpful too.

When working with residents, the first goal should be to prevent the development of depressive symptoms. We recognize that for many people the transition to living at a nursing home either temporarily or permanently may involve a lot of upheaval in their lives and is often accompanied by loss—loss of home, loss of skills, loss of roles, loss of family member—which require major adjustments. This transition point is an important point to detect and prevent depression. Therefore, the Prevention Resources section contains tools for trying to enhance the transitions for residents. Moving to a nursing home can also disrupt a person's ability to connect to the people who they care about and who sustain them emotionally. Therefore, we have included handouts and information for the resident and family members. These information sheets and tools can be used by or distributed by staff to help family members and friends better understand depression as a treatable condition.

As a next step, it is important to develop techniques to detect or assess the presence of depression in long term care residents. We know that the MDS has incorporated the PHQ-9 as a tool to screen for depression. However, we have included some additional Detection & Assessment Resources. This section offers resources to a variety of professionals, particularly MDs, CRNP's, nurses, and social workers. Readers will find assessment tools, a list of books, websites, and other resources on depression which may prove helpful.

Overall, we know that many, but not all, older adults with depression benefit from a combination of pharmacological and psychosocial interventions. Pharmacology is an important intervention and guidelines for prescribing antidepressant medication are discussed; however, many people respond to non-pharmacological interventions alone or in connection with medications. In the section on Intervention Resources, the reader will find information about promising psychosocial interventions for recreation/activities staff, social workers, nursing staff, and spiritual care staff.

It is our hope that this manual will not sit in the office of a staff development coordinator. We would love to see your facility have multiple copies or pull it apart and distribute pieces of it to various parties who may be interested in it. We recognize that it will require a multidisciplinary effort to address depression in the older adults you serve.

Disclosure

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- This project has also been guided by Geriatric Education Center of Pennsylvania with the Aging Institute of UPMC Senior Services and the University of Pittsburgh.
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CLINICAL PRACTICE GUIDELINES for DEPRESSION
Clinical Practice Guidelines for Depression

The clinical practice guidelines (CPGs) listed below have been compiled by expert advisory groups, drawing upon the best available research evidence. The purpose for including the CPGs in this toolkit is to ensure consistent and appropriate diagnosis, treatment, and referral for residents with depression. These guidelines are designed to assist practitioners by providing an analytical framework for the evaluation and treatment of patients, and are not intended to replace a practitioner’s judgment.

The guidelines have received approval from the National Health and Medical Research Council (NHMRC) and are considered to meet the standard for clinical practice guidelines. The approval is valid for five years. The CPGs listed are freely available here to promote their dissemination and use; however, copyright protections are enforced in full. No part of these guidelines may be reproduced except as permitted under section 107 and 108 of the United States Copyright Act.

We encourage you and your teams to use this information to ascertain best practices and assure that your diagnosis, treatment, and support for residents with depression is evidence based.


This lengthy resource provides important information for MDs and CRNPs about treatment of depression. It can be downloaded free from the above web link.


This resource was developed by the NICHE program (Nurses Improving Care for Healthsystem Elders) which is part of the NYU College of Nursing. The website for this organization is: nicheprogram.herokuapp.com.

To purchase the book, use the following Web site: www.springerpub.com/product/9780826171283#.Ueaqw9Kko3K.

Several nurses in the UPMC system have copies of the materials and can show them to you if you are interested.
PREVENTION RESOURCES
How to Use the Prevention Resources

Prevention begins prior to the placement of a resident in the nursing home. It starts with the family’s first visit prior to nursing home selection. Confidence and trust are built when your current residents and your staff provide a welcoming atmosphere and a positive attitude toward the potential resident and family. If the family’s first visit goes well, families will present your facility to the potential resident in a positive light. Once selection occurs, there are many things your staff can do to help a new resident transition from home or hospital to your facility to ease a sense of loss and prevent subsequent depression. For some people the move to a nursing home is a welcome relief if the resident has been isolated and living alone, often afraid of falls, or unable to prepare food and meet basic needs. However, for most residents and families the move is traumatic because of the multiple losses associated with admission to a nursing home—loss of health, loss of home, and loss of connections to neighbors, family, and friends. Therefore, all residents are considered to be at risk for situational depression upon arrival. For some the transition is even more traumatic when the resident has a history of a major depressive disorder.

This tool kit provides a variety of resources and tools you may use to help new residents and families during this major life transition. For example, the section called Resources for New Resident Transition, begins with “Packing the Suitcase” which provides suggestions on steps you can take to help a new resident and their family before admission. The “Packing List” provides suggestions to families for what to bring and what not to bring to the nursing home. And, while the resident might have been getting along with bedroom slippers at home, good shoes become very important for walking safely, so we’ve provided suggestions for the kind of shoes that are best suited to nursing home life.

These pages can be photocopied and given to residents’ families and friends. Not every idea or suggestion will be good for every resident. For example, some newly situated residents will respond well to introductions to your staff and to a tour of the facility, while others may be overwhelmed at first. These residents might respond better to a private dinner with family members in their new room. What we are trying to do is ease the resident’s anxiety upon entry to the nursing home. That is why the tool kit provides this list of many strategies to help with transitions. You will also find reminders for staff about business issues that also need attention during admission too.

The “Imagine you are 80” exercise is useful for your staff members or for the resident. When used with staff this exercise helps staff members learn about themselves, their attitudes and beliefs. When used with residents, it helps the staff learn about the resident and helps the resident discuss deeper feeling about what’s most important to them in order to prevent or decrease depression.

The “About Me” tool is a good way to help you connect to a resident in a personal way. With the “About Me” the resident and/or family work with you to fill out personal and helpful detailed information. This information is useful to staff in many ways. First, by asking about this information, you are telling the resident and/or family that you care about who they are as a person. Second, by having and posting this information in a private, yet accessible, place you help the staff know how best to care for the resident, particularly when they have trouble with memory.

Families need help to understand what their loved one is going through, and they need help for themselves, too. The “Resources and Information for Residents and Family Members” section provides information to help explain depression in the older adult to the family member. It offers a Caregiver Self-Assessment tool and provides caregiver self-help tools and Web sites including Alzheimer’s and other health-related information to help families understand their elderly family members and to support the caregivers as they live through this major life transition. Finally, it is important to note that there are differences between the sadness, grief, and depression a resident experiences with such a major life change. Aspects of diagnosing and treating situational and clinical depression follow in subsequent sections.
RESOURCES for NEW RESIDENT TRANSITION
PACKING THE SUITCASE

Prior to admission
Contact the patient and family at the hospital or home.

Provide information about your facility. In other words, start making them feel more at ease by making a connection and discussing the move, and what a typical day might look like. Discuss any comfort issues, possible pain or any other problems that are of an immediate concern. For example:
1. If urgent toileting needs...may need to have a bedside commode next to bed 2. If nauseated often, may need to ensure that the admitting physician is aware 3. If special diet, involve dietitian. Discuss what is important for staff to know.

Provide family with suggestions for clothing, shoes, and toiletries to bring to the facility. Discuss incontinence and the need for clothing items that are one size larger. Discuss glasses, hearing aids, dentures and suggest prescription information for record keeping. Provide family with the shoe safety handout. Suggest other items to bring such as a favorite pillow or blanket. It would be helpful if the family could bring in the items prior to admission. Discuss physician services and information about the facility ratings on Nursing Home Compare, and possibly a booklet or other literature about nursing homes.

First Impressions
- Welcome basket with card signed by unit staff members
- Meal with family member if possible
- Tour
- Activity calendar
- TV/phone information
- Typical day
- Staffing patterns
- Introductions
- Review meal times, med times
- Kitchen on unit
- Possible room blessing

Follow Up
- Review of orders with resident and family and have a brief discussion about what is listed in the orders.
- Advise about visiting (consider family members spreading out visits and not all coming at one time), dietary restrictions, what they can do to help the staff
- Continue introductions
- Look for opportunities to communicate
- Look for signs and symptoms that something is wrong
- Advise about care plan meeting and encourage their participation
- Check on comfort, meals, activities, physician, etc.
PACKING LIST

What Not to Pack
1. Cigarettes
2. Expensive jewelry
3. Pocket knives
4. Money (over 10 dollars)
5. Alcohol
6. Fragile or valuable items (knick knacks, artwork)
7. Pills/Supplements (Herbal)
8. Snacks that are restricted in regards to their dietary orders

What to Pack
1. Comfortable/easy to put on clothing such as jogging suits (one size bigger for pants if incontinent, slip on)
2. Glasses with label and prescription/doctor info
3. Hearing Aids with label and prescription/doctor info
4. Dentures/know where mold is for replacement and doctor info
5. Favorite comfort items such as pillow, blanket, robe, slippers, reading material, puzzles, etc.
6. Toiletries
7. Important papers to share with social worker
8. Snacks keeping in mind dietary restrictions
9. Good fitting shoes
10. Pictures and decorations for room

AGING INSTITUTE
of UPMC Senior Services and the University of Pittsburgh
What makes a shoe safe?

- A firm heel collar to provide stability
- Laces ensure the shoe stays on your foot when walking
- A bevelled heel to prevent slipping
- A broad, flared heel to maximise contact with the ground
- A textured sole to prevent slipping
- A thin, firm midsole so you can feel the ground underneath

What makes a shoe unsafe?

- Soft or stretched uppers make your foot slide around in the shoe
- Lack of laces means your foot can slide out of the shoe
- High heels should be avoided as they impair stability when walking
- Narrow heels make your foot unstable and can cause ankle sprains
- Slippery or worn soles are a balance hazard, particularly in wet weather

*By Jon B Marz, Prince of Wales Medical Research Institute*
Imagine You are 80

1. What would you hope for in your new physical environment (space, furnishings, room arrangements, location)?

2. What opportunities do you think should be available to you in your new setting?

3. What characteristics do you hope for in the other people who live and work there?

4. What characteristics of your new home environment (emotional climate) would you like (for example, attitudes towards other people, rules and regulations, and relationships of persons living and working there)?

5. What things about your past life would you like others to know about you so that they have a better understanding of you as a person?

6. How do you feel about the move and what would help you accept the change?

About Me

One of the best ways to prevent depression and to respond when someone is depressed is to connect to that person in a personal way, on an individual level. This “About Me” tool is useful when working with people in the nursing home in many ways. It can convey to staff important facts about a person, particularly if the person has any trouble with memory. Take the time to fill out this sheet with a family member and post it in the room somewhere. Some care centers actually have a designated place for the form where they post it privately yet it is still accessible to staff.

Full name  

1. Name the person prefers to be called  

2. Name of spouse or partner  

3. Important people in my life (children, parents, siblings, friends)  

4. My work in life  

5. Military background and branch  

6. Religious or spiritual preferences/practices  

7. Favorite music, song, sound  

8. Favorite movies, TV shows  

9. Favorite activities, interests, hobbies  

10. Likes to talk about  

11. Important things to know about me  

12. Favorite foods and beverages  

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RESOURCES and INFORMATION FOR RESIDENTS AND FAMILY MEMBERS
How common is depression in later life?
Depression affects more than 6.5 million of the 35 million Americans aged 65 or older. Most people in this stage of life with depression have been experiencing episodes of the illness during much of their lives. Others may experience a first onset in late life—even in their 80s and 90s. Depression in older persons is closely associated with dependency and disability and causes great distress for the individual and the family.

Why does depression in the older population often go untreated?
Depression in elderly people often goes untreated because many people think that depression is a normal part of aging—a natural reaction to chronic illness, loss and social transition. Elderly people do face noteworthy challenges to their connections through loss, and also face medical vulnerability and mortality. For the elderly population, depression can come in different sizes and shapes. Many elderly people and their families don’t recognize the symptoms of depression, aren’t aware that it is a medical illness and don’t know how it is treated. Others may mistake the symptoms of depression as signs of:

- dementia
- Alzheimer's Disease
- arthritis
- cancer
- heart disease
- Parkinson's disease
- stroke
- thyroid disorders

Also, many older persons think that depression is a character flaw and are worried about being teased or humiliated. They may blame themselves for their illness and be too ashamed to get help. Others worry that treatment would be too costly. Yet research has also shown that treatment is effective and, in fact, changes the brain when it works.

What are the consequences of untreated depression in older persons?
Late-life depression increases risk for medical illness and cognitive decline. Unrecognized and untreated depression has fatal consequences in terms of both suicide and nonsuicide mortality: older Caucasian males have the highest rate of suicide in the U.S. Depression is the single most significant risk factor for suicide in the elderly population. Tragically, many of those people who go on to die by suicide have reached out for help—20 percent see a doctor the day they die, 40 percent the week they die and 70 percent in the month they die. Yet depression is frequently missed. Elderly persons are more likely to seek treatment for other physical ailments than they are to seek treatment for depression.

Are symptoms of depression different in older persons than in younger persons?
Symptoms in older persons may differ somewhat from symptoms in other populations. Depression in older persons is at times characterized by:

- memory problems
- confusion
- social withdrawal
- loss of appetite
- weight loss
- vague complaints of pain
- inability to sleep
- irritability
- delusions (fixed false beliefs)
- hallucinations

Older depressed individuals often have severe feelings of sadness, but these feelings frequently are not acknowledged or openly shown; sometimes, when asked if they are depressed, the answer is “no.” Some general clues that someone may be experiencing depression are:

- persistent and vague complaints
- help-seeking
- moving in a slower manner
- demanding behavior

How can clinical depression be distinguished from normal sadness and grief?
It’s natural to feel grief in the face of major life changes that many elderly people experience, such as leaving a home of many years or losing a loved one. Sadness and grief are normal, temporary reactions to the inevitable losses and hardships of life. Unlike normal sadness, however, clinical depression doesn’t go away by itself and lasts for months. Clinical depression needs professional treatment to reduce duration and intensity of symptoms. Any unresolved depression can affect the body. For example, depression, if left untreated, is a risk for heart disease and can suppress the immune system, raising the risk of infection.
What causes depression in older persons?
Although there is no single, definitive answer to the question of cause, many factors—psychological, biological, environmental and genetic—likely contribute to the development of depression. Scientists think that some people inherit a biological make-up that makes them more prone to depression. Imbalances in certain brain chemicals like norepinephrine, serotonin and dopamine are thought to be involved in major depression.

While some people become depressed for no easily identified reason, depression tends to run in families, and the vulnerability is often passed from parents to children. When such a genetic vulnerability exists, other factors like prolonged stress, loss or a major life change can trigger the depression. For some older people, particularly those with lifelong histories of depression, the development of a disabling illness, loss of a spouse or a friend, retirement, moving out of the family home or some other stressful event may bring about the onset of a depressive episode. It should also be noted that depression can be a side effect of some medications commonly prescribed to older persons, such as medications to treat hypertension. Finally, depression in the elderly population can be complicated and compounded by dependence on substances such as alcohol, which acts as a depressant.

Are some older persons at higher risk for depression?
Older women are at a greater risk: women in general are twice as likely as men to become seriously depressed. Biological factors, like hormonal changes, may make older women more vulnerable. The stresses of maintaining relationships or caring for an ill loved one and children also typically fall more heavily on women, which could contribute to higher rates of depression. Unmarried and widowed individuals as well as those who lack a supportive social network also have elevated rates of depression.

Conditions such as heart attack, stroke, hip fracture or macular degeneration and procedures such as bypass surgery are known to be associated with the development of depression. In general, depression should be assessed as a possibility if recovery from medical procedure is delayed, treatments are refused or problems with discharge are encountered.

How is depression in older persons diagnosed?
A physical exam can determine if depressive symptoms are being caused by another medical illness. Medical concerns and their treatment are common in this population. A review of the individual’s medications is important: in some cases a simple medication change can reduce symptom intensity. A clinical and psychiatric interview is a key aspect of the assessment. Speaking with family members or close friends may be helpful in making a diagnosis. Blood tests and imaging studies (like a CT scan) are helpful in so far as they rule out other medical conditions that would require a different path of intervention.

Can depression in older persons be treated?
Fortunately, the treatment prognosis for depression is good. Once diagnosed, 80 percent of clinically depressed individuals can be effectively treated by medication, psychotherapy, electroconvulsive therapy (ECT) or any combination of the three. A novel treatment—transcranialmagnetic stimulation (TMS)—has been approved by the FDA and may be helpful for mild depression that has not been helped by one medication trial. Medication is effective for a majority of people with depression. Four groups of antidepressant medications have been used to effectively treat depressive illness: selective serotonin-reuptake inhibitors (SSRIs); norepinephrine and serotonin reuptake inhibitors (NSRIs); and less commonly, tricyclics and monoamineoxidaseinhibitors (MAOIs). Medication adherence is especially important, but can present challenges among forgetful individuals. It is important to note that all medicines have side effects as well as benefits, and the selection of the best treatment is often made based on tolerability of the side effects. ECT (also known as shock treatment) may be very useful in the treatment of severe depression in older adults. For carefully selected people, ECT can be a lifesaving intervention. For example, an 80-year-old man who lives alone, has been depressed for months, lost 60 pounds and has delusions about his body has a kind of presentation that may improve quickly with ECT. Fortunately, the treatment prognosis for depression is good. Once diagnosed, 80 percent of clinically depressed individuals can be effectively treated by medication, psychotherapy, electroconvulsive therapy (ECT) or any combination of the three. A novel treatment—transcranialmagnetic stimulation (TMS)—has been approved by the FDA and may be helpful for mild depression that has not been helped by one medication trial. Medication is effective for a majority of people with depression. Four groups of antidepressant medications have been used to effectively treat depressive illness: selective serotonin-reuptake inhibitors (SSRIs); norepinephrine and serotonin reuptake inhibitors (NSRIs); and less commonly, tricyclics and monoamineoxidaseinhibitors (MAOIs). Medication adherence is especially important, but can present challenges among forgetful individuals. It is important to note that all medicines have side effects as well as benefits, and the selection of the best treatment is often made based on tolerability of the side effects. ECT (also known as shock treatment) may be very useful in the treatment of severe depression in older adults. For carefully selected people, ECT can be a lifesaving intervention. For example, an 80-year-old man who lives alone, has been depressed for months, lost 60 pounds and has delusions about his body has a kind of presentation that may improve quickly with ECT. ECT can impact memory—an important consideration in comparing it to other interventions.

Medications can be beneficial for elderly individuals in treating the symptoms of depression. Medications are frequently combined with supportive psychotherapy or cognitive behavioral therapy to improve their effectiveness. Research has shown that depressed individuals may need to try more than one medication to get an optimal response.

Psychosocial treatment plays an essential role in the care of older patients who have significant life crises, lack social support or lack coping skills to deal with their life situations. Because large numbers of elderly people live alone, have inadequate support systems or do not have contact with a primary care physician, special efforts are needed to locate and identify these people to provide them with needed care. Natural supports like church or bridge group colleagues should be encouraged. There are services available to help older individuals, but the problem of clinical depression must be detected before treatment can begin.

Like diabetes or arthritis, depression is a chronic disease. Getting well is only the beginning of the challenge—the goal is staying well. For people experiencing their first episode of depression later in life, most experts would recommend treatment for six months to one year after acute treatment that achieves remission. For persons that have had two or three episodes during their lifetimes, treatment should extend up to two years after remission. For people with more than three recurrences of depression, treatment may be lifelong. The treatment that gets some one well is the treatment that will keep that person well.

Reviewed by Dr. Ken Duckworth, NAMI Medical Director, September 2009

DEPRESSION AND ADJUSTMENT IN THE NURSING HOME TOOL KIT 19
What is major depression?
Major depression is a serious medical illness affecting 15 million American adults or approximately 5-8 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss or passing mood states, major depression is persistent and can significantly interfere with an individual’s thoughts, behavior, mood, activity and physical health. Among all medical illnesses, major depression is the leading cause of disability in the United States and many other developed countries.

Depression occurs twice as frequently in women as in men for reasons that are not fully understood. More than one-half of those who experience a single episode of depression will continue to have episodes that occur as frequently as once or even twice a year. Without treatment, the frequency of depressive illness as well as the severity of symptoms tends to increase overtime. Left untreated, depression can lead to suicide.

Major depression, also known as clinical depression or unipolar depression, is only one type of depressive disorder. Other depressive disorders include dysthymia (chronic, less severe depression) and bipolar depression (the depressed phase of bipolar disorder). People who have bipolar disorder experience both depression and mania. Mania involves unusually and persistently elevated mood or irritability, elevated self-esteem and excessive energy, thoughts and talking.

What are the symptoms of major depression?
The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of major depression characteristically represent a significant change from how a person functioned before the illness. The symptoms of depression include:

- persistently sad or irritable mood
- pronounced changes in sleep, appetite and energy
- difficulty thinking, concentrating and remembering
- physical slowing or agitation
- lack of interest in or pleasure from activities that were once enjoyed
- feelings of guilt, worthlessness, hopelessness and emptiness
- recurrent thoughts of death or suicide
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and chronic pain

When several of these symptoms of depressive illness occur at the same time, last longer than two weeks and interfere with ordinary functioning, professional treatment is needed.

What are the causes of major depression?
There is no single cause of major depression. Psychological, biological and environmental factors may all contribute to its development. Whatever the specific causes of depression, scientific research has firmly established that major depression is a biological, medical illness.

Norepinephrine, serotonin and dopamine are three neurotransmitters (chemical messengers that transmit electrical signals between brain cells) thought to be involved with major depression. Scientists believe that if there is a chemical imbalance in these neurotransmitters, then clinical states of depression result. Antidepressant medications work by increasing the availability of neurotransmitters or by changing the sensitivity of the receptors for these chemical messengers.

Scientists have also found evidence of a genetic predisposition to major depression. There is an increased risk for developing depression when there is a family history of the illness. Not everyone with a genetic predisposition develops depression, but some people probably have a biological make-up that leaves them particularly vulnerable to developing depression. Life events, such as the death of a loved one, a major loss or change, chronic stress and alcohol and drug abuse, may trigger episodes of depression. Some illnesses such as heart disease and cancer and some medications may also trigger depressive episodes. It is also important to note that many depressive episodes occur spontaneously and are not triggered by a life crisis, physical illness or other risks.

How is major depression treated?
Although major depression can be a devastating illness, it is highly treatable. Between 80–90 percent of those diagnosed with major depression can be effectively treated and return to their usual daily activities and feelings. Many types of treatment are available and the type chosen depends on the individual and the severity and patterns of his or her illness. There are three well established types of treatment for depression: medications, psychotherapy and electroconvulsive therapy (ECT). For some people who have a seasonal component to their depression, light therapy maybe useful. These treatments maybe used alone or in combination. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise and smoking cessation, can result in better health, including mental health.
Major Depression FACT SHEET

Medication
It often takes two to four weeks for antidepressants to start having an effect and six to 12 weeks for antidepressants to have their full effect. The first antidepressant medications were introduced in the 1950s. Research has shown that imbalances in neurotransmitters like serotonin, dopamine and norepinephrine can be corrected with antidepressants. The FDA regularly approves different medicines; visit www.fda.gov for the most current list. Four groups of antidepressant medications are most often prescribed for depression:

- Selective serotonin reuptake inhibitors (SSRIs) act specifically on the neurotransmitter serotonin. They are the most common agents prescribed for depression worldwide. These agents block the reuptake of serotonin from the synapse to the nerve, thus artificially increasing the serotonin that is available in the synapse (this is functional serotonin, since it can become involved in signal transmission, the cardinal function of neurotransmitters). SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro) and fluvoxamine (Luvox).

- Serotonin and norepinephrine reuptake inhibitors (SNRIs) are the second-most popular antidepressants worldwide. These agents block the reuptake of both serotonin and norepinephrine from the synapse into the nerve (thus increasing the amounts of these chemicals that can participate in signal transmission). SNRIs include venlafaxine (Effexor) and duloxetine (Cymbalta).

- Bupropion (Wellbutrin) is a very popular antidepressant medication classified as a norepinephrine-dopamine reuptake inhibitor (NDRI). It acts by blocking the reuptake of dopamine and norepinephrine.

- Mirtazapine (Remeron) works differently from the compounds discussed above. Mirtazapine targets specific serotonin and nor-epinephrine receptors in the brain, thus indirectly increasing the activity of several brain circuits.

- Tricyclic antidepressants (TCAs) are older agents seldom used now as first-line treatment. They work similarly to the SNRIs, but have other neurochemical properties which result in very high side effect rates, as compared to almost all other antidepressants. They are sometimes used in cases where other antidepressants have not worked. TCAs include amitriptyline (Elavil, Limbitrol), desipramine (Norpramin), doxepin (Sinequan), imipramine (Norpramin, Tofranil), nortriptyline (Pamelor, Aventyl) and protriptyline (Vivactil).

- Monoamine oxidase inhibitors (MAOIs) are also seldom used now. They work by inactivating enzymes in the brain which catabolize (chew up) serotonin, norepinephrine and dopamine from the synapse, thus increasing the levels of these chemicals in the brain. They can sometimes be effective for people who do not respond to other medications or who have “atypical” depression with marked anxiety, excessive sleeping, irritability, hypochondria or phobic characteristics. However, they are the least safe antidepressants to use, as they have important medication interactions and require adherence to a particular diet. MAOIs include phenelzine (Nardil), isocarboxazid (Marplan) and tranylcypromine sulfate (Parnate).

- Nonantidepressant adjunctive agents. Often psychiatrists will combine the antidepressants mentioned above with each other (we call this a “combination”) or with agents which are not antidepressants themselves (we call this “augmentation”). These latter agents can include the atypical antipsychotic agents (aripiprazole [Abilify], olanzapine [Zyprexa], quetiapine [Seroquel], ziprasidone [Geodon], risperidone [Risperdal]), buspiropane (Buspar), thyroid hormone (triodothyronine or “T3”), the stimulants (methylphenidate [Ritalin], dextroamphetamine [Adderall]), dopamine receptor agonists (pramipexole [Mirapex], ropinirole [Requip]), lithium, lamotrigine (Lamictal), s-adenosyl methionine (SAMe), pindolol and steroid hormones (testosterone, estrogen, DHEA).

Individuals living with mental illness and their families must be cautious during the early stages of medication treatment because normal energy levels and the ability to take action often return before mood improves. At this time—when decisions are easier to make, but depression is still severe—the risk of suicide may temporarily increase.

Psychotherapy
There are several types of psychotherapy that have been shown to be effective for depression including cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). Research has shown that mild to moderate depression can often be treated successfully with either of these therapies used alone. However, severe depression appears more likely to respond to a combination of psychotherapy and medication.

- Cognitive behavioral therapy (CBT) helps to change the negative thinking and unsatisfying behavior associated with depression, while teaching people how to unlearn the behavioral patterns that contribute to their illness.

- Interpersonal therapy (IPT) focuses on improving troubled personal relationships and on adapting to new life roles that may have been associated with a person’s depression.

- Electroconvulsive therapy (ECT) is a highly effective treatment for severe depressive episodes. In situations where medication, psychotherapy and a combination of the two prove ineffective or work too slowly to relieve severe symptoms such as psychosis or thoughts of suicide, ECT maybe considered. ECT may also be considered for those who for one reason or another cannot take antidepressant medications.
What are the side effects of the medications used to treat depression?
Different medications produce different side effects and people differ in the type and severity of side effect they experience. About 50 percent of people who take antidepressant medications experience some side effects, particularly during the first weeks of treatment. Side effects that are particularly bothersome can often be treated by changing the dose of the medication, switching to a different medication or treating the side effect directly with additional medications. Rarely, serious side effects such as fainting, heart problems or seizure may occur, but they are almost always treatable.

- Tricyclic antidepressants (TCAs) cause side effects that include dry mouth, constipation, bladder problems, sexual problems, blurred vision, dizziness, drowsiness, skin rash and weight gain or loss.
- Monoamine oxidase inhibitors (MAOIs). Individuals taking MAOIs may have to be careful about eating certain smoked, fermented or pickled foods, drinking certain beverages or taking some medications because they can cause severe high blood pressure in combination with the medication. A range of other, less serious side effects occur including weight gain, constipation, dry mouth, dizziness, headache, drowsiness, insomnia and sexual side effects (problems with arousal or satisfaction).
- SSRIs and SNRIs tend to have fewer and different side effects, such as nausea, nervousness, insomnia, diarrhea, rash, agitation or sexual side effects (problems with arousal or orgasm).
- Bupropion generally causes fewer common side effects than TCAs and MAOIs. Its side effects include restlessness, insomnia, headache or a worsening of preexisting migraine conditions, tremor, dry mouth, agitation, confusion, rapid heartbeat, dizziness, nausea, constipation, menstrual complaints and rash.

Reviewed by Dr. Ken Duckworth, NAMI Medical Director, September 2009
Caregiver self-assessment questionnaire

How are YOU?

Caregivers are often so concerned with caring for their relative’s needs that they lose sight of their own well-being. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have ...

1. Had trouble keeping my mind on what I was doing ................... □ Yes □ No
2. Felt that I couldn’t leave my relative alone ........................... □ Yes □ No
3. Had difficulty making decisions .................................. □ Yes □ No
4. Felt completely overwhelmed ...... □ Yes □ No
5. Felt useful and needed ............... □ Yes □ No
6. Felt lonely ................................. □ Yes □ No
7. Been upset that my relative has changed so much from his/her former self .................... □ Yes □ No
8. Felt a loss of privacy and/or personal time ...................... □ Yes □ No
9. Been edgy or irritable ................. □ Yes □ No
10. Had sleep disturbed because of caring for my relative ....... □ Yes □ No
11. Had a crying spell(s) ............... □ Yes □ No
12. Felt strained between work and family responsibilities....... □ Yes □ No
13. Had back pain........................ □ Yes □ No
14. Felt ill (headaches, stomach problems or common cold)........ □ Yes □ No
15. Been satisfied with the support my family has given me........... □ Yes □ No
16. Found my relative’s living situation to be inconvenient or a barrier to care ................... □ Yes □ No
17. On a scale of 1 to 10, with 1 being “not stressful” to 10 being “extremely stressful,” please rate your current level of stress. _______
18. On a scale of 1 to 10, with 1 being “very healthy” to 10 being “very ill,” please rate your current health compared to what it was this time last year. _______

Comments:
(Please feel free to comment or provide feedback.)

________________________________________  
________________________________________  
________________________________________  
________________________________________  
________________________________________  
________________________________________
Caregiver Web Sites

Like much in life, caregiving has both positive and negative aspects to it. It is both a service we willingly offer to people we care about, and it also sometimes stresses us out. The caregiving community includes professional caregivers, like those in health care or social service agencies, and informal caregivers such as children, siblings, parents, friends and others in our lives. In fact, the value of informal caregiving is so great, that we could not begin to meet the needs of older adults or persons with disability with only professional caregivers. There simply are not enough professionals or enough money in our care systems to pay them. The listed web sites may be of interest to family and friend caregivers who would like to gain more information or connect with others who are caregivers.

AgingCare.com
www.agingcare.com

Aging Institute of UPMC Senior Services and the University of Pittsburgh
aging.upmc.com

American Association of Retired Persons:
www.aarp.com

Caregiver Action Network (formerly the National Family Caregiver Association)
www.caregiveraction.org

Caregiver Stress:
www.caregiverstress.com

Caring Today:
www.caringtoday.com

Eldercare Locator
www.eldercare.gov

Family Caregiver Alliance:
www.caregiver.org

HelpGuide.org
www.helpguide.org/home-pages/caregiving.htm

Medicare:
http://www.medicare.gov/campaigns/caregiver/caregiver.html

National Alliance for Caregiving:
www.caregiving.org

National Institute on Aging:
www.nia.nih.gov

Rosalynn Carter Institute for Caregiving:
www.rosalynnncarter.org

Strength for Caring:
www.strengthforcaring.com

This Caring Home:
www.ThisCaringHome.org

United Hospital Fund:
www.NextStepinCare.org

Well Spouse Association:
www.wellspouse.org
Health-related Associations and Support Groups

When faced with a health crisis, it sure helps to know that you’re not alone. With so many support groups in our community, there’s no need to be. Below are a number of health-related associations and support groups that are available to you should you need them.

**AIDS**

Pittsburgh AIDS Task Force
(412) 345-7456
www.pattf.org

**Arthritis**

Arthritis Foundation, Western Pennsylvania Chapter
(412) 566-1645
www.arthritis.org

**Rheumatoid Support**

Penn Hills
Rheumatoid Society, Inc.
(412) 371-8108

**Bereavement**

Bereavement Support Allison Park
Allison Park Church
(412) 487-7220

Memorial Park Presbyterian Church
(412) 364-9492

**Downtown Pittsburgh**

A Caring Place
(888) 734-4073

Catholic Charities Bereavement Office
(412) 456-6920

East McKeesport
St. Robert Bellarmine
(412) 824-2644

Greenfield
St. Rosalia-Lazarus
(412) 421-5766

McCandless
UPMC Passavant
(412) 367-6707

McKeesport
UPMC McKeesport
(412) 664-2057

Monroeville
Forbes Hospice
(412) 325-7200

Mt. Lebanon
Family Hospice and Palliative Care
(412) 572-8800

North Versailles
Three Rivers Hospice
(800) 282-0306

Ross Township
Anchorpoint Counseling Ministry
(412) 366-1300

Squirrel Hill
Jewish Community Center
(412) 422-5700

Squirrel Hill Good Grief Center
(412) 224-4700
http://ursulinesupportservices.org/services/good-grief-center/

Wexford
Good Samaritan Hospice
(724) 933-8888

**Brain Injuries**

Brain Injury Association of Pennsylvania
(866) 635-7097
www.biapa.org

**Cancer**

National Cancer Institute
(800) 422-6237
www.cancer.gov

**Brain Support**

Our Clubhouse
(412) 338-1919
www.ourclubhouse.org

**Look Good . . . Feel Better**

(800) 395-5665
www.cancer.org

**Brain Palsy**

United Cerebral Palsy/Community Living and Support Services
(412) 683-7100
www.ucpclass.org

**Crohn’s and Colitis**

Crohn’s and Colitis Foundation of America
(800) 343-3637
www.ccfa.org

**Cerebral Palsy**

Western PA Chapter
(800) 343-3637
www.ccfa.org

**Diabetes**

American Diabetes Association
(888) 342-2383
www.diabetes.org

**Diabetes Support**

Aspinwall
UPMC St. Margaret
(412) 784-4194

Bethel Park/Southside
Mercy Diabetes Program
(412) 232-5908

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Health-related Associations and Support Groups

continued

Monroeville
Joselyn Diabetes Center
(412) 858-4474

Natrona Heights
Allegheny Valley Hospital
(724) 367-2400

Epilepsy
Epilepsy Foundation
Western/Central PA
(412) 322-5880
(800) 361-5885
www.efwp.org

Heart
American Heart Association
(412) 824-3122
(800) 242-8721
www.americanheart.org

Kidney
American Kidney Fund
(800) 638-8299
www.kidneyfund.org

Leukemia
Leukemia and Lymphoma Society
(800) 955-4572
www.lls.org

Leukemia and Lymphoma Support
(800) 726-2873
Support groups meet monthly in Shadyside and Bethel Park.

Liver
American Liver Foundation
(412) 434-7044
(866) 434-7044
www.liverfoundation.org/chapters/westernpa

Lung
American Lung Association
1 (800) 586-4872
www.lungusa.org

Lupus
Lupus Foundation of PA
(412) 261-5886
(800) 800-5776
www.lupuspa.org

Lupus Support Homewood
Lupus Foundation of PA
(412) 243-3119

UPMC Passavant
(412) 527-3335

West Mifflin
Lupus Support Group
(412) 469-2079

Multiple Sclerosis
National Multiple Sclerosis Society
(412) 261-6347
(800) 344-4867
www.nationalmssociety.org/Chapters/PAX

Multiple Sclerosis
Myasthenia Gravis Association of Western Pennsylvania
(412) 566-1545
www.mgawpa.org

Myasthenia Gravis
Myasthenia Gravis
Association of Western Pennsylvania
(412) 566-1545
www.mgawpa.org

Osteoporosis
National Osteoporosis Foundation
(800) 231-4222
www.nof.org

Parkinson’s
American Parkinson’s Disease Association
(800) 223-2732
www.apdaparkinson.org

Parkinson Foundation of Western PA
(412) 365-2086
www.pfwpa.org

Parkinson’s Disease Support
East End Schenley Gardens
(412) 365-2086
www.pfwpa.org

Harmarville
(724) 568-4463

Sewickley
(412) 287-4831

UPMC
(412) 692-4916

Stroke
American Stroke Association
(412) 824-3122
(888) 478-7653
www.strokeassociation.org

Stroke Support
East Liberty
Vintage Senior Center
(412) 825-4216

Harmarville Rehabilitation Hospital
HealthSouth
(412) 828-1300

Homewood
Homewood Senior Center
(412) 244-4190

Plum
Plum Senior Center
(412) 795-2330

Squirrel Hill
Jewish Community Center
(412) 422-0415

Vision
Blind and Vision Rehabilitation Services of Pittsburgh
(412) 368-4400
(800) 706-5050
TTY (412) 368-4095
http://www.bvrs.pittsburgh.org/
Alzheimer’s Support

Support Groups

The Alzheimer’s Association sponsors support groups where individuals can connect with other families and caregivers who are dealing with the disease. Meeting with a group reduces feelings of isolation, provides techniques that can help ease the physical and emotional burden for both the diagnosed person and caregiver, and offers a chance to share practical ideas and feelings in a compassionate setting.

Alzheimer's Support Groups

Following is a list of Alzheimer's support groups in Allegheny County.

- **Allegheny Valley Hospital**, Tarentum (724) 226-7255
- **Anathan Club**, Squirrel Hill (412) 422-1550
- **Arden Courts**, Monroeville (412) 380-1300
- **Arden Courts**, Ross Township (412) 369-7887
- **Beulah Presbyterian Church**, Penn Hills (412) 792-0731
- **Broadmore Assisted Living**, Bridgeville (412) 221-0202
- **Christ Church**, North Hills, (877) 933-7750
- **Country Meadows**, Bridgeville (412) 257-2855
- **Elmcroft Assisted Living**, Allison Park (412) 487-6925
- **Harbour Assisted Living**, Green Tree (412) 571-1300
- **Hill House Association**, Hill District (412) 431-0557
- **Jewish Family and Children's Service**, Squirrel Hill (412) 422-7200
- **Juniper Village**, Forest Hills (412) 244-9901
- **Marian Manor**, Green Tree (412) 440-4367
- **McKeesport Hospital**, McKeesport (412) 664-2183
- **Mt. Vernon of South Park**, South Park (412) 655-3535
- ** Paramount Senior Living**, Baldwin (412) 650-3100
- **Paramount Senior Living at Bethel Park**, (412) 833-3500
- **Pleasant Hills Presbyterian Church**, Pleasant Hills (412) 655-2000
- **Presbyterian SeniorCare/Woodside Place**, Oakmont (412) 826-6505
- **PrimeTime Adult Day Services**, Bethel Park (412) 835-6661
- **Schenley Gardens**, Oakland (412) 621-4200
- **St. Stephen's Church**, Sewickley (memory loss group) (412) 741-1790
- **St. Stephen's Church**, Sewickley (caregiver group) (412) 741-1790
- **Sunrise of McCandless**, McCandless (412) 441-1241
- **Sunrise of Upper St. Clair**, Upper St. Clair (412) 831-2200
- **Sweetbriar Place**, Mt. Washington (412) 559-5419
- **The Haven of North Hills**, North Hills (412) 364-6411
- **The Pines of Mt. Lebanon**, Mt. Lebanon (412) 341-4400
- **UPMC St. Margaret**, Aspinwall (412) 784-5050
- **Valley Care**, Moon Township (412) 749-5257
- **Willow Lane**, McKees Rocks (412) 875-1606

Care Consultation

This service assists persons with Alzheimer's or related dementias and their families in planning for and dealing with all aspects of the illness. Components of Care Consultation include:

- assessment of needs;
- assistance with planning and problem solving;
- information and resource lists;
- supportive listening; and
- follow up, as needed.

Care Consultation is not case management, care management, counseling, crisis intervention or case advocacy, but part of it may identify the need for and refer families to appropriate agencies or persons that provide these services. Care coordinators are not trained to provide crisis intervention. Families with ongoing or extremely critical needs will be linked with resources in the community that are best able to support them.

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Prevention Video and Training Resources


  This brief video (13.5 minutes) gives a straightforward and simple overview of transitioning to a nursing home and the risk of depression. It could be useful for residents or families.


  This video series was created with the National Institutes of Mental Health. Topic segments include: Bereavement and Depression in Late-life, Caregiving, Complicated Grief, Dementia, Dementia: Non-pharmacological Treatment, Geriatric Pharmacology, Late-life Psychosis, Late-life Suicide, Minority Elders and Mental Health, Pharmacological Treatment of Late-life Depression, Psychotherapy for Late-life Depression, Successful Aging, and Symptoms of Late-life Depression. While most of the segments better fit with detection, assessment and intervention, several segments may be of use with residents, staff and caregivers for prevention purposes.
DETECTION and ASSESSMENT RESOURCES
How to Use the Detection and Assessment Resources

There are a countless number of assessments designed to detect symptoms of depression. The goal of this section is not to provide a repository for all of these measures as the MDS incorporates the PHQ-9 as a tool to screen for depression. The PHQ-9 is a well-validated assessment instrument, and we encourage the efforts for all long-term residents to be assessed using this measure, which is why it is included in the tool kit with instructions for interpretation. However, it is important to consider that depression is a multidimensional disorder and may present differently across residents. The Geriatric Depression Scale and Holmes-Rahe Life Stress Inventory are included as additional screening tools, not because we believe that additional assessments should be administered to residents but rather to broaden awareness that symptoms listed on these assessments should also be considered when interacting with long-term care residents.

The Geriatric Depression Scale removes many of the items related to physical symptoms, which often over-inflate depression scores in geriatric patients, and instead focuses on items related to social engagement, hopefulness, mood, and life satisfaction. The Holmes-Rahe Life Stress Inventory reminds us to consider all of the life events that may be contributing to or increasing the risk of resident’s depressed mood and also highlights that certain times of year may make a resident more apt to experience a depressed mood (for example, anniversary of spouse’s death or holidays). Information sheets in this section focus on important issues such as how depression and grief differ in the older adult population, how men experience depression differently from women, how to distinguish depression from delirium and dementia, and understanding suicide in older adults. For those interested in more extensive information, an article/book list and list of web resources have been provided.
Geriatric Depression Scale (Short Form)

Patient’s Name: ___________________________ Date: _______________________

**Instructions:** Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

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

**TOTAL**

(Sheikh & Yesavage, 1986)

**Scoring:**
Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

**Sources:**
PATIENT HEALTH QUESTIONNAIRE PHQ-9 FOR DEPRESSION

USING PHQ-9 DIAGNOSIS AND SCORE FOR INITIAL TREATMENT SELECTION

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (little pleasure, feeling depressed) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal symptoms*</td>
<td>Support, educate to call if worse; return in 1 month.</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ††</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Major depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>≥ 20</td>
<td>Major depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressant or psychotherapy (ask, “In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?”).

† † If symptoms present ≥ one month or severe functional impairment, consider active treatment.
# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**

**DATE:**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**add columns:**

| + | + | + |

**TOTAL:**

10. If you checked off any problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

---

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at [http://www.pfizer.com](http://www.pfizer.com). Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.
The Holmes-Rahe Life Stress Inventory

The Social Readjustment Rating Scale

INSTRUCTIONS: Mark down the point value of each of these life events that has happened to you during the previous year. Total these associated points.

<table>
<thead>
<tr>
<th>Life Event</th>
<th>Point Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Death of spouse</td>
<td>100</td>
</tr>
<tr>
<td>2. Divorce</td>
<td>73</td>
</tr>
<tr>
<td>3. Marital Separation from mate</td>
<td>65</td>
</tr>
<tr>
<td>4. Detention in jail or other institution</td>
<td>63</td>
</tr>
<tr>
<td>5. Death of a close family member</td>
<td>63</td>
</tr>
<tr>
<td>6. Major personal injury or illness</td>
<td>53</td>
</tr>
<tr>
<td>7. Marriage</td>
<td>50</td>
</tr>
<tr>
<td>8. Being fired at work</td>
<td>47</td>
</tr>
<tr>
<td>9. Marital reconciliation with mate</td>
<td>45</td>
</tr>
<tr>
<td>10. Retirement from work</td>
<td>45</td>
</tr>
<tr>
<td>11. Major change in the health or behavior of a family member</td>
<td>44</td>
</tr>
<tr>
<td>12. Pregnancy</td>
<td>40</td>
</tr>
<tr>
<td>13. Sexual Difficulties</td>
<td>39</td>
</tr>
<tr>
<td>14. Gaining a new family member (i.e. birth, adoption, older adult moving in, etc.)</td>
<td>39</td>
</tr>
<tr>
<td>15. Major business adjustment</td>
<td>39</td>
</tr>
<tr>
<td>16. Major change in financial state (i.e. a lot worse or better than usual)</td>
<td>38</td>
</tr>
<tr>
<td>17. Death of a close friend</td>
<td>37</td>
</tr>
<tr>
<td>18. Changing to a different line of work</td>
<td>36</td>
</tr>
<tr>
<td>19. Major change in number of arguments with spouse (i.e. a lot more or less)</td>
<td>35</td>
</tr>
<tr>
<td>20. Taking on a mortgage (for home, business, etc.)</td>
<td>31</td>
</tr>
<tr>
<td>21. Foreclosure on a mortgage or loan</td>
<td>30</td>
</tr>
<tr>
<td>22. Major change in responsibilities at work (i.e. promotion, demotion, etc.)</td>
<td>29</td>
</tr>
<tr>
<td>23. Son or daughter leaving home (marriage, college, military, etc.)</td>
<td>29</td>
</tr>
<tr>
<td>24. In-law troubles</td>
<td>29</td>
</tr>
<tr>
<td>25. Outstanding personal achievement</td>
<td>28</td>
</tr>
<tr>
<td>26. Spouse beginning or ceasing work outside the home</td>
<td>26</td>
</tr>
<tr>
<td>27. Beginning or ceasing formal schooling</td>
<td>26</td>
</tr>
<tr>
<td>28. Major change in living condition (i.e. new home, remodeling, deterioration, etc.)</td>
<td>25</td>
</tr>
<tr>
<td>29. Revision of personal habits (i.e. dress, associations, quit smoking, etc.)</td>
<td>24</td>
</tr>
<tr>
<td>30. Troubles with the boss</td>
<td>23</td>
</tr>
<tr>
<td>31. Major changes in working hours or conditions</td>
<td>20</td>
</tr>
<tr>
<td>32. Changes in residence</td>
<td>20</td>
</tr>
<tr>
<td>33. Changing to a new school</td>
<td>20</td>
</tr>
<tr>
<td>34. Major change in usual type and/or amount of recreation</td>
<td>19</td>
</tr>
<tr>
<td>35. Major change in church activity (i.e. a lot more or less)</td>
<td>19</td>
</tr>
<tr>
<td>36. Major change in social activities (i.e. clubs, movies, visiting, etc.)</td>
<td>18</td>
</tr>
<tr>
<td>37. Taking on a loan (i.e. car, tv, freezer, etc.)</td>
<td>17</td>
</tr>
<tr>
<td>38. Major change in sleeping habits (i.e. a lot more or less)</td>
<td>16</td>
</tr>
<tr>
<td>39. Major change in number of family get-togethers (i.e. a lot more or less)</td>
<td>15</td>
</tr>
<tr>
<td>40. Major change in eating habits (i.e. a lot more or less, eating hours, surroundings, etc)</td>
<td>15</td>
</tr>
<tr>
<td>41. Vacation</td>
<td>13</td>
</tr>
<tr>
<td>42. Major holidays</td>
<td>12</td>
</tr>
<tr>
<td>43. Minor violations of the law (i.e. traffic tickets, jaywalking, etc.)</td>
<td>11</td>
</tr>
</tbody>
</table>

Now, add up all the points you have to find your score.

150pts or less means a relatively low amount of life change and a low susceptibility to stress-induced health problems.

150 to 300pts implies about a 50% chance of a major stress-induced health problem in the next 2 years.

300pts or more raises the odds to about 80%, according to the Holmes-Rahe prediction model.


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34 DEPRESSION AND ADJUSTMENT IN THE NURSING HOME TOOL KIT
Understanding Depression and Grief in Older Adults

When an older resident is sad and low it is important to ask: Is this normal grief or is this depression. It is our job to recognize the differences between acute grief and depression so we can better help our residents in need. Residents experience losses. These include loss of health, loss of family members, loss of neighbors and friends, loss of job, loss of home, and loss of driving ability. With these losses they may experience acute grief reactions and/or depression.

Normal, Acute Grief

Physical symptoms:
- Fatigue/exhaustion
- Weakness
- Trouble sleeping
- Changes in appetite
- Aches and pains
- Restlessness
- Palpitations

Emotional symptoms:
- Sadness
- Anger, irritability
- Anxiety, panic
- Numbness
- Longing
- Abandonment
- Fear
- Guilt

Behavioral:
- Forgetfulness
- Difficulty concentrating
- Wandering aimlessly
- Sense of unreality or emptiness
- Searching for the deceased

Grief is a roller coaster ride. Grief involves a mix of emotions with good days and bad days however, the resident is able to experience moments of pleasure, laugh at a joke, and brighten up, unlike the steady state of depression.

Depression

Physical symptoms:
- Same as acute grief and:
  - Slow speech and body movements
  - Trouble concentrating on ADLs

Emotional symptoms:
- Same as acute grief and:
  - Intense and pervasive sense of guilt
  - Thoughts of suicide or a preoccupation with dying
  - Feelings of hopelessness or worthlessness
  - Loss of interest in socializing and hobbies

Men and Women Experience Depression Differently

Although men do develop the standard symptoms of depression they also tend to deny depression and try to cover it up. They can become irritable and aggressive, drink and engage in high risk behaviors. Sometimes it shows up as physical pain such as backache, frequent headaches and digestive disorders that don’t respond to normal treatment.

Men:
- Blame others
- Feel angry, irritable, and ego-inflated
- Feel suspicious and guarded
- Create conflicts
- Feel restless and agitated
- Need to control at all costs
- Find it weak to admit self-doubt and despair

Women:
- Blame themselves
- Feel sad, apathetic, and worthless
- Feel anxious and scared
- Avoid conflict at all cost
- Feel slowed down and nervous
- Find it easy to talk about self-doubt and despair

Risk factors:
- Loneliness and lack of support
- Inability to effectively deal with stress
- A history of alcohol or drug abuse
- Early childhood trauma or abuse
- Aging in isolation with few social contacts

Medical problems that can cause depression:
- Parkinson’s disease
- Stroke
- Heart disease
- Cancer
- Diabetes
- Thyroid disorders
- Vitamin B12 deficiencies
- Lupus
- Multiple sclerosis

Some prescription drugs that cause or worsen depression:
- Blood pressure medicine (clonidine)
- Beta-blockers (e.g., Lopressor, Inderal)
- Sleeping pills
- Tranquillizers (e.g., Valium, Xanax, Halcion)
- Calcium channel blockers
- Medications for Parkinson’s disease
- Ulcer medication (e.g., Zantac, Tagamet)
- Steroids
# Distinguishing Differences among Delirium, Depression, and Dementia

<table>
<thead>
<tr>
<th></th>
<th>Delirium</th>
<th>Depression</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long has this been going on?</td>
<td>Days to weeks</td>
<td>Weeks to months</td>
<td>Years</td>
</tr>
<tr>
<td>How abruptly did it start?</td>
<td>Abrupt, precise onset and identifiable date</td>
<td>Gradual onset that cannot be dated</td>
<td>Gradual onset that cannot be dated</td>
</tr>
<tr>
<td>Are the symptoms progressing? How fast?</td>
<td>Variable from moment to moment and hour to hour</td>
<td>Recovering in days to weeks</td>
<td>Progressing gradually over years</td>
</tr>
<tr>
<td>Are the symptoms improving? If so, how fast?</td>
<td>Recovering in days to weeks</td>
<td>Recovers in months to a year but can be refractory</td>
<td>Generally irreversible</td>
</tr>
<tr>
<td>Are there any psychomotor changes?</td>
<td>Prominent psychomotor changes (hypoactive or hyperactive)</td>
<td>Generally no psychomotor changes</td>
<td>Psychomotor changes occur at the later stage (unless depression concurrently develops)</td>
</tr>
<tr>
<td>Is there any physiological decline?</td>
<td>Prominent physiological decline</td>
<td>Less prominent physiological decline</td>
<td>Less prominent physiological decline</td>
</tr>
<tr>
<td>Is there any change in consciousness?</td>
<td>Clouded, altered, and changing level of consciousness</td>
<td>Consciousness generally is not altered</td>
<td>Consciousness not clouded until terminal</td>
</tr>
<tr>
<td>Is there any change in attention span?</td>
<td>Strikingly short attention span</td>
<td>Attention span not characteristically reduced</td>
<td>Attention span not characteristically reduced until late stage</td>
</tr>
<tr>
<td>Is there any disorientation?</td>
<td>Disorientation at the early stage</td>
<td>Generally no disorientation develops; often gives “don’t know” answer to orientation questions</td>
<td>Disorientation develops later in the illness and often gives near-miss answers to orientation questions</td>
</tr>
<tr>
<td>Is there any change in sleepwake cycle?</td>
<td>Disturbed sleep-wake cycle with hour-to-hour variation</td>
<td>Disturbed sleep-wake cycle with a complaint of insomnia or hypersomnia</td>
<td>Disturbed sleep-wake cycle with day-and-night reversal</td>
</tr>
<tr>
<td>Are there any changes in memory?</td>
<td>Day-to-day fluctuation in memory</td>
<td>Equal memory loss for recent and remote events. Has overt concern for memory loss</td>
<td>Memory loss greater for recent events than remote events</td>
</tr>
</tbody>
</table>


Fact Sheets for Residents:  
Look Out for the Well-Being of Yourself and Others  
Know the Warning Signs of Suicide  
After a Suicide: How to Help Yourself and Others  
2011

Instructions for Using the Fact Sheets for Residents
The Fact Sheets for Residents provide senior living community residents and their families with useful information on three topics: maintaining emotional health, preventing suicide, and coping with suicide. They are intended to be given to residents by staff or other mental health professionals. Since they cover emotionally sensitive topics, these sheets should be given to residents only in settings in which they can be discussed. A staff person can help explain the information, answer questions, and help residents deal with any feelings that may come up.

The following provides suggested settings in which the fact sheets can be distributed and discussed:

♦ Looking Out for the Well-Being of Yourself and Others:
  ◊ Family and Resident Workshop  
  ◊ Health promotion or wellness programs  

♦ Know the Warning Signs of Suicide:
  ◊ Family and Resident Workshop  
  ◊ Support group run by a social worker or other mental health professional  
  ◊ Individual sessions with a social worker or other mental health professional  

♦ After a Suicide: How to Help Yourself and Others:
  ◊ Community meetings, as described in the Guide, Tool 3.f: Community Support Meetings for Senior Living Communities  
  ◊ Support group run by a social worker or other mental health professional  
  ◊ Individual sessions with a social worker or other mental health professional  

The fact sheets may also be useful handouts for participants in the staff workshops. The sheets provide staff with the key information and wording to use in discussing issues related to emotional health and suicide with residents.

At the end of each fact sheet is space to fill in the names of relevant contact people from whom residents (or staff) can seek help. At least one person should be in your senior living community, such as a social worker or other mental health professional. Also list a contact person in a local agency, such as a community mental health center. Please be sure this information is on the fact sheets when you give them to residents (or staff).
Look Out for the Well-Being of Yourself and Others

No matter what age you are, it is important to look out for your own emotional well-being. This is especially true for older adults because of the special challenges at this stage of life. Taking charge of your emotional well-being can make a big difference.

Are you in pain? Do you feel depressed?
Are you lonely? Have you experienced a loss?
You don’t have to feel this way. Read on . . .

Take Care of Yourself

Your emotional well-being is affected by your health. If you need help or support, staff at your senior living community can help you see a medical or mental health provider. Your facility may also offer health and wellness activities.

Here are some suggestions to take care of your health:

♦ Make an appointment with a medical provider if you are in pain or have a physical illness.
♦ Seek treatment or talk to a counselor if you have depression or another mental health issue, or if you drink too much or abuse medications.
♦ Join a support group to help you cope with the loss of family and friends, financial problems, or other personal issues.
♦ Stay active and exercise regularly. Try taking a group exercise class or going on walks.
♦ Eat a healthy diet. Avoid too much sugar, salt, fat, and caffeine.

Taking care of your physical and emotional health will help you feel better and reduce feelings of helplessness.

Mrs. Williams

At 80 years old, Mrs. Williams was just settling into a senior living community when she broke her hip. Since she couldn’t walk, she slept most of the day and seemed very withdrawn. She said she felt her life was over.

Another resident was concerned that Mrs. Williams was depressed and told the staff. They talked with her children and decided she needed to see a counselor. Mrs. Williams did not like the idea, but her children insisted.

The counselor had Mrs. Williams take anti-depressants for six months and go to physical therapy. Her family provided support to her.

The staff encouraged her to get involved in activities she could do, such as arts and crafts and welcoming new residents. These activities gave her a sense of purpose and helped her build relationships.

Now Mrs. Williams is feeling better physically and emotionally and enjoys spending time with other residents and staff.
Know the Warning Signs of Suicide

Have you heard someone make these statements? Have you thought them yourself?

“I think I’m going to end it all.”
“I no longer want to live.”
“Death seems like the only way out.”

Have you seen someone doing any of these things? Are you doing them?

Hoarding pills. Getting a gun or knife. Looking for a high place from which to jump. Refusing food, medicine, or other treatment.

These behaviors and statements are warning signs of suicide. The person needs IMMEDIATE help. Contact a nurse, social worker, doctor, mental health professional, or clergy RIGHT AWAY.

• • •

Do either of these descriptions sound like your neighbor, a friend, or yourself?

♦ A resident has been drinking more than usual. He doesn’t think his life has any purpose now that his wife is gone. He yells at the food servers and maintenance staff for taking too long.

♦ Another resident has stopped coming to bridge club and exercise class. She paces around at night, unable to sleep. She says she feels hopeless, that nothing in her life will ever improve.

These residents may be showing warning signs that they are considering suicide. Get help if you notice any of these behaviors and moods in yourself or another resident.

3 warning signs that a person could be at immediate risk of suicide:

♦ Threatening or talking about wanting to kill or hurt him/herself

♦ Looking for ways to kill him/herself

♦ Talking or writing about death, dying, or suicide when this is not usual for the person.

Warning signs that a person could be considering suicide:

BEHAVIOR

♦ Withdrawing from family, friends, or others

♦ Sleeping all the time or unable to sleep

♦ Acting reckless

♦ Increasing use of alcohol or drugs

MOOD

♦ Hopeless or feeling trapped

♦ No sense of purpose in life

♦ Anxious or agitated

♦ Rage, uncontrolled anger

♦ Dramatic changes in mood
After a Suicide: How to Help Yourself and Others

When a person dies by suicide, it can have a huge impact on family members, friends, other residents, and staff. Whether you have lost someone by suicide or want to help another person who has, it is useful to know what to expect and how to best help someone else.

How to Help Yourself

Coping with a suicide can cause many emotions. Strong feelings are normal. No one has the same reaction, and emotions can change. Take time to figure out how you feel. You may be feeling any of the following:

- disbelief
- denial
- grief
- guilt
- anger
- shame

An attempted suicide can often bring up some of these same emotions.

Here are some tips for coping:

- **Give yourself time** to deal with the loss and accept whatever emotions you feel. Everyone grieves differently.
- **Talk about the person** who died with someone you trust—a family member, resident, or staff.
- **Honor the memory** of the person who died—set out pictures of the person in your room or write something about him or her.
- **Express your feelings** with a counselor or in a support group with others who are likely to understand what you are going through.
- **Stay with your daily routine** and take care of your basic needs—eat, sleep, and attend your regular activities.
- **Be prepared for holidays and anniversaries**, since they can be difficult emotionally—consider doing something special in memory of the person who died.

Why did it happen?

It’s common to try to figure out why someone took his or her life. Yet, the answers may not be known. The causes of suicide are complicated and different for each person. And, the person who died may be the only one able to answer your questions. At some point, most people accept that clear reasons may not exist, and that knowing why will not change what happened. This acceptance is a key step in healing.

Take Care of Yourself

The suicide of a family member, friend, or resident can affect your emotional health. Get help if you feel suicidal yourself.
Understanding Suicide and Older Adults

Suicide Risk in Older Adults:
The highest suicide rates of any age group are among persons aged 65 years and older.

Contributing factors to suicide risk in older adults:
• Depression in older adults that is undiagnosed and untreated
• Many older adults with suicidal thoughts want desperately to eliminate the unrelenting emotional or physical pain they are experiencing
• Alcohol and drug dependencies can also make people more vulnerable to depression and the feeling that life is no longer worth living.
• Other risk factors for suicide in the elderly include:
  - Recent death of a loved one
  - Physical illness, disability, or pain
  - Isolation and loneliness
  - Major life changes, such as retirement
  - Loss of independence
  - Loss of sense of purpose

What Suicidal Warning Signs Should I Be Aware Of?

Emotional Signs or Symptoms
• Feeling hopeless, unloved, anxious, or worthless
• Feeling angry about the events leading up to your suicidal thoughts
• Feeling guilty for not being able to make things better
• Experiencing dramatic mood changes
• Not deriving pleasure from, or losing interest in activities, hobbies, or socializing with friends
• A sudden sense of calm and happiness after being extremely depressed can mean that the person has made a decision to commit suicide

Behavioral Signs or Symptoms
• Giving away personal items and saying good-bye to loved ones
• Getting personal affairs in order, e.g., finances, care of a pet
• Acquiring a weapon or lethal amounts of medication
• Death, dying, or suicidal poems, notes, or journal entries
• Taking unnecessary risks; being reckless and/or impulsive
• Neglecting physical appearance
• Failure to take care of self or follow medical orders
• Unusual or unexpected visits or calls to family and friends. Saying goodbye to people as if they won’t be seen again.

Mental Signs or Symptoms
• Unable to concentrate or make decisions
• Talking about or seeming preoccupied with death
• Constant thoughts of death or hurting oneself
• Statements like:
  - “I wish I were dead.”
  - “I can’t take this life anymore.”
  - “I mess up everything I do.”
  - “You would be better off without me.”
  - “There is no hope.”
  - “Things will never get better.”
  - “I’m not sure I’ll be around.”

Physical Signs or Symptoms
• Poor sleeping patterns, nightmares
• Loss of appetite or increased appetite
• Lack of energy or hyperactivity
• Persistent headaches, stomachaches, or chronic pain

Why Are Older Adults Hesitant To Talk About Suicidal Thoughts?
Older adults often are hesitant to talk about their feelings of depression and thoughts of suicide due to a variety of reasons including:
• Misconceptions. Older adults, as well as family and friends, often believe that depression is a normal part of aging. As a result of this misconception, friends and professionals do not always look or listen for warning signs when an older person may be feeling desperate.
• Stigma. Many older adults hide their true feelings and thoughts from their physician, family, and others because they are embarrassed, fear they will be negatively judged.
• Ageism. Our society tends to value younger people more than older adults. Some older adults are hesitant to share their thoughts of suicide, erroneously thinking that nobody will care about their suffering or their future.

National Resources
• National Hopeline Network. The Network links crisis centers certified by the American Association of Suicidology (AAS)
  - Toll-free number: 1-800-784-2433 (SUICIDE)
  - Each call is quickly transferred to a participating crisis center nearest the caller’s location.
  - Web site: www.hopeline.com
• National Suicide Prevention Lifeline. A 24-hour, toll-free hotline funded by the federal government that will direct callers to a nearby crisis center
  - Phone: 1-800-273-8255 (TALK)
  - The Lifeline will accept calls from nonEnglish speakers.
  - Web site: www.suicidepreventionlifeline.org
• Center for Elderly Suicide Prevention. A 24-hour toll-free friendship line to receive emotional support, crisis intervention, and information and referrals.
  - Phone: 1-800-971-0061
Article and Book List for Diagnosis and Treatment


Useful Web Links and Video Resources for Detection and Assessment of Depression and Grief

• Depression in Older Adults from HelpGuide.org
  - www.helpguide.org/articles/depression/depression-in-older-adults-and-the-elderly.htm

  - This resource can be downloaded with resources for suicide prevention including PowerPoint presentations for staff, resident and family training on the topic. It also contains fact sheets included in this manual. It is free and may be ordered/downloaded from: http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515

• Geriatric Education Center of Pennsylvania, Aging Institute of UPMC Senior Services and the University of Pittsburgh (2009). The I am HERE series: Interventions for assessment of mental health in elders with resources and education. Pittsburgh, PA

  - This video series was created with the National Institutes of Mental Health. Topic segments include: Bereavement and Depression in Late-Life, Caregiving, Complicated Grief, Dementia, Dementia: Non-Pharmacological Treatment, Geriatric Pharmacology, Late-Life Psychosis, Late-Life Suicide, Minority Elders and Mental Health, Pharmacological Treatment of Late-Life Depression, Psychotherapy for Late-Life Depression, Successful Aging, Symptoms of Late-Life Depression

INTERVENTION RESOURCES
How to Use the Intervention Resources

There are many interventions for depression. Browsing in a bookstore, watching television, or even doing a professional literature search provides a lot of ideas. Not all of them are good ideas, and only some of them have been demonstrated as effective for older adults living in long-term care programs. Part of using evidence-based practices involves looking at the many ideas critically and selecting those which are most promising based on the research done with them to date. This section focuses primarily on introducing many psychosocial interventions and providing the reader with the most recent understanding of research on their efficacy. The strength of the evidence base varies by intervention. Some of them can be delivered by people from multiple disciplines. Others are better suited to specific disciplines. As you read the pages that follow, you will get general descriptions of each intervention. That description contains some detail, including links to some websites. For some of these interventions, there are entire books written on them or they require special training to implement. For others, not as much would be needed. These descriptions are meant to be a starting point which can take people back to their professional training or on a journey to learn more. To this end, the section has a list of articles and sources about the interventions as well as some specific web-based resources for activities/recreational therapy personnel. Notably, this section does not address pharmacological interventions. Readers can reference the clinical guidelines suggested in the first section of the manual to obtain this information. Please note, however, that research into geriatric depression suggests that many people benefit from a combination of pharmacological therapy (medication) and psychosocial interventions. The two can and do work well with one another.
Psychosocial Interventions for Depression

**Intervention Directly with the Resident**

- **Psychotherapy Interventions**
  - Cognitive behavioral therapy\(^1,\,2\)
  - Behavioral Therapy\(^1\)
  - Problem solving treatment\(^1,\,2\)
  - Interpersonal therapy\(^1,\,2\)
  - Reminiscence therapy\(^1,\,2\)
  - Cognitive bibliotherapy\(^1\)

- **Alternative Therapies\(^3\)**
  - Animal-assisted therapy\(^2\)
  - Horticulture therapy\(^2\)
  - Drama therapy\(^2\)
  - Music therapy\(^2\)
  - Art therapy\(^2\)

- **Other**
  - Exercise\(^2\)
  - Expressive physical touch\(^2\)
  - Aroma therapy\(^2\)

- **Group Therapies\(^5\)**
  - Reminiscence
  - CBT groups
  - Adjustment groups

**Intervention with Systems**

- **Eden Alternative\(^6\) and Culture Change Movement**

**Interventions with the Resident’s Support Network**

- **Family Psychoeducation\(^4,\,6\)**
- **Family Support Groups\(^6\)**
- **Family Transition Groups**

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2. Only CBT is listed as an evidence-based practice in this article. IPT and reminiscence therapy have the next degree of support. The remainder has some studies which indicate they hold promise and have worked for some populations. Adamek, M.E., & Slater, G.Y. (2008). Chapter 7; Depression and Anxiety. *Journal of Gerontological Social Work*, 50(S1), 151-189. doi: 10.1080/01634370802137876

3. Some questions exist whether it is the social aspect of these therapies which accounts for the benefits of this treatment. The research does not rise to the point of considering them evidence-based for depression in long-term care.


5. Many of the group therapies have not been tested to the point that they can be considered evidence-based for long-term care settings or older adults. They hold promise and may be an important choice for long-term care settings where social workers, recreation therapists and others may not have the time for individual therapies.

Descriptions of the Interventions in Alphabetical Order

**Animal-Assisted Therapy (AAT):** This therapy involves introducing an animal into the treatment plan of an individual for the purpose of alleviating anxiety or elevating mood. In the community, pets have been prescribed to assist people in combating loneliness. There is evidence of its potential benefit to alleviate depression, but more studies need to be done before it can be considered an evidence-based practice. It has been examined more for people with dementia. It is a cousin to Animal-assisted Activities where animals are generally introduced into the long-term care setting for the benefit of all without a specific therapeutic intention for particular residents. Generally, this therapy has been utilized or accessed through Recreational Therapy departments in long-term care settings.

**Aroma Therapy:** In the truest sense, aroma therapy involves using essential oils from various plants to promote healing and well-being. Typically the oils are inhaled or rubbed into the skin. Aroma therapy can be hard to distinguish from multisensory stimulation efforts, which may use other scents (such as brewing coffee to orient people to time or baking cookies to promote memories and a pleasant atmosphere) to promote well-being and have long been a part of activities used by recreational therapy departments in long-term care. The evidence base for aroma therapy to alleviate depression is promising but remains limited. The following web site has ideas and goals for aroma therapy in the nursing home. You may have to purchase some of the supplies www.aromatherapyplus.homestead.com/longtermcare.html

**Art Therapy:** This therapy involves helping residents connect to their emotions through creative expression and art. It allows residents to do this without relying upon words. The work can be done individually, in groups or within the context of family. Like other alternative therapies mentioned, it moves from being an activity to being therapeutic when it is being done for a specific purpose, such as alleviating depression. Trained professionals—art therapists—are able to assist in doing this therapeutic work. Many Recreation Therapy departments use art as an activity which may have therapeutic impact.

**Behavioral Therapy (BT):** Behavior therapy examines behaviors in the context of the environments where people live to find triggers (A = antecedents). BT then attempts to understand how those triggers support various behaviors (B = behaviors) and outcomes (C = consequences). The environmental reinforcements are then altered as a way to alter the mood or behavior of the resident. This intervention may include use of relaxation training, social skills training, or activity prompting. It also involves training staff members and family members to respond differently. The evidence suggests is may be particularly effective for persons with dementia.

**Cognitive Behavioral Therapy (CBT):** CBT is a brief, structured therapy which combines elements of cognitive and behavioral theory to help individuals. It has been extensively studied for treatment of depression and anxiety. Most often, the therapist (a social worker, psychologist, or some other trained professional) helps the person to identify cognitive distortions, to create alternative thoughts, and to experiment on ways to integrate alternative thoughts into his/her behavior. It is the psychosocial intervention with the strongest evidence base for recovery from depression for older adults, although it has been used more often in the community settings. CBT can be done in a group format.
Descriptions of the Interventions in Alphabetical Order

**Cognitive Bibliotherapy:** The idea of bibliotherapy is to use literature to help people cope with emotional challenges, like depression. Much of bibliotherapy adapts principles of CBT with a focus on restructuring thoughts which are linked to depression. Those thoughts are accessed using written materials and literature. This can be done individually or in groups. Literature suggests its use for mild or presyndromal depression. More studies are needed.

**Drama Therapy:** Per the North American Drama Therapy Association (2013), “Drama Therapy is an active, experiential approach to facilitating change. Through storytelling, projective play, purposeful improvisation, and performance, participants are invited to rehearse desired behaviors, practice being in relationship, expand and find flexibility between life roles, and perform the change they wish to be and see in the world.” This therapy is beginning to be explored for its effectiveness with older adults. It has not been commonly used in long-term care settings, but is considered to have potential.

**Eden Alternative and the Culture Change Movement:** The Eden Alternative and the Culture Change Movement in long-term care are philosophies of care and represent organizational or macro-level changes which long-term care settings generally adopt as a process over time. Both share a number of values and ideas which then drive changes to care systems. These system changes, in turn, result in reduction in distressing behaviors among residents (Burack, Weiner, and Reinhardt, 2012), greater satisfaction with care by residents and family members (Burack, Weiner, Reinhardt, & Annunziato, 2012); and greater job satisfaction and employee retention (Rosher, R.B. and Robinson, 2006). There are indicators as well that these changes may assist in reducing or preventing depression. Researchers and proponents acknowledge that additional research is needed to suggest this as an evidence-based practice. However, early results are promising (Rahman and Schnelle, 2008).

Central to the Eden and Culture Change efforts is the idea that long-term care facilities are homes first and foremost. People live in them and those people do not want their lives dictated by the medical model, or what works best for staff members. They want a place they can feel comfortable, where they be connected to people and things they like and care about. They want a home where they can live and thrive, not one where they simply exist. Returning control and autonomy to the resident is central to these efforts. A person-centered approach and individualization of care are also central to these efforts. The interventions that come out of both movements often change the way staff operates for various aspects of care and improve the quality of life for residents. Both movements have extensive resources on the web as well as training opportunities. Please see http://www.edenalt.org/ for more information on the Eden Alternative and https://www.pioneernetwork.net/ for information on the Culture Change Movement through the Pioneer Network. An article by White-Chu, Graves, Godfrey, Bonner, and Sloane may also be of interest. The full citation is in the reference list.
Exercise: Exercise has been demonstrated to have multiple benefits for older adults. In recent years, there has been some attention paid to its impact upon depression in populations of all ages. The literature currently suggests three possible ways exercise could be beneficial where depression is concerned. These are: (1) treatment for depression on its own, (2) exercise as mediating or adjunctive to other forms of treatment like psychotherapy or antidepressant medication, and (3) as preventative measure for depression (Strohle, 2009; Barbour and Blumenthal, 2005; Stepanenko, Bilbrey, Nevarez, Marquett, and Gallagher-Thompson, 2012). Studies have been small to date and do not reach the level of being considered evidence-based yet.

Expressive Physical Touch: This term was first coined in the 1970s as a way to distinguish between two types of touch—“expressive touch, which is a voluntary action that occurs spontaneously and is affective, and instrumental touch, which is deliberate physical contact that involves a task being done, such as bathing a client” (Buschmann, Hollinger-Smith, and Peterson-Kokkas, 1999, 292). The use of touch for the purpose of creating comfort and expressing emotion has the potential to help prevent and ameliorate depression. Nursing and long-term care staff members often note that touch can be more effective than words at times, and that if the only touch a person experiences is instrumental, it can be dehumanizing. There were some early studies suggesting that expressive touch impacted degree of depression, particularly for persons with dementia, but that research has not continued in recent years and does not reach the standard of being evidence-based.

Family Psychoeducation Groups or Workshops and Family Transition Groups: These groups or programs have been used and promoted as a best practice since the 1980s without much evidence published to support them, even as professionals who conduct them and people who attend find them useful. Use of time-limited groups or even single session workshops with families began at least 30 years ago as a way to assist families to transition to the role of caregiver for someone living in a care setting rather than the community and to understand the changes caused by advanced age and/or disease. A wide variety of topics are possible such as specific diseases, transition issues, normal aging, advance care planning, benefits and insurance, role transitions, etc. (LaBrake, 1996). The primary focus of such interventions is to fill a knowledge and/or skill gap for the family member so that he or she may stay successfully connected to the person receiving long-term care services.

Family Support Groups: Like psychoeducation and transition groups, support groups have an element of education to them. They differ in that a primary objective of such groups is the provision of social and emotional support to family members by other family members of people living in a long-term care setting. Caregiver support groups have been a mainstay intervention for Alzheimer’s caregivers since the 1980s. The format has often been an open group format that runs on an ongoing basis. However, time-limited formats are possible too.
Group Therapies: Many of the therapies mentioned in this resource can be used in a group format including art therapy, behavioral therapy, cognitive behavioral therapy, drama therapy, exercise, horticulture therapy, interpersonal therapy, music therapy, and reminiscence therapy. Guidance and training is available to professionals to adapt them to work with groups of residents. Reminisce therapy and CBT are the two which have been studied the most (Agronin, 2009). Additionally, Blazer (2003) mentions that dialectical behavior therapy and problem solving therapy have been employed with older adults who have depression with some early indicators that they work well with pharmacological approaches. There is some literature mentioning short-term adjustment or transition groups. Two group strategies have been widely employed for provision of psychosocial support to the family members of older adults in long-term care settings; these are family support groups and family transition groups (LaBrake, 1996). In addition to direct treatment, group therapies offer the potential for creating supportive networks of residents and or families within the long-term care facility or community. Even as groups have been used in long-term care settings for years, there are too few studies to indicate this as an evidence-based practice; groups are promising. Most studies of group therapy and older adults have been done with community dwelling individuals, not older adults residing in long-term care settings. Social workers and recreation therapists have some training in group work. Some nurses do also.

Horticulture Therapy: Horticulture therapy involves engaging a resident in horticultural activities for a specific therapeutic outcome. This therapy dates to the 1940s in rehabilitative care settings. In recent years there has been some work to see if it can be beneficial in the treatment of depression for older adults. When found in long-term care settings, it is typically introduced through the Recreational Therapy department. For more information, go to the American Horticultural Therapy Association http://ahta.org/sites/default/files/DefinitionsandPositions.pdf.

Interpersonal Therapy (IPT): This is another brief form of therapy which has proven effective for treatment of depression in older adults. Initially, residents would be educated about their diagnosis of depression. A personal inventory is completed which allows the therapist to develop and suggest a problem formulation in one of four categories and connect the depression to interpersonal issues. Then the resident and the therapist would work through the chosen interpersonal focus to alleviate the depression. Much of the research demonstrating the efficacy of this treatment for older adults has been done here in Pittsburgh at the Late Life Depression Program of UPMC. Additionally, some work has been done on IPT-CI (IPT for the cognitively impaired), which would involve a caregiver in the recovery process. Information on the principles of this therapy is accessible online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693/. It is an article by Markowitz and Weissman from 2004.

Music Therapy: Music therapy involves the use of music with residents to accomplish specific therapeutic goals, such as alleviating depression. There is a long history for using music in long-term care facilities due to its therapeutic value. Most often, it is used as an activity. However, for some residents when delivered by a credentialed professional, it can meet the standard of being a therapy. Often the introduction of therapeutic music into long-term care settings occurs through the recreational therapy department. More information is available at: http://www.musictherapy.org/.
Descriptions of the Interventions in Alphabetical Order

continued

**Problem Solving Treatment (PST):** The brief treatment works with residents to find solutions to the “here and now” issues which are contributing to their depression. The idea is to improve self-efficacy and alleviate symptoms. It was designed originally for use in the community through primary care in the United Kingdom. It has since been adopted as a part of IMPACT, now considered an evidence-based community treatment for depression in older adults. People generally have 6 to 10 sessions. The first one is longer; the rest are about 30 minutes. PST materials are on-line for those wishing to learn the treatment with videos, a training manual and explanations. [http://impact-uw.org/tools/pst_manual.html](http://impact-uw.org/tools/pst_manual.html)

**Spiritual Interventions:** Spiritual care offers a unique and healing way of being present with another individual. Clinical Chaplains are trained in both theology and human behavioral sciences so that regardless of an individual’s religious practice, the Chaplain can offer a healing, non-anxious, welcoming place. Spiritual care offers emotional and spiritual healing through hearing a person’s story, embracing the whole person, connecting and sharing with another, embracing grief, transforming pain, respecting mystery. Traditional spiritual practices with familiar prayers may be a part of the Spiritual Intervention, but at its heart it is a “companion-on-the-journey” model. In the long-term care setting, issues of an individual’s meaning, value, and roles can be supported and re-articulated within the context of spiritual care. Wisdom is seen as being able to integrate difficult experiences into a framework that provides meaning and understanding. Losses of various kinds can be grieved in community with another, and then offered a place in a wider world view, hopefully infused with a sense of purpose. Because depression is linked to psychosocial factors and losses, spiritual care can assist in relieving the depression symptoms. Practitioners and residents have reported anecdotal benefits for this model. The literature base is not as clear for it.

**Reminiscence Therapy:** This therapy involves discussing and exploring past activities, events, and experiences with either an individual or a group, sometimes using prompts like objects, photos, or music. It is more often done in groups than individually, but can be done individually. It is frequently done through Recreation Therapy departments in long-term care. Most studies have looked at it in connection to dementia care. It has also been taught to family members to use with people who have dementia. One study found that this therapy was effective in preventing depression for older adults who were relocating to long-term care settings (Haight, Michel and Hendrix, 1998).
Articles and References Cited for Psychosocial Interventions


Intervention Video and Training Resources


http://www.foxlearningsystems.com/what-we-do/existing-content/caring-for-those-who-cared-for-us/

This video series was created with the National Institutes of Mental Health. Topic segments include: Bereavement and Depression in Late-Life, Caregiving, Complicated Grief, Dementia, Dementia: Non-Pharmacological Treatment, Geriatric Pharmacology, Late-Life Psychosis, Late-Life Suicide, Minority Elders and Mental Health, Pharmacological Treatment of Late-Life Depression, Psychotherapy for Late-Life Depression, Successful Aging, Symptoms of Late-Life Depression. Some video segments demonstrate interventions and their efficacy.
Activities to Improve Your Spirits

1. Reading novels or magazines
2. Watching TV
3. Renting and watching a video
4. Learning a new craft or hobby
5. Camping
6. Working in politics or for a political or social cause
7. Having lunch with friends
8. Taking a shower
9. Being with animals
10. Singing in a group
11. Going to church socials
12. Playing a musical instrument
13. Going to the beach
14. Rearranging your furniture
15. Reading something spiritual
16. Going to a sporting event
17. Playing sports
18. Going to the movies
19. Cooking meals
20. Having a good cry
21. Going to a restaurant
22. Looking at beautiful flowers or plants
23. Saying prayers
24. Canning, making preserves, etc.
25. Taking a bath
26. Making food or crafts to sell or give away
27. Painting or drawing
28. Visiting people who are sick or shut in
29. Bowling
30. Gardening or doing yard work
31. Shopping
32. Sitting in the sun
33. Going to the zoo or amusement park
34. Playing board games
35. Doing outdoor work
36. Reading the newspaper
37. Swimming
38. Running, jogging or walking
39. While walking, notice new things
40. Playing Frisbee
41. Listening to music
42. Knitting, crocheting, needlework
43. Starting a new project
44. Having sex
45. Bird watching
46. Repairing things
47. Bicycling
48. Giving gifts
49. Going on outings (to the park, picnic)
50. Playing basketball
51. Helping someone
52. Seeing beautiful scenery
53. Hiking
54. Going to a museum
55. Fishing
56. Going to a health club
57. Writing letters, cards, notes
58. Going to luncheons, potlucks, etc.
59. Being with your spouse or partner
60. Going on field trips, nature walks, etc.
61. Expressing your love to someone
62. Caring for houseplants
63. Collecting things
64. Sewing
65. Going to auctions, garage sales, etc.
66. Doing volunteer work
67. Seeing old friends
68. Writing to old friends
69. Calling old friends
70. Going to the library

Creating Your Special Place Exercise

In creating your own special place, you will be making a retreat for relaxation and hearing your inner voice.

A special place might be at the end of a path that leads to a pond. Grass is under your feet, the pond is about 30 yards away and mountains are in the distance. You can feel the coolness of the air in this shady spot. The birds are singing. The sun is bright on the pond. The flowers’ sweet smells attract the bees buzzing over them.

Or your special place might be a sparkling clean kitchen with cinnamon buns baking in the oven. Through the kitchen window you can see fields of yellow wheat. A wind chime flutters in the breeze.

Try taping this exercise and playing it or have a friend read it to you slowly.

To go to your safe and special place, lie down, be totally comfortable. Close your eyes ... Walk slowly to a quiet place in your mind ... Your place can be inside or outside ... It needs to be peaceful and safe ... Picture yourself unloading your anxieties, your worries ... Notice the view in the distance ... What do you see? ... What do you smell? ... What do you hear? ... Notice what is before you ... Reach out and touch it ... How does it feel? ... Smell it ... Hear it ... Make the temperature comfortable ... Be safe here ... Look around for a special spot, a private spot ... Find the path to this place ... Feel the ground with your feet ... Look above you ... What do you see? ... Hear? ... Smell? ... Walk down this path until you can enter your own quiet, comfortable, safe place.

You have arrived at your special place ... What is under your feet? ... How does it feel? ... Take several steps ... What do you see above you? ... What do you hear? ... Do you hear something else? ... Reach out and touch something ... What is its texture? ...

Sit or lie in your special place ... Notice its smells, sounds, sights ... This is your place and nothing can harm you here ... If danger is here, expel it ... Spend a few minutes realizing you are relaxed, safe and comfortable.

Memorize this place’s smells, tastes, sights, sounds ... You can come back and relax here whenever you want ... Leave by the same path or entrance ... Notice the ground, touch things near you ... Look far away and appreciate the view ... Remind yourself this special place you created can be entered whenever you wish. Say an affirmation such as, “I can relax here,” or “This is my safe and special place. I can come here whenever I wish.”

Now open your eyes and spend a few seconds appreciating your relaxation.

Web-based Resources for Activities and Recreation Therapy Staff

These resources are not specific to depression. However, as recreation or activities staff persons plan their programming, these resources may be of use.

**Activity Connection:** Provides activity professionals with information on activity programming ideas for different levels of care. There is a fee for membership. Most of the UPMC nursing facilities are already using this.

[www.activityconnection.com](http://www.activityconnection.com)

**Activity Director Today:** Provides activity ideas, educational information, CMS information geared for activities, activity assessment forms, and much more. The first link is to the general site. The second one to information on men's activities.

[www.theactivitydirectorsoffice.com](http://www.theactivitydirectorsoffice.com)

[http://www.theactivitydirectorsoffice.com/MensActivities_Activities.html](http://www.theactivitydirectorsoffice.com/MensActivities_Activities.html)

**ActivityResources.Org:** “The purpose of this site is to provide activity professionals, working in adult health care settings, with quick and easy access to www links that may contain needed resources and information. If you bookmark this site, add it to your favorite places or make it your home page, it will always be at your fingertips.”


**Diane Grandstrom's Aromatherapy Plus:** Provides information about products for aromatherapy and ideas for the long-term care setting including ideas for enhancing quality of life using aroma therapy and goals of aroma therapy for long-term care. There is a fee for supplies.

[www.aromatherapyplus.homestead.com/longtermcare.html](http://www.aromatherapyplus.homestead.com/longtermcare.html)

**Re-Creative Resources, Inc.:** Provides ideas for creating men's activities in health care settings.

[http://www.recreativeresources.com/MensActivitiesinLongtermCare.htm](http://www.recreativeresources.com/MensActivitiesinLongtermCare.htm)