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AALNA Section

Depression in assisted living

Josh Allen, RN, C-AL *

Board Member, American Assisted Living Nurses Association, USA

Depression is a major health concern for older adults, including residents living in assisted living communities. While we are often focused on managing the physical health challenges of conditions such as diabetes and heart disease, or the cognitive impacts of dementia, depression actually ranks in the top five chronic conditions amongst our residents. In fact, the Centers for Disease Control and Prevention (CDC) estimate that 28% of assisted living residents are depressed.¹

Depression in older adults

An estimated 6.7% of U.S. adults experience major depressive disorder, with women being 70% more likely to face depression in their lifetime.² In older adults the likelihood of depression is even higher. According to the National Alliance on Mental Illness (NAMI), 6.5 million of the 35 million Americans aged 65 years or older.³

While the average age at onset of depression is 32 years old, it can affect people at any point in the lifespan.¹ Most older adults with depression have been experiencing episodes of the illness during much of their lifetime. But for some, depression has a first onset late in life, even into one's 80s or 90s.³

Lack of treatment is a major challenge for depressed older adults. According to NAMI there are many reasons for this:

Depression in elderly people often goes untreated because many people think that depression is a normal part of aging and 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
- Stroke
- Thyroid disorders

Also, many older persons think that depression is a character flaw and are worried about being made fun of or of being humiliated. They may blame themselves for their illness and are 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.

When it goes untreated, late-life depression increases the older adult's risk of medical illness and cognitive decline. If unrecognized and untreated the disease can even be fatal, due either to suicide or increased mortality related to medical illness.³

Signs and symptoms

It is important that every member of the assisted living care team understand, watch for, and report signs and symptoms of depression. These should never be attributed to "normal aging" or other assumptions. Any of these signs or symptoms should be reported to the resident's medical or mental health provider:

- Persistent sad, anxious, or "empty" feelings
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable, including sex
- Fatigue and decreased energy
- Difficulty concentrating, remembering details, and making decisions
- Insomnia, early-morning wakefulness, or excessive sleeping
- Overeating, or appetite loss
- Thoughts of suicide, suicide attempts
- Aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment.

* Corresponding author.
E-mail address: jallen@careandcompliance.com.

The symptoms of depression can present differently in older adults than what is typically seen in a younger population. Signs and symptoms to specifically watch for in older adults include:

- Memory problems
- Confusion
- Social withdrawal
- Loss of appetite
- Weight loss
- Vague complaints of pain
- Inability to sleep
- Irritability
- Delusions (fixed false beliefs)
- Hallucinations

Types of depression

There are several forms of depression that vary in presentation of symptoms, onset, and characteristics. According to the National Institute for Mental Health (NIMH) they include:

Major depression: severe symptoms that interfere with one's ability to work, sleep, concentrate, eat, and enjoy life. An episode can occur only once in a person's lifetime, but more often, a person has several episodes.

Persistent depressive disorder: depressed mood that lasts for at least 2 years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for 2 years.

Bipolar disorder: also called manic-depressive illness, is not as common as major depression or persistent depressive disorder. Bipolar disorder is characterized by cycling mood changes—from extreme highs (e.g., mania) to extreme lows (e.g., depression).

Some forms of depression are slightly different, or they may develop under unique circumstances. They include:

- Psychotic depression, which occurs when a person has severe depression plus some form of psychosis, such as having disturbing false beliefs or a break with reality (delusions), or hearing or seeing upsetting things that others cannot hear or see (hallucinations).
- Postpartum depression, which is much more serious than the "baby blues" that many women experience after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.
- Seasonal affective disorder (SAD), which is characterized by the onset of depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not get better with light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.

Treatment

Treatment for depression may include psychotherapy, medications, and in rare cases electroconvulsive therapy.

Antidepressant medications work by manipulating neurotransmitters, especially serotonin, norepinephrine, or dopamine.

The most popular antidepressants are selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa). Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta). SSRIs and SNRIs tend to have fewer side effects than older antidepressants. They can sometime lead to headaches, nausea, restlessness, and insomnia.

All antidepressants must be taken for at least four to six weeks before they have full effect. They should be taken as prescribed and any missed doses should be reported to the resident's physician. If an antidepressant is not effective the physician may slowly taper the resident to another medication.

For mild to moderate depression, psychotherapy may be the best treatment option.¹ The NIMH describes several forms of psychotherapy (or talk therapy):

Cognitive-behavioral therapy (CBT): Helps people with depression restructure negative thought patterns. Doing so helps people interpret their environment and interactions with others in a positive and realistic way. It may also help you recognize things that may be contributing to the depression and help you change behaviors that may be making the depression worse.

Interpersonal therapy (IPT): Helps people understand and work through troubled relationships that may cause their depression or make it worse.

Electroconvulsive therapy (ECT) may be prescribed when medications and psychotherapy alone are not enough to treat depression. ECT has greatly improved in recent years and can provide much needed relief for people with severe depression that has not responded to other treatments.¹

Suicide

Suicide is a very real risk for older adults who are depressed. In fact, according to the NIMH, older white males age 85 and older have the highest suicide rate in the United States.¹ Although residents may attempt suicide without telling anyone in advance, in many cases there are warning signs. If you resident talks about suicide or "wanted to end it all" this should be taken very seriously. Residents may verbalize a "lack of desire to go on" or other vague statements that hint at their suicidal thoughts or ideations. Seek immediate medical/mental health attention in these situations.

Conclusion

It is your goal as an assisted living provider to maximize the quality of life for every resident you care for. Monitoring for signs and symptoms of depression and assisting with treatment for those who are diagnosed is a critically important responsibility. Review this information with every member of your care team and implement strategies to ensure the best care possible for your residents. Depression is never a "normal" part of aging.

About AALNA

Founded in 2001, the American Assisted Living Nurses Association is the only national non-profit association dedicated exclusively to nursing in assisted living. Operated by nurses, for nurses. It is the vision of the American Assisted Living Nurses Association that Assisted living nurses practice within a holistic framework that can

maximize and maintain the assisted living resident's well-being and pursuit of quality of life. Learn more at www.alnursing.org.

About the author

Josh Allen is a Registered Nurse with over 20 years of experience in senior living. As the Director of InTouch at Home, Josh oversees all aspects of business development, care, services, and operations for the organization. As a part of the SRG Senior Living family of companies, InTouch at Home delivers personalized care and services to clients living in senior living communities as well as private residences across three states.

Josh also serves on the board of the American Assisted Living Nurses Association, and represents AALNA on the boards of the

Center for Excellence in Assisted Living and Coalition of Geriatric Nursing Organizations. Josh has previously served as President and CEO of Care and Compliance Group, a leading training solutions provider.

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