



MENTAL HEALTH AND OLDER ADULTS

CHAPTER 5: DEPRESSION IN OLDER ADULTS WITH DEMENTIA

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Profile

- ◆ Purpose: To teach master's-level direct practice social work students about depression in older adults with dementia.
 - Audience: Masters-level social work students.
 - Audience Size: Maximum 40.

Content

- ◆ Core Values
 - To recognize and treat older adults as people first.
 - To understand that older adults have goals and desires just like younger people, which may include independent living, meaningful and enjoyable activities, and mature relationships, and that they also have the capacity to learn, grow, and achieve these goals.
 - To foster and promote the understanding that older adults deserve courtesy, respect, and dignity in all interactions.
 - To provide a safe, caring environment in which to live.
 - To advocate for evidence-based interventions and services that are sensitive to diversity.
 - To attempt to change the environment to meet the resident's needs.
 - To make every effort to support attempts to build and maintain skills and promote independence.

- ◆ Informational Competencies

At the end of this module, students will know the following:

- Cognitive impairment in older adults exists on a continuum from normal age-associated memory decline (AAMD) to mild cognitive impairment (MCI) to dementia.

- Dementia is a constellation of symptoms caused by diseases and disorders that affect the brain, including strokes, Alzheimer's disease (AD), Parkinson's disease (PD), toxin exposure, infectious diseases, nutritional deficiencies, and others.
- Dementia may be either reversible or irreversible and either progressive or nonprogressive, depending on the cause of the dementia.
- Why it is important to assess and treat depression in individuals with dementia.
- The behavioral and psychological symptoms of dementia (BPSD) and the two clusters these symptoms fall into.
- The common depression screening protocol consists of the Mini Mental State Exam and either the Cornell Scale for Depression in Dementia (CSDD) or the Short Geriatric Depression Scale (GDS).
- The GDS should be used for patient with scores of 15 to 23 on the MMSE, and the CSDD should be used if the patient scores below 15 on the MMSE.
- If the GDS is 6 or greater or the CSDD is 11 or greater, the primary health care provider should be notified for further evaluation and/or treatment for clinically significant depression.
- Apathy has been found to be related to a higher frequency of both minor and major depression.
- Depression may be a risk factor for progression from MCI to dementia.
- Expert consensus recommends selective serotonin reuptake inhibitors (SSRIs) as the preferred pharmacological treatment for depression in patients with dementia.
- Physical and cognitive frailty, drug interactions, and polypharmacy may help provoke depressive and other symptoms in some patients with dementia and patients may be susceptible to adverse effects.
- Clinical guidelines specify the use of non-pharmacological treatments for the BPSD before the use of pharmacological treatments.
- Scientific evidence for the effectiveness of emotion-oriented therapies (Reality Orientation, Validation Therapy, and Reminiscence Therapy) is weak, and further research is needed.
- Scientific evidence for cognitive and behavioral therapies is somewhat stronger. Results of a few large randomized trial studies were consistent and showed benefits, compared to control groups, and the outcome effects on depression reduction were maintained over time.

◆ **Interventional Competencies**

At the end of this unit, trainees will be able to:

- Conduct an MMSE.
- Conduct a depression screening starting with a MMSE followed by either the GDS or the CSDD.
- Based on the results of their depression screening, make an appropriate recommendation for either additional assessment and treatment of depression or a follow up depression screening.

Time Needed:

1-2 hours, depending on class size and time spent on exercises.

Training Format:

Didactic lecture, exercises.

Equipment

Chalkboard, flipchart, or dry erase board with markers.
LCD projector & laptop computer.

Slides

PowerPoint slides (see separate file).

Review of the Literature

Review of the literature (see separate file).

Dementia and Behavioral and Psychological Symptoms of Dementia

- ◆ Cognitive impairment in older adults exists on a continuum from normal age-associated memory decline (AAMD) to mild cognitive impairment (MCI) to dementia.
- ◆ Dementia is a constellation of symptoms caused by diseases and disorders that affect the brain, including stroke, Alzheimer's disease (AD), Parkinson's disease (PD), toxin exposure, infectious diseases, nutritional deficiencies, and others. Dementia may be either reversible or irreversible and either progressive or nonprogressive depending on the cause.
- ◆ AD is believed to be the most common type of dementia (50-70%), followed by vascular dementia (VaD) ($\geq 20\%$) and dementia with Lewy bodies (DLB) ($\leq 20\%$); the remainder (e.g., frontotemporal dementia [FTD], dementia associated with PD) account for less than 10%. About 30% of people with AD also have VaD.
- ◆ Dementia involves progressive loss of memory and other cognitive functions such as problem-solving and emotional control. As dementia progresses, abilities to independently perform instrumental and basic activities of daily living are generally impaired.

Cognitive impairment in older adults exists on a continuum beginning with normal age-associated memory decline (AAMD), also called age-associated memory impairment (AAMI) or cognitive impairment no dementia (CIND). The next stage, which is earliest diagnosable stage of dementia, is called mild cognitive impairment (MCI). Individuals with MCI experience mild impairment of memory, concentration, and occupational performance (Agronin, 2008; See Table 1. Global Deterioration Scale). Mini-mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores of 24-27 (out of 30) are common in people with MCI. Dementia refers to a spectrum of brain disorders, all of which involve cognitive impairment but vary widely in terms of cause, course, and prognosis. The essential feature of dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia (deterioration of language function), apraxia (impaired ability to execute motor activities despite intact motor abilities, sensory function, and comprehension of the required task), agnosia (failure to recognize or identify objects despite intact sensory function), or a disturbance in executive functioning (ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior). Memory impairment is required to make the diagnosis of a dementia and is a prominent early symptom (DSM-IV-TR, American Psychiatric Association [APA], 2000).

Table 1. Global Deterioration Scale.

Stage 1	Normal; no memory complaints and no evident cognitive impairment.
Stage 2	Very mild; memory problem reported, but not evident in clinical interview.
Stage 3	Mild impairment in memory, concentration, and occupational performance.
Stage 4	Moderate impairment in memory, knowledge retrieval, and complex tasks.
Stage 5	Moderate to severe impairment in both recent and remote memory, frequent disorientation to time and place, and impairment in activities of daily living that indicates need for caregiver assistance.
Stage 6	Severe impairment with inability to tend to activities of daily living without assistance.
Stage 7	Very severe impairment in cognition, language, and motor skills, progressing to a less functional, vegetative state.

Agronin, 2008; Reisberg et al., 1982.

- ◆ Worldwide, dementia is one of the most disabling health conditions; it is the fourth leading cause of disease burden among adults ≥ 60 .
- ◆ 24.3 million persons had dementia in 2005, with 4.6 million new cases reported annually; the number is expected to double every 20 years.

An estimated 24.3 million people had dementia in 2005, with 4.6 million new cases of dementia occurring annually. The number of people affected is expected to double every 20 years (Ferri et al., 2005). Alzheimer's and other dementias ranked as the 4th leading cause of disease burden in adults age 60 and older worldwide, outranked only by heart disease, arthritis, and chronic obstructive pulmonary disease (World Health Organization, 2003).

- ◆ The most common instrument for dementia screening is the Mini-Mental State Examination (MMSE). The Mini-Cog is a briefer screen that is often used in primary care settings.

A variety of instruments are used to screen for dementia. The most common of these is the Mini-Mental State Examination (MMSE, Folstein et al. 1975). The MMSE is a 30-point scale that assesses orientation, memory registration and recall, attention, calculation, language, and constructional ability. It typically takes 5-10 minutes to complete, is relatively simple to administer, and provides a relatively high degree of sensitivity and specificity for dementia. Among its disadvantages are that differences in administration and scoring can lead to inconsistent results. It also contains an education and language/cultural bias, and at 10 minutes, it is too long to be practical for use in primary care settings in which physicians have limited time to administer a screening test (Brodsky, Withall, Altendorf, & Sachdev, 2007). The Mini-Cog (Borson et al., 2000) can be administered in under 5 minutes, has similar psychometric properties to the

MMSE, and has become popular in primary care settings. (See Table 2 for links to the MMSE and Mini-Cog).

Table 2. Links to Assessment Instruments.

Instrument	Web Link	Source
CSDD	http://www.michigan.gov/documents/mdch/bhs_CPG_Depression_Appendix_2_206523_7.pdf	Alexopoulos et al., 1988
GDS	http://www.stanford.edu/%7Eeyesavage/GDS.html (Available in several versions, including the short version, and several languages.)	Sheik & Yesavage, 1986
Mini-Cog	http://www.hartfordign.org/publications/trythis/issue03.pdf	Borson et al., 2000
MMSE	http://www.chcr.brown.edu/MMSE.PDF	Folstein et al., 1975

CSDD: Cornell Scale for Depression in Dementia; GDS: Short Geriatric Depression Scale; MMSE: Mini-Mental State Examination

- ◆ Behavioral and psychological symptoms of dementia (BPSD), also known as neuropsychiatric symptoms of dementia, affect up to 95% of those with dementia during the course of the illness. The appearance of BPSD are often the first signs that the illness is progressing.
- ◆ BPSD fall into two clusters, (1) behavioral and (2) psychological. Behavioral symptoms are usually identified through observation of the client and include physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviors, sexual disinhibition, hoarding, cursing, and shadowing. Psychological symptoms, primarily assessed through interviews with clients and caregivers, include depressed mood, anxiety, hallucinations, and delusions.
- ◆ BPSD reduce patients' quality of life, may accelerate cognitive and functional decline, are associated with increased mortality, increase the risk for institutionalization, significantly increase caregiver burden and stress, and are associated with increased rates of depression in caregivers.
- ◆ Behavioral symptoms are generally more prevalent in moderate to severe dementia. Psychological symptoms, such as depression, may cause greater distress to the client as they develop insight into the impact of dementia on their futures.

BPSD have important implications for the prognosis of dementia in older adults. BPSD reduce patients' quality of life, may accelerate cognitive and functional decline, and are associated with increased mortality (Amore, Tagariello, Laterza, & Savoia, 2007; Teng, Lu, & Cummings, 2007; Fitzpatrick, Kuller, Lopez, Kawas, & Jagust, 2005; Potter & Steffens, 2007). Furthermore, these symptoms significantly increase caregiver burden and stress, and are associated with increased rates of depression in caregivers (Black & Almeida, 2004). They have also been found to increase the risk for institutionalization (Coehlo, Hooker, & Bookman, 2007). Finally, management of BPSD has been estimated to account for approximately one-third of the total cost of dementia care (Beeri, Werner, Davidson, & Noy, 2002).

Prevalence, Comorbidity, and Significance of Depression in Dementia

- ◆ Depressive symptoms are very common in MCI and across the various types of dementia. The reported prevalence of depression in older patients with dementia ranges from 30% to 96%; moderate to high rates of depression or its symptoms are consistently reported for persons with MCI.
- ◆ The wide range of prevalence reported for depression in dementia is due to several factors: focus on symptoms versus specifically defined depressive disorders, underlying cause of dementia, stage of the illness, place of residence of the older adult, and instrument used to assess depression.
- ◆ Consequences of comorbidity of depression and MCI/dementia:
 - Greater impairments in activities of daily living.
 - Greater impairment of functional performance, above and beyond the effects of cognitive impairment alone.
 - Increased level of other BPSD.
 - Higher rates of institutionalization of older adults, likely due to the negative impact on caregivers.
 - Higher cost of treatment.

The reported prevalence of depression in older patients with dementia ranges from 30% to 96% (Amore et al., 2007; Kales, Chen, Blow, Welsh, & Mellow, 2005; Starkstein, Jorge, Mizrahi, & Robinson, 2005), and moderate to high rates of depression or its symptoms are consistently reported for persons with MCI (i.e., 36% by Palmer et al., 2007; 63.3% by Solfrizzi et al., 2007; 39% by Hwang, Masterman, Ortiz, Fairbanks, & Cummings, 2004). The width of the prevalence range for depression in dementia is due to several factors, including the following: differences in researchers' focus on symptoms versus specifically defined depressive disorders; diverse study samples varying in causes of dementia, stage of illness, country of residence, and placement of

older patient; and instrument variation used to assess depressive symptoms and disorders.

Assessment of Depression in Dementia

- ◆ Assessment of depression in individuals with dementia is difficult because long-term care residents with dementia present with signs and symptoms that overlap with depression (for example, anhedonia, irritability, flat affect).
- ◆ Current guidelines recommend screening for depression at least every 6 months.
- ◆ The depression screening assessment consists of (a) the MMSE, and either (b) the Cornell Scale for Depression in Dementia (CSDD), or the (c) Short Geriatric Depression Scale (GDS-15 item). Use the GDS for individuals scoring 15 to 23 on the MMSE and the CSDD if the individual scores below 15. The CSDD collects information from both the client and a caregiver or other reliable informant. Clients who score ≥ 6 on the GDS or ≥ 11 on the CSDD should be referred to the primary care provider for further evaluation and/or treatment for depression.
- ◆ If the older adult with dementia does not screen positive for depressive symptoms, the individual should be reevaluated in 1 month if clinically warranted, otherwise, 6 months later.
- ◆ Interview caregivers/informants on behalf of the individual with moderate to severe dementia.
- ◆ Attend to the biopsychosocial factors during assessment.
- ◆ Treatment of depression may improve both dementia and depression and may increase the time an older person lives at home prior to a needed nursing home placement.

Detection and assessment of depression in older adults with dementia can be challenging. Many long-term care residents with dementia present with signs and symptoms that overlap with depression (for example, anhedonia, irritability, flat affect) (Gauthier, 2003; Riccio, Solinas, Astara, & Mantovani, 2007). Based on current evidence-based practice guidelines, screening for depression should occur at least every 6 months (Brown, Raue, & Halpert, 2007). The depression screening assessment consists of the (a) Mini Mental State Exam (MMSE) used frequently to screen for dementia, and either the (b) Cornell Scale for Depression in Dementia (CSDD; Alexopoulos, Abrams, Young, & Shamoian, 1988), or the (c) Short Geriatric Depression Scale (GDS-15 item; Sheik & Yesavage, 1986) depending on patient cognitive functioning. The guidelines suggest using the GDS for patients scoring 15 to 23 on the MMSE, or the CSDD if the patient

scores below 15 on the MMSE. The CSDD collects interview information from both the patient and the informant. If patients score 6 or greater on the GDS, or 11 or greater on the CSDD, the primary health care provider should be notified for further evaluation and/or treatment for clinically significant depression (Brown et al., 2007). If the older adult with dementia does not screen positive for depressive symptoms, the guidelines suggest that the individual be reevaluated in 1 month if clinically warranted, otherwise, 6 months later. Interviewing caregivers and other reliable informants on behalf of the individual with moderate to severe dementia is also recommended (American Geriatrics Society & American Association of Geriatric Psychiatry, 2003). Attention needs to be paid to the biopsychosocial factors during assessment to obtain a clear picture of the patient.

Course and Presentation of Depression in Dementia

- ◆ Several studies indicate that depression in older adults with dementia tends to increase as cognitive decline in dementia progresses. Other research indicates higher prevalence rates of depression in the early stages of dementia with diminished prevalence as cognitive function becomes severely impaired and insight is lost. This apparent drop in prevalence may be due to differences in the presentation of depression in the later stages of dementia.
- ◆ Apathy has been found to be related to a higher frequency of both minor and major depression.

Lopez and colleagues (2003) examined the relationship between major depression and other observed psychiatric symptoms across mild, moderate, and severe stages of cognitive impairment. They found that fewer observed symptoms were associated with diagnosed depression as the stage of dementia increased. For example, confirmed depression in those with mild dementia was associated with anhedonia, sleep disturbance, depressed mood, and hopelessness, whereas moderate dementia and depression were associated with these symptoms, minus the anhedonia, and severe dementia with depression was associated only with hopelessness.

Another explanation of the differences in findings on the prevalence rates of depression over the course of dementia may be disagreement on whether and how to distinguish apathy from depression. Researchers administered a structured interview (developed from caregiver ratings) to measure apathy and depression separately. They reported that 12% met distinct criteria for both apathy and depression, 7% met criteria for apathy only, and 31% met criteria for depression only (Starkstein, Ingram, Garau, & Mizrahi, 2005). Supporting their argument that the two constructs were different, apathy, but not depression, was significantly associated with more severe cognitive deficits. However, a later study found that apathy was related to a higher frequency of

both minor and major depression, with apathy at baseline significantly predicting depression at follow-up evaluations, findings that support a relationship between the two constructs (Starkstein, Jorge, Mizrahi, & Robinson, 2006).

Consequences of Depression in Older Adults with Dementia

- ◆ Studies have identified pre-existing depression as a predictor or risk factor for subsequent dementia and have estimated that persons experiencing depression have approximately double the risk of developing dementia that those without a prior history of depression have.
- ◆ Depression may be a risk factor for progression from MCI to dementia.
- ◆ Depression in persons with MCI or dementia has been linked with increased severity of cognitive deficits.
- ◆ Co-morbid cognitive impairment and depression have been associated with several other negative consequences, including an increased risk of death and reduced quality of life reports from dementia patients and their caregivers.
- ◆ Although suicide attempts have been observed in less than 1% of dementia patients, suicidal ideation, intent, passive death wishes, and feelings that life is not worth living have been reported in 1% to 42% of dementia patients, particularly in those suffering from depression.

Depression may be a risk factor for progression from MCI to dementia. The occurrence of depression in persons with MCI or dementia has also been linked to increased general severity of cognitive deficits (Nakaaki et al., 2007). Co-morbid cognitive impairment and depression have also been associated with several other negative consequences, including an increased risk of death (Sutcliffe et al., 2007). Although suicide attempts have been observed in less than 1% of dementia patients, suicidal ideation, intent, passive death wishes, and feelings that life is not worth living have been reported in 1% to 42% of dementia patients, particularly in those suffering from depression (Thompson, Herrmann, Rapoport, & Lanctot, 2007; Tsai, Tsai, Yang, & Hwang, 2007).

Treatment of Depression in Dementia

Pharmacotherapy

- ◆ Depression is more likely to respond to medication than other BPSD.
- ◆ Pharmacological treatment of depression in dementia presents challenges due to the high level of comorbidity, use of multiple medications with the

accompanying risk of drug interactions, physical and cognitive frailty, and impaired ability to communicate among older adults with dementia.

◆ Antidepressants.

- Older adults with depression in dementia respond to tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs).
- Significant declines in cognitive scores are seen in individuals taking TCAs.
- At this time SSRIs are the preferred treatment for depression in older adults with dementia.

A recent meta-analysis (Thompson et al., 2007) reviewed treatment of depression with tricyclic antidepressants (TCA; imipramine and clomipramine), and SSRIs (sertraline and fluoxetine) in patients with dementia. The findings indicated that patient treatment response and remission was superior to placebo in the combined sample from all studies, but cautioned that significant declines in cognitive scores occurred during the use of TCAs. Other reviews (Buhr & White, 2006; Sink, Holden, & Yaffee, 2005) provide further support for positive effects of treatment with various antidepressants (including sertraline, fluoxetine, citalopram, trazodone, and moclobemide) on depression in dementia, with citalopram and sertraline being the most commonly prescribed (Caballero, Hitchcock, Beversdorf, Scharre, & Nahata, 2006; Daiello, 2007; Starkstein & Mizrahi, 2006). Alexopoulos, Jeste, Chung, Carpenter, Ross, and Docherty (2005) constructed an expert consensus response after surveying 50 experts in dementia from North America on preferred, alternate, and unacceptable treatment choices for BPSD. The general consensus was that SSRIs were the preferred pharmacological treatment for depression in patients with dementia.

◆ Antipsychotics.

- While a number of different antipsychotic drugs have been used with varying degrees of success in treating BPSD, including depression, older adults with dementia are at high risk for developing extrapyramidal symptoms (EPS), such as Parkinsonism and tardive dyskinesia.
- Atypical antipsychotic drugs, such as risperidone and olanzapine, have significant, though modest, effects and reduced risk of EPS at lower doses. However, there have been reports of increased risk of strokes and mortality with these drugs, though there is controversy about the degree of this risk or even whether there is any.

Different classes of antipsychotics have also been used to treat depression with varying degrees of success (Lee et al., 2004; Snowden, Sato, & Roy-Byrne, 2003). However, older adults with dementia taking haloperidol and other “typical”

antipsychotics have been found to be at significant risk of extrapyramidal symptoms (EPS), including parkinsonism and tardive dyskinesia (Sink et al., 2005). Atypical antipsychotics such as risperidone and olanzapine have been shown to have significant, though modest, effects, and fewer adverse effects than typical antipsychotics at lower doses (Herrmann & Lanctot, 2007; Sink et al., 2005). However, since both risperidone and olanzapine have been associated with an increased risk of stroke and associated mortality, subsequent safety warnings have led providers to be cautious and somewhat restrictive about their use in older patients with dementia. Yet, a recent meta-analysis (Katz et al., 2007) concluded that although cerebrovascular events and mortality observations across trials were more frequent in risperidone-treated groups, the frequency did not differ significantly from that in placebo groups.

- ◆ Other medications.
 - Cholinesterase inhibitors are used to treat both the cognitive deficits of dementia and BPSD. Positive effects have been found for rivastigmine in patients with a wide range of dementia, and apathy and anxiety are among the behavioral domains demonstrating the most consistent positive response.
 - Memantine, a drug that affects the glutamate neurotransmitter system, has been found to improve cognitive functioning as well as psychological symptoms of dementia (such as depression).
 - Anticonvulsant drugs, such as valproate and lamotrigine, have yielded some positive findings, though research, to date, has been insufficient to support conclusions about the effectiveness of this class of medications.
 - Finally, some research findings have indicated the effectiveness of a ginkgo biloba extract for improving cognitive functioning and enhancing mood among older adults with dementia and BPSD, though there continues to be controversy about the effectiveness of this intervention.

Cholinesterase inhibitors, which increase levels of acetylcholine, have been used to target cognitive deficits and BPSD with some success, particularly in patients with mild to moderate dementia (Birks, 2006; Garcia-Alloza, 2005). A recent review of the literature on the effects of rivastigmine on BPSD reports that positive effects have been found for patients with a wide range of dementia, and that apathy and anxiety are among the behavioral domains demonstrating the most consistent positive response (Figiel & Sadowsky, 2008).

A recent review and meta-analysis of the research on memantine for the treatment of psychological symptoms (e.g., depression) of dementia showed small but significant improvements with limited adverse effects (Maidment et al., 2008).

At least one clinical trial of valproate resulted in significant improvement in melancholic and sorrowful behaviors (Sival, Haffmans, Jansen, Duursma, &

Eikelenboom, 2002), but the results of other small trials are contradictory (Sink et al., 2005). Preliminary studies of another anticonvulsant, lamotrigine, in elderly patients with dementia noted improvement in symptoms of agitation and depression (Sajatovic, Ramsay, Nanry, & Thompson, 2007). Studies provide some support for the theory that Ginkgo biloba special extract EGb 761 enhances cognitive functioning and stabilizes mood in cognitively impaired elderly subjects (Woelk, Arnoldt, Kieser, & Hoerr, 2007). A review of the research (Birks & Grimely-Evans, 2007) concluded that the evidence that the extract has predictable and clinically significant benefit for older people with dementia or cognitive impairment is inconsistent and unconvincing. However, a recent trial of this extract involving patients with dementia found that compared to controls, those taking the extract experienced improvements in apathy and depression (Scripnikov, Khomenko, & Napryeyenko, 2007).

Non-pharmacological treatments for depression in dementia

- ◆ Clinical guidelines specify the use of non-pharmacological treatments for BPSD before pharmacological treatments are tried.

As well as avoiding potential effects of polypharmacy, drug interactions, or exacerbation of comorbid conditions, non-pharmacological treatments may improve the quality of life for the patient with dementia above and beyond the reduction of depression (Burgio & Fisher, 2000; Cohen-Mansfield, 2005; Woods, 2004).

Emotion-oriented therapies

- ◆ Reality Orientation groups were originally intended to reduce confusion by giving repeated orientation clues, e.g., the time of day, date, and season, but this was only partially successful. Research has suggested that the main benefits were the stimulation of the social group and the positive impact on staff, who acquired a better knowledge of the residents and their earlier lives and interests.
- ◆ Reminiscence Therapy encourages persons with dementia to talk about their pasts, and may utilize audiovisual aids such as old family photos and objects to retrieve positive events and emotions. Reminiscence provides persons with dementia a chance to interact positively with others; it can enhance an individuals' sense of identity, sense of worth, or general well-being, and may also stimulate memory processes.
- ◆ Validation Therapy is a type of psychosocial intervention for older adults with dementia. Basically, a therapist accepts the disorientation of a person with dementia and validates his/her feelings (Feil, 2002). This intervention is based on the assumption that individuals return to unfinished conflicts in

their past, providing a background for meaningful conversations addressing their feelings.

- ◆ Scientific evidence for the effectiveness of emotion-oriented therapies (Reality Orientation, Validation Therapy, and Reminiscence Therapy) is weak, and further research is needed.

Livingston and colleagues (2005) reported the results of 11 studies consisting of randomized and quasi-experimental designs on Reality Orientation. The largest controlled trial (N=57 subjects) demonstrated no differences between Reality Orientation and active hospital ward orientation (Hanley, McGuire, & Boyd, 1981). The smaller sample nonrandomized studies mostly showed benefits of Reality Orientation in decreasing depressive symptoms or delaying admission to an institution. The current research does not offer clear evidence of its benefits for older adults with dementia.

Two reviews that included information on Reminiscence Therapy reported potentially positive effects on depressed mood in patients with dementia, but caution that most trials were small or otherwise methodologically questionable and therefore the evidence is weak and inconclusive (Douglas, James, & Ballard, 2004; Livingston et al., 2005).

Neal and Briggs (2003) reviewed trials of Validation Therapy and reported that only one study (Toseland et al., 1997) showed a trend towards improvement of depression a year after completing therapy, but the finding was not statistically significant. Another recent study using Validation Therapy in a group format found similar results (Deponte & Missan, 2007). The empirical evidence for this therapy for depression in dementia is weak and unconvincing.

Cognitive and behavioral therapies

- ◆ Behavioral interventions.
 - Behavior therapy requires a period of detailed assessment in which the personal triggers, behaviors, and reinforcers are identified and their relationships made clear to the patient.
 - While a number of studies have demonstrated the effectiveness of behavior therapy for behavioral symptoms of dementia, there is limited support for its effectiveness in reducing the symptoms of depression.
- ◆ Cognitive behavioral interventions.

- Several small studies and case reports have demonstrated the effectiveness of group and individual cognitive behavioral techniques, such as distraction, relaxation, and cognitive restructuring, in reducing symptoms of depression in individuals with early stages of dementia. However, there have been no large scale trials of cognitive behavioral-therapies (CBT) in this population.
- ◆ Scientific evidence for the effectiveness of cognitive and behavioral therapies is somewhat stronger than emotion-oriented therapies in reducing depressive symptoms. As described below, results of a few larger randomized trial studies were consistent and showed benefits for the treatment groups compared to control groups, and the effects on depression reductions were maintained over time.

A recent systematic review examined 20 studies using behavioral management techniques for treating depressive (n= 3 studies) and neuropsychiatric symptoms (17 studies) in older adults with dementia (Livingston et al., 2005). Of the three evaluating depression outcomes, one large randomized controlled trial showed significant improvement in depressive symptoms at post-treatment and at 6-month follow-up in one large randomized controlled trial showed significant improvement in depressive symptoms immediately post-treatment and at 6-month follow-up examination in two treatment conditions: (1) one emphasizing patient pleasant events and one emphasizing caregiver problem solving, as compared to treatment as usual and waitlist control conditions (Teri, Logdson, Uomoto, & McCurry, 1997). The two smaller randomized trials also demonstrated significant reductions in behavioral symptoms compared to usual primary care (Benedict et al., 2000; Suhr, Anderson, & Tranel, 1999). However, no significant effects were found on depression (Benedict et al., 2000).

Hyer and colleagues (1990) compared the effectiveness of a 12-week group psychotherapy, in a cognitive behavioral format, to usual care in a small sample of 22 residents. At post-treatment, depression scores had decreased in the treatment group but not in the control group. Koder (1998) discussed two case reports in which cognitive behavioral therapy was offered using techniques such as relaxation, distraction, and cognitive restructuring. Teri, Curtis, Gallagher-Thompson, and Thompson (1994) reported positive findings from a clinical trial of CBT with people in the early stages of Alzheimer's disease. Individual and group CBT has also been used by other researchers with some favorable results (Kipling, Bailey, & Charlesworth, 1999).

There are several limitations to the literature on non-pharmacological interventions. First, most research studies have focused on behavioral and not depressive symptom outcomes. Second, the diversity of sample elderly populations makes it difficult to compare across studies. Third, the majority of studies lack a description of intervention protocols or manuals making it difficult to understand, analyze, or replicate the

treatment components. Finally, the inconsistency of follow-up protocols across studies provides further barriers to determining long-term effects of the intervention.

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Curriculum Resources



Suggested Readings:

- Gellis, Z. D. (2006). Mental health and emotional disorders among older adults. In B. Berkman (Ed.), *Oxford Handbook of Social Work in Health and Aging* (pp. 129-139). New York: Oxford University Press.

This chapter provides a literature review on the state of the knowledge on geriatric mental health disorders among community-dwelling older adults.

- Hyer, L., Carpenter, B., Bishmann, D., & Wu, H. S. (2005). Depression in long-term care. *Clinical Psychology: Science and Practice*, 12(3), 280-299.

This article provides an overview of depressive disorders among older adults in long-term care settings.

- National Institute on Aging. (2006). *Journey to recovery: 2005-2006 progress report on Alzheimer's disease*. Washington, DC: NIA. Download from http://www.nia.nih.gov/NR/rdonlyres/8726ED71-2A21-4054-8FCB-9184BACB3833/0/20062007_Progress_Report_on_Alzheimers_Disease.pdf

This NIA report provides up-to-date knowledge on Alzheimer's Disease.



Case Study in Dementia: Mrs. J.

The following case study was modified from the Assessment of Dementia case study downloaded at: <http://depts.washington.edu/geroctr/Curriculum3/CaseStudies/AssessmentDementia.doc>.

Mrs. J. is a 78-year-old, African American woman who lives in a small southern city. About a year ago, her husband died suddenly of a stroke, leaving Mrs. J. to live alone in her home of 52 years. It was the home where she had raised her three children, all of whom graduated from college, have professional careers, and now live in other parts of the state. Her family is a source of pride, and her home has numerous pictures of her children and grandchildren.

About 3 months ago, Mrs. J.'s oldest daughter, Vanessa, got a call from one of the neighbors. Vanessa lives a 4-hour drive from her mother—a drive that can often be longer in bad weather. The neighbor stated that Mrs. J. had walked to the neighborhood store in her pajamas and slippers. Because Mrs. J. has lived in the community for several years, people have been watching out for her since her husband died, and someone gave her a ride back home. Mrs. J. doesn't drive, and the temperature was fairly chilly that day.

As a result of the call, Vanessa went to Mrs. J.'s home for a visit. Although she and her siblings had been calling Mrs. J. regularly, no one had been to the family home in about 6 months. Vanessa was shocked at what she saw!

Mrs. J. had been a cook in a school cafeteria earlier in life and always kept her own kitchen spotless. But now the house was in disarray with several dirty pots and pans scattered throughout different rooms. In addition, odd things were in the refrigerator such as a light bulb and several pieces of mail. Many of the food products were out of date, and there was a foul smell in the kitchen. Trash covered the counters and floor.

Vanessa contacted her siblings to ask them if their mother had told any of them that she wasn't feeling well. Her brother, Anthony, remarked that their mother would often talk about Mr. J. in the present tense—but he thought that it was just her grief about his death. The younger brother, Darius, reported that his wife was typically the one who called their mother—about once a month. He didn't know if there had been any problems—his wife never said anything about it to him.

Vanessa also contacted the pastor of her church, Rev. M. He stated that Mrs. J. had been walking to church on Sundays, as usual, but he did notice that she left early a few times and other times seemed to come to service late. But like the brother, Anthony, he thought that this behavior was probably a grief reaction to the loss of her husband.

A final shock to Vanessa was when she went through her mother's mail. There were several overdue bills and one urgent notice that the electricity was going to be cut off if the balance wasn't paid. She owed several hundred dollars in past due heating, electric, and telephone bills.

Vanessa contacted her mother's primary care physician (Dr. P.) who said that she had last seen Mrs. J. for her regular checkup 3 months earlier and that she had missed her last appointment a week ago. Dr.

P. said that her staff had called to make another appointment but that her mother hadn't called them back yet. The doctor said that she had written a reminder for the nurse to contact Vanessa the same day that Vanessa called. Mrs. J. is being treated with medication for arthritis, hypertension, and gastroesophageal reflux (GERD), and all of these were under control at the last visit. Her weight was stable, and her only complaint was some difficulty staying asleep at night. Dr. P. reported that her mother's mood was sad but had improved some in the month before the last visit. The doctor asked about memory and concentration, but her mother denied having any problems and did not seem to be confused at the time of the last visit. When the doctor heard about the recent problem at the store and Vanessa's description of her mother's house, she was very surprised and asked that Mrs. J. be brought in immediately.

Activity #1. Class Discussion

Ask students to assume that they are social workers working with the primary care physician and that they have been asked to see Mrs. J. and her daughter prior to their meeting with Dr. P.

Ask students to consider the following assessment questions:

- What psychosocial factors are present in the case example that impact Mrs. J.'s physical and mental well-being?
- What instruments could be used to evaluate the cognitive and mental functioning of Mrs. J.?
- What instruments could be used to evaluate symptoms of depression?
- What should be the role of Mrs. J.'s family in care planning? Are there other informal support systems that should be involved?
- What multicultural issues are present in this case study?
- What issues are relevant to establishing rapport with Mrs. J. and her family?
- What type(s) of interventions would be appropriate?
- How would the interventions be evaluated?
- What programs or resources might be appropriate for Mrs. J.?
- What would characterize a culturally competent intervention?
- What would characterize culturally competent services and programs?
- What are some gaps in service that Mrs. J. might face?

Activity #2. Role plays

Divide students into groups of three.

Ask students to go online and download the MMSE.

Ask the students to assume the following roles:

Mrs. J.

Vanessa

Social worker

If a particular task only requires two people, the third person becomes an observer and after the task provides the feedback (questions and discussion) to each participant on the following points:

What did you do that you liked?

What would you do differently next time?

This is what you did that I liked...

This is what you might consider doing differently next time...

If time allows—and if appropriate for the particular students, you may ask the client in the role play to provide feedback to the social worker.

This is what you did that I liked...

This is how I felt when you...

This is what you might try next time...)

Remind students that the case example only provides an outline, they are to improvise additional details as needed. (Be kind to one another. The goal is not to “stump the chump” but to have an opportunity to practice using skills with an older adult and family member.)

Depending on the level and experience of the students, it may be necessary to model the tasks before doing the role plays.

Task #1: Social worker role plays administering an MMSE examination to Mrs. J. (Third student observes.) Score the MMSE. Based on the details of the case study, determine what stage Mrs. J. is on the Global Deterioration Scale.

After the role play, the observer provides feedback.

Task #2: Rotate roles. Based on the MMSE score, select either the CSDD or the Short GDS. Social worker introduces the screening and conducts a depression screening with Mrs. J.

Obtain the person’s agreement to be screened.

Explain the purpose for the screening.

Administer and score the depression screening instrument as instructions direct.

[If necessary based on the MMSE score, rotate roles and the social worker conducts the CSDD interview with Vanessa.]

Task #3: Rotate roles. Social worker discusses his/her concerns and makes initial treatment referrals for further diagnostic assessment to Dr. P. for possible psychotherapy and antidepressant medication.

Discuss the results of the MMSE, the GDS, and the depression screen with Mrs. J. and Vanessa.

Task #4 (optional): Ask one student to take the role of the social worker and the other to take the role of Dr. P. Social worker presents his/her concerns and the results of the MMSE, the Global Deterioration Scale, and the depression screen to Dr. P. (Remind students that Dr. P’s time is quite limited and that they will need to be concise and focused in their presentation of Mrs. J and her situation.)



Web Resources

On-line Assessment Instruments

John A. Hartford Institute for Geriatric Nursing *Try This. Try This: Best Practices in Nursing Care to Older Adults* is a series of assessment tools to provide knowledge of best practices in the care of older adults. Includes a general assessment tool (SPICES), the Katz Index of Independence in Activities of Daily Living; Mental Status Assessment of Older Adults (Mini-Cog), and the **Geriatric Depression Scale (GDS)** in English or Spanish.

<http://www.hartfordign.org/resources/education/tryThis.html>

Neurotransmitter.net Psychiatric Rating Scales Index. This link takes you to a list of conditions. Selecting one of these conditions takes you to a list of assessment instruments, many of which can be downloaded and used in your practice, others take you to a link to contact the instrument developer about use. (Includes scales for Anxiety, **Depression**, Parkinson's Disease, **Alzheimer's Disease and Dementia**, and Schizophrenia, among others.)

<http://www.neurotransmitter.net/ratingscales.html>

On-line Fact Sheets

Health and Age Depression Center. This site contains a brief description of depression with a link for more detailed information and another link to a self-test for depression. There is a section with articles and news about depression, and another section with questions and answers geared toward caregivers.

<http://www.healthandage.com/Home/?gm=20&gc=7&select.x=21&select.y=8>

NIMH (National Institute on Mental Health) Depression and Suicide Facts. This link provides information about depression and suicide in older adults. It is written for the consumer and includes a self-screen.

[Unfortunately, the font size is small and you would have to use the browser tool for zooming (increasing) size before printing out the pages. In Explorer: click on the "View" drop-down menu, then "text size," and increase the size. In FireFox: click on "View," "Zoom," then "Zoom-in."]

<http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml>



DVD and Video Resources

Assessment of Suicide Risk in an Older Adult Male. Geron 620 Mental Health and Aging, K-State Division of Continuing Education. Laurel Dinkel demonstrates an assessment of suicide risk in a white, older adult male. The video provides an outline of the interview including suicide risk and protective factors, the interview, and a post-interview discussion between Laurel and Janice Dinkel. This 60-minute DVD was developed specifically for social work students and is quite user-friendly for both bachelor's and master's level students. DVD, 60 minutes.

Initial Screening: Older Woman with Suspected Cognitive Impairment. Geron 620 Mental Health and Aging, K-State Division of Continuing Education. Laurel Dinkel demonstrates an initial assessment of a 77 y.o. woman with suspected cognitive impairment. The demonstration includes a brief history taking; assessment of current symptoms; administration of the Mini-Mental Status Exam, Clock Drawing Test, and Trail Making Test A and B; and presentation of recommendations and plan to the client and her daughter. The demonstration is followed by a post-interview discussion, between Laurel and Janice Dinkel, of the interview and the scoring and implications of the screening tools. This 60-minute DVD was developed specifically for social work students and is quite user-friendly for both bachelor's and master's level students. DVD, 60 minutes.

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