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Depression or Suicide in the Elderly: A Guide for Caregivers

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DEPRESSION OR SUICIDE IN THE ELDERLY: A GUIDE FOR CAREGIVERS

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Abstract

This project examines elements of depression and suicide in the elderly. An emphasis on accurate assessment for depression and potential suicide is an integral part of the project's focus. An overall theme evident in all references is how hopeless the elderly feel prior to thoughts, plans and actions to end their lives. Depression shows through signs of helplessness, passivity, detachment, physical debilitation, and despair. Biological, sociological, psychosocial and psychological factors associated with aging are discussed. The specific topics and teaching modules provide guidance with the hope that caregivers will begin to understand the devastating desperation that precedes elderly suicide attempts and/or successes.

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Chapter I

INTRODUCTION

The aging process is mesmerizing. The respect and genuine empathy deserving to each elderly individual are two qualities of care that this author strongly believes must be integrated into all levels of care. Too often the elderly are overlooked as insignificant human beings who have already lived their lives and who should quietly leave this world without a fuss. It is interesting that now, with an ever growing number of middle age baby boomers on the way to becoming elders, the interest is swinging to an enormous interest in the elderly. Despite the self-serving motives, it is encouraging that so much attention is being paid to the research and care of the elderly. It is long overdue. Now the interest peaks, because soon it will be this generation's turn to experience the trenches of old age. Now respect, care, treatment, cost, and pain control that elders have been experiencing for eons receive the focus of attention.

This project concentrates on the physiological, psychosocial, and psychological facets of depression and suicide in the elderly. Extensive research has taken place to ensure a broad spectrum of input and insight into this troublesome topic. It is not a pleasant one to think about, to observe, or to treat. Fortunately, however, depression can be treated. However, there are many factors involved in this illness. Often only the medical aspect of depression is addressed, the aging individual is unfortunately considered to be normal and expected to be depressed, and too few caregivers truly understand the complexity of this illness that can lead to the devastating decision to end one's life. The purpose of this project is to educate caregivers as to the physical, social, and psychological aspects of depression and suicide in the elderly, as well as present interventions and treatments appropriate for this very special population.

Chapter II

LITERATURE REVIEW

Mental health centers do not demonstrate a significant interest in providing extensive health services for elders. The elders are often misperceived as depressed individuals whose difficulties are believed to be the by-product of aging. Some mental health professionals view the elderly as having the best part of their lives behind them. As a result, the elderly are viewed as less deserving of attention (Gelfand, 1993).

According to Lewis, (1996), aging is based on four basic assumptions. First, aging is developmental. Second, old age is perceived as a gift of 20th century science and technology. Third, normal aging must be differentiated from pathologic aging. Fourth, there is no universally accepted theory of aging.

STRESS/DEPRESSION

According to the Geriatric Social Readjustment Scale by Amster, L. and Krauss, H. (1977) there are 25 stressful life events in the lives of older individuals. Some of them include death of spouse, institutionalization, death of a close family member, major personal illness or injury, major change in financial state, retirement, marital separation from mate,

eyesight failing, death of a close friend, major change in behavior or health of family member, and/or a major change in activities that produce gratifying results. The remaining stressors include a change in sexual behavior, change in job responsibilities, painful arthritis, feeling of slowing down, change in living conditions or environment, change in social activities, losing one's driver's license, reaching age 65, reaching age 70, major change in working hours/conditions, troubles with one's supervisor, holidays and anniversaries, argument with children, and/or an argument with spouse.

Depression is frequent following physical illness. Lowered self-esteem develops because of reduced social/personal value status, retirement, guilt over actions in the past and present (Butler, 1991). While stressors play an important role in depression, they also affect the quality of lives. The term "quality of life" produces a need to look at an intolerable situation as the "line of unbearability" that each person subconsciously reaches. There are certain steps of a process that occur once that line is crossed. First, a crisis is triggered. Second, individuals see the situation as hopeless and feel helpless to change the situation. If some form of intervention does not occur, they believe that the only

choice is to escape through death. It is at this point that depression becomes life threatening.

According to Langone, (1991) the elderly are especially prone to depression. Fifteen percent of elders 65 years of age or older suffer from it. Women are more susceptible. "Biological, sociological, and psychological factors, many of them associated with aging, may be behind the depression" (69).

There are two types of depression that are particularly pertinent to this discussion. They are reactive depression and endogenous depression. Reactive depression pertains to losses such as: self-esteem, good health, and children moving away. The elderly feel helpless and find their mental stability shaken. What compounds the loss is the lack of opportunity to compensate for what is now missing. Older adults are left to fill those seemingly bottomless gaps by themselves (at least that is the elders' perception) (Langone, 1991).

Endogenous depression comes from within from some disturbance, deficiency, or overabundance of certain brain chemicals. A person may inherit a tendency to develop a mental illness by inheriting a defect in brain chemistry. That

deficiency creates an imbalance of key chemical transmitters. another danger is that the disease/tumors can secrete hormones that act on the brain and alter one's mental state or side effects of certain medications, especially when combined with other drugs. Elders often take more medications than younger people, and the elderly person's body processes drugs differently. Seligman and Moore (1995) posit that the elderly are sometimes misdiagnosed with depression when what they really have is melancholia. They posit that melancholia seems more prevalent among the elderly than any other age group. To make an accurate diagnosis of depression, an examination of the criteria is paramount.

The DSM IV (APA, 1994) states that at least five of the following symptoms must have been present during the same two week period and exhibit period and exhibit a change from previous functioning with a minimum of one of the symptoms being depressed mood or loss of interest or pleasure. The list of symptoms includes a depressed mood most of the day that is indicated by a subjective report, diminished interest in activities most days, a significant weight loss, insomnia or hypersomnia every day, agitation or retardation of psychomotor abilities nearly every day, fatigue or loss of

energy every day, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to concentrate or make decisions, and recurrent thoughts of death. A condition of diagnosis is that the symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

To substantiate the severe potential, it is important to examine researchers' findings. Recurring thoughts of death or suicide are symptoms of depression (APA, 1994).

Seligman (1990) believes that depressed people may be in such severe emotional pain that they feel as though their symptoms will never end. Axelson (1985) states that some elderly people feel lonely and abandoned, helpless and powerless and that the likelihood of suicide increases 500 times when the person is deeply depressed. Foster (in Counseling Today, 1995) states that the elderly have the highest suicide rate of any other age group as a result of undiagnosed or untreated depression. She adds that infrequent visits from family members, few friends still living, and lack of mental stimulation contribute to the myth that growing old means living out remaining years lonely and depressed. Depression is a serious problem for the elderly

but often is erroneously attributed to somatic concerns, cognitive deficits, medical side effects, or expected changes of old age. Mood disorders typically have a more rapid onset than the other disorders, providing a clue to differential diagnosis. Obviously, this view renders a differing opinion than most of the research that is quite definitive about the elderly as potential suicide victims (McDonald, 1988).

According to Foster (1995) there is an added threat to the welfare of elders with a terminal illness. Such elders sometimes experience added stress to their situations by one or a combination of the following: pretending everything is okay, convincing others that they are taking necessary precautions, suffering side effects of medication, suffering from inept medical attention, experiencing relationship problems, feeling guilty, attempting to deal with daily trials and tribulations alone, falling victim to a time-bomb chronic illness, dealing with the outside world, realizing increased stress, and/or experiencing an economic trauma.

According to Warnick (1995) even supportive therapy with the terminally ill cannot be encouraging, because the illness will still be there. Seligman (1990) posits that depression may result as people find themselves in such

severe emotional pain that they feel as though their symptoms will never end. Suicide may seem like the only escape. Axelson (1985) states that some elderly feel lonely and abandoned, helpless and powerless. The likelihood of suicide increases 500 times when a person is deeply depressed (Axelson, 1985).

Coleman (1980) states that elderly people face many real problems and insecurities that are not characteristic of earlier life. Even well-integrated personalities may break down under the combined assault of cerebral changes and a stressful life situation. A prime example is retirement, which can be quite demoralizing if it is forced upon individuals. Many people depend on their work for status, for self-identity, for satisfying interpersonal relationships, and for supplying meaning in their lives. Retirement often fails to meet these needs, and there is a tendency to react with the feeling that one's usefulness and worth are at an end. This reaction contributes to a creation of physical and mental deterioration. "A depressed person is emotionally incapable of perceiving realistic alternative solutions to a difficult problem" p. 580. George Engel, University of Rochester Medical Center, explored the relationship between psychological attitudes and

the onsets of physical diseases. Seventy to eighty percent of the patients felt like giving up at the onset of disease. If people respond to life with hopelessness, depression and submission, a sociological change may be triggered that encourages development of already present disease potential. It is not an event's magnitude, but the way people react to it that determines whether a certain person gave up. The despair and depression must be treated (Butler, 1991).

SUICIDE

According to Miller (1979) The pattern of increased suicidal rates with aging individuals may be observed in almost every country that maintains suicide statistics. When compared to younger individuals, the older people tend to communicate suicidal intentions less frequently, use lethal weapons more often and are more successful in completing the attempt. Elders are less ambivalent than young people and are therefore less likely to be rescued; they do not usually use suicidal activities as manipulative tools toward others.

Warnick (1995) states that elderly people who are truly considering suicide rarely work with counselors. Instead, they withdraw and refuse to talk about their feelings, or show many signs of being suicidal. Yet, the suicidal rate in people over 65

has increased to twice that of all other ages. It is essential to differentiate between active and passive suicidal thinking. Active suicidal thinking is when a person concentrates on method. This does not mean that they will necessarily follow through, but the percentage of elderly suicides must be kept in mind. "People who are serious about suicide do not talk about it to family or ask for the intervention of counselors" (113).

Warnick (1995) adds that passive suicidal thinking is detected through statements that indicate a state of depression. As soon as the depression is alleviated, the person again wants to live. Yet another sector of elders say suicidal words and feel that way but are not truly depressed. They have rationally decided that they have had enough of life, are displeased with life as it is, and are ready to die.

Warnick (1995) posits that one basic reason geriatric suicides receive a very low priority with respect to saving people's lives is because they are people who have left the work force and are no longer economically productive. "The deaths of such people do not represent a serious loss to the economy" (6). It is also believed that "older people have already had a chance to live their lives, while younger people have not" (6). People are generally more accepting of geriatric

suicides and euthanasia when the purpose is to relieve pain, suffering and extreme anguish.

Suicide is complex. Why does suicide seem to be the answer? It is not what happens to the elderly that contributes to the depression/suicide, but rather how the individuals are equipped with coping skills. It is not the situation but rather how the person reacts to the difficulty that precedes a suicidal attempt (Warnick, 1995).

Miller (1979) believes that there are eight reactive patterns of suicide in the elderly population. The reactions are to severe physical illness, to severe mental illness, to dependency and or institutionalization, to spouse's death, to retirement, reaction to pathological personal relationship, to alcoholism/drug abuse, and to multiple factors.

Much variation among the patterns is due to individual responses to stressors. Each person reacts to stressors differently. For elders who have experienced multiple tragedies, their defenses and/or resources for relief may have been exhausted (Miller, 1979).

There is not just one factor that leads a person to a life or death dilemma. What may appear to others to be a small

problem might serve as the final element of stress that results in a suicide attempt (Miller, 1979).

According to Butler (1991) approximately 75% of all people who complete a suicide, contact a doctor shortly prior to their actions. Unfortunately, many physicians are ignorant of the seriousness and scope of the geriatric suicide situation, much less know how to help correct this tragedy. In one study, 74% of a group of attempters had recently been treated by a physician, while another study indicated that 60% of a group had been under medical care when they attempted to end their lives. Butler (1991) adds that suicidologists have concluded that "suicidal people seek out physicians as potential rescuers" (69). It would seem then that physicians are in an ideal position to assess and appropriately treat suicidal patients.

Kottler (1988) states that death is the ultimate failure and is especially tragic with suicide for self and those left behind, who are left with guilt, responsibility, and regret. Worden (1991) adds that nearly 750,000 people a year commit suicide, but fails to break that number into statistics regarding gender, age groups or previous attempts. This paper's author finds it interesting that while so much of the

data is substantiated by other studies, there are slight differences in exactly what the particular researcher chooses to measure as the target for his/her statistics.

So why do physicians fail to detect suicidal motivations in their patients? Butler (1991) provides the evidence that two doctors posited that suicide is a taboo subject that people are reluctant to discuss, that suicides create anxiety in physicians, that medical personnel do not receive adequate training in recognizing and managing suicidal patients, and physicians do not have the sociopsychological knowledge needed to be aware of familial factors in suicide. Finding that physicians are in such a trusted relationship with patients and that inadequacy abides at this level of care, it is no wonder that caregivers in general are ineptly prepared (Butler 1991). The learning modules presented in Chapter 3 are intended to provide education for appropriate care for depressed, suicidal patients. This author has undertaken a sincere attempt at providing the educational modules to address this lack of knowledge. The focus is on teamwork among caregivers, physicians, nurses, and family members.

Tuckman et al (1959) in Coleman (1980) provided a pioneering study of 742 suicides. Twenty-four percent left

notes, usually addressed to relatives or friends. The notes were usually coherent and legible. Emotionally the notes showed positive, negative and neutral affect or a combination of these components. Fifty-one percent of the notes showed positive affect, expressing affection, gratitude and concern for others.

Six percent of the suicide notes involved pure hostility or negative affect. Most hostility was directed toward others. In other cases, the hostility was directed inwardly and self-devaluation developed.

Suicide notes showing neutral feelings usually begin with a general addressee, i.e. "To Whom It May Concern." Often it is older persons who have lost a sense of a meaningful role in life and wish to leave in an orderly way. Tuckman et al's study (1959) discovered that 25% of the notes were emotionally neutral. Eighteen percent of the notes involved a mixture of positive and negative affect.

Cohen and Fiedler (1974) in Coleman (1980) concluded that the desire to be remembered positively by survivors may explain the large number of statements expressing positive affect. Statements of love and concern may be notewriters' way to reassure both the survivors and themselves of the

worth of their relationships as well as their personal worth. It is noteworthy to mention that people who have made previous suicide attempts are more likely to kill themselves than those who have not. In addition, about 10% of unsuccessful suicide attempters kill themselves at a later time.

The information gleened from Corsini's contribution (1989) shows that hopelessness is a predictor of eventual suicide. A 10 year longitudinal study of 207 depressed, suicidal patients, of which 90% rated high in hopelessness, scored nine or more on Beck's Hopelessness Scale and eventually killed themselves. Only one patient with a score under nine committed suicide. The greater the hopelessness, the more likely suicide will be the chosen solution. "Suicidal wishes often reflect a desire to escape from unbearable problems" (296).

The suicide rate among elderly individuals increased 25% from 1981-1986. The highest rate was among white men in their 80's. Older persons make up 12% of the population and 25% of reported suicides--5,000 to 8,000 yearly. In 1985, women were more likely to attempt suicide, while men were more likely to succeed when an attempt was made. The reasons behind suicide attempts include ill health,

painful illness and control. While death is certain, its timing and characteristics are not. Suicide defies control of death. There even exists control beyond the grave--those left behind are deeply affected with guilt, shame and regret. Suicide equals self-murder and lends meaning to motives of hatred of self or others. Suicide is a submissive, passive, desperate giving up. It represents not wanting to leave spouses penniless, not wanting to be a burden, or a perception of self that portrays failure. Depression that precedes suicide attempts develops from the perception that life is meaningless and useless (Corsini, 1989).

Hergenhahn (1990) provided the following information concerning suicide. The best predictors of true suicidal intent are the feelings of hopelessness and desperation. Suicide is very common in elders who are terminally ill or permanently debilitated, because they become incapable of engaging in future reproductive and productive behaviors. Life can become so unpredictable that the only certain thing that one can imagine is death. Death may appear to provide the only immediate certainty. In extreme cases the certainty of death may be preferable to the uncertainty of the future. Hergenhahn's (1990) thoughts appear to support other

sources on this subject. He also states that white elders are in a high risk group for suicide, but does not break the risk statistics into gender or particular age groups. "Suicide has been called the number one cause of unnecessary, premature, and stigmatizing death in the U.S." (Hergenhahn, 580). Older males forced into retirement, financial problems, death of a loved one, impaired physical health, and being unneeded and unwanted are conditions he attributes to the desperate act of suicide.

Kane & Kane (1981) state that suicide is a real risk. Suicide attempts are successful when there exist more serious intents, frailty, and social isolation. It is suspected that elderly suicides in institutions are underreported and that in passive self-neglect, the suicides are not recognized. Elders seem to be undertreated. In addition, the incorrect use of the word "senility" exaggerates problems in getting appropriate help to patients in a timely way.

Butler (1991) contributes the specifics that older people generally use drugs, guns, hanging, and jumping off high places as their suicidal means. Suicide is more likely to succeed in people 50 and older, and it is rare for people 65 and older to fail in their attempts. No explanation for this statistic was offered in the source.

Langone (1991) believes that suicide is a form of murder, which does not give the killer time to repent. "One never kills without something clouding the difference between right and wrong, between rational and irrational behavior" (78).

Langone (1991) adds that in the l980s, more older people began killing themselves. Depression seems to act as the catalyst for most of them. Elders hate to admit weakness and therefore do not reach out for help. Another explanation for the increase is "rational suicide," which refers to their perception that the quality of their lives will not be acceptable because of sickness or lack of money. With Alzheimer's and other incurable diseases, people know they are going to become helpless and costs are going to be high. They see suicide as the only way out.

The Hemlock Society is a right-to-die group that believes people with terminal illnesses should have the right to take their own lives. Since 1980 with very few members, they have grown to a census of 13,000. Portland (in Psychology Today, 1978) makes a case for the right of the elderly to choose to end their own lives if they decide that each day there is less to live for, or if they are in a state of physical and psychological deterioration. Many old people are subjected to an undignified

ending to life, particularly if they have certain terminal illnesses. Such elders have the right to end their lives before they become utterly miserable and a drain on their families. This belief supports the line of beliefs of the Hemlock Society.

Suicide in the elderly continues. One way in which an elderly individual can accomplish suicide is through self-neglect. The effects are subtle and gradual. Physician-assisted suicide or one of many nonviolent methods provided in the Final Exit, written by the founder of the Hemlock Society, are two of the most controversial topics in gerontology (Hooyman et al, 1996).

This author wishes to note that the information available *on individuals' right to die is voluminous and not the topic of* this project. Mention of some of the key issues serves only to tie in the complexity of the subject of suicide in the elderly. The right-to-die movement has added interest in the debates regarding euthanasia, which literally translated, is defined as "good death" (420). The issues surround three types of patients: the terminally ill who are conscious, the irreversibly comatose, and the brain-damaged or severely debilitated, who have good chances for survival although they will experience a low level of existence.

The following quote is an example of suicidal thinking. "Hotch if I can't exit on my own terms, then existence is impossible. Do you understand? That is how I've lived, and that is how I must live--or not live" (582). Ernest Hemingway wrote this letter shortly before he took his own life after receiving a diagnosis of a terminal illness. He was in deep despair, because he believed a series of ECTs administered during depression had robbed him of his memory--an essential tool for a writer.

TREATMENTS FOR INDIVIDUALS

Warnick (1995) believes that before one can treat a depressed patient, a distinction between situational and long-term depression must be made. Long-term depression refers to a person who has depressive tendencies and has suffered a lifetime of feeling low. This indicates a chemical imbalance that almost always requires medication in addition to counseling. Situational depression is a reaction to a particular tragedy or event that causes sadness.

Warnick (1995) continues by stating that counseling strategies include counseling and medication. With a depressed patient, a combination of supportive and cognitive therapies are used as deemed appropriate. At times clients

may be too devastated or mentally unprepared for cognitive therapy. In this case, a mini-analysis approach may be used to provide information about the client to build rapport and to encourage introspection. Clients will reach the point where they can discuss the precipitating episode that triggered the depression. Work may then begin to disarm the cause and to discover new ways of reacting to such stressors.

Medication should be prescribed by a psychiatrist. Since many elders take several medications, such a specialist is needed to correctly prescribe a safe, effective psychotropic regimen. Age in itself does not preclude medication. However, the frail elderly who lives alone presents a situation requiring caution and close monitoring by the psychiatrist. The major concern is whether the client can be trusted to take the drug as prescribed and whether the medication will negatively affect the client's mind or body. The aging body reacts, tolerates, and changes differently than a young body. Medication needs to be lifestyle and age appropriate.

Depression is often a symptom, not a cause. Counseling is helpful to deal with the cause of depression and to develop coping skills specific to clients' individual needs. Generally, clients who are suffering from situational

depression are given psychotropic medications as a last resort, whereas a client having a history of depression usually receives medication first.

Kleinke (1994) believes that it is important that clients and therapists agree on a contract for care that includes strict contingencies, paramount of which is a commitment for clients to inform the therapist when they are in danger of harming themselves. A direct caretaking response desperately demanded by clients is contraindicated. A mutual therapist/client relationship is more appropriate, because clients then assume primary responsibility for their well-being. Some therapists contract with clients from the beginning that they will be referred for crisis intervention or hospitalization if they become suicidal.

Beck (1985) suggests engaging potentially suicidal clients in the therapeutic process, so that they will want to see what happens next in their lives. He attempts to have clients agree to write down their thoughts whenever they feel suicidal, so they can bring them in for discussion. The therapist attempts to entice the client to analyze the relation between his/her past experiences, thinking patterns, and emotions. The problem that the author of this project sees with this is

that elderly individuals may not be capable of achieving such goals and may become more intensely despondent. Indeed, it appears that more attention needs to be given to this point.

TREATMENTS FOR GROUPS

Burnside (1994) states that elderly individuals whose depression is severe may be helped by encouraging them to talk, by listening without enabling them, by talking about any psychosomatic complaints, by offering the opportunity to express feelings in group meetings, and by monitoring the degree of depression. As information in unveiled, counselors can develop care plans that may be based on clients' individual needs or desires. Individualized care could include such tasks as preparing coffee the way they like it, attending to their personal hygienic needs, providing opportunities to openly verbalize an experienced loss, and utilizing additional information as it arises, an example of which would be discovering that two members were neighbors as children and then helping them to create a new friendship. Such care of the elderly can increase their comfort, provide a feeling of being cared about, and alleviate loneliness and hopelessness. A degree of pride, self-esteem and hope can then replace the thoughts and feelings of desperation.

Vecchione (in Burnside, 1994) states that adjustment problems in long term care facilities affect depression, loneliness and life satisfaction. Productive and meaningful activity can produce a positive impact. Burnside (1994) adds that the primary preventive interventions emphasize prevention and discovering the problem's source. Groups relevant to the aging population include the following issues: nutrition, exercise, osteoporosis, depression prevention, caregiving to Alzheimer's patients, concentrating on maintaining their health, stress-relief, and mind-body unity. Secondary interventions focus on early diagnosis and prompt treatment. The goals are to prevent further deterioration and to develop effective coping skills as a means to avoid similar situations in the future. One type of group that provides such tools is a support group. Support groups are designed to be self-help groups that provide assistance to the recovering elder and the family. Tertiary prevention includes intense treatment to control further disability (Burnside, 1994).

Corey (1990) addresses how counseling groups can be helpful to the elderly. Such groups can help the individual talk about and deal with the isolation of aging. Elders may feel that aging leaves them and their lives holding no meaning and that

the future simply holds a useless life. The elderly often feel unproductive, unneeded, and unwanted by society. In addition, the myths about aging sometimes become self-fulfilling prophecies. Counseling groups can do a lot to help older people challenge these myths and deal with the developmental tasks that they must face so that they can retain their integrity and self-respect. Groups can help the elderly break out of their isolation and can offer them the encouragement necessary to seek for and to find meaning in their lives. As a result, they can live fully rather than merely existing. Each person's circumstances will require individuation of this process, meaning that some elderly people will be more limited than others, need more help than others, or need help to face the inevitable death that has begun its process (Corey, 1990).

Corey (1990) posits that prevalent themes in the elderly population include loneliness, social isolation, loss, poverty, rejection, struggling to find meaning in life, dependency, feeling useless, hopeless and desperate, fear of death and dying, grief, sadness regarding physical and mental deterioration, and regrets from the past. Elders may be resistant to counseling, they may take longer to establish

trust. Elders are sensitive about being labeled when they receive mental health services. Due to physical and psychiatric problems, elders often have short attention spans, thus a group's pace needs to be slower. Elders' medications may interfere with cognitive abilities. Advanced senility produces differences with reality orientation. Physical ailments, transportation problems, or conflicting doctor appointments produce difficulty in attending group sessions regularly. Group work needs to be oriented to making present life more meaningful and enjoyable; elders need support and encouragement. Respect is shown to elders by accepting them, by hearing underlying messages, and by not treating them condescendingly. They need to be listened to, understood, and accepted. In addition, it is vital to remember that small changes happen slowly.

Some exercises for elderly groups (Corey & Corey,1992) include asking shy elders to go on an imaginary trip and to choose two people to go with them, asking elders to select new names and explain what their new names mean to them, asking elders to share a favorite photograph with the rest of the group, asking elders to talk about their birthplace in their families, using pictures they have drawn, asking elders to

describe important memories, and asking elders to share what they enjoy doing on their favorite holidays.

Corey & Corey (1992) share the following outcomes of group work with the elderly. It is noted that any change is expected to be slow and small. It is essential to take into account the basic limitations elderly individuals have with regard to change. Group members discover that they are not alone in experiencing problems, and they learn from other members' feedback. They realize that people have a right to their feelings, which is enhanced by the acceptance of other group members. The members become advertisers for the group meetings, encouraging patients who have not attended. Interaction between patients increases as they learn each other's names during group exercises. The group atmosphere is trusting, caring, and friendly and the members continue socializing outside the group. Members become actively involved in choosing activities that hold their interest rather than sitting idly. The level of talking deepens, expressing how good it feels to be listened to. At times, one group leads to the establishment of another group. Nurses report the improved affect of patients. They express desire to learn the skills needed to facilitate such groups. Staff become actively

involved in designing specific activities for specific patients and assist them in completing them.

Phoenix (1997) states that depression, especially in elderly women, is increasing. In an effort to treat depression, two nurses in a psychogeriatric clinic developed a treatment program consisting of 10 weekly group sessions for elderly women with depression. Key issues that were addressed were central to tailoring the experiences and enhancement of the learning that took place for members as well as the facilitators. Group process and insight with dynamic strategies for both teaching and learning were exercised. The group's demographics fit the following profile of an elderly woman: age range 65-81; urban dweller; diverse cultures, those widowed, married, single; different socioeconomic groups; and a primary education (Phoenix, 1997).

Themes for the 10 sessions encompassed such topics as depression, relationship of thoughts to depression, role of social factors in depression, goal setting, self-esteem, understanding family of origin, assertiveness, stress management, caring for one's body, and evaluation and termination. Phoenix (1997) provided objectives for this group

that included behavioral, cognitive, and psychological therapeutic approaches.

Behavioral techniques help to decrease anxiety, to decrease symptoms of depression, to provide goal-setting, and to teach assertiveness. Cognitive techniques provide knowledge about depression, coping skills, and the sharing of personal stories. Psychological approaches address self-esteem, social support, trust, and relationships.

Phoenix (1997) shared several key points of the study. First, elderly women experience depression twice as often as men. Second, nurses using a psychoeducational format and health promotion strategies, can facilitate women learning to cope with depression. Third, women in groups learn readily and eagerly, sharing their relevant personal stories as their comfort in the group setting is established. Fourth, due to identified needs of this group, future programs were identified.

Elaborating on the depression that often leads to suicide, Foster (in Counseling Today, 1995) researches the limited social interaction dilemma of the elderly. She discovers that nursing homes need to offer more stimulating activities for their patients, such as art and music.

In addition, it is discovered that poetry groups are successful because the residents discuss what is meaningful in their lives, personal relationships and lifelong learning. Obviously, everyone who joins such a group can participate, because they each have their individual life stories. Even if they choose or are not capable of verbalizing their experiences, they can listen to others and find common bonds. This process can alleviate a degree of loneliness and desolation. Additionally, music, art and pet therapies are sound programs to implement and to provide the feeling of intimacy that elders desperately desire.

CRISIS INTERVENTION

Miller (1992) suggests that individuals in a crisis should be encouraged to use coping strategies that have proved previously helpful. There will always be suicides. The goal needs to be to reduce the number rather than to prevent them altogether.

He continues by providing a substantial number of needs that demand attention, such as a firm national commitment to suicide reduction, public and private coordinated efforts, capable people being allowed to work as long as they desire. People who want to retire could be eased

into this by working fewer hours each of the three or four years prior to retirement. This would soften the retirement shock. Preretirement education and counseling could be provided far in advance of retirement. Postretirement counseling could continue for the first two years of retirement.

Physicians could be educated to recognize and to appropriately respond to suicidal clues from older patients. Such training could be presented through medical schools, internships, residencies, and continuing education programs. Free annual medical exams for individuals 60 years of age and older could detect illness, plus increase contacts with medical personnel. If those personnel were properly trained, they, too, could help detect suicidal symptoms.

Recently bereaved elders need to have their health monitored during the first year, because morbidity and mortality rates rise during the first year after a spouse's death. Family members could provide more attention and loving care. Reducing taboo against sex in later life could promote health. Suicide prevention centers and mental health centers could develop outreach programs for the purpose of identifying and treating potential suicidal elders.

Utilizing the older population as outreach workers would create mutually beneficial roles and part-time employment. Low-cost transportation to reasonably priced psychiatric and psychological services should be provided, without the usual social stigma that accompanies mental health care. General improved sensitivity and increased awareness of problems associated with aging would provide much needed education. Elders living alone should have a phone freely installed, with a lower monthly charge, as the phone may be their only link to emergency services. Free phone stickers with vital services' numbers could be distributed to elders.

Flyers included with social security checks could provide valuable information regarding available crisis services. Research funds to study geriatric suicides and funds for intervention programs seem vital for such an at-risk group. National programs to decrease elderly suicides could use financial help from large organizations of elders. National public information campaigns would familiarize people with suicidal symptoms. Magazines published for older individuals could include articles about geriatric suicides, designed as an educational forum. Leisure and recreational activities for

elders could provide enriching and fulfilling experiences for older and handicapped people with a greater deal of free time.

Continued development of studies on a so-called typical elderly suicidal individual could become so defined that people, who contacted large groups of elders, could then identify individuals who are highly at-risk. Then intervention techniques could be used to identify and to assist elders who are highly likely to become suicidal.

Warnick (1995) provided these seven ways to deal with a person in crisis: stay calm, try to get the client to talk, delve to determine whether the clients are considering hurting themselves and determine whether a plan exists, try to determine the problem behind the suicidal threat, identify clients' strengths, suggest all options to the situation the victims are facing, and when feasible, end the session with a plan delineated in an informal contract.

Gilliland and James (1993) offer a six-step crisis intervention model: define the problem, ensure safety, provide support, examine alternatives, plan, and commitment. In practical use, these steps need to be modified to include the needs of the elderly population. The reason for this is the addition of disorientation and confusion and the usual taking of

multiple medications by the elderly. Crisis interventions can last a few minutes to as long as several months. The term of treatment depends on the circumstances surrounding the elder's reasons for the attempt. It is important to remember that anyone in crisis is incapable of rational thought or behavior. The goal of crisis intervention is to stablize the elder so that he/she is capable of utilizing some coping skills, or to provide help until more qualified personnel arrive (Gilliland & James, 1993).

A crisis worker's task specifies that assessing (Gilliland & James, 1993) is "Overarching, continuous, and dynamically on-going throughout the crisis, evaluating the client's present situational crisis in terms of the client's ability to cope, personal threat, mobility...and making a judgment regarding type of action needed..." (30). How active a crisis worker becomes is determined by the condition of the elder client. If the client is mobile, the crisis worker needs to be nondirective; if the client is partially mobile, the crisis worker is collaborative; and if the client is immobile, the crisis work must be directive. The level of involvement is not that rigid, but serves as a guideline. Where on the continuum the crisis worker helps

the elder depends on where on that same continuum the elder patient functions. That is why accurate assessment is vital.

Assessment tasks as delineated by Gilliland & James (1993) include defining the problem, ensuring the client's safety, and providing support. This is accomplished through active listening. Active listening entails attending, observing, understanding, empathizing, being genuine, respecting, accepting, using nonjudgmental responses, and caring. Then it is time to act. A crisis worker must examine the alternatives, make plans, and then obtain commitment from the elderly patient. Becoming active means being part of the intervention on either a nondirective, collaborative, or directive level, remembering that these interventions depend wholely on the assessed needs of the client and the capabilities of the available support system.

If dementia is suspected, a medical and neurological exam is recommended. Take a thorough family history, give mini-mental tests, ask open-ended questions, and watch dynamics of family members and whether they concur with what the elder is stating. Ask about support system; take psychosocial history; provide counseling; and provide the name of local support group and other support services.

Small doses of cognitive therapy help clients take little steps in adapting to illness.

Counseling needs of the elderly are ignored by counselors and governmental agencies. This places unfair expectations on mental health professionals. Only 2% of the elderly population seek help. The reasons include lack of interest by mental health community, myths and attitudes among the elderly, such as I-can-do-it-myself. Some elders see counseling as a weakness, stigma and hefty expense (Warnick, 1995).

McDonald (1988) proposes these four alternatives as treatment approaches with depressed elders as they change thoughts, behaviors, and physiological states that contribute to depression. Included are cognitive restructuring, assertion training, designed success experiences, and referral to a psychiatrist. Cognitive restructuring is helpful when persons are depressed. They interpret the world, themselves and events in distorted ways. To attempt to remedy this problem, the client identifies events from that week and writes down the thoughts during and after the events. Second, the client identifies the thoughts that show distortion and then writes an alternative thought to replace the distorted one.

Another useful tool for elders capable of such a technique is assertion training. Individuals who feel responsible for unchangeable things become depressed, feeling helpless and passive. This type of client needs to learn effective and defensive forms of communication. There are three steps in this training: learning what assertion is, describing an assertive technique, and role playing and practicing.

Coleman (1980) provides the following model entitled Crisis Intervention for Suicide Attempts: First, a call is received at the suicide prevention center. Second, the crisis worker intervenes to avert the actual attempt. Third, the worker emphasizes a) maintaining contact with the person over a short period of time, b) helping the person realize that acute distress is impairing both his/her ability to assess the situation accurately and to choose among positive alternatives, and c)helping the person see alternative ways to deal with problems, taking a highly directive and supportive role, and helping him/her to see that present distress and turmoil will not continue forever. Fourth, helping the client to seek emergency medical treatment. Fifth, helping the client to seek mental health treatment.

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Hopefully, this literature review provides evidence that respect of elders' mental health is long overdue. The elderly represent a specific population deserving of age appropriate treatment. Understanding the special needs of elders provides treasured relief for an invaluable subculture of our population.

Chapter III

PROCESS USED FOR THIS PROJECT

After reviewing all the resources and examining various views on the aging process, depression and suicide, the task of focusing and creating teaching modules began. Calling upon eleven years of teaching experience, a system of devising topics, objectives, teaching techniques, methods for evaluation, and homework that would be appropriate for this project's purpose was utilized.

It was decided that three teaching modules would suffice. The topics of those three modules were chosen: assessing depression; recognizing suicidal symptoms in the elderly; and counseling/intervening with depressed or suicidal elders. The emphasis is on humane, effective, and genuine respect for the aged individual. In addition to lectures that include research material, the workshop will use Feeling Good by Dr. David Burns, the cost of which is included in the enrollment fee for this five-day seminar.

Chapter IV

MODULE ONE - IDENTIFYING AND ASSESSING DEPRESSION IN THE ELDERLY

DAY 1

8:00 a.m. - 8:30 a.m. Doughnuts and Coffee/Juice

8:30 a.m. - 8:45 a.m. Welcome; ***Introduction***

The aging process is mesmerizing. The respect and genuine empathy deserving to each elderly individual are two qualities of care that must be integrated into all levels of care. Too often the elderly are overlooked as being insignificant human beings who have already lived their lives, and who should quietly leave this world without a fuss. Isn't it interesting that now, with an evergrowing number of middle age baby boomers on the way to becoming elders that the interest is swinging to an enormous interest in the elderly. Despite the self-serving motives, it is encouraging that so much attention is being paid to the research and care of the elderly. It is long overdue. Now the interest peaks, because soon it will be this generation's turn to experience the trenches of old age. Now respect, care, treatment, cost, and pain that elders have been suffering for eons receive the focus.

This workshop concentrates on the physiological, psychosocial, and psychological facets of depression and

suicide in the elderly. Extensive research has taken place to ensure a broad spectrum of input and insight into this troublesome topic. It is not a pleasant one to think about, to observe, or to treat. Fortunately, however, depression can be treated. However, there are many factors involved in this illness. Often only the medical aspect of depression is addressed. The aging individual is unfortunately considered to be normal and expected to be depressed, and too few caregivers truly understand the complexity of this illness that can lead to the devastating decision to end one's life. The ***purpose of this workshop*** is to educate caregivers as to the physical, social, and psychological aspects of depression and suicide in the elderly as well as to present interventions and treatments appropriate for this very special population.

8:45 a.m. - 9:15 a.m. Administer ***Pre-test*** (Appendix 1); Discuss findings.

9:15 a.m. - 10:15 a.m. ***Lecture***. Participants will take notes, using note pads provided. Material used is from Chapter 2 of this project, speaker input, and Chapter 9, "Sadness is Not Depression" (Burns, 1980).

According to the Geriatric Social Readjustment Scale by Amster and Krauss (1977) there are 25 stressful life events in the lives of older individuals. Some of them include death of a spouse, institutionalization, death of a close family member, major personal illness or injury, major change in financial state, retirement, marital separation from mate, failing eyesight, death of a close friend, major change in behavior or health of family member, and/or a major change in acitivities that produce gratifying results. The remaining stressors include a change in sexual behavior, change in job responsibilities, painful arthritis, feeling of slowing down, change in living conditions or environment, change in social activities, losing one's driver's license, reaching age 65, reaching age 70, major change in working hours/conditions, troubles with one's supervisor, holidays and anniversaries, argument with children, and/or an argument with spouse. The danger of these stressors is that they can produce lowered self-esteem due to reduced social/personal value status and/or guilt over actions in the past and present (Butler, 1991). The elderly feel helpless and find their mental stability shaken. What compounds the loss is the lack of opportunity to compensate for what is now missing. Older adults are left

to fill those seemingly bottomless gaps by themselves; at least that is the elders' perception (Langone, 1991).

There are two types of depression that are particularly relevant to this workshop. They are reactive depression and endogenous depression. Reactive depression pertains to losses such as the ones delineated above and are considered to be normal and healthy responses to stress.

Endogenous depression comes from within, from some disturbance, deficiency, or overabundance of certain brain chemicals. A person may inherit a tendency to develop a mental illness by inheriting a defect in brain chemistry. That deficiency creates an imbalance of key chemical ttransmitters. Another danger is that the disease/tumors can secrete hormones that act on the brain and alter one's mental state. Yet another concern is side effects of certain medications, especially when combined with other drugs. Elders often take more medications than do younger people, and the elderly person's body processes drugs differently. Seligman and Moore (1995) posit that the elderly are sometimes misdiagnosed with depression when what they really have is melancholia. They posit that melancholia seems more prevalent among the elderly than do any other age group. To

make an accurate diagnosis of depression, an examination of the criteria is paramount.

The DSM IV (1994) states that at least five of the following symptoms must have been present during the same two week period and exhibit a change from previous functioning with a minimum of one of the symptoms being depressed mood or loss of interest or pleasure. The list of symptoms includes a depressed mood most of the day that is indicated by a subjective report, diminished interest in activities most days, a significant weight loss, insomnia or hypersomnia every day, agitation or retardation of psychomotor abilities nearly every day, fatigue or loss of energy every day, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to concentrate or make decisions, and recurrent thoughts of death. A condition of diagnosis is that the symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. Before a diagnosis is determined, other considerations must be explored.

According to Burns (1980) a distinctive difference between sadness and depression exists. Sadness is a normal reaction to a negative event in one's life that is caused by

realistic perceptions. The feelings and behaviors are actual responses to correct ideas about the loss or disappointment. Dr. Burns shares an account surrounding a patient and family during his internship rotation on a urology floor. An elderly man had successfully undergone surgery to remove a tumor from one of his kidneys. The operation appeared to be successful, until his kidneys began to fail, and it was discovered that the cancer had spread to his liver. There was no available medical recourse. His family began to gather from other parts of the country, but had not been informed as to the severity of the man's condition. Dr. Burns could tell that the man was beginning to slip into a coma, so when one of the sons asked him to remove the catheter to the man's bladder, he sought medical guidance concerning the appropriateness of this request, was shown how to remove the catheter, and proceeded back to the patient's room. The son thanked him graciously and remarked that he knew that the catheter had been uncomfortable for his father and that his father would appreciate his kindness. The son then asked for blunt answers to his father's medical condition. Dr. Burns had grown close to this patient, and tears began to run down his cheeks. He had to decide whether to stay in the room and let

his tears be seen, or retreat into the hallway to collect his emotions. He chose to stay in the room and told the family that their father was a beautiful person, that he could still hear them, but that he was slipping into a coma. It was time for them to be close to him and tell him goodbye. They did so, the man went into a coma, and within that hour, died. The relevance of this story is that through expression of real feelings to a very real loss, all parties were able to experience sadness of their loss on a much higher plane of tenderness and beauty. The sadness was based on correct thoughts and perceptions. That is the difference between sadness and depression, which is based on distortion of the truth.

The following scenario provides an example of depression in the elderly. An elderly woman is diagnosed with breast cancer. She is advised to have a radical mastectomy. She insists that she does not have cancer, despite the test results which have been shown and explained to her several times. She is cognitively capable of comprehending and processing information, and until one year ago worked as a very successful real estate broker. Her argument against the surgery is that she has no pain, feels fine, and believes the hospital and laboratories are in error. After her husband's

relentless pleading, she agrees to the surgery, which is scheduled. The surgery is successful and there appears no evidence or pathology report to indicate that the cancer has spread. Her prognosis is good, with close monitoring by her physician. Unfortunately, she begins to exhibit bothersome behaviors, including neglecting her daily hygiene, sitting in her room in the dark for hours at a time, eating meager portions of food, showing no interest in anything, and insisting that she is no longer a woman. She expresses that she wishes she had died on the operating table, that her life is over, and that everything has been taken away from her. She continues to hold the belief that the surgery had been unnecessary and blames her perceived worthlessness on her husband. While this may illustrate an exaggerated case of depression, it clearly shows the difference between sadness and depression. This woman's reaction to her loss is not based on reality or correct perceptions of the facts. Her feelings, beliefs, and behaviors are the result of distorted thinking. Indeed, the depression exhibited in this case exacerbates the true sadness that is understandable, expected, and healthy. Unfortunately, now she has two diseases to battle: cancer

and depression. How to treat the depressed elder will be addressed on the third day of this workshop.

10:15 a.m. - 10:30 a.m. ***Break***

10:30 a.m. - 11:15 a.m. Assign the following three questions to be discussed in voluntary ***triads***. Allow 15 minutes. Ask each group member to discuss one of the three questions. Allow 30 minutes. Note differences of opinions on the board and instruct the participants to add this information to their notes.

Question #1: What is the difference between sadness and depression?

Question #2: What are 10 life stressors common to depression? Why do they contribute in such a negative way to elders' lives?

Question #3: It is often said that the elderly are expected to be depressed. Do you agree or disagree? Explain your answer.

11:15 a.m. - 12:00 p.m. ***Practice***. Divide the group into three groups. Have each group create an outline for one of the three prior questions. The outline will be based on information gleened from the lecture and discussion. Make copies of the outlines for all participants.

12:00 p.m. - 1:00 p.m. ***Lunch***

1:00 p.m. - 1:45 p.m. Distribute the three outlines to all participants. Each ***group reports*** on its outline and conducts a question and answer period for the entire audience.

1:45 p.m. - 2:00 p.m. ***Break***

2:15 p.m. - 2:30 p.m. Distribute handouts (Appendix 2). Assignment: Read for tomorrow's session and be ready to discuss.

2:30 p.m. - 3:00 p.m. ***Questions and Answers; Dismissal***

Day Two (Module 1 continued)

8:00 a.m. - 8:30 a.m. Doughnuts and Coffee/Juice

8:30 a.m. - 10:00 a.m. ***Lecture***. ***Objective***: To identify and to diagnose types of depression in case studies. Read handouts from yesterday, interacting with the audience as questions are answered. Review the criteria for a diagnosis of depression.

Depression is a serious problem for the elderly but often is erroneously attributed to somatic concerns, cognitive deficits, medical side effects, or expected changes of old age. Mood disorders typically have a more rapid onset than the other disorders, providing a clue to differential diagnosis (Foster, 1995).

Added stressors for elders can include covert problems developed through a terminal illness. These may include: pretending everything is okay, convincing others that they are taking necessary precautions, suffering side effects of medication, suffering from inept medical attention, experiencing relationship problems, feeling guilty, attempting to deal with daily trials and tribulations alone, falling victim to a

time-bomb chronic illness, dealing with the outside world, realizing increassed stress and/or experiencing an economic trauma (Foster, 1995). Coleman (1980) states that elderly people face many real problems and insecurities that are not characteristic of earlier life. Even well-integrated personalities may break down under the combined assault of cerebral changes and a stressful life situation.

Physical and mental deterioration may develop if an elder's self-worth and sense of usefulness is threatened, such as in the case in forced retirement. Many people depend on their work for status, self-identity, satisfying interpersonal relationships, and supplying meaning in their lives. Suddenly they find themselves unfulfilled and as though they have no meaning to the world (Coleman, 1980).

If people respond to life with hopelessnes, depression and submission, a sociological change may be triggered that encourages development of already present disease potential. It is not the event's magnitude, but the way people react to it that determines whether a certain person gives up. The despair and depression must be treated (Butler, 1991).

10:00 a.m. - 10:15 a.m. ***Break***

10:15 a.m. - 11:00 a.m. ***Discussion***; conduct open forum discussion on pertinent data pursuant to the lecture.

11:00 a.m. - 12:00 p.m. Pass out case studies (Appendix 3); discuss in ***triads*** and report to class as a group, determining whether the study indicates depression; substantiate.

12:00 p.m. - 1:00 p.m. ***Lunch***

MODULE TWO - DEFINING THE METHODS AND REASONS FOR ELDERLY SUICIDE

1:00 p.m. - 2:30 p.m. ***Lecture***; Write "hopelessness" on the board and discuss its meaning as it applies to suicide.

It is essential to differentiate between active and passive suicidal thinking. Active suicidal thinking is when a person concentrates on method. This does not mean that they will necessarily follow through, but the percentage of elderly suicides must be kept in mind. "People who are serious about

suicide do not talk about it to family or ask for the intervention of counselors" (Warnick, 1995, 113). Passive suicidal thinking is detected through statements that indicate a state of depression. As soon as the depression is alleviated, the person again wants to live. Yet another sector of elders say suicidal words and feel that way but are not truly depressed. They have rationally decided that they have had enough of life, are displeased with life as it is, and are ready to die (Warnick, 1995).

It is not what happens to the elderly that contributes to the depression/suicide, but rather how the individuals are equipped with coping skills. It is not the situation but rather how the person reacts to the difficulty that precedes a suicidal attempt (Warnick, 1995). If the elder experiences multiple losses and stress, the reservoir of resources for relief may be exhausted. There is not just one factor that leads a person to a life or death dilemma. What may appear to others to be a small problem might serve as the final element of stress that results in a suicide attempt (Miller, 1979).

Corsini (1989) posits that the suicide rate among elderly individuals increased 25% from 1981-1986. The highest rate was among white men in their 80's. Older persons make up

12% of the population and 25% of reported suicides--5,000 to 8,000 yearly. In 1985, women were more likely to attempt suicide, while men were more likely to succeed when an attempt was made. The reasons behind suicide attempts include ill health, painful illness and control. While death is certain, its timing and characteristics are not. Suicide defies control of death. There even exists control beyond the grave--those left behind are deeply affected with guilt, shame and regret. Suicide equals self-murder and lends meaning to motives of hatred of self or others. Suicide is a submissive, passive, desperate giving up. It represents not wanting to leave spouses penniless, not wanting to be a burden, or a perception of self that portrays failure. Depression that precedes suicide attempts develops from the perception that life is meaningless and useless (Corsini, 1989). Hergenhahn (1990) states that life can become so unpredictable that the only certain thing that one can imagine is death. Death may appear to provide the only immediate certainty. Certainty of death may be preferable to the uncertainty of the future for some elders.

Kane & Kane (1981) state that suicide attempts are successful when there exists more serious intents, frailty, and

social isolation. It is suspected that elderly suicides in institutions are underreported and that in passive self-neglect, the suicides are not recognized. Older people generally use drugs, guns, hanging, and jumping off high places as their suicidal methods. Suicide is more likely to succeed in people 50 and older, and it is rare for people 65 and older to fail in their attempts. Langone (1991) believes that suicide is a form of murder, which does not give the killer time to repent. In the l980s, more older people began killing themselves. Depression seems to act as the catalyst for most of them. Elders hate to admit weakness and therefore do not reach out for help.

2:30 p.m. - 2:45 p.m. ***Break***

2:45 p.m. - 3:30 p.m. Encourage deeper levels of understanding by having the audience members ***role play*** life situations elders face; audience generated scenarios.

3:30 p.m. - 4:00 p.m. ***Debriefing*** of stirred up emotions from role playing. Hand out two articles (Appendix 4) by the National Mental Health Association to serve as a review. Read at home.

4:00 p.m. ***Dismissal***

MODULE THREE - LEARNING HOW TO TREAT DEPRESSED OR SUICIDAL ELDERS

8:00 a.m. - 8:30 a.m. Danish, Bagels and Coffee/Juice

8:30 a.m. - 10:00 a.m. ***Lecture***.

Warnick (1995) states that counseling strategies include counseling and medication. With a depressed patient, a combination of supportive and cognitive therapies are used as deemed appropriate. Clients may be too devastated or mentally unprepared for cognitive therapy. A mini-analysis approach may be used to provide information about the client to build rapport and to encourage introspection. Elders will reach the point where they can discuss the precipitating episode that triggered the depression. Work may then begin to disarm the cause and to discover new ways of reacting to such stressors.

Medication should be prescribed by a psychiatrist. Since many elders take several medications, such a specialist is needed to correctly prescribe a safe, effective psychotropic regimen. Age in itself does not preclude medication. However, the frail elderly who live alone presents a situation requiring caution and close monitoring by the psychiatrist. The major concern is whether the client can be trusted to take

the drug as prescribed and whether the medication will negatively affect the client's mind or body. The aging body reacts, tolerates, and changes differently than a young body. Medication needs to be lifestyle and age appropriate. Depression is often a symptom, not a cause. Counseling is helpful in dealing with the cause of depression and developing coping skills specific to clients' individual needs.

Kleinke (1994) believes it is important that elders and therapists agree on a contract for care that includes strict conditions, most importantly, that the elders will inform their therapists when they are in danger of harming themselves. Beck (1985) suggests engaging potentially suicidal clients in the therapeutic process so that they will want to see what happends next in their lives. He attempts to have clients agree to write down their thoughts whenever they feel suicidal, so they can bring them in for discussion.

Another approach to dealing with depressed elders is expressed by Burnside (1994) who states that elderly individuals whose depression is severe may be helped by encouraging them to talk, by listening without enabling them, by talking about any psychosomatic complaints, by offering the opportunity to express feelings in group meetings and by

monitoring the degree of depression. As information is unveiled, counselors can develop care plans that may be based on clients' individual needs or desires. Individualized care could include such tasks as preparing coffee the way they like it, attending to their personal hygienic needs, providing opportunities to openly verbalize an experienced loss, and utilizing additional information as it arises, an example being discovering two members were neighbors as children and helping them to create a new friendship. Such care of the elderly can increase their comfort, provide a feeling of being cared about, and alleviate loneliness and hopelessness. A degree of pride, self-esteem and hope can then replace the thoughts and feelings of desperation.

According to Burnside (1994) there are certain group topics that are relevant to the aging population. Possible issues include nutrition, exercise, osteoporosis, depression prevention, caregiving to Alzheimer's patients, concentrating on maintaining their health, stress relief, and mind-body unity. Secondary interventions focus on early diagnosis and prompt treatment. The goal is to prevent further deterioration, to develop effective coping skills as a means of avoiding similar situations in the future. One type of group that provides such

tools is a support group. Support groups are designed to be self-help groups that provide assistance to the recovering elder and the family.

Corey (1990) addresses how counseling groups can be helpful to the elderly. Such groups can help the individual talk about and deal with the isolation of aging. Elders may feel that aging leaves them and their lives holding no meaning and that the future simply holds a useless life. The elderly often feel unproductive, unneeded, and unwanted by society. In addition, the myths about aging sometime become self-fulfilling prophecies. Counseling groups can do a lot to help older people challenge these myths and deal with the developmental tasks that they must face so that they can retain their integrity and self-respect. Groups can help the elderly break out of their isolation and can offer the encouragement necessary to seeking and finding meaning in their lives. Each person's circumstances will require individuation of this process, meaning that some elderly people will be more limited than others, need more help than others, or need help to face the inevitable death that has begun its process (Corey, 1990).

Some special considerations for elderly groups include some elders' resistance to counseling, thus requiring a longer period for established rapport and trust. Due to physical and psychiatric problems, elders often have short attention spans, so a group's pace needs to be slower. Group work needs to be oriented to making present life more meaningful and enjoyable. As with any human being, elders need support and encouragement. Respect is shown to elders by accepting them, by hearing underlying messages, and by not treating them condescendingly. They need to be listened to, understood, and accepted. In addition, it is vital to remember that small changes happen slowly. Some exercises for elderly groups (Corey & Corey, 1992) include asking elders to go on an imaginary trip and to choose two people to go with them; this is helpful for shy individuals. Another method is asking elders to select new names and explaining what their new names mean; asking elders to share a favorite photograph with the rest of the group; and asking elders to talk about their birth order. Using pictures they have drawn, asking elders to describe important memories, and asking elders to share what they enjoy doing on their favorite holidays are also effective techniques (Corey, 1990).

Corey & Corey, (1992) share the following outcomes of group work with the elderly. Group members discover that they are not alone in experiencing problems, and they learn from other members' feedback. The realization that people have a right to their feelings is enhanced by their acceptance of other group members' feelings. The members become advertisers for the group meetings by encouraging patients who have not attended. Interaction between patients increases as they learn each other's names during group exercises. The group atmosphere is trusting, caring, and friendly and the members continue socializing outside the group. Members become actively involved in choosing activities that hold their interest rather than sitting idly. The level of talking deepens, expressing that it feels good to be listened to.

At times, one group leads to the establishment of another group. Nurses report the improved affect of patients and express desire to learn the skills needed to facilitate such group. Staff become actively involved in designing specific activities for specific patients and assist them in completing them.

Phoenix (1997) suggests themes for ten sessions which encompasses depression, relationship of thoughts to depression, role of social factors in depression, goal setting, self-esteem, understanding family of origin, assertiveness, stress management, personal hygiene, and evaluation and termination. Objectives for a group include behavioral, cognitive, and psychological therapeutic approaches.

Behavioral techniques help to decrease anxiety, to decrease symptoms of depression, to provide goal-setting, and to teach assertiveness. Cognitive techniques provide knowledge about depression, coping skills, and the sharing of personal stories. Psychological approaches address self-esteem, social support, trust, and relationships.

Elaborating on the depression that often leads to suicide, Foster (in Counseling Today, 1995) researches the limited social interaction dilemma of the elderly. She discovers that nursing homes need to offer more stimulating activities for their patients, such as art and music. In addition, it is discovered that poetry groups are successful because the residents discuss what is meaningful in their lives, personal relationships and lifelong learning.

Obviously, everyone who joins such a group can participate, because they each have their individual life stories. Even if they choose or are not capable of verbalizing their experiences, they can listen to others and find common bonds. This process can alleviate a degree of loneliness and desolation. Additionally, music, art and pet therapies are sound programs to implement and to provide the feeling of intimacy that elders desperately desire.

Crisis Intervention is approached in a variety of ways. Miller (1992) suggests that individuals in a crisis should be encouraged to use coping strategies that have proved previously helpful. A firm national commitment to suicide reduction as one of the major mental health priorities needs to be established. Public and private sectors need to coordinate efforts, allowing capablel people to work as long as they desire. People who want to retire could be eased into this by working fewer hours each of the three or four years prior to retirement. This would soften the retirement shock. Preretirement education and counseling could be provided far in advance of retirement. Postretirement counseling could continue the first two years of retirement. Physicians could be educated to recognize and appropriately respond to suicidal

clues from older patients. Such training could be presented through medical schools, internships, residencies, and continuing education programs. Free annual medical exams for individuals 60 years of age and older could detect illness plus increase contacts with medical personnel. If those personnel were properly trained, they, too, could help detect suicidal symptoms. Utilizing the older population as outreach workers would create mutually beneficial roles and part-time employment. These strategies obviously delineate preventative approaches to depression and suicide, but serve as pre-crisis interventions.

Warnick (1995) provides seven ways to deal with a person in crisis. When dealing with a crisis, stay calm, try to get the client to talk, ask delving questions to determine whether the client is considering hurting himself/herself. Determine whether a plan exists, try to determine the problem behind the suicidal threat, identify client's strengths, suggest all options to the situation being faced, and when feasible, end the session with a plan delineated in an informal contract.

Gilliland and James (1993) offer a six-step crisis intervention model. Define the problem, ensure safety, provide support, examine alternatives, plan, and commitment.

In practical use, these steps need to be modified to include the needs of the elderly population. The reason for this is the addition of disorientation and confusion and the usual taking of multiple medications. Crisis intervention can last a few minutes to as long as several months. The term of treatment depends on the circumstances surrounding the elder's reasons for the attempt. It is important to remember that anyone in crisis is incapable of rational thought or behavior. The goal of crisis intervention is to stablizing the elder so that he/she is capable of utilizing some coping skills, or to provide help until more qualified personnel arrrive. Assessment is an ongoing process during crisis intervention. (Gilliland & James, 1993).

Assessment tasks as delineated by Gilliland & James (1993) include defining the problem, ensuring the client's safety, and providing support. This is accomplished through active listening. Active listening entails attending, observing, understanding, empathy, genuineness, respect, acceptance, nonjudgmental responses, and apparent caring. Then it is time to act. A crisis worker must examine the alternatives, make plans, and then obtain commitment from the elderly patient.

If dementia is suspected, a medical and neurological exam is recommended. Take a thorough family history, give mini-mental tests, ask open-ended questions, and watch the dynamics of family members and whether they concur with what the elder is stating. Ask about support system, take psychosocial history, provide counseling, and provide the name of local support group and other support services.

McDonald (1988) proposes these four alternatives as treatment approaches with depressed elders as they change thoughts, behaviors, and physiological states that contribute to depression. Cognitive restructuring is helpful when persons are depressed. They interpret the world, themselves and events in distorted ways. To attempt to remedy this problem, first have the client identify events from that week and write down the thoughts during and after the events. Second, identify the thoughts that show distortion and then write an alternative thought to replace the distorted one.

Another useful tool for elders capable of such a technique is assertion training. Individuals who feel responsible for unchangeable things become depressed, feel helpless and passive. This type of client needs to learn effective and defensive forms of communication. There are

three steps in this training. The elder learns what assertion is, role play and practice. The remaining methods are designed success experiences and referral to a psychiatrist.

Coleman (1980) provides the following model for Crisis Intervention for Suicide Attempts. First, call a suicide prevention center to avert actual attempt. Second, place the emphasis on maintaining contact with the persons over a short period of time, and helping persons realize that acute distress is impairing their ability to assess the situation accurately and to choose among positive alternatives, and helping persons see preferable ways of dealing with problems. Further steps include taking highly directive and supportive roles, helping them to see that their present distress and turmoil will not continue forever, seek emergency medical treatment, which includes mental health treatment.

10:00 a.m. - 10:30 a.m. ***Discussion***. Review depression, especially that which goes untreated. Discuss suicide as a "natural" result.

10:30 a.m. - 11:00 a.m. ***Practice***. As a group, have the participants create scenarios that could possibly lead to the development of situational depression.

Next, ask them to do the same thing with endogenous depression. Then, assuming that both cases go untreated, have participants anticipate the outcomes in very specific terms as they relate to the elderly.

11:30 a.m. - 1:00 a.m. ***Catered lunch provided***.

1:00 p.m. - 1:15 p.m. ***Discussion***: hope vs. hopelessness

1:15 p.m. - 2:30 p.m. Participants alternate between being the depressed and/or suicidal elder and being the caregiver (***duads***). Time is allowed for practice and then the presentor closely observes each pair, verbally taking note of how the caregiver responds to the elder's needs. At least two pair need to be encouraged to role play a crisis line intervention.

3:30 p.m. - 4:00 p.m. ***Questions and answers***; ***debriefing*** for participants; ***Post-test*** covering the spectrum of the seminar (Appendix 5); ***closing remarks***.

Chapter V

CONCLUSION

This project devotes its focus to educating caregivers to respect and to providing genuine empathy to the elderly. Elders have long deserved age specific care and nurturance. Their status in today's society exemplifies the neglect younger generations have shown to their elders.

Baby boomers are rapidly showing an increased interest in the needs of the elderly, primarily because it is they who will soon desire quality care. Slowly changes are occurring as the topics of treatment, costs, and pain control for the last stage of life stare directly into their future plans.

Physiological, psychosocial, and psychological aspects of depression and suicide in the elderly have been thoroughly discussed. The research presents a broad spectrum of insight and information required to understand the intricacies of the aging process. Depression and suicide are two possible aspects of aging that obviously must be detected and diagnosed before intervention and treatment can be provided.

Assessment, intervention, and treatment can be appropriately conducted only if the caregivers are well versed in the physical, social, and psychological aspects of

depression and suicide in the elderly. This project focuses on presenting sufficient education so that caregivers can offer appropriate care for such a special population.

A mutual point of emphasis in all references is the hopelessness that the elderly feel prior to thoughts, plans, and actions to end their lives. Depression that accompanies hopelessness is evident as desperate elders begin to show signs of helplessness, passivity, detachment, physical debilitation, and despair.

The teaching modules provide guidance with the hope that caregivers will begin to understand the devastating desperation that precedes elderly suicide attempts and/or successes. Hopefully, caregivers will feel better prepared to offer the elderly the appropriate level of care and nurturance they truly deserve.

Appendix 1

ELDERLY DEPRESSION/SUICIDE PRE-TEST

Mark the statements either true or false.

____1. There are 20 stressful life events according to the Geriatric Social Readjustment Scale.

____2. It is normal for elders to be depressed.

____3. Reactive and situational depressions are synonomous.

____4. Endogenous depression is due to the brain's chemistry.

____5. Melancholia and depression are the same illness.

____6. Awakening during early hours is a symptom of depression.

____7. Depression is a mood disorder.

____8. The elderly bring depression on themselves by complaining about their problems.

____9. Pet therapy is effective when treating elders for depression.

___10. Suicide in the elderly is increasing due to a lack of caregiving.

Appendix 2

INFORMATION ON DEPRESSION

What is Depression?

The National Mental Health Association developed this factsheet as an introductory overview of depression. Please feel free to photocopy it and share it with others.

INFORMATION: THE KEY INGREDIENT FOR TREATING DEPRESSION

Depression is a word commonly used to describe temporarily "down" moods or sad feelings, but for a lot of people–at least 10 million in the U.S. alone–it means something much more serious.

For these individuals and those who care about them, depression is a severe illness, affecting their body, feelings and the way they live their lives. In some cases, it can cause death by suicide.

It's not an illness they choose, or one they could escape if he or she would "snap out of it", anymore than one decides to have diabetes or heart disease.

Fortunately, effective treatment (through medication, psychotherapy or a combination of both) is available for more than 80 percent of those with this illness, enabling them to live full, healthy lives. The most important part of treatment of any disorder is information--accurate, current facts on the causes, symptoms, treatment options and tips for coping. The patient, family and friends should all have this basic understanding of depression to ensure the fullest, quickest recovery.

MORE THAN A CASE OF THE BLUES

It's important to distinguish between normal feelings of sadness we all occasionally experience and what mental health professionals refer to as clinical depression.

Clinical depression refers to several serious conditions that are not related to occasional periods of dejection or even the intense feelings of grief that life brings to everybody at one time or another.

Depression takes many different forms, each of which varies from person to person. In general, though, clinical depression is referred to as either "major depression" (the "sad" kind), or "manic-depression" (the "up-and-down" kind).

WHAT CAUSES CLINICAL DEPRESSION?

Not everyone agrees on what specifically causes these conditions (also known as depressive disorders), but scientists do know that they're not caused by personal weaknesses, bad parenting other factors falsely attributed them.

In fact, leading theories indicate that the causes are mostly biological in nature, as with cancer, diabetes and other major illnesses.

Biological factors that are believed to contribute to the development of depressive disorders include heredity (some people may have a gene or genes that predisposes them to a depressive disorder) and chemical imbalances (some people's brains may not have the appropriate balance of chemicals needed to process behavioral information).

It's believed that in some cases, a stressful situation can bring these inherited traits and/or chemical imbalances to the forefront and change a person's behavior in much the same way stress is known to play a role in heart disease or other medical problems.

WHAT ARE THE SYMPTOMS OF CLINICAL DEPRESSION?

As with any other illness, clinical depression has recognizable symptoms. These vary from person to person, and not all people with depression have all the symptoms. In general, though, this list of symptoms gives a pretty clear idea as to whether you or someone you know has clinical "major" depression:

- persistent (more than several weeks) sad, anxious or "empty" mood
- feelings of hopelessness or pessimism
- loss of pleasure or interest in ordinary activities, such as sex
- problems with sleep (insomnia, early–morning waking or oversleeping)
- eating disturbances (loss of appetite or overeating)
- decreased energy, fatigue
- restlessness, irritability
- difficulty concentrating, remembering or making decisions
- inappropriate feelings of guilt
- thoughts of death or suicide (these should always be taken seriously)

Occasionally, the symptoms of depression masquerade as persistent physical ailments, such as headaches, digestive problems or chronic pain. If your family doctor can't find a specific health problem that might be causing these ailments, consider seeing a mental health professional for an evaluation.

Other people have a depressive disorder that involves something called mania, giving rise to the name "manic-depressive" illness. Because clinical depression is often associated only with feelings of sadness or listlessness, symptoms of manic-depressive illness can go unrecognized. These symptoms include:

- inappropriate elation
- insomnia
- unrealistic notions or self-attitudes
- dramatically increased talking, fidgeting or sexual activity
- racing thoughts
- inability to make decisions
- inappropriate social behaviors

You, a friend or someone in your family may have clinical depression and not even realize it. Sometimes, the very nature of the disorder can interfere with the ability to get help. Help is available. If you or someone you know shows the symptoms listed on this fact sheet, consider getting help from a mental health professional.

Contact these organizations for additional information:

National Mental Health Association
1021 Prince St., Alexandria, VA 22314
(800) 969-NMHA (703) 684-7722

National Depressive and Manic-Depressive Association
730 North Franklin, Ste. 501
Chicago, IL 60610
(312)642-0049

National Foundation for Depressive Illness
P.O. Box 2257
New York, NY 10116-2257

National Alliance For The Mentally Ill
2101 Wilson Blvd., Ste. 302
Arlington, VA 22201
(703) 524-7600

Depression/Awareness, Recognition And Treatment Program
National Institute of Mental Health
5600 Fishers Ln., Rm. 14C-02
Rockville, MD 20857
(301) 443-4140

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INFORMATION ON DEPRESSION

Who Gets Depression?

At least 10 million Americans have some form of clinical depression in any given six-month period, making it one of the most prevalent illnesses in our society today.

Its causes are believed to be largely biological and, like many other serious disorders, depression knows no social, economic or gender boundaries. Its symptoms–which include prolonged feelings of hopelessness and sadness, irritability, major changes in eating and sleeping habits, concentratioon / memory difficulties and physical complaints such as headaches or back pain–are likely to affect 25 percent of all women and 11.5 percent of all men at one time or another.

Children as young as five have been treated for depression, and some scientists estimate that as many as 65 percent of older Americans may have some form of depression.

The National Mental Health Association developed this factsheet to provide basic information on the prevalence of depressive disorders. Please feel free to photocopy it and share it with others.

DEPRESSION IN WOMEN

Depressive disorders are reported to affect twice as many women as men (25 percent of women vs. 11.5 percent of men). It's not yet known whether this difference is caused by something in the biological makeup of women that makes them more likely to have depression, or whether the numbers simply indicate that women are more likely than men to seek treatment for depression. Some scientists believe that fewer men are diagnosed because their depression is masked behind alcoholism or antisocial behavior.

DEPRESSION IN MEN

Slightly more than 11 percent of all American men will have a depressive disorder at some time in their lives. While lower than the number of women diagnosed with depression, this number dramatically illustrates how prevalent depression is in our society– and 11 percent is judged by many scientists to be far lower than the *actual* number of men with depression!

While women are more likely to attempt suicide than men, men are twice as likely to succeed because they generally use more lethal means. Scientists believe that suicide is often caused by depression.

DEPRESSION AND OLDER AMERICANS

Diagnosing depression among older Americans is extremely difficult, which accounts for the fact that estimates on how many older people have depression range from 10 to 65 percent.

Symptoms of depression in aged populations are often misdiagnosed as those of other illnesses. For example, memory loss, confused thinking or apathy is often attributed to senility (an organic brain syndrome) when they could actually be caused by clinical depression. On the other hand, early-waking and reduced appetite--both symptoms of depression--are common among older Americans who do not have depression.

While the resulting confusion on how to diagnose depression in older populations causes some controversy, it is known that self-report tests from

this age-group acknowledge more of the symptoms of depression than any other group. Older Americans also commit suicide at higher rates than any other U.S. population.

Careful observation by a knowledgeable person and a sophisticated medical evaluation may be necessary to recognize depression in an older person.

DEPRESSION IN CHILDREN AND ADOLESCENTS

While depression is known to affect all ages of children–from the very young to older adolescents--it is often difficult to detect. By nature, child and adolescent behavior is somewhat erratic, and people this age aren't always able to express their feelings and needs very well.

In many cases, depressive disorders express themselves differently in children and youth than in adults. Unable to cope with feelings of hopelessness or pessimism and other symptoms associated with depression, children may act out aggressively and develop a sense of rebellion at school and at home. At other times, their symptoms are dismissed as simply "part of growing up."

Like adults, some may "self-medicate" their illness with alcohol or drugs, further obscuring the true nature of their problem. Poor performance in school, sexual promiscuity, running away and truancy–all usually attributed to "bad behavior"–might actually be warning signs of depressive disorders.

Fortunately, the same help available for depression in adults is effective for children and adolescents as well.

Contact these organizations for additional info. mation:

National Depressive and Manic-Depressive Association
730 North Franklin, Ste. 501
Chicago, IL 60610
(312)642-0049

National Foundation For Depressive Illness
P.O. Box 2257
New York, NY 10116-2257

National Alliance For the Mentally Ill
2101 Wilson Blvd., Ste. 302
Arlington, VA 22201
(703) 524-7600

Depression / Awareness, Recognition And Treatment Program
National Institute of Mental Health
5600 Fishers Ln., Rm. 14C-02
Rockville, MD 20857
(301)443-4140

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For more information, please call
Jewish Hospital's Department of Psychiatry,
(314) 454-8560

JEWISH HOSPITAL
At Washington University Medical Center, St. Louis

Appendix 3

CASE STUDIES

Mrs. L. is a 67-year-old retired woman. She was a teacher for 30 years. At the same time she retired, her husband was diagnosed with terminal lung cancer. Her children are grown with families of their own, but live in the vicinity. Her friends have found her in bed in the middle of the day crying as hard as she could, refusing to eat, get dressed, or take a shower. She will not talk to her friends about the situation, because according to Mrs. L. "everything is just fine."

Mr. M. is a 75 year-old retired man, whom others have labeled "the frowning face of the community." His children state that he has always been nervous and afraid to participate in social activities. His wife died one year ago and he claims to be doing just fine. He has been taking medication for his anxiety, but claims it doesn't work.

Mrs. C. never married. She wears the newest styles, although she is 80 years old. She previously worked as a fashion designer before she was diagnosed with emphysema. She continues to smoke. She lives alone, continues to drive, has a relatively active social life, but little family contact. She smiles all the time. She is quiet, keeps a journal, and states that having to take oxygen with her continuously is no problem.

INFORMATION ON DEPRESSION

Causes of Depression

The National Mental Health Association prepared this factsheet to provide basic information on what's known about the causes of clinical depression. The information has been adopted from Depressive Illness: Treatments Bring New Hope, *a booklet from the U.S. Department of Health and Human Services. Please feel free to photocopy and share this factsheet with others.*

A Combination of Causes

Most scientists believe that this cause of clinical depressive disorders is related to at least three factors: genetics, biochemistry, and life events. Although the exact role played by these factors is not yet fully understood, substantial progress has been made in treating the symptoms, offering hope for at least 80 percent of those with a depressive disorder.

Genetic Factors

Studies of families with histories of high rates of depression have led scientists to conclude that vulnerability to the illnesses could be inherited, or passed on through the genes from one generation to another.

Recently, direct evidence of genetic vulnerability to a serious form of depression, called manic-depressive illness has been found: family members with the disorder were shown to have genes different (in a specific area of the cell) than those who were not ill. The illness may serve as an indication of a genetic abnormality that causes the illness For this reason the genes are called "genetic markers."

Long before sophisticated gene-mapping techniques provided evidence for genetic vulnerability, research with twins indicated that inheritance plays a role. Scientists have shown that if one identical twin suffers from depression, there is a 70 percent likelihood that the other will also be affected. Among nonidentical twins, however, the risk decreases to about 25 percent.

Since indentical twins have all their genes in common, and non-identical twins have only half their genes in common (as in siblings), the rates attest to genetic involvement.

Biochemical Factors

Almost 30 years ago, scientists observed that certain medications had strong mood-altering properties. The implications of these observations-that mood disorders such as depression could be a function of biochemical disturbance--prompted clinical and laboratory studies that revolutionized the concept and treatment of mental illnesses.

Since then, several types of medication have been developed and successfully used to treat the symptoms of depression, with new ones being developed and tested regularly.

How these medications work is being intensively studied. Central to most theories is the role of neurotransmitters--"chemical messengers"-- that convey electrical signals from one nerve cell to another. This chemical signaling sets in motion complex interaction in the nervous system that affects behavior, feelings and thought.

It's now believed that depressive and manic episodes are associated with improper functioning of particular neurotransmitters. Originally, it was thought that depression was caused by deficits in two such neurotransmitters–norepinephrine or serotonin–at critical locations in the nervous system,

and that mania was caused by an excess of these neurotransmitters.

More recently, it has become evident that a third transmitter, dopamine (and possibly others), may also be involved in mood disorders. It's not yet known whether these "biochemical disturbances" arise on their own or whether they're caused by some combination of stress, trauma, genetics and other conditions.

Life Events

Personal losses, financial problems, physical illness, midlife crises, sex role expectations and "psychosocial" phenonema such as personality, upbringing, and negative thinking styles have been cited as contributors to depressive illness. These factors, arising outside the body and brain, are often called "environmental" factors.

Any change, serious loss, or stress–divorce, the death of a loved one, the loss of a job-can trigger depressive feelings. In most cases, such feeling are temporary, but some people–who may have a pre-existing genetic or biochemical vulnerability–develop a depressive illness.

Trying to sift apart the environmental, biological and genetic causes of depressive illnesses is extremely complex. Confusion about terms–depressive *feelings* vs. depressive *illness*–add to the problems.

For example, depressive feelings and demoralization are certainly more common among the poor, the deprived, and those lacking social supports, yet it's not clear whether depressive illnesses are more prevalent among victims of such environmental stressors.

On the other hand, studies show that women are at greater risk than men for major depression at every age. In contrast, manic-depressive illness–much less prevalent than major depression–occurs about as frequently in men as in women. Whether this is because the biochemistry of women is different than men, or because they're subject to more environmental stress, or for some other reason, is not yet known.

Contact these organizations for additional information:

National Depressive and Manic-Depressive Association
730 North Franklin, Ste. 501
Chicago, IL 60610
(312)642-0049

National Foundation For Depressive Illness
P.O. Box 2257
New York, NY 10116-2257

National Alliance For the Mentally Ill
2101 Wilson Blvd., Ste. 302
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Rockville, MD 20857
(301)443-4140

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INFORMATION ON DEPRESSION

Recognizing Depression

The National Mental Health Association developed this factsheet to provide basic information on the symptoms and various terms associated with depressive disorders. Please feel free to photocopy it and share it with others.

RECOGNIZING DEPRESSION AS A SERIOUS HEALTH PROBLEM

Attitudes play an important role in determining whether the warning signs of depression are recognized. The idea that depression comes from a personal weakness or lack of will power is nothing more than an old wives' tale, but it persists. Outdated views such as these can make it difficult for someone to acknowledge the symptoms of clinical depression as the warning signs of a serious illness, and to get the necessary help for it.

By learning more about depressive disorders and their symptoms, people can recognize situations (with themselves or people they know) that call for help from a mental health professional.

DIFFERENT TYPES OF DEPRESSION

Depression is used to describe several different types of disorders, and scientists use many different (and sometimes complicated) systems to classify them according to their symptoms, severity, causes and other characteristics. The important thing to know is that depression can take many forms, affecting each person differently, and that some depressive disorders have symptoms that are very different from the "sad" behavior we normally associate with depression. To simplify things as much as possible, depressive disorders can generally be divided into two categories: depressive illnesses and manic-depressive illnesses.

Things to Remember

- Depression is an illness, not a personal weakness
- The symptoms of depression are recognizable.
- Treatment is available.

Checklist For Depressive Illness

Check any symptoms below you or someone you know has experienced for more than two weeks.

- ☐ sad, anxious, or "empty" mood.
- ☐ loss of interest or pleasure in ordinary activities, including sex
- ☐ decreased energy; fatigue, feeling "slowed down"
- ☐ sleep problems (insomnia, oversleeping, etc.)
- ☐ eating problems (loss of appetite, overeating)
- ☐ difficulty concentrating or remembering
- ☐ inappropriate feelings of guilt or worthlessness
- ☐ irritability
- ☐ recurring aches and pains
- ☐ thoughts of death or suicide

Checklist For Manic-Depressive Illness

These symptoms usually appear in periods that alternate with episodes of symptoms on the list above. Again, consider seeing a mental health professional if four or more persist for more than two weeks.

- ☐ excessively "high" mood
- ☐ decreased need for sleep
- ☐ increased energy
- ☐ increased talking, moving , sexual activity
- ☐ racing thoughts
- ☐ disturbed ability to make decisions

- ❑ over-confidence; grandiose notions
- ❑ being easily distracted

DEPRESSION AND OTHER ILLNESSES

Sometimes depression can look like other illnesses with symptoms such as headaches, backaches, joint pain, stomach problems, and other physical ailments. People with depression often focus on these symptoms because they're easier to describe than feelings of sadness, anxiety or tiredness.

Some signs of depression–such as memory lapse and difficulty concentrating–can mimic other disorders or medical problems, while other problems such as alcoholism and substance abuse may actually indicate an attempt to self-medicate a depressive disorder. It's always important to have a thorough medical examination to rule out other disorders before beginning treatment for depression.

TREATMENT IS AVAILABLE

Depression won't go away by itself, but in most cases there is effective treatment available–treatment that in many cases can relieve symptoms in a few short weeks. Treatment usually comes in the form of medication, psychotherapy, or a combination of both.

Medication is used to alter brain chemicals to improve mood, sleep, energy levels and concentration. Different people need different medications, and some need more than one to treat their depression. Psychotherapy also comes in many forms: cognitive therapy aims to help the patient recognize and change negative thinking patterns that can make their disorder worse; while interpersonal therapy focuses on helping the person deal more effectively with other people, because good relationships can help reduce the problems associated with depression.

WHERE TO GET HELP

Many different types of professionals in different settings can help treat depression. The list of national organizations can also provide information on what's available in your community as well as additional information on depressive disorders.

Contact these organizations for additional information:

National Mental Health Association
1021 Prince St., Alexandria, VA 22314
(800) 969-NMHA
(703) 684-7722

National Depressive and Manic-Depressive Association
730 North Franklin, Ste. 501
Chicago, IL 60610
(312) 642-0049

National Foundation for Depressive Illness
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Appendix 5

POST-TEST

Write a paper in response to the following aspects of aging:

your feelings toward the elderly population; how you would determine whether an elder was sad or depressed; how you would determine whether the elder was in danger of harming himself/herself; how you would therapeutically treat a depressed elder; and how you would intervene with a suicidal elder. Substantiate your statements with material from the lectures and/or assigned readings. Be sure to include your own therapeutic philosophy.

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