Understanding Depressive Symptoms: Chronic Sorrow in the Elderly

Methodological Considerations and Clinical Implications

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(The speaker has no conflicts of interest to disclose)

Aging

Medical illness

Mood

Learning Outcomes

Participants will be able to:

- Identify methodological and clinical considerations when evaluating depressive symptoms in older adults with chronic medical illness
- Formulate an assessment strategy to help identify and potentially prevent progression of depressive symptoms from Chronic Sorrow to MDD
- Create interventions related to multiple factors, especially medical illness
Depressive Symptoms: state vs course

- Chronic Sorrow describes fluctuating course vs one-point evaluation or generalization
- Pervasive, cyclical emotional response to identifiable triggers: hospitalization, worsening disease, decreasing function, complicating psychosocial stressors, missed developmental milestones WITH PERIODS OF "NORMALITY" in between
- Could also test as MDD
- My hypothesis: also both or progression (Lungren et al, 1996)

Study Questions

- What is the level of chronic sorrow in elderly patients with chronic medical illness?
- What is the level of depression in elderly patients with chronic medical illness?
- What is the relationship between chronic sorrow and depression in elderly patients with chronic medical illness as measured by the Kendall Chronic Sorrow Instrument (KCSI) and the PHQ-9?
- What is the relationship between chronic sorrow and depression in elderly patients with chronic medical illness as measured by the Damrosch and Perry Chronic Sorrow Visual Analog and the PHQ-9?

Sample Characteristics

- 11 men, 18 women
- Avg. age 83.14 years old
- Only 2 subjects of color
- Well educated, 8 still married
- 1.7 chronic illnesses
- Lived in senior housing
Study Results
No statistical correlations but frequencies were interesting:
- High rates of depression reported (34.47%, N=10) on PHQ-9
- High rates of CS (27.85%, N=8) on KCSI
- 13 chose CS graph
- 37.5% of those with positive PHQ 9 had positive KCSI = overlap or progression?

Methodological Considerations: my study
From study:
- Self-administered packets included LOTs of incomplete data
- Didn’t consider themselves sick but interested in study
- Stigma about depression/mental illness
- Overlapping results

Methodological Considerations: geriatric depression
Challenges in evaluating depression/medical illness/advanced age:
- Primary care tools vs population-specific measurement tools
- Neurovegetative signs
- Stereotypes and stigma
- Psychosocial context
- Pain
- Nutrition
- Sleep
- Polypharmacy
Case Study
- 67 yo male with 8 year history of early PD, chronic Lyme, ? head injury, somatization traits
- Anxious, depressed prior to diagnosis, uses intellectualization as primary defense, has used athletics, volunteer and generally high activity as primary coping mechanism since c’hood
- Ongoing evaluation of depression r/t and not r/t PD

Clinical Implications
- Stereotypes in caregivers: professional and family caregivers
- Stigma- perceptions of aging/mental illness by gender, race, social group, professionals
- Psychosocial context: perceived QoL, disability, isolation/loneliness, social support
- Unaddressed medical symptoms: pain/discomfort, mobility, IADLs, cognitive function

What Impacts Depression Progression?
The four “P”s:
- Predisposing
- Precipitating
- Perpetuating
- Protective
Perpetuating Factors with Chronic Medical Illness: perception and reality

- Loss of health, function, role, independence
- Pain/discomfort
- Change in relationships
- Interaction with healthcare system
- Illness trajectory
- Developmental considerations
- Cognitive function
- Mood

Interventions

- MDD treated with meds and/or psychotherapy (if CS or both, tx may not be appropriate/successful)
- No interventions tested specifically for CS
- Interesting possibilities when aging, depression and medical illness are targeted treatment - 2 nursing studies
- Dyadic interventions more successful in treating older adults with late life depression
  (Stahl et al, 2016)

Intervention Possibilities

- Psychoeducation
- Problem solving skills
- Behavioral activation
- VNA/office close monitoring of medical conditions and accessibility for adjustment
- More activity/stimulation/sx control on inpt units
- Assessment of supportive caregiver partners
THANK YOU!!

“When I consider that the nurses I train now will be the ones providing my care- I am suddenly very invested in what I can teach them! “