chapter 41

Common Psychosocial Care Problems of the Elderly

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Objectives

Upon completing this chapter, you should be able to:

Theory

1. Discuss general principles of care for elderly patients with altered cognitive functioning.
2. Assist with assessment of cognitive changes in the elderly patient.
3. Differentiate characteristics of delirium, dementia, and depression.
4. Identify options for keeping the cognitively impaired senior safe.
5. Implement strategies to decrease agitation, wandering, sundowning, and eating problems in patients.
6. Discuss the interrelationship among alcoholism, depression, and suicide in the elder.
7. Identify the four main categories of elder abuse.
8. List five crimes commonly occurring to the elderly.
9. Discuss two future psychosocial issues for the elderly.

Clinical Practice

1. Formulate a plan of care for the cognitively impaired elder.
2. Demonstrate the ability to interact therapeutically with patients with depression and suicidal tendencies.
3. Teach crime prevention suggestions to a group of elders.

Key Terms

age-associated memory impairment (p. 829)
Alzheimer disease (ĂWLZ-hī-měr, p. 833)
behavior modification (p. 834)
benign senescent forgetfulness (bē-NĪN sĕ-NĔS-ĕnt, p. 829)
creative behavioral therapies (p. 831)
delirium (dĕ-LĬR-ē-ŭm, p. 830)
dementia (dē-MĔN-shē-ă, p. 831)
depression (dē-PRĔSH-ŭn, p. 836)
electroconvulsive therapy (ECT) (ē-LĔK-trō-kŏn-VŬL-sĭv, p. 837)
nocturnal delirium (nŏk-TŬR-năl, p. 830)
paranoia (păr-ă-NŎY-ă, p. 835)
selective serotonin reuptake inhibitors (SSRIs) (p. 836)

The psychosocial status of the elderly is influenced by several factors, including functional limitations and external forces. Cognitive impairments, such as dementia, and physical care problems, such as altered mobility, are two examples of functional limitations. External forces may include economic and environmental factors such as income, housing, technology, geographic area, community resources, and crime. Individual life circumstances, such as the lack of a support system or loneliness and depression leading to alcohol abuse, can also influence the elder's overall well-being. These factors, individually or in combination, all affect the way elders perceive the health care system and ultimately respond to illness.

CHANGES IN COGNITIVE FUNCTIONING IN THE ELDERLY

Many misconceptions exist about the mental functioning of the elderly, given the negative attitudes of our American society toward growing old. People often assume that mental confusion and forgetfulness are typical of aging. However, few cognitive changes are attributable to age-related factors alone.

The terms **benign senescent forgetfulness** and **age-associated memory impairment** are often used to describe age-related changes in mental processes. These changes include a modest decline in short-term memory and a slight and gradual decline in cognitive skills such as calculation, abstraction, word fluency, verbal comprehension, spatial orientation, and inductive reasoning. **The elderly are as capable of learning new things as younger people, but their speed of processing information is slower.**

Examples of mental changes that are not due to the normal aging process include confusion, disorientation, inappropriate behavior, depression, and the inability to concentrate or follow directions. Major declines in cognitive functioning typically result from dementia and metabolic disorders; stress, such as that associated with relocation; alcohol abuse or undesirable medication effects; and vision or hearing impairments.

Dispiritedness and depression result from becoming withdrawn and detached from social interaction.

Think Critically

Can you think of a time you heard someone attribute confusion in an elder to "getting old"?

ASSESSMENT OF COGNITIVE CHANGES IN THE ELDERLY

The older adult with significant changes in mental functioning should be given a comprehensive mental status examination using a tool such as the Short Portable Mental Status Questionnaire (SPMSQ) or the Mini-Mental State Examination (MMSE). A detailed and accurate medical history and physical examination should be performed before making a judgment about the cause of altered mental functioning.

As a nurse, you need to understand that disorientation and other mental symptoms can have a physiologic basis. Carefully observe elderly and confused patients and question them and significant others about events preceding admission. Be patient and allow enough time for the elder to respond to questions. Compensate for sensory limitations during all interactions. Assess for factors that may contribute to an altered mental state, such as medication effects, a new environment, disease processes such as pneumonia or a urinary tract infection, fluid and electrolyte imbalance, or psychosocial stressors. Promptly report all information to assist in the appropriate diagnosis and treatment.

Clinical Cues

An elderly person who is experiencing a situation that makes him anxious may demonstrate temporary decreased cognitive function. Ask the patient, "Is anything causing you to worry at this time?"

COMMON COGNITIVE DISORDERS IN THE ELDERLY

CONFUSION

Patients with confusion have difficulty remembering, learning, following directions, and communicating their needs. Mental confusion can significantly influence a patient's dignity, independence, personality, and support system and may complicate diagnosis and treatment of a patient's illness. It can be caused by delirium, dementia, or numerous other often reversible conditions (Box 41-1).

Think Critically

Can you imagine how frustrating it would be to have difficulty remembering your own address? Do you ever have difficulty remembering something?

Box 41-1 Conditions Associated with Confusion

- Vascular insufficiency
- Trauma
- Tumors
- Central nervous system infections
- Hypotension
- Systemic disorders
- Pulmonary or cardiovascular diseases
- Metabolic disorders
- Electrolyte imbalance
- Anemia
- Altered renal function
- Drug toxicity
- Endocrine disorders
- Nutritional deficiencies
- Stress
- Pain
- Anesthesia
- Altered body temperature
- Dehydration
- Anxiety
- Depression or grief
- Fatigue
- Sensory deprivation or overload
- New environment
- Toxic substances

Box 41-2 Signs and Symptoms of Sundowning

These behaviors, which occur later in the day, may indicate sundowning in the person with dementia:

- Restlessness
- Increased anxiety
- Increased agitation
- Increased confusion
- Uncooperativeness
- Argumentativeness

DELIRIUM

Delirium is an acute confusional state that can occur suddenly or over a long period as a result of an underlying biologic cause or psychological stressor. Causes include stroke, tumors, infection, fluid and electrolyte imbalance, acute inflammatory disorders, drug reactions, toxins, and sensory deprivation or overload (even hospitalization). If left untreated, delirium can lead to coma or death. **Nocturnal delirium,** also known as sundown syndrome or sundowning, is the appearance or increase of symptoms of confusion or agitation in the late afternoon or early evening hours and usually continuing into the night (Box 41-2). Little is known about this disorder, which poses a management problem for caregivers. Impaired mental status, dehydration, fatigue, low lighting or increased shadows, and disruption in the internal body clock may contribute to sundowning.

Table 41-1 Differentiation of Delirium, Dementia, and Depression

	DELIRIUM	DEMENTIA	DEPRESSION
Onset	Sudden	Gradual	Gradual or rapid
Orientation	Disoriented, clouding of consciousness, fluctuating level of awareness	Disoriented	Oriented or disoriented
Affect, mood	Varies	Labile, inappropriate	Despair, worry
Behavior	Agitation; inability to perform ADLs; changes in sleep-wake cycle	Agitation or apathy; inability to perform ADLs	Apathy, agitation, self-neglect, appetite change
Speech	May be incoherent and inappropriate or coherent and appropriate	Sparse, repetitive; may initially lie to cover deficits; later does not conceal	Coherent; may not want to talk
Memory	Impaired for recent events; memory disturbed	Impaired for recent events, intact remote memory	Impaired; decreased ability to concentrate
Prognosis	Good; resolves with treatment	Poor; no return to predemented state	Resolves with treatment of cause or treatment of depression

Key: *ADLs*, Activities of daily living.

Box 41-3 Principles of Nursing Care for the Cognitively Impaired Elder

- Monitor and maintain physical well-being.
- Recognize the underlying meaning of actions and behaviors.
- Adjust the environment accordingly.
- Use concise, direct interactions.
- Maintain and enhance self-esteem and socialization.
- Implement strategies to enhance orientation.
- Maintain adequate nutrition.

DEMENTIA

Dementia is generally a permanent condition characterized by several cognitive deficits. It is characterized by a slow, insidious onset that affects memory, intellectual functioning, and the ability to problem-solve. Primarily seen in patients with Alzheimer disease (AD), it also occurs with brain tumors or with serious medical or surgical disorders. Symptoms of dementia may mask depression. The reverse is also true: the depressed person may be seen with symptoms similar to dementia, such as confusion and disorientation. Careful assessment is therefore essential to determine the cause of the patient's symptoms. Table 41-1 differentiates delirium, dementia, and depression.

The cognitive losses associated with dementia, delirium, and depression are similar; however, patients with each condition experience cognitive changes at different rates, and each responds differently to interventions. Thus interventions must be individualized, with ongoing commitment from both the health care team and the family. General principles of care for elders with altered cognitive functioning are summarized in Box 41-3.

Clinical Cues

Use of a light therapy box in the morning hours may decrease depression and alleviate sundown syndrome. The patient sits with the light shining on him for 20 to 30 minutes. He can watch TV, read, or do other sedentary tasks while under the light.

Specific Interventions for Confusion and Disorientation

Psychosocial Measures. There is little treatment for elders with dementia, so a behavioral approach is essential to enhance the elder's quality of life. Two basic types of behavioral management are psychosocial interventions and medication. The plan of care should also include considerations for the patient's family.

The primary goal of psychosocial interventions is to produce a feeling of well-being in the confused and disoriented elder. Although therapy is usually implemented by a social worker or the activity department, you can support therapy during patient care and evaluate changes in the patient's behavior to revise the plan of care as needed.

A variety of therapies can help patients who are experiencing confusion and disorientation regain their sense of who they are and what is happening in the environment around them. Once a therapy is initiated, it should be used consistently by everyone in contact with the patient, including the family, to avoid further confusion. Table 41-2 presents several types of psychosocial approaches, their purpose, and related activities.

Other psychosocial interventions include **creative behavioral therapies** such as art, music, and humor that can allow for self-expression and alleviate anxiety and depression. The goal of creative therapies is to slow the rate of deterioration and prevent institutionalization as long as possible. Having pets available can also meet many needs, such as companionship and the need for

Table 41-2 Psychosocial Approaches for Confusion and Disorientation

PURPOSE	ACTIVITIES
Reality Orientation	
Orient patient to person, place, and time.	Consistent 24 hr/day interaction with staff and family Continual reminders of day, year, time Consistent mealtimes, activities of daily living, treatment Memory aids such as TV, radio, newspaper, clock, calendar
Validation Therapy	
Decrease stress, promote self-esteem and communication, reduce chemical and physical restraints, and delay institutionalization.	Group support to encourage respect for the feelings of the individual from his perspective Activities such as singing favorite songs, reminiscing, sharing a memento or family photo
Reminiscence	
Reexamine past to promote socialization and mental stimulation; wrap up unresolved issues.	Individual or group sharing of information about past life and experiences
Remotivation Therapy	
Stimulate senses and provide new motivation in life through factual information rather than feelings.	Introduction of pictures, plants, animals, or sounds to encourage interaction
Resocialization	
Encourage socialization patterns within a group.	Assigned socialization roles in a group, such as serving each other refreshments

touch. Pets may help a person deal with the loneliness caused by the many losses experienced in old age, such as decreased income, death of a spouse, and loss of independence (Figure 41-1).

Think Critically

How could you use reminiscence to help an elder adapt to relocating to a nursing home?

Pharmacotherapy. Before administering medications to deal with problem behaviors, first implement all other types of nursing interventions and document their effectiveness. It is important to use drugs for valid psychological problems, and not just for annoying behaviors.

Adaptation is necessary when using psychotropic drugs with the elderly. Many psychotropic drugs require an extended time to have a therapeutic effect.

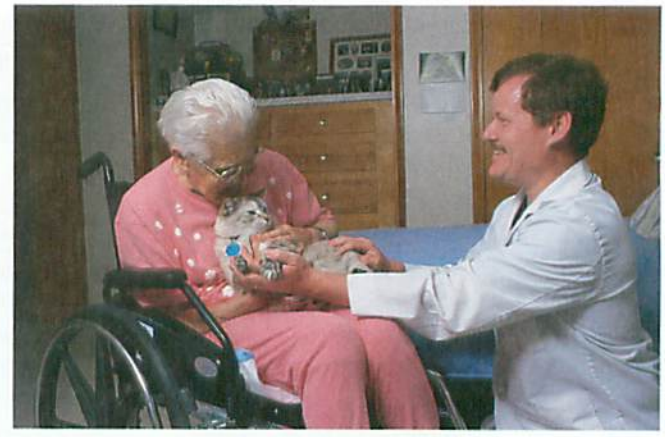

FIGURE 41-1 Pet therapy for the lonely, depressed elderly.

Toxicity and undesirable side effects such as constipation and orthostatic hypotension are not uncommon. Because of chronic health problems in an individual, some medications may be contraindicated or require careful administration. Thus patient and family teaching about medications is essential.

Major tranquilizers, also known as antipsychotics, such as chlorpromazine (Thorazine) or haloperidol (Haldol), are sometimes prescribed to manage the anxiety, agitation, hostility, and paranoia associated with dementia. In 2008 the U.S. Food and Drug Administration (FDA) ordered that a boxed ("black box") warning be placed on all antipsychotics when used with dementia-related psychosis, since they have been associated with increased risk of death (FDA, 2011). The "black box" warning is the strongest advisory the FDA makes before pulling a medication off the market. Legislators and hospital officials are scrutinizing the use of antipsychotics in nursing home residents. If an antipsychotic is prescribed, patients need to be closely monitored. **Minor tranquilizers** may also be used to treat symptoms of agitation and anxiety, although many medications in this category appear on the Beers Criteria (medication list) of Potentially Inappropriate Medications for the Elderly (Duke Clinical Research Institute, 2012). **Antidepressants** such as citalopram (Celexa) or duloxetine (Cymbalta) may be used if depression coexists with dementia. These drugs may improve appetite and sleep habits, enhance socialization, and increase energy levels. Hypnotics, antianxiety drugs, and anticonvulsants may also be helpful.

Think Critically

What interventions could you try before medicating a patient for anxiety or agitation?

Family Support. It is important to provide emotional and social support to the patient with dementia and to significant others. As caregivers, the entire family often experiences changes in lifestyle, privacy, and

socializaion. The caregiver may experience physical and mental exhaustion from providing round-the-clock care.

Adjusting to the reality that dementia is a chronic, irreversible condition that may result in a lingering death can be difficult. This places families in a situation of dealing with grief over a long time. Acceptance of a relative with dementia depends on personal coping strategies, support, and past experiences. Integrate the care of the family into the nursing care plan to enhance adjustment. Family members need ongoing support by the entire health care team. They may need an explanation regarding the disease or condition to help them better cope with the future.

Financial problems and multiple role responsibilities add to the burden of caregiving by the spouse or the adult children. Caregivers are also subject to loneliness, depression, and social isolation. An assessment of the caregiver's health and functional status, nutrition, and exercise patterns can allow for developing strategies to help families cope more effectively as caregivers. Encourage caregivers to take time out and attend to their own well-being.

Nurses can encourage families to consider adult day services or respite care if the elder resides at home. These types of care can provide for much-needed psychological and physical rest for the caregivers. Provide guidance in locating resources to explore. Referrals may include health care professionals, community mental health centers, area agencies on aging, or support groups for specific diseases such as AD.

Clinical Cues

Most large communities have respite care for those with dementia where the family caregivers can take the patient while they have a short break. For the patient who is a veteran, Department of Veterans Affairs facilities can often provide this care for up to 30 days each year. Often these are special units attached to a hospital or long-term care facility. Encourage qualified families to use this service.

Social implications for the resident in long-term care whose abilities continue to deteriorate relate to maintaining interactions with others for as long as possible. It is important to realize the family will continue to require support from the health care team.

Think Critically

What type of personal stress management strategies could you suggest to a caregiver of an Alzheimer patient?

ALZHEIMER DISEASE

Alzheimer disease (AD) is the most common form of dementia (estimates range from 60% to 80% of dementia patients) in the elderly and is the fifth leading cause of death in this population. With the graying of America, this disorder may pose a significant public health concern in future years.

Box 41-4 Stages of Alzheimer Disease

PRECLINICAL ALZHEIMER DISEASE
- Measurable biologic changes (biomarkers); specific biomarkers (yet to be named) may include brain imaging studies and protein in spinal fluid
- No obvious symptoms of memory loss or confusion
- Occurs years to perhaps decades before the next stage

MILD COGNITIVE IMPAIRMENT CAUSED BY ALZHEIMER DISEASE
- Mild changes in memory, reasoning, and visual perception
- Noticeable to person affected, friends, and family
- Capability of carrying out everyday activities

DEMENTIA CAUSED BY ALZHEIMER DISEASE
- Memory impairment
- Behavioral symptoms
- Impaired ability to function in daily life

Modified from Alzheimer's Association. (2011). *New diagnostic criteria for Alzheimer's disease.* Available at www.alz.org/research/diagnostic_criteria.

The loss of neurons in the frontal and temporal lobes accounts for the AD patient's inability to process and integrate new information and retrieve memory. Although many diagnostic tools are available to rule out some cognitive diseases, few can diagnose AD. Positron emission tomography (PET) has shown reduced lobe activity early in the disease. The diagnostic criteria for AD have been revised and now include three stages: preclinical AD, mild cognitive impairment, and dementia (Box 41-4). These stages are expected to be further refined, identifying specific biologic changes (biomarkers) for the disease.

Treatment and Nursing Interventions for Alzheimer Disease

Treatment is primarily symptomatic. Four cholinesterase inhibitor drugs—tacrine (Cognex), donepezil (Aricept), galantamine (Razadyne, formerly known as Reminyl), and rivastigmine (Exelon)—produce modest benefits early in the disease by improving memory, alertness, and social engagement. These drugs work by increasing acetylcholine in the cerebral cortex. Tacrine is associated with liver toxicity and is rarely prescribed, but if used must be monitored closely. Donepezil is administered once daily, causes less liver toxicity, and is also approved for late-stage use. Memantine (Namenda) is another type of medication, thought to protect nerve cells from excess stimulation from the neurotransmitter glutamate; it was the first treatment option for moderate to severe AD symptoms. Several new drugs are under development for AD, including medications delivered transdermally (by patch), nerve growth factor drugs, and antibodies that target and remove excess protein (beta amyloid) that builds up in the brains of Alzheimer patients.

Box 41-5 Nursing Diagnoses for the Cognitively Impaired Elder

- Acute confusion
- Anxiety
- Caregiver role strain
- Chronic low self-esteem
- Compromised family coping
- Deficient diversional activity
- Fatigue
- Fear
- Functional urinary incontinence
- Imbalanced nutrition: less than body requirements
- Impaired memory
- Impaired physical mobility
- Impaired social interaction
- Impaired verbal communication
- Interrupted family processes
- Risk for injury
- Risk for other-directed violence
- Self-care deficit
- Sleep deprivation

Other medications found to enhance cognitive functioning, improve behavioral problems, or delay the effects of the disease include estrogen, vitamin E, nonsteroidal anti-inflammatory drugs (NSAIDs), folic acid, and possibly the cholesterol-lowering statin drugs. General nursing interventions for AD patients depend on the severity of illness. Early in the disease process, nursing care for a confused patient (previously discussed) is necessary. Later in the disease process, nursing care is primarily supportive. Box 41-5 lists nursing diagnoses appropriate for the cognitively impaired older patient.

SAFETY FOR THE COGNITIVELY IMPAIRED

When a senior is cognitively impaired, home safety becomes an issue. When the impairment is mild, the patient may be able to stay in his own home safely. Otherwise, there must be adjustments to the living situation. When a person with dementia goes to live with relatives, they should attach alerting systems to outside doors to prevent the person from wandering out alone. Identification should be sewn into clothes and placed in a wallet or purse. An identification bracelet that is not easily removed is helpful if the person wanders. Measures need to be taken to alert the household if the person leaves the bedroom area at night so that the stove is not used without supervision. Sometimes residential placement is needed. Options include an assisted-living facility, a board-and-care facility, or a long-term care facility.

If the person still owns a car, driving is another safety issue. No one wants to give up independence. Families have great difficulty getting a senior to give up driving. One way to help is to suggest that a family member take the person wherever he wants to go for a month so that it becomes apparent that giving up the car doesn't mean staying at home. Another option is to research what alternative transportation is available and have a family member accompany the person the first few times that transportation is used. If that works well, then it can be pointed out that the person doesn't need to drive anymore to maintain his present lifestyle and independence. Another method is to see whether the person will consent to having an outside evaluation by a driver's education firm to determine safe driving capability. Of course, the person should only drive if confusion about direction is not an issue. Helpful information is available in the American Medical Association guide, *Physician's Guide to Assessing and Counseling Older Drivers* (www.ama-assn.org/ama/pub/category/10791.html). Driver rehabilitation specialists can be hired to help sharpen driving skills (www.driver-ed.org).

BEHAVIORS ASSOCIATED WITH COGNITIVE DISORDERS

Agitation, Hostility, and Paranoia

Violent behavior in the elderly may be the result of a lifelong psychological pattern, an organic condition, or an adverse reaction to multiple medications. Aggressive behavior may also occur as a self-protective response to confusion, fear, or sensory loss. Frequently it is associated with delirium, AD, other dementias, stroke, metabolic disorders, or hypoxia.

Agitation can be prevented and managed by watching carefully for signs of this behavior. Some patients show signs of increasing irritability before a severe problem occurs. Others may have sudden, explosive outbreaks. Notice if patients are talking very loudly, pacing more or faster, or making threats. Before an actual outburst occurs, try to engage the patient in conversation, using therapeutic communication skills (see Chapter 8). If seeing reflections in a mirror causes agitation, cover or remove the mirrors.

Matching the tone of the patient's voice may be calming. It may be advisable to step back 4 to 6 feet while conversing. With a patient who is disoriented or has a sensory deficit, you may want to approach more closely to maintain eye contact and touch. This must be done cautiously for everyone's protection. Move other patients or visitors out of the way as necessary.

Behavior modification is an intervention used to change agitated behavior by giving positive feedback for desired behaviors and negative feedback for undesired behaviors. Distraction may be used for the elder not favorably responding to behavior modification.

If a patient becomes violent, you must remember to protect the patient from his own behavior. You must call for help and, as a team member, decide what intervention will be most effective.

Points to consider for intervention are the patient's right to the least restrictive treatment and the federal and state regulations regarding the use of chemical

(medication) and physical protective devices. Before giving medications, it is necessary to try behavioral approaches and document their effectiveness. When all else fails and the patient poses a threat to his well-being or to others, protective devices may be necessary.

Paranoia can also be caused by dementia or psychological conditions such as schizophrenia. Patients with paranoia may misinterpret their environment and believe others are untrustworthy and out to get them. These patients may sound convincing and logical in their suspicious behaviors.

For the patient with paranoia, developing trust is the most important approach. Being consistent and reliable is perhaps the best way to develop trust in the relationship with the paranoid patient. Do not make promises you cannot keep. If you say you will do something, follow up with it. It is of utmost importance not to put any medication in a drink or food without the patient's knowledge so that trust is not broken.

? Think Critically

Why would it be especially important for you to offer explanations to a hearing-impaired patient experiencing paranoia or thinking that others are talking about him?

Wandering

Wandering may be a problem for the patient affected with a cognitive disorder. Wanderers tend to be individuals who were active before the onset of disease. For some, wandering may be goal directed, such as looking for the bathroom. Others may wander to combat boredom or restlessness. Nursing interventions include ensuring the environment is safe for wandering, informing and educating others about this problem, ensuring the patient has an identification bracelet, frequently checking the patient, observing for behaviors that trigger the wandering, diverting his attention, and maintaining a regular activity program. Many units are designed for wandering patients and even include gated outside areas in which to enjoy nature.

? Think Critically

What type of diversional activities could you use for a wandering patient who is trying to go home?

Sundown Syndrome

To alleviate the confusion and fears associated with sundowning, it is important for you to help the patient feel safe in his environment. Using a night-light, placing the call bell within reach, reducing stimulation in the environment, and moving the patient closer to the nurses' station can help minimize nocturnal confusion (Box 41-6). Protective devices should be used as a last-resort safety measure because they may add to the patient's anxiety.

Box 41-6 Proven Strategies and Interventions to Minimize Sundowning

- Limit outings and activities to the morning hours.
- For the person with Alzheimer disease, keep times of sensory stimulation short. Prevent sensory overload (e.g., television on, noisy children, lots of activity of others in the vicinity).
- Avoid caffeine drinks, caffeine-containing foods (such as chocolate), and sugar in the afternoon and evening.
- Prevent overnapping during the day, but keep the person well rested.
- Provide soothing music as dusk approaches and through the evening.
- Provide stimulating activities during the day along with exercise, but prevent exhaustion.
- Make certain physical needs are met and that the person isn't hungry, thirsty, wet, soiled, hot, or cold.
- Obtain treatment for arthritis or other discomfort, shortness of breath, urinary tract infection, cold or flu symptoms, etc.
- Provide a private "time-out" place for the person subject to sundowning.
- Keep surroundings as simple and familiar as possible with an uncluttered appearance. Remove mirrors and pictures if they seem to cause the person distress. Avoid changing things in the environment around once simplified.

? Think Critically

What would it feel like to awaken at night and think that the shadow cast on the wall is someone leaning over you with a knife?

Eating Problems

Adequate nutrition often becomes a problem for the patient with dementia. Common feeding challenges include lacking an appetite, refusing to open the mouth, holding food in the mouth, refusing to swallow food, and choking when swallowing.

Patient Teaching

Strategies to Improve Nutritional Status of the Cognitively Impaired Elder

- Provide mealtime companionship in a stress-free environment.
- Provide proper oral hygiene and properly fitting dentures.
- Inspect the mouth for gum or dental problems.
- Identify the "hungry time" of day.
- Serve meals in same place and at the same time.
- Provide frequent small meals and nutritious snacks.
- Serve favorite foods if possible.
- Limit food choices, and serve them in an attractive manner.
- Serve one food at a time to decrease confusion.
- Use liquid thickeners to prevent aspiration.
- Remind patient to open mouth, chew, and swallow.
- Avoid hurrying patient to eat.

DEPRESSION, ALCOHOLISM, AND SUICIDE

Depression (feelings of sadness, despair, or discouragement) in the elderly is often overlooked and untreated. It is the most common functional mental illness in the elderly, but is often mistaken for delirium or dementia. Up to half of long-term care residents have depression, and only about 25% of these cases are identified and treated (Spader, 2010).

Depression is often difficult to recognize because symptoms may be attributed to the aging process. Instead of complaining of a depressed mood, the elderly may complain of anorexia, sleep disturbances, lack of energy, and loss of interest and enjoyment in life. Depression in the elderly occurs to a great degree as a result of situational factors such as multiple losses. It is helpful to assess the elderly patient's mood periodically (Box 41-7). Undiagnosed and untreated, depression is a major contributor to alcoholism and suicide in the elderly.

Focused Assessment

Assessment of Depression in the Elderly

Signs and symptoms to look for include the following.

PHYSICAL ASSESSMENT

- Fatigue
- Headaches
- "Not feeling good"
- Memory impairment
- Vague aches and pains

PSYCHOSOCIAL ASSESSMENT

- Social withdrawal
- Loss of motivation and energy
- Envy or criticism of others
- Increasing demands on others
- Feelings of worthlessness and helplessness
- Appetite changes
- Sleep pattern changes
- Indecisiveness
- Obsessive worrying
- Poor outlook on life

Alcohol abuse, suicide, and depression are interrelated in that they each have similar risk factors associated with multiple losses. Loss of status and power, income, spouse, friends, health, and mobility contribute to feelings of despair and hopelessness. The elder's outlook on life is distorted, preventing him from exploring acceptable solutions to his problems.

Alcohol misuse is a serious concern in the elderly because it can interfere with the management of chronic diseases and heighten the risk of adverse drug reactions because of diminishing liver and kidney function. Alcoholism is often overlooked because so many elder problem drinkers are retired and hidden at home. Clues to alcoholism include depression, insomnia, mental confusion, frequent falls, self-neglect, and uncontrollable hypertension or diabetes, along with gastritis and anemia.

Box 41-7 Questionnaire to Determine Presence of Depression

MOOD SCALE (SHORT FORM)

Choose the best answer for how you have felt over the past week:

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

Modified from Yesavage, J. A., Brink, T. L., Rose, T. L., Lum, O., Huang, V., Adey, M. B., Leirer, V. O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17*(1), 37-49. Available at www.stanford.edu/~yesavage/GDS.html.

INTERVENTIONS FOR DEPRESSION, ALCOHOLISM, AND SUICIDE PREVENTION

Patients who are depressed are usually treated with psychotherapy and antidepressants. Hospitalization may be necessary if the patient is at risk of suicide.

Complementary and Alternative Therapies

Omega-3 Fatty Acids

New research suggests that omega-3 fatty acids may alleviate depression without dangerous side effects. Omega-3 fatty acids also aid cognition. Cod liver oil is rich in omega-3 fatty acids. Eating fish such as salmon, sardines, mackerel, and tuna can increase omega-3 intake. For those who do not like fish, supplement capsules of omega-3 fatty acids are available (Barclay, 2007).

The three main categories of medications used to treat depression are the tricyclic antidepressants, the monoamine oxidase inhibitors (MAOIs), and the **selective serotonin reuptake inhibitors (SSRIs).** Table 41-3 lists examples and important considerations for these medications.

Table 41-3 Antidepressants Used with Elders

	TRICYCLIC ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS (MAOIs)	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)
Examples	Amoxapine (Asendin) Amitriptyline hydrochloride (Elavil)	Phenelzine sulfate (Nardil) Tranylcypromine (Parnate)	Fluoxetine hydrochloride (Prozac) Sertraline hydrochloride (Zoloft) Paroxetine hydrochloride (Paxil) Citalopram (Celexa) Duloxetine (Cymbalta) Venlafaxine hydrochloride (Effexor)
Mode of action	Block reuptake of norepinephrine and serotonin	Affect monoamine neurotransmitter system	Inhibit reuptake of serotonin
Side effects, elder considerations	Dry mouth, blurred vision, tachycardia, constipation, urinary retention	Fewer cardiac side effects (compared with tricyclics) as long as tyramine-free diet adhered to	Start elderly with low dose Main side effect: gastrointestinal distress Dose tapered downward when drug is discontinued
Contraindications, precautions, and alerts	Contraindicated in patients with recent myocardial infarction or cardiac arrhythmias; increased risk of **death** in postmenopausal women	Tyramine-free diet required to avoid risk of **hypertensive crisis;** MAOIs interact with numerous prescribed and over-the-counter medications	SSRIs associated with **hemorrhagic and fatal stroke** in postmenopausal women *in one* large study (Smoller et al., 2009)
Other	Rarely prescribed since the development of SSRIs	Rarely prescribed because of drug-food interactions (tyramine)	Newest of the 3 categories; most commonly prescribed

Data from Kee, J. L. (2011). *Pharmacology: A Nursing Process Approach* (7th ed.). Philadelphia: Elsevier Saunders; Meiner, S. E. (2011). *Gerontologic Nursing* (4th ed.). St. Louis: Elsevier Mosby; and Smoller, J. W., Allison, M., Cochrane, B. B., Curb, J. D., Perlis, R. H., Robinson, J.G., et. al. (2009). Antidepressant use and risk of incident cardiovascular morbidity and mortality among postmenopausal women in the Women's Health Initiative study. *Archives of Internal Medicine, 169*(22): 2128-2139.

Electroconvulsive therapy (ECT) is a treatment option for those patients who have severe forms of depression and have not responded to several regimens of medication. ECT consists of electric shock to the brain delivered via electrodes attached to the patient's temples, producing tonic-clonic seizures. How this mechanism works is not clearly understood. The patient usually receives two or three treatments per week for several weeks.

The primary nursing responsibility for a depressed patient is to protect him from self-injury, especially *after* the patient has initiated antidepressant therapy. Before that time, he may not have the energy to commit suicide.

It may be difficult to communicate with a depressed patient because of his negative thoughts and behaviors. Genuine concern for the patient is essential. You need to help him set realistic, achievable goals. Start with small goals such as grooming and slowly work toward larger goals. Remember that goal setting and problem solving take concentration and energy that may not be available to the person who is still somewhat depressed. Providing a quiet environment conducive to sleep can help restore energy for individuals who complain of sleep deprivation.

Caregivers need to be alert to signs of potential suicide such as meticulous planning of personal affairs, giving away of treasured possessions, sudden euphoria, or statements of death wishes. Assisting the patient in improving self-esteem and taking part in meaningful activities may resolve the intent of suicide. It is important for you to build a trusting relationship with the suicidal patient to let him know you care. Spending time with your patient and actively listening are important ways of showing your concern.

If the patient makes references to suicide, ask him directly if he is planning to end his life. Referral to a mental health care provider or immediate crisis intervention is important for evaluation and treatment of suicidal behavior. However, as with any individual who believes suicide is the only answer, the elder may eventually carry out this act. In such cases, caregivers and family need support and possible counseling to resolve their grief.

? Think Critically

What response would you have for the elder who tells you he wishes he could go to sleep for the last time?

During the admission patient interview, assess the use of alcohol by depressed elders. Making a diagnosis of alcohol dependency is not necessarily difficult, but unless the patient admits he has a problem, long-term recovery is unlikely. Initial treatment for the older adult may consist of detoxification and stabilization in the hospital with reduced doses of benzodiazepines or shorter acting benzodiazepines and vitamin supplements. Once the patient is stable, therapy may consist

of group, behavioral, or individual therapy to help with depression, loneliness, and loss and to help build a social network.

Patient and family teaching must include information about the effects of alcohol on medications and on chronic health conditions. Referral to a 12-step program such as Alcoholics Anonymous (AA) for the patient, and Al-Anon for family members, can also be a beneficial part of treatment.

CRIMES AGAINST THE ELDERLY

ELDER ABUSE

Abuse is defined as the intentional infliction of physical or emotional discomfort or the deprivation of basic necessities for comfort or survival. It is estimated that only 1 in 14 cases of elder abuse is reported.

Elder abuse is most often inflicted by a spouse or adult children in the home, and it is often undetected. It is often related to caregiver stress, unresolved family conflicts, or families with a history of abuse. All forms of abuse are destructive and at the very least reduce the victim's self-esteem. Box 41-8 identifies the five different categories of abuse.

? Think Critically

Can you remember an incident in which perhaps you suspected abuse of a friend or an acquaintance?

The nurse's responsibilities include identifying those at risk and reporting suspected abuse. During assessment of potential abuse, avoid a condescending tone of voice or judgmental expression. Establishing a confidential, trusting relationship is necessary. Be certain to show a willingness to also listen to the caregiver's perspective. Assess the caregiver's early memories of relationships with the elder to learn of possible long-term conflicts.

Box 41-8 Categories of Elder Abuse

- **Physical:** Infliction of physical pain and injury via assault and battery. Using physical restraints or confining people against their will is also classified as physical abuse. It may also include the inappropriate use of drugs.
- **Sexual:** Infliction of nonconsensual sexual contact of any kind.
- **Psychological:** Verbal harassment, including intimidation, defamation, and isolation. It may also include threats of abandonment or physical violence. Psychological abuse laws vary from state to state.
- **Material:** Theft of elder's money, misuse of funds, or theft or misuse of possessions.
- **Neglect:** Failure to meet the needs of the elder, including leaving the person alone; withholding medication, food, or other necessities; and not assisting with activities of daily living or providing inadequate care.

Focused Assessment

Assessment of Suspected Signs and Symptoms of Abuse in the Elderly

When working with the elderly patient, be observant for the following:

- Unkempt, inappropriate dress and hygiene
- Malnourishment, dehydration
- Bruises or fractures of undetermined cause; cigarette burns
- Conflicting explanations about elder's condition
- Unusual fear exhibited by the elder
- Confusion not attributable to other causes
- Abnormal behavior in the caregiver
- Hostility displayed by caregiver in response to questions

You have a legal obligation to report elder abuse and are accorded protection from civil liability in most states that mandate reporting suspected abuse, as long as you made the report based on reasonable suspicion and in good faith (Meiner, 2011). Evidence of suspected abuse should be reported immediately to the appropriate agency for investigation. **The standard for reporting is usually a reasonable belief that an individual has been or is likely to be abused, neglected, or exploited.** Be aware that advocacy for the abused may be difficult because you may receive threats from those who resent your involvement. A common frustrating situation is the competent elder with full legal rights who refuses help or desires to remain in an environment that is unsafe or unacceptable. In this case the health care team must provide counseling about potential dangers but then honor the person's decision. If a person is legally incompetent, steps need to be taken for appropriate guardianship. Testifying in court about an abusive situation can be stressful for everyone involved.

Individual and/or group psychotherapy is often used to treat both victims and abusers. The victim should be removed from the home before entering treatment to avoid retaliation. Intensive psychotherapy may be necessary for the abuser with psychopathology. Support groups are also available for both victims and abusers. Long-term follow-up is essential to prevent further abuse.

SCAMS AND WHITE-COLLAR CRIME

Crime is of particular concern to the elderly because of their sense of vulnerability. Older adults do not suffer any greater physical injury or financial loss than younger people; however, the effects of crime, such as fear, isolation, loneliness, and feelings of powerlessness, may be more detrimental. Elders may even fall prey to Internet scams such as receiving email from someone posing as a relative emailing from a foreign land, who has "lost their wallet and passport." Location and income are often more significant than age in predicting crime. Some of the various crimes against older adults are listed in Box 41-9.

Box 41-9 Crimes or Scams Against the Elderly

- Personal or household theft
- Vehicular theft
- Purse snatching, pickpocketing
- Investment theft
- Mailbox theft
- Rape
- Assault
- Fraudulent schemes through white-collar crime
  - Donations, fundraisers
  - Investments
  - Toll-free numbers
  - Prize offers
  - Funeral planning
  - Home improvements
  - Telemarketing
  - Timesharing
  - Auto repair
  - Medical quackery

Nurses can be instrumental in reducing fear of crime and assisting elders in exploring security-conscious behaviors that will decrease vulnerability to victimization.

Patient Teaching

Crime Reduction Suggestions for the Elderly

Teach patients and people in the community the following:

- Attend a crime prevention program.
- Identify police or security personnel available in high-risk areas.
- Institute an informal surveillance or buddy system among neighbors.
- Keep doors locked with dead-bolt locks.
- Do not attach identification to key rings.
- If keys are lost, have locks changed.
- Lock windows; draw blinds or curtains at night.
- Keep all hidden entries such as garage or basement doors locked.
- Use a peephole. Confirm service person's identity by calling the service agency first before opening the door.
- Do not let strangers at your door or on the telephone know you are alone.
- Beware of telephone tricks; do not give information to strangers. Hang up on and report nuisance callers.
- Consider a pet to provide protection.
- Travel in groups.
- Carry a whistle or wear one around your neck.
- Carry few valuables on yourself; hide key and other valuables in inside pockets.
- Protect assets; keep money in bank; use direct deposit of Social Security and pension funds.

Think Critically

Can you think of a situation in which an elder you know was subtly scammed by a business?

Nurses also need to learn about referral programs in crime protection, prevention, and victim assistance. Federal programs through the U.S. Department of Housing and Urban Development offer crime prevention and victim counseling. State offices of aging and organizations such as AARP (formerly the American Association of Retired Persons) and National Crime Prevention Council have also proved beneficial in enhancing awareness of crime prevention.

FUTURE ISSUES OF CONCERN TO THE ELDERLY

It is not easy to predict the future, but the most appropriate word for the older-aged population may be *increasing*, in both number and age. The elderly will be the fastest growing segment of the population and will have the greatest effect on the delivery of health care. Older adults of tomorrow will be better educated, more involved in community and political activities, more Internet savvy, and more knowledgeable consumers of health care.

What will be the priorities in the future? How much funding will go toward research of life-threatening diseases of the elderly versus solving environmental problems that affect all populations? With the nation's long list of priorities, what decisions will be made?

Think Critically

What health care issues do you think **you** might face when you become elderly?

PLANNING FOR THE FUTURE

Expanding present services and developing new delivery systems will be challenges for the future. Safe housing and efficient mass transportation to stores and recreational facilities will continue to be needed, along with one-stop-shopping senior centers. This concept can allow for the coordination of multiple services such as home-delivered meals and chore services at a nominal cost, which can make a difference as to whether a person can remain at home or must be institutionalized.

Planning for the future will need to include lifelong learning opportunities that assist the elder with maintaining wellness, preparing for retirement and leisure time, financial planning, and coping with advances in technology. Other considerations are job training and retraining for "early retirees" who wish to remain employed. Health issues to be addressed include the rapidly rising rate of AIDS in the elderly and the health problems specific to the growing proportion of elderly women.

As we have discussed throughout this book, *Healthy People 2020* is a federal campaign designed to encourage people to adopt healthy lifestyles to maintain or improve their health. Emphasis is on health

promotion, protection, and prevention. The overall goal for older adults is to "improve the health, function, and quality of life of older adults."

Will the programs and services discussed become realities? The answer lies partially with the elderly of today. Individuals over 65 form a powerful political group with real voting power that can effectively make change happen. Combined with the advocacy of nursing power to access necessary resources, the new goals of *Healthy People 2020* can realistically be achieved.

Get Ready for the NCLEX® Examination!

Key Points

- Mental confusion and forgetfulness are not age-related processes.
- A comprehensive mental status examination, medical history, and physical examination are necessary before making a judgment about the cause of altered cognitive functioning.
- Confusion can be caused by delirium, dementia, or numerous other, often reversible, conditions.
- Cognitive changes associated with dementia, delirium, and depression are similar and must be differentiated through careful assessment.
- Behavioral management of the confused patient includes first psychosocial approaches and then medication, if psychosocial approaches are ineffective.
- A significant consideration in managing dementia is providing emotional and social support to both the patient and significant others.
- AD is the most common form of dementia and the fifth leading cause of death in the elderly.
- Common behaviors associated with cognitive disorders include agitation, hostility, paranoia, wandering, and sundown syndrome.
- Depression is the most common functional mental illness in the elderly. It is often undertreated, since symptoms may be attributed to aging.
- Alcohol abuse, suicide, and depression are interrelated and have similar risk factors.
- The exact number of abused elders is difficult to determine due to underreporting.
- Protection from civil liability is accorded to nurses who report abuse in good faith.
- Crimes and scams against the elderly include white-collar fraudulent schemes by professional people.
- Planning for the future for the elderly should include lifelong learning opportunities that address maintaining wellness; retirement, leisure, and financial planning; job training or retraining; and coping with advances in technology.

Additional Learning Resources

SG Go to your Study Guide for additional learning activities to help you master this chapter content.

evolve Go to your Evolve website (http://evolve.elsevier.com/deWit/fundamental) for the following FREE learning resources:

- Animations
- Answer Guidelines for Think Critically boxes and Critical Thinking Questions and Activities
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions for the NCLEX® Examination and more!

Online Resources

- *Alzheimer's Association*, www.alz.org
- *Geriatric Resources, Inc.*, www.geriatric-resources.com
- Rush Alzheimer's Disease Center (2004). *The Rush Manual for Caregivers* (6th ed.). Chicago: Author. Available at www.rush.edu/Rush_Document/CaregiversManual.pdf.
- Torres-Stanovik, R. (Ed.). (1990). *Alzheimer's Caregivers Handbook*. San Diego: Caregiver Education and Support Services, San Diego County Mental Health Services. Available at www.longtermcarelink.net/eldercare/the_caregivers_handbook.htm.
- *National Crime Prevention Council*, www.ncpc.org

Review Questions for the NCLEX® Examination

*Choose the **best** answer for each question.*

1. When it comes to learning, the elderly are:
   1. as capable as younger people, but slower to learn.
   2. less able to learn than younger people.
   3. able to learn as well as younger people.
   4. about a third less efficient at learning than a younger person.

2. Confusion is often a reversible condition in patients with:
   1. dementia.
   2. depression.
   3. delirium.
   4. Alzheimer disease.

3. Measures to keep the cognitively impaired elder safe in a home environment include: *(Select all that apply.)*
   1. placing alarms on the outside doors.
   2. removing knobs from the stove burners and oven at night.
   3. having the person carry a cell phone at all times.
   4. placing an identification bracelet on the person.
   5. getting the person a guide dog.

4. Which symptoms is the nurse most likely to observe in a depressed, elderly patient? *(Select all that apply.)*
   1. Anger
   2. Poor memory
   3. Insomnia
   4. Loss of motivation

5. Medications that work by increasing acetylcholine in the cerebral cortex may produce:
   1. a calming effect and less hostility.
   2. greater ability to organize and carry out tasks.
   3. greater ability to concentrate and learn new things.
   4. improved memory, alertness, and social engagement.

6. You recently admitted a patient with Alzheimer disease to your long-term care nursing unit. This patient appears restless and agitated. What should you do first?
   1. Obtain an order for restraints.
   2. Medicate the patient with Haldol.
   3. Assist the patient in attending his scheduled music group therapy.
   4. Obtain an order for Cymbalta.

7. When you suspect an elder is considering suicide, the most appropriate intervention is to:
   1. discuss suspicions with a significant other.
   2. ask the patient directly about such plans.
   3. constantly watch the patient.
   4. refer for mental health counseling.

8. The usual standard for reporting elder abuse is one:
   1. of 100% certainty.
   2. of reasonable belief that abuse has occurred or may occur.
   3. that is beyond a shadow of a doubt.
   4. with testimony of one or more eyewitnesses.

9. Long-term recovery from alcohol abuse is most likely to occur when:
   1. the family is supportive.
   2. the patient uses Antabuse.
   3. the patient undergoes detoxification with Librium.
   4. the patient admits to having a problem.

10. Strategies to help prevent crime include: *(Select all that apply.)*
    1. changing door locks after losing keys.
    2. using direct deposit for pension funds.
    3. using an informal buddy system in the neighborhood.
    4. checking a service person's ID after letting him in.
    5. avoiding clicking on an e-mail link from an unexpected or unknown sender.

Critical Thinking Activity

Read the clinical scenario and discuss the questions with your classmates.

Your 75-year-old male patient who is being discharged to his daughter's home has just been diagnosed with mild cognitive impairment. He has a history of alcohol abuse, but has "not had a drink in a couple of years." Donepezil has been prescribed in hopes of slowing disease progression.

1. What pharmacologic concerns might you have for this individual?
2. What type of education could you do with his family?
3. What type of community services could you refer the patient's daughter to for help in managing this disorder?

appendix

A American Nurses Association Standards of Practice

STANDARD 1. ASSESSMENT

The registered nurse collects comprehensive data pertinent to the patient's health or the situation.

Measurement Criteria

The registered nurse:

- Collects data in a systematic and ongoing process.
- Involves the patient, family, other healthcare providers, and environment, as appropriate, in holistic data collection.
- Prioritizes data collection activities based on the patient's immediate condition, or anticipated needs of the patient or situation.
- Uses appropriate evidence-based assessment techniques and instruments in collecting pertinent data.
- Uses analytical models and problem-solving tools.
- Synthesizes available data, information, and knowledge relevant to the situation to identify patterns and variances.
- Documents relevant data in a retrievable format.

STANDARD 2. DIAGNOSIS

The registered nurse analyzes the assessment data to determine the diagnoses or issues.

Measurement Criteria

The registered nurse:

- Derives the diagnoses or issues based on assessment data.
- Validates the diagnoses or issues with the patient, family, and other healthcare providers when possible and appropriate.
- Documents diagnoses or issues in a manner that facilitates the determination of the expected outcomes and plan.

STANDARD 3. OUTCOMES IDENTIFICATION

The registered nurse identifies expected outcomes for a plan individualized to the patient or the situation.

Measurement Criteria

The registered nurse:

- Involves the patient, family, and other healthcare providers in formulating expected outcomes when possible and appropriate.
- Derives culturally appropriate expected outcomes from the diagnoses.
- Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise when formulating expected outcomes.
- Defines expected outcomes in terms of the patient, patient values, ethical considerations, environment, or situation with such consideration as associated risks, benefits and costs, and current scientific evidence.
- Includes a time estimate for attainment of expected outcomes.
- Develops expected outcomes that provide direction for continuity of care.
- Modifies expected outcomes based on changes in the status of the patient or evaluation of the situation.
- Documents expected outcomes as measurable goals.

STANDARD 4. PLANNING

The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Measurement Criteria

The registered nurse:

- Develops an individualized plan considering patient characteristics or the situation (e.g., age and culturally appropriate, environmentally sensitive).
- Develops the plan in conjunction with the patient, family, and others, as appropriate.
- Includes strategies within the plan that address each of the identified nursing diagnoses or issues, which may include strategies for promotion and restoration of health and prevention of illness, injury, and disease.
- Provides for continuity within the plan.
- Incorporates an implementation pathway or timeline within the plan.
- Establishes the plan priorities with the patient, family, and others as appropriate.
- Utilizes the plan to provide direction to other members of the healthcare team.
