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The Evidences Based Protocol of Depression in the Elderly People

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Abstract

Aim: The purpose of this study was to develop the evidences-based protocol for depression in the elderly people.

Study Design: Integrated literature review.

Methodology: Integrated literature review in the systems of Chinese CEPS, Cinahl, Cochrone Library systems by the three keywords of depression, elderly, and evidences-based nursing.

Findings: The evidences-based protocol of depression in the elderly people was developed based on the validate literature that could be tested in the future for the elders who have or have not dementia. For those who do not have dementia, the protocol could screen the elders who were pseudo or truly dementia. For those who do have dementia, the protocol could go for the specific Comell Scale for Depression in Dementia (CSDD) for dementia elders. The pharmacological interventions were for the major depression elders; for instance, TCAs and SSRIs were applied in the acute stage, while, duloxetine, and alternative treatment as GMDZ were used in the relapse and maintaining stages. Additionally, the non-pharmacological interventions including the exercises, yoga, physical touch, music, art, horticultural, reminiscence, cognitive and psychotherapy therapies were suggested for the moderate and minor depression elders. The core nursing care issue for the major depression elders was the safety, for the moderate depression elders was autonomy, for the minor depression elders was the community and home care.

Conclusion: The evidences-based protocol of depression in the elderly people could provide the healthcare professionals in the long-term care facilities as the reference to care those who have or have not dementia

Keywords: Depression; Elderly; Evidences; Nursing health care

Introduction

Depression will be the second leading cause of disability worldwide and prevalent in developing countries globally according to the World Health Organization (WHO) report by 2020 [1]. The epidemiological study identified 35.2% of elderly depression in whole Taiwan, and 21.2% in the southern Taiwan. Additionally, the prevalence of elderly expression was 45.7%, 36.2%, and 22.2% in those living in nursing homes, intermediate care facilities, and domiciliary care facilities, respectively additionally, 64% of hospitalized elderly people have depression in Taiwan. Depression exerts severe influences in the physical, psychological, and social functions. The significant association of depression symptoms with recurrent falls twice during the past 2 years among the elderly population was identified in the systematic review literature. Additionally, the elderly people with mild, early-diagnosed, and relapsed depression reported a high risk of dementia based on many research findings. Furthermore, the consequences of depression disorders were the major factors causing a high risk of suicide for the elders and also reported a heavy burden on the family and society. The integrated literature review of depression in elderly people has identified the defining characteristics, related factors, assessment scales, pharmacological and non-pharmacological interventions of depression in elderly people. Although the pharmacological and non-pharmacological interventions of depression in elderly people have been reported, the comprehensive content and process of the evidences-based protocol was not yet developed.

Purpose: The purpose of this article was to develop the evidences-based protocol for depression in the elderly people.

Methodology

The authors applied three keywords of depression, elderly, nursing into Chinese CEPS, Cinahl, Cochrone Library systems with the selecting criteria by two authors in terms of the ABC evidences-based levels Regarding major depression, two unique interventions are providing the rules of patient safety for suicide prevention following the regulation of Organization, Providing OPD emergency patients the psychiatric assessment continuously to control or heal the etiology of depression. Regarding moderate and minor depression, five general interventions are promoting autonomy of self-control and self-efficacy as elders could participate in arranging their daily life schedule in a short term goal, identifying and promoting the strengths and current abilities of elders, providing the information of depression illness and treatment, Regarding physical touch, a single study of six elders who have conducted intimacy massage twice a day with 30 mins for three days of total six times and results identified the intimacy massage did significantly reduce the older depression and demonstrated will be shown in the following Figure 1.

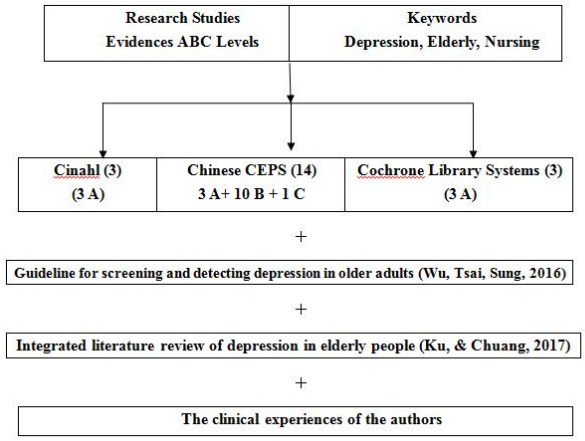

Figure 1: Depression of Evidences-Based levels.

Results

Among 18 evidences-based studies for depression in elderly people from 2008 to 2017, 14 studies from Chinese CEPS with 3A, 10B, and 1C evidences-based levels of research articles, 3 A evidence-based levels of studies from cinch and Cochrane library systems separately. Except for the 18 evidences-based studies, a guideline for screening and detecting depression in older adults the integrated literature review of depression in elderly people [2], and the clinical experiences of the authors were included into the evidences-based protocol for depression in the elderly people. Regarding 3 pharmacological interventions, the acute, relapse, and prevention stages of medical treatment for depression in the elderly population included alleviating the symptoms, maintaining healthy function, and preventing the recurrence of depression [3,4]. Specifically, the recurrent major depression in people aged 65 years or older with major depressive disorder could be alleviated by duloxetine taken for 8 weeks, but it also increases the risk of side effects such as thirst, constipation, diarrhea, and dizziness [4-6]. Compared with anti-depression medicines, herbal medicine only alleviates post-stroke depression in elderly people as the alternative treatment; however, it could not provide evidence for major depression and post-surgical depression [7]. For 15 non-pharmacological interventions for depression in elderly people included 5 exercises, 2 physical touch, 1 music therapy, 1 art therapy, 1 horticultural therapy, 2 reminiscence therapies, 1 cognitive therapy, and 2 psychotherapies. Regarding exercises, exercise therapy decreases the depression symptoms of elderly people and improves their self-esteem and quality of life by systematically reviewing 461 clinical trials [8]. After integrate literature review related to elderly depression and exercise, the short-term period and low strength of exercises could not significantly impact on elderly depression; however, the more participating into the exercise, the less level of depression was identified for the elderly people, results in improving their health, reducing the risk factor of illness, and increasing their body function [9,10]. A cross-sectional study and interviewed 1020 community-dwelling elders who exercised regularly tended to have a lower risk of depressive symptoms than their peers who did not exercise regularly and regular exercise was the only factor significantly related to a lack of depressive symptom for both groups of elderly men and women [11-14]. Except for the exercise, yoga is one kind of exercise for elderly people. After systematic review of literature, the depression of elders have significantly improved after conducting the yoga exercises; however, the quality of sleep could not be changed until 6 months later regardless of the frequencies and periods of yoga exercise courses [15]. Additionally, the other study identified that yoga exercises significantly decreased depression, sleep disturbance, and daytime dysfunction in 38 elderly people after 6 months [16].

Immediately however, once stop doing the massage, the elderly depression would be increased again, which means that intimacy massage could not maintain the function of reducing the elderly depression [17,18]. Additionally, after receiving the robot-assisted therapy by PARO for 40 mins, twice a week for 4 weeks, the depression and agitated behaviors of 12 older people with dementia significantly improved along with their verbal and body interactions were facilitated by nurses [19]. Regarding music therapy, a quasi-experimental study of 36 hospitalized elders who have listened the music from the third to seventh days with 30 mins daily in the experimental group comparing with the 33 ones in the control group and results identified that the depression scores were significantly lower in the experimental group than the control group [20]. For art therapy, the quasi- experimental study of 29 nursing home elders who have participated in 6 weeks of creative art activities twice a week with one hr each time of total 12 times comparing with 26 ones in the control group and results identified that depression scores in both groups were significantly improved, but the level of improvement was superior in the experimental group [21]. Regarding horticultural therapy, the depression and loneliness of 10 elderly patients living in a nursing home who underwent a 10-week program of indoor horticultural therapy with one 1.5-hrs session per week showed the significant improvements in terms of depression scores and the four positive themes of social connection, anticipation and hope, sense of achievement, and companionship [22].

For the reminiscence therapy, a systematic review and meta-analysis of 13 relevant studies with 852 cases to analyze the effects of reminiscence therapy in institutionalized elders and results identified that the reminiscence therapy did significantly improve the elderly depression [23]. For the reminiscence group, one quasi-experimental study of 12 elders in care home who have participated in the 8 units of reminiscence activities with 45 to 60 mins each unit comparing with the control group and results identified that depression scores in the experimental group were significantly decreased, but increased after closing the reminiscence activities six months later [24]. Regarding cognitive therapy, the significantly improved cognitive functions and decreased neuropsychiatric symptoms such as hallucinations, depression, apathetic expression, irritability, bizarre behavior among [23] elderly people with dementia who underwent individualized learning therapy for 30 minutes, twice a week was the evidences of this therapy Regarding psychotherapy, a medium effect size of psychotherapy for decreasing depression symptoms in elderly people, and the effect was maintained at follow-up by a meta-analysis of 17 clinical trials [25]. Among all types of psychotherapies, the Cognitive Behavioral Therapies (CBT), psychodynamic therapy, interpersonal therapy and supportive therapies, only a highly significant difference among groups was found in favor of CBT based on 7 trials for older depressed people and the authors suggested those elders suffered from mild depression and lived in a community setting that have the highly potential of being treated by the bibliotherapy [26].

The Evidences-Based Protocol of Depression in the elderly People

Based on the evidences-based guideline for screening and detecting depression in elderly people [27], the integrated literature review of depression in elderly people, integrate reviewing of 18 evidences-based literature on depression of elderly people, and the clinical experiences of the authors, an evidences-based protocol of depression in the elderly people is demonstrated in the Appendix I. Initially, healthcare professionals could identify the high risk group of elderly depression by assessing their defining characteristics, clinical indicators, and related factors. Lately, MMSE was tested their cognitive function as the normal (MMSE>23), and abnormal (MMSE<23) as well as the light abnormal and serious abnormal (MMSE<15). Furthermore, GDS was tested in the group of normal and light abnormal cognitive function to distinguish the pseudo-dementia from the truly-dementia. The elders with serious abnormal cognition were tested by Comell Scale for Depression in Dementia (CSDD) which is the specific depression scale for dementia elders. Regarding depression elders with the normal cognition, GDS scores are categorized into three groups of the major depression (GDS ≤ 11), moderate depression (GDS>6), and minor depression (GDS<6). Regarding depression elders with light abnormal cognition, GDS scores are categorized into two groups of the serious depression (GDS>6) and light depression (GDS<6). Similarly, regarding depression elders with the serious abnormal cognition, GDS scores are categorized into two groups of the serious depression (GDS>11) and light depression (GDS<11). All of different levels of cognition and depression for the elders are following up and referring by the different instructions shown in the Appendix I. Following the data of above assessment, the evidences-based interventions of depression in the elderly people are divided into the general interventions for all levels of depression, especially for the major depression, moderate/minor depression, and minor depression. There are many individual interventions under each category shown in the Appendix II. Eight general interventions for all levels of depression of elderly people included [28]

- Controlling or healing the etiology of depression.
- Avoiding stopping or changing the medicines which might induce the depression easily.
- Modifying or treating the interfere factors from the metabolism and body systems assessing and promoting the nutrition, elimination, sleep/rest pattern, physical comfort and releasing pain.
- Promoting physical function as regular exercises/activities, referring to physical or recreational therapies, arranging daily life schedule.
- Providing the social support as identifying the major supporter, spiritual needs, and related religion people.
- Assisting the problem-solving.
- Providing the psychological support as empathy, supportive listening, and encouraged expressing feeling, enhancing expectation, copying and adaptation, the positive joy of life review.

Regarding moderate and minor depression, five general interventions are promoting autonomy of self-control and self-efficacy as elders could participate in arranging their daily life schedule in a short term goal, identifying and promoting the strengths and current abilities of elders, providing the information of depression illness and treatment, educating the important regulations of taking anti-depression medications regularly to avoid relapse of illness and side effects of medicines, educating assistant or alternative therapies to alleviate the emotion as exercises, intimacy massage, music therapy, art therapy, horticultural therapy, reminiscence therapy, cognitive therapy, and psychotherapy Regarding minor depression, one unique intervention is to identify the psychiatric health care system in the community and consider psychiatric nursing home care [29].

Discussion and Conclusion

Active screening and post-screening services appropriately are crucial for the prevention of elderly depression. Therefore, the evidences-based protocol of depression in the elderly people was developed for screening the elderly depression comprehensively along with general and specific nursing interventions for the different levels of elderly cognition and depression. Additionally, the pharmacological and non-pharmacological interventions for depression in elderly people were developed in this article. The pharmacological interventions before 2010 [30] were focused on three major antidepressants (TCAs, SSRIs and MAOIs) which were effective in the treatment of older people, despite the relative under-treatment of older depressed. Although TCAs and SSRIs were the same efficacy; however, TCAs had the different gastro-intestinal and neuropsychiatric side effect profiles as well as associated with differing withdrawal rates when compared with SSRI. Additionally, antidepressant treatment of four weeks was likely to have a beneficial effect compared to placebo Furthermore, melatonin at one year demonstrated a significant worsening of mood and non-significant cognitive effects After 2010s duloxetine was reported as validate for the recurrent elderly depression and alternative treatment as GMDZ was suggested to be the assistant treatment for post-stroke elderly depression. Except for the pharmacological interventions, lifestyle change, depression-focused psychotherapy, psychopharmacological treatments, and electroconvulsive therapy have been proved to be effective in the current treatments of geriatric depression Additionally, the non-pharmacological interventions included the exercises, yoga, physical touch, music, art, horticultural, reminiscence, cognitive, and psycho therapies as the validate interventions for alleviating the elderly depression. Additionally, narrative therapy was the new way for the elders to write down own negative stories and transformed it into the positive thinking by themselves as the self-healing process however, narrative therapy has not been tested of its effectiveness for alleviating the elderly depression. Furthermore, the majority of non-pharmacological interventions for elderly depression could not maintain their functions of reducing depression after closing the intervention programs. In summary, the evidences-based protocol of depression in the elderly people was developed based on the validate literature that could be tested in the future for the elders who have or have not dementia. For those who do not have dementia, the protocol could screen the elders who were pseudo or truly dementia. For those who do have dementia, the protocol could go for the specific Comell Scale for Depression in Dementia (CSDD) for dementia elders. The pharmacological interventions were for the major depression elders for instance, TCAs and SSRIs were applied in the acute stage, while, duloxetine, and alternative treatment as GMDZ were used in the relapse and maintaining stages. Additionally, the non-pharmacological interventions including the exercises, yoga, physical touch, music, art, horticultural, reminiscence, cognitive and psychotherapy therapies were suggested for the moderate and minor depression elders [31]. The core nursing care issue for the major depression elders was the safety,

for the moderate depression elders was autonomy, for the minor depression elders was the community and home care.

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