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DEPRESSION & DISPIRITEDNESS IN LATER LIFE

A 'gray drizzle of horror' isn't inevitable.

OVERVIEW: The misconception that aging and depression are inevitably entwined is not only common but also dangerous. It can lead to a variety of adverse events, which might have been avoided had the depression been recognized and treated. However, recognizing depression in older adults can be difficult as it may present differently in this population than it does in younger adults. Furthermore, while treatment options are similar, adjustments may need to be made to deal with the physiological changes inherent to age. The authors address the recognition and treatment of depression in older adults. They also propose a diagnosis of dispiritedness, "a feeling of being in low spirits" that they have found to be common among older adults and suggest appropriate nursing interventions.

Depression is an insidious vacuum that crawls into your brain and pushes your mind out of the way. It is the complete absence of rational thought. . . . It isn't possible to roll over in bed because the capacity to plan and execute the required steps is too difficult to master Depression steals away whoever you were, prevents you from seeing who you might someday be, and replaces your life with a black hole.'

—from David Karp's *Speaking of Sadness: Depression, Disconnection and the Meanings of Illness*¹

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A NEW LOOK AT THE Old



Virginia Magrath, 79, a retired nurse, continued to put her professional skills to use as a full-time caregiver for her husband, John, who had Alzheimer disease. After his death, Virginia faced life on her own—for the first time in 50 years. Schulz and colleagues reported in the June 27, 2001, issue of the *Journal of the American Medical Association* that for “strained caregivers” like Magrath, distress did not increase after the death of a spouse. As she explained, “I’m just grateful that I don’t have anybody right now that I have to look after and take care of. I can do my own thing. I can go out and I don’t have to worry about what’s happening to John.” In contrast, the study also concluded that “among noncaregivers, losing one’s spouse results in increased depression and weight loss.”

“A despair beyond despair,” “a howling tempest in the brain,” “an inexplicable agony” are among the phrases novelist William Styron uses to describe depression in his 1990 memoir *Darkness Visible: A Memoir of Madness*.² Styron’s depression began soon after his 60th birthday: to many, this wouldn’t be a surprise. They might consider Styron’s depres-

sion, his “gray drizzle of horror,” to be an experience intrinsic to aging. Indeed, throughout much of history, aging and depression (or “melancholia”) have been viewed as synonymous. The Greek physician Rufus of Ephesus (98–117 CE) said of melancholia, “it was sufficiently common in the elderly as to seem to be an intrinsic feature of growing old.”³

MEDICATIONS THAT MAY CAUSE DEPRESSION

- Anticonvulsants
- Antiinflammatory
- antiinfective agents
- Antiparkinsonian drugs
- Antipsychotics
- Cardiovascular drugs
- Chemotherapeutics
- Hormones
- Sedatives and anxiolytics
- Stimulants

For a complete list, see Birrer RB, Vemuri SP. Depression in later life: a diagnostic and therapeutic challenge. *Am Fam Physician* 2004;69(10):2375-82.

DEPRESSION

"My vision is getting worse," says 67-year-old Gertrude Roland, a caregiver for her husband who has Alzheimer disease. "A lot of the time my whole body aches. I've lost interest in eating, and I seem to have lost weight. What if I can't care for my husband anymore? I'm reaching the end of my rope." Yet when asked if she is depressed, her response is an unqualified, "No." Some of Ms. Roland's statements imply otherwise, such as "I'm reaching the end of my rope." In addition, her focus on somatic complaints is common among older adults with depression.

Suggested Nursing Intervention Classification interventions: mood management, coping enhancement, suicide prevention, counseling

Such suppositions are wrong; depression is not an inevitable consequence of aging. In fact, the belief that it's normal for older adults to be less active, less engaged, and somatically preoccupied is a dangerous one.⁴ It means that symptoms may not be viewed as health issues and patients will not receive necessary treatment. It means that older adults suffer in silence, remaining either undiagnosed or misdiagnosed, and—most important—untreated. It means longer hospital stays, excessive use of health care services, decreased ability to follow health regimens, and an increase in morbidity and mortality rates.⁵ It means a greater risk of developing heart disease.⁶ And it can mean suicide. In 2002 people ages 65 years to 74 years represented 13.5% of suicides, but those 85 years and older represented 18% of suicides; 9.9% of suicides were committed by people ages 15 to 24 years.⁷

Depression is pervasive and can diminish the spark of life. It can cause sustained impairment in

physical, social, and psychological functioning. Many face their final years feeling empty, hopeless, and helpless—it doesn't have to be this way. Western society often undervalues the attributes of the elderly, ignoring their concerns and invalidating their existence. We don't have to do the same, we can help. Depression can be treated.

RECOGNIZING DEPRESSION

For 2,500 years, the two descriptions of depression that have recurred most often are being "in a darkness" and being "weighted down."⁸ But despite the longstanding awareness of the condition, depression still is often overlooked, especially in older adults. In one study, one in every three older patients treated in EDs displayed clinically significant symptoms of depression, yet ED personnel failed to identify depression in most of them.⁹ And it's expected that as baby boomers age, the number of older adults with depression will rise.¹⁰

Identifying depression in older adults can be difficult. The challenges include clinician and patient biases and the complexity of diagnosing older adults with medical and neurologic comorbidities. In addition, there can be a misattribution of symptoms; since the early 1990s, researchers have recognized that some symptoms common to older adults are different from those in younger adults. A recent study of 1,498 adults found that patients with depression between the ages of 51 and 75 years "had more middle and terminal insomnia, less irritability, and less hypersomnia. They were less likely to hold negative views of themselves or of their future and were less likely to report previous suicide attempts. Older patients were less likely to endorse symptoms consistent with generalized anxiety disorder, social phobia, panic disorder, and drug abuse"¹¹

In older adults, symptoms of depression may be similar to those of other conditions. Memory impairments are the cognitive deficits most frequently associated with depressive disorders in older adults. Lykestos and colleagues found that in 109 patients with Alzheimer disease, 27% had minor depression and 22% had major depression.⁴ While depression can result from dementia, cognitive impairment might also be secondary to depression. Furthermore, somatic symptoms of depression such as fatigue, insomnia, and changes in concentration or memory can be difficult to distinguish from the physical symptoms of aging and disease. Clinicians often attribute such symptoms of depression to other medical or neurologic conditions.

Risk factors include living alone, having little or no social support, being unmarried or widowed, going through recent bereavement, enduring chronic pain, being a caregiver, having a history of depression or a chronic illness, being incontinent, fearing death,

abusing substances, having a history of suicide attempts, or having a functional disability such as loss of mobility or vision (especially a recent loss).¹²

Having a chronic condition such as diabetes, stroke, heart disease, lung disease, or arthritis can make anyone vulnerable to depression. Comorbidities may include cancer, thyroid failure, postmenopause, vitamin B₁₂ deficiency, chronic pain, malnutrition, or functional disabilities. Medical conditions such as infection, incontinence, anemia, hypothyroidism, hyponatremia, hypercalcemia, hypoglycemia, congestive heart failure, and kidney failure often coexist with depressive syndromes.

Medications are another risk factor. Patients experiencing symptoms of depression while taking certain medications should be evaluated by a geriatric-mental health professional (see *Medications That May Cause Depression*, page TK). Accidental drug misuse or unexpected drug-drug interactions may result from the polypharmacy endemic among older adults.¹³

Major depression. According to the *Diagnostic and Statistical Manual-Text Revision (DSM-IV-TR)*, the symptoms of depression are the following¹⁴:

- depressed mood most of the time
- marked decrease in interest and enjoyment of most activities
- significant increase or decrease in weight
- insomnia or hypersomnia
- agitation or slowness
- fatigue
- feelings of guilt or worthlessness
- indecisiveness or a reduced ability to concentrate
- recurrent thoughts of death, suicidal ideation, or suicide attempt

For a diagnosis of major depression, five or more of these symptoms (except for weight change) must be evident nearly every day for a two-week period, and at least one complaint must be either depressed mood or loss of interest or enjoyment.

It's important to note that these diagnostic criteria don't apply specifically to older adults, who may display fewer symptoms. For example, Gallo and colleagues reported that older adults who expressed feelings of hopelessness and worthlessness admitted to thoughts of suicide, even though they did not display a depressed mood or loss of interest in activities.¹⁵ Symptoms common to older adults include "sleep disturbance, decreased appetite, weight loss, irritability, difficulty with concentration, and fatigue."¹⁵ Older adults may express feelings of hopelessness, anxiety, worry, or anhedonia (loss of pleasure). Unexplained somatic complaints are another common symptom of depression in this age group. Other depressive syndromes include affective disorders, bipolar disorder, dysthymic disorder, psychotic depression, depression secondary to another condi-

tion (medical illness or substance abuse), or an adjustment disorder with depressed mood or bereavement.

Dysthymia. Minor depression that persists for two years or more is diagnosed as dysthymia. It rarely begins late in life but may persist from midlife to late life; it sometimes follows an episode of major depression. Symptoms include decreased social activity, social withdrawal, inability to respond positively to praise or rewards, low self-esteem, self-depreciation, difficulty in coping with usual activities of daily living, a pessimistic attitude about the future, and regret.¹⁶

Milder forms of depression. Depression is best viewed as a spectrum, an illness that ranges from major depression to milder or "sub-threshold" syndromes of clinically significant symptoms that do not meet *DSM-IV-TR* diagnostic criteria for major depression. If "major depression is the startling collapse of a whole structure," as Andrew Solomon writes, minor depression is "a gradual and sometimes permanent thing that undermines people the way rust weakens iron."¹⁷ Indeed, depressive symptoms that don't meet the standard criteria of a specific disorder are two to four times more common in older adults,¹⁸ many of whom don't seek relief of their symptoms.

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Minor depression. The *DSM-IV-TR* criteria for diagnosing minor depression specify that at least two but not more than four of the symptoms for major depression be present. Depressive episodes may last two weeks or longer, but impairment will be less severe. Minor depression is considered "sub-syndromal," a syndrome that does not meet the criteria of any of the major depressive syndromes but may lead to an increased risk of major depression, a greater use of health care services, a higher risk of death, and decrease in the quality of life.¹⁹⁻²¹ Minor depression also affects physical and psychosocial function, as well as recovery from injury or illness. When encountering patients with minor depression,

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Seventy-eight-year-old Consuela Elador arrives at the outpatient clinic for her yearly flu shot. A widow, she is thin but otherwise appears healthy and carefully groomed. When the nurse asks, "How are your spirits?" she responds, "My life feels like it is in limbo. I have no purpose, direction. I've stopped belonging, being involved in anything. Life seems boring and I don't know what to do with myself. Everything seems kind of empty, but I don't know how to create new enthusiasm in my life. Sometimes, my enthusiasm returns briefly, but it always disappears again. My friends keep me going. I've also found that as I felt better about my work, doing things for people, and giving of myself, has helped me feel better. But I still haven't found what to do at home."

Suggested Nursing Intervention Classification interventions: socialization enhancement, hope instillation, role enhancement, self-esteem enhancement, spiritual growth facilitation, support system enhancement, activity therapy, reminiscence therapy

it's important to ensure that they receive further psychiatric evaluation or mental health services: as many as 50% of patients with minor depression develop major depression within two years.¹⁴ Gerontologic-mental health advanced practice nurses, psychiatric consultation-liaison nurses, and other mental health professionals should be considered for further evaluation and treatment.

Diagnostic tools. The nurses' role is central in identifying symptomatic patients, support, education, and referral for and coordination of the treatment of older adults with either major or sub-threshold depressive syndromes. The Nurses Improving Care for Healthsystem Elders (NICHE) standard protocol for depression in the older adults recommends that nurses assess all at-risk patients using a standardized screening tool.²² The recommended tool is the Geriatric Depression Scale (available at www.hartfordign.org/publication/trythis), which takes about 10 minutes to administer. Other inventories include the Center for Epidemiologic Studies Depression Scale, the Inventory of Psychic and Somatic Complaints in the Elderly, the Cornell Scale for Depression in Dementia, and the Beck Depression Inventory. Saur and colleagues and researchers from Project IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late-Life Depression) found that a nine-item depression subscale (PHQ-9) from the PRIME-MD Patient Health Questionnaire was a very useful, short, and easy-to-administer tool for identifying and monitoring major depression or subthreshold depressive syndromes in older adults.²³⁻²⁵

Patient observation and interview remain essential to diagnosis; depression scales are not a substitute (see *The Art of the Interview*, page TK). In many older adults, distress is revealed through physical, social, and psychological signs and symptoms, so attention to such cues is essential. For example, Gallo and Rabins suggest that "somatic complaints for which a medical etiology cannot be found" may signal significant depression in older adults.²⁶

Nonverbal cues like stooped posture, slowed speech and movement, and a lack of interest in self-care may be signs of depression. It can also be expressed through aggressive behavior; unrealistic fears; repetitive verbalizations (calling out for help); agitated shouting, yelling, or screaming; and repeated questions, health-related concerns, or foreboding statements.²⁷ These behaviors are especially common in long-term care settings.

Costs. Langa and colleagues estimated the cost of informal caregiving—the unpaid assistance given by spouses, adult children, and friends—of adults ages 70 and above who have depression to be \$9 billion a year.²⁸ They found that those with no depressive symptoms received an "average of 2.9 hours a week of informal care." In contrast, each week, on average, those with one to three symptoms received 4.3 hours of assistance, and those with four or more symptoms received six hours.

TREATMENT

Many older adults don't seek treatment because they don't consider feelings of worthlessness or agitation to be psychological or psychiatric concerns. In fact, the National Mental Health Association found that "only 38% of adults aged 65 and over believe that depression is a 'health' problem." Furthermore, 58% "believe that it is 'normal' for people to get depressed as they grow older." Finally, more than any other group, people in this age group believed they could "handle it themselves."²⁹

In patients with major depression, a combination of psychotherapy and pharmacology "generally results in improvements in the quality of the patient's life, enhanced functional capacity, possible improvement in medical health status, increased longevity, and lower health care costs."³⁰ While improvements may be seen within two weeks, the full effects of treatment may take several months to appear. Older adults with depression benefit from intensive and persistent treatment and may require longer periods of management than younger adults.³¹ The goals of treatment are to reduce symptoms, restore functioning, and prevent recurrence.³⁰

Psychotherapy may be the treatment of choice for mild depression, especially if it has helped the

patient previously. It's also useful when medications can't be used because of other medical conditions or potential adverse effects or interactions. In patients with moderate-to-severe depression, psychotherapy augments antidepressants.

Psychodynamic psychotherapy examines patients' defense mechanisms and interpretations of life events. Unconscious feelings or conflicts are uncovered and explored. The primary mechanisms of change are insight and the therapeutic relationship.

Interpersonal therapy, which focuses on relationships, losses, and changes in roles, helps people to develop effective communication and relationship skills.

Cognitive-behavioral therapy views depression as a consequence of self-defeating thinking patterns and involves problem-solving and the development of improved social skills. To initiate change, behaviors are modeled, practiced, and reinforced.

Problem-solving therapy helps patients identify critical issues and devise and implement appropriate solutions.

Group therapy can break the shell of depressive isolation. It enhances socialization, encourages changes in attitude, and supports personal development.³²

Family therapy may be a useful adjunct to individual therapy. It focuses on identifying family stressors and ameliorating dysfunctional patterns.

Electroconvulsive therapy (ECT) is an effective short-term treatment for severe depression.³³ The American Psychiatric Association recommends ECT when other treatments "have not been effective, cannot be tolerated, or (in life-threatening cases) will not help the patient quickly enough."³⁴ However, Van der Wurff cautions, "firm randomized evidence on the efficacy and safety of ECT in depressed elderly is missing."³⁵

Pharmacotherapy is the mainstay treatment for older adults with moderate-to-severe depression. The percentage of adults ages 65 years and older who use antidepressants grew from 9.3% in 1993 to 11.7% in 1997.³⁶

As the body ages, changes occur in the absorption, distribution, metabolism, and excretion of medications. As a result, older adults are more likely to experience higher plasma levels of medications, prolonged medication half-lives, and more significant and longer-lasting toxic effects. Older adults become more vulnerable to antihistaminic effects such as sedation and weight gain.³⁷ For example, the monoamine oxidase inhibitors (MAOIs) present a risk of orthostatic hypotension (a drop in blood pressure when standing up) which can increase risk of falling. Finally, sensory and cognitive deficits may contribute to medication nonadherence in older adults; there is also a greater

TIPS FOR NURSES BY HEALTH CARE SETTING

Hospital

Make the patient an active participant in care routines (for example, decision making and short-term goal setting), encouraging self-efficacy and personal control. Allow the patient time to discuss all feelings, but limit the amount of time he dwells on failures.

Nursing home

Establishing a healthy lifestyle—for example, adequate nutrition, sleep, and physical comfort—can be an important step toward mental health for people with depression. Promote these by providing adequate pain control, limiting caffeine, and encouraging a regular activity schedule.

Ambulatory care

Provide information (including phone numbers and addresses) on mental health care providers to patients who show signs of depression. Because people with depression can find it difficult to initiate new contacts, offer to make connections when appropriate or encourage caregivers to do so.

Home care

Teach caregivers about the nature of depression and connect them with outside support groups. Encourage the patient to plan coping strategies to deal with upcoming changes and to rely on friends and family for help. Finally, relaxation can be a mood enhancer—suggest activities such as massage or listening to music.

incidence of comorbidities, which will likely increase the number of medications the patient is taking. The addition of a new drug may intensify the potential for serious drug-drug interactions. Cost is also an important factor; many older adults are on fixed incomes.

Thus, antidepressant medications should be chosen carefully. Patients should be started at a low dosage, which should be gradually increased until the desired effect is achieved. Nurses should provide information about the medication in both written and verbal forms and closely monitor the patient's reactions. Older adults can respond slowly to antidepressants, and clinicians should assess for response at eight to 12 weeks.³⁸

Drugs used in the treatment of depression in older adults include the following:

MAOIs treat effectively the full range of mood disorders. But because of the potential for serious adverse effects resulting from drug-drug interactions, MAOIs are usually not used in this population unless all else fails.

THE ART OF THE INTERVIEW

Interviewing is an art, one that is especially important to master with older adults who may be reluctant to discuss mental health issues. Creating an environment of respect, compassion, and reassurance will help them feel more at ease; it will also increase the likelihood of obtaining accurate information.

Patience. Because verbal response slows with age, it may take awhile for some older adults to respond to questions. Don't assume that delays are due to a deficit in knowledge, comprehension, or memory. Nor should you rush a response. It's important to allow adequate time to answer questions; a rushed, authoritative interviewer will have difficulty forming a therapeutic alliance.

Tone. When talking to older adults, some clinicians sound as if they are talking to a child. Although this change in tone is likely unconscious, it's not wise: older adults can perceive this as being condescending. (Likewise, avoid stroking or patting the patient.) Take care to express yourself clearly through your choice of words and sentence structure. Avoid using slang, colloquialisms, jargon, abbreviations, and medical terminology. Choose words on the basis of your knowledge of the person's background. Likewise, phrase questions simply; avoid long, complex sentences, and rephrase when necessary. When family members are present, make sure to address the patient directly so he doesn't feel excluded.

Questions. Assessment for depression essentially rests on three questions:

- How many depressive symptoms are being experienced?
- How long have the symptoms lasted?
- How much do the symptoms interfere with the activities of daily living?

During an assessment, answers to questions such as "How are your spirits?" or "Do you still take interest in the things that usually interest you?" may provide clues about the presence of depression. Replies such as "I feel down in the dumps" or "I just don't feel like doing anything" warrant further assessment. Anhedonia, or the loss of a feeling of or an inability to feel pleasure or happiness in response to experiences that normally produce pleasure, is a core symptom of depression. Possible statements indicating anhedonia include "I no longer spend time with my grandchildren" or "I'm losing my sense of closeness to God."

Dispiritedness. Rather than asking directly whether life seems meaningless, which may be interpreted as a threatening question, nurses should carefully listen for themes of dispiritedness woven into the client's personal story. Dispiritedness may be expressed in terms of dissatisfaction with life or feeling insignificant, a loss of purpose, devalued, or empty. Dispiritedness includes feelings of being lost, helpless, and disconnected from things of value such as family, work, or a higher power.

Suicide. Finally, it's important to ask directly about thoughts of suicide or whether a patient feels life is worth living. Some elderly may deny suicidal thoughts but say that it would be fine to fall asleep and never wake up.

Tricyclic antidepressants were, until recently, the first-line treatment for depression. But they can produce troublesome adverse effects and create the potential for serious toxic reactions.

Selective serotonin reuptake inhibitors (SSRIs) are about equally effective as tricyclics—except, perhaps in the most severely depressed people—and they're more tolerable, safe, and simple to use.³⁷ SSRIs have replaced the tricyclics as first-line treatment for depression.

Antipsychotics are used when psychotic features are present in people with severe depression; in general, a combination of antipsychotics and antidepressants is the treatment of choice for psychotic depression.

Protocols. The Nursing Intervention Classification (NIC) has standardized 514 nursing interventions, and several can guide nurses' actions in caring for patients with depression.³⁹ In addition, outcome indicators measuring the effectiveness of nursing interventions can be selected using the Nursing Outcome Classification.⁴⁰ Through support of the John A. Hartford Foundation, the NICHE project has developed 14 protocols for treating older adults with depression.

SUICIDE PREVENTION

"What's the use, I might as well be dead." "My family would be better off without me." "I'm tired of living." Statements such as these signal an immediate need for assessment of suicide risk. If the patient can describe a specific suicide plan, constant supervision must be planned until he is hospitalized or the potential for carrying out the plan is no longer present.⁴¹ In one study of adults ages 75 years and older, "family conflict, serious physical illness, loneliness, and both major and minor depressions were associated with suicide."⁴² Economic problems were not found to be a predictor of suicide in this age group, although they were in adults between 65 and 74 years of age.

A suicide protocol, including a full suicide assessment and identification of risk factors, should be in place. Those responsible for the care of the patient should be informed and weapons or other means of self-harm removed. Consistent companionship, as well as close monitoring by a health care professional, are needed. In acute care settings, patients may require transfer to the psychiatric service; in outpatient settings, the patient will require continuous observation until arrangements are made for emergency psychiatric evaluation.

DISPIRITEDNESS

Despite great advances in the treatment of depression, concerns have been voiced about the overuse of psychotropic medications. Some are asking

whether emotions, such as unhappiness, have become “medicalized.” As the physician Ronald Dworkin wrote in *Public Interest* magazine, “Because the [clinical] environment under managed care is so rushed and impersonal, many doctors take the path of least resistance by prescribing medication whenever a patient is feeling ‘blue.’ Also, managed care companies save money when depressed patients receive medication rather than an indefinite number of counseling sessions.”⁴³ Dworkin continues: “medical science is moving beyond its traditional border to help people who are bored, sad, or experiencing low self-esteem. . . . It is hard to know where everyday unhappiness ends and clinical depression begins.”

Blazer asserts that clinicians “need to become aware of the existential aspects of depression in late life,”¹⁶ such as fear of death, isolation, and meaninglessness. Older adults with depression are likely to view the meaning and purpose of their lives in a negative light. We have conducted studies that explicate “dispiritedness,” which we consider a phenomenon that captures the existential aspects of depression.

The term *dispiritedness*, defined as the experience of being in low spirits, was first described in the psychological literature in 1971 as part of Jourard’s theory of “inspiration–dispiration.”⁴⁴ This theory asserts that individuals are “inspired” when they have hope, meaning, and purpose, and when they value existence. In contrast, a person who is dispirited feels unimportant, worthless, hopeless, isolated, and frustrated and believes life to be meaningless. Jourard contended that a person can become dispirited when social conditions are devoid of opportunity for inspiration and that aging is potentially dispiriting. Building on Jourard’s work, Bugental described dispiritedness as a “a recurrent sense of blunted intention,” characteristic of “low-spirited times.”⁴⁵ Dispiritedness is characterized by feelings of sadness, pessimism, and futility.⁴⁶

To more clearly describe the experience and distinguish dispiritedness from other syndromes of depression, we conducted a phenomenologic study of people in later life who identified themselves as having experienced “low spirits” or dispiritedness. We conducted a secondary data analysis (using van Manen’s 1990 hermeneutic–phenomenological method⁴⁷) of original dissertation research conducted by one of us (HKB) that initially examined dispiritedness in later life within the theoretical perspective of Rogers’s science of unitary human beings.^{48, 49}

Following interviews (which lasted between 40 and 70 minutes) with 11 participants, seven essential themes were identified. The themes describe the

structure of the experience of dispiritedness in later life and include 1) arising from life’s trying transitions (for example, participants described feeling low-spirited during common age-related transitional experiences such as menopause and retirement), and were experienced as being, 2) disengaged from meaning (expressed as a sense of meaninglessness in life, a void to be filled, or “really empty inside”); 3) a restricting loss of vigor and animation (“missing a spark of life” or feeling numb), 4) forlorn bewilderment (a feeling of being lost or trapped) and 5) moving between engagement and disengagement, while 6) remaining faithful to enduring connections, and 7) engaging in day-to-day living (participants described maintaining a sense of control in order to participate in everyday life, while living a life of quiet desperation).

DISPIRITEDNESS IN LATER LIFE IS CHARACTERIZED BY A FLUCTUATION BETWEEN BEING ACTIVELY ENGAGED IN AND DISCONNECTED FROM LIFE.

Participants did not describe insomnia, weight change, psychomotor agitation or retardation, diminished ability to think or concentrate, somatic complaints, or recurrent thoughts of death (symptoms that typically characterize major or minor depression). Nor did they experience “significant distress or impairment in social, occupational, or other important areas of functioning” for a two-week period, as required by *DSM-IV-TR* criteria. Rather, those who identified themselves as dispirited and not depressed indicated they were able to remain functional in their daily lives; their low spirits were therefore difficult for others to identify. The most prominent feature of dispiritedness is a sense that life has lost its meaning.

These distinctions make it clear that dispiritedness is different from minor and major depression and from dysphoria (which can be considered a symptom of minor or major depression as it also requires a time frame of two weeks or longer for diagnosis).⁵⁰ While people who meet the criteria of these depressive syndromes may also experience dispiritedness, one can be dispirited but not have major or minor depression.

'A NEW LOOK AT THE OLD' ONLINE

A series of Webcasts designed to improve multidisciplinary care.

Further explore the topics presented in the series, "A New Look at the Old" by going online; over the course of the series 15 free Webcasts will run, created through a collaboration of AJN, the Gerontological Society of America, and Trinity Healthforce Learning and sponsored in part through a grant from Atlantic Philanthropies. The most recent Webcast was "Dementia Focus: The Person Behind the Disease" and a new program will premier in January. For information on the schedule or to view an archive of previous Webcasts, go to www.nursingcenter.com/AJNolderadults. This Web site includes a forum for comments and questions about the Webcasts or articles in this series.

Dispiritedness in later life is characterized by a fluctuation between being actively engaged in and disconnected from life. It's a transitory feeling, as most participants described feeling dispirited for only a short period of time, sometimes less than a day. In addition, participants strongly believed that while they were not depressed, dispiritedness could lead to depression.

Interventions. Research participants identified three major paths that they used to transform feelings of dispiritedness. Nurses can facilitate such change by inspiring hope and encouraging older adults to keep active and maintain connections.⁴⁸

Inspiring hope. Ask patients to talk about positive aspects of their lives. Discuss dispiritedness with them; let them know it's temporary. Discuss their goals and help to revise them when necessary. Employ guided life review or reminiscence and encourage participation in spiritual programs according to the patient's beliefs. Emphasize their ability to resolve problems and find new meaning. The NIC intervention "spiritual Growth Facilitation" is a valuable reference.

Keeping active. Encourage patients to continue activities they once enjoyed or to take up those that they always wanted to try. Support them in reaching these new goals by identifying and obtaining necessary resources, arranging transportation (if needed), and making appropriate referrals.

Maintaining connections. Help patients nurture relationships by encouraging phone calls, correspondence, and visits. Encourage them to sustain spiritual connections by attending religious services and to build emotional support networks by attending support groups. ▼

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3.5 HOURS

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- discuss the manifestations and risk of depression in older adults.
- outline the risks of depressive illness in older adults, along with recommendations for screening and goals of therapy.
- plan the appropriate management strategies for older adults who are depressed, including recommendations for pharmacologic therapy.

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