

# Depression in Later Life

**RECOGNITION AND TREATMENT**



PNW 347

Revised July 2004

A Pacific Northwest Extension Publication  
Oregon State University • Washington State University • University of Idaho

# Contents

---

<b>What is depression?</b>	<b>2</b>
How depression differs from grief	
Types of depressive illness	
<b>Myths and facts about depression and suicide</b>	<b>4</b>
<b>What triggers depression?</b>	<b>7</b>
<b>Recognizing the signs of depression</b>	<b>9</b>
Age-related changes	
Denial	
Atypical signs	
Physical illness	
<b>Treatments for depression</b>	<b>12</b>
Medication therapy	
Psychotherapy	
Electroconvulsive therapy	
Alternative treatments	
<b>Helping the depressed person</b>	<b>18</b>
Encourage treatment	
Get expert help	
Seek help for yourself	
Listen and validate feelings	
Build a supportive environment	
Structure activity	
Give the person control	
Learn about medications	
Be alert to signs of suicide	
<b>Handling special problems</b>	<b>24</b>
When the person denies being depressed	
Helping from a distance	
Identifying and responding to a suicidal person	
<b>Summary</b>	<b>29</b>
<b>For further information</b>	<b>29</b>

## Authors

Vicki L. Schmall, Extension gerontology specialist emeritus; and Sally Bowman, Extension family development specialist; Oregon State University.

## Acknowledgments

Photos by Rod Schmall, West Linn, OR.

The authors are grateful to Clifford Singer, M.D., clinical director of geriatric psychiatry, Oregon Health and Science University, Portland, OR, for his valuable assistance in preparing this publication.

**Albert** is 78. Two years ago, his wife of 54 years died. Shortly thereafter, his closest friend also died. Since then he has become increasingly forgetful and uninterested in family activities. His children are concerned that “father has become senile.”

**Mrs. Jensen**, 74, has always been active socially. However, in the last few months she’s withdrawn into her home, isolating herself from family and friends. The easiest chore seems impossible. Formerly pleasurable activities are no longer enjoyable. She’s tired much of the time but has difficulty sleeping. Her daughter says, “I feel like a big black cloud is hanging over Mother. I’ve asked whether she’s depressed, but she says no. I don’t know what to do.”

**Mr. Jones’s** life revolved around his work. Since retiring 8 months ago, he feels lost and useless. He’s neglecting his appearance and drinking more.

**Martha**, 82, says, “My family would be better off without me.” Although she is mentally alert, her severe, crippling arthritis means she now must depend on others for assistance. She’s always prided herself on being independent. Lately she’s agitated much of the time and hostile toward family and friends. Her daughter often finds her still in bed at noon.



**F**or Albert, Mrs. Jensen, Mr. Jones, and Martha, life has lost its joy. They are suffering from depression. They may not recognize the symptoms of an underlying depression, may fear being labeled “crazy” or “weak” and therefore do not seek help, or may be too depressed and lack the energy to take action.

Depression is disabling. It can cause physical problems, and it can disrupt a marriage and a family. Living with a depressed person is not easy because depressed people tend to turn inward and not think about

---

This publication is designed to help you:

- ❑ Understand depression and factors related to its onset in later life
  - ❑ Recognize signs of depression and potential suicide
  - ❑ Learn about treatments for depression
  - ❑ Know what you can do if you suspect an older family member or friend is depressed or contemplating suicide
- 

others, and sometimes they become hostile. Family and friends might feel as if they are being driven away.

Severe depression can be life threatening. Health can fail rapidly. Depressed people appear to be more susceptible to infection and other illnesses, and they take longer to recover from illness than nondepressed people do.

Most people who commit suicide are depressed. Suicide is disturbingly common in the older population. Men over age 65 have the highest rate of suicide, three to four times greater than in the general population.

Recognizing the symptoms of depression is the first critical step in helping the depressed person. Unfortunately, depression often goes unrecognized in older people. It frequently is misdiagnosed or considered a natural part of aging. Sometimes people expect that to be old is to be depressed. However, depression is *not* inevitable, or even normal, in late life.

Depression is highly treatable. More than 80 percent of depressed people can be treated effectively and their symptoms alleviated within weeks. However, many depressed people never receive proper treatment, and undertreatment is a common problem. Without treatment,

depression can last for weeks, months, or even years.

In addition to a decreased quality of life, consequences of depression include higher rates of physical illness and death, increase in physician visits, and higher rates of hospitalization and institutionalization. The tragedy is not depression itself. The tragedy is ignored, undiagnosed, or untreated depression. People do not need to suffer its debilitating effects.

### **What is depression?**

When faced with the challenge of helping a depressed person, it's important first to understand depression yourself. As you begin to understand what depression is and is not, you will be better able to respond in helpful and caring ways.

Depression is one of the most common emotional disorders. It can occur in anyone—young or old, male or female, rich or poor. The term “depression” is used to describe a range of conditions, from a simple mood to severe depression. Regardless, sadness is a predominant feeling. Occasional feelings of unhappiness, feeling down, or being in a blue mood are normal. But when the feeling goes beyond normal mood swings and adversely affects one's life, the problem is depression, which is an illness.

## Severity of depression

There are many ways to describe depression. One way is by its severity—mild, moderate, or severe. The number of symptoms and their impact determine the severity of depression. Mild depression is the most common, but it also requires attention because even mild depression can deepen or persist.

### Mild depression

Mild depression is a brief, temporary sadness that is a normal reaction to stress, tension, frustration, and disappointment. It does not seriously interfere with functioning or daily activities. Professional treatment may not be needed. Emotional support from others and an opportunity to talk, or a change of pace or situation, may be all that is needed.

### Moderate depression

A moderate depression is more intense and lasts longer. It usually is caused by a loss or an upsetting event. Daily activities become more difficult, but the person usually still meets daily responsibilities. Professional help may be needed.

### Severe depression

A severely depressed person shows marked behavior changes and loss of interest in the outside world. Often, a chemical imbalance is involved. Ability to



function and cope is impaired. Professional treatment is needed.

## How depression differs from grief

Sometimes it's difficult to tell the difference between depression and grief. For example, both depressed and grieving people experience sadness, tearfulness, sleep problems, and appetite and weight changes. However, there are differences. Understanding them is important so that you can better recognize when a person may be depressed rather than grieving and you can offer the most appropriate support.

### Characteristics of depression

Depression may not have a specific trigger. Also, depressed people tend to be passive, remaining stuck in sadness for a long time. They have generalized feelings of helplessness, hopelessness, pessimism, and emptiness. They lack interest in previously enjoyed activities.

## **Myths and facts about depression and suicide**

**Myth** Depression is a normal part of aging.

**Fact** To be old is not to be depressed. An attitude of “I’d be depressed, too, if I were old” is a major barrier to helping a depressed older person. Depression should not be accepted as inevitable in later life. Unfortunately, the belief that late-life depression is normal stops many people from getting needed help.

**Myth** Older people cannot benefit from therapy.

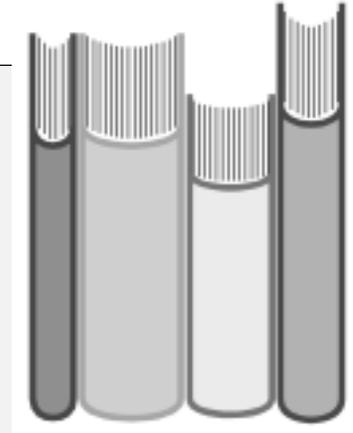
**Fact** Depression is treatable at any age. Older people also respond well to short-term psychotherapy.

**Myth** People who are depressed either lack willpower, are psychologically weak, or are “putting on an act.”

**Fact** To be depressed is not the person’s fault nor is it a sign of weakness. It’s as real as a heart attack. Depression is an illness involving genetic, biological, and environmental factors. However, some older people believe depression is a character defect and feel ashamed.

**Myth** People could control their depression if they just had the right attitude.

**Fact** The causes of depression are complex. Depression is a condition that people can’t simply will or wish away. They cannot just “pull themselves together” and get better. While some people can manage their depression through self-help, others need professional assistance.



**Myth** Older adults rarely commit suicide.

**Fact** Suicide rates of older adults are the highest of any age group in the United States. Twenty percent of all suicides are people age 65 and older.

**Myth** People who talk about suicide seldom take their lives.

**Fact** A person who talks about suicide is at high risk of doing so. Take suicidal statements and behaviors seriously.

**Myth** Asking a person whether she has thought about suicide increases the risk that she will attempt suicide.

**Fact** Asking about suicidal thoughts in depressed people does not increase the risk. In fact, by asking you are likely to save a life. Many people who have thought about suicide are relieved when asked.

**Myth** Older people who attempt suicide usually do so to gain attention or to manipulate family members.

**Fact** Older people seldom attempt suicide as a means to get attention or as a cry for help. Depression underlies up to two-thirds of their suicides. Most suicide attempts made by older people are well planned and completed.

A depressed person is likely to have low self-esteem and self-confidence and to feel he's a failure, unattractive, and unloved. He is likely to be unresponsive and humorless, incapable of being cheered up or happy even temporarily. He is likely to resist help and support.

Depressed people have difficulty identifying or describing their feelings. They tend to cry for no apparent reason, but crying does not bring relief. Inappropriate or excessive guilt is common. The person might dwell on past failures.

### **Characteristics of grief**

Grieving is a normal part of recovering from loss. Grieving is an active process; the person gradually progresses through the sadness toward recovery.

A grieving person experiences a range of feelings, including emotional pain and emptiness. He cries for an identifiable loss, and crying provides relief. He is more likely to accept support than a person who is depressed. You usually can persuade a person who is grieving to participate in activities, particularly as he begins to work through the grief. He will laugh sometimes and enjoy humor.

With grief, self-esteem usually remains intact; the person does not feel like a failure, although such feelings may be related to

the specific loss. Any feelings of self-blame and guilt relate directly to the loss, are episodic, and resolve as he heals. The grieving person is not likely to be suicidal.

Sometimes grief evolves into a serious depression, particularly when the grief process is blocked or mourning over a loss increasingly turns inward. Sadness for weeks, even months or years, after a loss or unwanted change is to be expected. But when intense sadness continues, when the person becomes stuck in sadness, or when he is increasingly unable to function on a daily basis, the grief has turned into depression. When thoughts of self-blame associated with a loss—for example, the “I should have...” recriminations common with the death of a loved one—



---

*People get depressed for different reasons. There may be one factor or many. The cause is important since it will determine the most appropriate help.*

---

become excessive or prolonged (last longer than 6 months), chances are the grief process has become complicated by depression.

### **Types of depressive illness**

Depressive illness comes in many forms. The most common are major depression, dysthymia, and bipolar disorder. Each type has its distinguishing features, yet all share some similar symptoms.

#### **Major depression**

Major depression differs from the normal “feeling down” in several ways. It is pervasive, persistent, and intense. It interferes with normal social and physical functioning. The person is not simply sad. She experiences an exaggerated sadness coupled with pessimism—she feels the sadness will persist indefinitely regardless of what might be done. She feels a loss of pleasure in life.

Two older people describe their experience with depression:

I felt like I was walking around in wet cement that kept getting harder and harder.

While depressed, I felt like I was in the middle of a black cloud that was getting blacker. I lost all feeling. I just didn't care about anything or anyone.

Some people who experience a major depression have only one or two episodes in a lifetime. Others have recurrent episodes and require ongoing medication.

#### **Dysthymia**

Dysthymia is a low-level depression that lasts 2 years or longer, during which time the person's depressed mood does not lift for more than 2 months at a time. Symptoms tend to be less severe than with major depression, but they can keep the person from feeling well or having a zest for life. The person still may be able to carry out daily responsibilities and obligations.

In contrast to the “black cloud” of a major depression, dysthymia has been likened to a “dim gray cloud” hanging over the person. Sometimes, people with dysthymia also experience a major depression on top of it. Without adequate treatment, dysthymia is more likely to become chronic.

#### **Bipolar disorder**

This illness, sometimes called manic-depression, involves emotions at two extremes, or poles: the person goes from depressive lows to manic highs. Although late onset of bipolar disorder is rare, people who are manic-depressive do grow old.

In the depressive phase, the individual suffers from symptoms typically associated with

depression. During the manic phase, she experiences a marked increase in energy, extreme insomnia, elation, and increased irritability. She may talk rapidly, be easily distracted, and have racing thoughts. Mania often affects thinking, judgment, and social behaviors. For example, a person in a manic phase may have grandiose ideas, go on shopping sprees, or make other unwise financial decisions.

Between episodes, the person might feel normal for extended times or might experience rapid mood swings. The duration and intensity of bipolar disorder varies tremendously.

### **What triggers depression?**

People get depressed for different reasons. There may be one factor or many. The cause is important since it will determine the most appropriate help. You will be better able to assist a depressed person, or even prevent depression, if you learn to recognize factors that can put an older person at risk for depression. Some of the following are common to people of all ages; others are more frequent in later life.

#### **Heredity**

Studies show that some depressive illnesses, particularly bipolar disorder, are hereditary. Genetic factors, however, usually do not show themselves for the first time in late life.



#### **Biochemical changes**

As we age, chemical imbalances in the brain can increase vulnerability to depression. A proper balance of brain chemicals is necessary to maintain normal mood. Imbalances of certain brain chemicals, particularly the neurotransmitters that are necessary for communication among the brain's nerve cells, are associated with depression.

#### **Drugs**

Depression can be a side effect of many medications. Among them are medications for high blood pressure and Parkinson's disease, and sedatives, tranquilizers, and anti-inflammatory drugs. A depression may develop immediately or may not show up for months after starting a medication.

Because alcohol is a depressant on the central nervous system, it can cause depression or intensify an existing depression. Some depressed people turn to alcohol for relief, but the alcohol may only mask the symptoms of depression.

### **Illness**

Some medical conditions can cause depression. These include thyroid disease, brain tumor, pernicious anemia, Parkinson's disease, cancer (particularly

cancer of the pancreas), uremia or kidney disease, and electrolyte imbalance. Sometimes depression is the first symptom of an undiagnosed medical problem.

Depression often is a reaction to illness, especially

one that produces chronic pain, disability, or dependence. Medical conditions associated with changes in body image (strokes, amputations, and problems in walking that require assistive devices) are particularly threatening. Medical conditions that provoke anticipation of greater loss of function or disability or of death (such as cancer, Alzheimer's disease, or cardiovascular disease) can bring on

depression. People who pride themselves on being independent and self-reliant may be particularly susceptible to depression when illness means increased dependence.

### **Personality**

People who have low self-esteem, are highly self-critical, consistently pessimistic, unusually passive and dependent, or easily overwhelmed by stress are more prone to depression.

People who are highly resourceful are less likely to become depressed than those with low levels of resourcefulness; if they do get depressed, they are more likely to recover quickly and are less likely to relapse.

### **Sensory loss**

Loss of sight and hearing can trigger depression. These changes not only can affect ability to function in the physical environment, but they also isolate people and make them more dependent. Even a slight hearing loss, for example, can be emotionally upsetting if it interferes with correctly understanding others. Many people withdraw from group interaction when it becomes difficult to hear.

### **Stress**

Living in a highly stressful situation over time—such as taking care of a spouse with dementia, living in poverty, or experiencing



declining health—can cause depression. Inability to adjust to a major life change—death of a spouse, divorce, death of an adult child, chronic illness, retirement, a forced move from one’s home—can precipitate depression.

The later years are often a time of loss. As one older person said, “The older I become, the more goodbyes I have to say as friends and relatives die one by one.” Losses frequently are in rapid succession. And, sometimes support networks are fragile or nonexistent.

Perceived loss of control often leads to depression. When people feel they can’t control significant life events or they believe their actions make no difference, they may develop a sense of helplessness. A person who feels both helpless and hopeless is at greater risk of suicide.

### **Seasons**

Research shows that the short days of winter, particularly in rainy, cloudy regions, can trigger a low-energy type of depression in susceptible individuals. This condition, called seasonal affective disorder (SAD), is an extreme form of the “winter blahs.”

## **Recognizing the signs of depression**

Despite depression’s many symptoms, it often goes unnoticed. Here’s why depression can be more challenging to recognize in older people.

### **Age-related changes**

Signs of depression sometimes look like normal, age-related changes. For example, many older people who are not depressed have stooped posture, reduced physical activity, increased sleep problems, and loss of appetite (caused by a decline in taste sensation).

### **Denial**

Older people tend to deny being depressed. Many grew up in an era when people did not talk about feelings, but “toughed things out.” Some feel that to be depressed is a sign that they are “weak” or “crazy.” Others fear that they will be placed in a mental institution or a nursing home. You need to observe changes in the person’s appearance and behavior rather than rely on what she says.

### **Atypical signs**

Depression may be dominated by moods other than sadness, such as agitation, irritability, or anxiety. The person may constantly complain, pace, and be easily angered. Paranoia and suspiciousness are also more

## **Recognizing the signs of depression**

If you wonder whether you or someone you know is seriously depressed, check the following list for signs you have observed.

### **Physical signs**

- Aches, pains, or other physical complaints that seem to have no physical basis
- Marked change in appetite (or weight loss or gain)
- Change in sleep patterns (insomnia, early waking, sleeping more than usual)
- Fatigue, lack of energy, being “slowed down”

### **Emotional signs**

- Pervasive sadness, anxiety, or “empty” mood
- Apathy (lack of feeling)
- Decreased pleasure or enjoyment
- Crying for no apparent reason
- Indifference to others

### **Changes in thoughts**

- Feelings of hopelessness, pessimism
- Feelings of worthlessness, self-reproach, inadequacy, helplessness
- Inappropriate or excessive guilt
- Inability to concentrate; slowed or disorganized thinking
- Forgetfulness
- Unable to make decisions or take action
- Recurrent thoughts of death or suicide

### **Changes in behavior**

- Loss of interest or pleasure in previously enjoyed activities, including sex
- Neglect of personal appearance, hygiene, home, and responsibilities
- Difficulty performing daily tasks; ordinary tasks are overwhelming
- Withdrawal from people and usual activities
- Increased use of alcohol and/or drugs
- Increased irritability or hostility
- Greater agitation, pacing, restlessness, hand wringing
- Suicide attempts or talking about suicide
- Giving away possessions and putting closure on relationships and tasks

common. Sometimes depression is expressed through hostile behavior. This is particularly important to recognize because such behavior can alienate family members and interfere with helpful assistance. One daughter said:

I remember my mother behaving in a hostile manner to her grandchildren, whom she once loved dearly. She was more likely to exhibit that behavior than to complain about feeling depressed.

Older depressed people often report memory problems that are greatly out of proportion to reality. Some will appear more confused than depressed. A common mistake in diagnosing depression is confusing depression with dementia (memory loss or impairment in mental functioning as a result of changes in the brain).

Older people are more likely to express emotional distress in terms of bodily symptoms. Vague complaints of aches and pains (for example, “I feel like I don’t have any blood” or “My body just feels heavy and weak”), unfounded fears about a serious illness, or complaints about health problems for which there is no medical basis can signal an underlying depression.

## Physical illness

Physical illness can mask depression, and depression can mimic physical illness. Many physical illnesses have symptoms similar to those produced by depression; for example, weakness, fatigue, social withdrawal, and appetite changes. This sometimes leads to a misdiagnosis of a physical illness when depression is the problem. When depression coexists with another medical illness and goes untreated, it can worsen or complicate the medical problem.

Your role is not to make the diagnosis of depression but, rather, to be aware of common signs and know how to locate and use available health care resources.

No single sign identifies depression. Depression involves a cluster of symptoms. A serious depression affects the entire person: physical well-being, feelings, thoughts, and behavior. The main features are a persistent sadness for at least 2 weeks and a change in usual patterns, behavior, and mood. For example, a once socially active woman becomes reclusive; a man who always took pride in his appearance dresses slovenly. The person also must experience several of the signs described in the box on page 10.

The more signs that are checked, the more likely the person is suffering from a serious depression and may need your assistance in seeking proper help.

If several of these symptoms have lasted 2 weeks or longer, or if the person's day-to-day functioning has been affected, get a medical evaluation.



Listen carefully to what the person says. Verbal statements often associated with depression and suicide include:

- I just feel down in the dumps.
- Nobody cares.
- No matter what I do, I can't do anything right.
- I just don't feel like doing anything.
- No one wants a dreary old woman/man around.
- My life is worthless.
- I'm tired of living.
- What's the use of living?



- My family would be better off without me.
- There's nothing to live for anymore.
- I feel like an empty shell.

As with other signs of depression, compare such statements with the way the person typically was in the past. If she previously

was satisfied with life, she might be seriously depressed. Coming from someone who always has been pessimistic and negative, these phrases might not be as significant. However, consider the possibility that the person has been depressed for a long time. Sometimes depression can develop so slowly as to seem natural. Without treatment, a depression can continue for months or even years.

### **Treatments for depression**

The earlier a depressed person receives help, the sooner the symptoms will be alleviated and the quicker the recovery. When depressed people who suffer from a medical problem are treated for both conditions, improvement in their physical health and overall well-being is better than for people who are treated for the medical problem alone. Treating the depression can increase the person's will and capacity to cope with ongoing medical problems.

Although several treatments are available, the most appropriate depends on the cause and severity of the depression, the availability and practicality of various treatments, and the person's medical condition. No single treatment works for everyone.

The three basic types of treatment are medication therapy, psychotherapy, and electroconvulsive therapy. Antidepressant medication and psychotherapy together often are more effective than either treatment alone.

Psychotherapy not only helps the person to feel understood and supported, it also increases her willingness to take medication.

Finding the right treatment can take time. No two people respond alike to treatment. Any treatment plan should be evaluated regularly so that appropriate decisions about continuation and/or changes can be made.

### **Medication therapy**

Antidepressant medications are especially effective in treating the symptoms of severe depression: lack of pleasure, sleep and appetite problems, and loss of energy. The medications work by bringing brain chemicals involved in depression back into balance. Antidepressant medications consistently reduce the symptoms of depression in 40 to 60 percent of those treated. This rate increases when medications are adjusted

---

*The earlier a depressed person receives help, the sooner the symptoms will be alleviated and the quicker the recovery.*

---

to individual needs or combined for increased effectiveness.

A medication that is effective for one person may not work well for another. And, it can take time to find the antidepressant that will work best.

Some people, particularly those with forms of recurring depression, need ongoing medication to prevent or alleviate further episodes, much as the diabetic requires insulin. For others, a short period of drug therapy is adequate. Because older people metabolize and excrete drugs more slowly than young adults, they may require lower initial and maintenance doses. Usually, an older person takes longer to respond to an antidepressant medication, possibly 2 to 6 weeks or longer before it takes maximum effect.

Sometimes people will stop taking a medication when they begin to feel better, thinking the medication has done its job. This can cause depression to recur in a few days. People frequently are maintained on an antidepressant medication for several months or longer after improvement to help prevent relapses.

Antidepressant medications should be used with caution to avoid adverse side effects. The potential for adverse side effects is even greater when a person is taking multiple medications.

---

Factors that a physician takes into account in prescribing a particular drug and its dosage include:

- Type of depression and specific symptoms
  - Severity of the depression
  - Presence of symptoms other than depression such as anxiety or obsessive-compulsive behavior
  - Age of the person
  - Individual and family history of response to a medication
  - Co-existing medical problems
- 

Pay attention to even mild side effects because they can cause some people to stop taking their medication. Most side effects can be minimized by minor adjustments in the size or timing of the dose or by changing to another medication. Close follow-ups are essential.

A person's history and behavior may suggest a lack of certain brain chemicals and so indicate a particular type of medication. Sometimes, it takes more than one try to find the medication that works best.

The following categories of medications are used for depression.

### **Selective Serotonin Reuptake Inhibitors (SSRI)**

Examples are citalopram (Celexa), escitalopram (Lexapro), sertraline (Zoloft), paroxetine (Paxil and generics), and fluoxetine (Prozac and generics). These are the most

---

*Sometimes,  
it takes more  
than one try  
to find the  
medication  
that works  
best.*

---

commonly prescribed medications for depression. They are particularly useful for people with anxiety symptoms as well as depression. Side effects can include headache, dizziness, nausea, insomnia and/or sedation, excessive sweating, and sexual dysfunction. All are reversible by changing the dose or discontinuing the medication. Most people experience no or few side effects. SSRIs are effective in individuals with mild to severe depression.

#### **Selective Norepinephrine Reuptake Inhibitors (NRI)**

This category of antidepressants is especially useful for people with low-energy depressions. These medications can increase initiative, motivation, attention, and concentration in depressed people; they generally do not improve anxiety-type symptoms. Common side effects include insomnia, anorexia, tremor, and sweating. The most commonly prescribed drug in this class, bupropion (Wellbutrin), may also help with smoking cessation.

#### **Nonselective Reuptake Inhibitors (NSRI)**

An example is venlafaxine (Effexor). Medications in this class increase the availability of both serotonin and norepinephrine to brain areas involved in mood regulation. They are often used in people in whom other

medications have not worked well. They can have side effects similar to both SSRIs and NRIs.

#### **Presynaptic antidepressants**

Examples are mirtazepine (Remeron and generics), and trazodone (Desyryl and generics). Some antidepressants work not by inhibiting the reuptake of neurochemicals from the space between neighboring brain cells (the synapse) but by stimulating brain cells to release more serotonin and norepinephrine. These medications can work well on their own but also are often used to augment the effects of other antidepressants.

#### **Tricyclic antidepressants**

Examples are the generics amitriptyline, nortriptyline, imipramine, desipramine, and clomipramine. These medications were the mainstay of medication therapy before SSRIs became available. They are used much less today because they take longer to work and side effects are common, particularly in older people. Side effects include sedation, dry mouth, and reduced blood pressure upon standing. Also, these medications are more likely to worsen cardiac arrhythmias and memory and concentration problems in older people. However, the tricyclic antidepressants can be useful in select circumstances; for example, if the person is not able

to tolerate SSRIs or is agitated and cannot sleep.

### **MAO inhibitors**

MAO inhibitors generally are reserved for people who do not respond to other types of antidepressants. Patients on these medications have to follow a careful diet to avoid a dangerous side effect involving high blood pressure. These medications generally are avoided in older adults due to interactions with other medications and because they more often have side effects.

### **Stimulants**

Examples are methylphenidate (Ritalin and others) and amphetamine (Dexadrine and others). These medications often are used for short-term treatment of persons in rehabilitation settings recovering from stroke, pneumonia, and other illnesses that may produce a state of lethargy and fatigue. These medications not only have mood-elevating effects but can also stimulate energy, alertness, and motivation. Side effects can include anxiety, agitation, decreased appetite, rapid heart rate, and increased blood pressure.

### **Mood stabilizers**

Examples are lamotrigine (Lamictal), sodium valproate (Depakote), and olanzapine (Zyprexa). Mood stabilizers are particularly effective for people with severe mood cycles associated with bipolar



disorder and other neurologic and psychiatric conditions. These medications also can be helpful in some cases of recurrent major depression. Lithium, the first proven mood stabilizer, is generally not used in older people except when other medications have been ineffective. Today, the primary medications used to treat older people with bipolar disorder and related conditions are sodium valproate or olanzapine.

### **Antipsychotic medications**

Medications for psychosis sometimes are used in very severe depressions accompanied by delusional thinking, hallucinations, or extreme agitation.

### **Psychotherapy**

Psychotherapy, or talk therapy, usually is used to treat mild to moderate depression but also can relieve severe depression. The depressed person works with a trained professional to solve problems that contribute to depression. Psychotherapy can



be particularly helpful when loss and grief, low self-esteem, or problems with relationships trigger the depression.

Antidepressant medication may bring a person sufficiently out of a depressive episode to face problems, and psychotherapy then can help the person to develop better coping responses. Psychotherapy helps people examine the underlying causes of depression and develop skills to manage the factors that contributed to their depression.

Age is not a determining factor in the success of psychotherapy. Older people respond well to psychotherapy; however, it may not be practical for those who have a significant hearing loss, are memory impaired, or are homebound.

Many mental health professionals provide psychotherapy, including psychiatrists, psychologists, clinical social workers, licensed counselors, and pastoral counselors. Besides depression, psychotherapists also can help people deal with and adjust to difficult life changes such as loss, chronic illness, and caregiving.

Three major psychotherapies, which may be used singly or together, are cognitive therapy, behavioral therapy, and interpersonal therapy.

### **Cognitive therapy**

Cognitive therapy helps people change negative thinking. It is based on the premise that mood is determined by the way a person interprets an event rather than by the event itself.

Depressed people tend to view themselves, their environment, and their future negatively. Cognitive therapy helps them monitor their thoughts, identify negative thought patterns that increase their vulnerability to depression, and restructure their thinking in positive ways.

### **Behavioral therapy**

Behavioral therapy emphasizes the importance of daily experiences and behavior. Depression can occur when a person experiences several unpleasant events or too few pleasant events. The goal is to increase the positive events (as determined for each individual). The therapist guides the person to develop skills or to access resources to make this possible.

### **Interpersonal therapy**

Interpersonal therapy focuses on relationship problems and role conflicts that contribute to the development of depression. Therapy addresses the way a person relates to significant people in life, and it helps change negative patterns and develop effective communication and relationship skills.

## Electroconvulsive therapy

Although many people have negative images about electroconvulsive therapy (ECT), it is one of the most effective treatments for severe depression. It has saved the lives of older people who otherwise would have starved to death or committed suicide. ECT may be considered when:

- A person is severely depressed and dangerously suicidal
- No other treatment has worked
- It would take too long for antidepressant medications to become effective, or
- A person cannot take antidepressant medications because of a medical condition and/or the medications' serious side effects

ECT passes a brief pulse of electricity between electrodes on the person's scalp. A series of treatments (a typical number is six to twelve) is given over several days to weeks, producing changes in brain function that can bring a person out of a serious depression quickly. Treatments generally are in an outpatient setting.

Modern methods have reduced the risks of ECT. The major side effects are some mild memory loss and confusion for a short time after each treatment. ECT, however, may exaggerate memory problems in people who were having problems with memory before treatment.

Prior to receiving ECT treatments, a 60-year-old woman, who had battled depression most of her adult life, wrote:

I can't work. I get too tired and when tired, I fall apart—depression and days in bed. Meds are not working for me any more... I am sick and tired of the whole thing. This is so tiresome, and at age 60 I find I don't have the will to struggle with it day after day.

After two treatments she wrote:

I've had only two treatments, and they have made all the difference! I now think of the future instead of death.

Following the end of treatment, she wrote:

The ECT's have been a life-saver. I have felt more solid emotionally than I have my entire life. I am so grateful!

## Alternative treatments

Many adults turn to alternative treatments for depression, either because traditional treatments are not effective or because they simply prefer herbal remedies. Before using any alternative treatment, consult a physician knowledgeable about depression.

The most common alternative treatments are herbal remedies.

---

*Age is not a determining factor in the success of psychotherapy.*

---

St. John's wort is the most commonly used herbal remedy for depression. Although studied extensively in Europe, in the United States St. John's wort is considered a nutrition supplement, not a medication, and therefore it is not regulated.

Because the action of St. John's wort is similar to that of SSRI medications, it should not be taken with antidepressant medications unless directed by a physician. Research about the

effectiveness of St. John's wort is inconclusive. It does have side effects, and people with hypertension or who are taking any other medications should be extremely cautious about taking it. St. John's wort should be taken only with the advice and follow-up of a physician.

### **Helping the depressed person**

As a family member or friend, you play a critical role in helping a depressed person return to full functioning. However, there is a fine line between helping people get well and enabling them to remain depressed. Sometimes helpers unknowingly reinforce depression; for example, if they

give attention primarily when the person is depressed or complaining. Consider the following as you reach out to help.

### **Encourage treatment**

One of the most important things you can do is encourage the depressed person to get a medical evaluation. However, expect to take an active role in making the appointment. The nature of depression—low energy, lack of motivation, and feelings of helplessness—makes it difficult for depressed people to take the initiative. Also, the older person may view depression and seeking help as a sign of weakness or personal failure, and therefore he may deny being depressed or may resist help. Because depression can cause confusion and forgetfulness, it's helpful if someone accompanies the person to the doctor.

Don't force the person into treatment or threaten institutionalization. Helping someone overcome depression should be positive, healing, and designed to return him to normal functioning. It should never be threatening or punishing. Communicate concern and caring, and give hope. For example, you might say:

Dad, I love you and I am concerned about you. In the last month I have seen you increasingly lose weight. John also told me



*St. John's wort*

you are no longer going out with the group. Your weekly bowling game has always been so important to you. I know this has been a difficult time, but there is help available that can help you feel better.

Avoid a power struggle with the person who refuses help. He has a right to remain depressed even though it is uncomfortable for you as well as for him. Only when the person's life is in danger should you intervene without permission.

### **Get expert help**

When someone close to you is depressed, remember you don't need to solve the problem all by yourself. Your best strategy is to locate and use the resources available to you.

### **When to get help**

It's better to seek help early than to wait for a crisis. It will be less stressful for both you and the depressed person. Here are some signs that professional help is necessary.

- You're wondering whether it's time for professional assistance. This usually means it *is* time.
- The depressive symptoms persist for more than 2 weeks.
- Depression is interfering with the person's daily functioning and activities.

- Depression is threatening the person's health.
- You observe signs of potential suicide.
- What you have done isn't working and you don't know what else to do.
- You are getting pulled down by the person's depression.

### **Where to get help**

Mental health services vary by community. If the person lives in a rural area, you may need to take her to a larger city for evaluation and development of a treatment plan.

When possible, consult with a professional who has experience working with older adults. The professional should be knowledgeable about mental health issues in later life and should believe that older people can recover from depression. Ask specifically about the professional's background or training in geriatrics or mental health issues among the aging. If a geriatric specialist is available in the community, that's usually a good place to start. Find out whether Medicare will pay for the professional's services.

Here are other resources.

### **The older person's physician**

When depression is suspected, the first step should be to arrange for a complete physical examination to uncover any physical illnesses or medications that may

---

*If a geriatric specialist is available in the community, that's usually a good place to start.*

---

be contributing to the person's depression. Go with her or call the doctor beforehand to explain your view of the situation. Be assertive. Tell the doctor the specific changes you see. Consider putting your observations in writing for the doctor.

It's unrealistic to expect the doctor to be aware of these changes in the person. Also, the person the doctor sees in a brief office visit can appear to be quite different from the person you see daily. If physical illness and medications are ruled out as a cause for the depression, ask for a referral to a mental health professional for evaluation and treatment.

**Community mental health center** Some centers provide a broad range of professional mental health services, including crisis intervention, at reasonable cost. Services are provided on a sliding fee scale; that is, fees are based on ability to pay. Some mental health centers provide outreach programs through senior centers.

**Mental health professionals in private practice** This group includes:

- Psychiatrists, who are medical doctors specializing in mental health treatments; they can prescribe medications
- Psychologists, who have Ph.D.s in psychology, specializing in psychological testing and therapy

- Psychiatric nurse practitioners are master's level nurses specializing in mental health care who, in many states, can prescribe medications
- Individual and family therapists
- Social workers who have specialized training in counseling and helping people cope with their problems

**Local and state hospital geriatric programs** These programs provide inpatient diagnostic work-ups and treatment.

**Clergy trained in counseling**

Many clergy are trained in counseling techniques. A person who has been active in a church, synagogue, or mosque may be more receptive to help from this source.

**Area agencies on aging** The local area agency on aging may be able to give you a list of agencies and professionals specializing in geriatric mental health problems.

**Seek help for yourself**

Because dealing with a depressed person can be frustrating, you may benefit from professional help. It's important not to let a person's depression get to you or drag you down. As one daughter said,

I didn't know who was being affected more by Mom's depression, Mom or me. After every visit, I was

a wreck. It seemed that nothing I did made a difference for her. And I'd end up feeling depressed!

Take care of yourself. A mental health specialist can help you to better understand depression, deal with your frustrations and negative feelings, and learn what your role should be in helping a person recover. Your seeking help also might serve as a "bridge" to get a resistant person to accept professional help.

### **Listen and validate feelings**

A depressed person needs to be listened to and understood. As one person said, "The opportunity to talk helps to get the sad out of you." Ask what is happening in the person's life and then really listen. Give the person a chance to talk about his feelings. Acknowledge the difficult situation(s) he has experienced and the hurt he may feel:

Dad, you've been through so much in the last few months, with the company cutting your position and your not being able to find another job. This must be painful. I know how important your work always has been to you. If this had happened to me, I would feel as if I'd been stabbed with a knife and it's twisting deeper and deeper. I'd be angry, wondering how the



company could do this to me after I've worked faithfully for 34 years. Is this somewhat how you're feeling?

Mom, I know that the move from your home to living in one room probably has been very difficult and filled with sadness. There must be many special memories associated with your home and a lot of things you have had to give up. What has been most difficult for you?

Allow the expression of anger and despair. By listening, you show concern and openness, and it's likely the person will tell you more.

---

*Don't try to talk the person out of his feelings. Telling him to cheer up or to quit thinking about problems will only make him feel worse.*

---

Older people experience many losses, some permanent, which can cause depression. Allow the person to move through the grief process at his own pace. If you rush him, he may stall and become stuck in the middle of the process.

Look beyond the loss itself to the meaning the person attaches to it. For example, a move from one's home to a care facility may be interpreted as "I'm no longer useful" or "My family doesn't love me." Or, the person may feel a total loss of control or see only more sadness in the future.

Don't try to talk the person out of his feelings. Telling him to cheer up or to quit thinking about problems will only make him feel worse. Avoid moralizing, telling him to try harder to get well, or pressuring him to "put on a smile," "snap out of it," or "pull yourself together." Such remarks imply that depression is willful. Pep talks only tell depressed people that their feelings are wrong or not important and that you really are not listening. Pat answers tell people that things are really simple if only they would try. **Depression is not simple.**

Avoid statements such as "Look at all you have. You can still. . .," "You've had a good life. Count your blessings," "You have everything to live for," "You are so much better off than....," or

"Don't worry. It'll all work out." Such statements do not communicate caring or that you understand; they only smother the person's efforts to talk things out.

### **Build a supportive environment**

Support from family and friends is critical. It helps keep a person from giving up or withdrawing further. Offer help when needed but avoid doing everything, which might increase feelings of helplessness.

It's often difficult to be around a person who is sad, negative, or complaining. You may have to educate family and friends about depression, its impact on functioning, and the person's feelings and needs. Upbeat, positive people who understand depression are particularly helpful.

Set up a system of calling and visiting regularly. Spending focused time with the person can show genuine caring and attention. Scheduling special time with the person, rather than just dropping in, may give him something to look forward to.

Provide support during and *after* treatment. When therapy has ended, your support is important as the person begins to use his newly acquired coping skills.

Practical help, such as transportation to a clinic or assistance with bills, may help speed the person's recovery. Or, perhaps



you can change a situation that is contributing to the depression. One daughter said,

What a difference it made when we moved Mom down to a first-floor apartment. She had become isolated, then depressed, after a fall down the stairs. Being on the first floor removed her fear and lifted the depression.

### **Structure activity**

Depression responds to structure and physical activity. If you can get depressed people involved in doing things, they generally begin feeling better. Exercise, such as walking, can make a difference, particularly for the mildly or moderately depressed person. However, you may have trouble motivating the person.

A depressed person tends to feel like a failure. It's important for

him to experience success. Try to find activities that reinforce pleasant events and build a sense of self-worth and adequacy. Point out his strengths in the process. You can help the person to succeed by assisting him to set small, attainable goals that have immediate results.

### **Give the person control**

Encourage as much control and decision making as the person can handle, but don't overwhelm her with decisions. Taking away power unnecessarily only reinforces feelings of inadequacy. Provide choices, but don't push or intrude more than necessary. Respect her autonomy. Because many depressed people have difficulty with decision making, you need to maintain a delicate balance.

### **Learn about medications**

Be aware of any medications the person is taking that could contribute to depression. If she is being treated with an antidepressant medication, know the therapeutic and side effects, the precautions, and what to expect so you can quickly spot problems. Know how antidepressants interact with other medications she may be taking. If a problem develops, talk to the doctor.

### **Be alert to signs of suicide**

Every depressed person is at risk of suicide, even someone you feel would never take his life. Be

---

*Depression responds to structure and physical activity.*

---

---

*Every depressed person is at risk of suicide, even someone you feel would never take his life.*

---

alert to potential signs of suicide and know what to do if you see them. Remove instruments of suicide, if possible.

### **Be watchful at holidays**

Holidays and anniversaries can be difficult for someone who is depressed. A loss linked to the day may seem more poignant. Or, the joyousness of a holiday may serve only to deepen, perhaps by contrast, feelings of sadness or aloneness. Be especially watchful at these times.

### **Handling special problems**

#### **When the person denies being depressed**

You may see many signs of depression, yet your relative or friend firmly denies it, blames the symptoms on stress or physical illness, and becomes angry that you would even think she's depressed. She may resist all help. There are no easy ways to deal with resistance; however, here are some ideas to help reduce the tension.

#### **Visit a mental health professional for yourself**

A therapist can help you develop ways to approach the person and to work through your feelings.

#### **Identify someone the person trusts**

Enlist the help of anyone who has "listening leverage" and influence with the depressed

person. This may be a physician, pastor, neighbor, friend, or family member. Many older people are more likely to accept treatment by a mental health professional if it is prescribed by their own medical doctor.

#### **Focus on depression as a medical illness**

The physical aspects of depression may be more acceptable to the person than "mental" issues. Therefore, you may have more success by focusing on the physical symptoms—for example, problems with sleep, appetite, and fatigue. Remember, a first step in evaluation is a thorough physical examination.

Explaining that depression is a medical condition and often is caused by illness, medications, or biochemical factors may reduce feelings of shame and make evaluation and treatment more acceptable. For example, you might say, "You may be feeling down because of a chemical imbalance."

#### **Concentrate on what the person acknowledges as a problem**

Identify what the person sees as the problem—for example, "I'm just so tired"—and address that rather than the depression itself.

#### **Encourage a medical check-up**

Be willing to make the doctor's appointment, take the person there, and perhaps even talk with

the doctor in advance about your observations. Once you are in the doctor's office, respect the person's autonomy by giving her private time with the doctor.

### **Use "I" messages**

Talk to the person using "I" messages, not "you" statements. In an "I" message, you speak about your feelings and identify the specific changes you have observed. For example, you might say:

I know you feel that you're doing fine, but I am concerned because you seem to be tired most of the time. I'd like you to see your doctor to reassure me that you're okay.

I'm worried about you because you've stopped going to the senior center and to church.

"You" statements sound dictatorial and tend to create defensiveness and resistance. "You" messages are usually commands, such as "You are depressed; you must quit denying it and go to the doctor," or statements that blame the person, such as "You brought this all on yourself." Sometimes these remarks give solutions or deny the person's feelings: "If you'd do..., then you wouldn't be depressed" or "You shouldn't feel depressed. You have so much to live for."



Sometimes it's necessary to wait for a crisis before the person recognizes the depression and the need for help. Be patient and don't give up.

### **Helping from a distance**

When you are separated geographically from the person who is depressed, it becomes more of a challenge to help. The following strategies may make the task less complicated.

#### **Learn about resources**

Use the telephone to find resources for both information and referral in the older person's community. These may include a mental health center, the person's doctor, a physician specializing in geriatrics, the area agency on aging, the local senior center, or a care manager to make home visits and to "bridge" the older person to a mental health specialist.

Encourage the older person to follow up on specific contacts you make. Then check her

---

*Explaining that depression is a medical condition often caused by illness, medications, or biochemical factors may reduce feelings of shame and make evaluation and treatment more acceptable.*

---



response and progress by telephone. Before talking with her physician, try to get her permission. This encourages her sense of control. Sometimes, however, a person will not give permission. If you ask for it and are told “no,” another approach is to use an “I” message and say that because of your concern and worry you need to call her physician. At least she will know what you’re doing.

### **Maintain regular contact**

Making frequent telephone calls and really listening shows you care. Although it can be difficult to listen to negative or pessimistic talk, it’s important to encourage communication. Sending letters, audio- and videotapes, family photos, and other surprises can help a person feel cared about and supported.

### **Find a local support person**

Seek out someone in the community you can trust to monitor your family member’s well-being and to provide accurate information about how she is doing. Be willing to pay for this help. Hiring a private care manager is one option.

### **Identifying and responding to a suicidal person**

Factors that put a depressed older person at high risk for suicide:

- Severe loss, such as loss of health or a significant person

- Feeling hopeless and helpless
- Living in isolation
- Prior suicide attempt
- Alcohol or drug abuse
- Detailed suicide plan, including the means, time, place, and method
- A readily available lethal weapon

Clues to suicidal intent generally are more subtle with older people than younger ones. The following are common warning signs that a depressed person may be contemplating suicide.

### **A sudden upswing in mood**

A sudden improvement in mood may be because the depressed person has reached a decision to end her life and has made a plan to do so.

### **Talking about suicide**

It’s less common for older people to talk directly about suicide, but when they do, listen and take action. Verbal clues are likely to be more indirect. For example:

- “You won’t have to worry about me much longer.”
- “Here, take these things. I won’t need them anymore.”
- “There’s just nothing to live for.”
- “I need to tie up loose ends.”
- “My time has come.”

### **Feeling hopeless and helpless**

A person who expresses a sense of worthlessness, helplessness,

and hopelessness through words or actions often begins to think of suicide as a way out.

### **Unusual behavior**

A sudden or dramatic change in behavior that is not characteristic of the person should be treated as a warning flag for suicide.

Here are examples of actions that may indicate suicidal intent:

- He suddenly writes a will and puts personal affairs in order, whereas previously he resisted doing so.
- She stockpiles medications or makes sudden requests for sleeping pills.
- He shows new interest or loses interest in church and religion.
- She has been active in the community but suddenly resigns from all organizations.
- He gives away important possessions.
- She has always been known as a “penny pincher” but now gives away large sums.
- He sells his home and other possessions without plans for replacement.
- She displays uncharacteristic affection and makes amends for things that have happened in the past.
- He increases alcohol use.
- She is preoccupied with death.

Be particularly vigilant when a person is coming out of a deep depression. This is a time of high risk for suicide. Earlier the person may have felt suicidal but was

too paralyzed to act on these feelings. Now, he may have the energy to take action.

The three most important actions to take to prevent suicide are to listen, ask questions, and get professional help.

### **Listen**

Listening is what suicide prevention is all about. Be aware of both obvious and subtle expressions of suicidal intent. Never ignore remarks about suicide. Take all expressions seriously. Most important is to be accepting, nonjudgmental, and supportive. This encourages the person to confide in you.

### **Ask questions**

You need to ask questions to assess the risk of suicide. Asking questions about suicide will not give the person the idea to take her life. In fact, asking questions often provides the opportunity for people to express their emotions, which if not expressed might prove fatal.

You can ask general questions such as “How is your life going?” or specific questions such as “Have you considered harming yourself?” “Have you thought about ending your life?” or “Are you thinking about suicide?” Don’t be afraid to say the word “suicide”; mere mention of the word will not create a desire to act it out.

---

*It's less common for older people to talk directly about suicide.... Verbal clues are likely to be more indirect.*

---

---

*The three most important actions to take to prevent suicide are to listen, ask questions, and get professional help.*

---

If the person denies wanting to die, the potential for suicide is probably low unless the person is an alcoholic, drug abuser, or psychotic (a mental disorder in which the person has irrational beliefs, is extremely impulsive, and has an impaired sense of reality). If the person hedges (“Who knows?”), responds with self-accusations (“I’m not fit to live”), or admits to having suicidal thoughts, the potential risk for suicide is high. Immediately ask these questions:

- How would you take your life?
- Do you have the means available?
- When would you do it?

Asking specific questions about the plan is important. The person who has a plan and the means available is at greatest risk.

### **Get professional help**

If there is a risk of suicide or if you are uncertain about the person’s intentions, get professional help immediately. At this point, the decision to get help might have to be taken from the person. At a later time, you may have to talk with her about having forced the decision; usually people are relieved, not angry, about that.

The following emergency services, available in most communities, will be provided immediately to the suicidal person.

### **Crisis lines and organizations**

Volunteers who staff these services receive special training in handling suicidal people and can assist you in getting help. Keep their telephone number in an easy-to-find location in case of an emergency.

**Mental health clinics** These clinics will give immediate attention to suicide threats, whether or not the depressed person is already a client. Most mental health clinics have a 24-hour telephone number.

**Hospital emergency room** A person who threatens or attempts suicide will receive immediate care in most hospital emergency rooms. Many hospitals have staff available 24 hours a day as part of the inpatient mental health unit. If you cannot get the person into an automobile and to the hospital, call an ambulance.

**Police or other emergency service agency** If other resources are not available or you can’t decide what to do, call 9-1-1 (or the emergency number in your area) or your local police. You will get help in deciding what to do and in dealing with the immediate crisis.

To intervene with the high-risk person:

- Act decisively
- Remove the means or weapon
- Summon help

- Remain with the person; do not leave a suicidal person alone. If possible, try to get the person to promise that he will not take any action for a specific period of time.

If the person is not at high risk for suicide, keep monitoring her. Reapproach her with questions about suicide if her mood or activity level deteriorates further or suddenly shows an upswing. Keep in frequent contact at least by telephone. If possible, have someone visit or have her see someone daily or every other day. Try to keep alcohol away from her. The combination of alcohol and depression places a person at higher risk for suicide. In fact, depression and alcohol together have been said to create “a deadly triangle” with suicide.

### **Summary**

Depression is one of the most treatable emotional disorders. Resources are available to help older people move out of their depression and back toward a happier life. Your job is to locate and use the assistance available to you. You can help manage the depression, but remember that you are not responsible for the cure.

You also may need to accept that no matter how much you might want to, you cannot replace the losses or undo the changes in your friend’s or family member’s

---

**H**ealing the emotions is all too often viewed as a sign of weakness, yet we don’t consider it weak to go to a doctor when we experience physical pain. Just as it’s okay to seek help in healing our bodies, we [must] seek help in healing our minds.

B.D. Colen  
*Health*, November 1988

---

life nor “make him happy.” You need to be realistic about what you can do and about your own personal limits.

### **For further information**

#### **PNW Extension publications**

*Aging Parents: Helping When Health Fails*, PNW 246.

*Alcohol Problems in Later Life*, PNW 342.

*Coping with Caregiving: How to Manage Stress When Caring for Older Relatives*, PNW 315.

*Sensory Changes in Later Life*, PNW 196.

*Helping Memory-impaired Elders: A Guide for Caregivers*, PNW 314.

*Using Medicine Safely in Later Life*, PNW 393.

*Living Arrangements in Later Life*, PNW 318.

*Hiring and Working Successfully with In-home Care Providers*, PNW 547.

*Making Decisions about a Nursing Home*, PNW 563.

## **Oregon Extension publications**

*Talking to Your Family and Doctor about Difficult Health Care Decisions*, EC 1386.

*If You Became Incapacitated, Who Would Make Decisions for You?*, FS 332.

Oregon and PNW publications are available from Oregon State University. PNW publications also are available from Washington State University and University of Idaho. Contact the offices below for information on availabilities, prices, quantity discounts, sales tax, and shipping and handling charges.

Publication Orders  
Extension & Station  
Communications  
Oregon State University  
422 Kerr Administration  
Corvallis, OR 97331-2119  
Fax: 514-737-0817  
Tel.: 541-737-2513  
puborders@oregonstate.edu  
<http://eesc.oregonstate.edu/>

Bulletin Office  
Cooperative Extension  
Washington State University  
P.O. Box 645912  
Pullman, WA 99164-5912  
Fax: 509-335-3006  
Tel.: 1-800-723-1763  
bulletin@coopext.cahe.wsu.edu  
<http://pubs.wsu.edu/>

Publications  
University of Idaho  
P.O. Box 442240  
Moscow, ID 83844-2240  
Fax: 208-885-4648  
Tel.: 208-885-7982  
calspubs@uidaho.edu  
<http://info.ag.uidaho.edu/>

© 2004 Oregon State University

---

Trade-name products and services are mentioned as illustrations only. This does not mean that the participating Extension Services endorse these products and services or that they intend to discriminate against products and services not mentioned.

---

Pacific Northwest Extension publications are produced cooperatively by the three Pacific Northwest Land-Grant universities: Oregon State University, Washington State University, and University of Idaho. Similar crops, climate, and topography create a natural geographic unit that crosses state lines. Since 1949, the PNW program has published more than 550 titles, preventing duplication of effort, broadening the availability of faculty specialists, and substantially reducing costs for the participating states.

Published and distributed in furtherance of the Acts of Congress of May 8 and June 30, 1914, by the Oregon State University Extension Service, Washington State University Cooperative Extension, the University of Idaho Cooperative Extension System, and the U.S. Department of Agriculture cooperating.

The three participating Extension Services offer educational programs, activities, and materials—without regard to race, color, religion, sex, sexual orientation, national origin, age, marital status, disability, and disabled veteran or Vietnam-era veteran status—as required by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Rehabilitation Act of 1973. The Oregon State University Extension Service, Washington State University Cooperative Extension, and the University of Idaho Cooperative Extension System are Equal Opportunity Employers. \$3.00

---

Published April 1990; revised July 2004.