3-180 Best strategies for severe depression

TIPS Question:

What are other best strategies when dealing with a resident's severe depression? For a resident with difficult behaviour – how do you approach? What are other ways for effective communications that are not mentioned in the book?

How do you apply P.I.E.C.E.S. for some family members who are in denial of resident's disease and are difficult to approach with treatment suggestions for resident?

Response:

You have brought forward some interesting questions and I will address them in sequence.

1. Treatment strategies for severe depression: Depression occurs in approximately 10 – 20% of institutionalised elderly, Pharmaco therapy is an important care strategy for severe depression, but non-pharmacological interventions are also as important for recovery. Social support is critical and can be through staff, family and friends. Engagement in activities that can build on past interests. If available cognitive, behavioural and interpersonal therapies can also be used. Often overlooked is the importance of physical activity/exercise. Research has shown that exercise programs are effective in reducing clinical depression in older persons. It also assists in reducing the risk of physical debilitation related to decreased activity related to the depression. For severe depression in the elderly ECT may be required.

2. Resident with "difficult behaviour": The best approach to start would be to go back to the 6-Question Template to better understand the behaviour. If you go to your U-First! wheel you will see it begins with "Understanding: my knowledge that all behaviour has meaning" and "what is the person trying to tell"? Has the resident's cognition been assessed? Has the behaviour been considered with the context of the "7A's" of losses of dementia? Often behaviours that may appear to be 'non-compliant' are related to cognitive changes caused by dementia (review question #5 of the P.I.E.C.E.S. template) and discuss with the care team. If there are no cognitive changes, the behaviour needs to be understood in the context of who this individual is as a person, e.g., always been independent, etc. These assessment strategies will then assist you and the care team to plan the best approach.

3. Communication: This is rather broad in scope. If you consider all of the physical/capabilities, intellectual, emotional, social, environmental factors (P.I.E.C.E.S.) that impair or enhance communication and consider in the interaction similar factors for the care team, the potential for enhanced or decreased communication is infinite. Perhaps you and the care team could share ideas at a team report/conference.

4. P.I.E.C.E.S. for family members: You have raised an excellent point and you are correct in considering this framework in "understanding all behaviour has meaning". All of us as individuals and as members of families and social systems are influenced by the factors identified in P.I.E.C.E.S. It is important to consider this when interacting with families to better understand their point of view and to better understand our own values and beliefs and how these are influencing our interactions. P.I.E.C.E.S. as applied to the family and staff is described in the P.I.E.C.E.S. Resource Guide.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*