Review of Depression Assessment Tools Resource Package
ADMINISTRATION AND SCORING GUIDELINES

**Scale/Screen:** Geriatric Depression Scale (GDS)
GDS 4, GDS 12, GDS 15

**Use(s):** For the detection of depression in older adults in a variety of settings.

**Time Taken:** Between 5-20 minutes depending on which GDS is selected.

**Rationale(s):**

The Geriatric Depression Scale was devised specifically for the screening of depression in older adults. The scale’s simple yes/no format was thought to facilitate greater acceptance from seniors. Questions focused primarily on associated somatic symptoms of depression were eliminated in order to reduce the possibility of false positives related to concomitant medical pathology or the effects of aging.

**Commentary:**

- The original thirty question Geriatric Depression Scale was the first depression screen constructed specifically for screening older adults for depression. Other scales were considered unsuitable because of their over-reliance on somatic symptoms which, in the elderly, may be part of the normal aging process or a chronic physical condition and not related to depressive illness.

- The scale was designed as a self or interview administered screening instrument. When used by mental health personnel, it has been most commonly administered as part of the clinical interview.

- The original scale was designed for use in community subjects but has since been found to be appropriate in primary care, medically ill inpatient settings, and in nursing home facilities.

- The 15 item version of the scale was formulated by Dr. Yesavage to make it more acceptable as a screen in primary care and also to facilitate its use in subjects with cognitive impairment.

- The 12 question version of the scale eliminates three questions which researchers found were confusing, inappropriate or ambiguous for residents of continuing care facilities (Sutcliffe).
• For example, the question “Do you prefer to stay at home rather than go out and do new things?” may have little meaning for people with limited opportunities for voluntary egress.

• Some studies have confirmed the screen’s appropriateness in subjects with dementia; other studies have questioned its use with this population. The severity of cognitive deficits is probably key. Where there is any doubt of the subject’s ability to adequately comprehend questions, a substitute scale such as the “Cornell Scale for Depression and Dementia” is advised.

**Administration:**

• The methods of administering the Geriatric Depression Scale may vary according to the population to be screened, the assessment setting, and the experience of the raters.

• The self-rating method is best reserved for subjects who are clearly unimpaired cognitively and fully understand the purpose of the screen and are motivated enough to complete the screen unassisted.

• For most elderly people, the interview rated option is preferred. Studies have shown it to be more acceptable to the elderly in general. One study found, for example, that only 65% of those with the self administered questionnaire completed it (O’Neill).

• A number of studies have indicated that the Geriatric Depression Scale’s sensitivity and specificity is less reliable in subjects who score 15 or less on the MMSE. Cognitively impaired individuals may deny both memory impairment and depressive symptoms. It is recommended therefore, that where there is any uncertainty regarding the subject’s cognitive status a two step procedure be followed, and the individual’s cognitive status be assessed by the SMMSE and the GDS administered only if the score exceeds 15 (McGinney) (Stiles).

• The introductory statement at the top of the GDS for self-rating reads “Choose the best answer for how you felt over the past week.” An example of an introduction for an interview-rated GDS could be, “I am going to ask you some standardized questions from this form to help me find out how your mood has been over the last week. You just need to answer yes or no to each question. This will only take a few minutes but we can take more time afterward to go into more detail if that is necessary. Is that okay? The first question is ....”
**Scoring:**

<table>
<thead>
<tr>
<th></th>
<th>Cutoff</th>
<th>Sensitivity</th>
<th>Specificity</th>
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<tbody>
<tr>
<td>GDS 15</td>
<td>5</td>
<td>80%</td>
<td>70%</td>
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<tr>
<td>GDS 12</td>
<td>5</td>
<td>78.6%</td>
<td>67%</td>
</tr>
<tr>
<td>GDS 4</td>
<td>1</td>
<td>85%</td>
<td>60%</td>
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</tbody>
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**References:**


Geriatric Depression Scale – Short Version

Date: ________________________________
Assessed By: __________________________

Circle the best answer for how you felt over the past week.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Are you basically satisfied with your life?</td>
<td>0</td>
<td>1</td>
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<tr>
<td>2. Have you dropped many of your activities and interests?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Do you feel that your life is empty?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Do you often get bored?</td>
<td>1</td>
<td>0</td>
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<tr>
<td>5. Are you in good spirits most of the time?</td>
<td>0</td>
<td>1</td>
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<tr>
<td>6. Are you afraid that something bad is going to happen to you?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Do you feel happy most of the time?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8. Do you often feel helpless?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Do you prefer to stay at home, rather than go out and do new things?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Do you feel you have more problems with memory than most?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Do you think it is wonderful to be alive?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>12. Do you feel pretty worthless the way you are now?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Do you feel full of energy?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14. Do you feel that your situation is hopeless?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. Do you think that most people are better off than you are?</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

TOTAL: /15

Questions 9, 10, and 15 can be dropped for residents of Long Term Care Facilities.
Questions 1, 3, 6, and 7 can be used as a general brief screen.
Questions 1, 2, 8, and 10 can be used as a brief screen for people with visual impairment.

Sheikh & Yesavage, 1986

Enquires: SAS Committee Chair/ Alberta Hospital Edmonton Community Geriatric Psychiatry, (780) 424-4660.
ADMINISTRATION AND SCORING GUIDELINES

Scale/Screen: Cornell Scale for Depression in Dementia

Use(s):
- A screen to help detect depressive illnesses in persons with dementia in hospital or in continuing care centres.
- The Cornell Scale has not been validated in community-dwelling subjects whose caregivers are primarily family members or health care aides.

Time Taken: Total administration and rating time is approximately 30 minutes (a 20 minute caregiver interview and a 10 minutes patient interview)

Rationale(s):
- Depression and dementia frequently co-exist, for example, symptoms and signs of depression have been found in up to 50% of demented subjects living in the community or in nursing homes.
- The use of self-rated or exclusively patient interview-rated screens for depression in subjects with dementia is problematic because impairments in concentration, memory, language and judgement may affect the subject’s ability to respond accurately and appropriately.
- The assessment of depression in those with a concomitant dementia may require longer periods of observation from an informant familiar with the subject’s variable behaviour and mood over a period of time (weeks).

Commentary:
- The Cornell Scale is a 19 item instrument. The items were selected from feedback received from geriatric psychiatrists and following a review of the literature on the phenomenology of depression in demented and non-demented patients. The scale was found to have satisfactory internal consistency and validity when measured against research diagnostic criteria and the Hamilton Depression Rating Scale.
- Items were devised so that they can be rated primarily by observation of the patient’s behaviour.
- Items are rated according to three distinct grades: “Absent”, “Mild or Intermittent” and “Severe”.

Enquiries: S.A.S. Committee Chair, c/o AHE Community Geriatric Psychiatry, (780) 424-4660
- The scale is designed to be used in settings where health professionals (mainly nurses are available) as reliable informants. Informal caregivers, such as family members, may have knowledge of the demented patient’s behaviour but, may be less familiar with the methods of clinical observation and reporting than nursing staff or other health professionals.

**Administration:**
- A two step procedure is used to administer the scale.
- The rater first interviews the caregiver on each of the scale’s 19 items.
- Caregivers should be familiar with the patient and be confident they can report on his/her behaviour over the past week.
- Symptoms and signs are described to the caregiver as they appear on the screen.
- The caregiver is asked to base his/her comments on direct observation of the patient’s behaviour during the previous week.
- For two of the items, “loss of interest”, “lack of energy”, the caregiver is advised that the change had to occur relatively acutely (within one month). For these two items, the caregiver is asked to describe the patient’s behaviour during the past week, and then, to provide information regarding the onset of the “loss of interest” and/or “lack of energy”.
- The “weight loss” item is based entirely on information about the patient’s weight during the previous month.
- Following the informant interview, the rater then briefly interviews the patient using the scale as the basis of the inquiry and observation.
- The rater may need to interview the caregiver again, following the patient interview, to resolve any significant disagreements or discrepancies between the caregiver’s report and the rater’s findings on direct interview and observation of the patient.

**Scoring:**
- The rater assigns a preliminary score (in pencil) after the informant interview and a final score following direct inquiry and observation of the patient. Items are scored as:

  0 = are absent
  1 = are present in mild or intermittent form
  2 = are present in severe form.

a) unable to evaluate signs and symptoms of depression:
Most items are rated on observations during the week prior to the interview. Two items, however, “loss of interest” and “lack of energy” have to be established as a relatively acute change in the patient’s behaviour, i.e., within a period of less than four weeks.

For the “weight loss” item, the patient has had to have lost more than five pounds in the previous month to score 2 on the scale.

The maximum score of the Cornell is 38. A score of greater than 12 indicates probable depressive disorder.

References:

- Sable JA, Dunn LB, Zisook S. Late-life depression, How to identify its symptoms and provide effective treatment, Geriatrics February 2002, Vol 57, No. 2, 18-35.
**Cornell Scale for Depression in Dementia**

Date: ______________________________________

Assessed By: ______________________________________

Please assess based on week before interview. No score should be given if signs or symptoms result from acute disability (e.g. fall or illness).

Please check as appropriate.

<table>
<thead>
<tr>
<th>Mood Related Signs</th>
<th>Unable to Evaluate</th>
<th>Absent</th>
<th>Mild to Intermittent</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety: anxious expression, worrying</td>
<td>a</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Sadness: sad voice, fearfulness</td>
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<tr>
<td>Loss of interest: less involved in usual activities (acute only, &lt; 1 month)</td>
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Score > 12 indicates probable depression

Have you/has the patient ever taken antidepressants?  __ Yes  __ No

Score

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Enquires: SAS Committee Chair/ Alberta Hospital Edmonton Community Geriatric Psychiatry, (780) 424-4660.
Cornell Scale for Depression in Dementia

Date: ______________________________
Assessed By: ____________________________

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Score > 12 indicates probable depression

Have you/has the patient ever taken antidepressants?  _ Yes  _ No

Score


Enquires: SAS Committee Chair/ Alberta Hospital Edmonton Community Geriatric Psychiatry, (780) 424-4660.
Review of Depression Assessment Tools Handout Package
Assessment of Depression

Learning Objectives

1. Identify possible causes of behaviour related to emotional health
2. Screen for depression using the Geriatric Depression Scale
3. Administer and score the Cornell Scale for Depression in Dementia

Major Depression

DSM-IV: A mood disorder characterized by five (or more) of the following symptoms that have been present during the same 2-week period and represent a change from previous functioning:

At least one of the symptoms is:

(a) depressed mood or
(b) loss of interest or pleasure
Major Depression (cont.)

a. Depressed mood most of the day, almost every day, for at least two weeks
b. Diminished interest or pleasure in almost all activities most of the day, almost every day, for at least two weeks

c. Significant weight loss or gain; change in appetite
d. Sleep disturbances (e.g. insomnia, waking early, hypersomnia)
e. Psychomotor agitation/retardation; feeling restless, "wired" or irritable

f. Fatigue; energy loss
g. Feeling of worthlessness, guilt or hopelessness
h. Impaired concentration; indecisiveness
i. Recurring thoughts of death/suicide
Atypical Presentation in the Elderly

a. Depressed mood is not always evident
b. Memory loss or difficulty with concentration
c. Anxiety of several weeks/months duration
d. Physical manifestations

e. Psychotic features
f. Functional decline
g. Apathy, withdrawal and loss of self-esteem
h. Suicide attempts

SIG E CAPS

S – Sleep is disturbed
I – Interest and capacity for joy are decreased
G – Guilt of lowered self-esteem are common
E – Energy and participation are lower than previously
C – Concentration is poor; memory problems may appear
A – Appetite is disturbed, usually with wt loss
P – Psychomotor retardation or agitation may be present
S – Suicidal ideation and thoughts of death are common
Geriatric Depression Scale (GDS)

- Specifically devised for screening depression with older adults
- Simple ‘yes/no’ format
- Original with 30 items
- Short version valid and reliable
- Applicability to dementia population?

Cornell Scale for Depression

- Quantitative rating
- Makes use of caregiver and resident information
- Scoring based on both observation and verbal feedback
- Screening tool; not diagnostic

Cornell: Format

- 2 interviews – resident and caregiver
- 19 questions - 5 major headings
- 2-point scale
- Maximum score of 38
- Ratings based on observations observed or reported previous week
Cornell: 2-point scale

0 = absent
1 = mild or intermittent
2 = severe
n/a = unable to evaluate

Cornell: Mood-Related Signs

- Anxiety... anxious expression, ruminations, worrying
- Sadness... sad expression, sad voice, tearfulness
- Lack of reactivity to pleasant events
- Irritability... easily annoyed, short tempered

Cornell: Behavioural Disturbance

- Agitation... restlessness, hand-wringing, hair-pulling
- Retardation... slow movements, slow speech, slow reactions
- Multiple physical complaints (score '0' if GI symptoms only)
- Loss of interest... less involved in usual activities, (score only if change occurred acutely, i.e., less than one month)
**Cornell: Physical Signs**

- **Appetite loss**… eating less than usual
- **Weight loss** (score ‘2’ if greater than five pounds in one month)
- **Lack of energy**… fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e. in less than one month)

**Cornell: Cyclic Functions**

- **Diurnal variation of mood symptoms**… worse in the morning
- **Difficulty falling asleep**… later than usual for this person
- **Multiple awakenings during sleep**
- **Early morning awakening**… earlier than usual for this person

**Cornell: Ideational Disturbance**

- **Suicide**… feels life is not worth living, has suicidal wishes, or makes suicide attempts
- **Poor self-esteem**… self-blame, self-depreciation, feelings of failure
- **Pessimism**… anticipation of the worst
- **Mood-congruent delusions**
- **Delusions of poverty**… illness, or loss
Cornell: Interpretation

Average
1.4 no psychiatric diagnosis
4.8 non-depressive psychiatric disorders
12.3 minor or probable major depressive disorder
24.8 definite major depressive disorder

“Depression is one of the most common and most treatable of all mental disorders in older adults.”

Piven (2001, p. 18)