CONFERENCE CALL-VHQC
October 4, 2006

Female: Good afternoon and welcome to today's conference call. The topic is: "Depression Assessment - Part Two. What are we doing for our residents?" The moderator today is Laurie Jessik. During the presentation all participant lines will be muted. You will be able to ask questions at the conclusion of the presentation by pressing 01 on your telephone keypad. If time does not allow for all questions to be answered, you may e-mail your questions to your state quality improvement organization. At the conclusion of the call there will be a brief polling session allowing you to provide feedback on the topics discussed. Now without further delay, I'll turn the conference call over to Laurie Jessik.

Laurie: Good afternoon. We'd like to thank you for participating on today's teleconference call on nonpharmacological interventions for depression. We are excited to be able to share with you today some resident centered interventions for the management of depressive symptoms. Before I introduce our speaker, I would like to recognize the sponsoring quality improvement organizations that have worked very hard to bring this educational opportunity to you. Delmarva, the QIO for D.C.; Georgia Medical Care Foundation, the QIO for Georgia; Delmarva, the QIO for Maryland; the Carolina Center for Medical Excellence, the QIO for North Carolina and South Carolina; Q Source, the QIO for Tennessee; and Virginia Healthcare Quality, the QIO for Virginia. This call will be muted during the presentation by the conference center for optimal quality, as the call is being recorded for posting to each of our web sites. You will be in the listen mode until the question and answer session, which begins approximately at about 2:45 p.m. Eastern Time and 1:45 p.m. Central Time. At that time if you have a question, please touch 01 on your telephone keypad and the operator will un-mute your phone. Please remain on the line following the 10-minute question and answer to complete a brief polling to evaluate this call. It is very important for us to receive your feedback so we can meet your needs on any of our future calls. Once again, if you do not have your questions answered today by Dr. Nygard, please send them to the quality improvement organization and we will send them to Dr. Nygard for a response. We would like to now introduce to all of you Dr. Kortner Nygard. He is a licensed clinical psychologist, and president and owner of GeroPsych Inc. in Nashville, Tennessee. He received his doctorate in clinical psychology from the University of Iowa in 1974. He currently provides diagnostic evaluation, referral and psychotherapy to geriatric residents with affective and cognitive problems in nursing homes and assisted living facilities. He also provides consultation with staff to promote best strategies for improving resident outcomes. Dr. Nygard is the vice president of New Senior Concepts, which provides management to an innovative assistive living facility that is sensitive to cultural factors. He is a certified Eden trainer, mentor, as well as the chairperson for the Tennessee Eden Alternative Coalition. Thank you Dr. Nygard for sharing your time and expertise with us today.

Dr. Nygard: Thank you for inviting me. I'm really honored to have an opportunity to talk to everyone. This is certainly a topic near and dear to my heart. Thank you all for

joining in today. I thought I'd give you a bit of a heads up about what I'm going to cover today – the old adage of "tell them what you are going to tell them and then tell them." I may skip the "tell them what you told them" part at the end. The emphasis on what I'm going to talk about today is looking at more nonpharmacological approaches to managing depression and also looking at things that are what I call CNA friendly: things that certified nursing assistants can, in many cases, implement themselves, so that you don't need necessarily a psychologist or something in house for all of these… for pretty much any of these interventions that I'm going to talk about today. By way of preview, I think the main points I want you all to come away with are that a lot of the depression that we see in long-term care and in nursing homes in particular stems from several issues. One is basically a grief process of dealing with losses. And it's not just the loss of loved ones, but also losses of people's position in society, their independence, their home that they lived in for the last how many years. Another major issue is basically, ageism. It's a… we live in a society that tends to devalue people as they age and that by itself often results in a feeling of worthlessness and being discarded. Another cause is not recognizing that there are different roles that people move through in life. I think we tend to recognize there being basically two phases to life, childhood and adulthood. And when you're in childhood, you're learning to be a citizen in our society and learning the skills that you need. As an adult you raise children, get a job, become a productive member of society, become a consumer of society's goods and services. There's a third phase to life that other cultures are more sensitive to and one descriptor to that is elder-hood; and that is a phase in which a person tends to be less active and more contemplative. They tend to spend more time thinking about what the meaning of their life is and has been, looking at memories that they have of things that have happened, and exploring their relationship with God and the afterlife. And they often in other cultures are sought after as wisdom keepers, sages. And that's a role that tends to be relatively absent in our culture. Another final point I'm going to emphasize is sort of the basics of a therapeutic relationship. There have been studies that look at, you know, which therapy technique is most effective, you know – is psychoanalysis better than transactional analysis, better than cognitive therapy, better than nondirective therapy. Whatever. They tend to find that the school of thought is relatively unimportant. But the main drivers of what happens in a therapeutic relationship when it's positive is first of all the relationship between the therapist and the clinic. It's important that that be built on a feeling of trust, a feeling that the therapist is an advocate and is a helpful supporter. Also a feeling of hope that things can improve. And also particularly with the elderly helping instill and re-instill a sense of meaning and purpose in life. You know as I mentioned, I think in our culture people tend to feel that their life has no meaning and no purpose anymore and that's something that we need to work to combat in order to combat the depression that comes from that. Well that's sort of an overview of what I'm going to talk about. I touched briefly on the notion of our culture and I think I'm not going to spend a lot of time on that. There are interesting studies that show that in Asian cultures, as people get older they acquire more stature in the culture. Our culture tends to be more oriented toward disposables. I think the BIC lighter stands for a lot in our culture. And so as people age, they tend to be pushed aside in many cases. And this is one cause of depression in the elderly, is people feel that they are cast aside and they don't have a meaningful role. There's also been a long tradition since World War II of the notion of the golden years and retirement and to

a large degree many people find that to be pretty hollow when they actually get to it. They've been looking forward their whole life to this and when they get there they find that it's kind of empty and I think it's because there is a loss of meaning and purpose. We find many elders going back to work. My next door neighbor is in his 70's and he said he lasted one year at home sitting around watching TV and playing golf and he called up… he was a management level person and he saw an ad in the paper for Avis to drive cars from one city to another to return them back to the home company and he took them up on that just to have something to do, where he felt like he was doing something outside of taking care of what he wanted. Volunteerism is something that is very useful and helpful as people age and particularly when they get to retirement age. When a person has a sense of meaning and purpose in their life it improves both their health and also any depression that they're experiencing. I know in nursing homes in particular that's a real challenge. Very often people are physically limited and/or cognitively limited and so there's perhaps fewer opportunities, but still I think it's important to realize that that is a key issue and anything we can do to improve that will help. Another cause of problems is there's a cultural expectation that as you age you deteriorate and that's pretty much the only view. And you need only walk into a card shop to look at birthday cards to see that that's a joke but it's also a belief that the joke is based on. There was an interesting study done by a psychologist by the name of Ellen Langer at Harvard and she took a group of volunteers who were 75 years old and broke them in two groups and asked one group to go… they both went on retreats. One group's purpose was simply to talk about various issues and have an interesting time out in the country. The other group's purpose was to, in any way they could, immerse themselves in being 20 years younger. And they did that in part by playing music from 20 years ago. They talked about… at this point, it was 1979, and so they talked about 1959 as the present. They did everything they could to get them thinking as though they were 20 years younger. And at the end of one week of doing this they found that there were improvements in speed of… in cognitive speed of problem solving. There were physical improvements in muscle strength. Many of them gained weight. Their posture improvement and their height increased so it was evidence that people tend to in part, talk themselves into a deterioration frame of mind and that in many ways accelerates whatever actual physical and cognitive deterioration happens.

I want to talk a little bit about depression indicators and I understand this has been covered to some degree in previous calls and those of you that have the power point presentation, you can see a list of those. It's helpful for staff to be alert to that because a lot of times these indicators pop up and staff doesn't think much about it or they think well the person is old, so what would you expect and not see it as a symptom of a reversible condition. But certainly changes in sleep and appetite, either increases or decreases, can be an indicator of depression. Loss of usual sources of joy or pleasure. If they find they don't enjoy watching television, they don't enjoy their favorite foods, they don't enjoy visits from people they used to like. They don't enjoy games or reading the paper or whatever it was. Physical lethargy. Becoming isolated. And it's important to distinguish between people who are isolated and feel lonely versus people who are isolated and enjoy the solitude. There is a difference between solitude and loneliness. I think the most graphic representation of that I heard is that solitude is what you seek

when you have a young child in the house and you go in the bathroom and lock the door. It's voluntary. It's something that gives you a moment to kind of breathe and settle your thoughts and get centered again. Loneliness is the pain that you feel when you would like companionship and you don't have access to it – a generalized feeling of malaise. Boredom is often a sign of mild depression and I think the reason is that there isn't anything that captures your interest, so it seems like nothing is worth doing. Certainly frequent crying episodes. Irritability is sometimes overlooked. Especially when there's a change and you get a person who is normally fairly even tempered and they become irritated at many things. It can be a sign of depression. And certainly suicidal ideation can be a sign of depression, but many people, particularly in their 80s and 90s, I find they typically have… they've kind of felt they've done what they came on this earth to do and they have a sense of completion in their life and they verbalize that they are ready to die whenever God calls them. That's sort of… that's a different state than saying I give up. Life is empty. I just wish I could die. For example a sign might be if they start giving away their possessions. Any of these depression indicators can also be caused by other things such as medication side effects, overdoses, infections such as UTIs, URIs. So there are multiple causes for these, but certainly if you see one of these it's worth investigating further. For the… in order for the certified nursing assistant to have some ability to implement some interventions, it is necessary to have a certain amount of management support. In one facility I'm in, I was talking with the director of nursing and she said, you know, we've got an increase in staffing levels… a slight increase, but it was increase nonetheless and so she is scheduling CNAs so that they have some time to sit and talk. It's getting the emphasis off of getting the tasks done, which is sort of the medical model and that's what CMS is starting to try to get us to move away from. Moving away from the strictly task-oriented, institution-oriented focus and instead look at the resident and say, gee, it's important to have time to talk, to bond with the resident. So having some support to try to change scheduling to allow that is certainly a big help. Also doing some staff training on re-orienting them toward the idea that we have a resident focus that the purpose is to try to provide an environment that's as much like being at home as possible and that's different in many cases from being in an institution which has a focus on the schedule and getting the jobs done and sort of more of almost an assembly line mentality sometimes when it runs too far. Consistent assignments of CNAs is very helpful and that's something that has only recently been advocated. For a long time, particularly in nursing training, and I know also in psychologists, another thing that is a simple anecdote is what's called a helper's high. In long-term type care people tend to focus increasingly on themselves and it's partly as a result of the way we're structured. We tend to look on people as a diagnosis, as a disability, and they tend to focus more and more inwardly, which is actually not good for their mental health or their physical health. People feel best when they're helping other people and one thing I encourage frequently is for people to…I call it calling on the sick. Because in this generation they understand what that means. And I tell them that the sick person is not down the street, they are possibly in the next bed or down the hall and if they're mobile at all and can roll their wheelchair down the hall, they can go visit somebody, if for nothing else, just to come in the door and say hello. Another thing that's very helpful that people can do for others is prayer. I kind of figured this one out when I had a woman who had Lou Gehrig's disease and was unable to do anything but blink her eyes and we managed

to communicate through that medium and she told me that the thing that made her life worthwhile….used to make her life worthwhile, was helping others. I was pretty stymied for awhile about what somebody could do for other people when all she could do is blink. One of the things that I came up with is the idea of praying for others and she actually took to that because the staff would come in and sometimes in the course of doing cares, they might talk a little bit about their life and she had some knowledge about what kinds of things they might need some help and support with. I mentioned call lights. Sometimes I find roommates sole extension of themselves to help others is pushing the call light when their roommate needs help and is not able to push the call light or can't find it or whatever. Some other things that are simple anecdotes are exercise. It's hard to get physically disabled to do enough exercise to really have a huge impact, but whatever they can do does help some, both in feeling more capable and also in producing some endorphins, which effect the emotional system in the brain. SAD or seasonal affective disorder is an identified and repeatable entity. A good number of people with depression have a pattern which usually starts with a period of feeling most euphoric in the early fall and feeling most dysphoric in the mid winter. Exposure to sunlight is a good antidote to that. The activities is also worth looking at. A lot of the activities in long term care tend to be somewhat…in many cases somewhat demeaning. I find residents say, well that feels childish to me and I'm not going to do it. So the challenge is to come up with activities that seem age appropriate and that's where we get into a sense of meaning and purpose. I've seen things such as helping stuff envelopes when there's a newsletter to mail out. Any kind of clerical work. There's a resident I know who is staying in bed all the time. We identified that the physical therapy department wouldn't mind having somebody who could pick up the phone when the phone rings and either take a message or put it on hold and this resident got talked into answering the physical therapy department's telephone. That was the only thing she would get out of bed for. But by golly she had a job. She had something important to do and she would go do it. I had a resident one time who was a male. He had been a person who laid flooring for a living and he'd gotten so debilitated that he had to retire early. He had lasted about six months and could not stand be out of work. Work was his life. So he went back to work in spite of the pain and worked another several years until it got to the point that it wasn't pain that limited him, he was simply physically unable to get up and down off the floor anymore and he had to retire and then he was pretty much unable to get around and he wound up in a nursing home and was depressed. I naïvely talked to him about what was causing the depression and he said that he really treasured having a job and I said well maybe we could get you some laundry to fold. I know that's something that a lot of times people will do for activity. And he stopped me in my tracks and he said, no, I don't want busy work. I want something that if I don't do it, something bad happens. Well that caught me up short. I had to do a lot of thinking about, OK, so what kind of a job can you give somebody that has some real responsibility to it, if they are a resident in a nursing home?

There are several pages or slides in the power point presentation that talk about resident choices. I tried to just brainstorm a list of possible things that might be all the way from simple things such as do you want the lights dim or bright. When do you when go to bed. When do you want to get up. Trying to keep down the noise level. Particularly I know

people complain that sometimes the staff is calling down the hall to another staff member or the laundry barrels are almost universally a major source of noise pollution. Overhead paging. I find a lot of places have loud overhead paging systems and I see residents actually kind of jump when they come on. They're louder than we think and when we work there we kind of get used to them and don't think about it. But a good standard is to go back to what do I like to have going on in my bedroom when I go to bed at night. There's a bunch of different kinds of bedtime choices listed there. Also at mealtime, interestingly enough, there are increasing efforts around the country to try to offer more choices at meals. It's more of a restaurant style menu and I thought the limitation to that was finances. That has to be much more expensive than the usual, you know, one main choice and then a backup that you see in long-term care. I've talked to some nursing homes that say they have made that transition and they now have basically short order menu just like in a 'meat and three' or in a cafeteria. And they said it is true that each meal prepared, item for item, costs somewhat more that way. But what happens is you have much less waste. That people eat what they order and instead of throwing out plate after plate after plate of food, there's not much left on the plates when people get through. So that the overall food cost actually are budget neutral. So that's an encouraging sign of something worth exploring. Talk about resident refrigerator rights. You know, you think about how often does any of us for having a sleepiness night, do we get up in the night and maybe walk in and open the refrigerator door and stare into it and see what's in there. Residents like that as much as everybody else does and that gives them a feeling more of being at home and less of being in a hospital or in an institution. I got some ideas about possible choices of hygiene. When they get showers. How they're done. There's an interesting approach to bathing called bathing without a battle. I believe there is a video or a DVD, which is done by Joann Rader and it's basically a bed bath system that is very well tolerated by residents who resist traditional showers. It's a good video and it kind of opens… it certainly opened my eyes and I hear good reports from facilities that are using it. Making the bathroom and the direction to go to the toilet easily accessible and well marked so that if a resident is having some confusion, they can find out where that is and kind of do it themselves rather than wait for assistance. Ideas about daily activities. I find a lot of people have funds in their resident account, but they don't know they are there and money is important to people, even when they go into long term care, which is not surprising. And having a sense of access to their money gives them a sense of control and power. Dressing selves. I know a lot of times staff finds it expedient to dress the person rather than have this person take a long time to dress themselves. My background is partly in rehabilitation and I'm a strong advocate of the idea that people need to continue doing things that are in the direction of being independent, even if it's a struggle. Even if it takes them a long time. In fact the things they probably most need to do are the things that are hardest for them. The easy things don't have much therapeutic value. But as people are able to do more things independently, they feel less dependent and less worn out, discarded, and worthless. So that helps people's mental states as well. I talk about the need to be useful and not just feel useful. I've seen people given the job of delivering the mail to the various residents in the facility and that, if properly organized, is perfectly legal, safe, and gives a person a real feeling of something important and contributing to others. Talk about the newsletter stuffing. There was a story that I was reminded of. I was in a facility one time and the fire alarm went off and

this time was a real "fire". It was smoke in the laundry area. So we had to get… I was in the lobby so we got everybody out of the lobby and put them in the front office. So then everybody is sitting around with nothing to do waiting for the fire department to give an all clear. And I noticed that there was a newsletter in process sitting on this table and there were stacks of newsletters; some of them folded and some of them in envelopes, and some of them with labels on them. And I talked to the office staff and said maybe we could get these residents who are sitting around here being bored, get them organized. So we organized an assembly line and we got them stuffing envelopes and putting out the mailing. At first the residents were saying, oh I don't want to do that. That looks too much like work. And we said, come on, it'll be fun. What we found as they got into it, they started laughing and telling stories and joking with each other and having a good time. The all clear came and they continued working on the newsletters until they got them all done and there was nothing left to do. The thing that really shocked me was the next week when I went back there, this one woman who has so much short-term memory limitations that she cannot find her room, even though it's the first room down the hall from the nurse's station. She always needs help finding her room, when she saw me she said, are we going to be able to go back in the office and work again today. I thought it was amazing that obviously having something constructive to do was really important to her and where her room was, well, that was not nearly so salient in her life. In some facilities, residents help set tables. They might care for planting beds. There was a resident in one home who hated being there. He felt he was no longer man because he had been put into a nursing home. There was a day program and a bus came by and picked him up every day and he reluctantly went on that because it was better than sitting around the nursing home, which he really hated. We hit on the idea that he had been a gardener most of his life as a hobby and so the administrator went out and bought him a rake and a trowel and some planting…some bed planting plants and a garden hose and said, you know, you can have the front flower bed in front of the drive up that goes to the front door of the facility if you want to work on it. Well this guy beamed and he jumped in and dug up what was there and replanted and watered it and nurtured it and cared for it. The next time I came back I saw him out working and he was smiling and happy and I went inside and the staff said that he had started refusing to go to the senior center because he had something important to do. That kind of story I've seen repeated over and over. If there's a facility dog, walking the dog, becoming a welcomer for new residents who move in and you sort of become big brother and big sister. Resident council. That's very often a kind of negative body. I had a resident one time tell me that she went to the complaint meeting. It took me a minute to figure out she was talking about the resident council. One thing I encourage resident councils to do and usually this falls on the activity person's shoulders, is to try to reformat it into a group that identifies problems that they can do something about, comes up with solutions, and then implements them. So it's not a situation where you're handing off problems to management, but instead you're saying what could we do to improve our lives and the lives of the people around us. A similar thing that gives people a sense of importance is fundraisers. I knew a woman who was a prominent relator in her community. She had been president of the realty board and she got in the nursing home and she got fairly depressed until they started having fundraisers where they baked and sold cookies on Friday afternoon. She loved being the person who collected the money. Even though the

money went to the resident council for the bingo games, etc., she got to take green stuff out of people's hands and put it in the till and that gave her a real sense of having been important again. A program that I'm going to just touch on because we could probably spend a whole call talking about it and brainstorming about it, but an idea I'm working on is trying to get residents to become consultants and advisors to the staff. Very often in long term care we have staff who, in their personal lives, have difficulties managing money, managing relationships. They don't always have the easiest life and one way for the facility to communicate caring about the staff, as well as caring about the residents, is to try to offer some…maybe some life skills support. And it occurred to me recently that our elders are people who have a lot of life experience. They may not know a lot about how to fix a computer, but they have been through hard financial times, physical illness, struggles in marriages, difficult teenagers, and they might be enlisted, particularly if they are pretty cognitively alert, they could be enlisted to help share some of their wisdom and so I wish I had some more specifics about how to do that. I'm in the process of trying to experiment with some things, but for now what I'm looking at is maybe having CNA's read up for an hour a week to go interview a resident and find out what they used to talk with friends and families about and where their possible field of expertise might be and then find some ways of getting the CNA to ask this person, well what you do in this situation or have you ever been in a situation like this and so…and in a subtle way start having the resident talking about some of the things they know, some of the solutions they know, and perhaps the staff member can benefit from that just in the process of listening to it. It also changes the relationship between the staff member and the resident from being one where the staff member is totally doing for the resident and to one which there is some exchange. Simple pleasures are also an intervention that can be helpful. One way of combating depression and the loss of enjoyment is to focus on little things. A lot of people who become depressed find that they don't enjoy things as much as they used to. That's pretty much universally true. And they lose touch with the fact that simple pleasures are things that are more pleasant than sitting there staring at the wall. But they tend not to do them because they aren't as pleasant as they used to be. So if something used to be a nine on a scale of one to ten and it's now a two, I tend to just feel like, well, it's not worth doing. So one of the things that is helpful is to get people noticing that when they do some pleasant things, they are a little bit enjoyable. They're just not as enjoyable as they used to be. So if you can lower their expectations, they're more likely to engage in something pleasurable, but you also need to do some interviewing and here again enlisting the CNAs is a great thing to do, is finding out what were simple pleasures that you used to engage in. Say before you came to the facility or things you did a month ago before you got down in the dumps. And getting a lot of detail. For example, somebody might say they like to wake up slowly in the morning. They like to sit in bed awhile. Maybe they like to listen to the radio. You know, do you like to listen to talk shows? Do you like to listen to oldies? Do you like to listen to classical music? What is it? Maybe they like to have a cup of coffee. Do they like to have it in bed? Do they like to have it sitting up in a chair by the window? Do they like to have it on the back deck? So you find out a lot of detail about what their simple pleasures used to be and then you try and oftentimes it takes some brainstorming with staff, you try to figure out how can we implement these in a nursing home in this day with this person's limitations. It requires changing these simple pleasures, but to the

degree you can get anything like them. Any echo of them. They are much appreciated and help pull people out of depression.

I mentioned grieving is something that's a major cause of depression. Loss of family members. One thing then to realize and teach staff about is that you don't need to tell people no, no don't cry, don't cry. Crying is a natural thing when somebody loses something of importance to them. We're waterproof, so some crying is all right. If they get to a point that they've been crying for several weeks and that's pretty much all they do, then that might be a different issue. But a lot of times I find staff, nurses in particular, are trying to minimize suffering and what they oftentimes do is try to block somebody from experiencing the grieving process. That pretty much needs time to pass. One thing we can do is to be supportive, but you don't want to try to talk them out of it. You don't try to give them little phrases that try to say you don't need to feel depressed. It's more important to simply be with the person and let them know that you are sensitive to what they're going through and you're supportive. Sometimes just being quiet with them, holding their hand is more of benefit than trying to say, you know, well natural cycle to all things in life, whatever. People also mourn the loss of their old self. They can't do what they used to. And it helps sometimes for people who are in long term care to realize that it's not the facility that they are unhappy with. It's the fact that they have changed. They have moved from being an adult to be an elder. They're not so much a doer anymore and they're becoming a person who simply is. They're a be-er instead of a doer. And helping them see that that's a natural change, it's a good change, most people who are busy, busy, busy are not very happy with what they're busy with. They're just busy. And real happiness comes from being able to experience quietude and the passage of the moments and enjoying each moment rather than enjoying something that's going to happen in the future. Running out of time here. Call light frustration I hear a lot. One thing that helps is in addition to the things that staff normally does such as pointing out the, you know, there are multiple people here and we get to people as soon as we can and that there are busy times, like around meals, that you're going have a longer wait for call light. Sometimes it helps people to, if they can, to keep a record. People tend to, when they feel frustrated, they tend to exaggerate how often that frustration happens and I find that if people meticulously keep a record every time they push the call light of how long did it take, they'll find out that yeah, sometimes it does take half an hour or even an hour. That happens rarely. And what happens most of the time is it's two minutes, four minutes, something like that. So that can help. Another thing, people get frustrated because they can't do it themselves. So having to wait is a frustration on top of the fact that they're not able to get themselves to the bathroom or whatever it is. It helped sometimes to help them come to the realization that a good chunk of their frustration is that they're not able to do it themselves. One thing I tell people to do is to plan ahead. If you tend to go to the toilet every two hours, then push your call light at one hour 45 minutes and figure it's going to take maybe 15 minutes on average for the person to get there and help. And if they plan ahead, then they don't get so frustrated because they feel like they can't stand to wait. Hope is crucial. I mentioned that at the beginning. Do not give…and I don't think anybody hardly ever does this, but don't give hope that's completely impossible. On the other hand, if anything, healthcare workers tend to try to avoid "false hope" and as the oncologist Bernie Segall says what is false hope. He said,

you know, hope is the prayer that things will improve in the future and that's always a good thing to be looking forward to prayer, to have… looking forward to the future will be better and working toward a goal that you have, even it's an unattainable goal, as long as it's somewhere in the realm of possibility, that gives a person some motivation to move ahead.

So to review, you know, therapeutic relationship, the relationship is crucial. It depends on empathy, that you understand what the other person is feeling. That you do something special for the person occasionally and that makes them feel like all the more that you're on their side and you're an ally. Residents have few people that sit and listen to them. So spending a little bit of time listening is a huge gift. One thing to be cautious of is there are some things that might look like depression that are not depression, such as there's a lot of this progressive wasting that goes on in the presence of good affect. The person is happy, cognitively pretty alert, tries to eat, feels like, you know, they deny that they are feeling depressed. They're frustrated in that they can't make themselves eat anymore. But usually that is not depression. Usually that is a medical psychological process and I think it's, as much as anything, the body kind of shutting down. Remembering that people sometimes like to be alone and they like some solitude. That's an important piece. I think that pretty much covers the main points here I wanted to cover. So you've gotten a four-hour talk in 50 minutes here. I'd be glad to take some questions if people have some things they want to ask or some comments they want to make.

Laurie: Thank you Dr. Nygard for presenting today. Michelle, I think we're ready now for taking some questions.

Michelle: Thank you. If anyone has a question, please press 01 on your telephone keypad. Once again, if you have a question, please press 01 on your telephone keypad. There are two questions in the queue. The first one comes from the Appalachian Christian Village. Go ahead please. You may go ahead with your question.

Male: Okay. The question is… from your experience, what's the most reliable depression screening tool; obviously keeping in mind the cognitive directions, cognitive level. There are so many tools around but I can't find… I couldn't find what's the most reliable one.

Dr. Nygard: Well actually the most reliable one might be the Hamilton D. That's a pretty complicated and long index. So I guess… I think there's not an easy answer to your question because the most reliable ones tend to be longer and more complicated and you're talking about also having to deal with the cognitive limitations. I tend to use a shortened version of the dementia rating scale. It's a 30-item scale and it's a pretty much a true/false answer system. And there's a short version of that that's 15 items and that seems to fit with people's attention span and it covers a wider range of cognitive levels. It's not as sensitive to change, but it's something worth doing. I can also give you my one-question depression screening instrument and that is you ask the person how old they feel like on the inside. And obviously if they feel like they're 100 on the inside and

they’re really 80, that’s a problem. If they feel like they’re 40 on the inside, that tends to mean they’re in pretty happy shape.

Michelle: Thank you and the next question comes from St. Joseph of the Pines. Go ahead please.

Female: Dr. Nygard, I was wondering if you could touch more on the issue of the residents feeling like they’re ready to go home, they’re ready to be with their family, they’re ready for God to call them as opposed to just giving up.

Dr. Nygard: Yeah, that really stymied me the first year or two I was doing this work and I think what I’ve come to these days is to first of all be emphatic and say, yeah that’ll be wonderful to see your loved ones again and, you know, that’s something that people look forward to and I can really understand that, particularly given that your life today is not what… 100 percent what you would like it to be. But then I usually pause a minute and then say, on the other hand, you don’t look like you’re about to die in the next day or so, so what do you want to do while you’re waiting. Do you want to be miserable, unhappy, depressed; or would you like to get some enjoyment out of the years that you do have on this planet. And most of the time people will admit, well, that’s true. I’m not in imminent danger of dying here so I need to find something to do while I’m here. Sometimes you can take a sort of religious approach and say, you know, we often tend to think that God has a purpose for our being in this world while we’re here and it might be worth doing some thinking about what could that be. Is there something I need to be doing? Is there somebody I need to be helping? Is there something I need to be learning rather than just sitting around drumming my fingers on the table waiting to die.

Female: Thank you.

Michelle: Thank you. The next question comes from Gallatin Health Care. Go ahead please.

Female: In college, I researched the benefits of laughter and in what ways could laughter therapy be implemented in the long-term care setting?

Dr. Nygard: Well actually not too far from you is the Bordo Hospital, which is a county facility and they have done something very innovative. They have instituted a clown school and it’s a certified… apparently there is a whole profession. It’s not just something that you do to be silly. There’s a whole profession of clowns and there’s codes of ethics and things about dress and stuff and so they have trained some of the staff. There are some high school volunteers who have been through the school and some residents and the medical director, and no, the medical director is not Patch Adams. And they do that. Anything that perhaps having a… perhaps a more high functioning group to watch movies in a small group in a quiet setting and have them pick something humorous and talk about the movie beforehand and afterwards and kind of help them stay for a minute on the idea that how do you feel after you’ve had a good laugh and how’s that different from the way I felt before I had the laugh. And then focusing on that feeling

helps it linger for a while. And also just giving some credibility to, you know, laughter is something more than just a frivolous waste of time. It's actually good for us and the more we can do it, the better. I find when I start talking to people about laughing they start laughing more in that conversation. It sort of gives permission to do more of that.

Michelle: Thank you. Ms. Jesick do we have time to take any further questions?

Laurie: Yes I think we have just a little bit more if there are any other questions out there.

Michelle: Thank you. We have two questions in the queue. The next one comes from Border Long Term Care. Go ahead please.

Female: Thank you for taking my question. Dr. Nygard, I want to know about the prayer. Is it a spontaneous event or is it something that is addressed on admission? Or it is part of a person's care plan? How do you handle that?

Dr. Nygard: I'm sorry you're talking about prayer?

Female: Yes, as an antidote for depression.

Dr. Nygard: Well let's see. What I do in that regard is I see myself as wearing a lot of different hats. I'm not just the psychologist and sometimes I'm the social worker and sometimes the maintenance person and sometimes the chaplain. But what I do when people express an interest in prayer is ask them if they want to pray right now and sometimes we'll do prayer. What I try to do is help them focus on asking God for strength. There are studies that show that people who ask for a miraculous cure tend to find their spiritual life less helpful than people who ask for strength. So one of the things I'm always cognisant of is trying to help them move in the direction of asking for first of all the strength to endure adversity and also the vision and the wisdom to see the lighter side of what is currently going on in their life and we do a little bit of talking about the glass can be half full or it can be half empty and then any situation there's a dark side and a bright side and we tend, when we get depressed, to look at only the dark side and if that worked, I would be a big advocate of it. But it makes people miserable. So I help them ask for help in looking at what's the bright side. One thing I find is that with a lot of people, particularly people who are more cognitively limited, the idea of having them look at the positive side of things is just beyond them. They don't grasp it. But they respond very well to saying if you were going to thank God right now for your blessings, what would you say to him. What things would you thank him for. People resonant with that and that's a good starting point.

Michelle: Thank you. And the final question comes from Ridgeview Terrace. Go ahead please.

Female: Yes. I just…as a social worker I'm feeling very squeezed between the fact that the state is only wanting to pay for the most physically impaired and the most cognitively

impaired people to be in the nursing home and then CMS is wanting us to treat them as they are the most independent and functional people. I'm not expressing myself very well, but I'm really having trouble understanding what I'm supposed to do, how I'm supposed to… and ask these things when I'm getting the sickest and most cognitively impaired people as residents.

Dr. Nygard: Well that's definitely a dilemma. Yeah. It would be ideal if we had the old population that we used to have in nursing homes. And you're right – today we are looking at people who are much more cognitively impaired and much more physically impaired. Nonetheless there are still choices at any level and so what I'm always trying to look to is not assuming that this person is capable of nothing for example. I find there tends to be a misunderstanding about dementia and this is true in people that work in nursing homes, physicians, judges, family members, and that is that… it's like pregnancy. You've either got it or you don't. And what we need to continually remind ourselves about it is just because a person has dementia doesn't mean they can't do anything. There are multiple areas that somebody can have dementia in. For example, short-term memory is just one. But as people get older, their memory slows down. The speed of retrieval slows down. But their ability to recognize patterns improves. That's one definition of wisdom. People may have good ability to kind of sense what's going on, but very poor ability to remember the person's name or that kind of thing. So I think it's helpful to be saying just because this person shows all these limitations, doesn't mean they're limited in all areas. I learned fairly early that people had no idea who I was the second, third, fourth time I came back to see certain people. But they knew whether they enjoyed our last visit. So there's sort of an affective memory that people have. And when somebody walks in the room who tends to give them orders and tell them, you got to do this now and I don't care what you want, I got to a job to do, they react to that person before they open their mouth. So there are different kinds of memory. And some of them are more impaired than others. The challenge for us in long-term care is to find what are this person's strengths. What's their pattern of loss and retention of skills and how can we find things that A, fit into what they can do and B, challenge them to grow some. I think a good philosophy is that a nursing home should be a place where people grow, not a place where people die. That completely turns long-term care on its head. It kind of violates all of our assumptions about it, but I think if we can keep reminding ourselves of that viewpoint, it opens up some ideas for dealing with it. And with what you described very accurately, it's kind of being between a rock and a hard place.

Michelle: Thank you. And that concludes the question and answer session. And at this time, we are going to continue with the polling session.