



# Engaging Aging

## Mental Health and Aging

By Reverend Myles Sheehan, SJ, M.D.

### In This Issue

Resources	6
Offices of NRRO	7
Calendar	7
Reminder	7

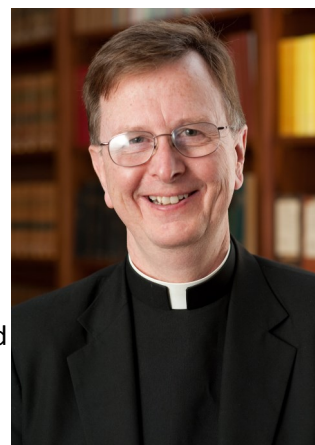
Any discussion of mental health and aging needs to begin with a factual and positive statement. Aging is not necessarily accompanied by problems with mental health. Indeed, some older persons find it the best time of life. With decreased concerns about work and family, there is the opportunity to grow personally and experience aspects of life one could not at earlier ages. But like any time of life, aging presents challenges and possibilities in mental health. Because of the increasing burden of illness and the frequency of age related losses in independence and function, mental health issues can be part of aging for many older persons. The impact of physical decline and illness may contribute to and combine with problems of mental health. Recognizing problems with mental health and finding treatment can bring significant improvement for older persons.

At any age, mental health issues do not exist separate from the reality of the individual affected. Illness is not just biological or psychological; the two intertwine and along with these factors is the spiritual and social life of the person. Changes with aging can affect all the aspects of a person, biological, psychological, social and spiritual. It can be difficult to untangle the varied strains. Is a person seemingly depressed because of a decrease in vision and the loss of a spouse? Is an older woman religious anxious because of a recent move back to the mother-house for more care, or is she showing signs of dementia and depression?

*“The part  
can never  
be well  
unless the  
whole is  
well.”*

*Plato*

**Reverend Myles Sheehan** served as Provincial of the New England Province of Jesuits from 2009 - 2014. He holds a Medical Degree from Dartmouth Medical School, a M.A. degree in Philosophy/Health Care Ethics from Loyola University of Chicago, and a M.Div. degree from Weston Jesuit School of Theology in Cambridge, MA. Fr. Sheehan has ministered as an Instructor in Medicine at Harvard Medical School, Director of Geriatric Consultation Services at Beth Israel Hospital, and Senior Associate Dean and Director of the Leischner Institute for Medical Education at Loyola University, Chicago. He is a member of the Board of Trustees of the Catholic Health Association and a Fellow of the American College of Physicians. His specialty is geriatric medicine and palliative care.



## Mental Health and Aging, continued

### Functional Impact is Key

Caring for older persons differs a bit from the care of younger persons in that particular attention is paid to the functional status of the individual and the impact of an illness. It may be that an older person could have several problems such as diabetes, hypertension, glaucoma, and depression, but be doing well, living independently and totally sufficient in self-care. Another person with just one or two of those problems could be in a very serious state and need assistance. In considering aging and mental illness, or any illness in older people, the functional impact is the key to guiding treatment.

Activities of daily living, e.g. transferring (getting out of bed or a chair), toileting, grooming, bathing, dressing, and eating, are essential elements of independence. Individuals who lack the ability to perform one or more of these activities often require assistance that sometimes involves residence in a nursing home. Instrumental activities of daily living do not have a discrete list; these are all the tasks that involve a person in managing a household and caring for oneself. They include managing finances, shopping, arranging transportation, housekeeping, cooking, and similar chores.

Whether addressing mental health or physical health, changes in function give clues that something serious is happening and needs attention. An older man may be sad and weepy after the death of his wife, but he continues to care for the house, pay the bills, go to Church, see his children and grandchildren, and maintain a neat and clean appearance. This is not

Doctor Kim M. Pierce, a primary care physician, examines Sister Jeanette Bussen, CSJ. Dr. Pierce comes monthly to the motherhouse of the Sisters of St. Joseph in Baden, PA, to provide routine care for sisters who are her patients. This eliminates transportation issues and affords Dr. Pierce the opportunity to interact with the sisters in their home environment.

depression. An older woman may have some difficulty remembering names, and occasionally misplace items. But she is also looking unkempt, has gotten lost while driving, is losing weight, and a visitor to her home finds it dusty and uncared for. This woman probably has a dementing illness like Alzheimer's and not simply some age related forgetfulness.

### Importance of Comprehensive Assessment

Recognizing changes in mental health in an older person means paying attention to the individual and not assuming that decline in behavior and function are normal as one gets older. Some changes may be more common in an older population, but that does not mean the change is normal. Rather, decline in thinking, social skills, and the ability to care for one's self should be a warning that there may be a potentially treatable process occurring that needs to be assessed. Even if a reversible cause for the decline cannot be identified, assessment of a person with changes in mental status can look to possibilities for providing care and support.

A good medical evaluation is crucial in evaluating concerns about mental health in older persons. Review of medications (some medications can be asso-



## Mental Health and Aging, continued

ciated with depression and changes in memory), evaluation of thyroid function (disturbances in thyroid function can cause depression and anxiety), and a basic review of blood counts and chemistries, along with a good physical exam are essential. Cataracts, other causes for decreased vision, and hearing loss can lead to isolation which in itself can lead to a withdrawn and seemingly confused person. Treating cataracts, improving hearing, and other interventions to increase mobility and the ability to engage life can be more important than medications or counseling. Some older people are disabled with arthritic problems involving the knees or hips. If feasible, treatment or joint replacement can give a person a new lease on life.

Attention to the social situation is also important in evaluating functional decline and possible mental health problems. Some older persons live alone, have little money, the neighborhood is not safe, it is difficult to shop and there are few friends with whom to interact. Occasionally, family members are taking advantage of an older person by diverting their social security payments, allegedly caring for them while otherwise using their finances, and, unfortunately, sometimes actively abusing an older relative or person. Obviously, a frightened older person without funds and terrorized by someone is going to be anxious and appear depressed. Psychoactive medication and counseling might be needed later on, but the immediate intervention of notifying the authorities about elder abuse and trying to change the living situation are the most important.

### Depression and Dementing Illnesses

The most common problems of mental health in aging are depression, anxiety, and behavioral difficulties associated with dementing illnesses like Alzheimer's disease. It should never be assumed that depression, anxiety, or diminished cognitive status is

normal for someone older. It is not, and there needs to be a medical workup into the cause for a person's decline. Dementia, either Alzheimer's disease or another type, for example, vascular type dementia, can have depression or other mood and behavioral changes as part of the clinical picture. Although dementing illnesses cannot be cured or reversed, treatment of depression and/or anxiety can lead to marked improvement in behavior and happiness for the person.

### Acute Changes Need Urgent Response

Sudden changes in behavior and mental status represent an emergency that demands immediate evaluation. The older person who has been doing well and functioning fine but who is found to be confused and not making sense has a life threatening emergency. This sudden change in mental status is known as a delirium and is characterized by: an acute change, over a day or a few hours; a lack of ability to pay attention and follow instructions; waxing and waning confusion over the course of the day; sometimes visual hallucinations; and verbal output that can be bizarre, paranoid, frightened, or angry. Delirium usually has a cause and these causes may be deadly if not recognized and treated; infections, heart attack, stroke, or an adverse drug reaction are common. Often, once the cause of the delirium is identified and treatment begun, improvement is common. A classic example of a sudden change in mental status would be the previously healthy older woman, perhaps living alone, who acquires a urinary tract infection or influenza. Within hours it can appear as if this woman is totally demented and unable to care for herself ever again. What is crucial is recognizing sudden change and deterioration in mental status and always getting emergency evaluation.



## Mental Health and Aging, continued

### Assessing Depression

Most elders are not depressed, but depression can occur commonly in older age. Risk factors would include previous history of depression, history of heavy alcohol use or alcoholism, chronic illness, the development of dementia, or long term isolation and loneliness. Being depressed is not the same thing as being sad. Depressed people are usually sad, but not all sad people are depressed. In trying to assess the presence of depression, health care providers consider changes in appetite, sleep, interests, activities, energy, concentration, activity level, thoughts of death or suicide, and sexual interest. Sometimes, older persons with depression will express a number of paranoid thoughts, e.g., individuals are poisoning them, stealing, trying to hurt them, etc. For religious, depression may manifest with scrupulosity and compulsive behavior around ritual actions (e.g., endlessly purifying the chalice and paten, deep worry over past confessions, obsessional fears about the possibility of a sin.) These assessments are made more challenging by the reality that physical illness or dementing illness may also present with similar changes, and that physical illness and dementia can be combined with depression.

### Community Settings Can Complicate Detection

Depression and the mental status changes associated with dementia may not be as easily identified in religious as they are in older people who live in their own homes or apartments. For those older religious who live in religious communities, a number of the tasks that are required for independent living are provided by the religious community; food is prepared, shopping is not required, transportation is available, bills are paid, and there is no particular need to clean, do housekeeping, or other chores. Thus, some of the things that would alert family members that mom or dad is not doing well, e.g., decreased hygiene, problems with paying bills, decreased interest, and forgetfulness, may not be noticed in a religious community until things have progressed. Another part of the reason for later presentations of depression or cognitive decline among religious can be a poor quality of life in the community; individuals may lead very private lives with interactions on a formal, social, and superficial level. Older religious may not feel it is their business to discuss concerns about a declining religious brother or sister, or might simply keep quiet and maintain a low profile lest attention be paid to him or her.

As in the case of delirium, an evaluation for depression must also include a thorough physical assessment, although it may not be as emergent as it is in delirium. Specific questioning about thoughts of suicide and death is very important. The highest rate of successful suicide in the United States is by men eighty five years of age or older. Although men and women religious are less likely to commit suicide, it does happen. In questioning older religious, it may



Ms. Patricia Pachell, CNA, interviews Sr. Michelle Callanan, a Sister of the Blessed Sacrament, at St. Michael's Hall, the congregation's assisted care residence in Bensalem, PA. In constant contact with residents, professional aides are excellent sources of diagnostic information as well as being care providers.

## Mental Health and Aging, continued

be that they have had recurrent and painful thoughts about suicide, intrusive thoughts about death, and a deep and frightening desire to die. Asking questions about these types of thoughts does not cause suicide. Instead, it allows the person to be relieved of the burden, permits engagement and opportunities to increase safety, and, in the case of the truly suicidal with an immediate plan, can be a life-saving intervention.

### Treatment

The good news is that treatment is often helpful in improving the mental health of a depressed individual. There are several facets to treatment. Attempts to engage the depressed person and provide opportunities for interactions, outings, and interventions geared to reduce isolation and loneliness are practical and useful. Some older persons will benefit with counseling. Newer antidepressant medications, although not risk free or perfect, are, however, useful and generally well tolerated. These medications are known as SSRI's (serotonin selective reuptake inhibitors) and have a number of different formulations. Many are very useful in also treating anxiety which can be a concomitant of the depression, a cause of the depression, or a separate illness.

### Differential Diagnosis

How can one tell the difference between an illness like Alzheimer's disease (or another dementia) and depression? First, it may not be easy and depression, as noted previously, can be part of the presentation or course of a dementing illness. Second, changes in memory and behavior need a medical assessment like the one outlined above. Testing mental status with a simple exam like the MMSE (Mini Mental State Exam) can give some clues. A person with a dementia, at least early in the course of the illness, will usually be able to pay attention and will have scattered deficits. Most people with Alzheimer's

early in the illness are socially well maintained and do not seem sad. Although not always the case, a person whose depression is causing the behavioral changes will likely have a diffuse loss of function and an apathetic or melancholy personality.

Many people, including some caregivers, are not exactly certain what is meant by dementia and what is the relation between Alzheimer's and dementia. "Dementia" is a medical term that means a usually irreversible decline in cognitive function that includes more than one aspect of cognition. For example, a person with a stroke may have some trouble with language but that does not mean the person has a dementia. On the other hand, a person who has problems with memory, language, comprehension, and conducting simple tasks may well have a dementia. "Dementia" is a generic term. Just like "dog" can mean a lot of types of dogs, "dementia" can mean a variety of dementing illnesses.

Alzheimer's is one type of dementia and a common one. People with Alzheimer's disease usually present with an insidious course of slow decline in memory, problems with language and word choice, episodes of getting lost in familiar territory, and other markers. Usually, one will notice functional changes as well: less attention to appearance and hygiene, financial errors, and sometimes weight loss due to decreased ability to shop and cook.

### Treatment for Alzheimer's

Treatment for people with Alzheimer's is supportive and includes efforts to assist in: improving function; maintaining independence to the degree possible; preparing for eventual decline by creating health care power of attorney (or other document depending on the jurisdiction); and attending to financial matters like wills and setting up trusts while the person still has sufficient decision making capability to take part in these decisions. Medications like donepezil can

## Mental Health and Aging, continued

provide some small degree of slowing of symptoms. But there is as of yet no treatment that reverses or stops the inexorable decline. There are a number of other types of dementia and it would be the subject of another article to go through these various diseases. Assessment and interventions as noted for Alzheimer's disease are appropriate in most of these other dementias.

It has been my experience that for many people with Alzheimer's disease and other dementias, their spiritual life can, at least in the early part of the disease, provide a significant strength. Long patterns of prayer, devotion, and recollection can be maintained despite other cognitive losses and allow maintenance of spiritual function long after some other aspects of function are lost. Long memorized and deeply loved prayers like the Rosary, or attendance at the Eucharist or Liturgy of the Hours, can provide continuity and peace. One might have trouble with names, not know the date or the day, and not have any idea who is the Pope, but in a day that consists of quiet prayer, those things do not matter very much. A person with a dementia can still remain engaged.

## Conclusions

Let me conclude by listing five important take home points:

1. Concerns about mental health changes in older persons need to be accompanied by a thorough medical evaluation.
2. A sudden change in thinking marked by confusion or bizarre behavior is a medical emergency and requires immediate attention.
3. Changes in an older person's function can give a significant clue to the presence of an illness like depression, anxiety, or a dementia.
4. Effective treatment for depression and anxiety is available.
5. Interventions that increase social well-being,

reinforce spiritual strengths, and improve common deficits with aging, e.g., vision, hearing, and mobility, can improve mental health and function.

## Resources

### ARTICLES

*Aging in the 21st Century: Psychologist Say Longer Lives Can Still Lead to Happier Golden Years.*

<http://www.apa.org/news/press/releases/2009/08/aging-21st.aspx>

Boileau, R. (2010). Spiritual Transformation Through Transcending Loss. *Presence*, 16 (3), 38-43. <http://www.sdiworld.org/sites/default/files/publications/article-Spiritual-Transformation-through-Transcending-Loss.pdf>

Kales, H.C., Gitlin, L.N., & Lyketsos, C.G. (2014). The Time is Now to Address Behavioral Symptoms of Dementia. *Generations*, 38 (3), 86-93.

McKevitt, Gerald L. (2011). The Gifts of Aging: Jesuit Elders in their Own Words. *Studies in the Spirituality of Jesuits*, 43 (3), 1-41. <http://ejournals.bc.edu/ojs/index.php/jesuit/article/view/2702>

### WEBSITES

The guidebook contains excellent information for older adults with mental health concerns and caregivers. Although resources are targeted specifically for New Hampshire residents, general content is valuable to all. Mental Health, Mental Illness, Healthy Aging: A NH Guide for Older Adults and Caregivers.

[http://www2.nami.org/Content/ContentGroups/Home4/Home\\_Page\\_Spotlights/Spotlight\\_1/Guidebook.pdf](http://www2.nami.org/Content/ContentGroups/Home4/Home_Page_Spotlights/Spotlight_1/Guidebook.pdf)

Centers for Disease Control, National Association for Chronic Disease Directors. 2013 [http://www.cdc.gov/aging/pdf/mental\\_health.pdf](http://www.cdc.gov/aging/pdf/mental_health.pdf)

## From the Offices of NRRO

### Brother Bob Metzger, SM, Associate Director for Planning and Education

It is the first of week of June as I write this piece for *Engaging Aging*, and here at NRRO we are busy finalizing the details for mailing out the distribution checks from the Retirement Fund for Religious collection. We are contacting the final few religious institutes that need to have their information clarified before we can determine the amount of assistance everyone will receive.



In the first three months of 2015 we have received almost 550 Direct Care Assistance applications from the religious institutes in this country. Almost 400 of them have requested a distribution from the collection. This year we will be distributing \$25 million. Our plan is to mail these distribution checks during the week of June 22<sup>nd</sup>. The remainder of the collection will be distributed in NRRO's planning and implementation process, for Management & Continuing Education Assistance and used for the operation of the office.

Once we have finished the distribution we will begin the work of compiling the statistical information received in this year's applications. The statistical information received in 2014 can be found on our website at: <http://www.usccb.org/about/national-religious-retirement-office/nrro-statistics.cfm>. The report with the 2015 information will be placed on our website by August 1<sup>st</sup> of this year.

Donations to the Retirement Fund for Religious once again reached our collection average of \$28 million. The generosity of donors to the collection

has been amazingly consistent throughout the 27 years of this appeal.

We ask all religious to remember these donors in their daily prayer for without them the work of the National Religious Retirement Office would not be possible.

## Calendar

### June 22

- Direct Care Assistance checks mailed

### August 5 - 8

- CMSM Assembly; Charlotte, NC

### August 11 - 15

- LCWR Assembly; Houston, TX

### August 18

- NRRO Webinar at 1 PM ET; Caring for and Understanding Members in the Dying Process

### September 12 - 16

- NCDC Annual Conference; Lake Buena Vista, FL

### October 6 - 8

- NRRO Planning and Implementation Workshop

### October 27 - 30

- RCRI National Conference

## Reminders

- Please send changes in address, phone, e-mail, or congregational leadership to the NRRO, c/o Tiffany Lezama (tlezama@usccb.org), so that we may keep our records and mailing lists updated.
- Anyone is free to copy and circulate *Engaging Aging*. Help us to expand our reach to new readers. If you would like to receive our mailing, please send your name and email address to the NRRO, c/o Tiffany Lezama (tlezama@usccb.org).

**U.S. Conference of Catholic Bishops**  
National Religious Retirement Office  
3211 4th Street N.E.  
Washington, DC 20017-1194

NON-PROFIT ORG.  
US POSTAGE  
PAID  
USCCB

**RETURN SERVICE REQUESTED**



## National Religious Retirement Office

**Sponsor of the Retirement Fund for Religious**

**3211 4th Street, NE**  
**Washington, DC 20017-1194**

**Phone:** (202) 541-3215

**Fax:** (202) 541-3053

**Email:** [retirement@usccb.org](mailto:retirement@usccb.org)

**Websites:**

[www.usccb.org/nrro](http://www.usccb.org/nrro)

[www.retiredreligious.org](http://www.retiredreligious.org)

The National Religious Retirement Office coordinates the national collection for the Retirement Fund for Religious and distributes these funds to eligible religious institutes for their retirement needs. Our mission is to support, educate, and assist religious institutes in the U.S. to embrace their current retirement reality and to plan for the future.

**Staff**

**Executive Director**

Sister Janice Bader, CPPS

[jbader@usccb.org](mailto:jbader@usccb.org)

**Associate Director of Fund Distribution**

Brother Hank Sammon, FMS, JCL

[hsammon@usccb.org](mailto:hsammon@usccb.org)

**Associate Director for Planning  
and Education**

Brother Bob Metzger, SM

[rmetzger@usccb.org](mailto:rmetzger@usccb.org)

**Grants Administrator**

Monica Glover

[mglover@usccb.org](mailto:mglover@usccb.org)

**Administrative Assistant**

Tiffany Lezama

[tlezama@usccb.org](mailto:tlezama@usccb.org)