

**Geriatrics, Palliative Care and  
Interprofessional Teamwork  
Curriculum**

**Module # 5 : Psychosocial Assessment**

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**Module #5: Psychosocial Assessment**

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## Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

### Module #5: Psychosocial Assessment

**I. Overview:** There is no unified consensus on what constitutes a psychosocial assessment. Nor is there a standardized assessment tool that the clinician can use. There are, however, a number of components that are necessary to address in order to fully understand the patient and his/her support system. If completed accurately and comprehensively, the patient will benefit from quality care and appropriate services that will insure health and well-being.

The knowledge gained from a comprehensive psychosocial assessment provides objective measurable information about the cognitive, social, psychological, spiritual, financial, and legal dimensions of the client system, as well as important subjective information about the entire client system's coping mechanisms and relationships. The clinician will need to develop a psychosocial assessment that best meets the needs of patients served, and one which helps to inform, guide, or contribute to making professional judgments about an appropriate care plan. <sup>1</sup>

It is the psychosocial aspects of an assessment that can be labeled the heart and soul of the comprehensive geriatric assessment. For it is through this part of the assessment that we determine who the patient is, from a systemic, individual and historical perspective. The clinician will understand the patient's typical behavior, coping capacities, motivations, and the nature of relationships. Once this segment of the assessment is complete, the clinician will be able to more successfully engage the patient, and the entire patient system, in a collaborative working relationship. <sup>2</sup>

### II. Learning Objectives

1. Delineate the main components of a Psychosocial Assessment
2. Define the purpose of the psychosocial assessment
3. Describe some of the formal measurement instruments used with older adults to assess for cognition and psychological status.
4. Identify other less structured ways to perform an assessment
5. Discuss what is meant by the informal support system and measurement tools used to assess for both support and strain/gain.

**III. Psychosocial Assessment:** For purposes of this curriculum, biographic/demographic, cognitive, psychological and social support will be addressed. The other critical elements of a psychosocial assessment, namely elder mistreatment, financial/legal, spiritual and substance abuse will be discussed in detail in later curriculum modules.

**IV. Biographic and Demographic Data:**

- Birth date and place
- Nationality/history of immigration
- Religion/affiliation/importance
- Siblings/alive/deceased/relationships/health
- Childhood
- Education
- Military history
- Marital history/significant others
- Offspring/birth order/relationship to parent/s and each other/current living arrangement/availability
- Occupation
- Hobbies/interests
- Retirement

**V. Cognitive Assessment:** Since the incidence and prevalence of dementing disorders increases in later life, it is necessary to assess the older adult's mental status to determine if the current living arrangement is appropriate and safe.<sup>3</sup> Assessment in this domain is equally crucial to detect reversible dementias (depression, delirium, etc) from non-reversible dementias (Alzheimer's disease, vascular dementia, frontal lobe, etc). Once screened, the clinician can then make an appropriate referral to a medical specialist (neurologist or psychiatrist) to formally diagnose and treat the patient. (See *Module 13: Depression, Delirium and Dementia* for more detailed information)

A. Prevalence of Cognitive Disorders: Cognitive impairment and psychiatric symptoms are relatively common in older adults, with an estimated 4-5 million of them experiencing cognitive disorders. Of community residing older adults, 5% aged 65-75 and 25-30% aged >85, evidence dementia, most commonly Alzheimer's disease. 60% of nursing home residents have dementia.<sup>4</sup>

B. Importance of Cognitive History: The clinician must have a detailed history from a reliable source of the patient's past functioning, which combined with the current level of functioning, will help to plan for future needs. While the authors encourage the use of standardized instruments to assess cognitive status it is important that the

findings, regardless of the measure being used, are understood within the larger context of older person's ability to process cognitive information. The ability of the older person to function safely within his or her daily routine can not always be measured by a single cognitive assessment instrument. Subjective information in combination with formal screening tools must be the basis of the cognitive assessment.

C. Diagnostic Indicators: Cognitive impairment and psychiatric disorder are often not recognized by health care professionals. In one study, older patients believed to suffer from moderate to severe impairment were evaluated by a psychiatrist prior to discharge from a medical or surgical ward. It was found that only 27% of the older patients evaluated were actually diagnosed with an impairment before discharge.<sup>5</sup>

Indicators of mental impairment that should prompt a mental status assessment

- Learning impairments
- Problem carrying out complex tasks
- Spatial disorientation
- Memory deficits
- Disturbances in cognition and behavior

D. Components of the Mental Status Assessment<sup>6</sup>

- Level of consciousness (alert, lethargic, coma)
- Physical appearance (clothing, grooming)
- Orientation to person, place, time
- Speech and language: comprehension, fluency, and repetition
- Emotional status
- Memory – immediate recall, short-term memory, and remote/long-term memory
- Attention and concentration – ability to focus selectively on stimuli in the environment
- Intelligence – ability to respond to unknown situation
- Judgment – ability to compare or evaluate alternatives
- Insight – ability to see and understand connections between objects and situations
- Writing and Construction Ability – ability to accurately reproduce simple objects
- General information – measure person's contact with their environment
- Perceptual disturbances (delusions/hallucinations)
- Trouble with spatial ability and orientation
- Behavioral disturbances

E. Screening Tools:

1. The Mini Mental Status Examination (MMSE)<sup>7</sup> [See Learning Resource A] is the most widely used screening instrument for cognition. This 30 item test assesses for orientation, calculation, language and immediate and delayed memory. Because of its widespread use, there is variation in administration and scoring. A score below 23 usually indicates cognitive compromise and warrants further testing.

2. The Clock Drawing Test<sup>8</sup> measures multiple cognitive and motor functions through a clock drawing task. The individual is given a piece of paper with a 4 to 6 inch circle drawn and is asked to write the numbers and draw the hands of the clock to show “10 past 11”. Although many clinicians use a qualitative evaluation, there are scales to rank the drawing for completeness and correctness or to rate specific components of the clock drawn and combine the ratings into a score. The clock drawing interpretation scale recommended by Mendez et al falls in to this latter category. Other screening tools include:

- Blessed Orientation-Memory-Concentration Test (BOMC)<sup>9</sup>
- Short Portable Mental Status Questionnaire (SPMSQ)<sup>10</sup> [See Learning Resource B]

3. . Unstructured Assessment: An unstructured form of cognitive assessment occurs throughout the entire assessment process. Once the family has provided reliable demographic information, the clinician can ask the older adult many of the same questions as a way to informally gauge memory and recall. Other more informal ways to test memory include:

- asking the older adult to perform a multi-task function (i.e. getting a glass of water)
- identifying people in family photos
- carrying on an informal conversation

The clinician should also ask the older adult to assess his/her own cognitive functioning. Understanding the older adult’s perception of their own functioning is especially informative to the overall assessment and care plan.

**VI. Psychological Assessment:** Psychological factors can have an impact on the severity, duration and recovery from illness in the elderly. Depression, anxiety and denial are common psychological reactions of those faced with illness. This component of the psychosocial assessment is needed in order for the clinician to differentiate these conditions from normal levels of sadness and worry. However, this is particularly difficult to do with the older adult since older adults are hesitant to discuss psychological problems due to a fear of being labeled as crazy, as a sign of weakness, or something to be ashamed of.<sup>11</sup> Further complicating this area of assessment are family members who will frequently attribute

sadness or worry as a normal part of aging and illness and will not be forthcoming with details of the older adult's psychological functioning.

A. While standardized measures are valuable screening tools, they are not the definitive assessment, but rather used in conjunction with direct observation and interview with the older adult and support system.<sup>12</sup>

B. Depression is significantly underdiagnosed and undertreated in older adults.<sup>13</sup> It can affect performance on mental status tests and should be considered when cognitive impairment is suspected. The following scales are frequently used with the older adult:

1. The Geriatric Depression Scale, (GDS) [Learning Resource C] designed by Yesavage,<sup>14</sup> was the first depression assessment scale explicitly for older adults and remains widely used due to its simplicity. The GDS is a 30 question survey answered with a "yes" or "no". A point is given for each answer that matches the answer in parenthesis. A score of 10 or more usually suggests depression.

2. The Beck Depression Inventory (BDI)<sup>15</sup> is a 21 item self rating report that assesses symptoms of depression and includes a broad range of questions. Individual questions are scored as 0, 1, 2, or 3. A totaled score of greater than 11 is indicative of depression. This scale relies heavily on physical symptoms, making it less useful for older adults with physical impairment. It is difficult to use with those who have cognitive impairment and those with communication and hearing problems.

3. The Cornell Scale for Depression in Dementia (CSDD)<sup>16</sup> [Learning Resource D) is used to assess depression in patients who suffer from dementia. The administration of the test takes slightly longer than the GDS. Patients who score 12 or greater should be referred for a follow-up.

C. With community residing older adults, **anxiety** is the most frequently encountered emotional disorder, even more prevalent than depression.<sup>17</sup> Despite this fact, little research has been done on anxiety in older adults. Many of the same symptoms of anxiety (i.e. shortness of breath, dizziness, tremors, etc) can be mistaken for other physiological conditions (i.e. Parkinson's disease, cardiovascular compromise, etc.).

1. The Beck Anxiety Inventory (BAI)<sup>18</sup> [Learning Resource E] is a 21-item self report questionnaire of common anxiety symptoms (see attached). Respondents rate the intensity of each symptom as 0, 1, 2 or 3, with a score of 22 – 35 indicating moderate anxiety, and a score over 36 as severe. It should be noted that there are other anxiety instruments, none of which appear to be used that frequently by care managers.

**VII. Social Assessment:** One-fourth of all caregivers are age 65-75. Ten percent are over 75 years old. Approximately 80% of all support to older adults is provided on an informal basis by either an adult child or a spouse. In 2005 family members providing care to someone with a memory impairment provided on average 30 hours per week. Thus it is not

surprising that those involved with providing support, especially to someone with cognitive impairment, can experience significant strain.<sup>19</sup>

A. Informal Support: These are individuals such as family, friends, and neighbors with whom the older adult is in contact. Exchange can be emotional, financial and/or instrumental and may be reciprocal (i.e., the flow of support may be from the elder to the younger person). This support network can provide social interaction and discourse, as well as services.

B. Formal Support: These include social welfare and health care delivery programs such as Home Care Services, Day Care, etc. This network plays an especially important role in mobile industrialized societies in which children may live far from their parents and is paid for either privately, through a third party source (i.e. Medicare, Medicaid, etc) or through a community based entitlement program.

C. Semi-formal Support: Includes neighborhood organizations, church groups, and clubs that the older adult must take the initiative to gain access to. Encouragement from the health care professional or family members is often very helpful.

D. Social Support Assessment Tools: There are a number of standardized instruments that measure social support, however not in a uniform way. While some focus on only family members, some focus on both family and friends,<sup>20</sup> while others focus only on the older persons perception of support<sup>21</sup>

1. The Lubben Social Support Scale<sup>22</sup> (Learning Resource F ) uses a series of nine questions to assess the client's social support system including family, and friends. This instrument can be used equally well with the client and the caregiver to provide a broad-based picture about the size of the support network and its availability to assist with care and decision making.
2. Another formal assessment instrument is the Norbeck Social Support Questionnaire.<sup>23</sup> [Learning Resource G] This scale has also been shown to have strong validity and it has demonstrated utility for measuring social support not only with caregivers, but also for the clients themselves. The Norbeck subscales permit some determination of the areas in which a person perceives adequate social support and those areas in which the person perceives social support as lacking. As previously mentioned, in addition to assessing the availability of support, it is important to then measure the level of strain or burden that those involved with providing support might be experiencing.
3. Informal Assessment: Aside from formal measures, clinicians can also use an informal, semi-structured interviewing process to assess social support, or use a combination of a semi-structured interview along with one of the many standardized instruments that can measure informal support.

- a. The semi-structured interview process will provide the clinician with valuable information about how individuals relate to each other as well as the care manager, while a standardized instrument reports quantified information that can be used as an objective outcome to evaluate the effects of the intervention.
- b. Whatever format used, the size of the network and the availability of assistance for the patient, as well as the caregiver, should be assessed by the conclusion of the social support assessment.

E. Assessment of Care-giver Burden: Not all supportive relationships are positive relationships. In fact there is overwhelming evidence that being a caregiver, especially a primary caregiver, can result in feelings of strain or burden as well as a growing body of evidence that some caregivers also report feelings of gain.<sup>24</sup> If there is evidence, or if the clinician has an intuitive feeling that a particular caregiver is at risk of becoming overwhelmed, it is advisable to assess the caregiver's level of burden. As with social support there are a number of instruments that can be used to assess the caregiver's burden and satisfaction.

1. The Lawton Scale of Appraised Burden and Appraised Satisfaction<sup>25</sup>
2. Caregiver Burden inventory<sup>26</sup>
3. Caregiver Strain Index (CSI)<sup>27</sup> (Learning Resource H ] are just some of the multidimensional scales that can be used to measure strain. The CSI has 13 items that assess 5 dimensions or sources of strain (Financial, Physical, Time, Social, and Employment). A positive response to more than 7 indicates a need for a more focused assessment to determine the most appropriate intervention.

## VIII. References

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- <sup>1</sup> Geron, S.M.C., D., (1994) *Guidelines for case management practice across the long-term care continuum* in *Report of the National Advisory Committee on Long-Term Care Case Management*. Connecticut Community Care, Inc: Bristol, CT.
- <sup>2</sup> Morano, B. & Morano, C., (2006) *Psychosocial Assessment* in *Handbook of Geriatric Care Management*, C. Cress, Editor: Jones and Bartlett Publishers: Sudbery MA:.(in press)
- <sup>3</sup> Langley, L.K., (2002) *Cognitive Assessment of Older Adults*, in *Assessing Older Persons*, R.L. Kane, R.A. Kane, Editor. Oxford University Press: New York.
- <sup>4</sup> Mariano, C., Gould, E., Mezey, M., & Fulmer, T., (Eds.). (1999). *Best nursing practices in care for older adults: Incorporating essential gerontologic content into baccalaureate nursing education*. (2<sup>nd</sup> ed). New York, NY: The John A. Hartford Foundation Institute for Geriatric Nursing, Division of Nursing, School of Education, New York University.
- <sup>5</sup> Gallo, J. J., Fulmer, T., Paveza, G. J., & Reichel, W. (2000). *Handbook of Geriatric Assessment*. (3<sup>rd</sup> ed.). Gaithersburg, MD: Aspen Publishers, Inc.
- <sup>6</sup> Mariano, C., Gould, E., Mezey, M., & Fulmer, T., (Eds.). (1999).
- <sup>7</sup> Folstein, M.F., Folstein, S.E., McHugh, P.R., (1975) "*Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician*." *Journal of Psychiatric Research*, **12**(3): p. 189-198.
- <sup>8</sup> Mendez, M.F., Ala, T., & Underwood, K.L.(1992) *Development of scoring criteria for the clock drawing task in Alzheimer's disease*. *Journal of American Geriatric Society*. **40**: p. 1095-1099.
- <sup>9</sup> Katzman, R., Brown, T., Fuld, P., Peck, A., Schechter, R., & Schimmel, H., *Validation of a short Orientation- Memory-Concentration Test of cognitive impairment*. *American Journal of Psychiatry*, 1983. **140**: p. 734-739
- <sup>10</sup> Pfeiffer, E., *A short portable mental status questionnaire for the assessment of organic brain deficit in elder patients*. *Journal of American Geriatric Society*. **23**: p. 433-441.
- <sup>11</sup> Gallo, J. J., Fulmer, T., Paveza, G. J., & Reichel, W. (2000).
- <sup>12</sup> Berkman, B.J., Maramaldi, P., Breon, E.A., & Howe, J.L., (2002) *Social Work Gerontological Assessment Revisited*. *Gerontological Social Work*.

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- <sup>13</sup> Grann, J.D., *Assessment of Emotions in Older Adults: Mood Disorders, Anxiety, psychological Well-Being, and Hope.*, in *Assessing older persons*, R.L.Kane, .R.A. Kane, Editor. (2000), Oxford University Press Inc: New York. p. 129-169.
- <sup>14</sup> Yesavage, J.A.B., T.L., *Development and validation of a geriatric depression scale: A preliminary report.* Journal of Psychiatric Research, 1983. **17**(37-49).
- <sup>15</sup> Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., Erbaugh, J., *An inventory for measuring depression.* Archives of General Psychiatry, 1961. **4**: p. 561-571.
- <sup>16</sup> Alexopoulos, GS, RC Abrams, RC Young, and CA Shamoian (1988) Cornell Scale for Depression in Dementia. Biol Psychiatry 23, 271-284.
- <sup>17</sup> Gellis, Z., *Older Adults with Mental and Emotional Problems.* Handbook of Social Work and Health in Aging, ed. B. Berkman. 2006, New York: Oxford University Press. 10.
- <sup>18</sup> Beck, A.T., Epstein, N., Brown, G. & Steer R., *An inventory for measuring clinical anxiety: Psychometric Properties.* Journal of Consulting and Clinical Psychology, 1988. **56**: p. 893-897.
- <sup>19</sup> Gallo, J. J., Fulmer, T., Paveza, G. J., & Reichel, W. (2000).
- <sup>20</sup> Antonucci, T.C., Sherman, A. M., Vanderwater, E.A., *Measures of social Support and caregiver burden.* Generations, 1997. **XXI**(1): p. 48-51.
- <sup>21</sup> Pearlin, L.I., Mullan, J.T., Semple, S.J., & Skaff, M.M., *Caregiving and the stress process: An overview of concepts and their measures.* The Gerontologist, 1990. **30**: p. 583-594.
- <sup>22</sup> Lubben, J., *Assessing social networks among elderly populations.* Family and Community Health, 1988. **11**(42-52).
- <sup>23</sup> Norbeck, J.S., Lindsey, A.M., & Carrieri, V.L., *The development of an instrument to measure social support.* Nursing Research, 1981. **30**: p. 264-269.
- <sup>24</sup> Morano, B. & Morano, C., (2006) *Psychosocial Assessment in Handbook of Geriatric Care Management*, C. Cress, Editor.
- <sup>25</sup> Lawton, M.P., Kleban, M. H., Moss, M., Rovine, M., & Glicksman, A., *Measuring caregiving appraisal.* Journal of Gerontology, 1989. **44**(3): p. P61-P71.
- <sup>26</sup> Novak, M., Guest, C., *Application of a Multidimensional Caregiver Burden Inventory.* The Gerontologist, 1989. **29**: p. 798-803.
- <sup>27</sup> Robinson, B.C., *Validatin of a Caregiver Strain Index.* Journal of Gerontology, 1983. **38**(3): p. 344-348.

**IX. Learning Resources:**

**Learning Resource A : The Folstein Mini-Mental Status Examination (MMSE)**

Maximum Score	Score	
		<b><u>Orientation</u></b>
5	( )	What is the (Year) (Season) (Date) (Day) (Month)? <i>One point for each correct response.</i>
5	( )	Where are we: (State) (County) (Town or City) (Hospital) (Floor)? <i>One point for each correct response.</i>
		<b><u>Registration</u></b>
3	( )	NAME 3 COMMON OBJECTS (e.g., apple, table, penny) <i>One point for each correct response.</i> Count trials and record. Trials:
		<b><u>Attention and Calculation</u></b>
5	( )	Serial 7's, backwards. <i>One point for each correct response.</i> Stop after 5 answers. Alternatively, spell "WORLD" backwards. <i>One point for each correct response.</i>
		<b><u>Recall</u></b>
3	( )	Ask for the 3 objects repeated above. <i>One point for each correct response.</i>
		<b><u>Language</u></b>
2	( )	Name a pencil and a watch.
1	( )	Repeat the following: <i>No ifs, ands, or buts.</i> "
3	( )	Follow a 3 stage command: <i>Take a paper in your right hand, fold it in half, and put it on the floor.</i> <i>One point for each correctly executed.</i>
1	( )	Read and obey the following: <b>Close your eyes.</b>
1	( )	Write a sentence.
1	( )	Copy the following design.

Severity of cognitive impairments

**Mild:** MMSE > 21    **Moderate:** MMSE 10-20    **Severe:** MMSE < 9

**The expected decline in MMSE scores in untreated mild to moderate Alzheimer's patients is 2 to 4 points per year.**

**Learning Resource B: The Short Portable Mental Status Questionnaire ( SPMSQ)**

Question	Response	Incorrect Responses
1. What are the date, month, and year?		
2. What is the day of the week?		
3. What is the name of this place?		
4. What is your phone number?		
5. How old are you?		
6. When were you born?		
7. Who is the current president?		
8. Who was the president before him?		
9. What was your mother's maiden name?		
10. Can you count backward from 20 by 3's?		

**SCORING:\***

0-2 errors: normal mental functioning

3-4 errors: mild cognitive impairment

5-7 errors: moderate cognitive impairment

8 or more errors: severe cognitive impairment

\*One more error is allowed in the scoring if a patient has had a grade school education or less.

\*One less error is allowed if the patient has had education beyond the high school level.

**Source: Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of American Geriatrics Society*. 23, 433-41.**

**Learning Resource C: Geriatric Depression Scale ( Short Form)**

Choose the best answer for how you have felt over the past week:

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

**Learning Resource C ( con't):\_Geriatric Depression Scale (Short Form scoring)**

Choose the best answer for how you have felt over the past week:

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

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

**Learning Resource D: Cornell Scale for Depression in Dementia**

The CSDD is specially designed for assessing depression in the elderly with dementia. Answer the items in each section and enter the value of the answer in the column labeled Score. Sum the scores of the items to determine the total score, and apply the interpretation rule that appears at the bottom of the page.

The ratings should be based on symptoms and signs occurring during the week prior to this assessment. No score should be given if symptoms result from physical disability or illness.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mood-Related Signs	Absent*	Mild or Intermittent	Severe	Score
1. Anxiety (anxious expression, ruminations, worrying)	0	1	2	_____
2. Sadness (sad expression, sad voice, tearfulness)	0	1	2	_____
3. Lack of reactivity to pleasant events	0	1	2	_____
4. Irritability (easily annoyed, short tempered)	0	1	2	_____
<b>Behavioral Disturbance</b>				
5. Agitation (restlessness, handwringing, hairpulling)	0	1	2	_____
6. Retardation (slow movements, slow speech, slow reactions)	0	1	2	_____
7. Multiple physical complaints (score 0 if GI symptoms only)	0	1	2	_____
8. Loss of interest (less involved in usual activities; score only if change occurred acutely, that is, in less than one month)	0	1	2	_____
<b>Physical Signs</b>				
9. Appetite loss (eating less than usual)	0	1	2	_____

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10. Weight loss (score 2 if greater than 5 lb in one month)	0	1	2	___
11. Lack of energy (fatigues easily, unable to sustain activities; score only if change occurred acutely, that is, in less than one month)	0	1	2	___
<b>Cyclic Functions</b>				
12. Diurnal variation of mood symptoms worse in the morning	0	1	2	___
13. Difficulty falling asleep later than usual for the resident	0	1	2	___
14. Multiple awakening during sleep	0	1	2	___
15. Early morning awakening earlier than usual for this individual	0	1	2	___
<b>Ideational Disturbance</b>				
16. Suicide (feels life is not worth living, has suicidal wishes, or makes suicide attempt)	0	1	2	___
17. Poor self-esteem (self-blame, self-depreciation, feelings of failure)	0	1	2	___
18. Pessimism (anticipation of the worst)	0	1	2	___
19. Mood-congruent delusions (delusions of poverty, illness, or loss)	0	1	2	___
<b>Total Score =</b>				___

### Interpretation of the Total Score

A total score of 8 or more suggests significant depressive symptoms.

\* Assign the item a score of 0 if you cannot detect or evaluate the sign or symptom.

Adapted from: Alexopoulos, et al. Cornell Scale for Depression in Dementia. *Biological Psychiatry* 1988;23(3):271-284.

**Learning Resource E: Beck Anxiety Inventory**

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
<b>Column Sum</b>				

**Scoring** - Total each column. Then total the columns to achieve a grand score. Write that score here: \_\_\_\_\_

### Learning Resource E (con't): Beck Anxiety Inventory--Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to “mask” the symptoms commonly associated with anxiety. Too little “anxiety” could indicate that you are detached from yourself, others, or your environment.

A grand sum between **22 – 35** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not “panic” time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

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**Learning Resource F: Lubben Social Network Scale**

<b>FAMILY NETWORKS</b>		
#1.	How many relatives do you see or hear from at least once a month (Note: Include in-laws with relatives)?	
	0 = Zero      3 = three or fours 1 = One      4 = five to eight 2 = Two      5 = nine or more	_____
#2.	Tell me about the relative with whom you have the most contact. How often do you see or hear from that person?	
	0 = Zero      3 = three or fours 1 = One      4 = five to eight 2 = Two      5 = nine or more	_____
#3.	How many relatives do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call for help?	
	0 = Zero      3 = three or fours 1 = One      4 = five to eight 2 = Two      5 = nine or more	_____
<b>FRIENDS NETWORKS</b>		
#4.	Do you have any close friends? That is, do you any friends with whom you feel at ease, can talk to about private matters, or can call on for help? If so how many?	
	0 = Zero      3 = three or fours 1 = One      4 = five to eight 2 = Two      5 = nine or more	_____
#5.	How many of theses friends do you see or hear from at least once a month?	
	0 = Zero      3 = three or fours 1 = One      4 = five to eight 2 = Two      5 = nine or more	_____
#6.	Tell me about the friend with whom you have the most contact? How often do you see or hear from that person?	
	0 = < monthly      3 = weekly 1 = Monthly      4 = a few times a week 2 = a few times month      5 = daily	_____

<b>CONFIDANT RELATIONSHIPS</b>						
#7.	When you have an important decision to make, do you have someone you can talk to about it?					
	Always    Very Often    Often    Sometimes    Seldom    Never					_____
	5            4            3            2            1            0					
#8.	When other people you know have an important decision to make, do they talk to you about it?					
	Always    Very Often    Often    Sometimes    Seldom    Never					_____
	5            4            3            2            1            0					
<b>HELPING OTHERS</b>						
#9.	Does any body rely on you to do something from them each day? For example shopping, cooking dinner, doing repairs, cleaning house, providing child care, etc. NO – If no, go on to #9b. YES – if yes, #9 is scored 5 and skip to #10					_____
#9b	Do you help anybody with things like shopping, filling out forms, doing repairs, providing child care, etc.?					
	Always    Very Often    Often    Sometimes    Seldom    Never					_____
	5            4            3            2            1            0					
<b>LIVING ARRANGEMENTS</b>						
#10.	Do you live alone or with other people? (NOTE: Include in-laws with the relatives.) 5 Live with spouse 4 Live with other relatives or friends 1 Live with other unrelated individuals (e.g., paid help) 0 live alone					_____
<b>TOTAL LSNS SCORE</b>						_____

**SCORING**

The total LSNS score is obtained by adding up scores from each of the ten individual items. Thus, total LSNS scores can range from 0 to 50. Scores on each item were anchored between 0 to 5 in order to permit equal weighting of the ten items. It is suggested that a score below 20 indicates risk for limited social networks.

**Learning Resource G: Norbeck Social Support Questionnaire\***

**Please list each significant person in your life and their relationship to you in the section headed Personal Network. Consider all the persons who provide personal support for you or who are important to you.**

Use only first names or initials and then indicate the person's relationship to you by choosing a corresponding number from the following list:

- |                               |                            |
|-------------------------------|----------------------------|
| 1 = spouse                    | 6 = health care provider   |
| 2 = family member or relative | 7 = counselor or therapist |
| 3 = friend                    | 8 = minister/priest/rabbi  |
| 4 = work or school associate  | 9 = other                  |
| 5 = neighbor                  |                            |

Example:

- |                   |   |
|-------------------|---|
| 1. <u>Mary T.</u> | 3 |
| 2. <u>Bob</u>     | 2 |
| 3. <u>M.T.</u>    | 6 |
| 4. <u>Sam</u>     | 5 |
| 5. <u>Mrs. R</u>  | 7 |

**You do not have to use all the spaces. Use only as many as you have important persons in your life.**

When you have finished your list, please answer questions 1 through 8 for each of the persons on your personal network list.

**PERSONAL NETWORK**

First Name	Relationship
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

For each person that you listed, please answer the following questions by writing in the number that applies.

- 1 = not at all      2 = a little      3 = moderately      4 = quite a bit      5 = a great deal

Question 1:

Question 2:

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How much does this person make you  
liked or loved?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Question 3:**

How much can you confide in this person?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Question 5:**

If you needed to borrow \$10, a ride to the doctor,  
or some other immediate help, how much could  
this person usually help?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

How much does this person make you feel  
respected or admired?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Question 4:**

How much does this person agree  
with or support your actions or  
thoughts?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Question 6:**

If you were confined to bed for  
how much could this person help  
you

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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Question 7:  
How long have you known this person?

- 1 = less than 6 months
- 2 = 6 to 12 months
- 3 = 1 to 2 years
- 4 = 2 to 5 years
- 5 = more than 5 years

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Question 8:  
How frequently do you usually have contact with this person? (phone calls, visits, or letters)

- 5 = daily
- 4 = weekly
- 3 = monthly
- 2 = a few times a year
- 1 = once a year or less

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Question 9:  
**During the past year, have you lost any important relationship due to moving, a job change, divorce or separation, death, or some other reason?**

- 0 = NO
  - 1 = YES
- If yes:

*Please indicate the number of persons from each category who are no longer available to you.*

- |  |                                     |
|--|-------------------------------------|
| _____ <i>spouse</i>                      | _____ <i>health care providers</i>  |
| _____ <i>family members or relatives</i> | _____ <i>counselor or therapist</i> |
| _____ <i>friends</i>                     | _____ <i>minister/priest/rabbi</i>  |
| _____ <i>work or school associates</i>   | _____ <i>other (specify)</i>        |
| _____ <i>neighbors</i>                   |                                     |

*b. Overall, how much of your support was provided by these people who are no longer available to you?*

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0 = none at all      1 = a little      2 = a moderate amount      3 = quite a bit

4 = a great deal

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Adapted with permission from J Norbeck et al., The Development of an Instrument to Measure Social Support, *Nursing Research*, Vol. 30, No. 5, pp. 264-269, 1981, and Vol. 32, No. 1, pp. 4-9, 1983, Lippincott Williams & Wilkins.

**Learning Resource H: Caregiver Strain Index**

**The Caregiver Strain Index:** I am going to read a list of things that other people have found to be difficult. Would you tell me if any of these apply to you? (Give examples)

	Yes=1	No=0
Sleep is disturbed (e.g., because _____ is in and out of bed or wanders around at night)		
It is inconvenient (e.g., because helping takes so much time or it s a long drive over to help)		
It is a physical strain (e.g., because of lifting in and out of a chair; effort or concentration is required)		
It is confining (e.g., helping restricts free time or cannot go visiting)		
There have been family adjustments (e.g., because helping has disrupted routine; there has been no privacy)		
There have been changes in personal plans (e.g., had to turn down a job; could not go on vacation)		
There have been other demands on my time (e.g., from other family members)		
There have been emotional adjustments (e.g., because of severe arguments)		
Some behavior is upsetting (e.g., because of incontinence; _____ has trouble remembering things; or _____ accuses people of taking things)		
It is upsetting to find _____ has changed so much from his/her former self (e.g., he/she is a different person than he/she used to be )		
There have been work adjustments (e.g., because of having to take time off)		
It is a financial strain		
Feeling completely overwhelmed (e.g., because of worry about _____; concerns about how you will manage)		
<b>TOTAL SCORE</b> (Count yes responses. Any positive answer may indicate a need for intervention in that area. A score of 7 or higher indicates a high level of stress.)		