How To try this

By Sherry A. Greenberg, MSN, APRN,BC, GNP

The Geriatric Depression Scale: Short Form

Depression in older adults is underdiagnosed; try this short, simple tool to screen for depression.

Ed Eckstein

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Overview: Depression is underrecognized in older adults, especially those with chronic conditions such as heart disease and arthritis. Left untreated, depression may progress and have dramatic effects on overall health. The Geriatric Depression Scale: Short Form is a 15-question screening tool for depression in older adults that takes five to seven minutes to complete and can be filled out by the patient or administered by a provider with minimal training in its use. The questions focus on mood; the score can help clinicians decide whether further assessment is needed. (This screening tool is included in a series, *Try This: Best Practices in Nursing Care to Older Adults,* from the Hartford Institute for Geriatric Nursing at New York University's College of Nursing.) For a free online video demonstrating the use of this tool, go to http://links.lww.com/A101.

Web Video

Watch a video demonstrating the use and interpretation of the Geriatric Depression Scale: Short Form at http://links.lww.com/A101.

A Closer Look

Get more information about depression in and assessment of older adults.

Try This: The Geriatric Depression Scale

This is the *Try This* tool in its original form. See page 67.

Online Only

Unique online material is available for this article. Direct URL citations appear in the printed text; simply type the URL into any Web browser.

Charlotte Balzan, a 78-year-old woman living in a two-bedroom apartment in New York City, has felt lonely for the past two years, since the death of her husband of 45 years. (This case is a composite, based on my experience.) She has one son who lives in Maryland, whom she speaks with weekly but rarely sees. Ms. Balzan has no close friends and isn't active in the nearby senior center, nor does she participate in other activities. Recently diagnosed with hypertension and treated with hydrochlorothiazide (HydroDIURIL and others) 12.5 mg once daily, she has been visited by a home care nurse twice weekly for blood pressure monitoring and medication-adherence assessment. On these visits Ms. Balzan says she has "nothing to do" and bemoans what she sees as the poor condition of her apartment, which is clean but cluttered with newspapers and has old plumbing, heating, and air-conditioning systems. She doesn't want to move or have her apartment cleaned. She has no known history of depression or other psychological disorders.

When the home care nurse visits one early afternoon, she finds Ms. Balzan still wearing her nightgown, little food in the refrigerator, some canned goods in the cabinets, and several piles of dirty laundry. Ms. Balzan appears apathetic. She says that she sleeps poorly, is fatigued, and has little appetite. Upon examination, Ms. Balzan is afebrile, her vital signs are stable, and her blood pressure is well controlled. The nurse finds no evidence of acute illness. Recent routine laboratory tests showed nothing abnormal.

The home care nurse completes a routine Outcome and Assessment Information Set (OASIS) assessment, which includes checking reported or observed depressive symptoms, including depressed mood, sense of failure or self-reproach, hopelessness, recurrent thoughts of death, or thoughts of suicide.[1] Ms. Balzan says she has none of these. But the nurse observes a flat affect, and because of this, along with the nonspecific nature of the complaints and her disinterest in activities, the nurse suspects depression. Because the OASIS, which one study has suggested may fail to identify depression in many people,[2] is a checklist and doesn't include detailed questions on mood, the nurse decides to administer the Geriatric Depression Scale: Short Form (GDS: SF),

which is designed specifically to assess for depressed mood in older adults.

THE GERIATRIC DEPRESSION SCALE: SHORT FORM

Developed in 1986 to screen for depression in older adults, the GDS: SF has been used in community, acute, and long-term care settings. The GDS: SF consists of 15 questions requiring "yes" or "no" answers and can be completed quickly (see the tool on page 67). Although the tool itself states that a score above 5 is suggestive of depression and a score equal to or greater than 10 is almost always indicative of depression, a more detailed scoring is often more helpful in rating depression. A score of

- 0 to 4 isn't typically cause for concern.
- 5 to 8 suggests mild depression.
- 9 to 11 suggests moderate depression.
- 12 to 15 suggests severe depression.

All GDS: SF questions relate to mood, rather than the physical symptoms frequently reported by older adults. It was modified from the original 30-item form to focus on items with the highest correlation to depressive symptoms in validation studies.[3] It's shorter than other assessment tools for depression in this population and requires little training to administer.

The GDS: SF is useful in assessing older adults who are ill or well; are easily fatigued; have a short attention span; or have mild to moderate, though not severe, cognitive impairment. It can be completed in less than seven minutes. Older adults may have an easier time providing the GDS: SF's yes-or-no responses than choosing answers, as is required on other depression screening tools. Two other benefits of both the long and short forms are that the GDS is in the public domain and has been translated into many languages.

For detailed definitions of depression in older adults, see *Why Screen for Depression?* on page 63.

ADMINISTERING THE GDS: SF

The GDS: SF may be used in any setting—acute care, primary care, home care, assisted living, or long-term care. It can be completed by the patient before a clinical visit or during a provider interview, in person or by telephone.[15, 16] If a patient cannot read because of illiteracy or low vision, the GDS: SF should be administered by interview.

Introduce the tool and instruct patients by saying, for example, "I'm going to ask you some questions about your mood. Please answer 'yes' or 'no' based on how you have felt over the past week." The GDS: SF should be administered in a private, quiet room when the clinician is not rushed. The provider should speak slowly and clearly, maintain good eye contact, and tell the patient that these are routine questions. If necessary, an interpreter should administer the questionnaire in the patient's language. To view "Demonstrating the GDS: SF Screening," the online video segment showing a nurse administering the GDS: SF in an assisted-living facility, go to http://links.lww.com/A102.

Challenges that may arise. When patients offer detailed explanations rather than "yes" or "no" answers, nod politely, and repeat the directions: "We can talk more about this later, please answer either 'yes' or 'no' based on how you have felt over the past week." If patients respond with "I don't know" to any of the questions, as often occurs with depressed patients, redirect them by saying, for example, "Overall, would you say more 'yes' or more 'no' based on how you've felt over the past week?" and then repeat the question. It's often helpful to ask family members or friends to wait outside the room so you can ask the questions in private. This prevents others from answering for the patient or influencing the answers. Patients often feel more able to state feelings if family members and friends are not present.

Patients who neither speak nor write may point to the words "yes" or "no" written on paper or a board to respond. Those with even mild dementia may not fully understand the questions, and Burke and colleagues found that the GDS: SF has poor validity as a screening tool in this population.[17] In such cases, it's possible to use a version of the GDS: SF in which family members or caregivers answer the 15 questions for the patient. That version is available in English and Spanish at www.stanford.edu/~yesavage/GDS_INFORMANT_MEASURES.htm.

SCORING AND INTERPRETING RESULTS

For the purposes of scoring, answer in each of the 15 questions on the GDS: SF is in **bold type** to emphasize its significance to depression and to assist the clinician in scoring the items. As can be seen on page 68, 10 of the "yes" responses and five of the "no" responses are bold. The higher the total number of bold responses, the greater the likelihood that a patient requires further assessment for depression. If the patient is providing written rather than oral responses, give her or him a printed form that contains no responses in bold, which could influence their choice of answers. (Such a form can be found at www.stanford.edu/~yesavage/GDS.english.short.html.) For patients who don't answer one or more items, the score may be prorated. For example, if the patient answers 12 of the 15 items, four of these with bolded responses, the patient's total score will be 4

Why Screen for Depression?

Depression may be broadly defined as a mood disorder that has affective, cognitive, and physical signs and symptoms.[4] Symptoms range from mild to severe and may progress with time; marking the most severe form are suicidal ideation, psychotic features such as hallucinations and delusions, and excessive somatic complaints.[4] Depression, unlike seasonal affective disorder or moderate bereavement, usually doesn't resolve on its own and may persist or progress if left untreated.

Depression is classified as minor or major. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*), lists the following criteria for the diagnosis of "major depressive episode" (the primary criterion in the diagnosis of major depressive disorder)[5]:

- persistently depressed mood
- diminished ability to take pleasure in activities
- feelings of worthlessness or excessive guilt
- difficulty thinking and concentrating; indecisiveness
- thoughts of death, suicidal ideation, suicide attempts
- excessive tiredness
- significantly altered appetite and weight
- too much or too little sleep
- psychomotor agitation or retardation

For an episode to meet the criteria, the symptoms shouldn't be the direct result of a drug or a medical condition, and at least five of the nine criteria must be present almost daily for two weeks or longer and involve "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[5] *At least one of the symptoms must be depressed mood or diminished pleasure or interest in activities.*

The *DSM-IV-TR* criteria for the diagnosis of "minor depressive disorder" includes depressive episodes of at least two weeks' duration, with the patient meeting fewer than five but at least two of the criteria required for major depressive disorder. As with major depressive disorder, at least one of the symptoms present must be depressed mood or diminished pleasure or interest in activities. Older adults with depressive symptoms that do not meet *DSM-IV-TR* criteria for major or minor depression are considered to have subsyndromal depression. Since they don't meet *DSM-IV-TR* criteria, they often don't receive treatment.[6] Both minor and subsyndromal depression, if left untreated, may increase the risk of physical, cognitive, and social impairment, as well as delayed recovery from acute illness and surgery, and may lead to major depression, more frequent and costly use of health care services, poorer physical and social functioning, and a poorer quality of life.[7, 8]

Incidence and prevalence. One metaanalysis found "clinically significant depressive symptoms" reported in 3% to 26% of community-dwelling older adults, 10% of older medical outpatients, 23% of older acute care patients, and 16% to 30% of older nursing home residents.[9] The prevalence of depression in patients with Alzheimer disease is 23% to 55%,[10] and one study found that patients with arthritis or heart disease are 18% more likely to experience depression, with functional limitation as the strongest factor associated with depression.[11] In older adults, somatic symptoms such as pain may mask depressive symptoms and lead to underdiagnosis of depression, a disorder that is often treatable.

Depression is a leading risk factor for suicide. In 2004 people ages 65 and older constituted 12% of the U.S. population but accounted for 16% of suicides.[12] In 2004, 14.3 of every 100,000 people ages 65 and older died by suicide—higher than the rate of about 11 per 100,000 in the general population.[12, 13] Non-Hispanic white men ages 85 and older were the subgroup most likely to die by suicide, with a disturbingly high rate of 50 suicides per 100,000 in that age group.[12] And a 2004 study by Juurlink and colleagues found that older adults who died by suicide "were almost twice as likely to have visited a physician in the week before death" than were living control subjects.[14] To view the online video segment "Recognizing Geriatric Depression," go to http://links.lww.com/A103.

plus one-third of the three unanswered questions—that is, 4 plus 1, making a total score of 5.[18] Any score higher than 5 warrants a comprehensive assessment and, if indicated, evaluation for suicidality. Although the GDS: SF is a useful tool in screening for depression in older adults, it's not diagnostic and not a substitute for clinical observation and judgment. The GDS: SF helps to quantify and validate the nurse's suspicions and concerns about depression. A comprehensive assessment involves input from others, including such specialists as a geriatrician, geriatric nurse, geriatric social worker, geriatric psychiatrist, pharmacist, and dietitian. The video segment discussing scoring, "The Interpretation of

the GDS: SF," is available online at http://links.lww.com/A104.

Ms. Balzan's GDS: SF score was 8 of 15. Her responses receiving one point each included not feeling satisfied with her life, dropping many activities and interests, feeling that her life was empty, feeling bored, not being in good spirits most of the time, not feeling happy most of the time, preferring to stay home rather than to go out and do new things, and not feeling full of energy. Taking into account not only her score but also her apathy, her poor self-care (in bathing and doing laundry), the paucity of food in the apartment, and her poor appetite, the nurse decided it would be wise to call Ms. Balzan's primary care provider, an NP.

CULTURAL CONSIDERATIONS

The concept of depression may vary by culture. For example, in a small study of 50 elderly African American outpatients at a large urban hospital, many said that they didn't understand questions such as *Do you feel that your situation is hopeless?* and *Do you feel pretty worthless the way you are now?*[19] The authors speculate that culture and religion can affect the meaning of *worthlessness* and *hopelessness*, although the patients' level of education didn't significantly affect their understanding of the questions. The study highlights the need for larger studies that examine other populations' responses to these questions.

One study notes that older adults living in Korea and those in the United States hold very different concepts of depression.[20] In Korea, for example, older adults tend to live with their families. When asked, "Do you prefer to stay at home, rather than going out and doing new things?" a positive response may not indicate depression as much as it would in an older adult in the United States. According to the authors, "Korean elderly [patients] who are suffering with depressive symptoms may choose going out as one of the coping strategies to escape their depressive moods . . . especially when the main cause of their depressive symptoms is related to family matters." Despite such differences, the authors found their own Korean translation of the GDS: SF to be a reliable measure for use with older Koreans.

A study using a regional probability study sample of elderly Asian immigrants living in New York City showed that the long and short forms of the GDS were reliable in assessing depression in that population.[21] Using the long form, the researchers found that 40% of 407 elderly immigrants from India, China, Vietnam, Japan, and the Philippines screened positive for depression. Such data strongly suggest a need for depression screening with older immigrant populations in this country.

Translations of the GDS: SF are in the public domain and available in various languages, including Spanish, Chinese, French, and Korean (among others), and can be downloaded for free from the Web site of the Aging Clinical Research Center of Stanford University and the Veterans Affairs Palo Alto Health Care System, www.stanford.edu/~yesavage/GDS.html. A literature search finds no studies of validity and reliability for the GDS: SF in translation (scoring of all versions is the same). It's important to bear in mind the significant cultural differences in how people express emotion.[20, 22] More cross-cultural research is needed.

COMMUNICATING THE RESULTS

The GDS: SF score and responses along with related symptoms from the patient's history need to be documented in the chart and shared with the other care providers. Nurses may be the only ones who've had repeated contact with a patient, and important information must be communicated to other staff members. When describing the patient to other providers, include information related to the patient's self-care, recent changes in health, somatic complaints, medications, personal losses, weight changes, sleep patterns, activity level, substance use or abuse, and suicidal ideation. An interdisciplinary approach is best; older adults often have interconnected physical, psychiatric, functional, social, and financial issues. The video segment discussing communicating results, "The Communication and Utilization of Findings," is available online at http://links.lww.com/A105.

When discussing results with patients and families, remember that the GDS: SF is a screening tool, not a diagnostic tool. Results give a basis for discussion; make sure that patients and families know that a comprehensive assessment—by a psychiatric nurse, NP, geriatrician, or geropsychiatrist—is needed to diagnose depression. The GDS: SF may be repeated as needed to screen for or to monitor the severity of depression over time. The GDS: SF does not contain a question related to suicidal ideation and may be a poor predictor of suicidality.[23] If a provider suspects that a patient may harm her- or himself, a detailed assessment for suicidal ideation should be performed and a plan of care developed. If a patient is suicidal, with or without a detailed plan, the patient should not be left alone and help should be sought immediately. The toll-free National Suicide Prevention Lifeline is available 24 hours a day, seven days a week: (800) 273-TALK (8255).

Ms. Balzan, continued. The nurse discussed the findings with the patient: "Ms. Balzan, your answers to these questions lead me to think that maybe you're depressed. Your primary care provider should know so that she can do a more thorough assessment. With your permission I'd like to talk with her about this." Ms. Balzan allowed the nurse to call from her apartment (although she didn't have to approve the call; the nurse had sufficient reason for concern). The nurse reported to Ms. Balzan's NP, "I am currently visiting Charlotte Balzan. Though her vital signs are stable and her blood pressure is well controlled, I'm concerned about her mood. She's still wearing her nightgown, has little food available, and hasn't bathed in a while. And there are several piles of dirty laundry in the apartment. She appears apathetic, says that she sleeps poorly, and complains of fatigue and little appetite. Thinking she might be depressed, I completed a GDS: SF; her score is 8 out of 15. She's not feeling satisfied with her life, is dropping many activities and interests, feels that her life is empty, feels bored, isn't in good spirits most of the time, isn't feeling happy most of the time, prefers to stay home rather than go out and do new things, and isn't feeling full of energy. I was hoping you could fit her into your home visit schedule today."

When Ms. Balzan's NP saw her later that day, she obtained a thorough history and performed a physical examination and in-depth psychological assessment. The NP told Ms. Balzan that she would benefit from an inpatient stay on a geropsychiatry unit, where she would be assessed and treated for depression by a team of providers. Ms. Balzan consented and was admitted to a nearby private hospital where her NP could follow her along with a geropsychiatrist and other team members on the inpatient unit. There, Ms. Balzan was treated for major depression with group and individual therapy, as well as an antidepressant.

After the inpatient stay, Ms. Balzan moved into an assisted-living facility near her son. Outpatient therapy was arranged for ongoing evaluation of depression, adverse effects of the antidepressant, and adjustment to the move. Ms. Balzan sold her apartment to finance the move. When her home health care nurse called to follow up, Ms. Balzan still spoke of boredom, sleepiness, and loneliness, but she said that she ate meals in the dining room with others at the facility, participated in scheduled activities, and had lunch regularly with her son. Ms. Balzan recognized that she was no longer able to handle the upkeep on her apartment; she was grateful, she said, to live with others her age.

Watch It!

Go to http//links.lww.com/A101 to watch a nurse use the GDS: SF to screen an older woman for depression and discuss ways to meet the challenges of administering it and interpreting and quickly acting on findings. Then watch the health care team plan short- and long-term interventions to alleviate the woman's depression.

View this video in its entirety and then apply for CE credit at www.nursingcenter.com/AJNolderadults; click on the *How to Try This* series. All videos are free and in a downloadable format (not streaming video) that requires Windows Media Player.

CONSIDER THIS

There are other screening and assessment tools for depression, but the GDS: SF stands out as the best tool to use with older adults. (Go to http://links.lww.com/A117 for a comparison of the GDS: SF with other tools used to screen for depression.) The following questions and answers provide additional insight into the use of this tool.

What is the evidence for using the GDS: SF? According to the original study on the GDS: SF, the tool was moderately reliable and valid as a screening tool for depression in older adults.[3] For a more in-depth discussion of psychometrics, see "Define Your Terms," by series coeditor Nancy Stotts and Katherine Alderich, page 71.

- *Reliability.* The GDS: SF has demonstrated moderate reliability. In one study of 960 functionally impaired, cognitively intact primary care patients ages 65 and older, Friedman and colleagues reported moderate internal consistency (a Cronbach α coefficient of 0.749).[23] The functional status of the older adult did not significantly affect the reliability.
- *Validity.* In this same study by Friedman and colleagues, the GDS has moderate correlations with measures of depressed mood and life satisfaction.[23] For criterion validity:
  - *Sensitivity.* The original research established that the GDS: SF could identify 92% of the people who were actually depressed.[3] The study by Friedman and colleagues found that the sensitivity increased with a lower cutoff score: it was 81.45% with a cutoff score of 6 and 89.5% with a cutoff score of 5.[23]
  - *Specificity.* The tool accurately identified 89% of those who were not depressed in the original study.[3] The study by Friedman and colleagues found that this varies with the cutoff score: it was 75.36% with a cutoff score of 6 and 65.3% with a cutoff score of 5.[23]

Online Resources

For more information on the GDS: SF and other geriatric assessment tools and best practices, go to www.hartfordign.org, the Web site of the John A. Hartford Foundation–funded Hartford Institute for Geriatric Nursing at New York University College of Nursing. The institute focuses on improving the quality of care provided to older adults by promoting excellence in geriatric nursing practice, education, research, and policy. Download the original *Try This* document on the GDS: SF by going to www.hartfordign.org/publications/trythis/issue04.pdf.

Also, **Special Topics in Long-Term Care,** at www.hartfordign.org/resources/special_topics/spectopics.html, includes information relevant to the long-term care setting. This site links to information on pertinent issues such as wandering and elopement litigation, ethical issues related to cultural change, and more.

For a list of other online resources go to http://links.lww.com/A118. And go to www.nursingcenter.com/AJNolderadults and click on the *How To Try This* link to access all articles and videos in this series.

For more discussion of the psychometric properties of the GDS: SF, go to http://links.lww.com/A119.

Does the GDS: SF work as well in people who are functionally impaired? A study demonstrated that the reliability and validity of the tool did not differ significantly when used to assess community-dwelling older adults with either low or high functional impairment.[23] So nurses should be able to use it with the same level of confidence with older adults with varying levels of functional capacity.

Has the GDS: SF been used in special populations? The tool's use with adults who have Parkinson disease has been examined in several studies. One study compared the psychometric properties of the GDS: SF and the Hamilton Depression Rating Scale in 148 outpatients with Parkinson disease.[24] Thirty-two subjects (22%) were diagnosed with a depressive disorder. Although the Hamilton Depression Rating Scale, designed to rate the severity of symptoms in patients already diagnosed with depression, provided a more comprehensive evaluation of depressive symptoms, the GDS: SF identified critical symptoms of depression in those with Parkinson disease.

A literature review of 45 studies of depression and Parkinson disease from 1922 through 1998 found that 31% of people with the disease experience depression at some point.[25] In older adults with Parkinson disease, depression negatively affects function,[26] the quality of life,[27] caregiver well-being,[28] and cognition.[29] But depression in patients with Parkinson disease may be underrecognized and too rarely treated.[30,31] Because the GDS: SF is a brief instrument and can be self-administered, it's useful for distinguishing depressed from nondepressed older adults in this population.

What about its use with patients with Alzheimer disease or other conditions? Limited work has been done on using the GDS: SF in screening for depression in older adults with Alzheimer disease, chronic pain, heart disease, diabetes, and other chronic or degenerative conditions that afflict this population and may affect mood.

Now it's your turn to try this. ▼

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Routine use of a Try This *tool may require formal review and approval by your employer.*

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try this: Best Practices in Nursing Care to Older Adults
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The Geriatric Depression Scale (GDS)

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WHY: Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older. Both major and minor depression are reported in 13% of community dwelling older adults, 24% of older medical outpatients, 30% of older acute care patients, and 43% of nursing home dwelling older adults (Blazer, 2002a). Contrary to popular belief, depression is not a natural part of aging. Depression is often reversible with prompt and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive and social impairment, as well as delayed recovery from medical illness and surgery, increased health care utilization, and suicide.

BEST TOOL: While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression.

The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued. It takes about 5 to 7 minutes to complete.

TARGET POPULATION: The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

VALIDITY AND RELIABILITY: The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation ($r = .84$, $p < .001$) (Sheikh & Yesavage, 1986).

STRENGTHS AND LIMITATIONS: The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

FOLLOW-UP: The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

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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

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.

A score > 5 points should warrant a follow-up comprehensive assessment.

Source: http://www.stanford.edu/~yesavage/GDS.html

try this: Best Practices in Nursing Care to Older Adults

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