general assessment series

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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 with clinically significant depressive symptoms reaching 13% in older adults aged 80 and older (Blazer, 2009). Major depression is reported in 5-16% of community dwelling older adults, up to 54% in the first year living in a nursing home, and 10-12% of hospitalized older adults (Blazer, 2009; McKenzie & Harvath, 2016). Depression is more common in those with multiple chronic conditions.

Depression is not a natural part of aging. Depression is often reversible with prompt recognition and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive, functional, and social impairment, as well as decreased quality of life, 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 care, and long-term care settings.

VALIDITY AND RELIABILITY: The GDS was found to have a 92% sensitivity and an 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 ($r = 0.84$, $p < .001$) (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: https://consultgeri.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
This scale is in the public domain.

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