Dementia Support Australia

Guide to using the Cornell Scale for depression in dementia

The Cornell Scale for Depression in Dementia (CSDD) was specifically developed to assess signs and symptoms of major depression in people living with dementia. The CSDD is designed to be completed by someone that has regular contact with the resident, and an understanding of the resident's symptoms of depression **over the previous week**. In general, this is done with input by nursing staff and in consultation with the person's General Practitioner.

It is important to remember that:

- The CSDD is **not** a diagnostic tool – it is a screening tool.
- The CSDD is reliable for those with a Mini-Mental State Examination (MMSE) score of 17 or more; it has not been validated in any group of people with a MMSE of less than 17.
- There are a number of items in the CSDD that overlap with symptoms of behavioural and psychological symptoms of dementia and so all results should be closely scrutinised.[1]

1 Goodarzi, Z., Mele, B., Roberts, D., Holroyd-Leduc, J. Depression Case Finding in Individuals with Dementia: A Systematic Review and Meta-Analysis. *The American Geriatrics Society*. 2017; 65: 937–948.

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There are five categories of questions to be assessed and a total of 19 items to be measured. Each item is rated for severity on a scale of 0–2 (0=absent, 1=mild or intermittent, 2=severe). There is also an 'Unable to rate' measure in circumstances where the resident's symptoms are the result of physical disability or illness, or for some other reason are unascertainable.

Once the CSDD has been completed, the item scores are added.

- Scores above 10 indicate a probable major depression.
- Scores above 18 indicate a definite major depression.
- Scores below 6 as a rule are associated with absence of significant depressive symptoms.

Information on assessing each of the items is set out below.

A. Mood related signs

1. **Anxiety:** *(anxious expression, ruminations, worrying)*

Does the resident have an anxious, tense, distressed or apprehensive expression? Have they been feeling anxious in the past week? Have they been worrying about things they may not ordinarily worry about, or ruminating over things that may not be that important?

2. **Sadness:** *(sad expression, sad voice, tearfulness)*

Has the resident been feeling down, sad, or blue this past week? Have they been crying at all? How many days out of the past week have they been feeling like this? For how long each day?

3. **Lack of reactivity to pleasant events:** *(does not cheer up when offered pleasant activities)*

Is the resident able to respond to friendly or supportive remarks or to humour? If a pleasant event were to occur today (e.g., going out with their spouse, friends, seeing grandchildren), would the resident be able to enjoy it fully, or might their mood get in the way of their interest in the event or activity?

Does the resident's mood affect any of the following:

- their ability to enjoy activities that used to give them pleasure?
- their surroundings?
- their feelings for family and friends?

4. **Irritability:** *(easily annoyed, short tempered)*

Observe whether the resident is easily annoyed and short-tempered. Has the resident felt short tempered or easily annoyed in the past week? Have they been feeling irritable, impatient, or angry this week?

B. Behavioural disturbance

5. Agitation: *(restlessness, handwringing, hairpulling)*

Has the resident been fidgety or restless this past week or unable to sit still for at least an hour? Was the resident so physically agitated that you or others noticed it? Agitation may include such behaviours as playing with one's hands, hair, hand-wringing, hair-pulling, and/or lip biting. Have you observed any such behaviour in the resident during the past week?

6. Slowness: *(slow movements, slow speech, slow reactions)*

Has the resident been talking or moving more slowly than is normal for them. This item should be scored exclusively on the basis of observations. Slowness is characterised by:

- slow speech
- delayed response to questions
- decreased motor activity and/or reactions

7. Multiple physical complaints: *(complaints about physical health more than is reasonable)*

In the past week, has the resident had any of the following physical symptoms (in excess of what is normal for them):

- indigestion
- constipation
- diarrhoea
- stomach cramps
- belching
- heart palpitations
- headaches
- muscles aches
- joint pain
- backache
- hyperventilation (shortness of breath)
- frequent urination
- sweating

If yes to any of the above: How much have these things been bothering the resident? How bad have they become and how often have they occurred in the past week? Do not rate symptoms that are side effects from taking medications or those that are only related to gastrointestinal ailments.

8. Loss of interest: *(less involved in usual activities – score only if change occurred acutely, and/or has lasted less than one month)*

How has the resident been spending their time this past week? Have they felt interested in their usual activities and hobbies? Has the resident spent any less time engaging in these activities? Has the resident had to be prompted to do the things they normally enjoy? Have they stopped doing anything they used to do? Can the resident look forward to anything or have they lost interest in many of the hobbies from which they used to derive pleasure?

Ratings of this item should be based on loss of interest during the past week. This item should be rated 0 if the loss of interest is long-standing (longer than 1 month) and there has been no worsening during the past month. This item should be rated 0, if the resident has not been engaged in activities because of physical illness or disability or if the resident has persistent apathy as part of his/her dementia.

C. Physical signs

9. Appetite Loss: *(eating less than usual)*

How has the resident's appetite been this past week compared to normal? Has it decreased at all? Have they felt less hungry or had to be reminded to eat? Have others had to urge or force them to eat?

Rate 1 if there is appetite loss but the resident is still eating on their own. Rate 2 if the residents eats only with others' encouragement or urging.

10. Weight Loss: *(decrease in weight)*

Has the resident lost any weight in the past month that they have not meant to or been trying to lose? (If not sure: are the resident's clothes any looser?) If weight loss is associated with a present illness (i.e., not due to diet or exercise) how many kilograms has the resident lost?

Rate 2 if weight loss is greater than 2.5kgs in the past month.

11. Lack of energy: *(fatigues easily, unable to sustain activities – score only if change occurred acutely, and/or has lasted less than one month)*

Does the resident appear fatigued or drained of energy? How has the resident's energy been this past week compared to normal? Has the resident been tired all the time? Have they asked to take naps because of fatigue? This week, has the resident had any of the following symptoms due to lack of energy only (*not* due to physical problems):

- heaviness in limbs, back, or head?
- felt like they are dragging through the day?
- has the resident been fatigued more easily this week?

Ratings of this item should be based on lack of energy during the week prior to the interview. This item should be rated 0 if the lack of energy is long-standing (longer than 1 month) and there has been no worsening during the past month.

D. Changes in daily/nightly mood and behaviours

12. Changes in mood: *(mood changes as the day progresses with symptoms worse in the morning)*

Regarding the resident's mood (their feelings and symptoms of depression), is there any part of the day in which they usually feel better or worse (or does it not make any difference, or vary according to the day or situation)? If yes to a difference in mood during the day: Is the resident's depression worse in the morning or the evening? If worse in the morning: Is this a mild or a very noticeable difference?

The resident must consistently feel worse in the mornings (as compared to evenings) for this item to be rated.

13. Difficulty falling asleep: *(later than usual for this individual)*

Has the resident had any trouble falling asleep this past week? Does it take them longer than usual to fall asleep once they get into bed (i.e., more than 30 min)?

Rate 1 if the resident only had trouble falling asleep a few nights in the past week. Rate 2 if they have had difficulty falling asleep every night this past week.

14. Multiple awakenings during sleep: *(wakes up more than usual for this individual)*

Has the resident been waking up in the middle of the night this past week? If yes: do they get out of bed? Is this just to go to the bathroom and then they go back to sleep? Do not rate if waking is only to go to the bathroom and then the resident is able to fall right back asleep. Rate 1 if the resident's sleep has been restless and disturbed only occasionally in the past week and if the resident has not got up out of bed (besides going to the bathroom). Rate 2 if the resident gets out of bed in the middle of the night (for reasons other than voiding), and/or has been waking up every night in the past week.

15. Early morning awakenings: *(earlier than usual for this individual)*

Has the resident been waking up any earlier this week than s/he normally does (without an alarm clock or someone waking them up)? If yes: how much earlier is s/he waking up than is normal for them? Does the resident get out of bed when they wake up early, or do they stay in bed and/or go back to sleep?

Rate 1 if the resident wakes up on their own but then goes back to sleep. Rate 2 if the resident wakes earlier than usual and then gets out of bed for the day (i.e., cannot fall back asleep).

E. Ideational disturbance

16. Suicide: *(feels life is not worth living, has suicidal wishes)*

During the past week, has the resident had any thoughts that life is not worth living? Has the resident had any thoughts of hurting themselves?

Rate 1 for passive suicidal ideation (i.e., feels life isn't worth living). Rate 2 for active suicidal wishes, and/or any recent suicide attempts, gestures, or plans. History of suicide attempt in a subject with no passive or active suicidal ideation does not in itself justify a score.

17. Poor self esteem: *(self-blame, poor self-esteem, feelings of failure)*

How has the resident been feeling about themself this past week? Has the resident been feeling especially critical of themself, feeling that they have done things wrong or let others down? Has the resident been feeling guilty about anything they have or have not done? Has the resident been comparing themself to others, or feeling worthless, or like a failure? Has the resident described themself as "no good" or "inferior"?

Rate 1 for loss of self-esteem or self-reproach. Rate 2 for feelings of failure, or statements that the resident is "worthless", "inferior", or "no good".

18. Pessimism: *(anticipation of the worst)*

Has the resident felt pessimistic or discouraged about their future this past week? Can they see their situation improving? Can the resident be reassured by others that things will be okay or that their situation will improve?

Rate 1 if the resident feels pessimistic, but can be reassured by self or others. Rate 2 if the resident feels hopeless and cannot be reassured that their future will be okay.

19. Depressing delusions: *(delusions of poverty, illness, or loss)*

Has the resident been having ideas that others may find strange? Does the resident think their present illness is a punishment, or that they have brought it on themself in some irrational way? Does the resident think they have less money or material possessions than they really have?

References

Alexopoulos GA, Abrams RC, Young RC & Shamoian CA: Cornell scale for depression in dementia. Biol Psych, 1988, 23:271-284.

Alexopoulos GS, Abrams RC, Young RC, Shamoian CA: Use of the Cornell scale in nondemented patients. J Amer Geriatr Soc 36:230-236, 1988.