



A normal MRI scan of a patient with severe depression is compared with a R-cerebral blood flow SPECT scan showing low frontal lobe blood flow characteristic of depression. The fusion image confirms the area of low blood flow is anatomically normal.

Understanding Late life Depression

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What is depression? How is late-life depression different?

Most individuals will experience feelings of sadness throughout the course of their lives, over something that has gone wrong or perhaps because of some loss. This mood may pass in time, or other events may become a distraction. But nevertheless people cope and are able to continue to function in their everyday life.

In contrast, what psychologists call “clinical depression” is a persistent, sad mood lasting two weeks or longer, sometimes accompanied by lack of sleep or other symptoms (see box below). In cases of clinical depression people are impaired in their ability to function at work, at home or in social relationships. Such people are unlikely to cheer themselves up or pull themselves out of the depression without some sort of assistance.

Common symptoms of depression

- Persistent sadness lasting two or more weeks
- Significant decrease or increase in appetite or weight
- Insomnia or excess sleep nearly every day
- Agitation or retardation (being slowed down), noticeable to other people
- Fatigue or loss of energy
- Feelings of worthlessness, helplessness or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Withdrawing from regular social activities
- Recurrent thoughts of death or suicide

Late onset depression or late-life depression is defined as an episode of clinical depression occurring after the age of 60 in an individual who previously had never experienced clinical depression. Important aspects of late-life depression – such as how it is experienced and changes over time, its underlying causes, its treatment and likely outcome – seem to be different from those aspects of earlier onset or chronic depression. Late-life depression is often not diagnosed because older adults and health care professionals may incorrectly think the depressive symptoms are part of the normal ageing process.

Late-life depression differs from earlier onset depression in that there is:

- an increased chance of experiencing thinking and memory problems (these are often more pronounced than feelings of sadness)
- an increased likelihood that a medical illness may also be present
- some chance that changes in the structure of the brain may be present
- a decreased chance of a family history of mood disorders
- a greater likelihood of experiencing higher rates of fatigue and agitation.

Episodes of late-life depression may be of greater length than episodes of earlier onset depression and may reoccur with greater frequency. The likely outcome for late-life depression is mixed. Some individuals make a complete recovery while others have greater difficulty in achieving a successful outcome. Many factors play a role in an individual's recovery.

Factors associated with improved chance of recovery from late-life depression

- Having a family history of depression
- Being female
- Having an extroverted personality
- Having no history of substance abuse or a psychotic illness
- Not having to be hospitalised for the depression
- Having high levels of social support*.

* Social support is perhaps the most important factor. Research allowing for the effects of age, sex or depressive symptoms still found social support was highly likely to lead to positive treatment outcomes.

Causes and risk factors for late-life depression

The causes of depression include biological factors, psychological factors and social factors. We know that some people are at increased risk for developing depression because of family history or previous episodes of depression or anxiety disorders. However, family history seems to play a less important role in late-life depression. At all ages, women are at greater risk than men for developing clinical depression.

In late-life depression causes may include physical illness and disability (especially due to stroke), grief, or social isolation. In some cases, late-life depression is probably caused by small stroke-like damage to areas of the brain involved in regulating mood. One group at particular risk for late-life depression is older carers, who can be under increased stress due to their care-giving responsibilities.

Clinical depression is not normal in older people. This is a common but potentially dangerous myth. As with younger people, older adults go through life changes that can often lead to temporary feelings of sadness, which are considered normal. For example, after the death of a spouse or other loved one, an older person may experience many of the symptoms of clinical depression. However, sadness that persists, that is associated with the symptoms of clinical depression described above, or is accompanied by impairments in everyday function or thoughts of suicide, is not normal. While it is true that older adults with chronic illnesses are more at risk for developing depression later in life, the statement, "If I were sick or disabled, I would be depressed too" is another dangerous myth.

There are several potential risks resulting from untreated depression in older adults. Probably the most serious risk of late-life depression is mortality – depressed older persons are more likely to die, either by suicide or by a worsening of an accompanying medical illness. Studies have shown that the suicide rate for older adults in most countries is higher than that of any other age group, with older men having a higher risk. Several studies have found that many older adults who commit suicide had visited their GP very close to the time of the suicide – 20 per cent on the same day and 40 per cent within one week of

the suicide. This fact demonstrates the need for primary care physicians to be alert to the signs and symptoms of depression in later life.

Research has also shown that depressed older adults are more disabled than their non-depressed peers, and that they tend to recover more poorly from medical illnesses such as stroke or hip fracture. Depression is one of the more treatable conditions in older adults yet can severely impact on quality as well as length of life. Depression in older adults should be an illness that is taken seriously and treated promptly.

Treatment

The good news about late-life depression is that it is treatable, with between 40 and 60 per cent of people showing sustained recovery with standard treatment. Another 15 – 20 per cent of cases may relapse, while the remainder does not recover as well following treatment.

Unfortunately older adults often do not receive treatment for their depression. This may be due to several factors, including a) older adults not mentioning depressive symptoms to their GP, or not recognizing the signs of depression in themselves, and b) the GP or other health professional not recognizing the depressive symptoms, often because they are mistaken for simply the results of illness or the side-effects of medications.

A number of psychological treatments and medications may prove useful in treating late-life depression.

Psychological treatments

Psychotherapy is helpful to about 60 per cent of depressed people who undergo treatment. Effective psychological treatments can include helping people to get out of depressing thinking habits, to constructively tackle life problems, to rebuild or replace rewarding activities, or to improve relationships. Where the depression is associated with marital problems, solving those often helps to solve the depression. Research-based psychotherapy, as offered by clinical psychologists, can work at least as well as drug therapy, with the advantages of getting faster results, no side-effects, and being more lastingly helpful. However, not every depressed person wants or is helped by psychotherapy.

Psychological or drug treatment?

Drug treatments

Antidepressant drugs are helpful to about 60 per cent of depressed people who use them. Antidepressant drugs work by changing some of the chemicals in the brain. This is sometimes misunderstood as showing the depression was caused by a 'chemical imbalance' in the brain. That would be like saying a headache is caused by not having enough paracetamol or aspirin in your brain.

Some people who take antidepressant drugs suffer side effects such as sexual dysfunction, nausea, sleep problems, diarrhoea, or anxiety. These side effects sometimes improve over time. A common problem is that drugs do not improve mood immediately, but can take two or more weeks to achieve a helpful effect. During this time, patients are at risk of ceasing taking the medication, because they see it as having side effects and not helping. A longer-term view is necessary: these side effects may go away in a few days or weeks, while improvement of mood may occur in the long term. Another problem can be that the depression returns when the person stops taking the drugs. However, antidepressant drugs can be the preferred, most helpful, or only available treatment for some people. If you decide to try antidepressant drugs, it is important to tell your doctor about any medications you already use to avoid the risk of drug interactions.

Psychological

Some people experience more successful outcomes using psychological treatment for their depression, while others find drug treatment more preferable and successful. Sometimes people do well on a combination of both treatment approaches.

The next step

If you are considering treatment for depression, it is important to find the approach that works best for you. Talk about your options with your GP or you can discuss psychological treatments with a psychologist.

Where to go for help

To talk to an APS Psychologist today, ask your GP for a referral to PBP Consultancy or write to prabu1@pbpconsultancy.com or visit www.pbpconsultancy.com or T/+61 41639056