JOHANN SCHUTTE
CLINICAL PSYCHOLOGIST
www.js.net.nz
johann@js.net.nz

Late-Life Depression

Late-life depression (LLD) refers to the presence of significant clinical depression in terms of the DSM IV nosology in individuals over 60 years of age.

In addition to the mood component, LLD frequently manifests as physical symptoms. LLD is hypothesized to aggravate existing physical illness, to predispose patients to other illnesses, and to result in functional impairment. Major Depression (DSM IV) is a significant predictor of suicide in the elderly, particularly elderly men. It appears to be more recurrent and chronic than depression in younger populations. Where females tend to suffer depression more than males at younger ages, this gender difference is greatly reduced in the elderly population.

Somatic complaints such as hypochondriacal misinterpretation of bodily sensation, fatigue, sleeping problems and decreased appetite are more frequently found in depression amongst the elderly, but also occur as a consequence of the natural ageing process. Additionally, a key diagnostic marker for LLD is complaints about cognitive decline in general. Several studies have found an inverse correlation between LLD and executive function, psychomotor speed, information processing speed, attention, working and verbal memory, expressive language and visual-spatial ability. Neuroimaging studies have found evidence of neuropathology in persons with LLD. Some of the neuropathological correlates of LLD are white matter lesions, reduced frontal and hippocampal volume, neuro-endocrinological impairment along the HPA axis and neurotransmitter deficits.

In particular, the co-localization of white matter lesions and atrophy and the positive correlation of these symptoms with age have led to speculation that LLD constitutes a distinct syndrome and that both depression and cognitive impairment are caused neurologically, however the relationship between LLD and cognitive decline is likely to be highly complex and remains unclear and controversial in terms of dynamic and etiological association.

The complexity of the relationship between LLD and cognitive decline is further demonstrated by the effectiveness of pharmacological treatment for the affective component of depression, and stimulatory brain training exercises and memory strategies which often leads to an improvement in cognitive function and general functionality. However, a proportion of LLD patients show persisting cognitive deficits, despite improved mood. Some anti-depressants such as the tricyclics through their anti-cholinergic properties, adversely affect cognitive function for which reason they're avoided in LLD. SSRIs appear to be more likely to benefit LLD patients, however even these medicines may lead to cognitive impairment, particularly in memory and visuospatial ability.

ECT is often recommended for LLD, particularly where pharmacotherapy has failed, with the basic rationale that ECT treatment is preferable to leaving the patient untreated. ECT is a risk for patients who have suffered stroke in the preceding six months. ECT is known to precipitate delirium in patients who have brain disease and is known to lead to impaired cognitive function, particularly memory, with the impairment gradually remitting over time.

With regard to geriatric patients, the most frequent referral request is for clarification as to whether memory problems are attributable to dementia or depression, or both. This is an important differential diagnostic issue, as depression and dementia exist co-morbidly in 20%-30% of patients. Numerous psychometric instruments exist with which one might use along with interview strategies, clinical observation and collateral reports towards strengthening differential diagnostic confidence.

Last review of this document, April 2012

Although differentiation between depression and dementia is often difficult, and sometimes impossible, there are a few distinctions research has put forward that relate to course and clinical presentation.

Clinical course

Depression typically shows a comparatively rapid course and clearly demarcated onset. Dementia is slower and more insidious in development, and less distinct in onset.

24 hour variation

In depression early morning awakening is common, whereas in dementia it is not. Cognitive losses associated with dementia tend to be more noticeable at night, with a similar pattern rarely shown in depression.

Insight

With depression, patients typically are able to provide detailed descriptions of cognitive loss and dysfunction. Dementia patients rarely complain about losses and show a much more variable awareness of dysfunction.

Behaviour – Complaint congruency

Patients with depression are less likely to show behaviour (such as dressing apraxia) congruent with reported losses. In dementia, cognitive deterioration is behaviourally evident, with patients clearly struggling to complete tasks, such as dressing.

Affect and mood

Dementia patients rarely complain about losses and are more likely to be shallow (unperturbed) in affect. Depressed patients are more likely to be concerned, and perturbed by their losses. Delusions, if present are usually mood related in depression, whereas delusions in dementia are mood-independent when they occur.

Libido

Diminished in depression, variable in dementia.

Test performance

Patients with depression tend to give up or avoid attempting, typically by declaring inability early on in the presented task and may show inconsistent and variable performance in the testing situation. The dementia patient is more tenacious in attempt and shows a more consistent and invariant pattern of underperformance.

	Depression	Dementia
Clinical course	Demarcated onset, faster development and course	Insidious, unclear in onset, slow development
Variation	Early morning awakening.	Early morning awakening usually not a problem. Nocturnal emphasis of cognitive losses.
Insight	Perturbed by losses.	Lack of concern and awareness.

Last review of this document, April 2012

Behaviour	Less behavioural consistency with reported losses.	More behavioural consistency between reported losses and behavioural dysfunction.
Affect and Mood	Morbid, despondent.	Unperturbed, shallow affect.
Libido	More likely to be diminished.	Less likely to be diminished.
Test performance	Low volition, perseverance, variable underperformance.	More tenacious in attempts. Consistent underperformance.

Last review of this document, April 2012