

MENTAL HEALTH SERVICES AND LATE-ONSET DEPRESSION

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Abstract

As the number of Americans aged 60 and over increases substantially in the coming years, so is the incidence of depression among this age group. The purpose of this report is to explore the mental health needs of older Americans, the ways in which they are undiagnosed or under-diagnosed for depression, the clinical challenges associated with treating depression in the elderly, and the barriers that are in place due to social, psychological, financial and governmental factors. With the “Baby Boom” generation (those born between 1946-1964) entering their senior years, there will be an increased need for Marriage and Family Therapists to be cognizant of the rise in depression and familiar with the treatment options and limitations. Marriage and Family Therapists adhere to the Systems Theory and thus are uniquely qualified to act as a bridge between the medical and mental health communities. This report will promote the collaborative approach to healthcare and the way in which Marriage and Family Therapists can contribute to the treatment of depression in the aged.

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Dedication

This report is dedicated to my mother, Kathleen Fennessy McGill, and to the memory of my father, James F. McGill. Throughout their lives, they have been shining examples of how humor and perseverance can make life enjoyable. They are also great examples of how to handle the later years of life and how to manage adversity in old age. My father, who had multiple, serious health issues before his death, was funny and witty and engaged in the lives of his loved ones right up until the end. I hope that I will be half as selfless and loving when I meet hardships. I miss him every day of my life.

CHAPTER 1 - Introduction

Ours is a youthful society. As a nation, we prize youth, vigor, productivity and activity. The result of this societal obsession with youth is the relegation of the elderly to the backburner of the national mindset. Historically, little attention has been focused on older adults, their concerns, their environments, their health or their well-being. Yet this myopia comes at a high price. As the “graying of the nation” continues, older adults and their physical, mental and emotional needs will tax the country’s current available healthcare resources. In order for society to meet these demands, changes will have to be made in the way that healthcare is provided. More and more healthcare providers are recognizing the importance of an integrated approach to the elderly’s health concerns. The integrated medical model includes mental health as an important component of the overall well-being of older adults. For the purposes of this report, older adults will refer to people who are over the age of sixty.

Mental Health in the U.S.

Mental health and mental illness should be part of the national discussion about the healthcare of older adults. Until very recently, mental health has been a neglected field of study in terms of national healthcare. Furthermore, mental health has been treated as a separate entity from physical health. It was not until 1999 that the first White House Conference on Mental Health was convened. The report that resulted from the initial conference, published by the Department of Health and Human Services (HHS), detailed the seriousness of the mental health situation in the United States, especially among the elderly. According to the report, mental disorders collectively account for more than 15 % of the overall burden of diseases from all causes, slightly more than the burden associated with all forms of cancer. In terms of economic impact, mental disorders rank second among diseases in the number of days that workers miss work due to ill health and the amount of time that caregivers must devote to people suffering from mental health crises.

Older Americans

The situation among older Americans is even more severe. Mental illness among older adults has been found to exacerbate existing physical problems and also to be the seed that may

start the growth of somatic problems. As people age, not only do they encounter challenges to their physical health, but environmental factors that can lead to mental illness increase: bereavement, loss of employment, end-of-life issues, and so forth. Unattended bereavement that lasts longer than two months has been associated with a higher risk of depression and death from suicide, heart attacks and other causes (Conwell, 1995; Frasure-Smith Lesperance & Talajic, 1995; Zisook & Schacter, 1993).

Chief among the mental illnesses that plague older adults is depression. Clinical depression and dysthymia account for the majority of mental disorders among the elderly. Of recent concern and study is the number of adults who do not meet the criteria for major and minor depression as established in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) but who exhibit subsyndromal signs of depression. Roney (1994) has termed this a “shadow” syndrome, implying that depression among the aged operates beneath the bright lights of the nation’s attention and quietly rages within the populace.

Late onset depression is defined as the manifestation of depressive symptoms in individuals over the age of 60 who have not previously experienced depressive episodes (National Institute of Mental Health [NIMH], 2002). Older adults who have had depressive episodes during their earlier adult years and who experience depression again in late life are said to have recurrent geriatric depression.

Depression, major, minor or subsyndromal, has a significant impact on the quality of life of the older person. As depression strikes, there is an increase in the functional disability of older people (Lenze, 2005). The effects of the depression then ricochet throughout the entire system. Health care expenditures increase dramatically, cognitive impairments can ensue and relationships suffer.

Although I have painted a distressing picture of geriatric mental health, there are reasons to hope for the future and room to improve the current situation. During the past decade, research institutions and government agencies have collaborated to get an understanding of the process of normal aging. The physical, biological, social, mental, spiritual and environmental influences upon the elderly have been examined to give us a broad idea of what is normal aging and what is not. Rowe and Kahn (1997) postulated that successful aging is contingent upon three factors: avoiding disease and disability, sustaining high cognitive and physical functioning

and engaging with life. Engaging with life is defined to mean the pursuit and maintenance of interpersonal relationships and productive activities.

Themes of the report

The broad themes of this report are that a) depressions among the aged are disabling; b) mental health and mental illness are part and parcel of geriatric healthcare; c) interpersonal relationships among the elderly are negatively impacted by depression; and d) treatment for depression is effective in older adults and is well within the purview of the Marriage and Family Therapist.

In examining this topic, Chapter I will provide a broad overview of the issue, its relevance to the field of study of mental health and my personal interest in it. The purpose of this report is to highlight the need for greater awareness of the pernicious effects of depression on older adults and to promote ways in which Marriage and Family Therapists can respond to depression among their geriatric clients.

Chapter II will be a review of the literature in these areas. Studies citing the link between physical and mental health will be reviewed as well as the link between depression and interpersonal relationships. Also included in this chapter will be a brief discussion of the gaps in research and the direction of future research.

Chapter III will be a brief outline of the normal aging process. This will be used in order to place depression among the aged in the context of what can be normally expected—sadness due to life changes-- and when it snowballs into insidious depression.

Chapter IV will discuss the clinical issues associated with depression among older adults. Theories of treatment will be discussed including medical models, collaborative models and the integration of Marriage and Family Therapy approaches. As depression is commonly treated with a combination of pharmaceutical and behavioral therapies, this chapter will include a brief outline of the specific pharmacology interventions currently employed to treat depression in the elderly. Limitations and advantages of the various approaches will be discussed as well as barriers to compliance and access.

Chapter V is the conclusion of the report with a poem and summation of aging.

Personal interest in geriatric mental health

“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epic of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way.” Charles Dickens, *A Tale of Two Cities*, p.1

Charles Dickens opened his classic tale of London and Paris during the French Revolution with these memorable words. As I reflect on the words, I realize that they could be a fitting description of old age and attitudes about aging. Whereas one person could look on his or her late life years as a “spring of hope” with “everything before us,” another person might well consider them “the winter of despair” and “with nothing before us.” As a society, we could perceive old age as “the age of wisdom” or as “the age of foolishness.”

The reality of the late life years is probably as replete with seemingly contradictory emotions as the opening paragraph of *A Tale of Two Cities*. How one views these years, deals with challenges and responds to this stage of life depends upon a great many factors. Some of these factors are beyond the control of the aged and some are not. The mental health of the aged person is a major factor in how they navigate the sometimes choppy seas of senior citizenship. But as the African saying goes, smooth seas do not make skillful sailors. Marriage and Family Therapists might not be able to calm the raging waters of aging, but they can provide a safe port for the older adults who are trying to navigate rough times while experiencing depression.

My grandfather’s story

If I recognize the challenges of growing old, it is because I witnessed the hardships of my grandfather’s last years. My grandfather, James E. McGill, was born in 1900 in the small, Western Massachusetts town of Hinsdale. Until his seventies, my grandfather was happy and healthy. He had been a stellar athlete in his youth, playing semi-professional baseball throughout New England. He had kept fit in adulthood. He had a steady job that he enjoyed at the Post Office in Pittsfield, Massachusetts. He never smoked or drank and his only indulgence was a daily doughnut. He had had a loving marriage until my grandmother’s death and he had successfully raised his three children.

In his seventies, he was diagnosed with Parkinson's Disease. At first, the signs of the disease were negligible and my grandfather was his same, humorous self. He was quick to make a joke about some of his infirmities and never complained about the indignities visited upon him. My grandmother had died of cancer ten years previously and my aunt, a nurse, was my grandfather's caregiver.

Three years into the disease, my grandfather's body was ravaged. Although he still valiantly made an effort to accept his situation with dignity, he slipped further and further into isolation and—well, not despair, exactly—but deep despondence. He had lost his will to live and to do battle with Parkinson's. He had lost his health, his mobility, his independence and his enjoyment of life. Most hurtful to those of us who witnessed his deterioration, was the loss of his sense of humor. Humor had always been the family's foundation for dealing with life's vicissitudes and when this core of his being was vandalized by disease, we, too lost hope. His last five or six years of life were truly difficult and devastating. As with a fair number of the elderly, the end of my grandfather's life was mired in medical considerations. His medical condition then precipitated a change in his mood and personality. It was a sad finale to a full life.

My Grandmother's story

At the same time that my paternal grandfather was succumbing to his illness, I was able to observe a good end-of-life stage with maternal grandmother. Her name was Mamie Spillane Fennessy and she was born in Ireland in 1995. She and her husband came to Boston in 1925 with three children. Five more children would be born in this country, with my mother being the second-youngest. Life was not always easy for an immigrant family of ten. My grandfather worked as a carpenter at the Naval Shipyard in Boston until he was laid off during the Great Depression. After the Depression, he resumed working and again worked at the shipyards until he died on Christmas Day at the age of 58 from a heart attack.

My grandmother adapted to widowhood, began working as a cleaning lady in a local hospital, and still found time to travel, take classes and stay active. With such a large family, she had a good support network. Although she learned to ski in her fifties (on a visit to Chile to visit my aunt), she never learned to drive. This was actually beneficial because she walked everywhere –grocery shopping, doctors' appointments, even to my house ten miles away when

she was about 75 years old! My grandmother was strong physically and mentally; the resources she had to use when she was young—adaptability and engagement in her immediate environment—were the sources of her well-being in her advanced years.

My memories of my grandmother are fairly consistent throughout my childhood. She was a loving, strong woman who would take hordes of visiting grandchildren on 5 to 8 mile hikes (there was no choice in the matter and no bribes given, either. My grandmother was not a woman to be brooked). She was always ready to drop any activity in favor of a day trip with my family or longer trips to Ireland and elsewhere in the country or world. She had a large home that she lived in by herself and took care of well. While she did not have a lot of money, she had always been frugal and lived simply enough that she had enough money to meet her needs.

In 1982, when I was 18 years old, my grandmother was diagnosed with cancer that had spread to her bones. Up until she was diagnosed, she had continued living just as she always had. She had lost a bit of pep in the preceding months, but was still active and enthusiastic. She never slowed the pace of her daily activities. About three months after her diagnosis, she moved into our house where she died six weeks later. She was confined to bed for the last two weeks of her life. As old age goes, it was very easy. She was mentally and physically alert throughout her 87 years and had maintained her independence up until the end. It is the standard of old age and health to which I now aspire.

My grandparents died within a year of each other and the juxtaposition of their experiences offers a stark image of the range of possibilities for geriatric health and well-being. Their experiences at the end of life—and, thus, my family's experiences—are the genesis of my interest in the subject. Both of my grandparents, my maternal grandmother and my paternal grandfather, enriched my life in many ways. Their love for their grandchildren during their lives was the foundation for my strong extended family bonds. Their experiences at the end of their lives are the foundation for my professional focus on geriatric care.

It is no more possible to chronicle all of the various permutations that exist in the realm of geriatric well-being as it is to chronicle the personal experiences of the aged. Yet, hopefully, this report will reflect a slice of the experiences of a large number of older Americans. My hope is that this report will contribute to a greater awareness among academic, cultural and clinical communities of the challenges and satisfactions of treating the elderly population. Along with this recognition will come greater and better ways to embrace the end of life. In this way, the

aged will be removed from the backburner of society's mindset and take their rightful place alongside citizens of all ages.

CHAPTER 2 - Review of Literature

Depression has spared no culture and no time period throughout recorded history. Hippocrates is thought to have been the first person in the western world to describe mental disturbances and to coin the term “melancholia” or black bile of the mental anguish of its sufferers. It has always been a part of the mental landscape, albeit under different names and with varying degrees of acceptance. In recent years, it has also been the focus of much research. The research itself has been done by a plethora of medical and mental health professionals. Oncologists have researched the effect of cancer on patients’ moods and cardiac researchers have documented the enormous psychological impact of bad cardiac health on patients so much that the term “vascular depression” is now recognized in medical circles. In return, psychotherapists have done studies on the prevalence of cardiac conditions among people with depression in a sort of dueling debate over which came first—the depression or the heart condition. Studies have linked diabetes and depression, sleep and eating disorders and depression, chronic pain and depression, and disabilities and depression. Just about every medical condition under the sun has had its turn juggling with the discovery that depression is either a precursor to the health condition or a result of the health issue. Geriatric depression is no different and has been the focus of more research in recent years.

Terms

Late-onset depression, defined as an initial experience with major or minor depression after the age of 60, is quite similar in some ways to depression that occurs earlier in life. Yet it does contain some distinct differences that lead some researchers to believe that it has its own etiology. Patients who are older than sixty at first onset of depression have been found to show greater apathy (Krishnan, Hays, Tupier, George & Blazer, 1995) and less lifetime personality dysfunction (Abrams, Rosedahl, Card, & Alexopoulos, 1994.) There are certain risk factors that increase the chances of experiencing depression in later life and these will be more fully discussed in the chapter on clinical considerations. For Marriage and Family Therapists, it is incumbent upon them to realize that depression in late life carries with it more responsibilities to the client and will undoubtedly mean more interaction with both the social circle of the client and

the medical team treating the client. Comorbidity of depression and a huge variety of somatic diseases is so well-established that the Marriage and Family Therapist cannot hope to improve overall mental health of the aged person without considering the overall physical health. The literature that recognizes the interface of these two areas is gaining currency among medical and mental health professionals. It is now up to the healthcare system to elaborate ways that elderly patients can be promised access to collaborative teams to combat the high incidence of untreated depression in late life.

Collaborative Efforts

A collaborative approach has been found to be extremely effective in treating depression in the older person. Katon (2006) studied 1, 801 patients aged 60 and older who were experiencing major depression or dysthymic disorder. Katon's study, Improving Mood Promoting Access to Collaborative Treatment (IMPACT) showed positive results for the clients at least a year after treatment had ended. The time-frame for this study is significant in that most previous studies followed patients for just a year while Katon's study showed the residual effects of a collaborative approach. The patients who were diagnosed with depression or dysthymia (a less severe form of depression) were given a choice at the outset to start treatment with either psychotherapy or medications. Patients were also allowed to augment their chosen initial preference with the other option if the initial treatment was found to be insufficient. In other words, if a patient initially chose to be treated solely through medication but had not improved within a reasonable time frame, he or she was then given the option of supplementing medications with psychotherapy and vice-versa. The fact that patients were able to choose the initial treatment was also shown to be beneficial in that some people have very strong ideas about certain treatments and might not have been compliant if they were assigned to a treatment option with which they were not familiar or comfortable.

The results of the study are a promising harbinger of what is possible when the medical community works collaboratively with the mental health community. Depression-free days were measured at six month intervals. The elderly patients showed marked improvement in the number of depression-free days—from 0-6 at initial screening to 52 days at the 12 and 18 month marks to 54 depression-free days at the 18-24 month marks. The nurse or psychotherapist who

administered the evaluations worked within the patient's primary care clinic and helped follow the patient's adherence to the treatment and reported their progress to their physicians.

The cost of implementing collaborative programs is an integral part of the collaborative scenario. If the programs are not going to be fiscally prudent, it is unlikely that there will be wide-spread adoption of integrated, collaborative healthcare. Katon's study compared the health costs associated with treatment of depressed elderly patients and those in the study. Over the course of the two year study, it was discovered that the initial health care costs increased the first year but were offset by a decrease in medication. Thus, overall, the net cost the first year was \$180.00 but the net savings the second year was \$175.00

The researchers of this study hoped that it would spark a change in the current system in which only 10% of elderly patients with depression are seen by a mental health professional. Referrals from primary care offices were ineffective because less than 50% of the patients who were referred to mental health facilities ever made appointments with a mental health specialist.. Only half of those that did make an appointment went more than once or twice. The stigma, the extra effort, ambulatory considerations and medical priorities were cited as reasons that the elderly did not pursue mental health care outside of their primary care physician's office.

Ethics

Effective and efficient collaboration is a high ideal that has not yet proved to be attainable throughout the medical and mental health care system. Ethical considerations are an important aspect of the collaborative model and one that needs to be briefly addressed in this report. Mitchell and Coyne (2009) discovered that there are some major barriers to collaboration between medical personnel and mental health therapists. Half of the physicians surveyed cited structural and organizational barriers that included lack of time to talk with patients, lack of reimbursements by insurance companies for depression treatment and a lack of specialized care for the depressed patient. In the study, physicians had not only failed to properly diagnose depression in 29% of the patients who were actually depressed, but they failed to refer the ones that they correctly diagnosed with depression to mental health experts, preferring to take a "wait and see" attitude.

Diamond and Scheifler (2007) discussed the confusion that can reign among professionals on a treatment team. Although the authors stated that the therapist "knows the

client better, is more aware of his or her life goals and is better able to predict how he or she will think and feel about a medication decision” (p. 47), they posited that psychotherapists can cede ultimate authority for the patient’s progress to the physician because they are unfamiliar with the medications. Both of these scenarios, a physician untrained in mental health and a therapist unwilling to clearly take responsibility for the patient’s overall health, are ripe for ethical dilemmas. Is the physician ethically obligated to screen for depression and to refer depressed patients to a mental health expert? Is the Marriage and Family Therapist obligated to be fluent in the language of medical professionals and to have more than a cursory knowledge of medications? Does the client have the right to insist that his or her treatment encompass both the medical and the mental health providers? It is beyond the scope of this report to definitively answer those questions, and it is also evident that there are financial and legal issues at stake, but Marriage and Family Therapists who are treating elderly patients should be aware of the ethical ramifications of choosing to collaborate with medical staff or choosing to remain separate.

Mental and Medical Health Services

The health care system in the United States is currently in flux. It is difficult to know if radical changes are going to be made in how we manage our health and if a collaborative approach is going to be supported by the medical and mental health professionals as well as the Government. According to Murray and Lopez (1997), by the year 2020, heart disease and depression will be the two leading diseases worldwide. As I mentioned in the introduction, there is a robust debate about the cause and effect between cardiac conditions and depression. Some studies have shown the incidence of heart disease and depression comorbidity to be as high as 48% of heart patients (Gottlieb, Khatta, Friedman, Embinder, Katzen & Baker, 2004). These patients reported significantly lower satisfaction with their quality of life than did non-depressed patients and were less likely to take their medications or alter their lifestyle (Lane, Chong & Lip, 2006 as cited in Clabby & Haworth) which then increased the likelihood of recurrent cardiac problems.

Contributions of Marriage and Family Therapists

Because most of the older adults in this country receive their care through primary care physicians, it seems to make sense that Marriage and Family Therapists should work alongside

them in ensuring the mental health of their patients. Disease Management Programs (DMP) are now a part of some clinics and healthcare settings and have been shown to be successful in treating depression as part of the patient's roster of concerns. Physicians might initially use a screening tool such as the Beck Depression Inventory (BDI) or one that has been introduced for physicians to use with their aged patients, the SIGECAPS (sleep, interests, guilt, energy, concentration, appetite, psychomotor disturbances, suicidality). Instead of asking a general, open-ended question, physicians can do a simple yet broad assessment which covers a range of areas where depressive symptoms might be detected.

Case History

Clabby and Haworth (2007) presented a textbook case that beautifully illustrates the collaborative nature of the DMP and the way in which a systems theory approach to health ensures the optimum outcome. In the case study they described, a patient with cardiac problems was identified as suffering from depression. He also had a wife with terminal cancer. The treatment program that was initiated with the physician included family meetings with the patient and his adult children and his wife, regular office visits to his physician, 'phone calls and psychological support from a psychotherapist within the physician's office. Medication for the depression was considered but ultimately discarded as an option because of the fear of polypharmaceutical side effects. Using Cognitive Behavioral Therapy (CBT), the psychotherapist implemented an approach labeled SPEAK, which stands for Schedule, Pleasurable Activities, Exercise, Assertiveness, and Kind Words to self. It was developed in order to facilitate primary care physician's knowledge of and promotion of CBT techniques. In concert, the physician and the psychotherapist encouraged the patient to set up a daily schedule, pursue pleasurable hobbies, increase the amount of moderate daily exercise, learn to be less stoic and to voice feelings and opinions, and to reframe painful events or negative thoughts into more positive internal dialogue. The physician and the in-house psychotherapist moved in concert with one another to promote the physical and mental well-being of the patient. The patient thrived, dealt with bereavement during this collaborative time and lived a much fuller and happier life due to the integration of his medical and psychological treatments.

Gaps in Research

The exorbitant cost of health care in the United States is most likely at the root of the delegation of mental health care to a secondary consideration. Mental health care is treated like a distant relative who does not need to be acknowledged until he shows up for a visit. Yet all the data show how important mental health is to physical health and vice-versa. Freudenstein, Jagger, Arthur, & Donner-Banshoff (2001) asserted that there is an increasing need for research that investigates the non-pharmacological treatments for the elderly with depression who are being treated at primary care settings. The distinct characteristics of late-onset depression deserve attention. The National Institutes for Health promulgated the need for long-term treatment planning in patients with depression who are over the age of 70 (Conference on Diagnosis and Treatment of Late Life Depression). There seems to be a dearth of research in the areas of the rates of remission among elderly depressed people and the time it takes to recover or the time between recurrences. In addition, more studies that investigate the integral and important collaboration between physicians and mental health professionals are necessary so that holistic approaches to health care are not only recognized but are realistic and attainable for all older Americans.

CHAPTER 3 - Successful Aging

The topic of this report is depression among the elderly. Although major and minor depressions may be frequent interlopers in the lives of some elderly people, it is not a part of the normal aging process. A thorough discussion of the biological, psychological and social transitions that occur is beyond the scope of this report. However, in order to understand and appreciate the etiology of depression in the elderly, it is necessary to have a rudimentary knowledge of what constitute the “normal” aging processes. As with any discussion of the elements of the human body and mind, there are wide variations in what occurs as we age and when it occurs. Still, a broad overview of successful aging is helpful to the discussion at hand.

The Biological Process

Health and well-being are the twin cornerstones of successful aging. As 78 million “baby boomers”, those born between 1946 and 1964, enter their late life years, their health and wellbeing are the focus of research and analysis. While much has been discovered to date about aging, much remains a mystery. Yet, one must appreciate that even contemplation of successful aging is a recent luxury. During the past century, the average life span in the United States has increased from 47 years to just over 75 years (National Center for Health Statistics [NCHS], 2000).

Improvements in the length of the life span can be viewed as a double-edged sword. Better living conditions, more nutritious foods and better health care have combined to produce a generation of longer-living individuals. But as we live longer, our bodies and minds are challenged as never before.

The human body has a limited life span. Yogurt commercials and Methuselah notwithstanding, most people do not live past 100. From the time of conception until the time of death, our bodies undergo enormous changes. Cellular theories include the idea that there is a finite number of divisions that human cells can make before they die. Other theories propose the idea that cells cross-link and cause stiffening or that free radicals (unstable molecules) contribute to the aging process (Cavanaugh & Blanchard-Green, 2002). All of the theories incorporate the idea that our biological processes are unable to continue indefinitely.

Changes in Appearance

Normal Aging causes changes in our appearance, mobility, intellect and vital functions, including our sensory system, cardiovascular system, respiratory system, reproductive system, immune system and nervous system (Cavanaugh & Blanchard-Fields, 2002). The most obvious and least problematic signs of aging usually begin in mid-life. Skin begins to wrinkle, hair loses its pigmentation and starts to thin, and voices may be less resonant. While those changes may be troublesome and psychologically disturbing to some people, rarely do they interfere with the quality of life. In addition, the plethora of beauty products on the market today and the expertise of hairdressers and plastic surgeons have mitigated or delayed the outward signs of aging in our society.

Less obvious but having more of an impact on the lives of the elderly are changes in mobility. As we age, loss of bone strength becomes an issue. Compression on the spine results in a loss of height for both men and women. Men, on average, lose 1 inch of height after their mid-fifties and women lose an average of 2 inches (de Groot, Perdigao, & Deurenberg, 1996). Mobility is also affected by cartilage reduction in the joints resulting in osteoarthritis and rheumatoid arthritis. Some loss in strength and endurance is to be expected in the aging process.

Cognitive Functions

Nothing is stagnant about our minds and bodies. Infancy, childhood, adolescence, young adulthood, mid-life and the late life years are simply points on a body's continuum. The mind is no different; it changes at every stage of life. Yet the changes in the brain that come with old age are probably the most dreaded. The specter of senility hangs over society's perception of the elderly. When an elderly aunt forgets our name we question whether it is a harmless "senior moment" or the sign of incipient Alzheimer's. When our young neighbor forgets our name, we hardly give it a thought. To be sure, there are declines in cognitive functioning as we age, but they are generally not as severe as universally perceived. Most older people do experience memory changes in some neurological domains. So, while the elderly may lose the ability to retrieve stored information as quickly as they did when they were younger (Smith & Earles, 1996), the healthy aged retain a large portion of their long-term memory and are able to adapt to decrements in other areas of their brains.

Sensory System

The sensory system has several age-related changes. The structure of the eye changes so that there is a decreased amount of light that passes through the eye. There are also changes in the ability to adjust and focus. Other changes in the eye such as glaucoma and cataracts are the results of diseases. Retinal deterioration can occur and cause macular degeneration. Hearing is affected in the elderly and loss is usually in the ability to hear higher-pitched tones. While taste buds in the elderly suffer minimal decline, the ability to detect odors falls precipitously after the age of 60 (Cavanaugh, & Blanchard-Fields, 2002).

Cardiac System

In the United States, heart attacks and heart disease account for a sizable portion of the ill health in seniors, causing 1 in 5 deaths (American Heart Association, 2009). Changes in the heart muscle are inevitable and appear in all people, even those without heart disease. As we age, it is harder for the heart muscle to pump efficiently as the muscle becomes less elastic. Newer theories as to why the heart changes as we age refute the idea that fat deposits cause heart disease. Instead, they focus on the possibility of inflammation of the heart muscle caused by an overactive immune system or irritation of the coronary blood vessel wall (Mahoney & Restak, 1999). Still, these changes occur gradually in most people and the heart muscle is able to respond appropriately to normal activities for the healthy elderly.

Respiratory System

Changes to the respiratory system are easy to observe for researchers but difficult to determine why. As we grow older, the rib cage and the air passageways become stiffer. Breathing can become labored for older adults and the membranes of the air sacs in the lungs deteriorate. However, researchers have been unable to establish whether these age-related deficits are a part of normal aging or are the result of environmental factors like pollution.

Reproductive System

As we age, both men and women undergo changes in their reproductive systems. For women, the most profound change is the loss of the ability to bear children when menopause occurs. The ovaries stop producing eggs and there is a decrease in the amount of estrogen and

progesterone in the system. The libido of some women may be affected by these changes but can be addressed by various medications and hormone therapy.

For men, the changes are less dramatic. The quality of and quantity of sperm decline, but men are still half as fertile at 80 as they were at 25 (Whitbourne, 2002). Problems for men in this age range are often associated with changes in the prostate gland. As men age, the prostate gland becomes larger and stiffer and may obstruct the urinary tract. Sexual performance may be impacted with men experiencing more difficulty in becoming aroused, maintaining an erection and having orgasms (American Association for Retired Persons, 2007).

The brief descriptions of the aging process are but a basic primer in the many changes that occur as we age. The point of delineating the changes is to acquaint the reader with what is considered normal and what is not in terms of the biological processes that take place in later life. Some diminutions in function are to be expected. Yet, more and more Americans are reaching the age of 65 in better physical and mental health than in the past (Mental Health: Surgeon General's Report, 1999).

CHAPTER 4 - Clinical Issues Associated with Treating Depression in Older Adults

The onset of depression—major, minor or subsyndromal—in later life is different in its nature and course than depressive illness that occurs earlier in the life span. While it shares many similar clinical characteristics, the distinguishing features are profound enough that some researchers are hypothesizing that late onset depression is a distinct phenomenological entity (Rapp, Dahlman, Sano, Grossman, Hartounian & Gorman, 2005).

Before we begin a discussion of the clinical symptoms of late onset depression, it would be wise to remind ourselves of the diagnostic criteria for Major Depressive Disorder and Dysthymia, the two categories of mood disorders that deal with depression that are classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000).

The criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure and do not include symptoms that are clearly due to a general medical condition or depressed mood-incongruent delusions or hallucinations.
- (1) Mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels empty or sad) or observation made by others.
 - (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective report or observation made by others).
 - (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.
 - (4) Insomnia or hypersomnia nearly every day.
 - (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

- (6) Fatigue or loss of energy nearly every day
 - (7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode
 - C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
 - D. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.
 - E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation, with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

The diagnostic criteria for Dysthymic Disorder

- A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least two years.
- B. Presence, while depressed, of two (or more) of the following:
 - (1) poor appetite or overeating
 - (2) insomnia or hypersomnia
 - (3) low energy or fatigue
 - (4) low self-esteem
 - (5) poor concentration or difficulty making decisions
 - (6) feelings of hopelessness
- C. During the 2-year period of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. No Major Depressive Episode has been present during the first 2 years of the disturbance.

The guidelines used for assessing depression in the general population are also used for assessing depression in older adults. There are some assessment tools (Beck Depression Inventory or the Geriatric Depression Scale) that are designed specifically for older adults and are used in conjunction with the DSM criteria. Yet, it is easy to see why it would be more difficult to tease out a diagnosis of depression among the geriatric population from the ailments that might accompany old age, from pharmaceutical effects for treatment of diseases, from drug interactions or even from bereavement. There is increasing evidence that mental health disorders among older adults have been severely underdiagnosed and undertreated (Friedhoff, 1994).

In this day and age of rampant radio and television shows devoted to the public airing of emotions, feelings, opinions and beliefs, it is hard for anyone of the younger generation to imagine that depression and other mental illnesses were once taboo subjects. Certainly, mental illness still has a certain stigma, but discussion of mental health is becoming the norm in society rather than an aberration. Yet, the current older adults in American society were not raised to readily examine their mental status. In the opinion of this author, the reluctance on the part of the World War II generation to seek help for mental health is a cohort effect. The “pick yourself up by the bootstrap” mentality was in full force. Thus, the aforementioned difficulties in diagnosing depression among the geriatric population are compounded by their inability to label their conditions as depressive episodes. Cox and Reifler (1994) found that older adults do not want to label their feelings as depression, using instead the terms “pessimism” or “helplessness.” Gallo, Royall & Anthony (1999) found that older adults were much less likely than younger participants in a study to endorse statements relating to dysthymia.

Although clinicians at this time must use the guidelines for diagnosing depression as set forth in the DSM-IV-TR, research has revealed that there is a subset of features that might make it easier for physicians, clinicians and therapists to recognize late onset depression. Older adults with late onset depression manifest greater apathy (Krishnan et al., 1995), seem to have had less dysfunction in their daily lives than those with recurrent geriatric depression (Abrams et al., 1994), experience more and greater cognitive deficits, especially in the areas of memory and cognitive functioning (Salloway, Malloy, Kohn, Gillard, Duffy, Rogg, Tung, Richardson, Thomas & Westlake, 1996), and are more prone to suffer from a variety of illnesses, but especially cardiovascular diseases (Rapp et al., 2005).

Etiology of depression

The etiology of depression –whether early or late onset—is still a bit of a mystery. Many genetic, environmental, social, spiritual and situational factors come into play in the development or avoidance of depression. There are several factors, though, that seem to provide a cushion against the possibility of late onset depression. Staying active and connected with your community (Perls, Silver & Lauerman, 1999; Seligman, 2002) is a key indicator in emotional well-being in the aged population. Having a stable marriage and a life-long adaptive coping style (Rowe & Kahn, 1997; Vaillant, 2002) are integral to mental health and the avoidance of depressive episodes. Seligman (2002) has created an equation to express the factors that are involved in aging well and without depression:

$$H \text{ (enduring happiness)} = S \text{ (your set of genetic factors)} + C \text{ (circumstances of your life)} + V \text{ (factors under voluntary control such as belief systems, sense of optimism and thoughts and feelings about the past).}$$

Just as there are protective factors that can ameliorate the chances of experiencing late onset depression, there are risk factors that increase the chances of experiencing depression: widowhood (Bruce, & Huff, 1990; Zisook & Shucster, 1993; Mendes de Leon, Kasl, & Jacobs, 1994), physical illness, especially of a chronic nature (Cadoret & Widmer, 1988; Harlow, Goldberg, & Comstock, 1991), lower educational attainment, usually less than a high school diploma (Wallace & O'Hara, 1992; Gallo et al., 1999), inability to perform activities of daily living (Bruce & Hoff, 1994), and heavy alcohol consumption (Saunders, Copeland, Dewey, Davidson, McWilliam, Sharma, & Sullivan, 1991). Other factors that have less impact yet are still significant in the development of depression are being female, being a nursing home resident, and being a caregiver for an ill family member (Schneider, 1995).

Depression is not a normal part of aging. Although it may be difficult to diagnose in older adults, it is a very treatable condition. In fact, several studies have shown that the efficacy of treatments in adults with late onset depression is just as effective as treatments designed for earlier onset depression (Reynolds & Kupfer, 1999).

As with the treatment of Major Depressive Disorder and Dysthymia among the general population, there are many possible approaches to treating depression in older adults. The most difficult part of dealing with depression in older adults is ensuring that they receive treatment in the first place.

Pharmacological Interventions

Pharmacological treatments, as well as psychosocial treatments, are used to treat late onset depression. Pharmacological treatments generally refer to the use of antidepressants. Psychosocial treatments may include Cognitive-Behavioral Therapy, other models of psychotherapy, light therapy and electroconvulsive therapy.

Marriage and Family Therapists who will be treating the geriatric population owe it to their clients to be familiar with the antidepressant medications that their clients might be taking. While it would be unreasonable to suggest that Marriage and Family Therapists with a geriatric clientele must have complete medical knowledge, it would be negligent of these therapists not to have a thorough understanding of some of the more common physical conditions of older adults, a more-than-cursory familiarity with drug interactions, and the efficacy and effectiveness of talk therapy treatments. Geriatric clients carry unique considerations that must be recognized and honored by therapists.

Pharmacological treatment of late onset depression is based on the use of three families of drugs. Reynolds and Kupfer (1999) stated that about 60 to 80 percent of patients respond to pharmacological treatment of depression, roughly the same percentage as in younger adults. The response rate is defined as reducing depressive symptoms or the severity of symptoms by 50 percent.

The family of antidepressants known as Selective Serotonin Reuptake Inhibitors (SSRIs) is often the first choice of medication for older adults. SSRIs include the drugs known as Prozac, Zoloft and Serzone. The advantage of prescribing SSRIs is that the dosing patterns are easy and the side effects are minor. SSRIs may cause anxiety, restlessness and insomnia, sexual dysfunction and gastrointestinal discomfort, but they are reported to have fewer cardiovascular side effects than other families of antidepressants (National Institutes of Mental Health [NIMH], 2002). However, there is the possibility of drug-drug interaction with SSRIs and a complete inventory of the clients' medications must be reviewed by the physician when prescribing SSRIs to older adults.

Tricyclic Antidepressants (TCAs) are a common weapon in the pharmacological arsenal to treat depression in all ages. However, the usual side effects of TCA use—dry mouth, urinary retention and constipation—may cause much greater problems in older adults than they do in

younger ones. TCAs may also exacerbate preexisting cardiac disease and increase the chances of severe confusion in older adults.

Monamine Oxidase Inhibitors (MAOIs) are considered less effective than TCAs and have greater lethal risks when they interact with foods that contain dopamine or tyramine (e.g., cheddar cheese, wine, chicken liver). MAOIs can raise blood pressure, especially in older adults so they are rarely used in treating older patients.

The second generation of non SSRI drugs include Bupropion, Venlafaxine, Nefazadone and Mirtazapane. Several studies have shown these medications to be effective in treating the elderly. However, the disadvantages of these drugs include their high cost and their more complicated dosing patterns.

There are also non-pharmaceutical approaches to treating depression. Electroconvulsive Therapy (ECT) is a highly controversial treatment but is regarded as an effective intervention when clients do not respond to other forms of treatment. ECT induces seizures in the brain by means of administering electrical currents. It is usually reserved to treat severe cases of depression of suicidal or psychotic patients. The response rate for electroconvulsive therapy is 50 to 70 percent (NIMH, 2002). One of the advantages of electroconvulsive therapy with older adults is the avoidance of any drug interaction and the faster response time. The risks include temporary or, rarely, permanent memory loss following ECT. Patients with cardiac conditions should avoid electroconvulsive therapy as it can lead to death from coronary infarction.

Just as Electroconvulsive Therapy is reserved for the treatment of severe depression, light therapy is usually used in cases of minor depressive episodes, especially Seasonal Affective Disorder (SAD). Light therapy involves the use of full-spectrum or white light in order to increase the level of serotonin in the body's system and, thus, decrease the depressive symptoms (WholehealthMD.com, 2000). As a treatment for older adults with minor depression, it has the advantage of being easy to administer (a light box is used if natural sunlight is not available or advisable) with no potential for drug interaction.

Marriage and Family Therapy

The area of most interest to those of us in the Marriage and Family Therapy field for treatment of depression in older adults is, of course, psychosocial therapy. According to the Surgeon General's Report (1999), the forms of treatment that are most effective for older adults

include Cognitive-Behavioral, Brief Problem-Solving Therapy, and Interpersonal Therapy. A third-wave Cognitive-Behavioral approach called Acceptance and Commitment Therapy (ACT) also shows promise in treating depression.

One variation of talk therapy called Reminiscence Therapy has been designed specifically for older adults. Reminiscence Therapy involves remembering and reflecting on the client's life experiences in different realms. Butler (1974; 1991) has found this intervention to be successful in both individual and group settings. The purpose of this type of therapy is to review the clients' lives and help them to celebrate the positive aspects of it and come to terms with the negative aspects of it. My own experience in this realm at Meadowlark Hills Retirement Community leads me to believe that this is a particularly powerful way in which to help older adults overcome angst about their past and enjoy their present. I led a weekly group in the dementia unit that was devoted to reminiscing. It seemed to be the highlight of the clients' week. This approach is usually employed within nursing homes, assisted living centers or with senior citizens who have much milder degrees of depression. In fact, it could easily be designed for older citizens with no major mental health issues as a way to enhance their appreciation of their contribution to life. I personally believe that people of all ages could benefit from a regular review of their lives and a pat on the back for the successes they have engineered in their lives.

Cognitive Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) has been demonstrated to be effective in treating late onset mental health disorders (Stanley, Beck & Glassco, 1996; Beck & Stanley, 1997). CBT's interventions are designed to promote necessary skills for daily life, alter negative thought patterns and reduce or remove disturbed emotional states that can produce or exacerbate mental disorders. Older adults who are not experiencing dementia can benefit from a course of therapy that includes CBT. Cognitive therapies that help clients cope with chronic illness or substance abuse have been found to ameliorate depressive symptoms (Dick-Siskin, 2002)

Case History

In my clinical work at Meadowlark Assisted Living Center, I incorporated a well-known CBT technique when dealing with a very pervasive issue among the residents there. My client, Mrs. M, was distressed that her son and his family did not visit her often. Mrs. M. was a fairly active resident with no signs of mental decline who had been widowed approximately 5 years

previously at which time she moved into Meadowlark. Mrs. M's son lived in a nearby town. Her daughter lived out of state, called frequently and visited at least twice yearly. Mrs. M. confided in me that she was puzzled and upset that she seemed to get more attention from her far-away daughter than she did from her son who lived nearby. There had been no unusual family skirmishes or tensions which might lead to this quasi-estrangement nor did Mrs. M. chalk it up to gender differences in her children. She said that up until a couple of years prior to our sessions, her son had been quite attentive, visiting often and bringing his children with him. When I prodded her to examine what had changed in the last couple of years, she revealed that her arthritis has worsened in the past two years and she had been in a constant state of low-level but chronic pain. A recent hip replacement had ameliorated much of her condition. I then asked her to describe her interactions with her son when he did visit. It was almost like a sitcom parody. Mrs. M would greet her son, then ask why he hadn't visited, ask why her grandchildren avoided her and then told him how much pain she had been in since he last visited. It seemed to be that a cloud of negativity had enveloped Mrs. M, perhaps diagnosable as depression. Her son had responded by avoidance which only increased Mrs. M's sadness, frustration and depression.

Mrs. M. situation mirrors that of many elderly people. Low-level depression had been triggered most likely by a physical ailment, had affected her relationship with her family, and had not been resolved even when the physical condition had improved. As Mrs. M. was an alert and intelligent woman, I was able to incorporate a technique that involved awareness, introspection and evaluation: the 4 column approach. In the first column, I recorded the factual information: her son does not visit often. In the second column, I recorded her thoughts about this: "He doesn't care about me." "I'm all alone most of the time" In the third column, I wrote down what negative and dysfunctional behaviors ensued from her negative thoughts: as soon as her son arrives, she accosts him with accusations and makes the visit as unpleasant as possible to let him know how unhappy she is. In the fourth column, we explored her past successful visits with her son. Before her move to Meadowlark, she and her son frequently visited with each other, discussed daily events and the talked about the happenings with her grandchildren. They laughed and got along. She agreed that perhaps she could make the visits more enjoyable and not attack her son for not showing up.

As it happens, a few weeks later, I stopped by her rooms at Meadowlark to check in on her and her son was there. Mrs. M happily told me that this was her son's second visit since I

last saw her. There seemed to be no tension in the room and I mentioned to the son how much his mother appreciated his visits. They both seemed to be enjoying themselves. I do not know how this ultimately played out, but I do believe that this case contains valuable lessons for those working with the elderly. I altered the therapeutic approach by writing all of the comments in the four columns myself so that Mrs. M would not be put-off by that component of the therapy. I also didn't specify or ask her to specify any concrete goal (i.e., asking your son to visit once a week). Instead, we worked to get her to recognize how to enhance her relationship and what might have led to such a disagreeable situation. I would like to point out that this therapy and this resolution might not have been possible if Mrs. M were still experiencing chronic pain. Pain almost always precludes a person from being good company and I would have had a much different therapeutic approach with Mrs. M and with her son if she were still in poor physical health.

Brief Problem-Solving Therapy

Brief problem-Solving Therapy is also considered helpful and usually lasts up to 4 months. It is designed to address the social skills aspect of the client's life that may be enhancing the risk of depression. Problem-solving techniques are practiced as are interventions that focus on time management, financial management and dealing with stressors. This approach works well with the aged because it addresses very specific issues in a very practical manner. Older individuals who are wary of the entire genre of psychotherapy are often more receptive to learning techniques to improve daily life.

Interpersonal Psychotherapy

Interpersonal Psychotherapy (ITP) originally began as a means to dealing with mid-life issues such as role transitions, interpersonal disputes and grief. It has been found to be effective with younger adults (Mynors-Wallis, Gath, Lloyd-Thomas & Tomlinson (1995), although more research is needed to see if it is as efficacious with older clientele. Certainly, many of the issues with which ITP deals are ones that would also be experienced by older adults.

Acceptance and Commitment Therapy

A third-wave Cognitive-Behavioral therapeutic approach is labeled Acceptance and Commitment Therapy (ACT). Based on Relational Frame Theory, ACT was pioneered by Stephen C. Hayes just over a dozen years ago. ACT has at its core the concepts of mindfulness, acceptance and values. ACT assumes that suffering is a part of the human condition and that much energy is expended in trying to avoid this natural condition. Unpleasant memories and acting in conflict with one's values usually lead people to use a number of methods of avoidance that actually exacerbate the suffering. ACT teaches that it is far better and psychologically healthy to embrace reality, become aware of one's own inner values, reflect on the situation and act according to a full awareness of the reality of the situation and the values that one brings to it. It is a fusion of internal change and external behaviors. Clients are encouraged to accept realities and to learn to defuse their negative thoughts and this will ultimately lead to a change in the external environment.

Acceptance and Commitment Therapy has been empirically tested and has done well in clinical trials with a number of mental health issues, including depression (Gaudio and Herbert, 2006.) Given my admittedly limited knowledge and exposure to ACT, I think that it would be a good therapeutic approach to use with the aged. It encourages people to live a life more committed to meaningfulness and mindfulness rather than defending a conceptualized self. In the later years, it is undeniable that they will encounter grief and suffering. Acceptance and Commitment Therapy is a short-term approach that will enable the elderly patient with depression to face unpleasant memories or events, recognize the negative feelings associated with them, and learn to defuse these negative emotions in a healthy way.

Contrary to popular myth, older adults can and do respond to psychotherapeutic interventions. While they present a unique set of challenges to clinicians, successful treatment is well within reach. It is especially efficacious if used in conjunction with anti-depressants. A meta-analysis of 89 studies (Pinquart, Duberstein & Lyness, 2006) showed that there was a marked improvement in both clinician-rated and self-rated depressive scales among the elderly who were being treated with both some form of psychotherapy and antidepressants. I believe this negates the attitude among some people that it is not worth the effort or the cost to treat the aged for depression. The elderly are just as deserving of a good quality of life as people in their youth or mid-life and should have their mental health needs met. Practitioners need to be able to

modify successful therapeutic techniques in order to take into account the clients' mental acuity, physical conditions, and social environments.

CHAPTER 5 - Chapter 5-Conclusion

In my youth, I occasionally watched the popular television show Star Trek. I was always impressed by the opening voice-over that proclaimed space to be the “final frontier.” At some point, would space truly be the last mystery of the universe? Would humankind ever be able to research, analyze and, most importantly, comprehend the seemingly endless swirl of questions that surround every human experience? I think not.

I believe that there are many frontiers here on earth that remain only partially explored and inadequately understood. I believe that knowledge of the physical, mental, and spiritual worlds of older adults is now truly the “final frontier” of life’s journey. The pioneers of this frontier are the researchers, gerontologists and older adults themselves who are breaking new ground in their approach to and appreciation of the later-life years.

My report addresses the issue of depression and older adults. In doing this report, I spent countless hours reading the research associated with depressive illness and older adults. I also reflected on my experiences with the older adults in my family. My clinical experiences working at Meadowlark Hills Retirement Community enriched my understanding of the many issues and concerns that abound among older adults. Of course, my understanding of the issues will evolve and improve as I spend more time in the field of geriatric mental health.

Yet, I do believe that perceptions can create reality and that the perceptions of “old age” should be the first to be reformed. The Baby Boom generation seems to be doing a good job in turning on its head previous expectations of the elderly. Barry Barkan, a civil rights activist, wrote the following poem in 1976 when he was aged 34. The poem heralds the new status of our older citizens and is to be treasured for its understanding of the special place that older adults deserve in our world.

The Live Oak Definition of an Elder

An elder is a person

Who is still growing,

Still a learner

Still with potential and

Whose life continues to have within it
Promise for and connection to the future.
An elder is still in pursuit of happiness
Joy and pleasure
And her or his birthright to these
Remain intact.
Moreover, an elder is a person
Who deserves respect
And honor
And whose work it is
To synthesize wisdom from long life experience and
Formulate this into a legacy
For future generations.

Barkan's simple poem is a stark reminder that the final frontier of life is as valuable as the beginning and middle of life's journey. Younger people need to acknowledge this concept, society needs to support this concept and older adults need to embrace this concept. In so doing, we will have created an environment in which the late life years can truly be "the best of times."

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