Updates on Mental Health Problems in Late Life

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Meharry Consortium Geriatric Education Center
Objectives

• Name three misconceptions about psychiatric disorders in older adults
• Identify three assessment strategies to uncover psychiatric disorders in older adults
• Explain the physical health manifestations of mental health problems in older adults
GERIATRIC PSYCHIATRIC DISORDERS:
AN UPDATE

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Disclosures

Nothing to Disclose
What Will be Covered

- Mood Disorders – Major Depression
- Anxiety Disorders – Generalized Anxiety
- Substance Use Disorders – Alcohol Use
- Delirium – the mother of all comorbidities
Major Depression
Diagnostic Criteria for Major Depression

Five of the following symptoms present during the same 2-week period, at least one being depressed mood or loss of interest or pleasure:

- Additional symptoms
  - Weight loss
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness
  - Problems concentrating
  - Recurrent thoughts of death or suicidal thoughts
Late life depression is diagnosed by a careful history!

Screening scales (GDS, Beck, CES-D)

The diagnostic work-up which includes complete blood cell count, urinalysis, thyroid screen, chemistry screen, & electrocardiogram.

These studies are more helpful in documenting medical problems that may complicate therapy than in diagnosis.

Imaging studies may be helpful in diagnosis of vascular depression.
The frequency of antidepressant prescriptions has increased dramatically over the past 15 years among the elderly, with currently over 10% of older adults taking antidepressants. (Blazer et al, 2001)

McKeown et al, 2006 has suggested this may contribute to the decrease in suicides over the past 15 years in the elderly.
# Pharmacotherapy of Late Life Depression

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<tr>
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<tr>
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<td>10-40mg</td>
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<tr>
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<td>50-200mg</td>
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<tr>
<td>Fluoxetine</td>
<td>10mg</td>
<td>5 -20mg</td>
</tr>
<tr>
<td>Citalopram</td>
<td>10mg</td>
<td>10-20mg</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10mg</td>
<td>10-20mg</td>
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Interpersonal Psychotherapy

- A structured, time (10-15 session) manualized therapy for depressive disorders
- In the initial phase, the depressive symptoms are explored and depressive symptoms are linked to recent events.
- One of four possible treatment focuses are selected: complicated grief, interpersonal conflict, role transition, and interpersonal deficit.
Combined Interpersonal Psychotherapy and Pharmacotherapy: Highly Effective

Reynolds et al, 1999 In young old subjects without comorbidities treated for major depression with combined psychotherapy and pharmacotherapy fewer than 20% met criteria for treatment resistance by lack of response to acute treatment or by relapsing during continuing treatment.
Electroconvulsive Therapy
Indications

- Severe/psychotic late life depression
- Severe depression not responding to antidepressant medications
- Moderate to severe depression in a person who has previously responded to ECT
- Serious suicidal risk
Supportive Family Intervention

- Interpreting changes in the elderly’s behavior
- Guidance in managing certain dysfunctional behaviors
- Preventive strategies for potentially dangerous behaviors, i.e., suicide attempts
Prevention of Relapse in Major Depression

- Reynolds et al, 2006 – tested efficacy of paroxetine and monthly interpersonal psychotherapy over two years in 70+ year olds.
- MD occurred in 35% of the patients with combined therapy, 37% with paroxetine alone, 68% with placebo and psychotherapy, 58% with placebo and clinical management.
- The relative risk of recurrence with placebo was 2.4 times that among those receiving paroxetine.
- Patients with fewer and less severe coexisting medical conditions (such as hypertension or cardiac disease) received greater benefit from paroxetine.
Late life depression may not be as frequent as at other stages of the life cycle, yet frequency is high in the physically and cognitively impaired.

Older adults appear more vulnerable to biological causes of depression, such as depression secondary to vascular lesions in the brain.

Older adults who are cognitively intact may experience a buffering of depression because of a lifetime of cumulative wisdom coupled with a different view of events given their age.

The combination of psychotherapy and antidepressant medications is optimal for treating major depression.

ECT is indicated for specific and severe cases.
Generalized Anxiety Disorder
Diagnosis of Generalized Anxiety

- Older adults may not find terms such as anxiety or worry to be relevant, but may prefer a term such as “concern.”

- May ask a question such as, “Older adults often deal with stress: how do you feel in times of stress?”

- During the evaluation should focus on:
  - Level of distress
  - Time consumed by the anxiety symptoms
  - Avoidance
  - Physical symptoms
Excessive anxiety and worry on most days lasting at least six months.
- Difficulty controlling worry
- Anxiety and worry associated with three or more of the following:
  - Restlessness/feeling on edge
  - Fatigue
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Not attributable to a physical illness (such as hyperthyroidism)
- The symptoms cause significant distress and/or impaired function
Frequency of Anxiety Disorders

- Generalized anxiety disorder among the most frequent psychiatric problems which older adults experience.
- Usually the symptoms are less severe than major depression but older adults in the community may experience a prevalence of 3-5%.
- First onset in late life may be as high as 50%.
- Anxiolytics remain among the most frequently prescribed medications for older adults, primarily prescribed by primary care doctors.
Generalized anxiety is often comorbid with another problem:

- Generalized anxiety is often comorbid with depression.
- Also associated with cardiovascular disease, especially associated with shortness of breath.
- Parkinson’s disease may be a particularly anxiogenic illness because of its association with both subcortical disease but also with autonomic dysfunction and lack of control over basic movements.
- Stroke often causes generalized anxiety.
Dementing illnesses also frequently causes anxiety symptoms perhaps due to increased deposit of amyloid in the posterior cingulate region.

The social milieu of older adults may be a particular precipitant of generalized anxiety
- Crowding and noise in long term care facilities
- Concerns for safety
- Concerns about family
Pharmacologic Treatment

- Benzodiazepines
  - Lorazepam 0.5mg bid
  - Alprazolam 0.5mg bid

- Selective Serotonin Reuptake Inhibitors
  - Escitalopram 10-20mg po qd
  - Paroxetine 10-20mg qd
  - Sertraline 50mg qd

- Antipsychotics not recommended
Non-Traditional Therapies

- No empirical data supports the use of any of these therapies
  - Stress reduction techniques (Mindfulness based therapies, Tai Chi, yoga, etc.) Yet these may be effective (we just do not have the evidence)
  - Complementary medicine should be used with caution.
    - Kava Kava (banned in several European countries)
    - Valerian
    - Passion flower
    - Camomile (tea is probably quite safe)
Cognitive behavioral therapies (CBT) have proved effective in promoting psychoeducation, problem-solving skills training, exposure exercises and sleep hygiene.

Relaxation training, however, may be the most important contribution of CBT and can be fairly easily incorporated into a primary care setting.

Bibliotherapy was shown effective in one trial. Reading and discussion the reading and this may be especially appropriate in retirement communities.
Key Points for the Treatment of Generalized Anxiety Disorder

- Generalized anxiety is more frequent than usually assumed so much ask the patient to elicit the symptoms.

- The evidence base for treatments is limited (more so than for major depression) but is gradually emerging.

- Clinicians must take care in the use of medications, especially those with potential for addiction and tolerance as well as side effects.

- Evaluate potential comorbidities carefully and when possible address these first.
Alcohol Use Disorders
Views to the Future
Without Evidence

- Substance use disorders are rare and will continue to be rare among older adults. We have more pressing public health concerns.

- Substance use disorders will increase dramatically in the elderly as the baby boom generation enters late life. The cohort effect will be predominant.

We must consider a more nuanced & evidence based view.
America’s 78 million baby boomers are heading into retirement with more than their considerable, health and education. They are also bringing into their golden years an epidemic of drug and alcohol abuse…that has yet to be recognized, according to a recent Institute of Medicine report.

Richard Friedman, A Rising Tide of Substance Abuse, April 29
Background – At Risk Alcohol Use

- Alcohol use (and abuse) among middle aged and older adults has historically been less frequent than young adults, yet the frequency is increasing.

- In the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 37% of women and 55% of men 65+ years of age reported that they were current drinkers.

- Just over 1% of elderly women and 4.8% of elderly men were thought to have a 12-month DSM-IV diagnosis of abuse or dependence.
Background – At Risk Alcohol Use in Later Life

• Reasons for the increasing prevalence in these age groups possibly include:
  
  – alcohol use in moderate quantities has not been found to lead to a significant increase in adverse health outcomes and may actually improve health;
  
  – rising cohorts into these age groups have historically consumed more alcohol than past cohorts during the 20th century.
Background – At Risk Alcohol Use, A Changing Picture

- Younger cohorts carry a heavier burden of alcohol use.
- Certain patterns of alcohol use may lead to unique risks for adverse consequences, such as binge drinking.
- Risk may not be limited to older white males, as has historically been reported in the literature.
Assessment of Alcohol Use

- Alcohol use was defined as consuming at least one drink of any type of alcoholic beverage.

- “A drink” was explicitly described to respondents as a can or bottle of beer; a wine cooler or a glass of wine, champagne, or sherry; a shot of liquor; or a mixed drink with liquor in it.

- Survey respondents were asked their use of alcohol in the past year.

- Alcohol users also reported “the usual number of drinks” that they drank on a drinking day during the past 30 days, and the number of days that they had 5 or more drinks on the same occasion.
Assessment of Alcohol Use

- We classified respondents into four mutually exclusive groups:
  - **no use** of alcohol in the past year
  - **low risk** (no more than 1 drink on a usual drinking day within the past 30 days)
  - **at risk** (2 or more drinks on a usual drinking day within the past 30 days)
  - **binge drinking** (defined as drinking 5 or more drinks on the same occasion on at least one day within the past 30 days)
In a 10 year follow-up of the HRS, among subjects 50-65, the investigators found the following trajectories:

- Consistent infrequent and non-drinkers (40.6%)
- Increasing drinkers (5.5%)
- Decreasing drinkers (7.6%)
- Consistent at-risk drinkers (15.6%)
- Consistent moderate drinkers (30.7%)

Infrequent drinkers initially were less likely to follow an increasing trajectory if they were older.

Bobo et al, AJGP, 2013
Medical and Psychiatric Comorbidity of Alcohol Use Disorders

- The most common psychiatric comorbidity is depression (in up to 21% of persons).
- Alcohol use can often be a cause and a comorbidity for neurocognitive disorders (and difficulty to distinguish – regardless the alcohol should be stopped).
- Sleep disorders frequently co-occur with excessive alcohol use.
- Must screen for falls
Various treatments for alcohol misuse have been demonstrated to be effective

- Brief interventions (Motivational interviewing or even simple physician counseling)
- Psychotherapy
- 12-step programs
- Pharmacotherapy
  - Disulfiram
  - Nalotrexone
  - Acamprosate (mechanism is not known and no studies have demonstrated efficacy)
Key Points on Alcohol Use Disorders in Later Life

- The potential adverse consequences of at risk and binge drinking increase as individuals age (falls, memory loss, liver disease, etc.)

- The elderly are more susceptible to health problems yet may be overlooked by clinicians (we don’t ask!)

- In addition, usual screening instruments such as the CAGE questionnaire often used to screen for alcohol problems is of little value in identifying people who binge.

- Treatment episodes for SUDs in later life are increasing proportionally (most of which are secondary to alcohol misuse)
Given physiological changes associated with aging, adults 65+ years of age should consume no more than one standard drink a day.

Alcohol also acts synergistically with other medications, especially the benzodiazepines.

The symptoms of alcohol misuse often are confounded with symptoms of medical illnesses.
Delirium – the mother of all comorbidities
Diagnostic Criteria for Delirium

DSM-5

- A disturbance of attention (reduced ability to direct, focus, sustain and shift attention) and awareness (reduced orientation to the environment)
- Develops over a short period of time
- An additional disturbance in cognition (e.g., memory, disorientation, language, visuospatial ability or perception)
- Not better explained by another neurocognitive disorder
- Evidence that the disturbance is a direct consequence of another medical condition, substance intoxication or withdrawal, or exposure to a toxin.
The diagnosis of delirium requires a present/abnormal rating for criteria: (1), (2), and either (3) or (4).

(1) **ACUTE ONSET AND FLUCTUATION COURSE**

Is there evidence of an acute change in mental status from the patient’s baseline?

-AND-

Did this behavior fluctuate during the past day, that is, tend to come and go or increase and decrease in severity?
(2) INATTENTION

Does the patient have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?
(3) **DISORGANIZED THINKING**

Is the patient’s speech disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
(4) **ALTERED LEVEL OF CONSCIOUSNESS**

Overall, how would you rate this patient’s level of consciousness?

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
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<tbody>
<tr>
<td>Alert</td>
<td>Vigilant (hyperalert)</td>
</tr>
<tr>
<td></td>
<td>Lethargic (drowsy, easily aroused)</td>
</tr>
<tr>
<td></td>
<td>Stupor (difficult to arouse)</td>
</tr>
<tr>
<td></td>
<td>Coma (unarousable)</td>
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Frequent causes of delirium

- Predisposing causes
  - Older age
  - Severe chronic illness
  - Neurological disease or neurocognitive disorder
  - Dehydration
  - Drugs (psychoactive drugs, treatment with many drugs, alcohol over a long period of time)
  - Functional dependence and immobility
  - Visual and hearing impairment
Frequent causes of delirium

- Precipitating causes
  - Drugs (the list is LONG)
  - Change in environment (such as hospital or ICU or move to a new home)
  - Acute illness onset (e.g., bowel obstruction)
  - Pain
  - Acute onset of a neurological disease (stroke)
  - Infections
  - Hypoxia
  - Blood loss
  - Surgery
Non-pharmacological Management

- Target risk factors (older age, change in environment, medications) and attempt to intervene before the onset of delirium.
- Use reorienting approaches when possible (clock in room, keep some light on, minimize the use of physical restraints, verbally orient patient to each procedure).
- Attempt to increase patient’s mobility, adjust sleep/wake cycle to allow for uninterrupted periods of sleep.
Pharmacological Treatment of Delirium

- Only use in patients who have severe agitation that interferes with medical treatments.
- Use the lowest dose of medication possible so the patient may remain alert yet calm.
- Haloperidol is the first line treatment and is best administered orally if possible (1.5-3mg per 24 hours).
- Monitor vital signs before administering each dose.
- Avoid benzodiazepines (except in alcohol and sedative/hypnotic withdrawal).
Key Points about Delirium

- Delirium is a **common and preventable** problem among older adults
- Delirium is the **most frequent complication** of hospitalization
- Patients with delirium have a worse prognosis than patients without
- Simple assessments are available, such as the CAM
- Delirium causes are usually multiple
- Both **pharmacological and non-pharmacological approaches to delirium treatment** are indicated
We have seen one older adult when we have seen one older adult – diversity

The foundation of the diagnostic workup is the interview. We learn by listening, not by checklists.

A thorough medication history is essential though it takes time – electronic records will help.

The key outcome we must trace is functional status - ADLs, social interaction, economic well-being, support network, cognitive capacity.

Geriatric psychiatry is family psychiatry.