GERIATRIC PSYCHIATRY: TREATING DEPRESSION AND ANXIETY

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

✓ Any conflicts of interest?
OBJECTIVES

1. Learn about prevalence and risk factors for depression and anxiety in older adults
2. Become informed about the interplay between neurocognitive and neuropsychiatric symptoms among older adults
3. Understand how treatment of depression and anxiety needs to be modified for older adults
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DEPRESSION

Past Year Prevalence of Major Depressive Episode Among U.S. Adults (2016)

Data Courtesy of SAMHSA
A MORE DETAILED VIEW OF DEPRESSION

Is well-being U-shaped over the life cycle?

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ANXIETY


Data from National Comorbidity Survey Replication (NCS–R)

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PREVALENCE OF DEPRESSION AND ANXIETY DROPS WITH AGE – WHY?

Possible explanations
• Survivorship bias
• Fewer factors leading to depression (doubtful given age-related stressors of disease and loneliness)
• Higher resilience with increasing age: learning how to cope with life, lower perception of stressors

Evidence
• Studies show that “happy older people live longer”

RISK FACTORS IN OLDER ADULTS

• (Loneliness)
• (Disability)
• (Medical Problems)
• Comorbidity associated with neurocognitive disorders or changing cognition in older age
WHAT IS NORMAL AGING?

Most cognitive abilities decline linearly throughout the life span — two standard deviations of decline in processing speed and memory retrieval.

Summary

THE COMPLEX RELATIONSHIP BETWEEN AGING, COGNITIVE CHANCE, DEPRESSION AND ANXIETY - 1

• Depression or anxiety can be prodromal signs of cognitive change, due to a shared etiology.

• Therefore: do a MOCA on any older adult with new-onset depression or anxiety.

• Cognitive chance is a potent driver of depression and anxiety (mediated by fear of dementia, perception of deficits, and reduction in activity level).
• Age-related cognitive change reduces cognitive reserve, hence older adults may have higher vulnerability to the cognitive impairment associated with depression.

• This accounts for no more than \(~4\) points loss on the MOCA “scattered deficits”.
COGNITIVE DECLINE AND DEPRESSION

• Primary neurocognitive disorders may present with depression or anxiety (*stronger connection*)

• Primary depression in an older person can present with cognitive symptoms (*weaker connection*)
COMMON NEUROPSYCHIATRIC SYMPTOMS IN ALZHEIMER’S DISEASE:

• Apathy (17-84%)
• Depression (8-74%)
• Anxiety (7-69%)
• Aggression (11-46%)
• Delusions (3-54%; delusions of theft common; others are paranoia, delusions of infidelity, phantom border or imposter delusions)
• Hallucinations (1-39%; usually visual, less common auditory, rarely tactile or olfactory)

Frequencies by Wang et al., Current Neuropharmacology, 2016, 14, 307-313
COGNITIVE DECLINE AND DEPRESSION PERSPECTIVE OF FAMILIES AND CARE PARTNERS

• Apathy (most frequent NPS in AD) is often mistaken for depression.
• Families often ascribe cognitive lapses to “*not trying hard enough*” due to depression, orneriness, etc.
• Providers and families often latch on to *depression as the most benign explanation* for overall decline.
TREATMENT – WHAT IS DIFFERENT IN THE OLDER PATIENT – 1

• High prevalence of sexual side effects with SSRIs.
• If at all possible, I do not use SSRIs in sexually active older men (ask about intimacy).
• Bupropion (risk of increasing anxiety) and mirtazapine (risk of sedation) have no sexual side effects.
TREATMENT – WHAT IS DIFFERENT IN THE OLDER PATIENT – 2

• Higher risk of **QT prolongation** – do not use citalopram, use escitalopram.

• Higher risk of **hyponatremia** – always check **blood electrolytes** (ideally before treatment and every 6 months).

• Consider **lower starting doses and slower dose increases** (weigh this advice by age, general frailty, and severity of psychiatric symptoms).
TREATMENT – WHAT IS DIFFERENT IN THE OLDER PATIENT – 3

• Higher risk of sedation and falls: use benzodiazepines and low-potency antipsychotics with caution.

• But: do not be afraid to use both, as clinically warranted.
BEHAVIORAL TREATMENTS IN THE COGNITIVELY COMPROMISED OLDER ADULT

**Depression**

- **Behavioral activation:** regular activities driven by schedule rather than internal mood state, starting with the shortest, least stressful tolerable activity.

- **Scheduled pleasant events:** make an inventory of desired pleasant events, then schedule and realize them with the help of a care partner.

**General**

- **Relieve boredom** (consider Senior Center or Dementia – Friendly activities)

- **Increase exercise**

- **(Consider Mindfulness)**
BEHAVIORAL INTERVENTIONS FOR CARE PARTNERS

• Education about cognitive impairment (realistic expectations, prognosis)
• Teach redirection and distraction – avoid arguing or reasoning
• Referral to community support http://www.alz.org/, http://www.theaftd.org/
• Teach behavioral activation
• Teach scheduled pleasant events
BEHAVIORAL INTERVENTIONS FOR SEVERELY IMPAIRED PATIENTS – THINGS TO TRY

• Companion animal
• Gardening, nature exposure
• Aromatherapy
• Music
• Massage/touch/acupressure
• Bright light
• Dance/exercise

(and others, reviewed in Abraha et al, BMJ Open 2017, 7)

Bottom line:
• Individual studies often show benefit, meta-analyses tend not to.
• Intervention needs to be tailored to the patient’s personality and preferences.
• Nothing works for everybody, but something may work for somebody.
• Give care partners suggestions, and invite them to experiment.
QUESTIONS ?