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Psychiatry and Addictions Case Conference

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GERIATRIC PSYCHIATRY: TREATING DEPRESSION AND ANXIETY

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UW Medicine
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Integrated Care Training Program
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project ECHO

GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

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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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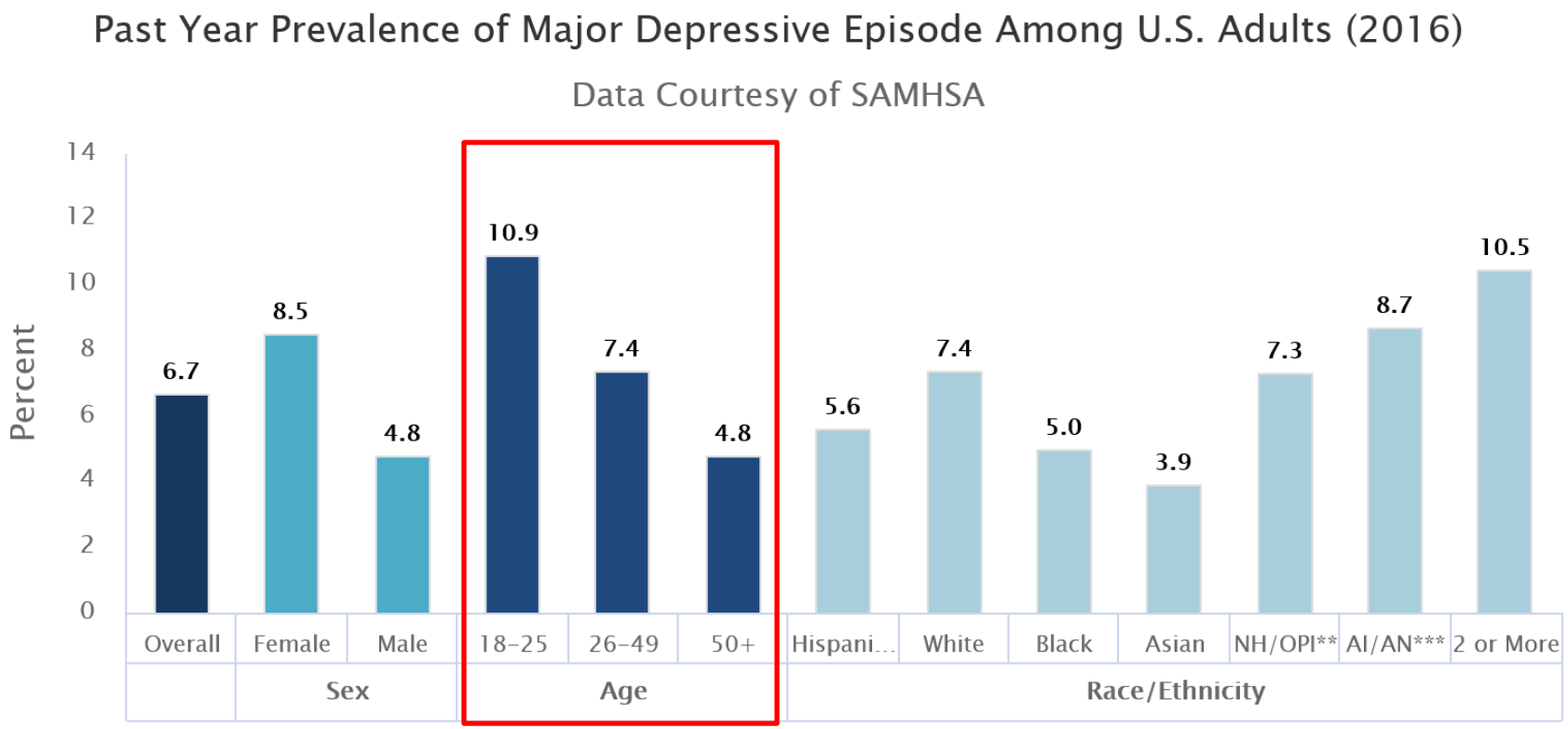
DEPRESSION



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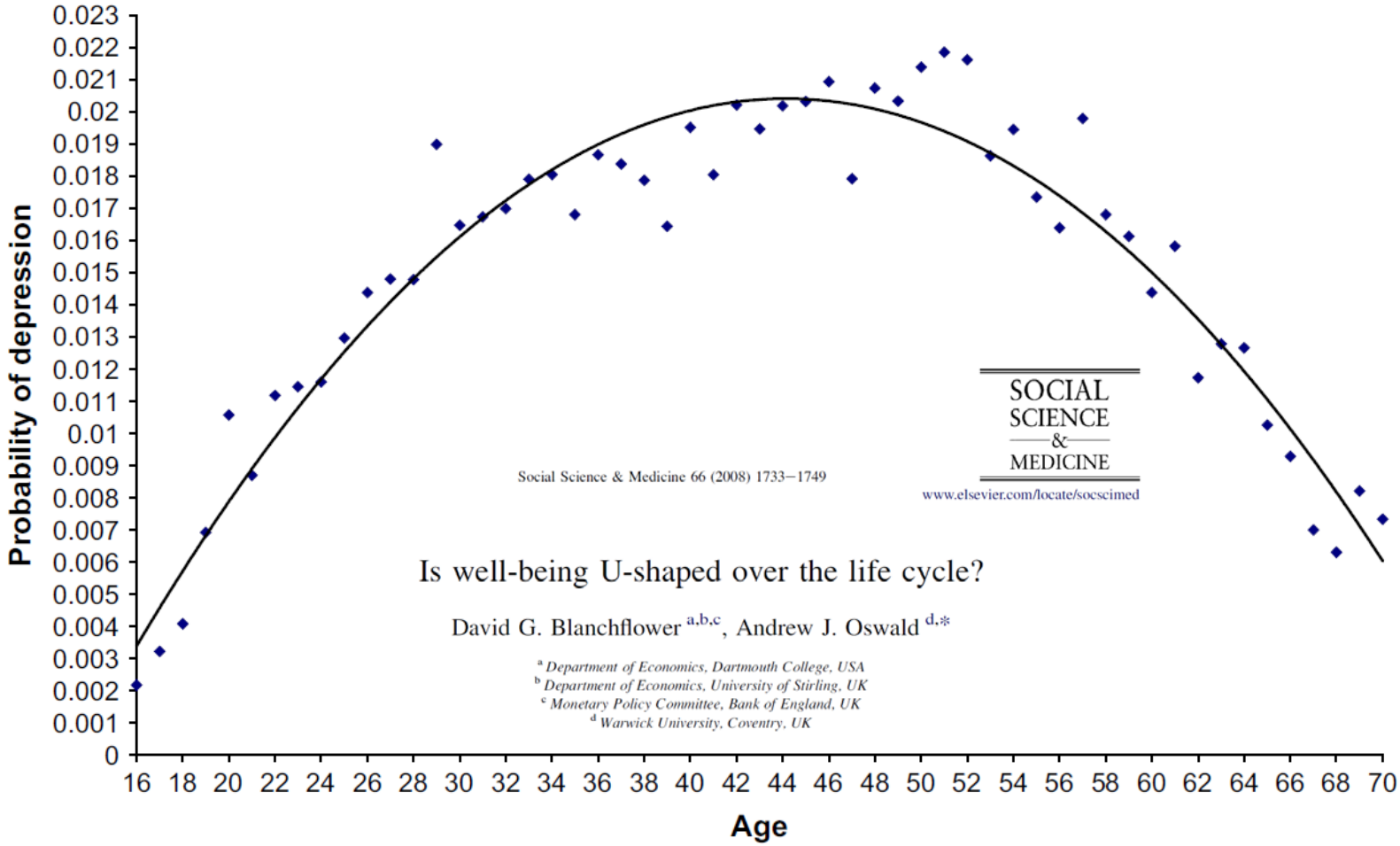
A MORE DETAILED VIEW OF DEPRESSION



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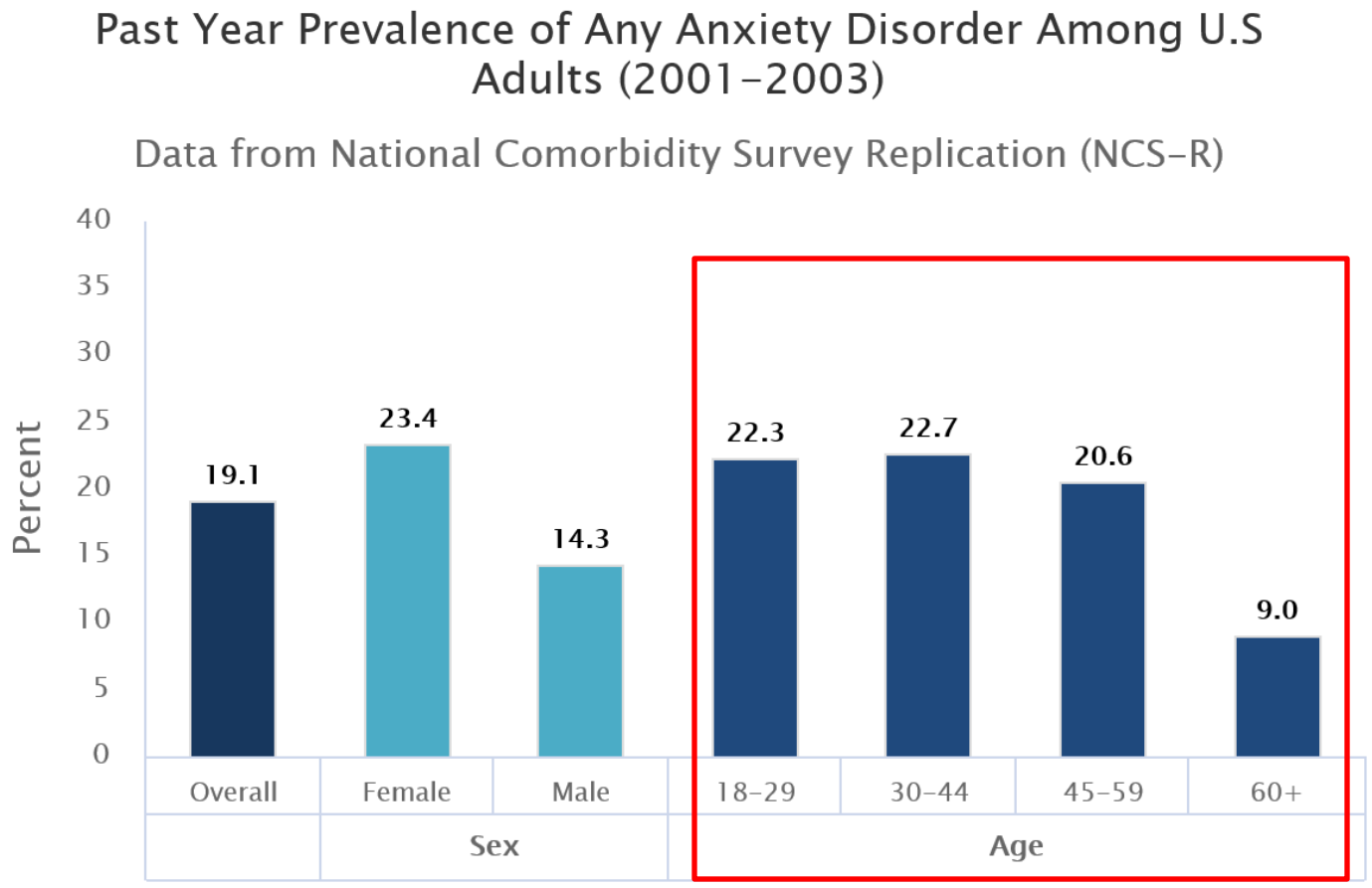
ANXIETY



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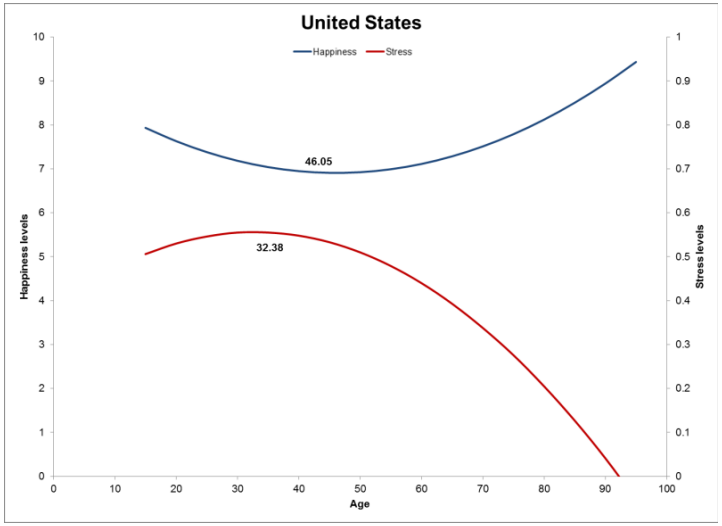
PREVALENCE OF DEPRESSION AND ANXIETY DROPS WITH AGE – WHY ?

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”
-



Happiness, Stress, and Age: How the U-Curve Varies across People and Places. Carol Graham and Julia Ruiz Pozuelo. Journal of Population Economics, 30th Anniversary Issue,August 2016

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RISK FACTORS IN OLDER ADULTS

- (Loneliness)
- (Disability)
- (Medical Problems)
- Comorbidity associated with neurocognitive disorders or changing cognition in older age

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WHAT IS NORMAL AGING?

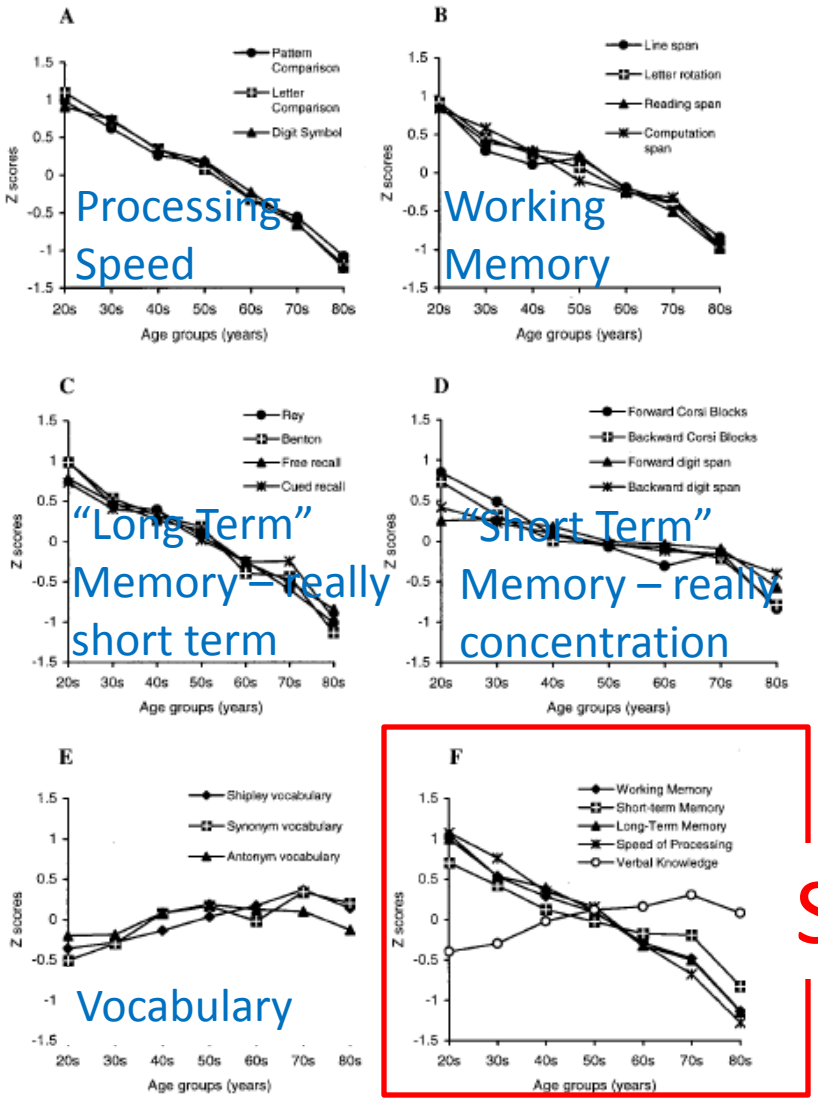

Figure 1. Life span performance measures. A: Speed of processing measures. B: Working memory measures (visuospatial and verbal). C: Long-term memory measures (visuospatial and verbal). D: Short-term memory measures (visuospatial and verbal). E: Knowledge-based verbal ability measures. F: A composite view of the aforementioned measures. Composite scores for each construct represent the *z* score of the average of all measures for that construct.

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

Summary

Models of Visuospatial and Verbal Memory Across the Adult Life Span, Park et al., Psychology and Aging 2002, Vol. 17, No. 2, 299–320

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).

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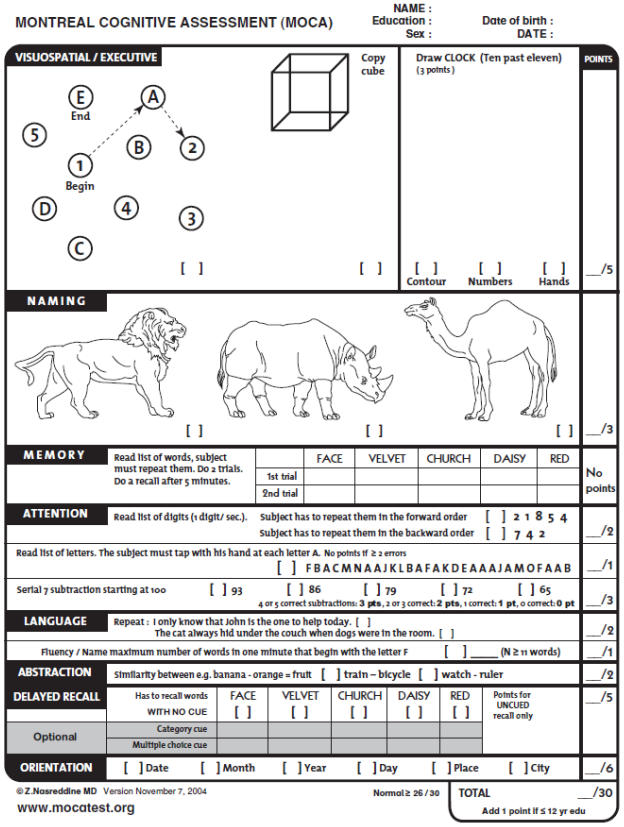
THE COMPLEX RELATIONSHIP BETWEEN AGING, COGNITIVE CHANCE, DEPRESSION AND ANXIETY - 2

- 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".


MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — POINTS

Copy cube

Draw CLOCK (Ten past eleven) (3 points)

End, Begin, A, B, C, D, E, 1, 2, 3, 4, 5

[ ] [ ] [ ] Contour [ ] Numbers [ ] Hands __/5

NAMING

[ ] [ ] [ ] __/3

MEMORY — Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION — Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 2 1 8 5 4. Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt __/3

LANGUAGE — Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words) __/1

ABSTRACTION — Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

DELAYED RECALL

	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
Has to recall words WITH NO CUE	[ ]	[ ]	[ ]	[ ]	[ ]	
Optional: Category cue						
Optional: Multiple choice cue						

__/5

ORIENTATION — [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

©Z.Nasreddine MD Version November 7, 2004
www.mocatest.org

Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yr edu

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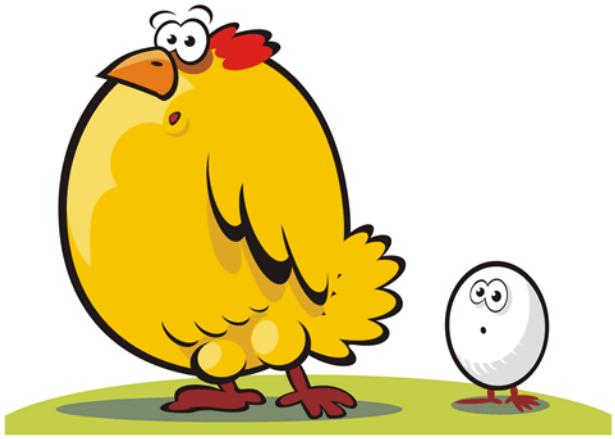
COGNITIVE DECLINE AND DEPRESSION



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

- Primary depression in an older person can present with cognitive symptoms (*weaker connection*)

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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 most 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

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COGNITIVE DECLINE AND DEPRESSION PERSPECTIVE OF FAMILIES AND CARE PARTNERS

- Apathy (most frequent NPS in AD) is often mistook 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.

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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)**

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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

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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.

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QUESTIONS ?

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