UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

GEROPSYCHIATRY UPDATE

RUTH KOHEN, MD
UNIVERSITY OF WASHINGTON

4/16/2020

UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

UW PACC

GENERAL DISCLOSURES

UW PACC is also supported by Coordinated Care of Washington

SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

UW PACC

SPEAKER DISCLOSURES

✓ No conflicts of interest

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose:

Mark Duncan MD
Barb McCann PhD
Anna Ratzliff MD PhD
Rick Ries MD
Kari Stephens PhD
Cameron Casey
Betsy Payn
Diana Roll
Cara Towle MSN RN
Niambi Kanye

UW PACC

UW PACC REGISTRATION

Please be sure that you have completed the full UW PACC series registration.

If you have not yet registered, please email uwpacc@uw.edu so we can send you a link.

UW PACC

OBJECTIVES

1. Discuss the presentation of depression and anxiety in older patients
2. Review cognitive screening
3. Discuss how treatment approaches differ in the older patient compared to younger clients

UW PACC

BUT FIRST…A WARNING

- This is not a geropsychiatry update as much as a review.
- There have been sadly very few developments in geropsychiatry.
- Trials of new anti-dementia drugs have universally failed despite initial promise and occasional hand-waving from the pharmaceutical companies sponsoring them.

Madeline Ashton:
Bottoms up!

Lisle Von Rhoman:
But first, a warning!

Madeline Ashton:
NOW a warning?

From the 1992 black comedy "Death Becomes Her"

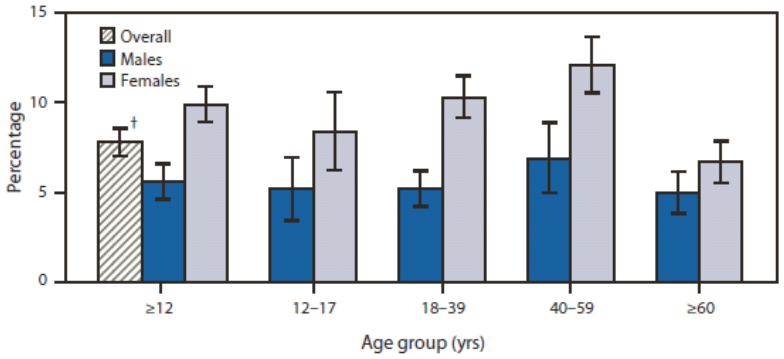
UW PACC

PATIENT WITH DEPRESSION OR ANXIETY IN MY OFFICE

- Does my approach to the patient change if (s)he is 75 rather than 35 years old?
- Yes, because new onset depression or anxiety in an older patient can be a warning sign of dementia – details coming up

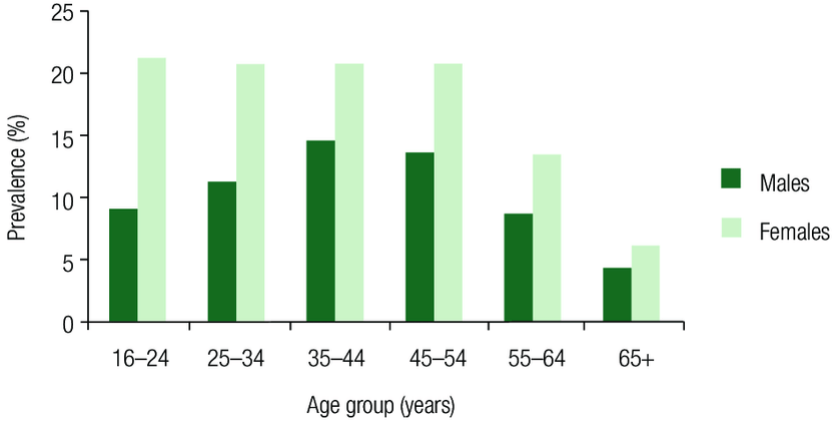
DEPRESSION AND ANXIETY OVER THE LIFE SPAN

Depression

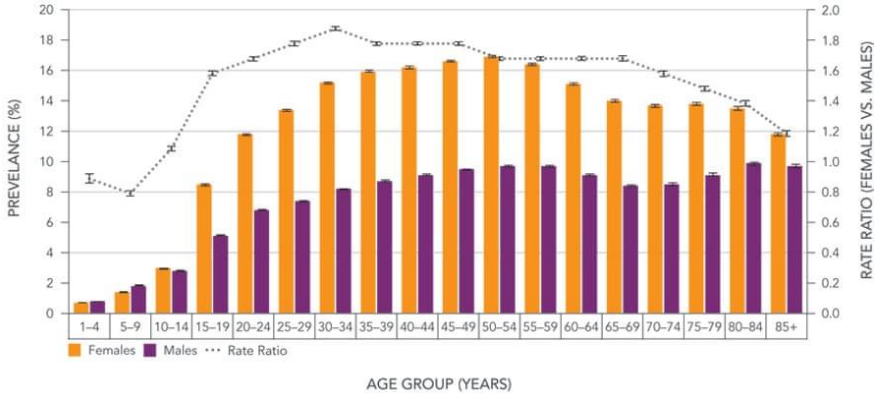


Source: cdc.gov

Anxiety



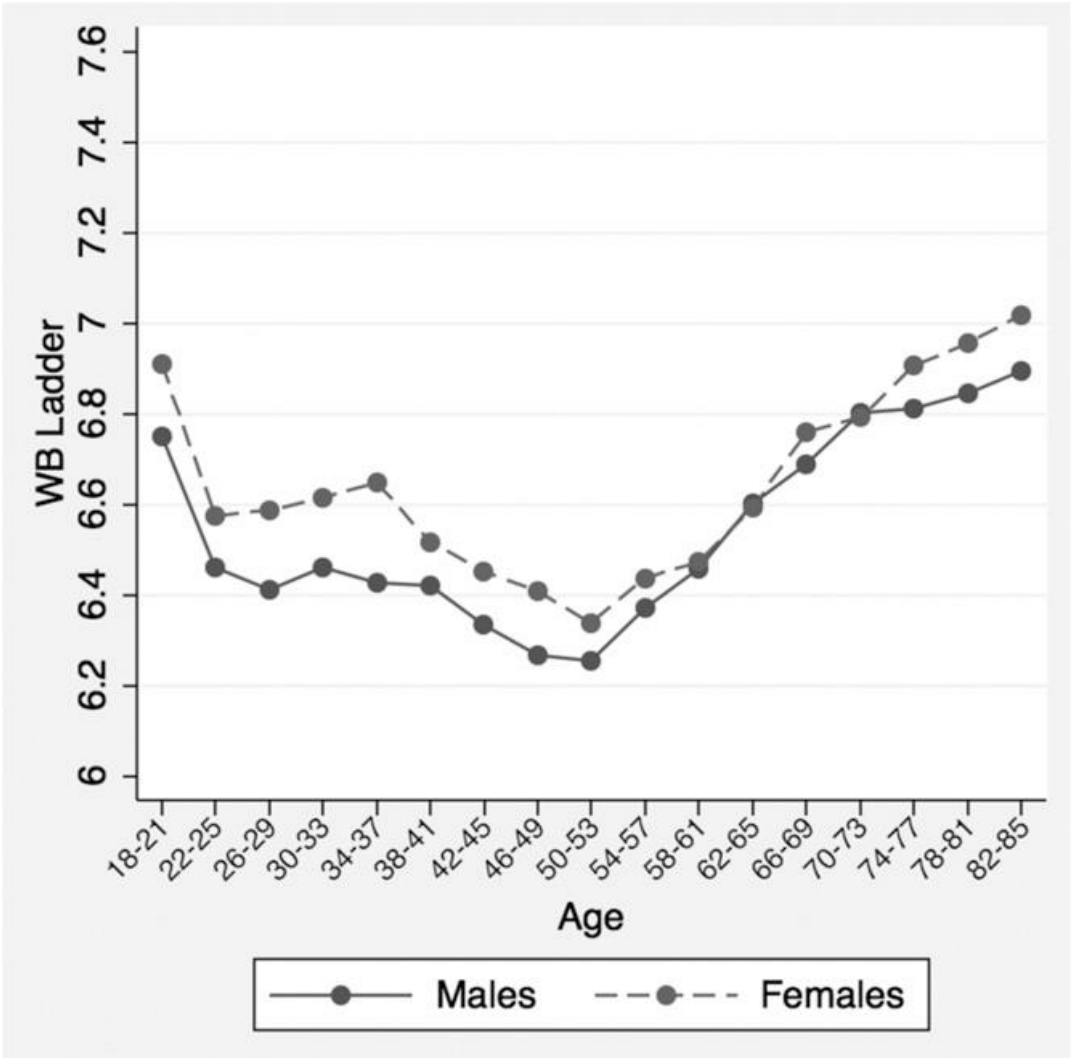
Slade, Timothy & Johnston, Amy & Teesson, Maree & Whiteford, Harvey & Burgess, Philip & Pirkis, J. & Saw, S.. (2009). The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing.



Age-specific annual prevalence (%) and rate ratios of the use of health services for mood and anxiety disorders among people aged one year and older, by sex, Canada, 2009-2010, source: The Guardian Online

UW PACC

Why are older patients less depressed and anxious?
What does this mean?



SUBJECTIVE WELL-BEING: THE FLIP SIDE TO DEPRESSION AND ANXIETY

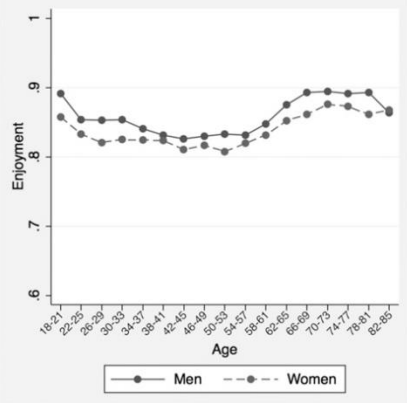
Source: Stone et al, PNAS 2010, 9985-9990

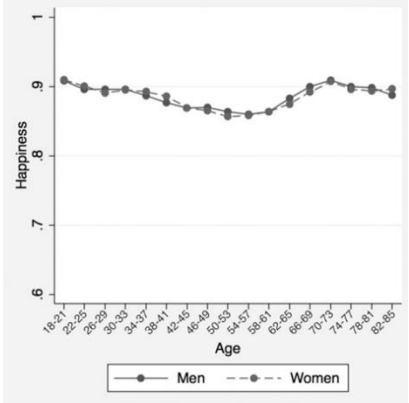
Telephone survey of **340,847 people living in the US**

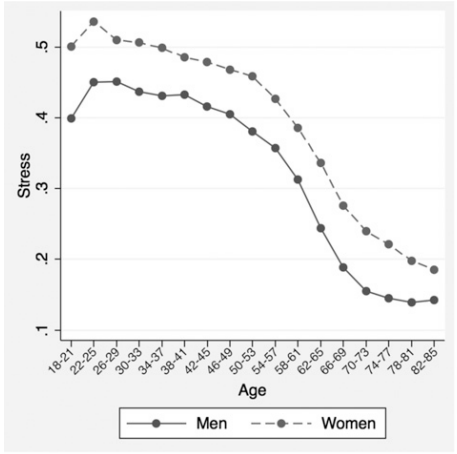
The Global WB question was as follows: "Please imagine a ladder with steps numbered from 0 at the bottom to 10 at the top. The top of the ladder represents the best possible life for you, and the bottom of the ladder represents the worst possible life for you. On which step of the ladder would you say you personally feel you stand at this time?"

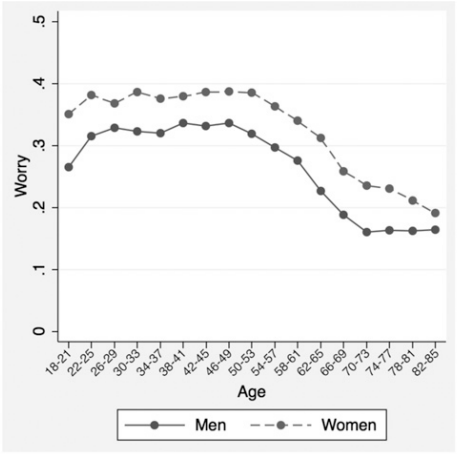
UW PACC

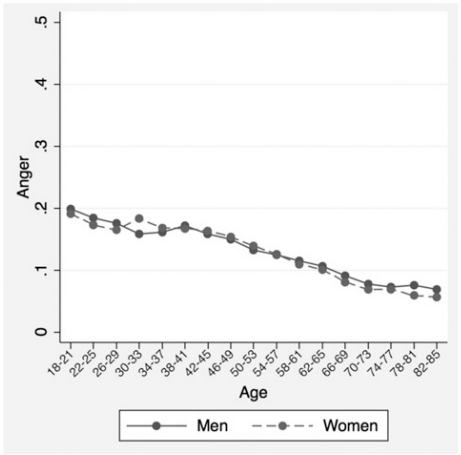
AFFECT IMPROVES OVER THE LIFE SPAN

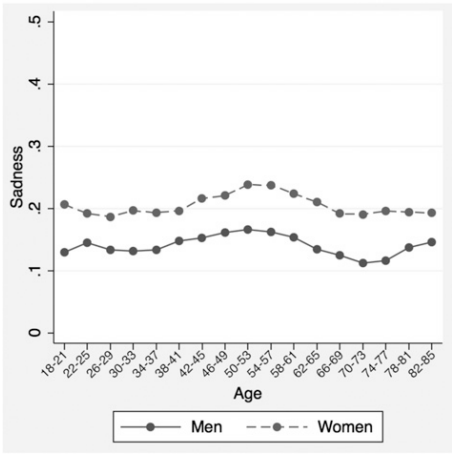












Affect questions had “No/Yes” response options and were worded as follows: “Did you experience the following feelings during A LOT OF THE DAY yesterday? How about _____?” where each affect (positive affect adjectives: Enjoyment, Happiness; negative affect adjectives: Stress, Worry, Anger, Sadness) was answered separately.

UW PACC

WHY?

Possible explanations for improved affect in the elderly:

- Cohort phenomenon: older folks are made of sterner stuff.
- With increased wisdom comes greater happiness.

Counter-arguments:

- The same U-shaped happiness curve has been seen across different cultures.
- Apes have the same U-shaped curve.

Probable reason that explains the concordance between man and apes: Survivor bias - unhappiness leads to self-destructive behavior or is bad for body and brain in other ways.

Evidence for a midlife crisis in great apes consistent with the U-shape in human well-being. Alexander Weiss, James E. King, Miho Inoue-Murayama, Tetsuro Matsuzawa, and Andrew J. Oswald. PNAS December 4, 2012 109 (49) 19949-19952

DEPRESSION & ANXIETY

- Depression and anxiety are less common in patients over 60 years than in younger patients.

- This is accompanied by greater feelings of subjective well-being, enjoyment, and happiness along with less intense or frequent feelings of stress, worry, anger, or sadness.

- The most likely explanation for this is survivor bias.

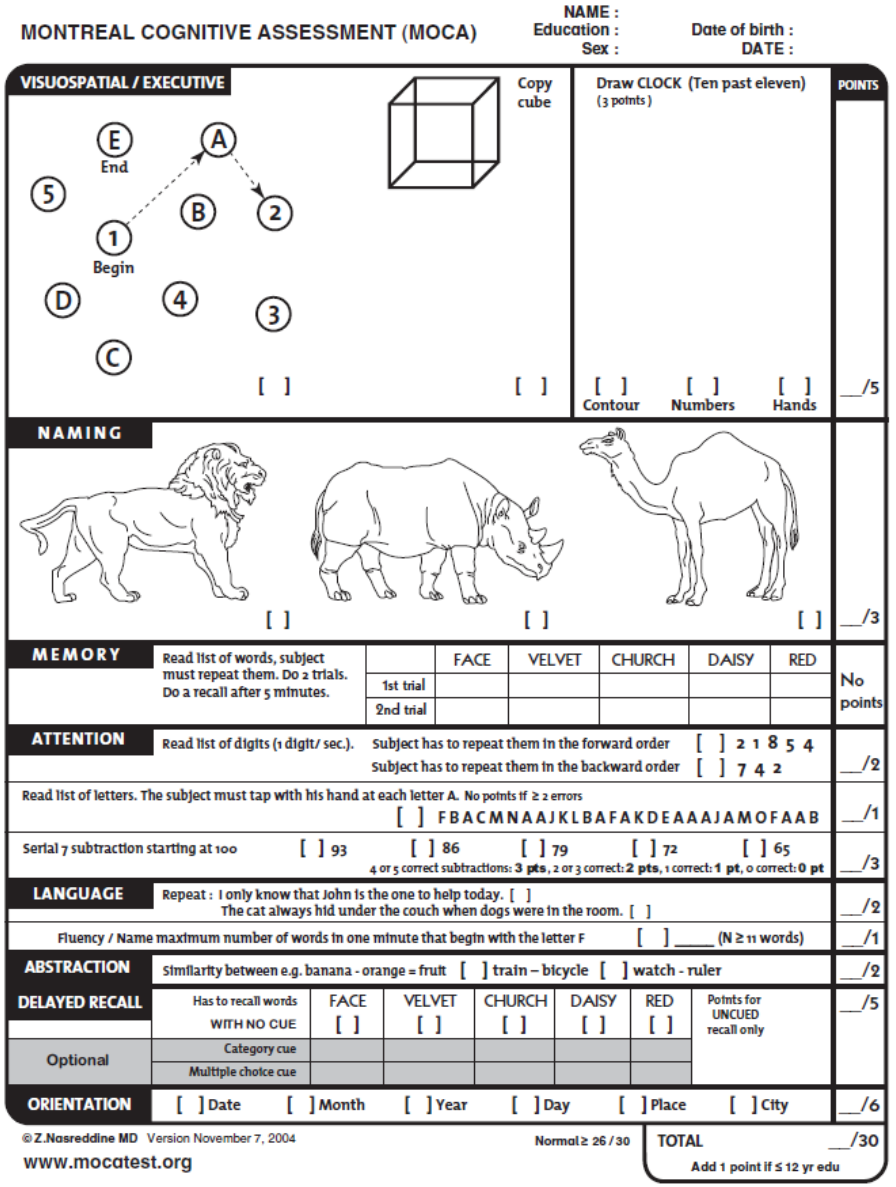
UW PACC

HOW OLDER PATIENTS DIFFER

- Depression or anxiety are potentially driven by neurodegenerative changes that eventually manifest as dementia (up to 5 years ahead of time).
- Hence any new presentation of depression or anxiety in an older patient should prompt cognitive screening.

MOCA

- Takes about 20 minutes to administer
- Gives you about 2/3 of the information you would get from a full 4-hour neuropsychological test battery



MONTREAL COGNITIVE ASSESSMENT (MOCA)

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

VISUOSPATIAL / EXECUTIVE — Copy cube — Draw CLOCK (Ten past eleven) (3 points) — POINTS

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

[ ] [ ] [ ] 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

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

UW PACC

Mini-Cog™

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: ____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

MINI-COG:

Developed for cognitive screening in primary care, i.e. for busy PCPs.

1 – I would like you to remember three words for me: (village, kitchen, baby). Could you please repeat these words for me now? (let's try again) Please remember those words, I am going to ask you again later.

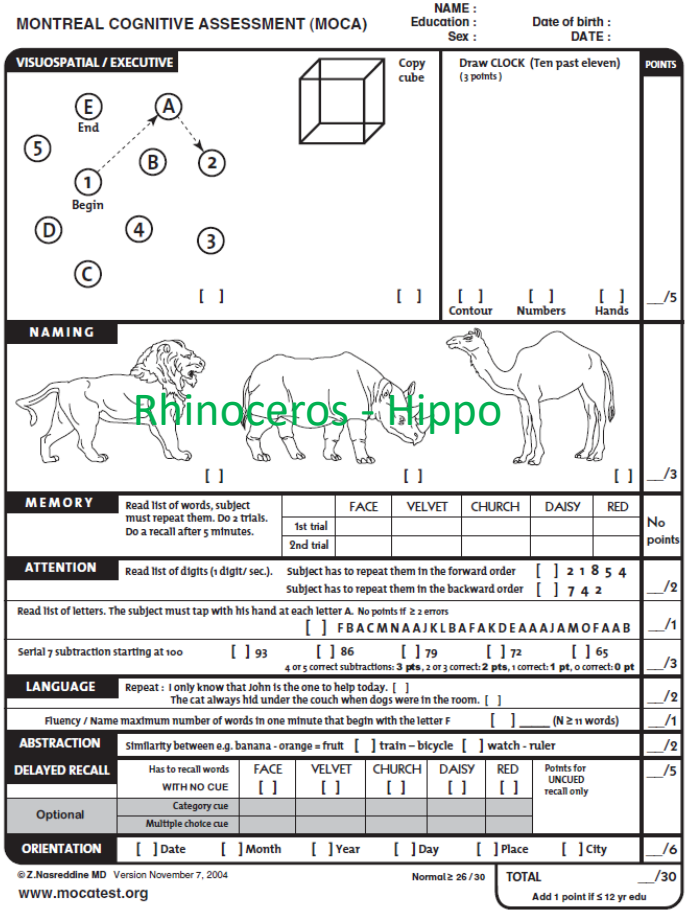
2 – Could you please draw a clock face for me? (draw the face, and all the numbers) Please have the hands show ten past 11 (make sure your patient has reading glasses).

3 – Can you tell me which three words I asked you to remember earlier? (give first category cues, then multiple choice cues if your patient struggles)

UW PACC

MOCA ADDITIONAL INFORMATION OVER MINI-COG

- Trails and cube in addition to clock – trails is more sensitive to executive dysfunction than clock drawing
- More extensive memory testing (5 words)
- Language testing
- **Less useful:** attention (not sensitive enough), abstraction (no specific clinical correlation)



COGNITIVE IMPAIRMENT IS CLASSIFIED IN 2 DIMENSIONS:

Severity

- Mild neurocognitive disorder = mild cognitive impairment (MCI): modest cognitive decline with does not interfere with capacity for independence
- Major neurocognitive disorder = dementia: cognitive decline interferes with independence

Cause

- A specific neurodegenerative process that causes that causes the mild or major neurocognitive disorders.
- Example: *MCI due to Alzheimer's disease* – i.e. Alzheimer's disease and dementia are not synonymous.

ALZHEIMER'S DISEASE – MOST COMMON

(1/3 OF PEOPLE OVER AGE 85)

Key presenting symptoms

- Strongly reduced ability to make new memories, leading to:
  1. Repeated identical questions
  2. Re-telling the same story multiple times
- Word finding difficulties
- Giving up prior activities (socializing, reading, house work, computer)

…often misdiagnosed as:

- **Depression**

Family members wonder about depression as the cause of social withdrawal or reduced engagement in activities.

- **Inattention**

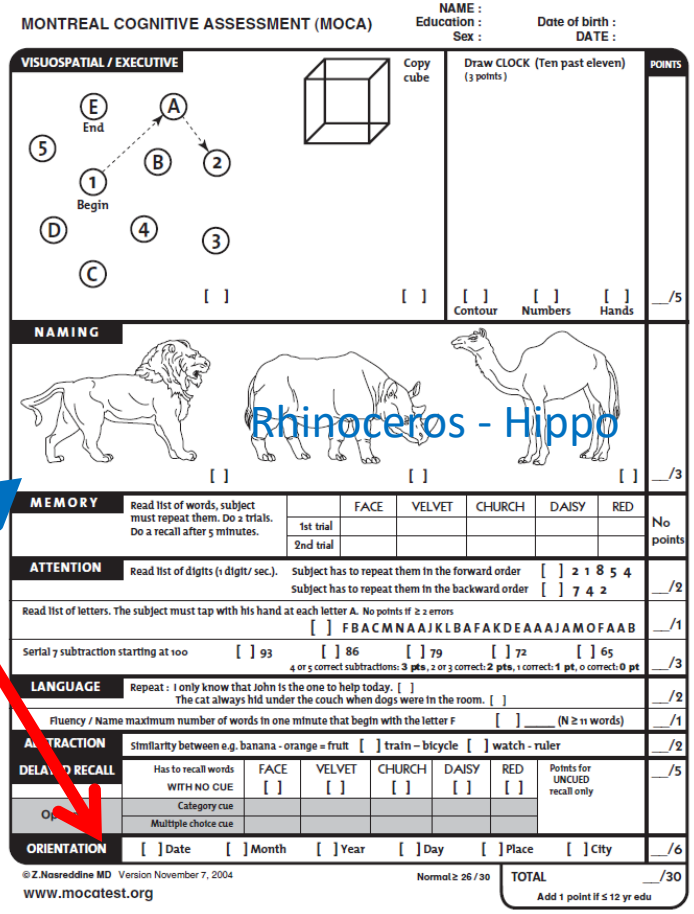
Spouses complain about their husband/wife not listening to them.

ALZHEIMER'S DISEASE

Key presenting symptoms

- Strongly reduced ability to make new memories, leading to:
  1. Repeated identical questions
  2. Re-telling the same story multiple times
- Word finding difficulties
- Giving up prior activities (socializing, reading, house work, computer)

Typical MOCA pattern

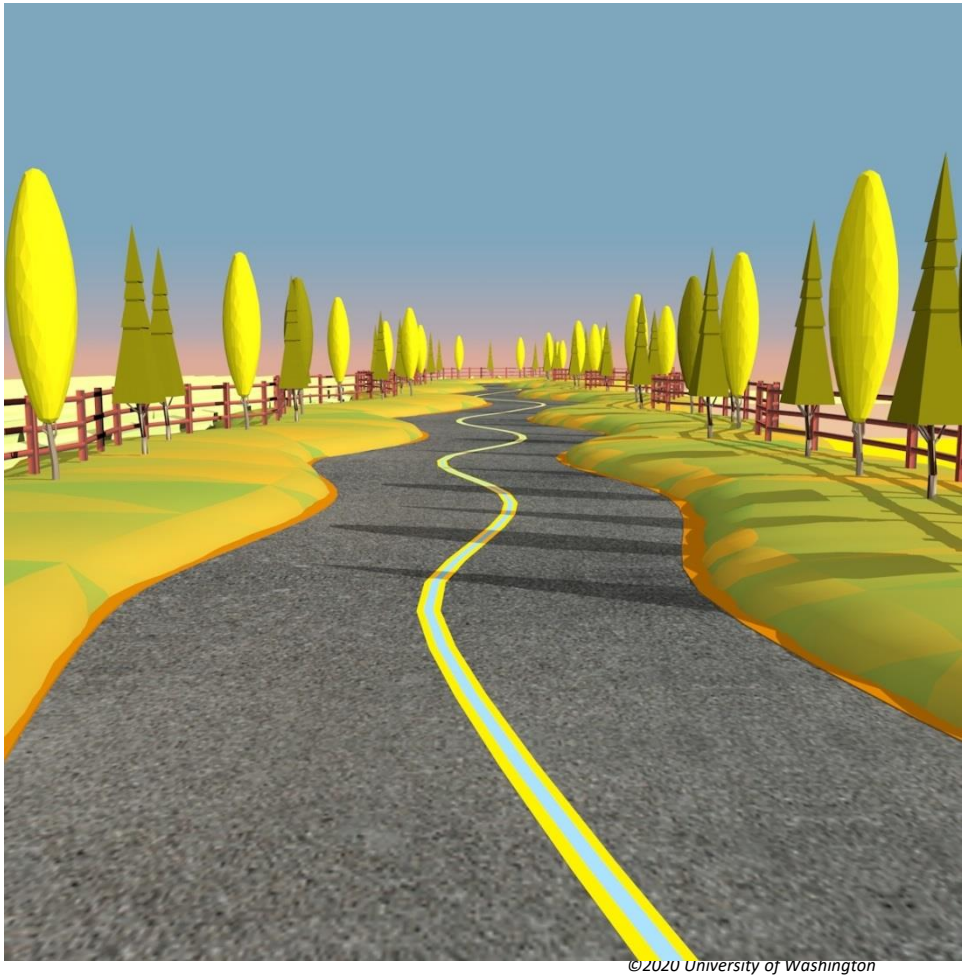


THE INTERPLAY BETWEEN COGNITIVE CHANGE AND DEPRESSION

- Age-related cognitive change reduces cognitive reserve, hence older adults may have higher vulnerability to the cognitive impairment associated with depression. This may lead to what textbooks have described as depressive "pseudodementia"…
- BUT: *unless the patient is catatonically depressed*, depression alone accounts for *no more than ~4 points loss on the MOCA*.
- The cognitive impact of depression or anxiety typically manifests as **"scattered deficits"** on an almost normal MOCA (or on neuropsychological testing).
- **Cognitive chance is a potent driver of depression** through a) neuropathological changes, b) perception of deficits, and c) reduction in activity level due to cognitive difficulties.

UW PACC

RULES FOR THE ROAD IN THE ASSESSMENT AND TREATMENT OF OLDER PATIENTS PRESENTING WITH PSYCHIATRIC SYMPTOMS



#1: CONSIDER COGNITIVE DIVERSITY

- Cognitive change is a lifelong process that leaves your older clients vulnerable to the cognitive effects of medications, medical illness, and psychiatric conditions like ADHD.
- Patients with low average cognitive function to start with may do poorly in old age, even in the absence of dementia.
- Have a low threshold for cognitive screening (MOCA).

WHAT IS NORMAL AGING?

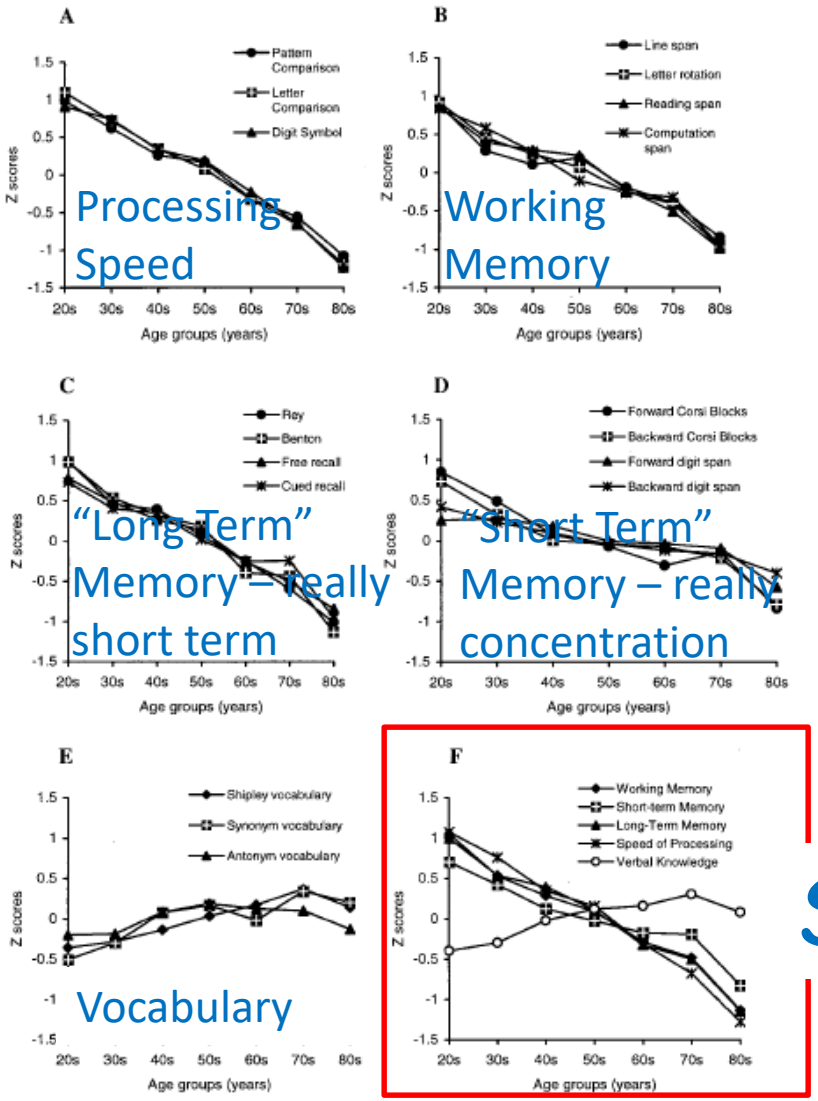


Figure 1. Life span performance measures. A: Speed of processing measures. B: Working memory measures (visuospatial and verbal). C: Long-term memory measures (visuospatial and verbal). D: Short-term memory measures (visuospatial and verbal). E: Knowledge-based verbal ability measures. F: A composite 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

#2: DEMENTIA AND PSYCHIATRIC SYMPTOMS TRAVEL TOGETHER

- Psychiatric symptoms can be an early marker for a neurodegenerative disorder. Nonetheless, they need to be treated just like primary psychiatric symptoms.
- From a psychosocial perspective, cognitive impairment is a potent driver of depression and anxiety through inactivity, boredom, and perceptions of loss.

#3: COGNITIVE CHANGE IS OFTEN MISDIAGNOSED AS DEPRESSION

- Apathy, giving up things that have become too cognitively challenging, taking less part in conversation due to difficulties with memory and language are often interpreted as depression by care givers and some health care providers.
- Avoid over-diagnosing symptoms of neurocognitive disorder as depression.

#4: MEDICATIONS NEED TO BE ADJUSTED TO FIT THE ELDERLY

- SSRIs tend to destroy sexual function in older men (less so in older women).
- Check labs for hyponatremia every 6 months.
- Use lower doses.
- Use all psychotropic medications in the elderly with great caution. Monitor for falls.

#5: TREAT THE SYSTEM

- In older patient with cognitive impairment, your "client" tends to be not only the patient, but also her support system: spouse, children, formal care givers.
- Do family sessions.
- Call the assisted living facility.
- Educate care partners.