BEYOND DEMENTIA: WHAT EVERYONE SHOULD KNOW ABOUT MENTAL HEALTH IN THE ELDERLY:

Beyond Managing “Behavior”…
Delivering Accurate & Effective Mental Healthcare

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OLD AGE: COMING AT YOU!!

WORLDWIDE STATISTICS:

• Number of people $\geq 60$ doubled since 1980
• Number of people $\geq 80$ will $\uparrow 4x$ to 395 million by 2050
• Within the next five years, adults $\geq 65$ will outnumber children $< age 5$
• By 2050, elderly will outnumber all children $< age 14$

www.who.int/world-health-day/2012/toolkit/background/en/index.html
COMPONENTS OF MENTAL HEALTH

• BIOLOGICAL PIECE
  - GENES
  - DISORDERS OF BRAIN CHEMISTRY IMBALANCE
  - EFFECTS OF MEDICAL ILLNESSES
  - EFFECTS OF MEDICATIONS (PRESCRIBED & NOT)
  - EFFECTS OF SUBSTANCE USE / ABUSE

• PSYCHOLOGICAL PIECE
  - PERSONALITY STYLE
  - THINKING STYLE
  - LEARNED BEHAVIOR

• SOCIAL PIECE
  - FAMILY & COMMUNITY STRUCTURE & SUPPORTS
BIOLOGICAL CHANGES AS PEOPLE AGE

- More chronic medical illness – more doctors involved & (+/-) needing to communicate
- More prescribed & OTC medications & “supplements”
- More mental vulnerability to acute medical illness
- Often decreased nutrition / absorption
- Decreased clearing of all substances
- More mental vulnerability to all drugs: medications, OTC, ETOH, THC, etc.
- Decreased acuity of senses
- Often a decrease in mobility
Estimated Prevalence of Major Psychiatric Disorders in Younger vs. Older Americans from 1970-2030

Jeste. 1999
Adverse Drug Reactions (ADRs) as a Function of Increasing Age

PSYCHOSOCIAL CHANGE AS PEOPLE AGE

- FOR SOME: AN INCREASE IN QOL!
- OFTEN LOSS OF SPOUSE
- OFTEN SUPPORTS: CHILDREN, FRIENDS, ETC. ARE LESS AVAILABLE
- OFTEN LOSS OF WORK LIFE
- CAN RESULT IN:
  - DECREASED SOCIALIZATION / INTERACTIONS
  - DECREASED OBSERVATION
  - ABSENCE OF A SOCIAL RHYTHM
  - LONELINESS
IS THE PATIENT’S BEHAVIOR:

• DUE TO A PERSON HAVING *DIMINISHED COGNITIVE FUNCTION* REVERSIBLE / NONREVERSIBLE

• DUE SOLELY TO THE EFFECTS OF A MENTAL HEALTH DISORDER

• DUE TO DIFFICULTIES IN COPING – – PSYCHOLOGICALLY ORSOCIALY

• DUE TO BOTH OF THE ABOVE
WHAT DO WE MEAN BY COGNITIVE DYSFUNCTION?

- DECREASED ALERTNESS
- DECREASED CONCENTRATION
- TASK CONFUSION
- DECREASED MEMORY
- ORIENTATION – PERSON/PLACE/TIME
CAUSES OF DECREASED COGNITION:

- INADEQUATE SLEEP
- “ENERGY” DRINKS
- OTC MEDICATIONS
- NUTRITIONAL “SUPPLEMENTS”
- ALCOHOL / STREET DRUG USE
- MEDICAL ILLNESS
- PRESCRIBED MEDICAL / PSYCHIATRIC MEDS
- DRUG – DRUG INTERACTIONS
- DRUG – SUBSTANCE INTERACTIONS
- MENTAL ILLNESS
- DEMENTIAS
EXAMPLES OF MEDICAL CAUSES OF CONFUSION

- HYPOTHYROIDISM
- SLEEP APNEA
- DECREASED CARDIAC OUTPUT
- TIA
- HYPER / HYPOGLYCEMIA
- MIGRAINE
- MANY, MANY OTHERS
A QUICK WORD ON DEMENTIAS

• PSEUDO-DEMENTIA

• PRE-SENILE DEMENTIA

• MULTI-INFARCT DEMENTIA

• SENILE DEMENTIA, ALZHEIMERS TYPE
CURRENT FACTS ON MENTAL HEALTHCARE

• 1 OUT OF 3 PEOPLE WILL HAVE SOME FORM OF CHEMICAL IMBALANCE AT SOME POINT IN THEIR LIVES…
• ONLY 50% WILL SEEK PROFESSIONAL HELP
• ONLY 50% OF THOSE WHO SEEK HELP WILL RECEIVE ACCURATE DIAGNOSIS & EFFECTIVE TREATMENT
• THEREFORE, ONLY 25% OF THOSE SUFFERING FROM A CHEMICAL IMBALANCE WILL GET APPROPRIATE CARE…
THE DIFFERENCE BETWEEN INTELLIGENCE & WISDOM

INTELLIGENCE IS KNOWING THAT 50% OF ALL YOU READ AND HEAR IS GARBAGE;

WISDOM IS KNOWING WHICH 50%

ANONYMOUS
A POLITICALLY INCORRECT ASSESSMENT OF MENTAL HEALTHCARE IN THE U.S. IN 2016

• A VERY SMALL MINORITY OF PSYCHIATRISTS ARE SKILLED IN THE DIAGNOSIS AND TREATMENT OF MOOD DISORDERS ESPECIALLY IN THE ELDERLY

• APPROXIMATELY 80% OF PSYCHIATRIC MEDICATION PRESCRIBED TO ADULTS ARE PRESCRIBED BY PRIMARY CARE DOCTORS (NON-PSYCHIATRISTS)

• PSYCHOLOGISTS & SOCIAL WORKERS CAN ALSO “PARTicipate” IN MIS-MEDICATION

• “HOUSTON, WE HAVE A PROBLEM…”
IMPACT ON PEOPLE WHO HAVE AN UNTREATED CHEMICAL IMBALANCE

- LESS THAN OPTIMAL FUNCTION: DECREASED QUALITY OF LIFE
- TROUBLED RELATIONSHIPS WITH FAMILY / CAREGIVERS
- SELF-MEDICATION WITH SUBSTANCES – ALCOHOL, “POT”, ETC
- INCREASED RISK OF IMPULSIVE ACTIONS: SUICIDE, ETC
- THERAPY DOESN’T HELP MUCH IF A PERSON HAS A CHEMICAL IMBALANCE
MISDIAGNOSIS RATES IN CLASSIC BIPOLAR DISORDER

69% OF BIPOLAR PATIENTS INITIALLY MISDIAGNOSED (73% IN 1992) HIRSCHFELD DATA (2003)

31% WAITED ≥ 10 YEARS FOR FIRST ACCURATE DIAGNOSIS HIRSCHFELD DATA (2003)

• MOST FREQUENT ADULT MISDIAGNOSIS IS DEPRESSION

SWISS STUDY: 50% DIAGNOSED WITH DEPRESSION REDIAGNOSED WITH BIPOLAR DISORDER TEN YEARS LATER

• MOST FREQUENT IN CHILDREN IS USUALLY ADD OR ADHD
CLASSIC BIPOLAR DISORDER vs. BIPOLAR SPECTRUM DISORDER

- LIFETIME PREVALENCE OF “CLASSIC” BIPOLAR DISORDER = 2%
- LIFETIME PREVALENCE OF BIPOLAR SPECTRUM DISORDER = 10-12%

Benazzi, Akiskal, Hirschfield, etc.
The Bipolar Iceberg

The rare kids who meet full diagnostic criteria for either bipolar I or bipolar II are "just the tip of the iceberg" according to some researchers.

- Kids that meet bipolar I or II criteria
- Kids labeled bipolar but actually subsyndromal or prodromal
- Kids at high risk, with "cycloptaxia"

Adapted from Youngstrom, AACAP, Toronto 2005
WHAT MAKES A MOOD SYMPTOM BE PATHOLOGICAL

EITHER:

SYMPTOM / MOOD *OUT OF CONTEXT*

OR:

SYMPTOM / MOOD *IN CONTEXT, BUT OUT OF PROPORTION*
PURE DEPRESSIVE SPECTRUM

• **A STATE OF DECREASED DRIVE OR ENERGY**

• INCREASED NEED FOR SLEEP
• MOVING LIKE IN SLOW MOTION
• DEPRESSED MOOD / DECREASED SMILING / INCREASED CRYING
• DECREASED ENERGY / INTERESTS / ENJOYMENT OF PREVIOUSLY ENJOYED ACTIVITIES
• HELPLESSNESS / HOPELESSNESS
• SLOWED THINKING / SPEECH

• **DECREASE** IN REACTIVITY TO STRESSORS
NORMAL

VS.

ANTI-DEPRESSANTS

PROZAC, FOR EXAMPLE

PURE DEPRESSIVE SPECTRUM

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PURE MANIC SPECTRUM OFTEN MISDIAGNOSED AS ANXIETY DISORDER, PANIC DISORDER, “PMS”, OCD, ADD, ADHD OR AS A PRIMARY SUBSTANCE ABUSE PROBLEM

- A STATE OF INCREASED / AMPLIFIED DRIVE OR ENERGY

- DECREASED ABILITY TO FALL ASLEEP OR STAY ASLEEP
- IMPULSIVE / HYPERACTIVITY
- AMPLIFIED IRRITATION (IRRITABILITY),
- MOOD LABILITY – WIDER RANGE / QUICKER SHIFTS OF MOOD
- RACING OR FAST THOUGHTS / JUMPING TOPICS / CLUTTERED THOUGHTS
- OBSESSIVE THOUGHTS / COMPULSIVE BEHAVIORS
- PRESSURED SPEECH – INCREASED RATE, VOLUME, QUANTITY OR FREQUENCY OF SPEECH
- AMPLIFIED ANXIETY / WORRY / PANIC / EXCITABILITY
- AMPLIFIED SMILING / LAUGHTER
- AMPLIFIED TEASING, AMPLIFIED SEXUALITY, OTHER AMPLIFIED STATES

- INCREASE IN REACTIVITY TO STRESSORS

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NORMAL

VS.

PURE MANIC SPECTRUM

MOOD STABILIZERS
LITHIUM,
FOR EXAMPLE

NORMAL
PURE MANIC SPECTRUM

OFTEN MISDIAGNOSED AS:

ANXIETY DISORDER
PANIC DISORDER
“PMS”
PTSD
OCD
ADD / ADHD
PRIMARY SUBSTANCE ABUSE PROBLEM
TREATMENT OF MIXED STATE BIPOLAR SPECTRUM DISORDERS

NORMAL

VS. OR OR

MOOD STABILIZERS

NORMAL

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MISTREATMENT OF MIXED STATE BIPOLAR SPECTRUM DISORDERS
Older –age BD (OABD) Occurs in Varying Circumstances

- Those who have been ill for many years—“early onset”
- Onset later in life (esp after age 50)
- Illness associated w/ medical conditions (secondary mania).
- Newly diagnosed individuals with a mood disorder history
- As in younger patients, geriatric BD is often mis/under-diagnosed and is complicated by comorbidity

Increased Cycle Frequency with Duration of Bipolar Disorder

Adapted from Post, 1984.
APPROPRIATE PSYCHIATRIC MEDICATION USE

- **NOT** FOR WHEN THERAPY IS “NOT WORKING”

- **NOT** TO HELP PEOPLE “GET THROUGH” THEIR LIFE EXPERIENCE

- SHOULD ONLY BE USED WHEN A SPECIFIC DISORDER, *HOWEVER SUBTLE*, IS PRESENT

- IF A SPECIFIC DISORDER IS PRESENT, EFFECTIVE PHARMACOLOGY IS CRITICAL

- “MEDICATION MANAGEMENT” IS NOT TREATMENT
CLASSES OF MEDICATIONS

- ANTIDEPRESSANTS
- “TRADITIONAL” MOOD STABILIZERS
- 1ST GENERATION ANTIPSYCHOTICS
- 2ND GENERATION ANTIPSYCHOTICS
- PSYCHOSTIMULANTS
- ANTIANXIETY AGENTS
ANTIDEPRESSANTS

- BEST RESERVED FOR PURE DEPRESSIONS
- CAN MAKE BIPOLAR PATIENTS WORSE OR EVEN SUICIDAL OR HOMICIDAL
- OLDER “TRICYCLIC “ MEDICATIONS
  - LIKE ELAVIL, TOFRANIL, PAMELOR
- NEWER “SSRI”s
  - LIKE PROZAC, ZOLOFT, CELEXA, PAXIL, ETC.
- NEWER “SNRI”s
  - LIKE EFFEXOR
MOOD STABILIZERS

• LITHIUM IS STILL THE INDUSTRY STANDARD
• EVEN LITHIUM IS 100% EFFECTIVE < 40% OF THE TIME
• MOST PATIENTS WILL REQUIRE > 1 MEDICATION
• MORE (APPROPRIATE) MEDICATIONS AT LOWER DOSES IS OFTEN BETTER THAN FEWER MEDICATIONS A HIGHER DOSES
• AVERAGE NIMH PATIENT IN 90’S: >3 MEDS
• BLOOD LEVELS ARE CRITICAL W/ SOME MEDS
MOOD STABILIZERS

- LITHIUM
- CARBAMAZEPINE – AKA TEGRETOL, EQUETRO, CARBATROL
- DIVALPROEX SODIUM – AKA DEPAKOTE
- OXCARBAZEPINE – AKA TRILEPTAL
- GABAPENTIN – AKA NEURONTIN
- PREGABALIN - AKA LYRICA
- LEVETIRACETAM – AKA KEPPRA
- TOPIRAMATE – AKA TOPAMAX
- ZONISAMIDE – AKA ZONEGRAN
- N - ACETYL CYSTEINE
- NIMODIPINE – AKA NIMOTOP
MOOD STABILIZERS

- BIPOLAR DISORDER OFTEN REQUIRES (RATIONAL) POLYPHARMACY

- 68% OF PTS. W/ BIPOLAR DISORDER ARE ON MORE THAN 1 PSYCHOTROPIC MEDICATION\(^1\)

- LITHIUM ALONE IS EFFECTIVE < 40% OF THE TIME

- RESPONSE RATES ARE ~50% FOR VALPROATE & LITHIUM\(^2\)

1st Generation Antipsychotics

- e.g. MELLARIL, HALDOL, PROLIXIN, THORAZINE, NAVANE

- RARELY USED ANYMORE
2ND GENERATION ANTIPSYCHOTICS

• BEST USED TO MANAGE BIPOLAR AGITATION WHILE TITRATING TRADITIONAL MOOD STABILIZERS

• e.g. CLOZARIL, RISPERDAL, ZYPREXA, SEROQUEL, GEODON, ABILIFY, LATUDA, ETC.

• ANTIPSYCHOTICS WITH MOOD STABILIZING ABILITIES
ANTI-ANXIETY AGENTS

• EXTREMELY LIMITED APPROPRIATE USE FOR VERY SHORT-TERM MANAGEMENT OF ANXIETY OR DIFFICULTY SLEEPING

• VALIUM CLASS
  – KLONOPIN, ATIVAN, XANAX

• ATYPICAL CLASS
  – BUSPAR, VISTARIL
PSYCHOSTIMULANTS

- AMPHETAMINE DERIVATIVES – RITALIN, ETC
- CYLERT
- STRATTERA
- MANY OTHERS…
- OFTEN MISPRESCRIBED
- REMEMBER: CAN BE CALMING IN A YOUNG PERSON - **EVEN WHEN THERE IS NO DIAGNOSIS OF ADHD!**
MENTAL HEALTH CHALLENGES IN THE ELDERLY

- IS THERE A BIOLOGICAL MENTAL HEALTH PROBLEM PRESENT?
- HAVE ALL MENTAL HEALTH COMPONENTS BEEN ACCURATELY ASSESSED?
- IS THE DIAGNOSIS ACCURATE ???
- IS TREATMENT OPTIMALLY EFFECTIVE ???
- IS THE PERSON MANAGED TO “FEEL BETTER” - OR TREATED TO REMISSION?
WHAT YOU CAN DO:

- **ASK** ABOUT SYMPTOMS / HISTORY / MEDS / DRUGS
- TEACH CAREGIVERS TO NOTICE MENTAL ILLNESS
- BE SKEPTICAL ABOUT THE ACCURACY OF DIAGNOSES & THE APPROPRIATENESS OF TREATMENT
- REMEMBER THAT “SPECTRUM ILLNESSES” ARE THE RULE NOT THE EXCEPTION
- DIFFERENTIATE BETWEEN PALLIATION & REMISSION
- HAVE AN “EXPERT” WITH WHOM TO DISCUSS CASES
- REFER FOR EXPERT DIAGNOSIS & TREATMENT
TAKE HOME MESSAGES:

• SYMPTOMS OFTEN APPEAR TO BE CHARACTER-BASED, BUT ARE ACTUALLY “AMPLIFICATIONS” OF “BASELINE” CHARACTER

• RECOGNIZE THAT SOME DECREASED COGNITION CAN BE PARTIALLY REVERSED!!!

• RECOGNIZE SUBSYNDROMAL MOOD DISORDERS!!!

• DO NOT EXPECT TO FIND “TEXTBOOK” PRESENTATIONS

• MIXED STATES ARE FAR MORE PREVALENT THAN PURE STATES

• USE THE MOOD DISORDER QUESTIONNAIRE
OF TEN, YOU NEED A PRO…

PLEASE FEEL FREE TO CALL & REVIEW A CASE!

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