Geriatrics Update: Psychiatry

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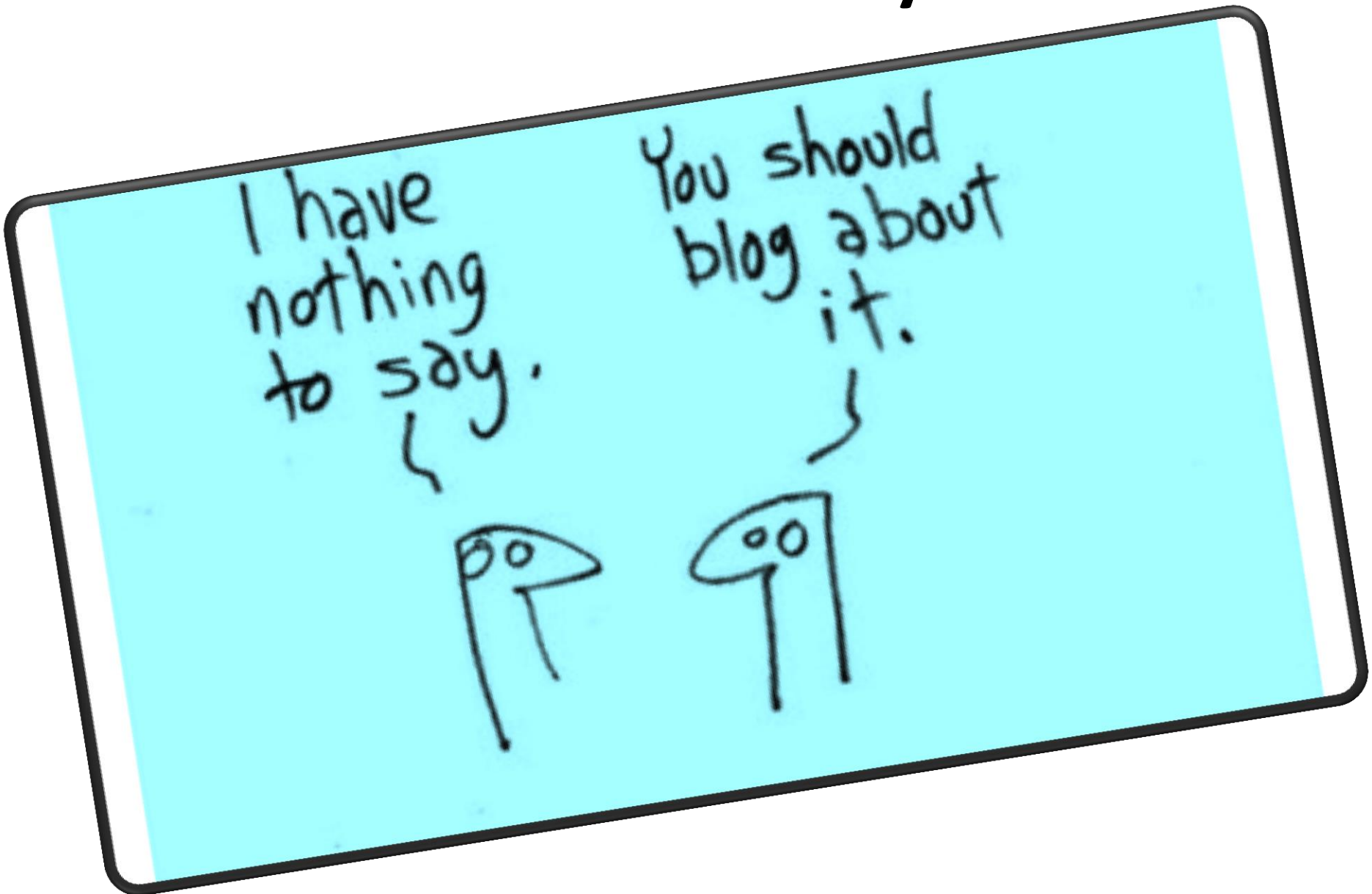
No commercial or industry disclosures



Objectives

- **Enhance Understanding of Common Mood, Anxiety and Psychotic Disorders in the Elderly**
  - **Symptom** Features
  - **Risk** Issues
  - **Treatment** Approaches
    - **Psychotherapeutic**
    - **Pharmacologic**
      - **Treatment** Planning
      - RX **Initiation and Discontinuation**

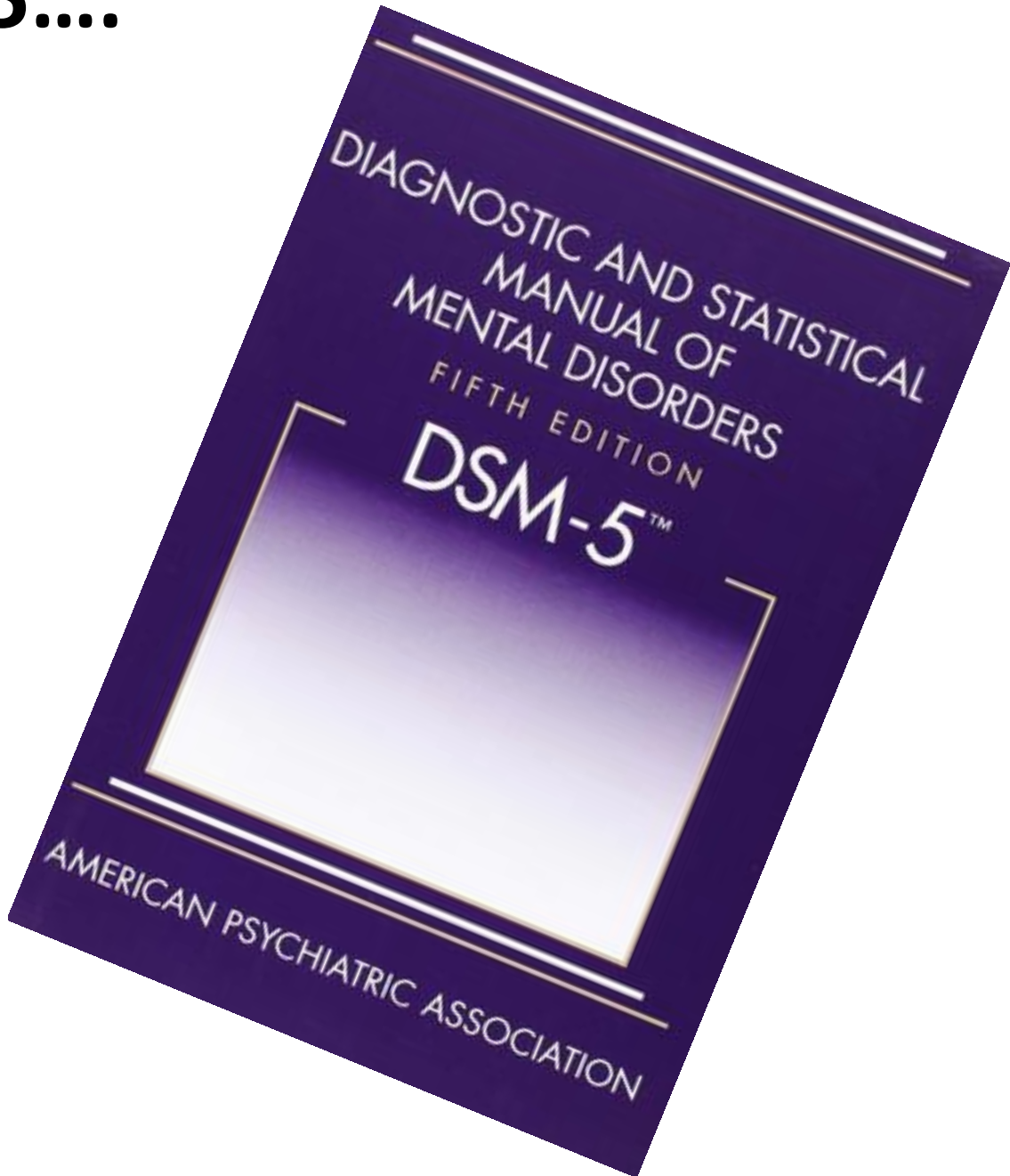
TRIGGERS for screening for mental health symptoms

- Comprehensive Geriatric Assessments
- Chronic Medical Illness
- Medically Unexplained Symptoms
- Non-Adherence (appointments and treatments)
- Frequent ED visits or recurrent admissions
- Bereavement and other major stressors
- Insomnia complaints
- New/Early Dementia Diagnoses
- New admissions to LTC or RH settings

The New DSM 5….

- Do you have to master it?
- Do you have to remember whether you need 5 criteria of 9 or 3 criteria of 6?

- NO…BUT
  - Good to start to become familiar with new nomenclature



QUESTION….

Which of the following no longer ‘lives’ in the DSM 5 (vs the DSM 4)?

A. Panic Disorder

B. Major Depressive Disorder

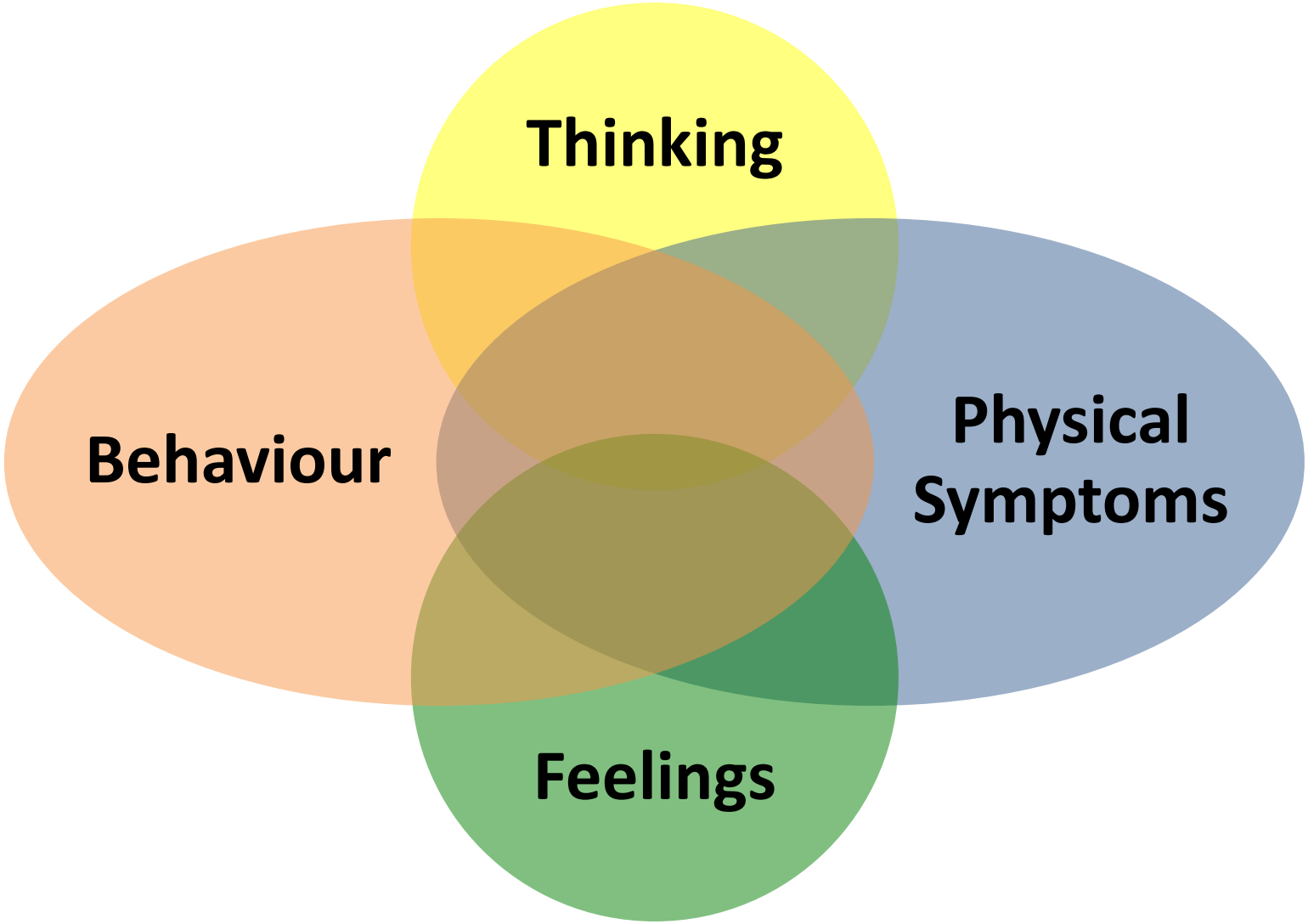
C. Generalized Anxiety Disorder

D. Axis II

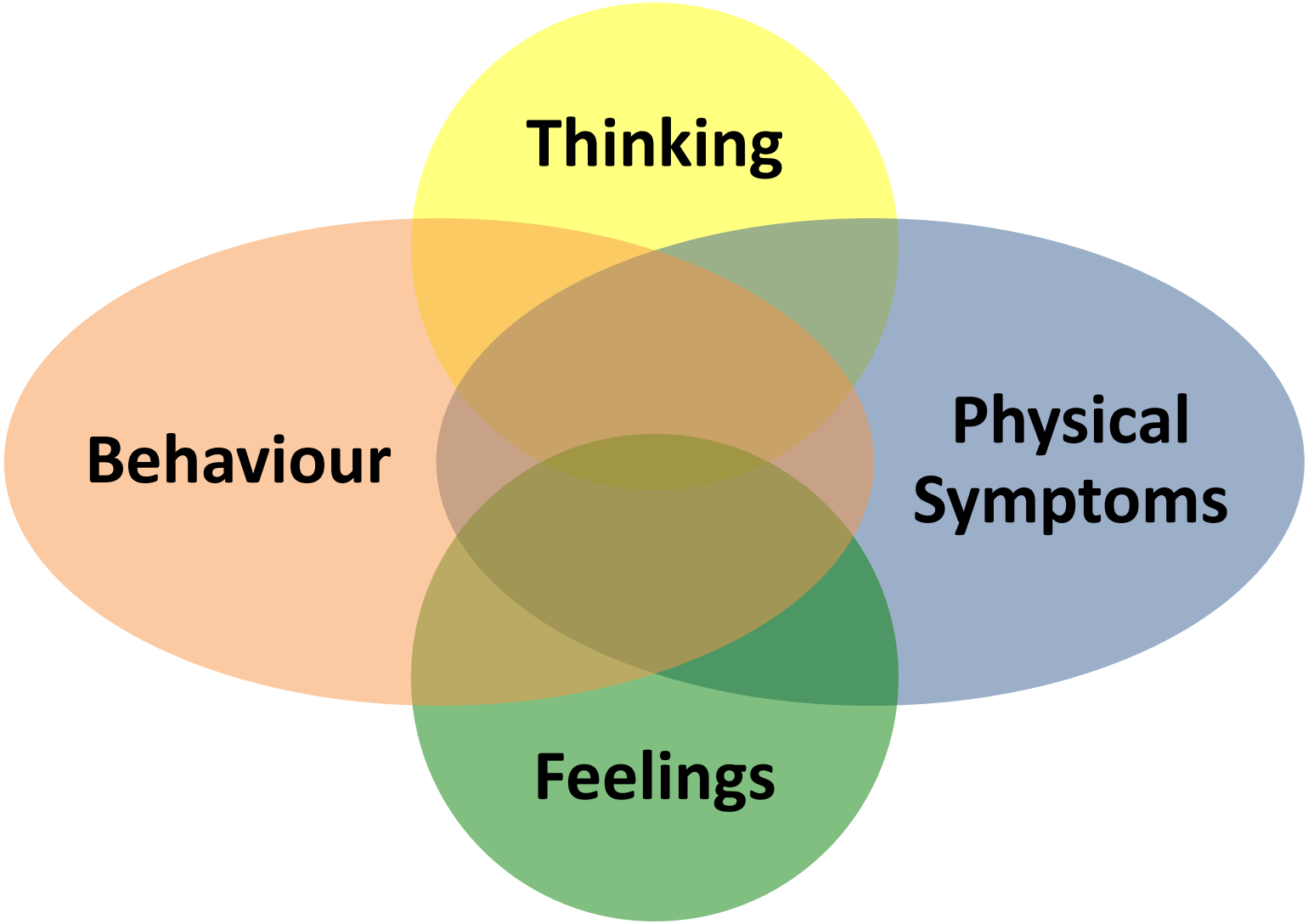
An Approach to Psychiatric Assessment/Diagnosis

- Identify **suffering** and **poor functioning**
- **Screen for psychiatric symptoms** when patients are suffering and functioning poorly: **is there a link**?
- Ask questions about **mood, thinking, behaviour and physical symptoms** to develop a DDX and formulation
- Include questions about **personality and longitudinal coping styles** to understand how psychiatric symptoms and functioning fit within personality style
  - **Personality** = a way of interacting with/thinking about the world, others and oneself in a particular pattern than predicts future coping, self-regulation, self-esteem, adaptation and relationship success

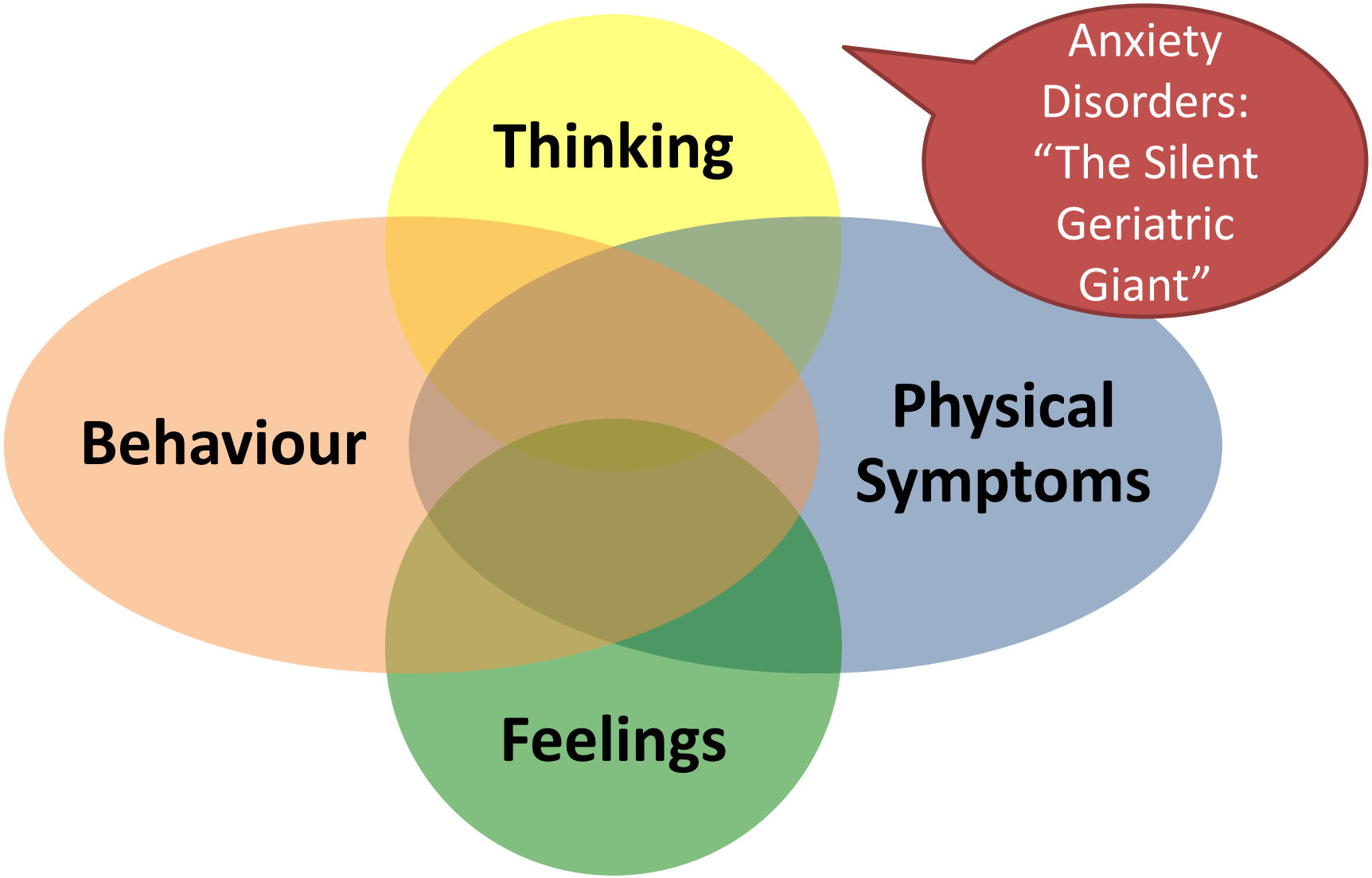
Psychiatric Disorders



Anxiety Disorders



Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder, Social Phobia, Post-Traumatic Stress Disorder



QUESTION….

What is the most prevalent anxiety disorder in the elderly population?

A. Specific Phobia

B. Generalized Anxiety Disorder

C. Panic Disorder

D. Obsessive Compulsive Disorder

Anxiety Disorders

Thinking

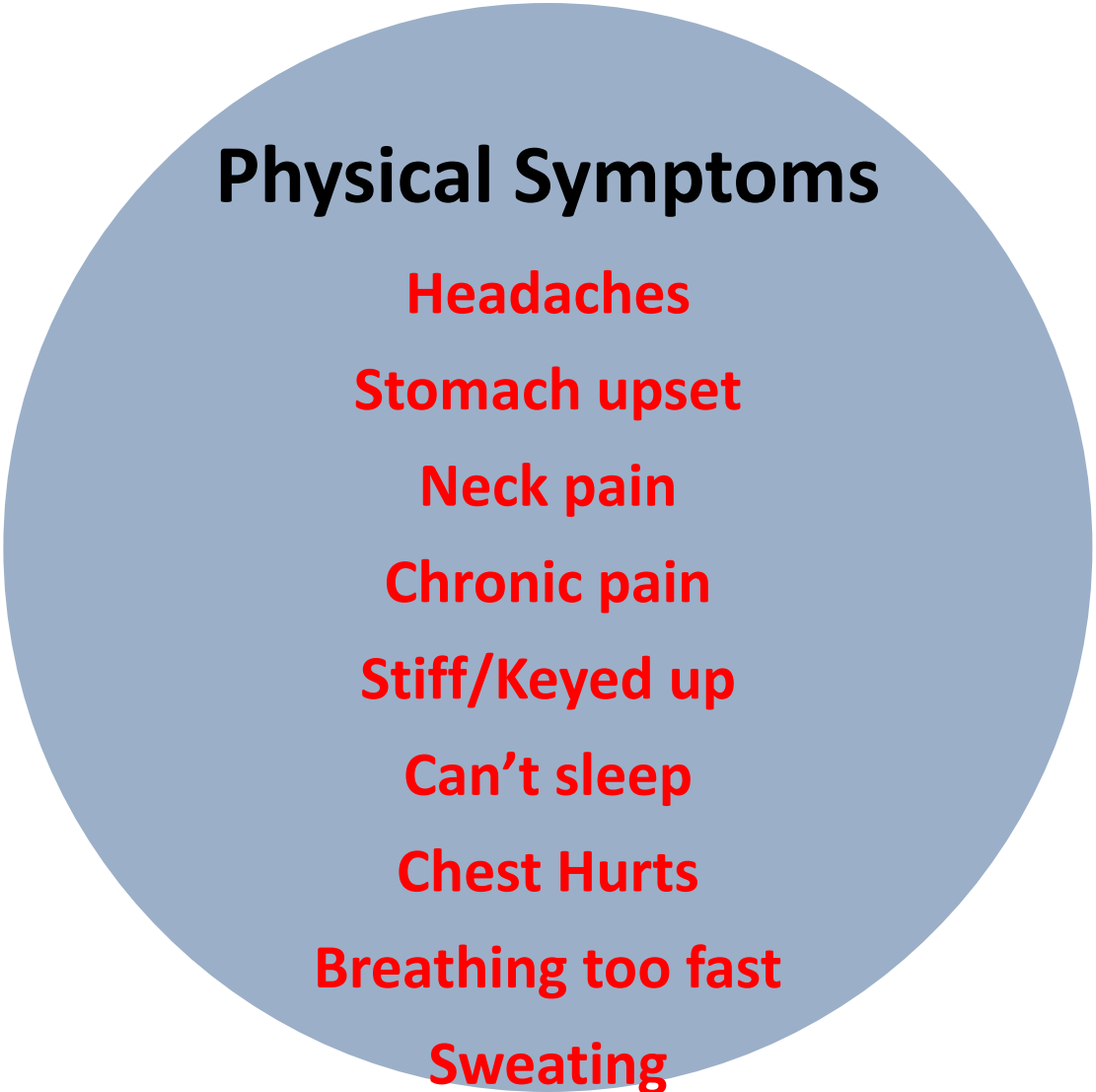
What if something bad happens?

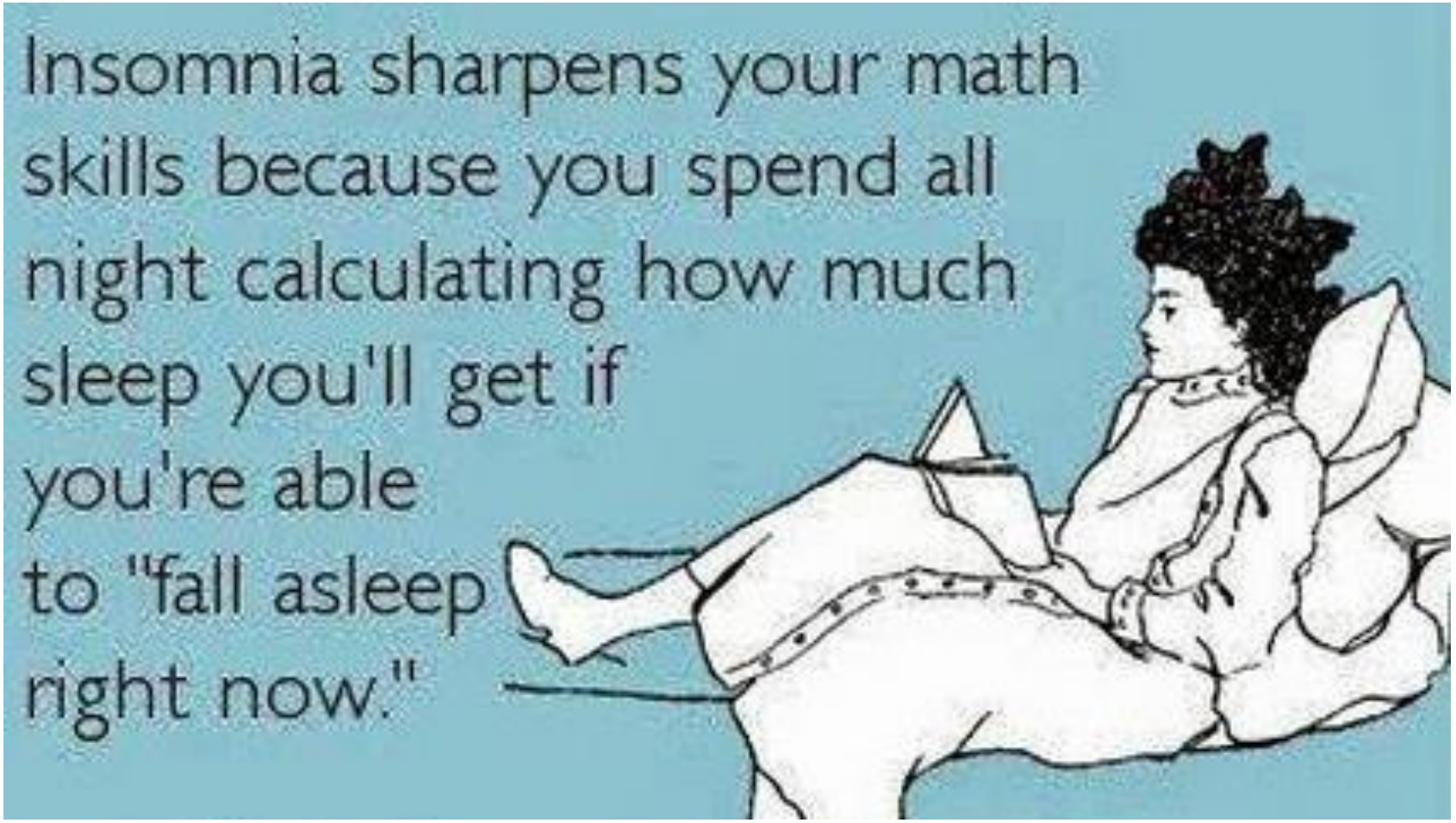
Something bad will probably happen

There are risks here

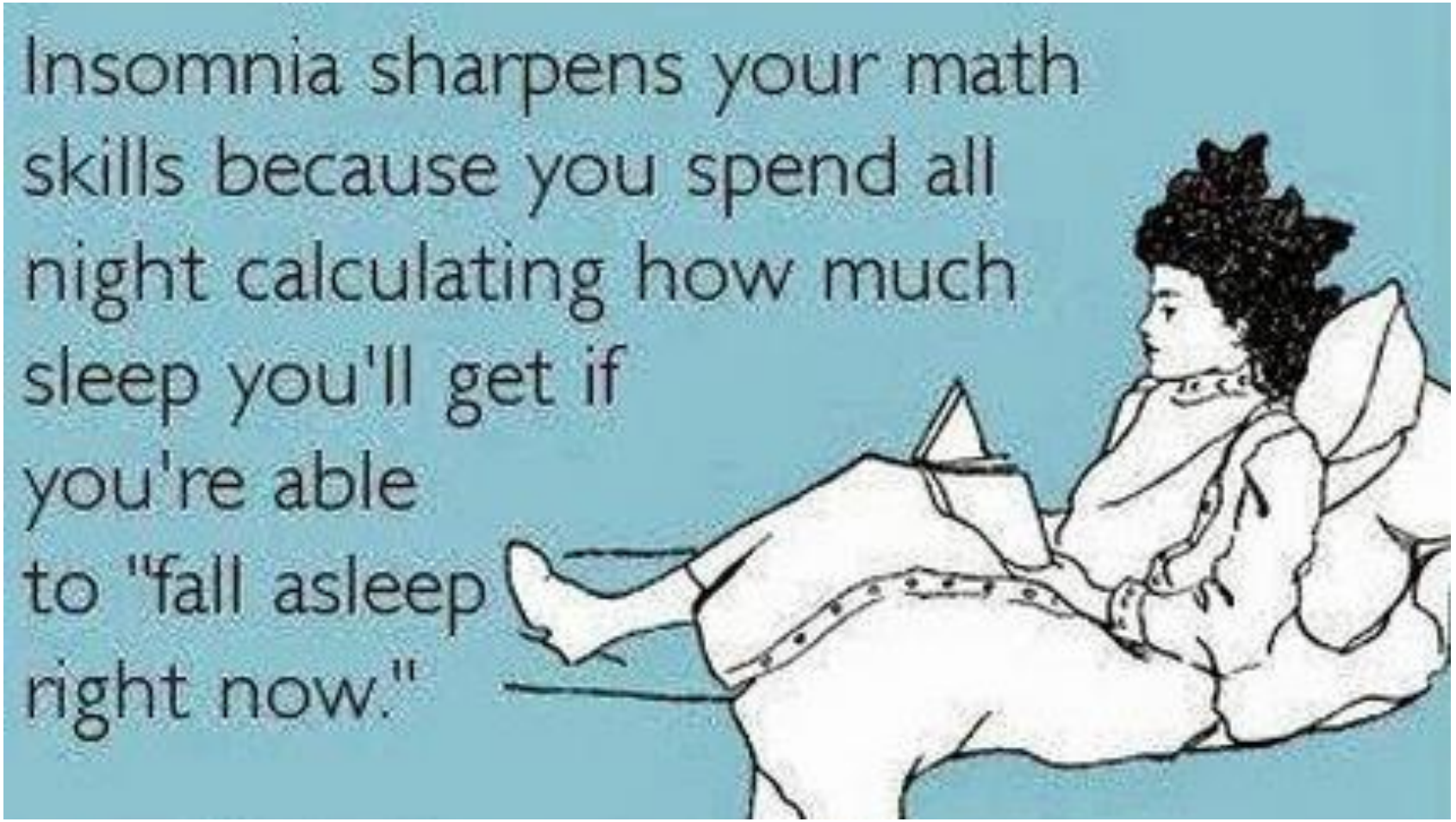
My kids, my money, my health, are all precarious

Anxiety Disorders




Insomnia sharpens your math skills because you spend all night calculating how much sleep you'll get if you're able to "fall asleep right now."

INSOMNIA is a risk factor for suicide



Anxiety Disorders

Anxiety Disorders

Behaviour

Avoids feared thing

Tries to neutralize/counteract

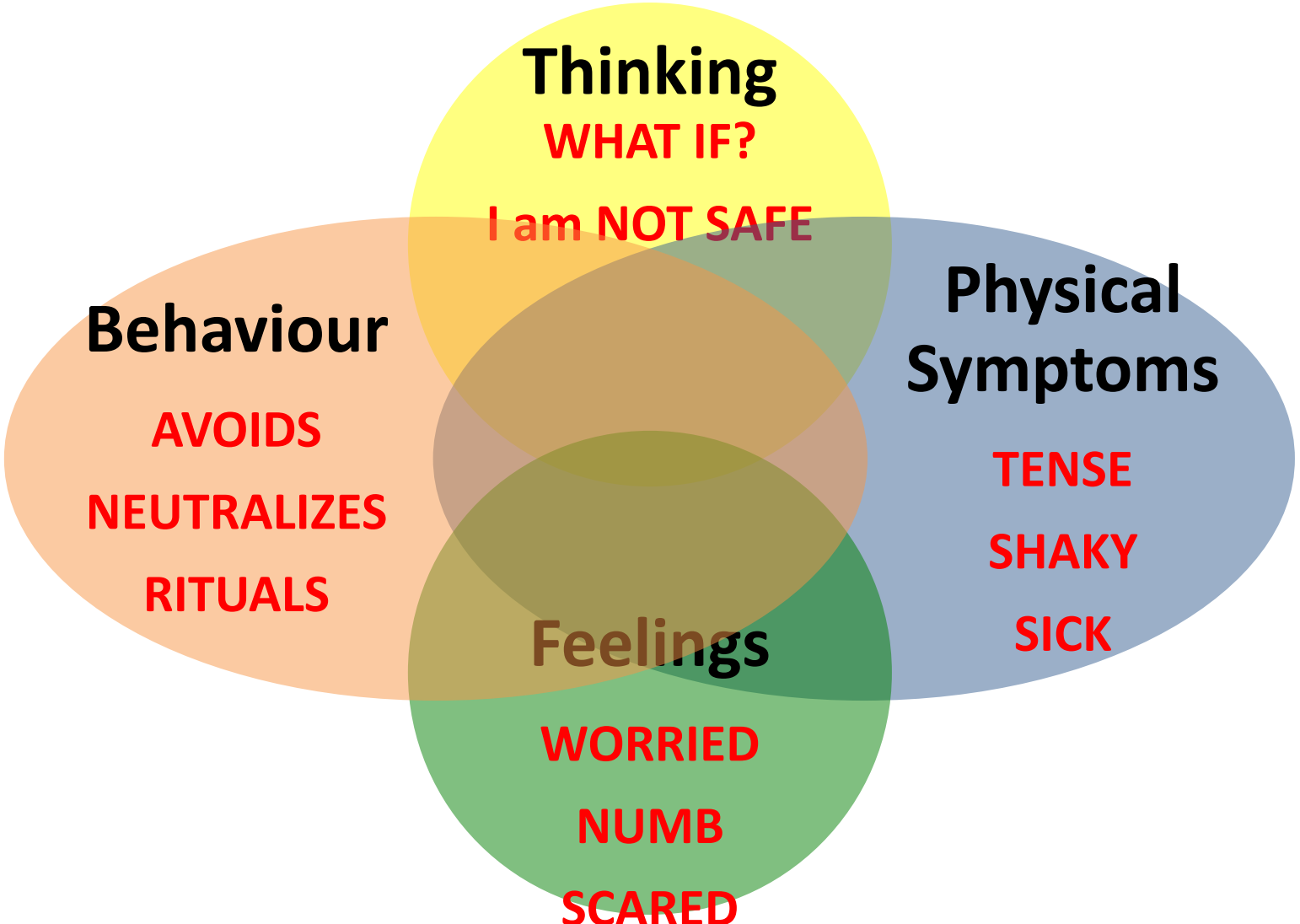
Won't try new things

Asks for lots of reassurance:

Won't change RX

Always wants to change RX

Anxiety Disorders



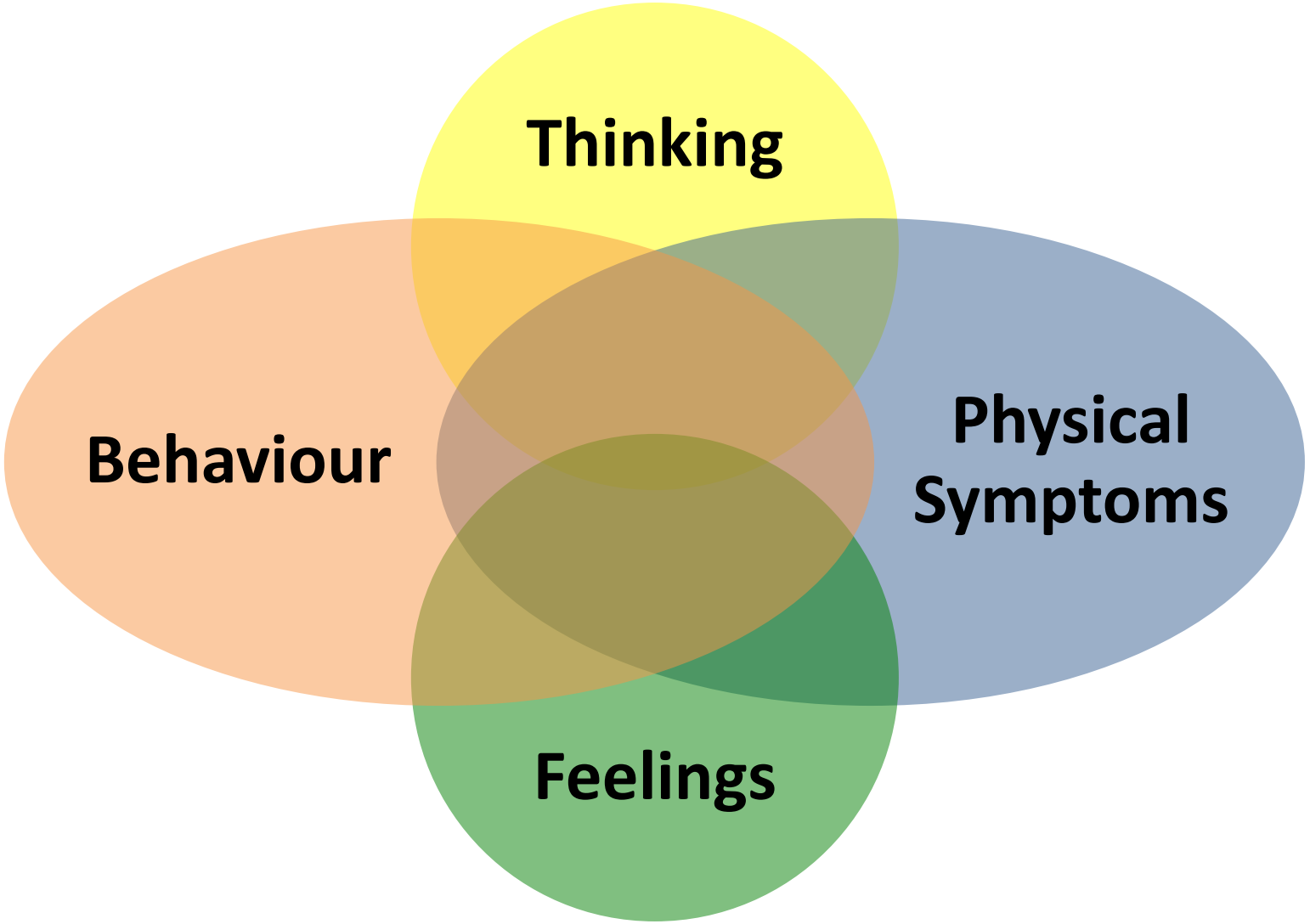
Anxiety Disorders

Key Medical Contributors to Exclude/Optimize	• Cardiac Arrhythmias, Steroid RX, Substance Use Disorders, hyperthyroidism, Medication Side effects, Restless Legs, Respiratory Disorders
Key Psychotherapeutic Concepts/Techniques	• Psychoeducation re fight/flight response and role of exposure in treatment & avoidance in perpetuating symptoms • Cognitive Behavioural Therapy • Graded Exposure
First Line RX Interventions	• Psychotherapy and SSRI RX • Sleep Hygiene • Cautious, time-limited adjunctive Sleep aids
Special Mentions & Risk Issues	• Insomnia as a risk for amplifying disorder AND a risk for sleep RX dependence • Risk of Secondary ETOH or BZD abuse • Fear of falling: risk for decreased functioning/mobility post fall if not addressed

Anxiety Disorders RX Treatment

Useful References for treatment Guidance	www.canmat.org **Wetherall et al. Evidence Based Treatment of Geriatric Anxiety Disorders. Psychiatric Clinics of N. America. 2005** **AJ Flint. Anxiety Disorders in Late Life. Can Fam Physician. Nov 1999 Vol 45.** **Cassidy and Katz. The Silent Geriatric Giant: Anxiety Disorders in Late Life. Geriatrics and Aging 2008.**
First-Line Medication Recommendations	**SSRI RX eg. Sertraline** (start 25mg/day; average 100mg/day)**, Citalopram** (start 5-10mg/day; average 10-20 mg/day), **Escitalopram** (start 2.5-5 mg/day; average 10 mg/day) **SNRI RX eg. Venlafaxine** (start 37.5 mg/day; average 150-225mg)**, Desvenlafaxine**
Dosing Recommendations	Similar to younger patients + geriatric '**start low, go slow'** **BUT aim for remission AND be guided by DOSE LIMITING SIDE EFFECTS not DOSE**
Duration	**Typically life-long disorders** though can reassess q 6-12 month especially if anxiety amplification triggered by **now-remitted/resolved stressors**
Second-Line OR Adjunctive RX	**Benzodiazepine** e.g. Lorazepam/Clonazepam- falls, dependence, delirium caution **TCA** eg. Nortriptyline, Clomipramine- anticholinergic and cardiac caution **SHOULD avoid** Diazepam (too long ½ life) and Alprazolam (too short ½ life)
Additional Notes/Cautions	• Health Canada Advisory re: SSRI RX especially Citalopram • BP increase risk for SNRI • Risk of sensitivity to side effects in anxious patient • Risks/Needs associated with adjunctive benzodiazepine use

Mood Disorders



QUESTION….

Which symptoms are not consistent with typical/normal bereavement?

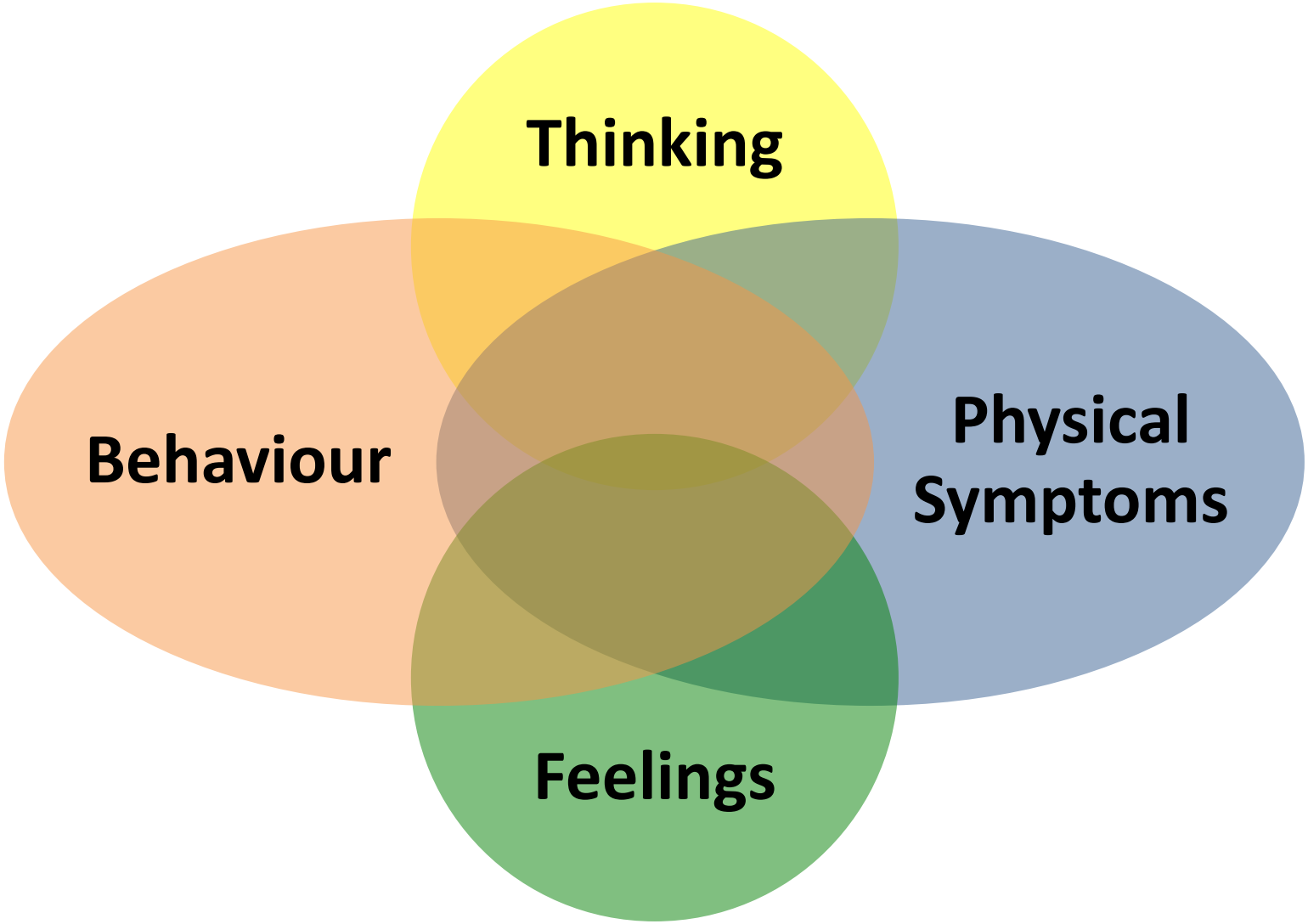
A. Hallucinations of the deceased

B. Severe Worthlessness

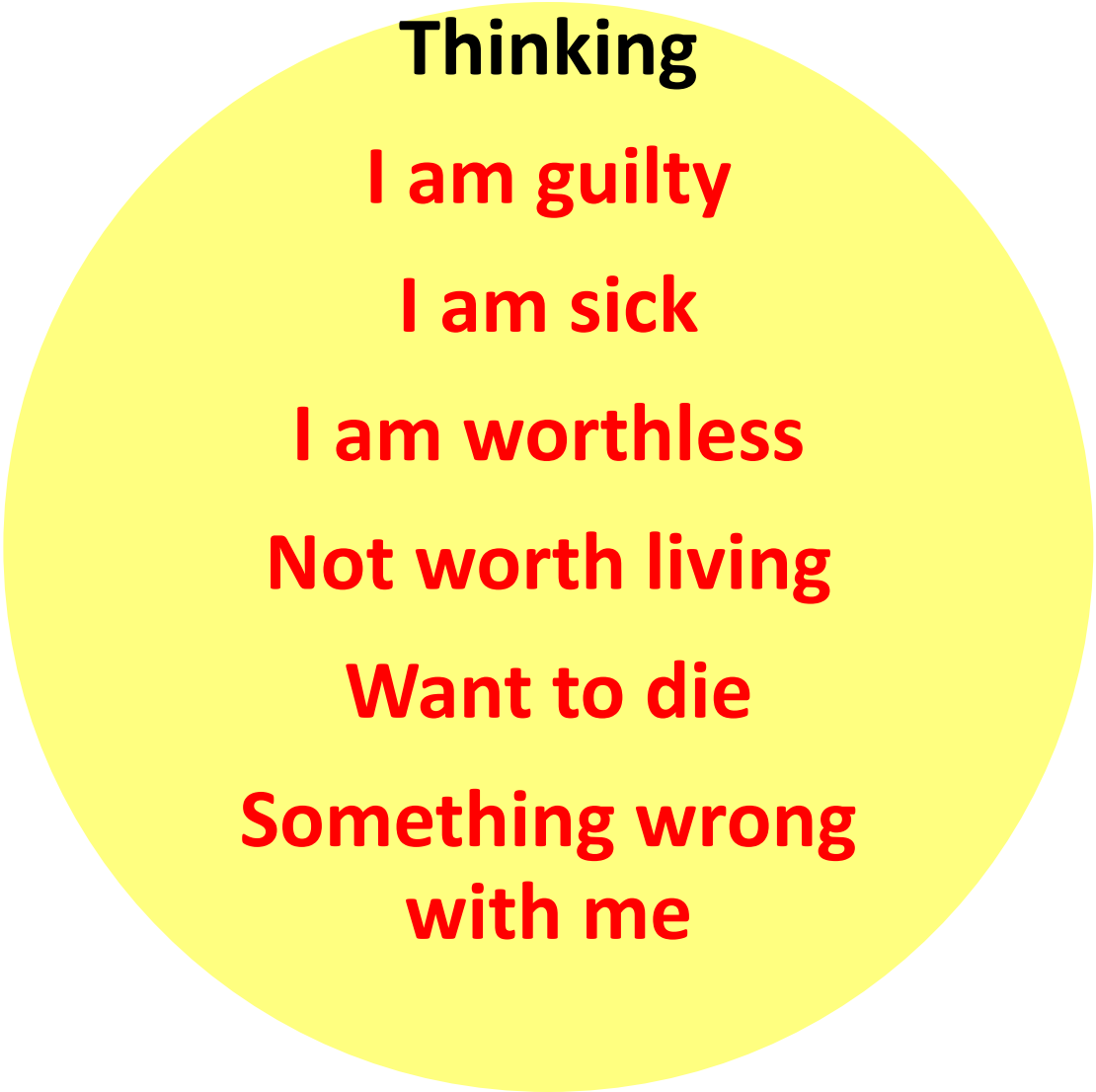
C. Low Mood

D. Insomnia

Major Depression, Dysthymia



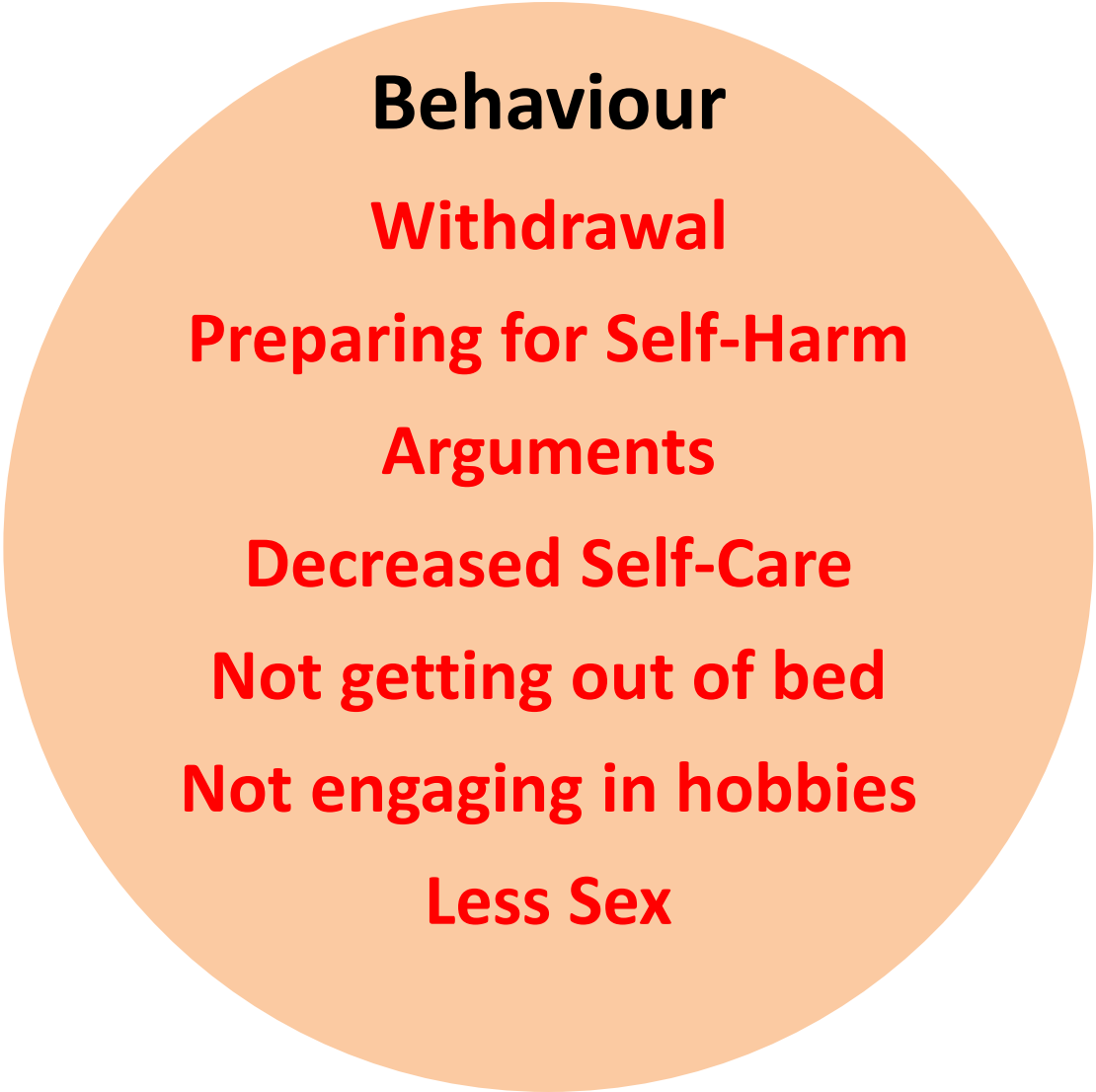
Depressive Disorders



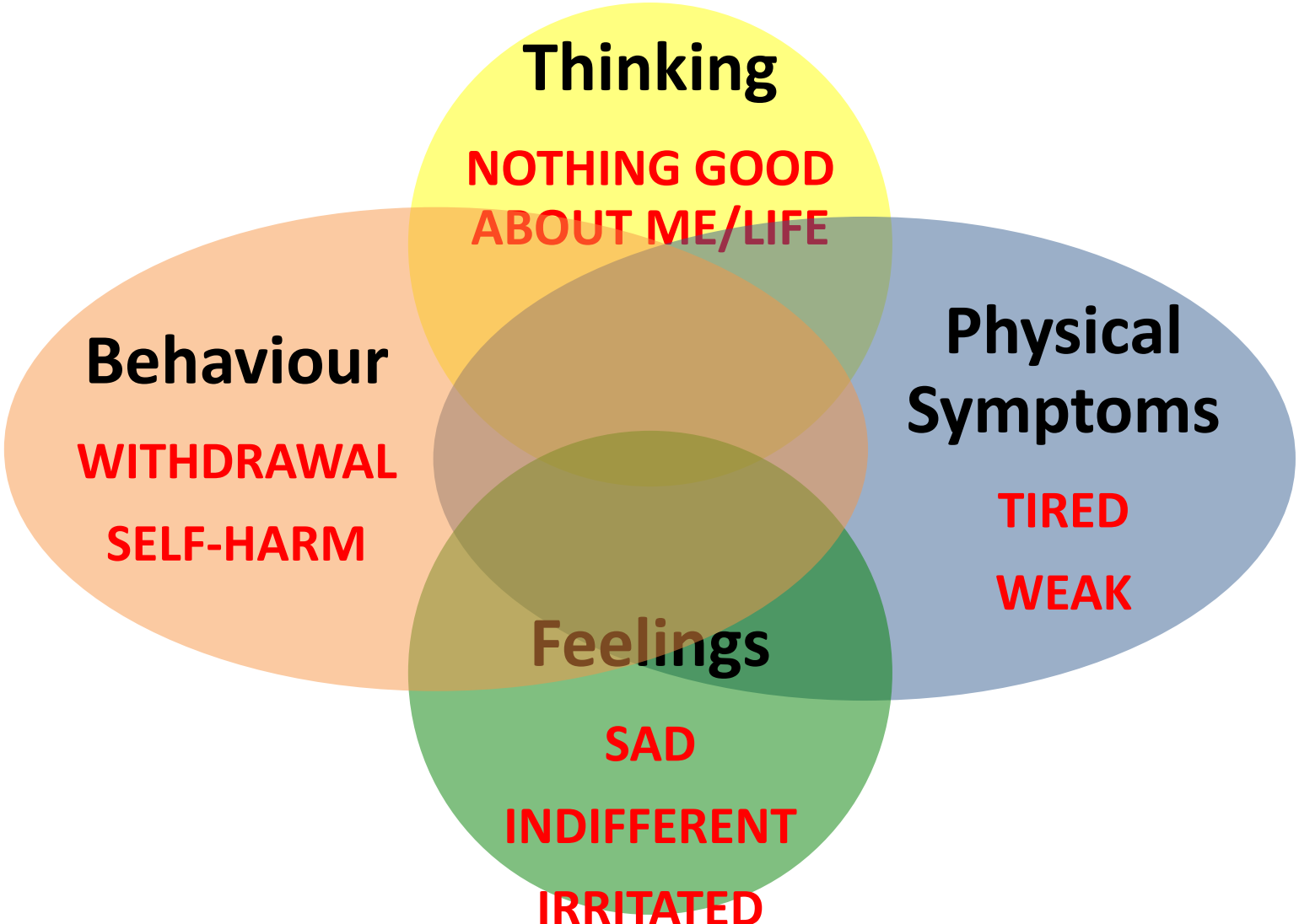
Depressive Disorders

Depressive Disorders

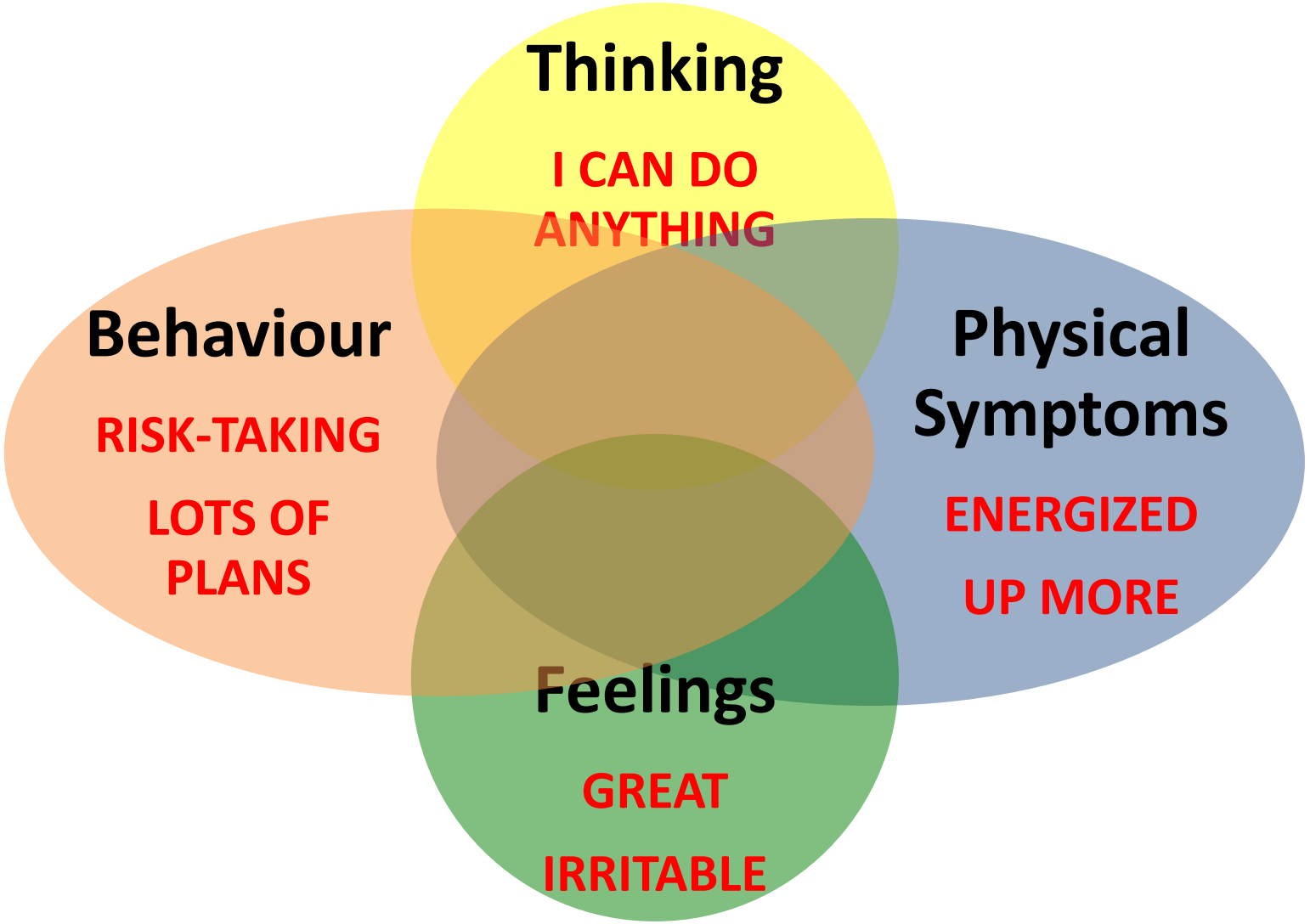
Depressive Disorders



Depressive Disorders



Bipolar Spectrum Disorders-Manic



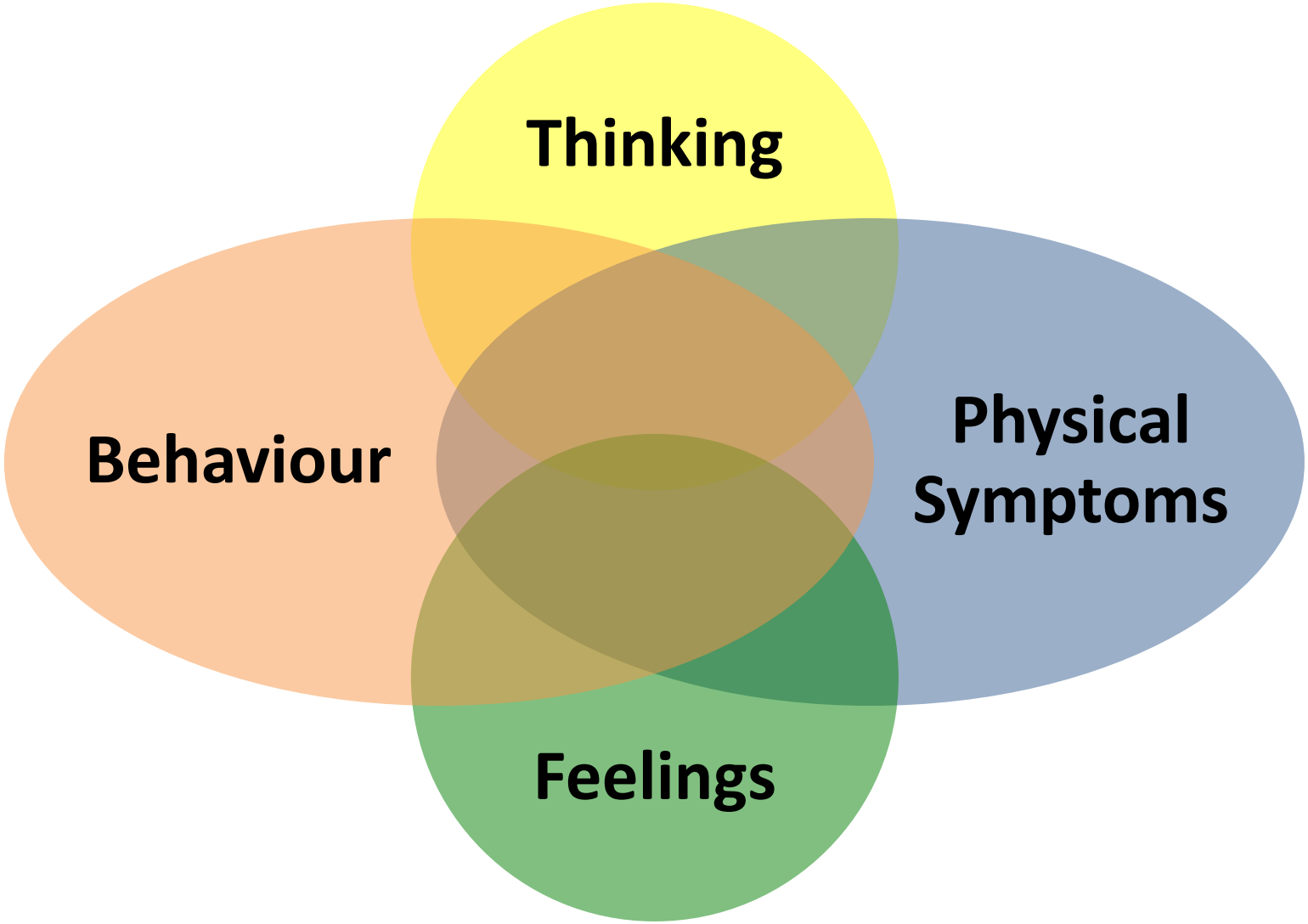
DEPRESSION

Key Medical Contributors to Exclude/Optimize	• **Hypothyroidism, Vitamin Deficiency, Anemia, Chronic Pain, Primary Sleep Disorder, ETOH Abuse** • **Withdrawal/Apathy as presenting symptom of Dementia/Major Neurocognitive Disorder** • **Sub-Syndromal Hypoactive Delirium** • **Caregivers**
Key Psychotherapeutic Concepts/Techniques	• Problem Solving Therapy • Cognitive Behavioural Therapy • Mindfulness • Interpersonal Therapy • Reminiscence
First Line RX Interventions	• Psychotherapy for mild • Psychotherapy plus RX for moderate/severe +/- Psychotic Features • ECT for severe, safety-risking OR refractory
Special Mentions & Risk Issues	• Risk for Self Harm • Risk for Self-Neglect • Driving Impact with Illness or Treatment • Consider Beck Depression Inventory

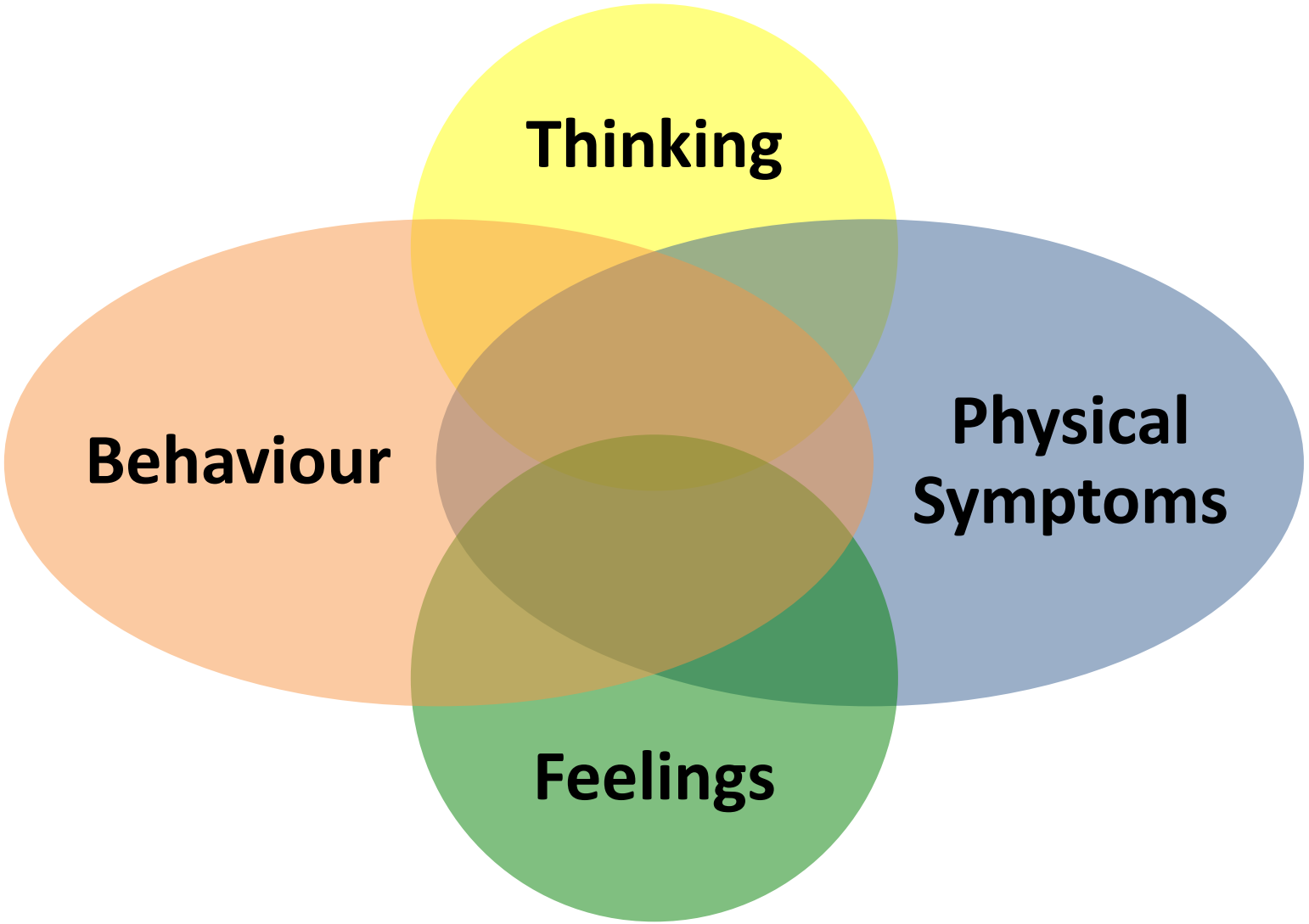
Depressive Disorders RX Treatment

Useful References for treatment Guidance	www.canmat.org www.ccsmh.ca **B Wiese. Geriatric Depression: The use of antidepressants in the elderly. BCMJ. 2011** **Shanmugham et al. Evidence-based Pharmacologic Interventions for Geriatric Depression. Psychiatric Clin N Am. 2005** **Mulsant et al. Pharmacological Treatment of Depression in Older Primary Care Patient: The Prospect Algorithm. FOCUS. 2004**
First-Line Medication Recommendations	**SSRI RX eg. Sertraline** (start 25mg/day; average 100mg/day)**, Citalopram** (start 10mg/day; average 10-20 mg/day), **Escitalopram** (start 5 mg/day; average 10 mg/day) **SNRI RX eg. Venlafaxine** (start 37.5 mg/day; average 150-225mg)**, Desvenlafaxine** **NDRI Bupropion SR** (start 100 mg qam; average 100mg bid) **NaSSA Mirtazepine** (start 15 mg qhs; average 30-45 mg qhs)
Dosing Recommendations	Similar to younger patients + geriatric '**start low, go slow'** **BUT aim for remission AND be guided by DOSE LIMITING SIDE EFFECTS not DOSE**
Duration	**One Episode-** Treat/Remit x 1-2 years then reassess/ slow taper if well/no stressors **>2 Episodes OR Severe/Psychotic Episode**: sustained/chronic treatment
Second-Line OR Adjunctive RX	**SWITCH to Alternate FIRST LINE AGENT OR AUGMENT if partial remission of SX** **TCA** eg. Nortriptyline (mono OR augmentation), - anticholinergic & cardiac caution **Lithium** (150mg-600 mg/day), Methylphenidate (5-10mg twice daily; not HS!) **Neuroleptic** eg. Risperdal or Quetiapine
Additional Notes/Cautions	• **Health Canada Advisory** re: SSRI RX especially Citalopram • BP increase risk for SNRI, SIADH Risk Esp for SSRIs, Falls Risks • Risk of energizing SI before remission of mood episode • Consider mental health referral with psychotic depression, bipolar disorder, SI

Psychotic Disorders



Schizophrenia, Schizoaffective Disorder,
Delusional Disorder, Mood disorder with Psychotic Features



QUESTION….

Which of the following is true regarding Very Late Onset Schizophrenia?

A. More common in men

B. Good Prognosis/Response To Tx

C. More negative symptoms

D. Less Risk of Tardive Dyskinesia

Psychotic Disorders

Thinking

People are stealing from me

People are targeting me

People are deceiving me

***I am hearing/seeing/smelling ___**

I am not what I seem

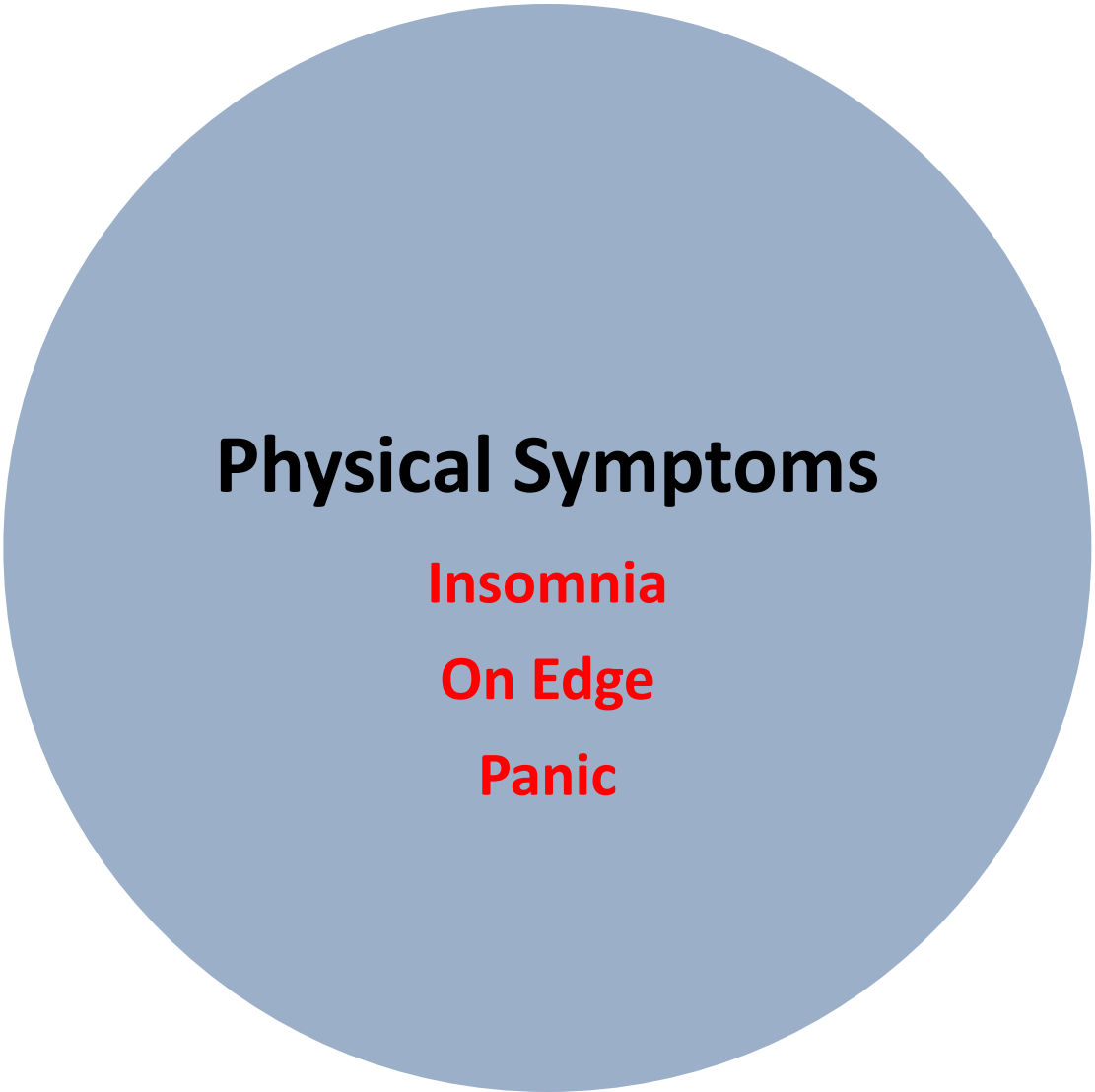
I am extra important

There is more wrong with me than people realize

Something unusual that other people think is impossible, IS happening

Information in the TV, newspapers, is just for me

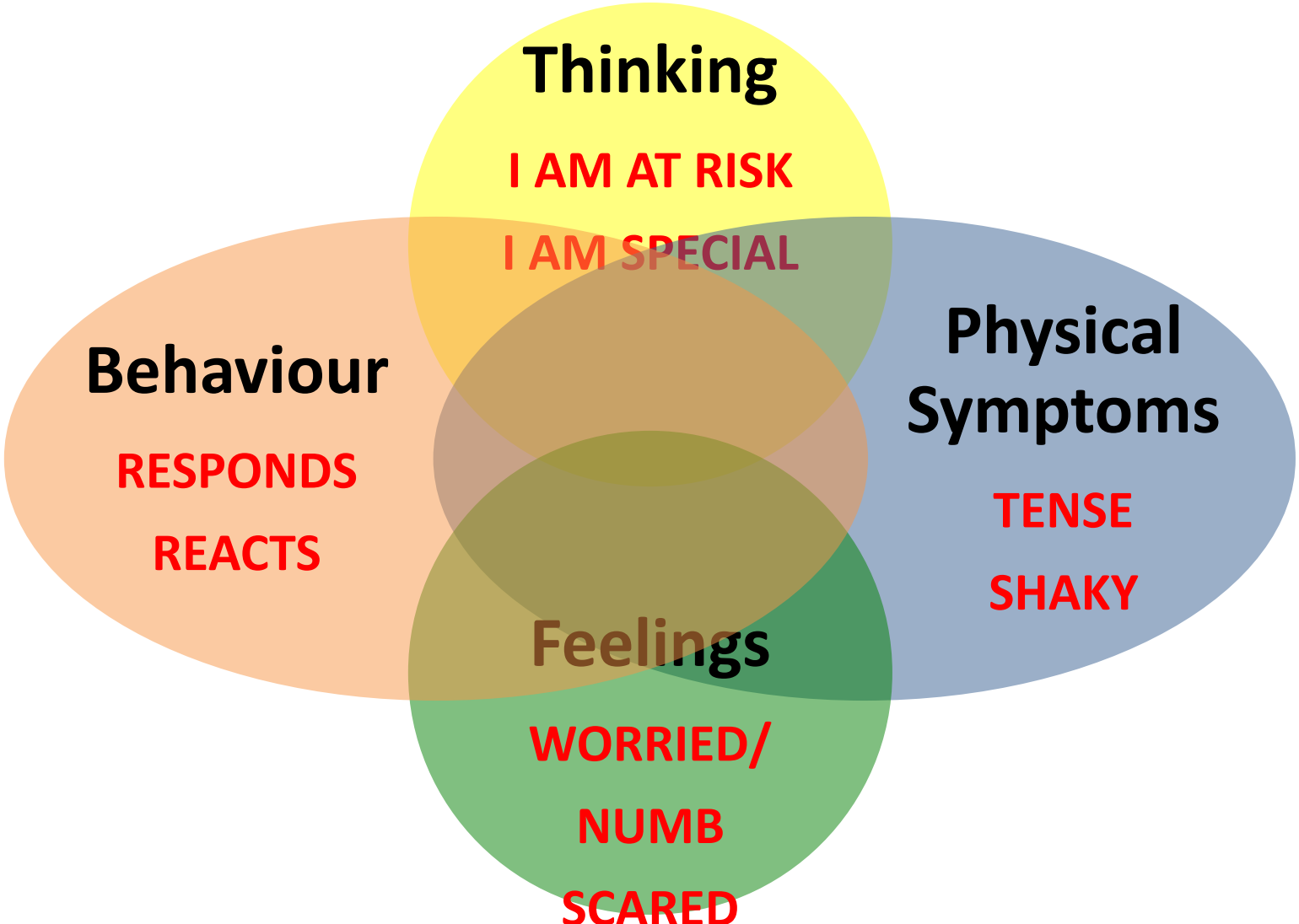
Psychotic Disorders



Psychotic Disorders

Psychotic Disorders

Psychotic Disorders



Psychotic Disorders

Key Medical Contributors to Exclude/Optimize	• Delirium Causes (Lytes, Infections, new RX) • Steroid RX, Vascular Events, New Seizure Disorder, CNS Pathology, First Symptom of Dementia and/or Lewy Body Dementia • Substance Abuse, Sensory Impairment, Sleep Disorder
Key Psychotherapeutic Concepts/Techniques	• Reassurance of safety • Rapport maintenance • Reality Testing • Cognitive Techniques: evidence, other explanations
First Line RX Interventions	• Neuroleptic RX • ECT if impacting safety (eating, behaviour) or refractory sx
Special Mentions & Risk Issues	• Feeling targeted or at risk can lead to SI or SA • Important to inquire re weapons/preparations for death

Psychotic Disorders RX Treatment

Useful References for treatment Guidance	**S Targum. Treating Psychotic Symptoms in Elderly Patients. Primary Care Companion J Clin Psychiatry 2001.** **G Alexopoulos et al. Using antipsychotic agents in older patients. J Clin Psychiatry 2004.** **G Maguire. Impact of Antipsychotics on Geriatric Patients: Efficacy, Dosing and Compliance. Primary Care Companion to the Journal of Clinical Psychiatry.**
First-Line Medication Recommendations	**Atypical Neuroleptic RX: Lower Risk of TD, EPS** Risperdal (start 0.25 mg/day; average 0.5-3mg/day) (depot available) Olanzapine (start 2.5 mg po qhs; average 5-15 mg po qhs) Quetiapine (start 25 mg-50 mg po qhs; average 50-300mg/day- consider XR) Aripiprazole (start 2-5mg/day; average 10-30mg/day) Clozapine (for refractory or high EPS-vulnerable patients) **Typical Neuroleptic RX: More options if Depot Required but increased TD, EPS risk** **Eg. Haldol(most potent/least anticholinergic), Loxapine(mid-potency), Chlorpromazine (very sedating/anticholinergic)**
Dosing Recommendations	Similar to younger patients + geriatric '**start low, go slow'** **BUT aim for remission AND be guided by DOSE LIMITING SIDE EFFECTS not DOSE**
Duration	• **Depends on specific Psychotic Disorder, severity, duration, typical trajectory** • **Schizophrenia typically requires life-long treatment but psychotic symptoms often lessen in older age** • **For psychotic depression, follow depression treatment duration guidelines** • **Tapers of RX should be slow (over weeks/months) with vigilant monitoring for relapse**
Second-Line OR Adjunctive RX	**For mood disorders with psychotic features, antidepressant PLUS neuroleptic indicated**
Additional Notes/Cautions	• **Health Canada Advisory re: Neuroleptic Use in Patient with Dementia NOT explicit re patients WITHOUT dementia but may be similar risks; less metabolic risks with aging** • **Consider risk of falls, prolonged QT synergistic risks**

PHEW!

Questions?