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112 GERIATRIC PSYCHIATRY WARDS TIP Work up an elderly patient for major depression when they present with memory loss or nonspecific physical complaints. Normal Aging Factors associated with normal aging include: ■ Decreased muscle mass/increased fat. ■ Impaired vision and hearing. WARDS TIP Patients with a major neurocognitive disorder are more likely to confabulate when they do not know an answer, whereas depressed patients may just say that they don’t know. When pressed for an answer, depressed patients will often show the ability to answer correctly. Major Depression Pseudodementia WARDS QUESTION Q: What is the most common psychiatric disorder in the elderly? A: Major depressive disorder. The geriatric population of the United States is projected to more than double by the year 2050, boosted in a large part by the aging Baby Boomer generation. Nearly 20% of people over the age of 60 have a psychiatric disorder. The suicide rate of elderly (aged 85 and older) white men is five times the national average. Common diagnoses in elderly patients include mood disorders, anxiety disorders, and neurocognitive disorders, though many psychiatric disorders in this population remain underreported and untreated. ■ Decreased

brain weight/enlarged ventricles and sulci. ■ Minor forgetfulness (sometimes called age-associated memory impairment or benign senescent forgetfulness). Major depression is a common disorder in the geriatric population, with depressive symptoms present in 5–15% of the elderly. Depression is associated with poor physical health: ■ Post-myocardial infarction (MI) patients who develop depression have a four times increased rate of death. ■ Stroke patients who develop depression have a greater than three times increased rate of death during the 10 years following their stroke. ■ Patients with depression newly admitted to nursing homes have an increase in 1-year mortality rate. Symptoms of major depression in the elderly often include problems with memory and cognitive functioning. Because this clinical picture may be mistaken for a major neurocognitive disorder (dementia), it is termed pseudodementia. Pseudodementia is the presence of apparent cognitive deficits in patients with major depression. Patients may appear to be suffering from a neurocognitive disorder (dementia); however, their symptoms are secondary to their underlying depression, although it can be difficult to differentiate the two (see Table 9-1). TABLE 9-1. Dementia versus Pseudodementia (Depression) Dementia Pseudodementia (Depression) Onset is insidious. Onset is more acute. Sundowning is common (↑ confusion at night). Sundowning is uncommon. Will guess at answers (confabulate). Often answers “I don’t know.” Patient is unaware of problems. Patient is aware of problems. Cognitive deficits do not improve with antidepressant treatment. Cognitive deficits improve with antidepressants.

TREATMENT ■ Supportive psychotherapy. ■ Community resources: Senior centers, senior services, support groups, etc. ■ Antidepressant medications (selective serotonin reuptake inhibitors [SSRIs] and other newer antidepressants have fewer side effects and are preferable to tricyclic antidepressants [TCAs] or monoamine oxidase [MAO] inhibitors). ■ Elderly patients are sensitive to side effects of medications so it’s important to start at a very low dose and titrate slowly up to the full dose of the antidepressant: “Start low and go slow!” ■ If using TCAs in elderly patients, nortriptyline is favored because it has the fewest anticholinergic side effects. ■ At lower doses, mirtazapine can increase appetite and be sedating; it is dosed at bedtime for depressed patients who particularly suffer from decreased appetite and sleep disturbances. ■ Methylphenidate can be used at low doses as an adjunct to antidepressants for patients with severe depression and/or psychomotor retardation; however, it may cause insomnia if given in the afternoon or evening. Also, be aware of the risk of arrhythmia in patients with cardiac disease. ■ Electroconvulsive therapy (ECT) may be used in place of antidepressants (ECT is safe and effective in the elderly). Mrs. Brennan is a 72-year-old female who considers herself to be in good health. She goes out to lunch with friends three times a week and looks forward to her Saturday bridge games at the local senior center. Unfortunately, her husband has suffered from years of ill health, including five myocardial infarctions and a serious stroke last year that left him barely able to walk. You are a geriatric psychiatrist who has been treating Mrs. Brennan’s husband for depression that began after his last stroke. Mrs. Brennan always comes along to appointments so that she can stay informed about her husband’s medical care. You become concerned when your patient uncharacteristically misses an appointment and does not return your phone message. Finally, a month later, you are surprised to see Mrs. Brennan walk into your office alone. She enters the room slowly, and you notice that she has lost some weight since you last saw her. She sits down but does not make eye contact. Finally, she begins to talk in a soft, monotone voice, explaining that her husband had another stroke last month and was moved to a hospice facility, where he passed away 2 weeks ago. She begins to cry, and you hand her some tissues. The two of you talk some more about her husband’s death and how she is coping with it. She reports that her daughter visits

her frequently and has invited her to spend the weekends with her. Although Mrs. Brennan reports that she feels “down,” she reports that she is making an effort to go on with her life because that is what her husband would have wanted. She says that she went out to lunch with her friends this week and adds that they are very supportive. Mrs. Brennan also reports that it is difficult for her to realize that her husband is no longer there and says that she has heard his voice calling her a couple of times this week. As she leaves your office, you tell her she is welcome to come back whenever she wants. Is Mrs. Brennan having a normal grief reaction? Yes, Mrs. Brennan is going through a normal grieving process, also known as bereavement. Although she displays some symptoms suggestive of GERIATRIC PSYCHIATRY WARDS QUESTION Q: What demographic has the highest rate of completed suicides? A: White elderly males.

114 GERIATRIC PSYCHIATRY WARDS TIP The elderly are very sensitive to side effects of medications, particularly anticholinergic effects of antidepressants. Bereavement major depression (psychomotor retardation, depressed mood), and reports the presence of auditory hallucinations (her husband’s voice), these symptoms are commonly encountered in bereavement and are considered a normal reaction to her sudden loss. Three months later, you receive a phone call from Mrs. Brennan’s daughter, who expresses concern about her mother. She tells you that her mother has to be urged to shower, wear clean clothes, and eat regularly. Mrs. Brennan has stopped participating in her bridge group and has not been out with her friends in many weeks. The daughter also worries about Mrs. Brennan’s increasing forgetfulness and memory problems. She asks if she can bring her in for an appointment with you. You agree and schedule Mrs. Brennan the next day. Mrs. Brennan enters your office with her daughter by her side. She is dressed in a wrinkled pantsuit and is wearing scuffed shoes. Her hair is clean but lies limply against her head. She appears much thinner than the last time you saw her. Her eyes are downcast, and she appears sad. You try to engage her in conversation, but her answers to your questions are soft and short. When you do an assessment of her memory, you note that she answers basic questions with “I don’t know” and scores poorly on the mini-mental state exam questions. What is Mrs. Brennan’s most likely diagnosis now? Mrs. Brennan is most likely suffering from a major depressive episode. Her symptoms now fulfill criteria for major depressive disorder and have been present for over 2 weeks. Since her memory problems began after she began experiencing depressive symptoms, these are likely secondary to depression. When this occurs, it is often referred to as “pseudodementia.” If this is the case, as her depression is treated her memory deficits will improve. What are possible treatment options for Mrs. Brennan? Supportive psychotherapy and a medication trial of an SSRI would be excellent first-line treatments. In addition, you suggest to Mrs. Brennan and her daughter to consider visiting her local senior center to learn what kinds of services from which she might benefit. In 1969, Elisabeth Kübler-Ross, MD, published a book called On Death and Dying, in which she proposed a model of bereavement, the Five Stages of Grief. ■ Denial: “This isn’t happening to me. I don’t feel sick.” ■ Anger: “It’s my ex-husband’s fault for smoking around me all those years!” ■ Bargaining: “Maybe if I exercise and improve my diet, I’ll get better.” ■ Depression: “There’s no hope for a cure. I will die of this cancer.” ■ Acceptance: “I may have cancer, but I’ve always been a fighter—why stop now?” There is some controversy surrounding this model (e.g., people may not experience all of the stages or they may go through them in a different order) as grief is a very individualized experience; there is no “correct” way to mourn a loss. However, it is important to be able to distinguish normal grief reactions from unhealthy, pathological ones. ■ Normal grief may involve many intense feelings, including guilt and sadness, sleep disturbances, appetite changes, and illusions/hallucinations (not always

pathological in some cultures). These feelings generally abate within 6 months of the loss, and the patient's ability to function appropriately in their life is preserved.

■ Bereavement-associated depression is a major depression that begins with a concrete death or loss in the patient's life. It is often difficult to distinguish between depression and grief, since many symptoms are similar. •• Look for generalized feelings of hopelessness, helplessness, severe guilt and worthlessness, neurovegetative symptoms (e.g., insomnia, appetite/ weight changes, low energy), and suicidal ideation, in addition to grief symptoms. •• Treatment for depression is recommended in patients who have at least 2 weeks of persistent depressive symptoms. Substance Use ■ Forty percent of the 65 plus-year-old population drink alcohol, and up to 16% are heavy drinkers who may experience adverse health events from the amount of alcohol they use or from its interaction with medications and impact on chronic disease processes. It is important to screen elderly patients for substance use. ■ Age-related effects of alcohol: •• Elderly people have a lower amount of alcohol dehydrogenase in their livers which can lead to higher blood alcohol levels (BALs) with fewer drinks as compared to younger adults. •• The amount of water in the body lessens with age, resulting in a higher percentage of alcohol in the blood of elderly compared to younger individuals after drinking the same amount of alcohol. •• The central nervous system becomes more sensitive to alcohol with age. ■ Chronic medical conditions worsened by alcohol: •• Liver diseases (cirrhosis, hepatitis). •• Gastrointestinal (GI) diseases (GI bleeding, gastric reflux, ulcer). •• Cardiovascular diseases (hypertension, heart failure). •• Metabolic/endocrine diseases (gout, diabetes). •• Mental disorders (depression, anxiety). ■ Alcohol and medication interactions (see Table 9-2). TABLE 9-2. Alcohol and Medication Interactions Medication Result of Concurrent Alcohol Use H2 blockers Higher BALs Benzodiazepines, tricyclics, narcotics, barbiturates, antihistamines ↑ sedation Aspirin, NSAIDs Prolonged bleeding time; irritation of gastric lining Metronidazole, sulfonamides, long-acting hypoglycemics Nausea and vomiting Reserpine, nitroglycerin, hydralazine ↑ risk of hypotension Acetaminophen, isoniazid, phenylbutazone ↑hepatotoxicity Antihypertensives, antidiabetics, ulcer drugs, gout medications Worsen underlying disease GERIATRIC PSYCHIATRY

116 GERIATRIC PSYCHIATRY ■ Mood disorders: ■ Psychosis: WARDS TIP Visual hallucinations early in dementia suggest a diagnosis of neurocognitive disorder due to Lewy body disease. Antipsychotics should be avoided as these patients are sensitive to extrapyramidal symptoms (EPS). TREATMENT ■ Nonpharmacological treatments: WARDS QUESTION Q: What is common condition in the geriatric population that can mimic depression? A: Delirium. ■ Pharmacological treatments: •• Antipsychotics: Psychiatric Manifestations of Major Neurocognitive Disorders (Dementia) Behavioral symptoms are quite common in patients with major neurocognitive disorders, and are often the source of many psychosocial problems surrounding their care. Agitation and aggression can be distressing and dangerous for caregivers, as well as unsafe for patients. Behavioral disinhibition is fairly common in major neurocognitive disorders and causes patients to act in ways that are quite unlike their typical behaviors (e.g., stripping off clothes in public, sexualized behavior, cursing). •• Difficult to diagnose in a patient with confirmed major neurocognitive disorder. •• Patients with major neurocognitive disorders may display many symptoms of depression (such as apathy) that are merely natural manifestations of their disease. ■ Aggression may be provoked by the following: •• Patient's confusion in the setting of cognitive, memory, and language deficits. •• Patient's inability to communicate discomfort or basic needs such as constipation, hunger, thirst, need to urinate, or pain. •• Patient's hallucinations or

delusions. •• Patient with additional delirium •• Delusions are reported in up to 50% of Alzheimer patients. •• Hallucinations (mostly auditory and/or visual) can be seen in at least 25% of patients with a major neurocognitive disorder. •• If hallucinations do not bother the patient or interfere with caring for the patient, pharmacotherapy is unnecessary. Behavioral and environmental treatments for behavioral symptoms are much preferred in the elderly. Pharmacological methods are appropriate in the setting of potentially harmful behaviors, but care must be taken in dosing, duration of treatment, and interactions with other medications. •• Music, art, exercise, and pet therapy. •• Strict daily schedules to minimize changes in routine. •• Continual reorientation of patient. •• Reducing stimuli (quiet living environments that are light during the day and dark at night). •• Surrounding with familiar objects (family photos, a favorite quilt, etc.). •• Ensuring patient has hearing aids, eyeglasses, and other basic needs.

- Limited efficacy in treating agitation, and carry increased risk of mortality that must be discussed in a risk-benefit assessment with patient and caregivers.
- Try olanzapine (Zyprexa) or quetiapine (Seroquel) in patients with severe symptoms.
- Can also use short-term haloperidol (Haldol) or risperidone (Risperdal).
- Can be useful in psychiatric emergencies. •• Anxiolytics:
- Anxiety symptoms may be due to unrecognized depression and respond well to an SSRI.
- Reserve benzodiazepines for very short-term, acute episodes and remember to watch for disinhibition (paradoxical agitation) and worsening confusion.
- Mood stabilizers: Few studies on their efficacy in the elderly. Sleep Disturbance The incidence of sleep disorders increases with aging. Elderly people often report difficulty sleeping, daytime drowsiness, and daytime napping. ■ Outside of normal changes associated with aging (see Table 9-3), causes of sleep disturbances may include other medical conditions, drug/alcohol use, social stressors, and medications. ■ Patients with movement disorders (Parkinson disease, progressive supranuclear palsy) have shallow sleep and may be more restless at night because of trouble turning in bed. ■ Restless leg movements during sleep, likely due to a dopamine imbalance, are called periodic leg movements (PLMs). ■ Nonpharmacological treatment approaches should be tried first (alcohol cessation, increased daily structure, elimination of daytime naps, encouraging daylight exposure, treatment of underlying medical conditions that may be exacerbating sleep problems). ■ Sedative-hypnotic drugs are more likely to cause side effects when used by the elderly (memory impairment, ataxia, paradoxical excitement, and rebound insomnia) and increase risk of falls. ■ If sedative-hypnotics must be prescribed, medications such as trazodone are safer than the more sedating benzodiazepines, but be careful of orthostasis. Other Issues RESTRAINTS ■ In nonemergency situations, restraints should be used as a last resort and the patient should be reassessed at regular intervals. TABLE 9-3. Normal Sleep Changes in Geriatric Patients Rapid eye movement (REM) sleep ↓ REM latency and ↓ total REM Non-REM sleep ↑ amounts of stage 1 and 2 sleep, ↓ amounts of stage 3 and 4 sleep (deep sleep) Sleep efficiency ↓ (frequent nocturnal awakenings) Amount of total sleep ↓ Sleep cycle Sleep cycle advances (earlier to bed, earlier to rise) GERIATRIC PSYCHIATRY

 ■ Patient safety, health, and well-being should be the most important concern in the matter of restraint use. ■ Evaluate ABCs in a restrained patient: airway, breathing, and circulation. ■ Many older people are on multiple medications (“polypharmacy”). ■ They suffer from more side effects because of

decreased lean body mass and impaired liver and kidney function. ■ When confronted with a new symptom in an elderly patient on multiple medications, always try to remove a medication before adding one. ■ Types: Physical abuse, psychological abuse (threats, insults, etc.), neglect (withholding of care), exploitation (misuse of finances), and rarely sexual abuse. ■ Approximately 10% of all people more than 65 years old; underreported by victims. ■ Perpetrator is usually a caregiver (spouse or adult child) who lives with the victim. ■ Physicians are mandated to report suspected elder abuse. ■ Provide care and rehabilitation for chronically ill and impaired patients as well as for those who are in need of short-term care before returning to their prior living arrangements. ■ The majority of patients stay permanently, and fewer than half are discharged after only a short period of time. ■ Careful medication review is imperative for nursing home patients who experience frequent hospitalizations and subsequent medication changes. ■ Caregiver burnout is very common in families of these patients, and can negatively affect patient care.