Basic Mental Health & Assessment
Issues in Older Adults

Presented by

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Geropsychiatric Dx Categories

- Recurrent functional impairment – chronic schizophrenia – long term MH issues
- Late onset functional impairment – depression – did OK when younger - late life challenges generate symptoms
- Neurocognitive impairment – dementia, delirium
- Minimally impaired – transient situational disturbance – tough adjustment to aging

Recurrent Functional Impairment

- Need stable living environment
- Case management
- Supportive therapist to deal with everyday living issues, monitor meds
- Day Treatment Program
- Community living vs ALFs vs NHs
- Emphasis should be on “recovery”

Late Onset Functional Impairment

- Problems typically center around losses patient has recently experienced
- Stabilize acute crisis
- Talk with family re recent stressors
- Individual therapy to address losses
- Group therapy – support & socialization

Neurocognitive Impairment – address acute problems 1st

- Delirium – identify & treat causes
- Stroke victims – depression affects rehab
- Dementia pts – can become depressed & psychotic – should be diagnosed & treated before “disruptive” behavior occurs – need person-centered approach
- After stabilization, focus on support to caregivers and teaching behavioral skills
Families of Dementia Pts

- Explain diagnosis & prognosis
- Education – what dementia is & isn’t
- Allow caregivers to ventilate concerns
- Problem-solving re difficult behaviors
- Aricept / Low dose psychiatric meds
- Brief respite hospitalizations
- Peer support groups
- Evaluate Nursing Home Placement option

Minimally Impaired

- Need to pass on unique shared legacy – could be knowledge & skills, family history, financial bequest or inheritance
- Life Review – gain perspective on life, generate meaning, achieve ego-integrity, gain wisdom
Detection & Treatment of Depression among Older Adults

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Myths of Mental Illness
- Mental illness is incurable
- Depression is a natural consequence of aging
- Preoccupation with death is typical of older adults
- Treatment of depression in older adults is ineffective

Prevalence in Older Adults
- Rates for older adults in community settings meeting the full (5) criteria for depression probably slightly less than in young adults
- Rates for dysthymic disorder (chronic minor depression where only 2 criteria are met) are slightly more in older adults
- Overall findings suggest that rates of depression for community dwelling older adults are similar to those of community dwelling younger adults

Prevalence of depression
- Most common late onset problem, and one of the most common late life problems
- Rates of depression in older adults are much higher in hospital, assisted living facility and nursing home settings than they are in community settings
Consequences of Late Life Depression

- Excess disability
- Functional decline
- Increased health service utilization
- Medical morbidity & mortality
- Reduced quality of life
- Caregiver burden – ½ of spouses depressed
- Suicide

Causes of Depression

- Genetics – inherited vulnerability
- Biological – changes in brain chemicals (decreases in norepinephrine, serotonin?) (but “chemical imbalance” theory has never been proven)
- Psychosocial – accumulation of losses – more typical of late onset depression

Common Losses of Aging

- Deaths of spouses, relatives, friends
- Retirement
- Parenting Role
- Health & Functioning
- Independence
- Prestige

Depression, Grief & Mourning

- Grief – personal emotional reaction to a loss
- Mourning – public display of grief
- Complicated Grief – Can be distinguished from depression & PTSD – (DSM-5 labels CG as depression)
  - Sustained negative mood change beyond the ‘normal’ bereavement period (3 months) – controversy in new DSM (reduce the time before it may be considered pathology?)
  - Preoccupation with thoughts of the deceased, searching & yearning for the deceased, disbelief about the death, crying, being stunned & not accepting the death
Symptoms of Depression

- Persistent sad, anxious, or “empty mood”
- Feelings of hopelessness, pessimism
- Loss of interest or pleasure in activities
- Sleep disturbance (too much / too little)
- Crying spells

Symptoms of Depression (cont)

- Eating disturbance (too much / too little)
- Decreased energy, fatigue, ennui
- Suicidal thoughts, gestures, attempts – white males over 75 have highest suicide rate

Symptoms Particularly Prominent in Older Adults

- Difficulty with concentration, making decisions
- Vague physical symptoms or chronic pain not responsive to treatment
- Memory complaints
- Anxiety
- Irritability
- Depletion syndrome – withdrawal, apathy, less energy
- However, less sadness, guilt, admission of suicidality

Rules of Thumb to Distinguish Depression from Dementia

- Depressed older adults are more likely to have prior depressive episodes
- Self-reported memory problems are more common among depressed patients
- With depression, more typically a sudden onset of ‘memory’ problems
Rules of Thumb (cont)
- Depressed people show affective changes along with cognitive changes.
- Errors on mental status exams variable & motivational.
- ‘Pseudodementia’ = Acute global cognitive changes - biochemical concomitants of depression.
- Depressed focus on disabilities; PWDs make light of memory problems.

Involutional Melancholia
Gradual onset age 40-55 (women) 50-65 (men):
- Anxiety & agitation & restlessness
- Somatic concern & Hypochondriasis
- Guilt ridden
- Occasional somatic or nihilistic delusions
- Insomnia
- Anorexia & weight loss

Depression comorbid with dementia
Depression & dementia frequently co-exist
Depression exacerbates memory problems
Late onset depression is a risk factor for development of dementia – perhaps due to executive/vascular involvement.

Depression in Dementia
- Resistance to care
- Lack of participation in care
- Refusal to eat
- Lethargy
- Increasing dependency
- Social withdrawal
Depression in Dementia (cont)
- Rapid deterioration in functioning
- Agitation, catastrophic reactions
- Delusions (e.g., about being poisoned)
- MDS has an item assessing depression
- Depression is now considered an indicator of QOL

Bio-psycho-social Intervention
- Medical Approaches
  - Physical – thorough exam should R/O physical causes of depression (med side-effects, lung cancer)
  - Biological – SSRI anti-depressants (Zoloft, Prozac) more benign side-effect profile than Tricyclics (Elavil) – less cardiotoxic
  - ECT – effective, but used as last resort – high relapse rates

Social Treatment
- Depression & social isolation are associated in older adults – older white males living alone without religious affiliation are highest risk for suicide
- Referral to Sr. Ctrs, volunteer organizations, church groups - replace losses, increase social support, feel productive again

Psychotherapy
- Helps older adults accept & ‘replace’ losses
- Confronts myth that aged person cannot change
CBT
Evidence-based treatment for depression in older adults
Teaches ways of changing negativistic, over-generalized thinking patterns e.g., being unable to do what you used to be able to do doesn’t mean that you are a complete failure as a person
Gallagher-Thompson’s work indicates that CBT may need to be supplemented by interpersonal therapy if older adult has a personality disorder

Interpersonal Therapy
- IPT is effective in treatment of depressed adults & preventing recurrences
- Appears well suited to deal with the interpersonal losses of older adults:
  - Grief/loss
  - Role transitions
  - Interpersonal conflict
  - Poor social skills

CBT Modifications
Some older adults less familiar with psychotherapy – need to be educated about what it's about before they accept it
Need to adapt to sensory impairments such as vision or auditory problems e.g., use bigger print for homework assignment
Older adults process information slower – need to simplify instructions, go slower, repeat, make sure person understands,
Materials can be adapted for those with cognitive impairment

Group & Family Therapy
- Group – Allows older individuals to discuss common aging issues; offers peer support
- Life review - evaluative reminiscence gains perspective on the past & affirmation from others – ‘probably efficacious treatment for depression’ – usually conducted in groups
- Family – chronic or late life marital stressors; estrangement from adult children; grandparenting strains
Grief Therapy

- Controversial area
- Debate over whether all bereaved should be offered grief therapy – treatment should never be mandated
- Many older adults are resilient and manage fine on their own with time
- Challenge will be to identify those who are most at risk for development of complicated grief

Final Points

- Each older person deserves an individualized assessment & treatment
- Many need combined approaches i.e., those depressed with PDs may need CBT + interpersonal therapy + meds
- Health professionals should aggressively assess depression in older adults just as with young adults
Serious Mental Illness

in Older Adults

SMI

• Longstanding psychiatric problems that significantly interfere with day-to-day living
• Most admitted to NHs for ‘medical’ reasons
• Many ALFs have people with SMI of all ages

Examples:
Schizophrenia; Major Depressive Disorder; Bipolar Disorder; Schizoaffective Disorder; Delusional Disorder

Schizophrenia – thought disorder (thought insertion, thought broadcasting, personalized messages); Mean Age of Onset – early-mid 20’s

2 or more of the following during 1-month period:
• Delusions – fixed false beliefs
• Hallucinations-auditory mis-perceptions common
• Disorganized speech – word salad
• Grossly disorganized behavior - catatonict
• Negative symptoms i.e., show little emotion, thinking not logical; isolate; low energy & interest
Paranoid;Disorganized;Catatonic;Undifferentiated

These sub-types are poorly defined & of little use

Late Life Schizophrenia

• Less severe positive symptoms; perhaps more negative symptoms (due to institutionalization; chronic meds?)
• Older adults with schizophrenia face many challenges – parental caregivers die
• Few placement options – 85% live in community
• 10% of NH residents have SMI – NH staff not well equipped – may over-medicate – concerned that they may hurt the older female residents
• ALFs – not well regulated re MH concerns
• SMI community programs not geared for older adults
• Limited research
Late onset Schizophrenia vs. older adults with early onset Schizophrenia

- Onset after age 40 = 20% of those with schizophrenia; onset after age 50 = 7%
- Late onset – more likely to be female
- Late onset – more likely to be paranoid type
- Late onset – less likely to exhibit negative symptoms
- Late onset – better prognosis

Late-Life Schizophrenia Treatment

- Course of schizophrenia better than expected
- Better prognosis: Associated with less severe negative symptoms & shorter illness duration
- Maintain on anti-psychotic meds, but perhaps lower dosage due to age changes
- Low emotionally expressive (EE) caregivers – don’t argue; more supportive; prioritize issues
- Social skills training

Late-Life Schizophrenia Treatment

- Individuals with schizophrenia prefer living in the community versus hospitals or institutions
- Those with schizophrenia function better in the community than in institutions
- Recovery movement – accept ‘illness’, but it does not define the person - still lead ‘normal’ lives
- Least restrictive environment - Olmstead Act
- Community care managers – encourage self-determination
- Affirm client choices even if professionals & families believe they know better than client

HOPES study

- Mueser et al. (2010) compared HOPES program to treatment as usual (TAU): 183 participants with SMI, aged 50+
  - HOPES (Helping Older People Experience Success)
    - Pharmacotherapy, case management, and year-long skills training phase, year-long maintenance phase
    - Developed to reduce long-term medical burden & to improve psychosocial functioning in SMI community living older adults
  - TAU (treatment as usual)
    - Pharmacotherapy and case management
HOPES (2)

- When added to the typical case management exposure, those in HOPES showed significantly greater improvement
- HOPES group improved more in social skills, community functioning, negative symptoms, self efficacy, & recreation
- Psychosocial rehabilitation, when paired with case management, can benefit older adults with SMI who have long-standing impairments in functioning

Costs of Institutionalization & Use of Case Management (Australia)

- Preston & Fazio (2000): to “identify whether chronic mentally ill persons after receiving intensive case management could demonstrate improved inpatient service utilization compared with a matched control group cohort”
- 80 participants matched with a control group
- Used the Mental Health Classification & Service Costs Project to calculate costs of each treatment

Preston & Fazio results

- Intensive case management “can be efficacious in reducing inpatient service utilization and cost effective when compared with standard community treatment” received by matched controls
- Total cost difference after one year
  - $396,111 in favor of intensive case management
- Total cost difference after two years
  - $801,475 in favor of intensive case management
- Intensive case management is effective in reducing overall costs related to inpatient service utilization and possible institutionalization

Assertive Community Treatment (ACT) – may work for older adults

- Team model – provides in vivo services and interventions to keep pts in community
- Living skills, housing, family support, health care, finances, counseling, meds, work
- Services provided 24/7 – wrap-around model
- Reduces hospitalizations; high consumer satisfaction; not more costly than case management or hospital/rehab care
Effectiveness of ACT for Older Patients With SMI: An RCT

• 62 outpts (60+ yrs) with SMI who were difficult to engage in psychiatric treatment randomly assigned to the intervention or control group.
• Relative to patients with TAU, more pts allocated to ACT had a first contact within three months.
• ACT for older pts also had fewer dropouts from treatment.
• No differences for other primary & secondary outcome variables (# of unmet needs; mental health care use; psychosocial functioning scores).

Mania – mood disorder; mean age of onset in 20’s

• Elevated expansive mood - exuberant
• Inflated self-esteem – “I am the greatest”
• Intrusive – “in your face”
• Decreased sleep – always “on the go”
• Pressured speech – can’t stop talking
• Flight of ideas – go from 1 idea to another
• Agitation if they don’t get their way
• Excessive pleasure-seeking

Late-Life Mania

• Some have more extreme highs than lows throughout their lives
• Myth that mania burns itself out with age
• Even though individuals are older, they can still have mania for the first time in their life
• Sometimes mania caused by anti-depressants or steroids – get a medical evaluation
• Little research done on mania in LTC settings

Bipolar Disorder - Treatment

• Lithium & other meds sig reduce but do not eliminate manic episodes. Major side-effects
• Family therapy & education re how to deal with current stress – family reluctant to have pt in remission resume responsibility
• Unlike those with schizophrenia, those with treated bipolar disorder often can maintain high level leadership positions
### Schizoaffective disorder
- Mixed symptoms of schizophrenia & bipolar disorder
- Disorders in thinking & mood
- Often on both mood stabilizers & anti-psychotics – side-effects can be tough
- ? Increased mortality rates for older adults
- Little research in this area

### Delusional Disorder - onset typically late - between age 40-60
- 2nd most common late onset dx (depression 1st)
- Believe something to be (un)true, despite contrary evidence (otherwise thinking logical)
- Delusions of grandeur, persecution, erotomania, jealousy, somatic
- Associated with hearing & vision problems
- Associated with mild memory problems
- Associated with living alone – lack consensual validation - no one challenges odd beliefs
- Can still live in the community – but QOL suffers

### Delusional Disorder Treatment
- Anti-psychotic medications
- Correct vision & hearing
- Increase socialization
- Need to build trust with 1 or 2 select persons
- Not enough research done on this topic, especially in LTC
Dementia – Major or mild neurocognitive disorder

- Generalized cognitive decline
- Must include memory deficits
- Irreversible
- Impairment in ADLs & IADLs
- No cures
- Many different causes of dementia

How do Memory Problems of Dementia differ from Normals

<table>
<thead>
<tr>
<th>Normal</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person can’t remember a phone #</td>
<td>Person can’t remember where s/he lives</td>
</tr>
<tr>
<td>Person forgets a detail of an event</td>
<td>Person forgets the whole event</td>
</tr>
<tr>
<td>Person remembers afterwards</td>
<td>Person completely forgets</td>
</tr>
<tr>
<td>Memory problems - an annoyance</td>
<td>Memory problems – interfere with living</td>
</tr>
</tbody>
</table>

Dementia vs. Delirium

- Cognitive deficits
- Clear consciousness
- Develops gradually over a long time
- Not associated with acute med problem
- Continued cognitive decline
- Risk factor for delirium

- Cognitive deficits
- Inability to attend
- Develops acutely over a short time period
- Caused by a general medical condition
- Usually improves with treatment – not always
- Can have dementia

Dementia & Depression

- Reflect memory problems & lack of initiative – can get confused
- Frequently co-exist
- Depression makes cognitive symptoms worse
- Late life depression is a risk factor for dementia – unclear why
Dementia vs. depression

<table>
<thead>
<tr>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory problems are permanent</td>
<td>Memory problems reversible if treated</td>
</tr>
<tr>
<td>Memory problems are relatively constant through the day</td>
<td>Memory problems are variable depending upon mood</td>
</tr>
<tr>
<td>Person denies memory problems</td>
<td>Person tends to call attention to problems</td>
</tr>
<tr>
<td>Person in OK mood</td>
<td>Person sad</td>
</tr>
</tbody>
</table>

Types of dementia - most cases are mixed types

- Alzheimer's Disease – plaques & tangles
- Vascular dementia – multiple strokes
- Lewy-Body Disease – hallucinations & PD like symptoms
- Alcohol-related
- Head Trauma (TBI)
- Parkinsons’ disease (PD)
- Huntington’s Disease
- Creutzfeldt-Jakob’s Disease – Mad Cow

Alzheimer’s Disease

- Most common form of dementia
- Accounts for 60-70% of dementia cases
- Over the age of 65 ~ 10% have AD
- Over the age of 85 ~ 40-50% have AD

- Vascular dementia is second most common

The cognitive impairment in AD is due to decline in neurons in the cortex. A healthy normally aged neuron is shown at the top and one in the later stages of Alzheimer's disease bottom.
How is dementia diagnosed?

- Need thorough history & medical exam to rule out physical causes
- Include EEGs, CAT scans & MRIs to rule out tumors, delirium
- Definitive dx on autopsy
- Diagnosis is made earlier now (MCI)
- New technologies (PET scans) & neuro testing making diagnosis more reliable

Psychological testing

- Mental status exams (MMSE; SPMSQ) are screening tools – test mostly verbal skills - not dx instruments
- Neuropsych testing can provide info re sub-types & cognitive strengths – but few interventions capitalize on this info
- Psych testing can help differentiate dementia from depression – this is important because depression is treatable

Early diagnosis

- Researchers believe that dementia is a neuropathological process that begins many years before clinical signs occur
- Dementia is diagnosed earlier & earlier
- What are the ethics of diagnosing a terminal condition before clinical signs are apparent without any treatment in sight?
- Plan for future vs. greater worry
Treatment

• Treat all other medical problems
• Aricept – may slow decline a bit in early stage; Memantine may help a bit in later stage
• Psychoactive meds not very effective in treating behavior problems, but can be helpful in improving mood
• Anti-psychotics – FDA warning – increased risk of cardiac problems, diabetes, mortality
• How about behavioral interventions for AD?

Caregivers

• Most interventions focus on caregivers – they do not abandon their loved ones
• Caregivers exhibit emotional, physical financial, social, and vocational stress
• Need to take a break from caregiving
• Respite care
• Support groups
• Other living arrangements – NHP; ALFs?

Don’t forget the PWD

• Support autonomy
• Include in health care decision-making based on capacity to participate
• Include in family discussions
• Garner assent for interventions and research trials even if incompetent
Reminiscence

- The act or process of recollecting past experiences or events
- A narration of past experiences
- The act of recalling or narrating past experiences

Butler: "A naturally occurring, universal mental process characterized by the progressive return to consciousness of past experience, and particularly, the resurgence of unresolved conflicts; simultaneously, . . . prompted by the realization of approaching dissolution and death, and the inability to maintain one's sense of personal invulnerability."


Life Review Reminiscence

- Butler - evaluative reminiscence - viewed as something positive, not as a memory problem or “living in the past”
- Erikson - integrity vs. despair stage
- A successful life review may put life in perspective and promote integrity
- Jung – older adults primed for change – coincides with notion of life review

FUNCTIONS OF GENERAL REMINISCENCE

- intrapersonal
- interpersonal
- 6 types (Watt & Wong qualitative analysis)
- 7 factors (Webster’s findings re RFS scale)
  1) Boredom Reduction; Conversation; Bitterness Revival – Negative
  2) Death Preparation; Identity/Problem-solving; Intimacy Maintenance; Teach/inform – Life Review
### Research findings with RFS – O’Rourke et al.

- Mental health associated with self-positive reminiscence functions (identity, problem-solving, death preparation)
- Physical health negatively associated with self-negative functions (bitterness revival, boredom reduction, intimacy maintenance)
- Prosocial functions (teach/inform, conversation) may have indirect positive effects on health

### General Research Findings on Reminiscence & Older Adults

- Not universal - only some older adults
- Young & elders reminisce same amount
- Older adults use more evaluative type i.e., death preparation & intimacy maintenance
- Not just triggered by approaching death – often caused by life crises
- Perhaps helps to achieve wisdom for some

### Only Aging-specific Treatment

- Life review therapy – structured activities by a professional therapist attempting to facilitate natural process
- Reminiscence intervention – past-oriented unstructured activities planned by laypersons for diversion or education

### Setting - Life Review & Reminiscence

- Atmosphere - warm & cordial
- Encourage within group socializing
- Well-lit soundproofed room
- Minimize distractions
Life Review Group Composition

- Conducted with cognitively intact members
- Participants motivated to examine life
- Requires ego strength & good general MH
- Not so disgruntled with old age to retrospectively negatively interpret past

LIFE REVIEW GOALS
Interpersonal & Intraperpersonal

- Bear witness to life stories – public voicing creates aging bond between members
- Identify a legacy for future generations
- Encourage a more affirming view of past
- Recognize that wisdom born of experience can be put to good current use
- Generate meaning from aging experience

STRUCTURE OF LIFE REVIEW GROUP

- 6-10 members - optimal group size
- Weekly meetings - assures continuity
- 60-90 minute sessions – perhaps shorter in LTC settings
- Closed time-limited groups preferred

LIFE REVIEW CONTENT

- Syllabus handed out at beginning
- 1st session - introduction to life review
- Topics - most important figures in life; school experiences; work histories; relationships; earliest memories etc.
- Encourage homework
- Last session – summarize accomplishments
**RESPONSIBILITIES OF GROUP LEADERS**

- Keep members ‘on track’
- Encourage all to participate; don’t allow one to dominate
- Be directive & supportive
- Focus on content - not group dynamics
- Denial mechanisms - gently confronted

**Goals of Reminiscence Groups**

- A way of re-connecting with remote past
- Promote positive view of life
- Mental stimulation
- Encourage socialization
- Keep active
- Reduce boredom

**Reminiscence Exercises**

- Sing-a-longs
- Name that Tune
- Movement & Dance
- Current Events & how they relate to past
- Sensory stimulation – what do these smells remind you of?
- Arts & Crafts focusing on the past e.g., draw the house you grew up in

**Evaluation**

- Life review – effective treatment for depression in community dwelling older adults – need more research
- Reminiscence groups – have been found to reduce depression and improve mood in cognitively impaired older adults in NHs
- No permanent effect on memory
Research Directions

• Practice & research should mutually inform
• Theory should guide research & practice
• Qualitative & quantitative studies necessary
• Evaluate short & long term consequences
• Are benefits specific to reminiscing?
• Investigate negative reactions