ECHO IDAHO

Behavioral Health in Primary Care

Mood Disorders in the Geriatric Population

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Objectives

1. Describe common geriatric mood disorders
2. Describe best practices in assessment of geriatric mood disorders
3. Discuss best practices in treatment of geriatric mood disorders

Common geriatric mood disorders

- Depression
- Mania
- Apathy
- Mood symptoms in the context of dementia
- Pseudobulbar affect
- Mood symptoms in the context of PTSD / Trauma (includes moral injury)
- Mood symptoms in the context of personality disorders

Uncommon geriatric mood disorders

- ADHD related emotional dysregulation
- Autism spectrum disorder with irritability
- Anxiety related anger, aggression and depression

“Depression” due to hearing loss” – demoralization

- F-80, retired teacher, widowed, children supportive
- Depression (no hope, avoids friends, hearing problems, memory problems, PHQ-9 15)
- Rx: audiologist referral – hearing improved, depression cleared, memory problems improved; omeprazole changed to pantoprazole; escitalopram eventually tapered and discontinued; social prescribing, art as prescription

Major Depression

- F-72, receptionist, retired. Husband supportive
- Depressive symptoms (frequently crying, not eating or sleeping well for months)
- Rx: medical workup (thyroid, vitamin deficiencies, pain); rational deprescribing (taper lorazepam over two weeks, taper and discontinue trazodone, taper and discontinue gabapentin given for "neuropathy"); evidence based non-drug Rx – counseling, behavioral activation, bright light therapy, exercise therapy; antidepressant duloxetine trial, chamomile extract; family support and guidance; pain management with topical agents; TMS considered

Depression in the context of dementia

- F-78, nurse, retired, widow, daughter supportive but stressed out
- Depressive symptoms (suicidal statements when put in memory care)
- Rx: medical workup (pain); rational deprescribing; evidence based non-drug Rx – counseling, individualized pleasant activity schedule IPAS, exercise therapy, gratitude-based interventions; antidepressant considered but avoided due to risk of falls, low sodium, bleeding; family support and guidance; adult day program

Mania

- M-65, retired police officer, brother supportive
- Mania with psychosis
- Rx: medical workup; rational deprescribing (ropinirole tapered and discontinued, was being given for RLS; discontinued prn ibuprofen); lithium and risperidone; family education

Apathy

- M-68, retired accountant, nursing home resident after stroke
- No interest in anything – diagnosed with "depression" and given sertraline
- Rx: taper and discontinue sertraline, staff and family education about apathy, discussion of trial of methylphenidate, music and exercise and pets and grandchildren-based interventions

Diagnosis – personal opinion

- Accurate diagnosis and identification of key biopsychosocial determinants is key to reduction in suffering / successful outcomes
- Misdiagnosis is very common primarily due to "fast medicine" and lack of team-based care

Comprehensive holistic assessment

- Medical problems (includes hearing, vision, pain, delirium, neurological conditions)
- Medication induced (includes intoxication, withdrawal, drug-drug interactions)
- Substance induced (includes intoxication, withdrawal, protracted withdrawal)
- Environment induced (e.g., loneliness, abuse, neglect, hospitalization, institutionalization, secure units, excessive noise, lack of structure and routine and predictability, lack of outdoors and green spaces and natural light)

Best Practices

Evidence-based care (prioritizing promoting Hope and reducing fear)

Biopsychosocial spiritual approach

4M's of Age-Friendly Health Care

Best practices

Trauma-informed care

DIEBA – Diversity, Equity, Inclusion, Belonging, Anti-Ageism (Anti-Dementia-ism)

Team approach

Case: Long buried sorrow

What is her yelling? A sign, a signal. A symptom of moral anguish calling our souls to understand her plight . My patient had never learned to experience her feelings as there was no one in her childhood or later who accepted her fully, who understood and supported her. And now with advanced dementia long buried sorrow that could never be expressed is set free and only touch and soothing voice can do the miracle of bringing her some solace. No meds please. No meds.

Medications – key risks in geriatric patients

All psychotropics: falls

Antidepressants: falls, bleeding (if used with anticoagulants), hyponatremia

Antipsychotics: Parkinsonism, akathisia, Tardive dyskinesias

Lithium: lithium toxicity

Anticonvulsants: valproate as harmful as lithium

Neurostimulation interventions underutilized

- TMS
- ECT

Psychedelics not adequately studied in geriatric population

- Psilocybin
- Ketamine

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Thank you

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