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Geriatric Psychiatry for the General Psychiatrist

1

Overview/Objectives

- Focus on:
  - **Depression**
  - **Dementia**
- Touch upon:
  - Anxiety
  - Substance use
  - Sleep

2

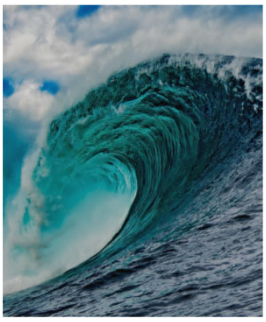
Case: Mrs M.

- 78 year old woman
- Summary of referral: "Sad old lady lives alone"
- Depression and anxiety
- Sleep changes: "Nightcap"
- Forgetfulness
- Medical issues: hypertension, elevated cholesterol, DM Type 2

3

The Demographic Imperative

- 15% of US population age 65+; expected to increase up to 22% by 2050
- 18-28% of the older adult population has significant psychiatric symptoms
  - This adds up to 9-13 million older Americans
  - 1600 geriatric psychiatrists in the US
  - 1:5600-6900



Jeste et al Arch Gen Psychiatry 56 (1999): 848-853.
https://www.census.gov/quickfacts/table/PST045215/00
http://www.americangeriatrics.org/advocacy_public_policy/gwps/gwps_faq/id-3183

4

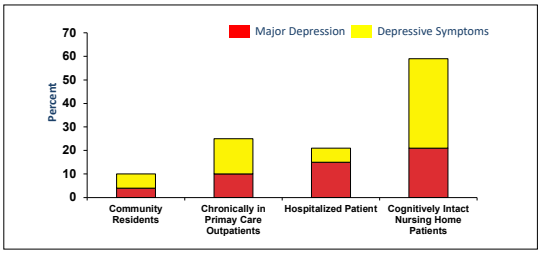
Later-Life Depression

- Depressive symptoms present in 8-16% of community adults
- MDD in the community is low 1-2% (lower than younger ages)
- First onset of depression after age 60 is common, about 50% of all episodes in older adults
- Prevalence increases with medical complexity

Alexopoulos GS *The Lancet*, 365 (2005), 1961-1970.
Byrne GJ Medicographia (2012) 34, 2339345.
Blazer DG. Journal of Gerontology: Medical Sciences, 58 (2003), 249-265.

5

Prevalence of later-life depression by health/independence status

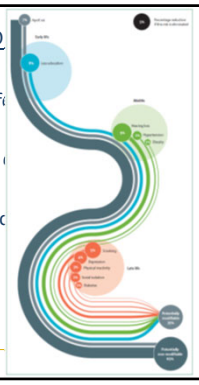


Adapted from Reynolds: Depression in later life: is it time for prevention?

6

LLD Creates Pro

- Causes individual suff… s baseline function
- Increases health care … eased motivation … adherence
- Independent risk facto… oses to dementia … x risk death



7

Risk Factors for Later-Life Depression

- Prior history
- Family history
- Medical illness/illness burden
- Psychosocial changes/poor social support
- Caregiver burden

8

A Word about Caregiving

- Caregivers are 2x as likely as non-caregivers to develop depression
- Spousal caregivers that experience emotional strain are significantly more likely to die than non-caregivers

- Exacerbating factors:
  - Caring for a person with behavioral symptoms of dementia
  - Receipt of limited help from others

9

What does LLD look like?

DSM V Criteria (must have symptoms for 2 weeks or more)

- Depressed mood
  - Anxiety; Irritability (48% meet criteria for GAD*)

  OR
- Anhedonia—lack of enjoyment
  - Withdrawal from social activities
  - "I don't feel well enough"
  - "I don't have the energy"
  - Neglect of personal appearance or of the home
- Sleep disturbance
- Appetite/weight change

10

What does LLD look like?

- Decreased energy
  - May be hard to distinguish from that caused by other illness
- Motor agitation (pacing/fidgeting) or retardation (feeling slowed)
- Decreased concentration
  - Forgetfulness; may be hard to distinguish from early dementia
- Guilt/worthlessness
- Suicidal ideation
- Worsened physical or pain symptoms

YOU DON'T HAVE TO FEEL **SAD** TO BE DEPRESSED!!!!!

11

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	Yes / ***No***	
2.	Have you dropped many of your activities and interests?	***Yes*** / No	
3.	Do you feel that your life is empty?	***Yes*** / No	
4.	Do you often get bored?	***Yes*** / No	
5.	Are you in good spirits most of the time?	Yes / ***No***	
6.	Are you afraid that something bad is going to happen to you?	***Yes*** / No	
7.	Do you feel happy most of the time?	Yes / ***No***	
8.	Do you often feel helpless?	***Yes*** / No	
9.	Do you prefer to stay at home, rather than going out and doing new things?	***Yes*** / No	
10.	Do you feel you have more problems with memory than most people?	***Yes*** / No	
11.	Do you think it is wonderful to be alive?	Yes / ***No***	
12.	Do you feel pretty worthless the way you are now?	***Yes*** / No	
13.	Do you feel full of energy?	Yes / ***No***	
14.	Do you feel that your situation is hopeless?	***Yes*** / No	
15.	Do you think that most people are better off than you are?	***Yes*** / No	
		TOTAL	

(Sheikh & Yesavage, 1986)

Scoring:

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

12

Bereavement

- In first 2 yrs of widowhood, distress is common
- After year 2, 14% of bereaved have MDD
  - Subsyndromal symptoms more common
- Therapy helps most with subsyndromal sx
- Treat with meds if severe symptoms:
  - Thoughts of death
  - Greatly impaired functioning

13

Medical Comorbidity with Depression

- Cardiac disease
  - ~20% of cardiac patients
  - Post-MI patients with depression have significantly higher death rates

- Diabetes
  - 12% MDD, 9-30% Depressive sx
- Post CVA
  - 20-50% (50% with vascular dementia have MDD)

- Neurodegenerative illnesses
  - 20-40% of Parkinson's patients
  - ~20% of Alzheimer's patients

14

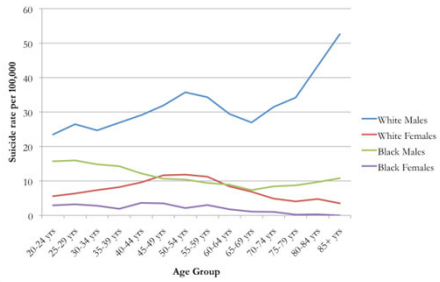
Differential Diagnosis of Geriatric Depression

- Dementia
- Substance abuse
- Prescription meds
- Endocrine d/o
- Metabolic d/o
- Neoplasms
- Infections
- Other mood disorder

- Days-Weeks
  - DELIRIUM
- Weeks-Months
  - DEPRESSION
- Months-Years
  - DEMENTIA

15

2013 Suicide Rates in US—Age, Race, and Gender



16

Later-Life Depression and Suicide

- Older white men have the one of the highest suicide rates
  - ***5-6X*** the rate of the general population
    - 6000 older adults commit suicide each year
    - 17 per day
    - 1 every 84 minutes
- Majority had seen a primary care physician in the last month of life
  - 39% in the last week –-> Always ask!
- Most suicidal patients have a diagnosable depression

17

Suicide Risk Factors

- Depression
- Substance abuse/dep
- Physical decline
- Physical illness
- Terminal illness
- Pain
- Loss of independence
- Economic problems
- Social isolation
- Retirement difficulties
- Loneliness-1/3 report
- Recent loss of significant other
- Anxiety

18

Later-Life Depression and Cognition

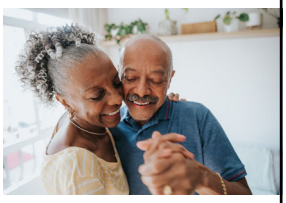
- Depression and cognitive problems "travel" together
- Non-demented elderly with depression often have difficulty with concentration, speed of mental processing and executive function
  - Many of these symptoms may subside with treatment, but can be an early manifestation of a more permanent disorder
- Depression may either be a prodrome of dementia or a risk factor for it

Byers, A. L., & Yaffe, K. *Nature Reviews Neurology*, 2011, 7(6), 323-331.

19

Later-Life Depression is Treatable!

- 60-70% improve with medications
- Reduces suffering
- Restores optimal level of function and independence
- Decreases health care costs



20

Treatment of Mood Disorders Non-Pharmacologic

- Optimizing treatment of medical conditions
- Shoring up social supports
- Increasing activity
- Religion/Spirituality
- Therapy helpful for mild-moderate depression especially if life stressors

21

Evidence-Based Psychotherapy for Later-Life Depression

- Cognitive Behavioral Therapy
  - Focus on faulty perceptions, pessimistic predisposition; use of homework and behavioral activation
- Problem-Solving Therapy
  - Helpful for patients with executive dysfunction; pragmatic focus, solutions elicited from patient
- Interpersonal Therapy
  - Present-oriented, focus on interpersonal conflict, role changes

Klosses, D. N., Leon, A. C., & Areán, P. A. (2011). *Psychiatric Clinics North America*, 34(2), 377-401

22

Start Low, Go Slow, Don't Stop!
(particularly in anxious patients)

- Start Low
  - 1/4-1/2 the usual starting dose for younger adults
  - If anxious, or older, but work it up as tolerated.
- Go Slow
  - If minimal improvement, increase q6-8 weeks
- Don't Stop
  - If needed for symptom resolution, get to near-max doses
- Be Patient
  - Up to 12 weeks for anxiety

23

Treatment Duration

- Single episode
  - 6-9 months after remission, taper slowly
- Recurrent or psychotic/severe
  - 3 strikes and you're on!
- Continuing treatment prevents relapse

Reynolds CF et al *New England Journal of Medicine*, 354 (2006), 1130-1138.

24

SSRIs

- Mechanism: Block reuptake of 5-HT
- First line treatment, safer in overdose
- Common Side Effects:
  - GI upset, usually transit
  - Headache
  - Sexual side effects
  - "Early activation"
  - Discontinuation syndrome
  - -HypoNa
  - -Anti-platelet effects
  - -Insomnia/somnolence
  - -Generally minimal weight gain, about 1% per year
  - -Falls/fracture?

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25

SSRIs

- Indications for depression and many anxiety d/o
- ***Sertraline** (Zoloft) start 25, range 50-250
- ***Citalopram** (Celexa) start 10, range 10-20
- ***Escitalopram** (Lexapro) start 5, range 10-20
- Paroxetine (Paxil) start 10, range 10-50
- Fluoxetine (Prozac) start 10, range 10-120
- Fluvoxamine (Luvox) start 25, range 50-300

*SSRIs with fewest interactions

*2011 FDA warning

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26

SNRIs

- Mechanism: 5-HT and NE reuptake blockade
- Duloxetine (Cymbalta) start 20, range 20-120
- Venlafaxine (Effexor) start 37.5, range 75-375
- Desvenlafaxine (Pristiq) start 50, range 50-100
- More activation
- Increase in diastolic BP
- Withdrawal syndromes
- Indication for chronic pain

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27

Bupropion (Wellbutrin)

- Mechanism: NE>>DA
- Fewer sexual SE, less weight gain
- Risk of seizures
- Agitation, insomnia, confusion, tremor
- Smoking cessation
- Variable dosing formulations- SR, XL
- Start 100-150 mg, range 100-450 mg

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28

Mirtazapine (Remeron)

- Mechanism: NE/5-HT, some alpha blockade
- Prominent histamine 1 blocker
  - Sedation, weight gain are benefits (or SE)
- 5-HT3 antagonist – anti-nausea effects
- Few sexual side effects
- Start 7.5 mg, range 15-60 mg (inverse dose response curve)
- 0.1% incidence of neutropenia

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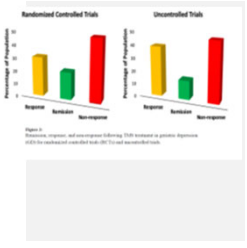
29

Transcranial Magnetic Stimulation

- Need for treatments that preserve cognition and reduce polypharmacy
- TMS is safe and very well-tolerated
- With current protocols, about 50% attain response (about half of which attain remission)
- Brain-related changes of aging may alter how TMS reaches the cortex and impact treatment response
- New optimized protocols hold promise for the treatment of later-life depression (targeting specific regions or altering sessions/pulse count)



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30

Electroconvulsive Therapy (ECT)

- Safe, effective, most rapid treatment for depression and mania- up to 85% response
- Indications:
  - Failure of medications
  - Intolerance of medications
  - Cannot wait for medication trial, acute suicidality, catatonia
- Mortality rate 1/10,000; usually cardiac

UC DAVIS HEALTH Galvez et al Curr Psychiatry Rep 2015 31

31

Case

- 78 year old woman
- Depression and anxiety
  - GDS of 10, passive suicidal ideation
  - Generalized anxiety
- Sleep changes: "Nightcap"
  - Shot before bed to help her fall asleep; middle awakening
- Forgetfulness
  - MOCA of 25
- Medical issues:
  - Abnormal TSH
- Psychosocial: rich life tapestry; bereavement; good candidate for psychotherapy

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32

Dementia and BPSD

- Devastating syndrome affecting 5 million people in US, 16 million by 2050
- **Non-cognitive behavioral and psychological symptoms of dementia (BPSD)** are universal (>98%)
  - Can occur at any disease stage
  - Occur with every type of dementia
  - Often dominate the disease course
  - Associated with poor outcomes
  - Role of the family caregiver is critical

- Depression
- Anxiety
- Apathy
- Psychosis
- Agitation
- Aggression
- And "many more"

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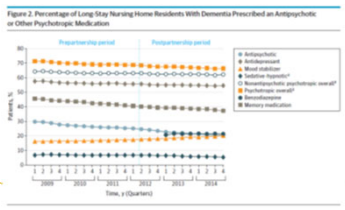
33

Antipsychotic use HAS declined—but does that mean that fewer people with dementia are being medicated with psychiatric drugs?

- Programs such as CMS' National Partnership have driven down nursing home AP use
- Unintended consequences?: Shift to other psychotropics with less evidence of benefit and similar risks?



Maust, Kales et al JAMA Internal Med 2018

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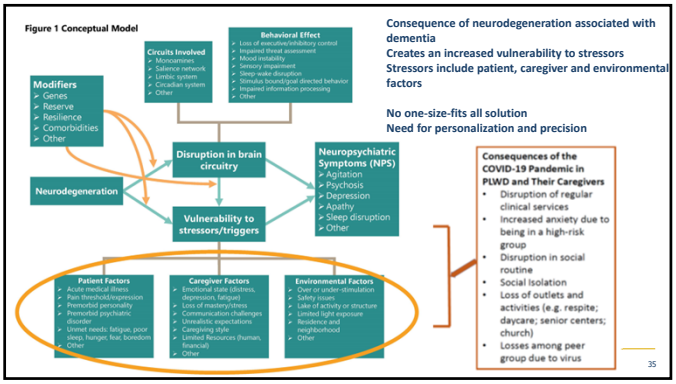
34



Consequence of neurodegeneration associated with dementia
Creates an increased vulnerability to stressors
Stressors include patient, caregiver and environmental factors

No one-size-fits all solution
Need for personalization and precision

Consequences of the COVID-19 Pandemic in PLWD and Their Caregivers

- Disruption of regular clinical services
- Increased anxiety due to being in a high-risk group
- Disruption in social routine
- Social Isolation
- Loss of outlets and activities (e.g. respite; daycare; senior centers; church)
- Losses among peer group due to virus

35

35

Does how we treat behaviors currently make sense?

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36

Non-pharmacologic approaches: best evidence

- Behavioral, environmental, and caregiver supportive interventions that have a growing evidence base
- Most significant evidence base for caregiver interventions that train caregivers to:
  - Use problem-solving skills to manage behaviors
  - Increase tailored activity for the person with dementia
  - Enhance communication in the dyad
  - Reduce environmental complexity
  - Simplify tasks for the person with dementia

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37

The DICE Approach

- Program for Positive Aging organized and funded a 2011 meeting of national experts across disciplines
  - Consider possible etiologies
  - Include caregiver in process
  - Integrate pharmacologic and non-pharmacologic
  - Build in flexibility to use in various care settings
  - Goal to avoid knee-jerk prescribing without assessment of underlying causes
  - ***We need to better PACKAGE non-pharmacologic approaches**

Kales, Gitlin, Lyketsos JAGS 2014

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38

- **Describe** a behavior that challenges; who, what, where, when, and how the behavior occurs
- **Investigate** thinking like a detective and explore the person with dementia, the caregivers, and environment for possible clues to triggers underlying possible causes of behavior
- **Create** a prescription in collaboration with your team to help prevent and manage behaviors
- **Evaluate** and review prescription effectiveness, and modify or restart the process as needed

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39

How does DICE differ from other approaches out there?

- Approach is algorithmic
  - Simple but elegant
  - Designed to be easy to remember and to help create "good habits"
- Integrates pharmacologic and non-pharmacologic approaches
- Expands the discussion of medications beyond psychiatric medications to other medications (for pain, infection, constipation, etc)
- Strategies are tailored to the PWD, caregiver and environment

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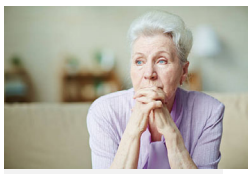
40

Case: Mrs. M.

- 85 year old woman
- Now with dementia
  - MOCA 18
  - Neuropsychological testing consistent with a neurodegenerative process
- Family calls that patient is getting "agitated" at home; "Can you give her something to calm down"



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41

DESCRIBE

- Full and accurate description of the behavior
- Critical step often left out
  - Do we treat "shortness of breath" with antibiotics without history, physical or labs?
- Full description leads to underlying cause possibilities
- ***Clinical scenario**: Mrs. M with "agitation"*
- Learn to "play it back like a scene from a movie"

WHO?
WHEN?
WHERE?
WHAT?

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42

DESCRIBE the problem behavior

Mrs. M:

- "Agitation": moved into daughter's home recently. Asking the same questions over and over. Gets anxious about upcoming appointments. Starts to follow daughter all over the house.

Family:

- Approaches Mrs. M in haste; overburdened
- Confrontational/negative tone: "I already told you that you have your doctor's appointment tomorrow!"

Environment

- No structure to the day.
- No activities.
- Mrs. M. mostly sitting in chair watching TV.

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43

INVESTIGATE

- Another "left out" step
- This step is led by the clues from DESCRIBE
- Play "detective" to search for underlying causes/triggers of behavioral symptoms
- Triggers often come from ≥1 of three categories

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44

Patient Factors

Problem	What you might notice
Pain	• Holding or rubbing part of body • Fast breathing • Groaning or moaning • Tension • Pushing away when touched
Constipation	• Pain and difficulty opening bowels • Hard poo • Pain on touching stomach
UTI (Urinary Tract Infection)	• Burning pain on passing urine • Urinating more frequently • Cloudy or different smelling urine
Recent changes in medication	• Dose changes in long-standing medications • New medications causing behavioral changes (e.g. Benadryl, Ditropan)

Caregiver Factors

- "Doing this on purpose"
- Reacting harshly
- Offering too many choices
- Expecting more than possible
- Feeling stressed, anxious, depressed
- Family, facility or cultural expectations

Environmental Factors

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45

INVESTIGATE underlying causes

Mrs. M:

- Past history of depression/anxiety; not currently depressed
- Anxious component
- Ditropan for incontinence; anticholinergic effect? (confusion)
- Type II Diabetes; are blood sugars under control?
- Is safety at risk?

Family:

- Communication is not optimal (negative tone, critical, confrontational)
- Lack of education about dementia stages (multistep commands)
- Is safety at risk?

Environment

- Lack of structure
- Lack of personalized activities
- TV on

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46

CREATE-Six general strategies

- Manage any physical problems

- Provide family/staff education/support
- Improve communication

- Create meaningful and tailored activities

- Simplify tasks

- Ensure the environment is safe

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47

Create/implement collaborative treatment plan

Mrs. M:

- Consider replacing Ditropan with a more bladder-selective agent
- Low blood sugars pre-meal could be triggering irritability; schedule snack if lunch is late
- Hold on increasing antidepressant for anxiety to see if non-pharmacologic strategies could work

Family:

- Psychoeducation on dementia stages and simplifying communications
- Offer choices but limited
- "Playing the role"; go with the affect (reassure)
- Inform of events as they occur; use of a calendar or white board
- Change tone (replacing negative, critical, confrontational tone); calm touch
- "Set the stage" for activities with communication

Environment

- Structure
- Increase the amount of natural light in the room for cuing
- TV may overstimulate
- Create activities tailored to interest/abilities

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48

PD-DOC

Describe

Date 1-24-2018

Behavioral severity/frequency: Rate the severity and frequency of the behavior from 0 to 4. If the severity and frequency are different, pick the higher score (e.g. a behavior that is daily but mild should be scored as a 4)

0 =none and/or never
1 =mild and/or occasionally
2 =moderate and/or sometimes
3 =severe and/or frequently
4 =very severe and/or daily

APATHY OR INDIFFERENCE

49

Evaluate the interventions

Mrs. M:
- Did a new bladder medication impact behavior?
- Did stabilizing blood sugars impact behavior?

Family:
- Was calendar or white board implemented?
- Were family members able to improve the quality of communication?
  - Tone; avoiding confrontation; simplification; informing of events as they occur; playing the "role" of a calm caregiver; "going with" the affect

Environment:
- What new activities were created and what impact?
- Was adding structure to the day helpful?
- What impact did improving lighting have?

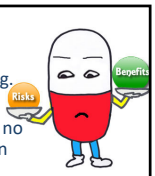
50

What medications are approved by the US Food and Drug Administration for dementia behaviors?

- NONE!
- All use of psychiatric medications in dementia is "off label"
  Drugs are approved and "labeled" by the FDA after being rigorously tested for specific uses
  Off-label use means using a drug that is approved for one condition, for another condition that it is not approved for

51

Risk/Benefit



- Off-label use of medication is not necessarily a bad thing (e.g. rare diseases and cancer)
- However, with psychiatric medications in dementia, there is no FDA indication because the **risks** (many side effects and even death) outweighs the **benefits** (modest efficacy at best) in many cases
- *The DICE Approach does not prohibit medications*
- But rather, we encourage **careful consideration of the risks and benefits in EVERY case**

52

Safety first!

- Always assess safety as part of the DESCRIBE step!
- If anyone's safety is at risk, call the doctor immediately

- Psychiatric medications as a first-line therapy in **THREE cases**
  - *Major (clinical) depression with or without suicidal thoughts*
  - *Aggression with risk of harm to self or others*
  - *Psychosis with risk of harm to self or others*
- Note: People with chronic mental illness

53

Goal of the DICE Approach

- Avoid the "knee-jerk" use of medications without assessing the possible underlying causes
- Knee-jerk medication use ("agitation"=Risperdal) causes many problems
  - Worsening of symptoms
  - Ignoring the underlying cause (pain, urinary tract infection)
  - Unnecessary sedation and other side effects (including falls, worsened memory)
  - Worsened quality of life
  - Death

54

Consider the following….

- Be careful not to medicate the distress of
  - The caregiver/family
  - The staff at facilities
  - Yourself!
- Consider whether the "science-based" pharmacologic approach (e.g dopamine receptor blockade of antipsychotics) is really the most evidence-based and patient-centered.
- Medications do NOT treat: repetitive questions; wandering; unfriendliness; poor self-care.

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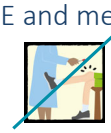
55

Last overview thoughts about DICE and medications

- Avoid knee-jerk use of psychiatric medications
- Rather use a targeted approach to medications



- Expand the consideration of "medications" with behavior to non-psychiatric medications
  - Pain control
  - Antibiotics for infections
  - Bowel regimens for constipation
- *Patients need to be told to never stop medications without consulting the prescribing provider*

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56

Commonly used medications

- ***Memory medications:*** symptomatic improvement of memory but have been touted as helpful to improve behavior

Medication	Benefit	Risk
Cholinesterase Inhibitors (Aricept, Razadyne, Excelon)	• RCTs have **not** shown improvement in behaviors with dementia except for Parkinson's disease dementia	• Diarrhea • Nausea/vomiting • Heart rate slowing
Namenda (Memantine)	• **No** evidence for behavior improvement in RCTs	• Dizziness • Headache • Confusion • Constipation

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57

Commonly used medications-II

- ***Antidepressants:*** used for depression, anxiety and agitation in dementia

Medication	Benefit	Risk
Older antidepressants (e.g. Pamelor or nortriptyline, Elavil or amitriptyline)	• Research trials have **not** shown improvement in behaviors	• Low blood pressure • Seizures • Diabetes • Anticholinergic effects • Heart rhythm problems • Weight change • Falls
Newer antidepressants (e.g. Celexa/citalopram, Zoloft/sertraline)	• **Mixed results in depression trials** • **Promise for the treatment of agitation and possibly psychosis**	• Nausea and vomiting • Headaches • Sleep changes • Diarrhea • Low sodium levels • GI bleeding • Possible heart rhythm abnormalities

58

Commonly used medications-III

- ***Benzodiazepines:*** anti-anxiety and sleeping medications

Medication	Benefit	Risk
Benzodiazepines (e.g. Ativan/lorazepam, Valium/diazepam, Xanax/alprazolam)	• Research trials have **not** shown improvement in behaviors • Only use is **short-term crisis management** if the person's behavior is truly dangerous	• Worsened memory • Excess drowsiness • Balance problems and risk of falls • Slowed breathing rate • Dependency/withdrawal • Can make behavior worse!

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59

Commonly used medications-IV

- ***Antipsychotics:*** the only medication with some good but modest evidence of efficacy, BUT….

Medication	Benefit	Risk
Older antipsychotics (e.g. Haldol/haloperidol)	• Research trials have **not** shown improvement in behaviors • Only use is **short-term crisis management** if the person's behavior is truly dangerous or in hospitalized patients with delirium	• Similar side effects to the newer antipsychotics but worse (higher risk of mortality)
Newer antipsychotics (e.g. Risperdal/risperidone, Seroquel/quetiapine)	• Risperdal has been found to **improve behaviors like agitation in a limited/modest way** • Useful if the person is **psychotic** • Useful for **short-term crisis management**	• Anticholinergic effects • Low blood pressure • Abnormal heart rhythms • Parkinson-like symptoms • Abnormal movements • Weight gain • Diabetes • Worsened memory

60

Commonly used medications-V

- ***Mood stabilizers:*** used for seizure disorders and bipolar disorder but have also been used for behavior in dementia

Medication	Benefit	Risk
Depakote/valproic acid	• Research trials have not shown improvement in behaviors	• Sleepiness • Abnormal walking • Tremor • Hair loss • Lower platelet count • Confusion • Liver or pancreas problems • Increased blood ammonia • Increased risk of death
Tegretol/carbamazepine	• Some evidence that it may be helpful for agitation	• Hepatitis • Blood abnormalities • Confusion
Gabapentin	• No evidence from research trials of benefit	• Drowsiness • Dizziness • Loss of coordination • Fluid retention in extremities • Nystagmus

61

Sleep

- People with dementia often have trouble with sleep
- Always try non-medication routes FIRST as most sleep medications have significant side effects (ESPECIALLY FALLS!)
- Use DICE to figure out the underlying cause of sleep problems
  - Pain
  - Napping during the day
  - Caffeine
  - Not enough daytime activity or exercise
  - Lack of established routines
  - Lack of enough natural light

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62

Use a night light
Create a quiet bed-time routine
Calming music
Evaluate environment and remediate temperature, noise, light, shadows, or other possible disturbances

If all non-medication routes have failed, and the caregiver is losing sleep, consider a trial of:
- low-dose trazodone (25-50 mg)
- mirtazapine (7.5 mg)
- Melatonin

NO BENZOS

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63

Summary

- Depression and dementia are the most common later-life psychiatric syndromes
- Later-life depression may present differently than in earlier life but is highly treatable
- Behavioral and environmental approaches are first-line treatments for behavioral disturbances in dementia

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64