



# Psychiatric Care of the Aging Veteran

DR. LORI SUVALSKY

DR. JAMES CHAMBLISS

# Financial Disclosures

- ▶ Lori Suvalsky, M.D. – spouse own stock in Pfizer
- ▶ James Chambliss, M.D., MPH – nothing to disclose

# Objectives

- ▶ Recognize an aging Veteran with need for psychiatric care.
- ▶ Describe non-pharmacological interventions for helping aging Veterans in need of psychiatric care.
- ▶ Describe the role of pharmacological interventions for helping aging veterans in need of psychiatric care.
- ▶ Understand some of the differences between diagnosis and treatment in older Veterans compared with younger Veterans

# Patient Presentation

- ▶ Veteran R.D. is a 78-year-old male who was admitted (after this was suggested by his neurologist) to the VA for behavioral issues at home
  - ▶ Wandering/getting lost when picking up grandchildren
  - ▶ Wife reported increased anger and confusion/memory problems at the time of admission
  - ▶ Disorganization was a prominent feature of cognitive impairments
  - ▶ Anxiety related to not remembering what wife had told him minutes earlier
- ▶ Veteran demonstrated confabulation to some degree, though some of the “fantastic” stories he told about his life turned out to be true!
  - ▶ History of being a boxer with numerous knock outs/possible brain injuries
  - ▶ History of being a real estate agent – “the best our town ever saw”
  - ▶ History of farming successfully

# Diagnoses and Previous Treatment

- ▶ Previous records (and report from wife) indicated a remote diagnosis of Bipolar Affective Disorder though not treated for this at the time of admission (previous treatment with lithium, buspirone)
- ▶ Veteran was seeing a community provider and was on high dose opiates (hydrocodone/acetaminophen 10/650 mg q.i.d. p.r.n. – used regularly and sometimes excessively), as well as long-standing benzodiazepines (clonazepam 1 mg twice daily) – both had been taken regularly for at least 10+ (possibly 20) years
- ▶ Veteran had been previously diagnosed with Posttraumatic Stress Disorder related to military combat trauma – current symptoms were challenging to elucidate due to cognitive problems
- ▶ Veteran had a history of multiple suicide attempts, but most severe was hanging himself – found by son who cut him down – required cervical spine fusion (C3-T1) related to this – this was the inciting incident that resulted in his long-term opiate prescription
- ▶ Dementia diagnosis (“Major Neurocognitive Disorder”) was made several years ago – there was speculation that this might be multifactorial, including Alzheimer’s features, vascular features, and some possible contribution from CTE

# Hospital Course

- ▶ Veteran had been briefly treated with divalproex by neurology due to increased impulsivity (partially chosen based on history of bipolar disorder)
- ▶ First change made to regimen was to start risperidone (subsequent dose escalation to max of 2 mg + PRNs, ultimately discontinued due to concern for ambulation difficulties, possible stroke-like presentation, and significant sedation on this dose); melatonin was also started
- ▶ Divalproex had been discontinued prior to admission by neurology due to concerns it had increased anxiety (wife disagreed – felt divalproex had been helpful) – it was therefore restarted once this was discussed with wife when risperidone was ultimately not tolerated by Veteran; eventually, gabapentin was also started with good results for anxiety and acting out behaviors – both scheduled and PRN
- ▶ Team discussed importance of tapering clonazepam, replacement of hydrocodone/acetaminophen with buprenorphine/naloxone – however, first Veteran was trialed on regular acetaminophen with lower dose opiate and the window was stretched from every 4 hours to every 6 hours – and demonstrated good pain control
- ▶ Ultimately, buprenorphine/naloxone was not started, as Veteran's pain control was adequate with creams, NSAIDs, and acetaminophen, and he demonstrated no evidence of withdrawal from opiates despite his incredibly long history on them

## Hospital Course, con't.

- ▶ Clonazepam was tapered during the hospitalization from 1 mg twice daily to 0.25 mg in the morning (to be discontinued on 8/8/20) and 0.5 mg at bedtime (to be reduced to 0.25 mg on 7/25/20 and discontinued completely 2 weeks after the morning dose) – no ill effects (withdrawal, evidence of need for the medication) were noted throughout this taper
- ▶ OT and Neuropsych testing completed during hospitalization – both supported the need for 24/7 supervision due to the severity of his cognitive deficits/executive functioning, which wife was not able to provide
- ▶ Veteran's wife worked with Social Work on an application for the Iowa Veteran's Home and he was ultimately accepted on CLC-1 (dementia unit within the VA) while waiting for a bed to become available

# Posttraumatic Stress Disorder

UNIQUE FINDINGS IN OLDER ADULTS



# PTSD in Older Adults

- ▶ 50-90% of US older adults have been exposed to at least one type of potentially traumatic event<sup>1</sup>
- ▶ Lifetime prevalence of PTSD ranges from 3.6-6.3% among men and 7.9-13.8% among women<sup>2</sup>
  - ▶ Lower rates of PTSD in older adults compared to younger adults
  - ▶ Recent meta-analysis suggested prevalence of PTSD among Afghanistan/Iraq veterans up to 23%<sup>2</sup>
- ▶ Prevalence of US Veterans with exposure to traumatic events ranges from 85-87%<sup>1</sup>
- ▶ Older Veterans are in fact at risk for experiencing multiple traumatic events over the course of their lifetime
- ▶ There is some evidence to suggest that stressors associated with aging can exacerbate PTSD symptoms
  - ▶ Role and functional changes like retirement, bereavement, physical issues, decreased autonomy, decreased social support

# Posttraumatic Stress Disorder

- ▶ PTSD is a disorder that can develop after a person experiences or witnesses an extremely stressful or traumatic event
- ▶ Symptoms include intrusions (distressing memories, nightmares, flashbacks), avoidance of reminders of the trauma (thoughts, people, situations), negative alterations in cognition or mood (negative beliefs or emotional state, feeling detached, inability to experience positive emotions), and hyperarousal (irritable behavior, hypervigilance, exaggerated startle)
- ▶ To meet criteria, symptoms must begin or increase following the trauma, last for at least one month, and cause clinically significant distress or impairment in functioning



## PTSD cont.

- ▶ It is useful to place assessment within a life-span developmental framework recognizing that PTSD symptoms in older adults are occurring within developmental trajectories, including late-life challenges, such as changing social networks and medical conditions, as well as late-life strengths in coping, and a potential late-life press for life review and reconciliation
- ▶ It seems that older adults have lower intensity intrusions and less avoidance due to implementation of a lifetime of coping strategies
- ▶ However, PTSD carries negative implications on cardiovascular and other health

# PTSD in Older Adults



- ▶ As of 2015, 9.7 million US veterans were 65 years of age or older<sup>1</sup>
- ▶ Some studies have attempted to look at age as an indicator for prognosis and seem to show some worsening of prognosis in older (55 or older) versus younger<sup>1</sup>
  - ▶ Recommendation is multi-faceted treatment (psychotherapies, medications)
  - ▶ Veterans 65 years of age or older are significantly less likely to receive mental health treatment than those 50-64<sup>2</sup>
  - ▶ Veterans 65+ were also more likely to only receive medications as treatment whereas those 50-64 were more likely to receive only psychotherapy<sup>2</sup>
- ▶ PTSD is also associated with alterations in neurocognitive functioning at the behavioral and neural level, including impairments in verbal learning, speed of information processing, attention/working memory, verbal memory, and executive functioning
- ▶ PTSD is a risk factor for development of Major Neurocognitive Disorder or Dementia
  - ▶ PTSD is associated with an accelerated or premature aging process<sup>2</sup>

# Psychotherapy

- ▶ Almost all RCTs of psychotherapy for PTSD do not include older adults
- ▶ Evidence-based psychotherapies for PTSD include prolonged exposure, cognitive processing therapy, cognitive behavioral therapy with trauma focus, and eye movement desensitization reprocessing – much of the work to tailor these treatments for sufferers of PTSD were developed through the VA system
- ▶ Consensus seems to be that psychotherapies that do not include a trauma processing component are less beneficial<sup>1</sup>
- ▶ Exposure appears to be an important aspect of evidence-based therapies for PTSD, and this treatment strategy is safe and effective for older adults for ameliorating trauma symptoms<sup>1</sup>
  - ▶ This is important because it was previously believed to set the patient up for increase in physiological arousal, and thus, was considered potentially harmful

# Narrative Exposure Therapy

- ▶ Evidence supports Narrative Exposure Therapy (NET) to be of more benefit than psychoeducation<sup>1</sup>
- ▶ NET is a short-term treatment strategy that involves the reconstruction of fragmented memories or traumatic experiences into coherent narrations of a survivor's life history
  - ▶ NET helps patients conceptualize the traumatic events using a lifespan perspective

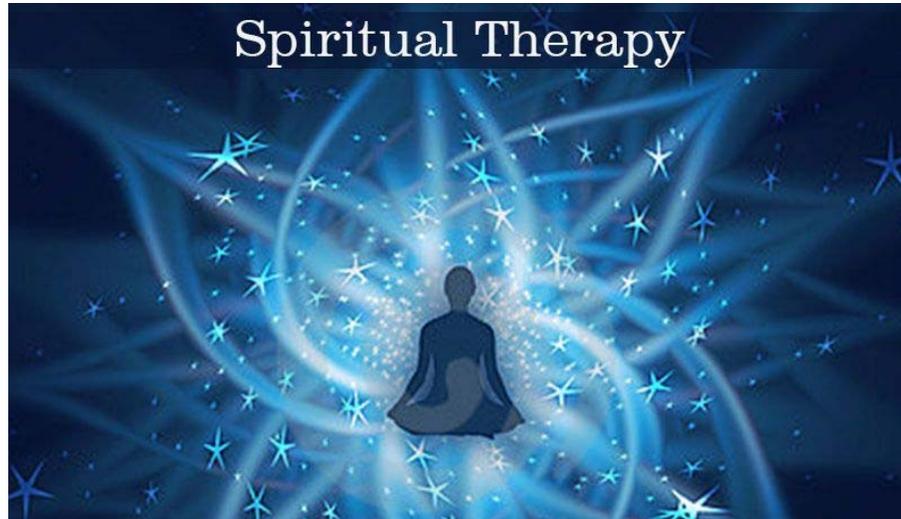


# Integrative Testimonial Therapy

- ▶ A study of Veterans from WWII found that Integrative Testimonial Therapy (ITT) decreased PTSD symptoms compared to delayed treatment by improving symptoms to sub-syndromal PTSD criteria<sup>1</sup>
- ▶ ITT is a therapist-assisted, internet-based writing therapy, modified for older patients
  - ▶ Participants complete written essays focused on
    - ▶ biographical reconstruction of their life
    - ▶ trauma exposure
    - ▶ cognitive restructuring

# Spiritually-focused Trauma Intervention

- ▶ A study found that older woman with interpersonal trauma and PTSD symptoms benefited from a spiritually-focused trauma intervention compared to controls<sup>1</sup>







# Dementia (Major Neurocognitive Disorders)

TYPES, TYPICAL PATTERNS, AND TREATMENT STRATEGIES

# Dementia - Natural History of Symptom Development

- ▶ “Precognitive” stage – mood and sleep changes, anxiety, agitation and apathy symptoms
- ▶ Pathological changes in the brain felt to precede the onset of clinical symptoms by a decade or two<sup>3</sup>
- ▶ Neurodegenerative or vascular damage disrupts frontal-subcortical circuits in the brain, affecting drive, affect regulation, salience, perception and impulse control
- ▶ The regulation of emotion and behavior is subtly altered as cognitive performance begins to slip<sup>3</sup>
- ▶ There is not clear evidence through the literature to support that Veterans are at a different level of risk than non-Veterans to develop Major Neurocognitive Disorders (of the dementing type) other than what can be described as related to other Veteran-associated risk factors

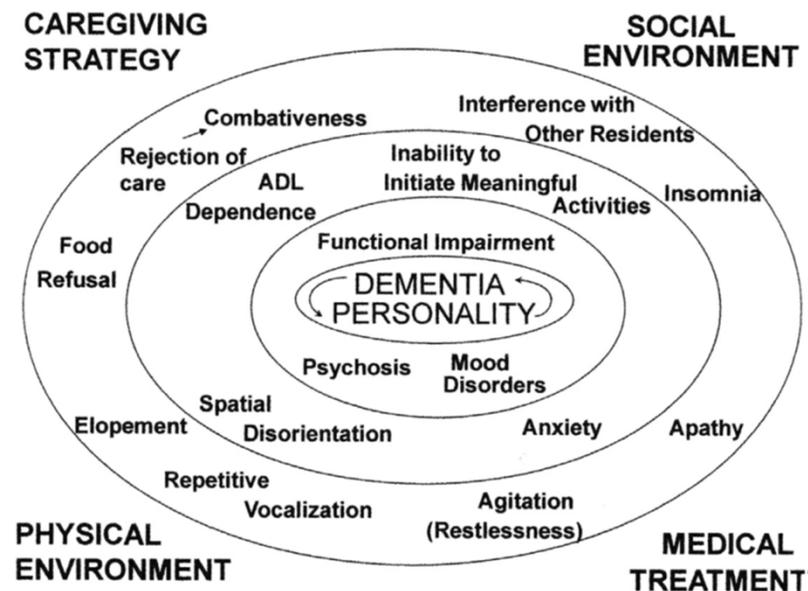
# Mild Cognitive Impairment

- ▶ Prevalence of MCI is 18-35% in those older than 65 years of age<sup>3</sup>
- ▶ Advancement from MCI to Dementia is estimated to be ~25% each year<sup>3</sup>
- ▶ Almost 1/3 of dementia patients come to psychiatry prior to dementia diagnosis<sup>3</sup>
- ▶ Late-life psychiatric disorders are amenable to treatment even in the presence of cognitive impairment
- ▶ Early diagnosis of neurocognitive disorders and subsequent intervention can slow progression and support function



# Behavior problems

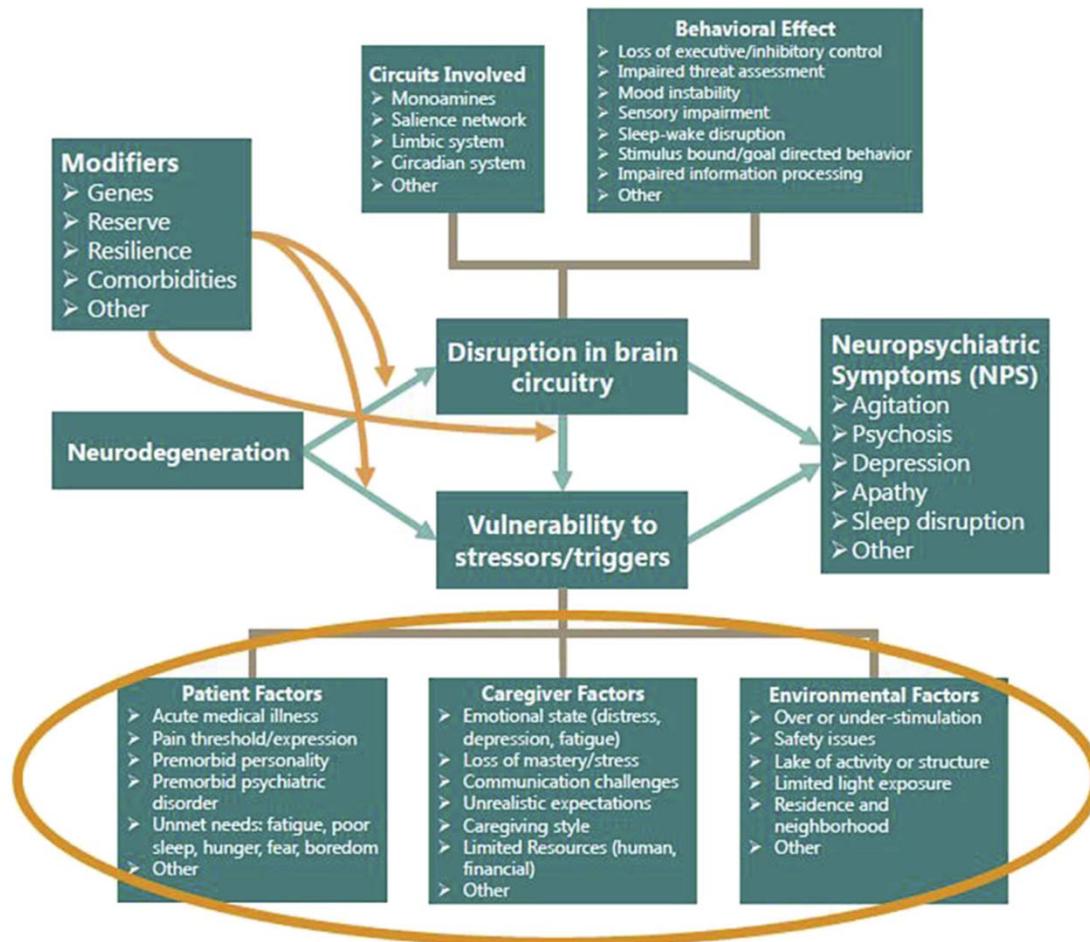
- ▶ Behavior symptoms caused by dementia come in 3 main categories: (1) functional impairment, (2) mood disorders, and (3) psychosis
  - ▶ Progression often leads to secondary and tertiary symptoms
  - ▶ Be cautious not to treat only the peripheral symptoms rather than addressing the primary dementia categories:
    - ▶ For example, it is better to provide a patient with meaningful activity that keeps the person awake during the day, then treating insomnia with hypnotics



# Common Behavioral Manifestations

**Table 1**  
Types of behavioral and psychological symptoms of dementia

Agitation	Walking aimlessly Pacing Trailing Restlessness Repetitive actions
Aggression	Aggressive resistance Physical aggression Verbal aggression
Apathy	Withdrawn Lack of interest Amotivation
Depression	Sad Tearful Hopeless Anxiety Guilt
Psychosis	Hallucinations Delusions Misidentifications
Disinhibition	Socially and sexually inappropriate behavior



# Causes of Behavioral and Psychological Symptoms of Dementia

# Dementia Types – Typical Symptoms

- ▶ Alzheimer disease – increase in neuroticism, decline in extraversion, and decline in conscientiousness
- ▶ Fronto-temporal dementia – personality changes include loss of empathy, inappropriateness of affect, and behavioral disinhibition
- ▶ Lewy Body dementia – apathy, diminished emotional responsiveness, and purposeless hyperactivity, and they relinquish hobbies
- ▶ Vascular dementia – apathy, disinhibition, and accentuation of previous traits, such as egocentricity, paranoid attitudes, and irritability

# Objective Behavioral Checklist

- ▶ Caregiving strategy may either precipitate or prevent rejection of care
- ▶ Social environment may precipitate or prevent problematic interaction with residents

Box 1 Cohen-Mansfield Agitation Inventory (CMAI)
Physical/Aggressive
1. Hitting (including self)
2. Kicking
3. Grabbing onto people
4. Pushing
5. Throwing things
6. Biting
7. Scratching
8. Spitting
9. Hurting self or others
10. Tearing things or destroying property
11. Making physical sexual advances
Physical/Nonaggressive
12. Pace, aimless wandering
13. Inappropriate dress or disrobing
14. Trying to get to a different place
15. Intentional falling
16. Eating/drinking inappropriate substance
17. Handling things inappropriately
18. Hiding things
19. Hoarding things
20. Performing repetitive mannerisms
21. General restlessness
Verbal/Aggressive
22. Screaming
23. Making verbal sexual advances
24. Cursing or verbal aggression
Verbal/Nonaggressive
25. Repetitive sentences or questions
26. Strange noises (weird laughter or crying)
27. Complaining
28. Negativism
29. Constant unwarranted request for attention or help
<i>From Cohen-Mansfield J. Instruction Manual for Jiska Cohen-Mansfield Agitation Inventory (CMAI). 1991. Available at: <a href="https://shine-dementia.wikispaces.com/file/view/Cohen-Mansfield+Agitation+Inventory+(CMAI).pdf">https://shine-dementia.wikispaces.com/file/view/Cohen-Mansfield+Agitation+Inventory+(CMAI).pdf</a>; with permission. © Cohen-Mansfield.</i>

# Apathy

- ▶ Management is important, as many who experience apathy suffer from decreased quality of life
- ▶ Apathy is the most common behavioral symptom in Alzheimer disease<sup>5</sup>
- ▶ Apathy occurs in 27% of dementia patients living in the community<sup>5</sup>
- ▶ Prevalence of apathy felt to be associated with a more aggressive progression of dementia<sup>5</sup>
  - ▶ Faster progression of cognitive, functional, and emotional impairment
- ▶ Apathy is related to neurofibrillary tangles in the anterior cingulate and reduced perfusion in the left anterior cingulate, right inferior and medial gyrus frontalis, and left orbitofrontal gyrus and right gyrus lingualis<sup>5</sup>
- ▶ Apathy can look like depression, but depression typically causes loss of interest and diminished activity; whereas, apathy tends to be a neutral experience due to an emotional deficit state
  - ▶ Apathy may influence daily functioning more than depression
  - ▶ Apathy is often associated with small cerebrovascular disease, however, this is not true in depression
  - ▶ Apathy is significantly negatively related to reduced independence in activities of daily living, shorter survival duration after nursing home admission, and poorer outcomes in physical rehabilitation<sup>5</sup>
  - ▶ Apathy is strongly associated with increased mortality, negative impact on disability and management of other diseases, and may cause increased weight loss<sup>5</sup>

# Treatment of Apathy

- ▶ Recommendation is to focus on non-pharmacologic interventions
  - ▶ Type of activity not as important as quality and duration (continuous activity programming 7 days a week is optimal)
- ▶ Namaste Care takes place in a pleasant environment and provides activities with a loving touch approach<sup>5</sup>
  - ▶ Namaste Care, a program developed in 2003 by Joyce Simard, MSW, can be found throughout the United States, Australia, the United Kingdom, Greece, and the Czech Republic
- ▶ Lifestyle engagement activity program
  - ▶ Trained case managers set meaningful social and/or recreational goals with patients and promote independence
- ▶ Environmental modifications
  - ▶ Clarity and strength of environmental stimulation significantly lowers levels of apathy
- ▶ Social robots
  - ▶ Study used humanoid pet robots to interact with patients, found decrease of apathy BUT an increase of delusions<sup>5</sup>
- ▶ Some evidence indicates cholinesterase inhibitors and memantine may help address apathy, but those results were unable to be replicated in subsequent studies<sup>5</sup>
- ▶ Limited literature suggests methylphenidate can be beneficial in the treatment of apathy<sup>5</sup>
- ▶ There is evidence that lowering doses of antipsychotics can also decrease apathy<sup>5</sup>

# Agitation

- ▶ A common problem in dementia patients is that “aggressive” behaviors are typically related to rejection of care – often appears that the patient is defending themselves from unwanted attention and can become combative (reactive aggression), which is different than agitation
- ▶ Agitation is defined as motor restlessness, heightened responsivity to stimuli, irritability, inappropriate and/or purposeless verbal or motor activity, decreased sleep, and fluctuation of symptoms over time
- ▶ The distinction between refusal of care and agitation is very important because nonpharmacological management strategies differ for each

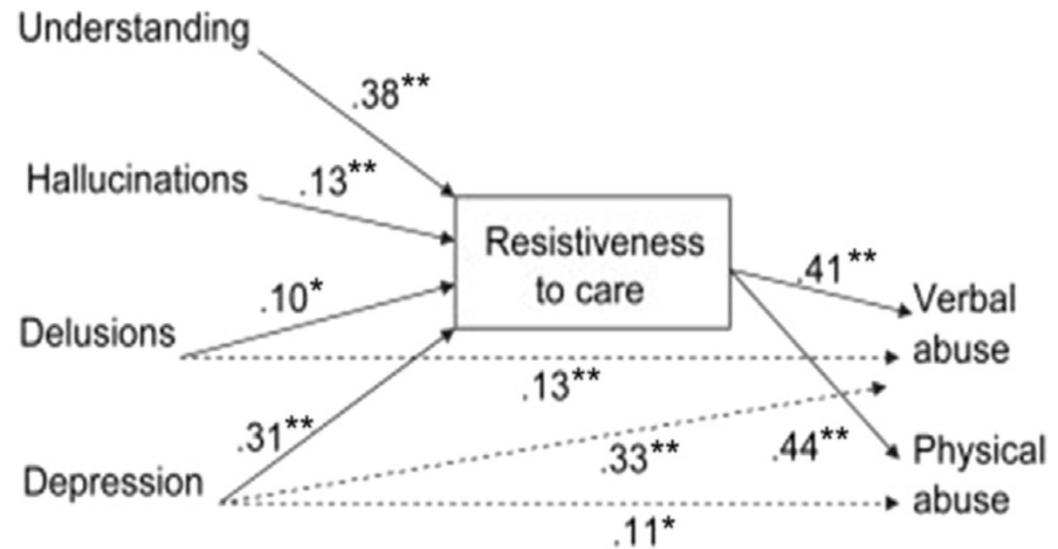


# Treating Agitation

- ▶ First step is address physical and environmental conditions
- ▶ Next step is initiate meaningful activities
  - ▶ Occupational therapy, **music therapy**<sup>7</sup>, live human interaction
  - ▶ Light therapy and aromatherapy have been studied but not found to be significantly beneficial for institutionalized patients with Alzheimer's disease<sup>7</sup>
- ▶ There is a strong association of agitation with depression so antidepressants should be considered – SSRI's are typically well tolerated in older adults and are preferable to TCA's, MAOI's, or atypical medications such as bupropion
- ▶ If there is evidence of delusions or hallucinations, antipsychotics may be helpful (weighing risks and benefits due to Black Box Warning)
- ▶ Benzodiazepines are NOT recommended for treatment of agitation, as the literature does NOT demonstrate good evidence for their effectiveness, and they are associated with cognitive impairment, disinhibition, falls, sedation, and respiratory depression<sup>6</sup>

# Aggression

- ▶ Proactive aggression is defined as behavior that anticipates a “reward” and involves planning and premeditation
- ▶ Reactive aggression is an impulsive aggressive response to a perceived threat, loss, danger, or provocation
- ▶ Patients with dementia rarely exhibit proactive aggression as their executive functioning is often impaired<sup>5</sup>



# Aggression Treatment

- ▶ First step is to concentrate on improving communication
  - ▶ Veteran's/Older adult's premorbid communication style should also be considered
    - ▶ Can be improved using cognitive-linguistic stimulation<sup>5</sup>
- ▶ Another strategy is changing the type of caregiving intervention
  - ▶ Example, give bed bath instead of shower
- ▶ Nonverbal communication can be improved by massage therapy
  - ▶ There is some evidence that frequent limited massage could decrease rejection of care and combative behavior<sup>5</sup>
  - ▶ This is offered at the VA Central Iowa Health Care System
  - ▶ Namaste Care combined massage of hands, feet and scalp with pleasant environment and found significant decrease rejection of care<sup>5</sup>
    - ▶ They found that being touched for massage made them more accepting of being touched for bathing and other ADLs<sup>5</sup>
- ▶ Some evidence supports cholinesterase inhibitors and memantine may help communication difficulties<sup>5</sup>
- ▶ Due to strong relationship of abusive behavior and depression, use of antidepressant can be helpful<sup>5</sup>
- ▶ If delusions or hallucinations are present, antipsychotics may be helpful<sup>5</sup>

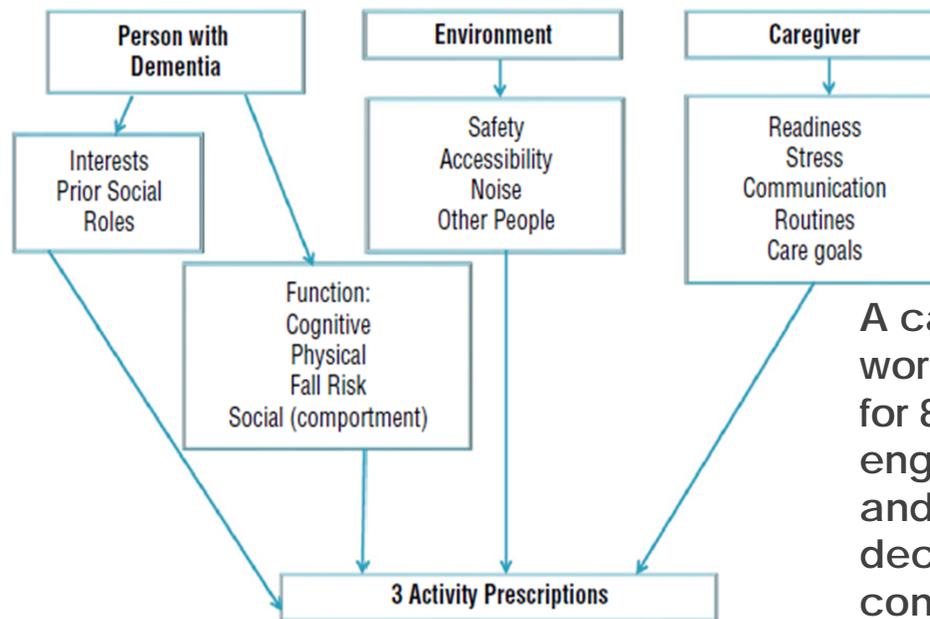


# Nonpharmacologic Treatments for Dementia

- ▶ Ecobiopsychosocial treatments are endorsed by multiple professional societies as first-line treatment for management of behavioral disturbances including the American Psychiatric Association, American Geriatrics Society, and American Association for Geriatric Psychiatry
- ▶ This has not, however, been translated to real world care provided due to lack of provider training, time required to implement interventions, lack of reimbursement, and heterogeneity of interventions
- ▶ Reminiscence therapy (discussion of past experiences)
- ▶ Aromotherapy
- ▶ A soothing and stimulating environment (Snoezelen)
- ▶ Acupuncture
  - ▶ Offered at Central Iowa VA HCS
- ▶ Caregiver-supportive interventions – most evidence
  - ▶ Problem-solving with the caregiver to identify modifiable causes of behaviors and enhanced communication within the patient and caregiver dyad.

# New Ways for Better Days: Tailoring Activities for Persons with Dementia and Their Caregivers

Figure 1. Simplified Decision Matrix for Tailored Activity Selection.



A case report utilizing TAP found that after working with an occupational therapist for 8 sessions, the person with dementia's engagement in activity increased by 50% and his frequency of vocal disturbance decreased, and the caregiver felt more confident with care<sup>8</sup>

# Environmental Treatments

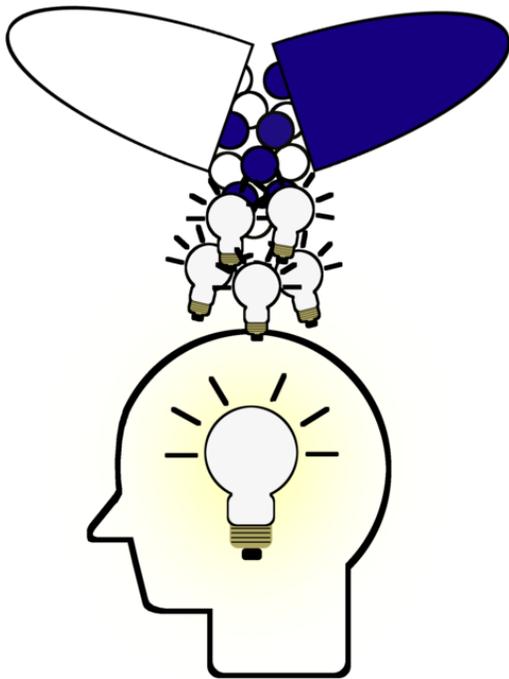
- ▶ There has been growing evidence for the role of the environment in preventing and reducing behaviors but there are few randomized controlled trials to evaluate this
- ▶ Correcting over-stimulation or under-stimulation
- ▶ Addressing safety problems
- ▶ Increasing activities and structure
- ▶ Establishing routine



# Pharmacologic Treatment: Antipsychotics

- ▶ Approximately 70% of individuals with dementia will experience agitation and 75% will experience symptoms of psychosis such as delusions or hallucinations<sup>4</sup>
- ▶ The CATIE-AD trial found that random assignment to quetiapine, olanzapine, risperidone or placebo showed adverse effects were greater than benefits
  - ▶ Greater incidence of sedation in older adults, as well as confusion and weight gain
- ▶ However, risperidone was found to decrease agitation<sup>4</sup>
- ▶ Olanzapine was found effective for behavior disturbances and psychosis (though concern for anticholinergic effects compared to other atypical antipsychotics)
- ▶ Aripiprazole has limited evidence to support improvement with aggression likely related to tendency to be more activating than other atypical antipsychotics<sup>4</sup>
- ▶ Improved aggression with haloperidol
  - ▶ BUT a retrospective cohort study found Haldol associated with a 1.5 times the risk of mortality when compared to SGAs<sup>4</sup>
  - ▶ A study comparing Haldol to Risperdal, found that Haldol had higher rate of drug-induced movement disorder<sup>4</sup>

# Antipsychotics con't.



- ▶ Another review found that aripiprazole, risperidone and olanzapine result in a modest improvement in neuropsychiatric symptoms and clinical global impression score at the expense of higher risk of adverse effects when compared to placebo<sup>11</sup>
  - ▶ Increased risk of myocardial infarction and bone fracture<sup>11</sup>
- ▶ Evidence regarding the benefits and harms of ziprasidone, asenapine, iloperidone and paliperidone in adults with dementia is insufficient to analyze or make judgements<sup>11</sup>

# Prazosin for the Treatment of Dementia

- ▶ Antagonizes norepinephrine effects at brain post-synaptic alpha-1 receptors
- ▶ A double-blinded, placebo controlled, parallel group study examined prazosin for treating agitation and aggression in patients with Alzheimer's disease and found an improvement in behavioral disturbances <sup>4</sup>
  - ▶ Used clinical global impression of change, neuropsychiatric inventory, and brief psychiatry rating scale
- ▶ This study excluded patients with persistent psychosis such as paranoid ideation and auditory hallucinations<sup>4</sup>

# Anticonvulsants for Treatment of Dementia

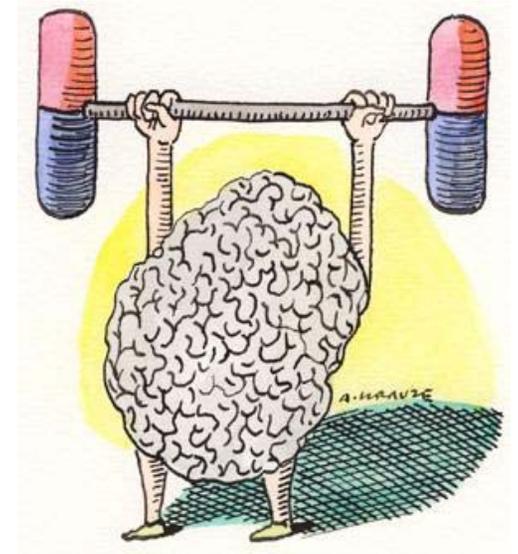
- ▶ Gabapentin was found to decrease behavioral disturbances<sup>4</sup>
  - ▶ Works on the GABA system
- ▶ Valproate/divalproex has been thought to have some neuroprotective qualities such as neuronal injury, activation of BCL-2 with decreased apoptosis, increased cell survival, and possibly reduce neurofibrillary tangles
  - ▶ Initial evidence suggested this medication might delay clinically significant psychosis or agitation
  - ▶ This was not found to be the case in one study, and in fact, this study showed increased unsteady gait, tremor, diarrhea, somnolence, weakness, and greater loss of hippocampus and brain volume on MRI<sup>4</sup>

# Antidepressants for Treatment of Dementia

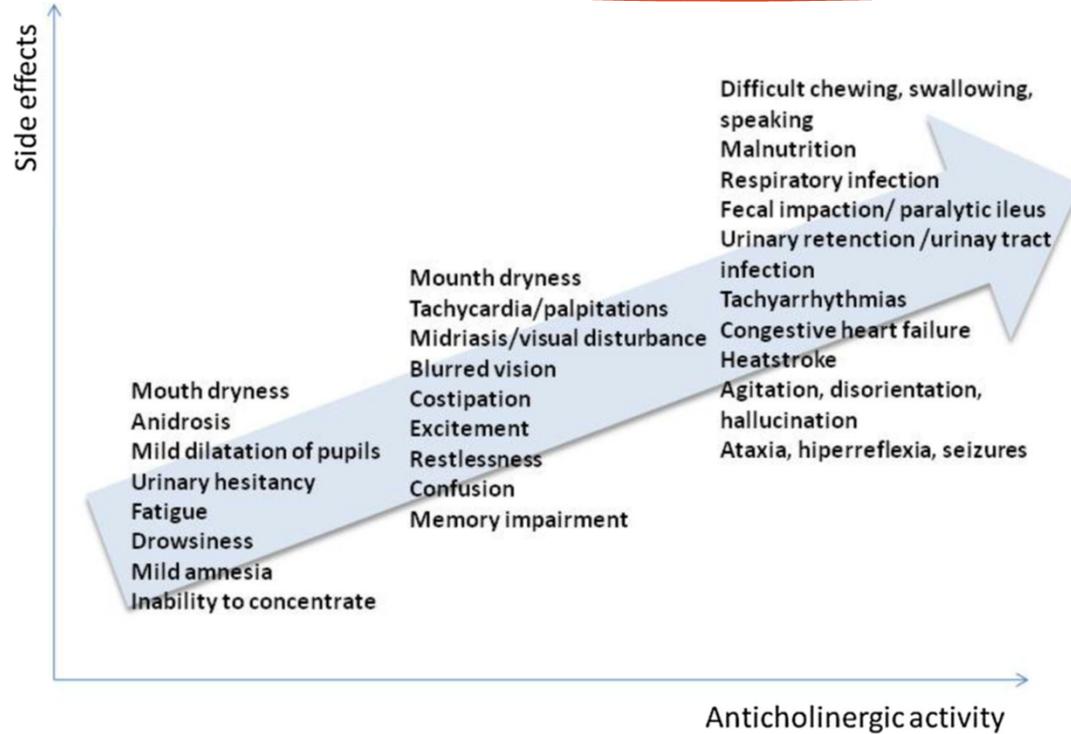
- ▶ Citalopram has more data to support its use to treat primary agitation
  - ▶ Superior to placebo for decreasing agitation<sup>4</sup>
  - ▶ Similar improvement as risperidone for agitation<sup>4</sup>
  - ▶ Superior to perphenazine for agitation<sup>4</sup>
  - ▶ Concern for QTc issues limits use in this group
- ▶ Trazodone is being examined
  - ▶ Double-blind comparison with Haldol found no significant difference in improvement between the groups<sup>4</sup>

# Cognitive Enhancers

- ▶ Limbic cortices that control emotional regulation receive extensive cholinergic innervations – dementia is associated with cholinergic deficits
  - ▶ Multicenter, blinded, randomized trial found no significant difference between placebo and donepezil with treating behavior disturbances<sup>4</sup>
- ▶ Memantine is an N-methyl-D-aspartate antagonist, which reduces glutamatergic dysfunction
  - ▶ When compared to placebo for treatment of agitation found to have no difference<sup>4</sup>



# Anticholinergic Treatment Concerns in Dementia



# Sleep Disorders

- ▶ Sleep disorders in dementia affect emotional and physical health, may worsen cognitive symptoms, and reduce quality of life<sup>9</sup>
- ▶ The causes of sleep disorders in dementia are complex and multiple strategies may be needed for their successful treatment<sup>9</sup>
- ▶ Research into potential management strategies – both nonpharmacological and pharmacological – have not produced convincing proof of efficiency<sup>9</sup>
- ▶ Emerging evidence suggests multicomponent interventions might work, but controlled trials are needed to determine their acceptability and cost effectiveness and clinical effectiveness<sup>9</sup>
- ▶ Things to consider include; bright light therapy, music therapy, physical activity, melatonin, and antidepressants<sup>9</sup>



# Treatment of Sleep Disorders in Older Adults

- ▶ Recommendation is to avoid antipsychotics unless “the symptoms either cause significant suffering, distress and/or pose an imminent threat to the patient or others”
- ▶ Increased risk of cerebrovascular events and mortality (Black Box Warning) with atypical antipsychotics
- ▶ Treatment of behaviors via nonpharmacological management poses significant challenges and antipsychotics remain one of the only evidence-based treatments available for significant behavioral symptoms in dementia
- ▶ Must have risk/benefit conversation and make efforts to stop antipsychotic when possible – since patient is often not able to do this, involvement of substitute decision maker is needed
  - ▶ Risks of not treating aggression and agitation – loss of housing and longer hospital stays



**Any  
questions?**

PTSD

DEMENTIA

SLEEP PROBLEMS

# References

- ▶ 1) Kaiser, Anica Pless. Cook, Joan M. Glick, Debra M. Moye, Jennifer. "Posttraumatic Stress Disorder in Older Adults: a conceptual review." *Clin. Gerontol.* 2019; 42(4): 359-376.
- ▶ 2) Palmer, Barton. Raskind, Murray. "Posttraumatic stress disorder and aging". *Am J Geriatric Psychiatry* 24:3, March 2016.
- ▶ 3) Laboni, Andrea. Rapoport, Mark. "Detecting and managing Neuropsychiatric symptoms in dementia: What psychiatrists need to know and why." *Can J Psych.* 2017. Vol 62(3) 158-160.
- ▶ 4) Lochhead, Jeannie D. Nelson, Michele A. Maguire, Gerald A. "The treatment of behavioral disturbances and psychosis associated with dementia". *Psychiatr. Pol.* 2016; 50(2): 311-322.
- ▶ 5) Volicer, Ladislav. "Behavioral problems and Dementia". *Clin. Geriatrics Med* 34 (2018) 637-651.6 Gerlach, Lauren B. Kales, Helen C. "Managing behavioral and psychological symptoms of dementia". *Psychiatr Clin N Am.* 41 (2018) 127-139.
- ▶ 7) Millan-Calenti, Jose Carlos. Lorenzo-Lopez, Laura. Alonso-Bua, Begona. De Labra, Carmen. Gonzalez-Abraldes, Isabel. Maseda, Ana. "Optimal nonpharmacological management of agitation in Alzheimer's disease: challenges and solutions". *Clinical Interventions in Aging.* 2016:11 175-184

## References, con't.

- ▶ 8) Marx, Katherine A. Scott, Janie B. Verrier Piersol, Catherine. Gitlin, Laura N. "Tailored activities to reduce neuropsychiatric behaviors in persons with dementia: Case Report". *The American Journal of Occupational Therapy*. March/April 2019. Vol 73. No 2.
- ▶ 9) Kinnunen, Kirsi M. Vikhanova, Anastasia. Livingston, Gill. "The management of sleep disorders in dementia: an update". *Curr Opin Psychiatry*. 2017, 30:491-497
- ▶ 10) Torrisi, Michele. Cacciola, Alberto. Marra, Angela. De Luca, Rosario. Bramanti, Placido. Salvatore Calabro, Rocco. "Inappropriate behaviors and hypersexuality in individuals with dementia: An overview of a neglected issue". *Geriatr Gerontol Int* 2017; 17: 865-874.
- ▶ 11) Farlow, Martin R. Shamliyan, Tatyana A. "Benefits and harms of atypical antipsychotics for agitation in adults with dementia". *European Neuropsychopharmacology* (2017) 27, 217-231.
- ▶ 12) Collamati, Agnese. Martone, Anna Maria. Poscia, Andrea. Brandi, Vincenzo. Celi, Michela. Marzetti, Emanuele. Cherubini, Antonio. Landi, Francesco. "Anticholinergic drugs and negative outcomes in the older population: from biological plausibility to clinical evidence". *Aging Clin Exp Res* (2016) 28:25-35
- ▶ 13) Berigan, Timothy R. "Gabapentin in the Treatment of Posttraumatic Stress Disorder". *Prim Care Companion J Clin Psychiatry*. 2000 Jun; 2(3): 105.