Severe Persistent Mental Illness and Ageing (with a touch of personality)

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2023 Toronto Geriatrics Update Course
Friday November 10th
9:00 – 9:50 AM EST

Sinai Health | Healthy Ageing and Geriatrics

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

Conflicts

Grants: CIHR

Positions: salary support from Sinai Health for role as Vice-President Medical Affairs; and from Provincial Geriatrics Leadership Ontario (PGLO) as Medical Director, Geriatric Psychiatry

Industry: have received stipend from Eli Lilly for talk on health care system planning

I will not be making specific medication recommendations in today's talk, and medications if discussed will refer to generic names.

Objectives

- Understand how major mental illness may present as we age
- Learn when and how to ask for help from your psychiatry colleagues
- Approach personality from a life course perspective, rather than from specific disorder approach
- Understand how trauma history is relevant in clinical presentations in ageing

Schizophrenia

- 2 or more of s/s in a month period (less if tx)
- (must include 1,2,or3)
  - 1.delusions 2. hallucination 3. disorganized speech
  - 4. disorg. Behaviour 5. negative symptoms

  Sign disruption in major life fxn domains

  Continuous disturb of at least 6 mo

Bipolar Disorder (Type 1)

Presence of mania for at least one week

Mania: (3 required, or 4 if mood irritable)

grandiosity, less sleep, speech pressure/rapis, flight of ideas, distractibility, increase in activity, risk taking

Impairment, not due to anything else

Majority of time in depression/euthymic

Thinking broadly about psychosis

A little like “chest pain”
Eg of different models:

Amphetamines ---------- increase DA release
Cocaine ----------prevent DA reuptake
LSD/ecstasy ----------5HT1 receptor agonist
PCP/ketamine ----------impairs NMDA receptor

leading to XS GLU in cleft

Antipsychotic Medication

- 1st and 2nd generation no difference in efficacy
- (CATIE, CUTLASS)
- Variation is SE profile
- For SCZ 10-20 % “good outcome”, 50 % “poor outcome”, 20-30 % “fail to respond” and half of these respond to clozapine
- Better for positive symptoms, less so for negative symptoms
- Blockade of D2 receptors in mesolimbic area
- Dosing around 3 mg haloperidol sufficient, clinical effect 65-70%, EPS 75 -80% blockade

(Kapur et al, Am J Psych, PET study 1st episode, Apr 2000)

Adverse effects Antipsychotics

- Weight gain
- Dystonia
- Akathesia
- Parkinsonism
- Tardive Dyskinesia
- Hyperproloactinemia
- Neuroleptic Malignant Syndrome

Anti-psychotics BPSD risk

1. Risk of death:

atypical antipsychotic 3.5% vs 2.5% placebo over a 12 week period

2. Risk of stroke:

Odds ratio 9.9 in 1st week on typical/atypical

Odds ratio 1 by 3rd month

Treating Schizophrenia

- Education, social support
- Medication: antipsychotic, ?clozapine
- Also focus on negative symptoms (difficult)

As age positive symptoms may wane somewhat, negative symptoms unchanged

15 – 20 year reduction in life expectancy

Bipolar disorder (Type 1) Treatment

- Mania

- Emergency – first focus on safety
- Medications – in emergency, in maintenance
  - In emergency: benzo's, anti-psychotics, early introduction mood stabilizer – lithium, valproic acid
  - Maintenance: mood stabilizer

“mood stabilizer”

- Lithium ---- gold standard, but can be contra-indicated in elderly due to renal status
- Valproic acid
  - First recognized 1966, makes GABA system work better (ie. generally slows down the brain)
  - Liver metabolism
  - SE: nausea, wt gain, tremor (other less common)
  - Drug interactions: potentiates benzo, fluoxetine, TCA; ***lamotrigine
  - Does not interact with antipsychotic medication

Ageing psychopharm (pharmokinetic)

Absorption: decrease surface area, decreased gut blood flow

Distribution: decreased water, increased fat, decreased muscle mass, decreased albumin

Metabolism: decreased hepatic mass/blood flow

Excretion: decreased renal blood flow, decreased GFR

Psychiatric Polypharmacy

- ALL psychiatric drugs are designed specifically to cross the blood brain barrier
- All side effects are exacerbated by age
- Polypharmacy dangerous – risk of motor effects, cog. effects, and “drug cascades”
  - Eg akathesia, trazodone, multiple antipsychotics

Major mental illness

- HISTORY
- Talk to family !!!!
- Escalation of symptoms
- Make a diagnosis
- Ask for help
- Use medication safely – with clear understanding of indication, how follow response, and goal of treatment.
- SAFETY

Trauma Context Society (1)

Trauma is common: 70-80 % of over 65 yrs will have experienced at least one traumatic event (1)

Violence against women is common: 25 % of women experience intimate partner violence; 10 % survive rape over a lifetime (2,3)

First Nations people have survived a residential school system, the Sixties Scoop, and disproportionate rates of incarceration (5 % of population, 30% of Federal penitentiary population) (4)

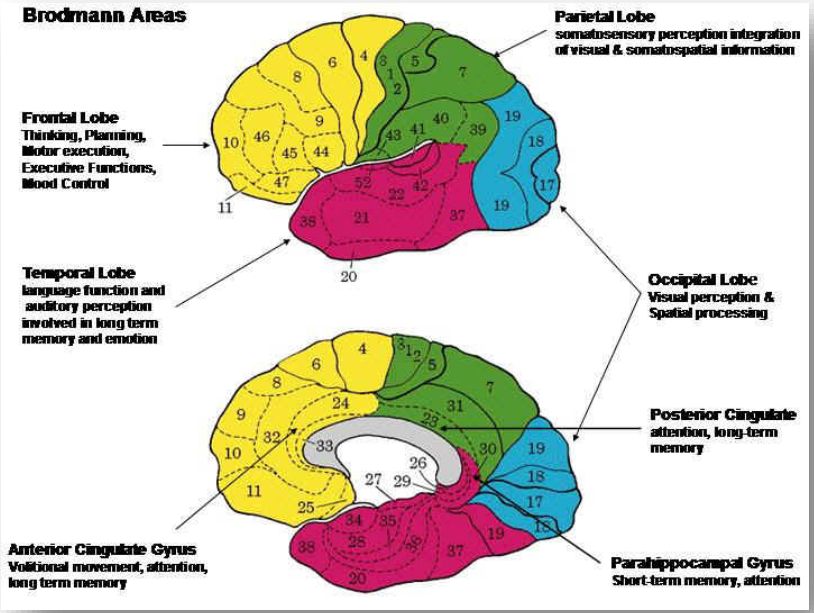
Trauma Context Society (2)

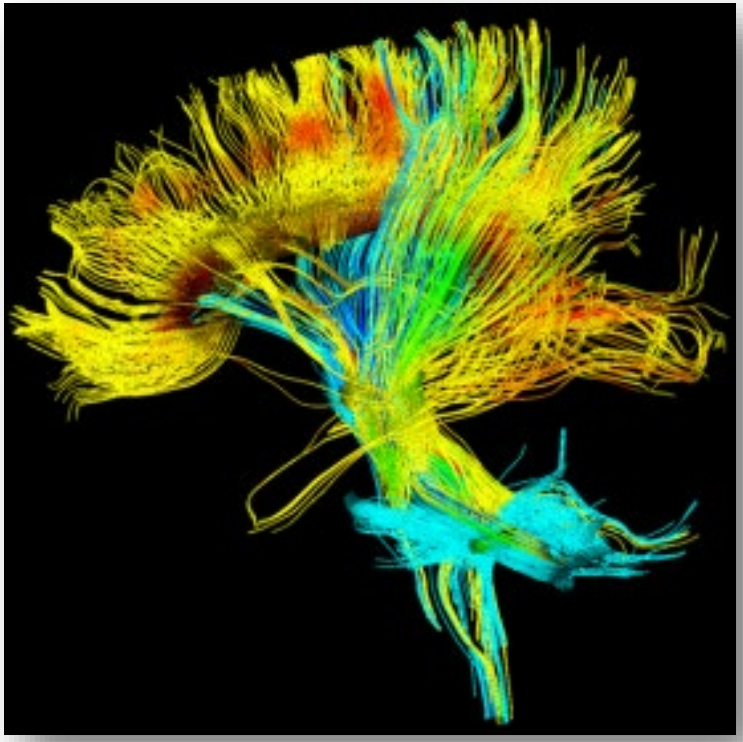
Immigrant and refugee communities, racialized communities, and LGBTQ+ experience higher rates of physical violence and assault (5)

Health care system not account for, nor acknowledge, degree of trauma
experienced by patients (6)

structure

connectivity





Executive function

Planning

Organizing

Sequencing

Abstracting

“inner experience manager”

Personality

What are the “tasks” of personality ?

Emotional regulation

Coping with adversity

Identity formation

Social relationships

Emotional life learned

- Attachment theory
- “two-hit” model Winnicott
- Adult attachment styles
  - Self
  - Other

Adult attachment styles (relationship)

		other	
		+	-
Self	+	secure	dismissive
	-	dependent	insecure

We age the way we live

We die the way we age

Thank you

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Questions?