Antidepressants and Anxiolytics in the Elderly
Samuel J. Garloff, DO

“Of all the people only those are at leisure who make time for philosophy, only they truly live. Not satisfied to merely keep good watch over their own days, they annex every age to their own. All the harvest of the past is added to their store. Only an ingrate would fail to see that these great architects of venerable thoughts were born for us and have designed a way of life for us.”

- Seneca

Disclosures
1. I am not certified in anything
2. I am not a fellow in any college
3. I have no hospital affiliations
4. I am retired!
Depression in the Elderly

A. Common, not necessarily normal
B. 6 million Americans are 65 and older
C. 10% receive treatment

How Does Depression in the Elderly Differ from Depression in Younger Adults?

A. Lasts longer
B. Increased risk of cardiac illness/death
C. Increased risk of suicide
   1. White males
   2. Twice the risk in 80-84 y/o population
   3. Lack of social support: death of spouse; retirement; relocation

How is Insomnia Related to Depression in the Elderly?

A. Melatonin
B. Low dose doxepin
C. Avoid benzodiazepine/hypnotics
What Are Risk Factors for Depression in the Elderly?
Factors that increase the risk of depression in the elderly include:

- Being female
- Being single, unmarried, divorced or widowed
- Lack of a supportive social network
- Stressful life events

What Are Risk Factors for Depression in the Elderly? cont.
Physical conditions like stroke, hypertension, atrial fibrillation, diabetes, cancer, dementia and chronic pain further increase the risk of depression. Additionally, the following risk factors for depression are often seen in the elderly:

- Certain medicines or combination of medicines
- Damage to body image (from amputation, cancer, surgery or heart attack)
- Family history of major depressive disorder
- Fear of death
- Living alone, social isolation
- Other illnesses
- Past suicide attempt(s)
- Presence of chronic or severe pain
- Previous history of depression
- Recent loss of a loved one
- Substance abuse

What Treatments Are Available for Depression in the Elderly?

A. Medication
B. Psychotherapy/counseling
C. ECT
D. RTMS (repetitive transcranial magnetic stimulation)
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Barriers to Treatment

A. Side effects of medication
B. Availability of therapy, ECT, TMS
C. Stigma
D. Cost

Table 1.
Presentation of depression in the elderly: X indicates the symptom is prominent; XX indicates the symptom is very prominent.

<table>
<thead>
<tr>
<th>Typical Symptoms</th>
<th>Prominent in Elderly Patients</th>
<th>Prominent in Younger Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIG E CAPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sleep (insomnia or excess sleep)</td>
<td>XX</td>
<td>X</td>
</tr>
<tr>
<td>• Interest (anhedonia)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• Guilt</td>
<td>X (often feeling a burden to family)</td>
<td>XX</td>
</tr>
<tr>
<td>• Energy</td>
<td>XX</td>
<td>X</td>
</tr>
<tr>
<td>• Concentration</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• Affect (depression)</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>• Psychomotor changes</td>
<td>XX</td>
<td>X</td>
</tr>
<tr>
<td>• Suicide</td>
<td>X (higher rate, especially for older men)</td>
<td>X</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anxiety</td>
<td>XX</td>
<td>X</td>
</tr>
<tr>
<td>• Decreased appetite or weight loss</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>• Complaints of memory loss</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>• Pain</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Fatigue</td>
<td>XX</td>
<td>X</td>
</tr>
</tbody>
</table>

Table 2.
Antidepressant choices for older patients

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Trade Name</th>
<th>Starting Dose, MGD</th>
<th>Average Dose, MGD</th>
<th>Maximum Recommended Dose, MGD</th>
<th>Comments and Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>Celexa</td>
<td>10</td>
<td>20‐40</td>
<td>20 for those older than 65 y 40 for others</td>
<td>QTc prolongation</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Cipralex</td>
<td>5</td>
<td>10‐20</td>
<td>10 for those older than 65 y 20 for others</td>
<td>QTc prolongation</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Zoloft</td>
<td>25</td>
<td>50‐150</td>
<td>200</td>
<td>Like all SSRIs, risk of nausea, suicidal</td>
</tr>
<tr>
<td>SNRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Effexor</td>
<td>37.5</td>
<td>75‐225</td>
<td>375 *</td>
<td>Might increase blood pressure</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bupropion</td>
<td>Wellbutrin</td>
<td>100</td>
<td>100 twice daily</td>
<td>150 twice daily</td>
<td>Might cause seizures</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>Remeron</td>
<td>15</td>
<td>30‐45</td>
<td>45</td>
<td>Might cause sedation, especially at lower doses</td>
</tr>
<tr>
<td>Tricyclic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Norpramin</td>
<td>10‐25</td>
<td>50‐150</td>
<td>300</td>
<td>Anticholinergic properties; cardiovascular side effects; monitor blood levels</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>Aventyl</td>
<td>10‐25</td>
<td>60‐160</td>
<td>200</td>
<td>Anticholinergic properties; cardiovascular side effects; monitor blood levels</td>
</tr>
</tbody>
</table>
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A Thought

A. A < Ag
B. Ag > P+C
C. A < P+C
D. P > 3%
E. C = 20%

Generalized Anxiety in the Elderly

A. 90% will also have depression, bipolar disorder, dysthymia or substance abuse
B. Elderly patients with generalized anxiety disorder tend to experience more physical symptoms, and less intense emotional disruption
C. Drugs may not be the best choice for older patients because they are more prone to side effects.
D. Cognitive behavioral therapy is a good first-line psychotherapy for treating generalized anxiety disorder in the elderly.
E. 3% first developed GAD after 65 years of age
F. 32% heritable
G. 2/3 are female

Treatment

A. Psychotherapy
   CBT – 46% success rate – Cochrane
   – FTF
   – Phone calls
B. Medications
   Buspirone – Fewer side effects
   – Less drug-drug interaction
   SSRI – Escitalopram – 69%
   – Paroxetine
   SNRI – Duloxetine
   – Venlafaxine
   Adverse Reactions – Hyponatremia
   – Bone fractures
   Benzodiazepines – Why?
Caveats

A. International Psychogeriatrics – 1999
B. Co-morbidities: Rapid heart rate; hypertension; decreased focus; headaches; pain
C. Single, elderly, women, childhood, traumas, alcohol abuse, elder abuse, insomnia, proper med use
D. GI upset, hyperthyroidism, DM, CV disease, COPD
E. Is it Parkinsons?
F. Is it Dementia?

Another Thought

A. 4
B. 300
C. 4

Physicians Grow Old Too

A. High doctor suicide rates have been reported since 1858. Yet more than 150 years later, the root causes of these suicides remain unaddressed.
B. Physician suicide is a public health crisis. One million Americans lose their doctors to suicide each year.
C. Many doctors have lost a colleague to suicide. Some have lost up to eight during their career – with no opportunity to grieve.
Physicians Grow Old Too, cont.

**D. We lose way more men than women.** For every female physician, there are seven men. Suicide methods vary by region and gender. Women prefer to overdose and men choose firearms. Gunshot wounds prevail out West. Jumping is popular in New York City. In India, doctors have been found hanging from ceiling fans.

**E. Male anesthesiologists are at highest risk.** These doctors kill themselves by overdose. Many have been found dead in hospital call rooms where they are supposed to be resting between cases.

Physicians Grow Old Too, cont.

**F. Lots of doctors kill themselves in hospitals.** They jump from hospital windows or rooftops. They shoot or stab themselves in hospital parking lots. They’re found hanging in hospital chapels. Physicians often choose to die in a place where they’ve been emotionally invested and wounded.

**G. “Happy” doctors also die by suicide.** Many doctors who die by suicide appear as the happiest, most well-adjusted people on the outside. Just back from Disneyland, just bought tickets for a family cruise, just gave a thumbs-up to the team after a successful surgery – to mention only a few cases from the list – and hours later they shoot themselves in the head. Doctors are masters of disguise. Even fun-loving docs who crack jokes and make patients smile all day may be suffering in silence.

Physicians Grow Old Too, cont.

**H. Family members of doctors who have killed themselves are also at high risk of suicide.** Sometimes even by the same method. A year after a depressed Kaitlyn Elkins, a star third-year medical student, chose suicide by helium inhalation, her mother, Rhonda, died by the same method. At the mother’s funeral, her husband said, “Medical school has killed half my family.”

**I. Suicidal doctors are rarely homicidal.**

**J. Patient deaths hurt doctors.** A lot. Even when there’s no medical error, doctors may never forgive themselves for losing a patient. Suicide is the ultimate self-punishment. In several cases, the death of a patient seemed to be the key factor in pushing them over the edge.
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Physicians Grow Old Too, cont.

K. Malpractice suits can be devastating. Humans make mistakes. Yet even doctors make mistakes, they’re publicly shamed in court, on TV and in newspapers (that live online forever). Many continue to suffer the agony of harming someone else – unintentionally – for the rest of our lives.

L. Academic distress kills medical students’ dreams. Failing medical-board exams and not getting a post-medical-school assignment in a specialty of choice has led to suicides. Doctors can be shattered if they fail to gain a residency: Before his suicide, Robert Chu, unmatched to residency, wrote a letter to medical officials and government leaders calling out a system that he said ruined his career.

Physicians Grow Old Too, cont.

M. Assembly-line medicine kills doctors. Brilliant, compassionate people can’t care for complex patients in 15-minute slots. When punished or fired by administrators for “inefficiency” or “low productivity,” doctors may become suicidal. Pressure from insurance companies and government mandates crush these talented people who just want to help patients. Many doctors cite inhumane working conditions in their suicide notes.

Physicians Grow Old Too, cont.

N. Bullying, hazing and sleep deprivation increase suicide risk. Medical training is rampant with deplorable conditions – such as working nonstop for 24 hours or more – that are not permitted in other industries. Physicians report hallucinations, life-threatening seizures, depression and suicide due to sleep deprivation. Fatigued doctors have felt responsible for harming patients. Resident physicians are now “capped” at 28-hour shifts and 80-hour workweeks. If they “violate” work hours (by caring for patients), they can be forced to lie on their time cards or be written up as “inefficient” and sent to a psychiatrist for stimulant medications. Some doctors kill themselves for fear of harming a patient as a result of their extreme sleep deprivation.
Physicians Grow Old Too, cont.

O. Blaming doctors increases suicides. Words such as “burnout” are often employed by medical institutions to shift blame to doctors for their emotional distress while deflecting attention from unsafe working conditions. When doctors are punished with loss of residency positions or hospital privileges for occupationally-induced mental health conditions, they can become even more hopeless and desperate.

Physicians Grow Old Too, cont.

P. Doctors who need help don’t seek it because they fear mental health care won’t remain confidential. So they drive out of town, pay cash and use fake names to hide from state medical boards, hospitals and insurance plans out of fear that they will lose state licensure, hospital privileges and health plan participation. (Even if confidential care were available, physicians in training have little time to access care when working 80 to 100 hours per week.)

Good News!

A. DO student number has grown by 85% in the past 10 years. The number of osteopathic medical students in the United States has grown 85% in the past 10 years, according to a report from the AOA. That brings the total number of DO students and physicians to 137,099 in 2017. There are now 34 DO schools in the United States operating at 49 sites, and enrollment has increased an average of 25% every 5 years. For comparison, the number of students seeking MDs has risen 18.6% for 2008 to 2017, according to the Association of American Medical Colleges (AAMC).
Good News! cont.

B. More than half of DOs are aged less than 45 years.

The DO profession is increasingly popular in the younger ranks, the report shows. As of 2017, more than half of all DOs (54%) were aged 45 years or younger. The report notes that 41% of DOs are women, and women aged less than 45 years make up 47% of DOs, a number that has been growing steadily for the past 25 years.

Good News! cont.

C. Most go into primary care.

Most DOs (56%) go into primary care, the numbers show, with 32.4% landing in family medicine, 17% in internal medicine, and 6.7% in pediatrics. The top nonprimary care specialties for DOs were emergency medicine (9.7%), followed by anesthesiology (4.3%) and obstetrics and gynecology (4.2%).

If you add other generalist physicians that are also in acute shortage – general surgery, psychiatry, ob-gyn, emergency medicine – we’re graduating about 82% in primary are generalist medicine.”

“If you let your head get too big, it’ll break your neck”
- Elvis
References

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- ACP Internist: Mental Health (/SEARCH/?SITE=ACP_INTERNIST&O=%22MENTAL+HEALTH%22&REQUIREDFIELDS=KEYWORDS:MENTAL+HEALTH). JANUARY 2013 (/ARCHIVES/2013/01/)

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