Mental Illness in the Elderly

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Goals for today

- Distinguish between “threats to mental health” and mental illness
- Briefly discuss common late life disorders
- Review nursing interventions to promote health, reduce symptoms

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Mental Health vs. Illness

- Mental Illness: A group of illnesses that are attributed to brain changes

- Mental Health: A state of emotional and psychological well-being that extends beyond the absence of illness

Not really different from physical illness and health!

Mental Health & Illness

- Behavioral and psychological symptoms at ANY AGE may be caused by either
  - Mental ILLNESS, or
  - THREATS to Mental HEALTH

Understanding DIFFERENCES is often key to providing needed care!
Stop and LOOK!

- Knowing the person “behind the illness’ is critically important!

Think again!

- Who IS this person?? And as important, who has this person been throughout his life?
EXAMINE!

… the causes of behavioral and psychological symptoms AND how we manage our own feelings!

I think he is just really lonely... and needy today!
(Sigh!) I need to be patient!

The “Real Problem?”

Many behaviors “look the same . . .”
- Anxiety, fear, restlessness
- Verbal “assaults” or name-calling
- Apathy, indifference
- Restiveness, refusal to participate
- Failure to cooperate or comply
### Many Possible Causes

<table>
<thead>
<tr>
<th>MENTAL HEALTH</th>
<th>MENTAL ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality traits</td>
<td>Dementia, such as Alzheimer’s disease</td>
</tr>
<tr>
<td>Loss &amp; life change</td>
<td>Delirium</td>
</tr>
<tr>
<td>Loss of control</td>
<td>Depression</td>
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<tr>
<td>Situational stress</td>
<td>Anxiety disorder</td>
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<tr>
<td>Loneliness/social isolation</td>
<td>Long-standing MI</td>
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### Threats to Mental Health

- Problem not “manageable” with usual coping methods → failure to adapt → *behavioral symptoms*
- Supportive interventions are needed
  - Help RESIDENT cope, possibly using new methods
  - Change what STAFF do to reduce problems
**Personality Traits**

- Coping, managing, ways of interacting with others were not effective earlier in life & are not effective NOW!
  - BLAME
  - CRITICIZE
  - GOSSIP

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**Loss & Change**

... associated with advanced age can affect coping

- Health
- Mobility
- Sensory input
- Activity
- Relocation
- Finances
- Loss of loved ones: death, divorce, separation
**Loss of Control**

- My tea is NOT hot enough, AGAIN!!!
- My medicine is to be taken at NOON, not at 1 pm!!!!

Residents...

- Can’t you people ever get it straight?!

Get a life. I’ve got 10 people to think about besides YOU!!!

**Situational Stress**

I’ve HAD IT with you people!! Why don’t you listen?!? I’ve lived a long life! I’m not stupid!! What on earth does it take to get you to do it MY way?!

... Like everyone else, residents will react to situations or events that are upsetting to them.
Loneliness, Social Isolation

- Common & painful
- Associated with loss & life change
- Triggered by relocation, new health problems
- Antecedent to depression
- Avoidable & treatable!

Threats to Mental Health

Key principles of care
- Identify SOURCE of stress, unhappiness, “problem” behaviors
- Focus on PAST COPING methods with similar type of stress
- Identify and support ABILITIES
- Employ available RESOURCES
Mental Illness: New or persisting?

- Common late life disorders (new onset)
  - Dementia
  - Delirium
  - Depression
  - Anxiety
- Persisting illness from early in life
  - Schizophrenia
  - Bipolar disorder
  - Personality disorder
  - Trauma-related
  - Alcohol/substance abuse

Dementia: Criteria

- Multiple cognitive deficits
  - MEMORY impairment
  - EXECUTIVE FUNCTION:
    - Ability to plan, organize, sequence, abstract
  - APHASIA: Language
  - APRAXIA: Movement
  - AGNOSIA: Recognition of common objects
Dementia: Non-Cognitive Symptoms

- Behavioral & psychological symptoms
  - Delusions, hallucinations, illusions
  - Anxiety, depression, apathy, paranoia
  - Irritability, agitation, pacing/wandering
  - Sleep-wake, appetite/eating disturbances

- Occur at some point in 90% of persons with dementia

- ALL considered treatable!

Dementia: Course

<table>
<thead>
<tr>
<th></th>
<th>Early</th>
<th>Confused</th>
<th>Ambulatory</th>
<th>Late</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td></td>
<td></td>
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</table>

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Assessment: General

- Comprehensive assessment is critical
- Rule in & rule out
  - CAUSAL factor
  - CONTRIBUTING factors
- Identify strengths & resources that promote adaptation & wellness

Algorithm for Treating Behavioral and Psychological Symptoms of Dementia (aka Problem Behaviors)
Identify & Treat Contributing Factors

- For EACH behavioral problem, determine
  - Frequency
  - Duration
  - Intensity
  - Characteristics

- Identify, assess, treat, eliminate antecedents & triggers

*Every question suggests an intervention!!!*

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ABC’s for dementia

- **Describe the Behavior.** Consider each problem as a separate challenge!
  - Is the behavior safe/dangerous? How long/often does it occur? Who is it a problem for???

- **Assess Antecedents & triggers**
  - What else is going on? Who is there? What are they doing? What is contributing?

- **Review Consequences & reactions**
  - What happens next? How do others respond? Do these responses make it worse?
Dementia: Interventions

- Individualize: *Who is THIS person?*
  - Longstanding habits, values, beliefs
- Support losses in “prosthetic manner”
  - Do what person cannot do for self
  - Do not “take over” and “do to” person
  - Assist ONLY as necessary
    - ★ Encourage, cue verbally, simplify task
    - ★ Organize for person, help get started

Delirium

- ACUTE Confusion
- Characterized by RAPID ONSET
  - Hours to days
  - Notable change from previous level of function
- Highly TREATABLE & REVERSIBLE
**Delirium: Criteria**

- Change in CONSCIOUSNESS, as evidenced in the loss of ability to sustain, shift, or focus ATTENTION
- RAPID ONSET of symptom
- FLUCTUATING symptoms throughout the day

**Delirium: Course**

De Lira = Latin for “Off the track”

![Graph showing fluctuating symptoms throughout the day with morning, afternoon, and night phases]
Growing evidence for 1 question

Is the person more confused today than USUAL?

If Yes, then use CAM!!!

Try this: CAM

The Confusion Assessment Method (CAM)

Why: Delirium occurs in 25-60% of older hospitalized patients, and is associated with an increased risk of nursing home admission, increased costs, length of stay, mortality rates, functional decline, and increased use of chemical and physical restraints. Risk factors for delirium include older age, dementia, infection, severe illness, multiple co-morbidities, dehydration, psychotropic medication use, alcoholism, vision impairment, and fractures. Delirium is often unrecognized by clinicians. Therefore, patients should be assessed frequently using a standardized tool to facilitate prompt identification and management of delirium and underlying etiology.
Confusion Assessment Method

1. Acute onset
2. Inattention
3. Disorganized thinking
4. Altered consciousness
5. Disorientation
6. Memory impairment
7. Perceptual disturbance
8. Psychomotor disturbance
9. Altered sleep-wake

Note: 9 symptoms are the criteria for delirium diagnosis!!!

Delirium and dementia??

Remember! Delirium can overlap on dementia! Check it out!

- Infection
- Hypoxia
- Metabolic
- Endocrine
- Sensory deficits
- Medications

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How to Use the Try This Series for Assessing Delirium and Dementia

Change in Mental Status or Other Behaviors That Would Trigger Assessment
- Agitation or lethargy
- Fluctuating or altered LOC
- Memory impairment or disorganized thinking
- Wandering

Uncooperativeness or failure to follow instructions
- Change in behavior or function
- Indifference
- Stupor

Assess for delirium

CAM + facility’s mental status evaluation

Possible delirium with dementia
Possible delirium without dementia
Probably not delirium

Use the Delirium Superimposed on Dementia (Try This) Algorithm

Contact primary care provider to investigate the cause of behavior change

Assess for dementia using the Mini-Cog or Recognition of Dementia in Hospitalized Older Adults

Treat and manage: use facility protocol to determine cause, modify risk factors, protect patient, and perform ongoing assessments to monitor response.

Delirium Superimposed on Dementia Algorithm

Assess for pre-hospital cognitive function:
- Review the patient’s medical record for indications of pre-existing dementia and/or functional difficulties.
- Ask the patient or their family, if any, whether the patient has a diagnosis of dementia or signs and symptoms of possible dementia.
-obb2

Assess for and identify delirium promptly:
- Acute change in cognition (memory loss, disorientation, hallucinations, delusions, and impaired functioning)
- Acute change in behavior (agitation, inactivity, disorientation, and confusion)
- Severe change in LOC (see Try This: Wandering in the Hospitalized Older Adult). Educate the family about the nature of delirium.
- Assessing this is not a “recognition of dementia” but an acute or emergent health issue.
- Use an instrument, such as the Confusion Assessment Method (CAM), to identify changes quickly (Inouye, 1990).

Assess for physiologic causes and risk factors for delirium:
- Medications (see Try This: Beers Criteria)
- Pneumonia
- Urinary retention
- Hypernatremia
- Hypochloremia
- Hypoglycemia
- Pain (see Try This: Assessing Pain)
- Dehydration

Prevent injury:
- Nurse may need’s station (monitor for excessive noise and stimulation due to location, motion,REN
- Bernard
- Pay attention to fall-risk patients
- Nonnarcotic analgesics should be used when possible
- Use of restraints

Modify other risk factors:
- Environmental stimuli
- Level of activity
- Non-pharmacologic
- Therapeutic
- Norepinephrine

Follow-up assessment:
- Continue to assess cognition using CAM and observing behaviors.
- Monitor hydration and nutrition.
- Educate and counsel family regarding signs of re-occurrence and duration (2 weeks to 6 months) of delirium.

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Delirium: Interventions

First and Foremost . . .

- Identify & treat UNDERLYING CAUSES!!
- Assure SAFETY

Delirium: Intervention

- REASSURE
  - Provide information to patient & family
- Re-ORIENT
  - Gently “correct” misperceptions, misbeliefs
  - Provide environmental cues (e.g., calendar, clock, other items) to help stay “on track”
- Promote accurate SENSORY INPUT
  - Increase lighting, glasses, hearing aides
- Increase HYDRATION & AMBULATION
Depression

☑ The most common psychiatric illness for people of all ages
☑ Under- and misdiagnosed in older adults
☑ Mistaken for “problems of aging”

Depression: Criteria

❖ DEPRESSED MOOD most of the day, everyday

OR

❖ LOSS OF INTEREST or PLEASURE nearly every day

and at least 4 additional symptoms . . .
**Depression: Criteria**

- WEIGHT loss or gain
- SLEEP disturbance
- PSYCHOMOTOR agitation or retardation
- FATIGUE or loss of energy
- WORTHLESSNESS, inappropriate GUILT
- Loss of ability to THINK, CONCENTRATE, make DECISIONS
- Recurrent thoughts of DEATH

*Depression without sadness is common in late life!!!*

**Depression: Course**
Depression: Contributing factors

Many factors to consider . . .
- Co-morbid medical illness
- Cognitive impairment / dementia
- Anxiety
- Pain
- Social function
- Physical function
- Loss/change/stress
- Resources & abilities

Cycle of Depression

Thoughts & Feelings
- negative thoughts,
- sadness, hopelessness,
- low self worth

Behavior
- decreased physical
  or social activity,
- decreased
  productivity,
- alcohol or drug
  use

Stressors
- medical illness,
- work or family
  problems, loss &
  life change

Physical Problems
- pain, low energy,
- poor sleep, poor
  concentration

Depression
**Depression Screening Tools**

- Geriatric Depression Rating Scale: 30 yes/no items
- Cornell Scale for Depression in Dementia: 19 items
- Minimum Data Set Version 3.0: PHQ-9 + irritability item

**Patient Health Questionnaire**

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
3. Trouble falling or staying asleep, sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself, feeling like a failure
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking slowly, or being restless and moving around more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way
**PHQ-9 Scoring**

- Score each item:
  0 = Not at all
  1 = Several days
  2 = More than half the days
  3 = Nearly every day
- Total each column
- Add across columns to get a total score: 0 to 27

- Apply cut-points:
  - 0 to 4 – depression is not significant
  - 5 to 9 – mild depression
  - 10 to 14 – moderate depression; any score over 10 is considered clinically significant;
  - 15 or greater – severe depression

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**24-7 Interventions: Most Potent!**

- Every interaction has “Therapeutic Potential”
  - Support and encouragement ➔ to “get going” or to try new things
  - Structure in daily activities ➔ provides safety and security;
  - Interaction and involvement ➔ adds meaning and purpose to life
  - Respectful, compassionate care ➔ reinforce self worth!
Consider Thoughts & Feelings

- Accept feelings & perspectives as REAL TO THEM
- Listen without being judgmental → “You shouldn’t feel that way!”
- Avoid correcting → “Things aren’t that bad!” “That’s not true!”
- Allow to express strong emotions → Anger, crying, wishing they were dead

Address Physical Problems

- Nutrition/weight maintenance
- Elimination
- Sleep/rest patterns
- Energy level
- Concentration
- Pain management
Reduce Stressors

- Review depression assessment
  - Current stressors?
  - Resources & abilities?
- Rally support & assistance
- Involve others
  - Family members
  - Team members
  - Community services
- Make “simple” adjustments in routine, cares

Promote Positive Behavior

- Increase activity/exercise
- Create “mastery” experiences
- Promote socialization
- Encourage autonomy
  - Self care
  - Activity engagement
  - Problem-solving
- Reduce, discourage alcohol, drugs

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Anxiety

- A “normal” reaction to social stress
- A symptom of:
  - psychiatric illness
  - physical illness
  - medication reactions
- The PRIMARY symptom of anxiety disorders:
  - Generalized anxiety disorder
  - Phobia
  - Anxious depression

*Like depression, anxiety causes many physical symptoms!!!*

Anxiety AND . . .

- Anxiety commonly co-occurs with:
  - Dementia
  - Depression
  - Delirium
  - Paranoia
- Difficult to distinguish from physical health conditions
## Anxiety Assessment → GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it’s hard to sit still</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add columns: _____ + _____ + _____

Total: _________________________

## Anxiety Interventions

- **Staff approaches**
  - Ask: Is worry “real” or exaggerated?
  - Assist with problem-solving
  - Distract with pleasant activities

- **Apply depression care interventions**
  - Address anxiety-related problems
  - Engage in pleasant activities
Serious & Persistent MI

- Diagnosis early in life
- Persistent course of illness/disability extends into later life
- Medication interventions often work well
- Common goals of care
  - Enhance function, socialization, engagement
  - Reduce “institutional syndrome”
  - Avoid acute illness relapse

Serious & Persistent MI

- **Schizophrenia**: delusions, hallucinations, disorganized thinking, negative symptoms (diminished emotional expression or avolition)
  - Lifetime prevalence ➔ 0.3% to 0.7%
  - Average age of onset ➔
    - Males: Early to mid-20s
    - Females: Late 20s
  - Psychotic symptoms tend to diminish over life course (changes in dopamine activity?)
Serious & Persistent MI

❖ **Bipolar I disorders:** distinct manic episode (4 criteria) + depressive episode
  ✓ Prevalence → 0.6%
  ✓ Average age of onset → 18 years
  ✓ Onset in mid- to late life possible (60s, 70s)
    ★ BPD due to another medical conditions
    ★ Substance/medication induced BPD

Serious & Persistent MI

❖ **Personality Disorders:** enduring pattern of inner experience & behavior that
  ✓ Deviates expectation of the person’s culture
  ✓ Is pervasive & inflexible
  ✓ Has on onset in adolescence / early adulthood
  ✓ Is stable over time
  ✓ Leads to distress & impairment
Serious & Persistent MI

- **Personality disorders**: 3 clusters, prevalence varies
  - Paranoid: distrust, suspiciousness (4.4%)
  - Schizoid: detachment from social relationships (4.9%)
  - Schizotypal: eccentricities, acute discomfort in close relationships (4.6%)
  - Antisocial: disregard/violations of others rights (3.3%)
  - Histrionic: emotionality, attention-seeking (1.8%)
  - Narcissistic: grandiosity, need for admirations (6.2%)
  - Borderline: instability in relationships, self-image (5.9%)
  - Avoidant: social inhibition, inadequacy (2.4%)
  - Dependent: submissive, clinging behavior (0.6%)
  - Obsessive-compulsive: orderliness, control (7.9%)

- **Posttraumatic Stress Disorders (PTSD)**: psychological & behavioral symptoms following exposure to traumatic event(s)
  - Intrusive symptoms: memories, dreams, flashbacks, intense psychological distress, physiological reactions
  - Avoidance of reminders: activities, places, people
  - Negative thinking & mood: horror, fear, anger; exaggerated negative beliefs, distortions
  - Marked arousal & reactivity: irritable/angry outbursts, hypervigilance, difficulty concentrating
Serious & Persistent MI

PTSD, continued

✓ Lifetime risk at age 75 years → 8.7%
✓ Highest rates in
  ★ Veterans: military combat/internment; think about WWII, Vietnam, Korea
  ★ High risk occupations: firefighters, police, EMT
  ★ Survivors of rape, physical abuse; think about unknown history of abuse given cohort
  ★ Ethnic/political internment, genocide: WWII, holocaust, South Africa, more
✓ Particularly important: Cognitively impaired!

Serious & Persistent MI

Use long-standing history to guide you!

✓ What has worked in the past?
  ★ Medications? Therapies?
  ★ Lifestyle choices?
  ★ Activity involvement? (less may be more comfortable!)
✓ What “tipped” the balance of coping?
  ★ New medical illness, medications?
  ★ Loss of kinship system in relocation? Difficulty making new friends?
  ★ What can be done to reestablish “normal”?
Mental Illness: Key principles

- Identify CAUSE of symptoms to determine treatments → Dementia? Depression? Anxiety disorder?
- Take ALL concerns SERIOUSLY
- Respond PROMPTLY to behaviors; don’t “wait to see what happens”
- Try to understand problems from the resident’s point of view!!

Promote & Monitor Health

- Nutrition
- Elimination
- Sleep/rest patterns
- Physical comfort
- Pain management
  - relaxation methods
  - medication
  - alternative therapies
Encourage Physical Activity

- Exercise programs
- Referrals
  - physical therapy
  - occupational therapy
  - recreational therapy
- Develop daily activity schedule
- Provide encourage to do what they CAN

Encourage Engagement with Life

- Involvement in meaning-FULL activities
  - Productivity
  - Giving something to others
  - Enjoyment, pleasure, gratification
  - Activities that fill us up when we begin to feel empty!
**Medication: Only when Indicated!**

- Non-drug interventions FIRST!
- Medication therapy
  - Treat “specific indications”
    - Depression
    - Anxiety
    - Psychosis
  - Use Beers Criteria to avoid adverse effect/reactions

**Summary**

- Examine underlying causes!
  - Threat to mental HEALTH?
  - Symptom of mental ILLNESS?
- Adjust routines and adapt care
- Promote health
- Infuse meaningful activities
- Use community resources
- Refer for professional treatment
- Monitor progress and keep going!!!
More resources

- Visit the Iowa Geriatric Education Center
  http://www.healthcare.uiowa.edu/igec/