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Disorders of the Elderly: Dementia, Depression, Anxiety, and Late life Schizophrenia

William McDonald, M.D.

Hosted by Andrew Schorr

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Introduction

Andrew Schorr:

Hello and welcome once again to Patient Power. I'm Andrew Schorr. It's the only program on radio or on the internet day after day where we talk about really significant health issues and we do it from the patient's perspective. So I ask the questions you're probably wondering. I've lived through some of it through cancer and some other chronic conditions in my family, and so I'm kind of your advocate. And we are blessed with the fact that we always have leading, high credibility experts on.

Now, if you think, just a few days ago if you were listening live on Health Radio Network to my program we were talking to a psychiatrist from Massachusetts General Hospital in Harvard about an approach for treatment-resistant depression for maybe the 10 to 20 percent of people who may not be responding to individual or combination drug therapy. We're going to talk about depression a little more today but from a different perspective and not just depression but also other things that affect the elderly. Dementia, and does that mean it's Alzheimer's or something else, and it can be, anxiety and even late life schizophrenia. Now, as you get older is your mind as sharp as it was before? And is that just aging or is that illness? And can somebody be helped back to better health or is it just the way things go when you get older?

So there's a lot to talk about, and it could be you or any of us who get older, and when does that again process start and affect your mind in that way or is it mom or dad or grandma or grandpa or Uncle Charlie or Aunt Susie who you love very much and want the best for.

So here's our expert for today, and I'm looking forward to this conversation because I think so many of us just don't know what to make of changes in the mind as we get older for ourselves or a loved one. That's Dr. William Mc Donald. He joins us from Atlanta and the Emory University School of Medicine. He's chief of geriatric psychiatry and he's director of the Fuqua Center for Late Life Depression at Emory.

Dr. McDonald, thanks so much for being with us on Patient Power today.

Dr. McDonald:

Well, thanks for having me, Andrew. I look forward to talking with people about this.

Andrew Schorr:

Yeah, I know. It's really important.

So I always start with sort of my personal frame of reference. So I had Aunt Bella when I used to live in Los Angeles and I reconnected with my mom's aunt, so my great aunt, Aunt Bella. And she was sharp as a tack at 96, I think till her dying day. And then I've got my in-laws also in Los Angeles, and I love them dearly, and I've been wondering, and I'd say this directly to my father-in-law, sometimes he seems a little forgetful at 75 or 76. So he's not like Aunt Bella who, you know, she just noticed everything and just seemed like she was 20, and then there's my father-in-law where he seems a little forgetful and I've read books and people say, Well, gee, maybe we should have some tests to see is that early onset of Alzheimer's or could it be something else, or is he just the nutty professor, you know.

Dr. McDonald:

Yeah.

Memory Loss

Andrew Schorr:

So we worry about our loved ones. So maybe you could help me. How does this affect people differently at different ages? And how do you know when you need to look further to sort of work it up, if you will, to use a medical term?

Dr. McDonald:

Sure. The normal aging certainly has memory loss as part of it, and there's a wide range of how much memory people lose and how quickly they lose it. And it seems dependent on a number of factors, genetic factors. We know now that Alzheimer's disease, which is the most common form of dementia or memory loss, has a genetic component to it, a fairly strong family history component. But we also know that just normal aging, patients can develop Alzheimer's disease. So if you look at people who are 85 and older about 40 percent of them will have clinically diagnosable Alzheimer's disease so that even the brains of people who looked normal when they were alive, didn't look like they had a lot of memory problems, for instance your aunt, will show some of the changes that we associate with Alzheimer's disease.

So why do some people develop it quickly and other people develop it more slowly and not even show clinical evidence of it while they're alive. Well, some of that may be genetic, but some of it also may be lifestyle. So if your lifestyle is such that you kept a

good diet, you exercised and you've exercised your mind, you've actually done word puzzles or worked late into your 70s and 80s, you might actually stave off Alzheimer's disease a little bit longer. So we see that in people with head injury Alzheimer's appears to develop a little bit earlier.

So there's certain things you can do that can make it appear earlier. Certain things you can do in terms of smoking or a bad diet with high cholesterol that cause all sorts of vascular changes, and you may see the Alzheimer's disease come out a little bit earlier. So I don't know about your aunt. I don't know if she drank or smoked or if she had a family history of Alzheimer's, but all those things can affect how soon you would see the illness emerge.

The question about who you would take and when you would take your uncle to go see someone is a really important one. I think family members are asking this all the time. I mean what is normal aging. You can talk to older people, and they'll say, Well, I just think I've got normal memory problems. A lot of my friends have normal memory problems. But, you know, there are a lot of things that can cause memory loss that are very treatable, for instance B-12 deficiency. So going to your doctor even if you have any question about it, let your doctor do a general medical work-up and make sure that there's not some treatable cause of the memory loss. Hypothyroidism can be a cause of memory loss. Depression can be a cause of memory loss, and those are very treatable. And if they're caught early enough you can really stave off the memory loss. But there is a normal memory loss associated with aging too and your doctor should be able to sort those two out pretty clearly.

Andrew Schorr:

What we'll do, Dr. McDonald is we'll get into all this as we continue. I definitely want to know more about the B-12 and thyroid conditions and how it affects all that. And then we'll also be talking more about how do you discuss with your loved one that you want to help them be evaluated to see, are there ways they can be helped and do that in a respectful way? Because I'm sure you see it every day of the week, it's the adult child who's the advocate, and as those roles reverse it's very difficult for us and how to do that in a loving, respectful way and not produce more anxiety in the older senior. So we'll talk more about that.

We're visiting with Dr. William McDonald who's chief of geriatric psychiatry and the director of the Fuqua Center for Late Life Depression, and he's at Emory University School of Medicine, the Medical Center there in Atlanta.

We'll be back with your calls, your questions and a lot more discussion on an important topic as we continue live on Patient Power. Stay with us.

Depression in the Elderly

Andrew Schorr:

Thank you for joining us live on Health Radio Network today. Andrew Schorr here broadcasting from sunny Seattle I'm happy to say. My kids have a tent pitched on the deck here, and we had a lot of rain my producers joke about that, of course it rains in Seattle. So I'm kind of drying it out because my daughter is going to be going away to school and she likes these sleepovers with about four teen-age girls in there. So we've got to dry it out, air it out, so I'm happy for the sun. I hope it's sunny where you are today.

You know, we think about our kids. We also as adult children think about our parents, and as you can imagine with today's topic talking about later in life mental health issues I'm getting e-mails now from lots of people who are concerned about their dad or mom or mother-in-law, etc. And it's exactly what I was talking about as we visit with Dr. William McDonald from Emory who's a psychiatrist there and chief of geriatric psychiatry.

So, Dr. McDonald, let me pose some questions to you and I think it really relates. So here's Susan from Colgate, North Dakota. I'm not sure where that is, but here we go. She writes, "My 78-year-old father lives with me. He and my mom were married for 39 years before my mom died in 1993. The ten-year anniversary of her death hit him very hard. He is very depressed. He says things like, I can die today, tomorrow, any day. It doesn't matter to me and I'm glad I'm on my way out, not on my way into this world." So Susan says, "I feel like he's giving up. Should I look into serious psychiatric help?"

Dr. McDonald:

There's a prejudice, it's called ageism and it doesn't sound like Susan has it but it's the sense that when older people reach a certain age they just give up, and they feel life's no longer worth living. And it's interesting that that's not true at all when you look at general studies of the elderly. And the symptoms that she's giving of her father are the clear symptoms of major depression. And depression and anxiety affect about a third of older people.

And the good news is that it's very treatable, treatable with medications and psychotherapy. And the treatment can be very effective. People can get completely better. And what sounds like has happened to her father is that he has slipped into a major depression. Again, it can be fairly common in older people, particularly in older people with the loss such as the one he has had. And he's not only lost his wife but in moving in with a loving daughter he's probably missing some of the community that's surrounding him there and was also protective to him so that he has a number of things to deal with

And definitely she should seek care from either her primary physician, it sounds like she may be in a smaller town where she may only have a primary physician. And again

primary physicians give out 60 percent of the depression treatments in this country. They're not all done by psychiatrists. So being seen by a primary care physician is perfectly reasonable and acceptable. The medications are very safe and even people in their 90s and can be very effective. Even people with multiple medical problems can get a lot better with the medications that we have to offer now.

And one thing to consider is that the elderly, particularly older men have a suicide rate that's about six times the general population. In other words, their risk of suicide is much higher than you would see in just the general population and quite high nationally. So an older man saying he's having thoughts of death is something that would be of real concern for all of us.

Andrew Schorr:

Wow. Well, you are the director of the Fuqua Center for Late Life Depression there in Atlanta, so while Susan is way over in North Dakota she may not get on a plane with dad to go to Atlanta, but tell us what you would do if she were nearby and they came over to your center. How would you proceed with a gentleman like that? And maybe we can use that as a model for maybe what people should look for from afar.

Dr. McDonald:

Sure. Well, one thing to recognize is that psychiatry is not available in about half the counties in Georgia, for instance, and people generally work with their primary care physicians. In Georgia we have a telemedicine project where we work with people in rural counties over a computer. Essentially they can go to their doctor and be seen in front of a computer so we can help with the diagnosis.

But what we would do is a full, comprehensive psychiatric examination, and very importantly it would include a medical work-up. So for somebody Susan's father's age he could have medical problems that could be contributing to his depressed mood, his low energy, even his feelings of hopelessness, and we talked about some of them before. But it could be his blood pressure medication. Maybe his blood pressure medication is the type of medication that could cause depression as a side effect, and you could relate back that when he started that medication, even though it's related to the death of his wife maybe at the same time he had some changes in some of his medication. So really kind of carefully looking at his medication, doing a full physical work-up, trying to make certain that you look for any of the treatable causes of depression is really the first step.

And once all that's been cleared we have a couple of things that we can offer people here which have actually been very successful. One is a peer support group. We tried a number of different types of groups, but the one that works the best was a group that had older people who had depression leading the group. It's essentially free to anyone who wants to be in the group, and it's a very successful group. We also have day treatment programs where people go during the day and then go home at night rather than being locked in a hospital all day. They get psychotherapy during the day.

And there's plenty of evidence that even though sometimes older people will object to group therapy or individual psychotherapy they actually do very well once they start into it. Once they start into it, it's hard to get them to stop. But they have a prejudice I think against it. Though didn't grow up in the Prozac generation, and their feelings about psychiatry are really very tainted, and many of them just feel really uncomfortable being in a psychiatric situation. And that's why I think if Susan would call her primary care physician, let him know the situation, let him know what her concerns are about her father before he goes in there, let me him know that she has some very real concerns that he's having depression, he's talking about death and talking about suicide, so he can be prepared when dad walks in to really address those questions with him.

Because I would imagine if her father went to her primary care physician he would never admit to suicidal thoughts, never admit to depressive thoughts. So one of the things we do here is we usually see people with their families because it usually is the caregiver who's brought the patient in, and it's usually the caregiver who's the impetus for the appointment, and if they don't come in the room we'll miss a lot of the valuable information, because older people are usually very guarded about talking about issues related to depression. It has a very bad feeling to them to talk about being depressed. It makes them think of a personal weakness rather than a medical condition, which is the way we feel about it.

Andrew Schorr:

Right. I want to mention, and we'll be getting into this a lot more in depth and we have many other questions, there's a movie I came across and you might like it too, Doctor, is, if you can find a video store, it's not a big movie, Boynton Beach.

Dr. McDonald:

Oh, I know that movie.

Andrew Schorr:

Yeah, down in Florida.

Dr. McDonald:

Yeah, it's a great movie.

Andrew Schorr:

Where people had had different losses and sort of had their own support group to kind of move forward. I think Diane Cannon was in it and a number of big stars who were a little older. So I highly recommend that, folks. Boynton Beach.

So we're going to take a break and we're going to continue our discussion about mental health issues in older people, and we welcome your calls. And we'll be visiting as we continue with Dr. William McDonald at Emory University in Atlanta. We'll be back with a lot more on Patient Power live on Health Radio Network.

The show is Patient Power with Andrew Schorr broadcasting live from Seattle. And my partner today is Dr. William McDonald, chief of geriatric psychiatry and the director of the Fuqua Center for Late Life Depression at Emory University in the School of Medicine there in the Medical Center there in Atlanta. And the Fuqua center is pretty unique and was established in 1999 following a gift from the J.B. Fuqua Foundation to develop a center of excellence, as Dr. McDonald was describing what they do there for the treatment of late life depression, and so that's really neat. And it sounds like as the baby boomers get older and our parents get older and live longer this is such vital services.

Dr. McDonald, before we talk more generally maybe there's a website for your center that you'd like to give people because I know you have a lot of information there, and then we'll post that as well. And if there's a phone number please feel free to give that as well.

Dr. McDonald:

Well, Emory has a toll-free phone number that people can call to get information and to get to us also, and that's 1-800-75-Emory. And there are nurses there until about seven o'clock our time who can then transfer you to either us or to other sites within Emory that make sense, that after talking to you make sense for you to visit. The website we have, of course all web addresses are difficult to find, but if you were to just put into Google "Fuqua Center for Late Life Depression" we come right up. And Fuqua is Fuqua. So if you just put in Fuqua Center for Late Life Depression it will put up, and there aren't too many Fuqua centers so that will pull us right up and you can just get right to us. And there's information on depression there as well as depression information for medications and referral networks.

Moving a Senior to a Care Center

Andrew Schorr:

That's great. Okay. Let's go back to some questions, Dr. McDonald. Now, I alluded earlier to the idea of how do you respectfully as an adult child help your dad or mom or other relative or friend who's a senior that you love get them to the doctor to get the kind of evaluation that you describe or if they have a diagnosis have them get to a proper facility. And we got a question like that from Beatrice who is in Atlanta, so maybe she's been over to your Fuqua center. She writes, "My 89-year-old mom has been diagnosed with Alzheimer's dementia and refuses to go to a proper care facility. A very good nursing home is ready to accept her, but my problem is in getting her there. How should I go about telling mom this may be her best option?"

Dr. McDonald:

Well, you're right, it is a very common question that we get asked all the time. It's difficult to sort of switch roles to be the caregiver when you might have been an adult child of a mother and see your mother drifting away and you really need to step in and help her. And I think the most important thing you can do is to keep in mind that what you're doing you're doing for her own good and sometimes you just have to force the issue. Bring the other children with you, make sure you've got everybody behind it and take her.

There are a couple of things that everyone should do as their parents get older that can make this much, much easier. And the first is to make certain that they have a will and that they will clearly specify their assets, but also to get what's called a durable power of attorney. And while an older adult still has their mental faculties it's very easy to do. You can do it in a lawyer's office in a couple of minutes, really. And what a durable power of attorney allows you to do, and you can do it for healthcare or for personal finances, but it basically says that when the person who signs it becomes incapacitated in any way, either physically or mentally, then whoever they assign can take over either their healthcare or they can take over their personal finances. In that situation as Beatrice has, having a mother who is dementing, she could then have control of her finances as well as her healthcare and she could sign her into the nursing home.

Once someone's demented and they refuse and they become unreasonable in trying to work with them, then it becomes much more difficult, and most nursing homes won't take people involuntarily, so it becomes very difficult to assign them. One resource that everyone has in every community that's a wonderful resource is the Alzheimer's Associations. I'm sure there's even one in South Dakota that would be available to the last person. But the Alzheimer's Association are wonderful resources. They're free. They hold seminars. They have elder care lawyers that are on staff that people can refer to that can really help people in these difficult situations. In a situation like this there's nothing better than to talk to other people who have been in the same situation and can help you strategize and talk about ways that they've managed some of these difficult situations. So I'd really recommend the Alzheimer's Association for anyone in this sort of difficult situation.

Andrew Schorr:

Okay. Yes, I've done programs with them, and I think they're great and have tremendous resources.

Let me ask you this question. So I've talked on other editions of Patient Power about my dad, Max, who was an attorney first in New York then down in Florida and kept practicing until his prostate cancer advanced and he became critically ill and in intensive care and died pretty soon after that at age 92. And, you know, he was very sharp. Being a lawyer he really kept his mind sharp. He played bridge and talked about all these things we can do. But earlier on my mom, and they had been married 55 years, developed advanced

colon cancer, and over the course of a long time, actually four and a half years, then led to her demise. And I remember vividly taking my dad out to lunch one day when I had gone to visit my mom, and she was pretty sick, you know. And he'd been dealing with it for months and months, and I said, Dad, you know, you're a patient too.

Dr. McDonald:

Right.

Dealing with Stress as a Caregiver

Andrew Schorr:

And we need to give you breaks and support you because it's very trying on you. And actually this happens to a lot of people where, as we've heard, somebody predeceases another or even that demise as it's unfolding is very hard on the other one just as a caregiver.

And Barbara wrote in from Lexington, Kentucky and she says, "My mom is suffering from dementia and my dad is tired of dealing with it." So he's fatigued, and I'm sure it's very difficult. So we've talked a little bit about helping the actually patient, but maybe should we define patient a little more broadly, and there may be another senior who's been a caregiver and they're just totally devastated and worn out. And when do we seek help for them?

Dr. McDonald:

Well, that's a really very important point that I think medicine has ignored for a long time. There was a recent study in a very prominent medical journal that looked at if a spouse was hospitalized for anyone of a number of different conditions, and it looked at the partners' death rate over the next year and compared it to a group of people whose spouse was not hospitalized, the death rates were dramatically higher. And the implication is that the stress on the caregiver in many ways is amplified. If you take the husband of an Alzheimer's patient, the stress isn't with the Alzheimer's patient. The stress is with the spouse who's actively watching their loved one change and having to stay up in the middle of the night to take care of them.

And we've noticed that time and time again. We have a caregiver support group here which meets weekly, and it's been a real asset, again, people who have been in that situation taking care of each other, much as was done at the Alzheimer's Association. And I you can't stress the importance enough of taking care of the caregiver. We've seen many cases where I'm paying attention to the patient who has Alzheimer's and missing the fact that the spouse is the one who really needs help and needs to get treatment.

And we usually address it pretty straightforwardly, much as you did with your dad. And the way we try and address it is, Who else is going to take care of Mom if you get sick. And if you don't take care of yourself, you're the one life line she's got, so we really need

to keep you healthy, if not for yourself, to take care of your partner and make sure that she stays healthy because you're the real life line for her. So we really need to be spending more time with you and not just Mom.

So your approach with your dad is exactly what you need to do. You need to do it early, and I think it can have a direct bearing on the health of the caregiver.

Financial Support

Andrew Schorr:

You know, one thing I always say with people with any health concern is, you know, you are not the first person to feel this way. You are not the first person to have this diagnosis. You're not the first one to be a spouse or a family member where somebody has gotten this news. Draw on that support and that knowledge. And it is there for you. And I think you're right when you talk about the Alzheimer's Association. There are other associations, as you know, that deal with anxiety and depression and they're really committed to making that connection.

Well, I've got another question that came in from Lisa in San Diego, and she really has the financial part of it. So she's asking about the qualification requirements for Medi-Cal insurance, but it could be different in other states, and they're kind of wrestling with the Department of Health and mother-in-law has Alzheimer's. Can you get help with those financial issues as well, the elder care issues, because, you know, you want to get the care but you also want to get financial support so that you don't get abrupt trying to get mom or dad what they need.

Dr. McDonald:

Right. Well, you know, there are lawyers who are specific for this area of law that, really, they're elder care lawyers, and Alzheimer's Association usually links people to those lawyers. Two weeks ago in Atlanta there was an elder care lawyer who gave a very good talk on what you need to do with your assets and exactly that. You're right. Medi-Cal will be different than Medicare in Georgia. It was very specific about what you need to do with your resources. And even if you didn't have a family member with Alzheimer's disease, if you had a family member who just needed some help and you wanted to make sure that you didn't bankrupt the family but yet provide the care for them, visiting an elder care lawyer makes a lot of sense.

And I really have faith in the Alzheimer's Association. I think they're pretty open and that they screen people pretty carefully, and I think they're a good resource for finding a good lawyer to help you in a situation like this, and they can let you know what the fees are. But it might be worth paying a nominal fee up front in order to get all the affairs in order.

And again one of the things we see rather commonly is just wills that don't make sense. There's a lot that needs to be done for an older person legally, and a bad will that doesn't

cite everything in it in any case will make it very difficult for the children and the surviving spouse. So trying to get all these affairs in order, particularly when the patient is of sound mind and can really make decisions and make their own decisions is very, very important as your parents age. Or as you age.

Late Life Schizophrenia

Andrew Schorr:

I wanted to make a comment. We have done programs, and I have a fellow I've had on a number of times, a great guy from Austin, Texas, Jim Comer, who wrote a book about when roles reverse. And his mom has Alzheimer's and his dad had a stroke, and he was a single child but at 50 years old was thrown into the breach and had to move from California to try to play catch-up. And his number one advice is don't be playing catch-up when it's a crisis but try to plan.

And these documents you're talking about and having the discussion like I did with my dad just related to supporting him in a time of stress but more broadly than that, understanding that we're all going to age, there's different things are going to happen, different stresses that come into play, different illnesses that may develop late in life, have that discussion early in a loving way. And I can't stress that enough. But, folks, you might look for Jim Comer, *When Roles Reverse*, and then there are links to that program also on patientpower.info website.

Well, Dr. McDonald, in our title for today's program we call out diseases and disorders of the elderly. Dementia and depression we've talked about. But we haven't talked about anxiety and late life schizophrenia. So maybe we can talk for a minute about that. I want to take schizophrenia first. I think of that as, sort of split personality. But, what is it, and how does that develop later in life and what do we do about it?

Dr. McDonald:

The term for it, schizophrenia really implies a psychotic disorder that in general people hallucinate, they hear voices or see things or they have delusions or fixed false beliefs. They become paranoid and think people are trying to harm them when they are not. It's generally a disease of people early in life. The onset of it usually is in your 20s. It's very heritable, that is, in general people have family members who have had schizophrenia, and it doesn't really come on late in life.

What does happen late in life is a disorder called paraphrenia, which has also been called late-life schizophrenia, and people become very delusional and disorganized. It's fairly rare. It's probably about one, two percent of the older population. But when it occurs people develop very fixed ideas that people are going to harm them or do things to them. And it can become very difficult to treat. Last lady I had who had it was brought in by her daughter, very nice family who happened to also be a very wealthy family.

And they unfortunately hadn't taken care of their finances and this woman had become very psychotic and very ill and she held the family fortune. They essentially had owned a lot of property that had really gone astronomically higher in price, and she was controlling it but had a very delusional thought that people could see through walls and people could watch her walking through the house, and so it was very difficult to treat because the patient looked at me and said there's nothing wrong. This is actually happening to me. And the family members had no durable power of attorney, no way of controlling the finances, and they were all frightened that if they confronted her she might actually cut them out of the will or harm them in some way. So it was a very difficult situation to treat.

Andrew Schorr:

There's a book in that story somewhere, I think. That would be a great one.

Dr. McDonald:

You know, it was one of those situations where everybody had the best intentions and the patient was telling the story, she was very clear in the way she talked about it. If she were to talk to you to you on the street you wouldn't believe there was something wrong, but she had this very fixed delusion. So it's fairly rare, but when you see it can be very, very difficult to treat.

Dealing with Anxiety

Andrew Schorr:

Let's take a minute just to talk about anxiety now or even maybe related to that, what would it be, OCD, because I know that my wife's grandpa as he was in his 80s and 90s he would check the lock on the door 50 times a day. So whether that was he was obsessive-compulsive or anxious, but he really worried about somebody coming in the door. And he worried and lost sleep about it.

Dr. McDonald:

And it's interesting, older people, depression more frequently comes out as anxiety. And the phrase in the south, I don't know if it's the same in Seattle, is you can ask somebody if they have a nerve problem and they'll readily respond, Yes, I do, when it's very difficult to ask them if they have a depression problem. But people can really recognize nervousness and anxiety, and it's one of those symptoms that when an older person has it they'll sort of readily acknowledge it and often seek treatment for it. Depression and anxiety, though, in older people probably aren't that separate from one another. They tend to occur together. And I don't know about your relative but you'll oftentimes see people with that sort of checking and that worried nature, actually underneath all that be depressed.

That's important because the treatments for depression are the serotonin reuptake inhibitors, things like Prozac, Paxil, Zoloft, and those are really safe medications to use in

older patients. They're nonaddictive. They don't tend to have a lot of drug interactions so patients can do quite well on them for years. The problem is the patients who present with anxiety are the ones who often get put on Valium and Xanax and Ativan and some drugs that can be very addictive in older people and have very serious consequences on both their thinking as well as their alertness. And they're the types of drugs that cause people to get quote-unquote doopy. And this can be very dangerous in an older person who could be still driving a car, who could trip down stairs in the middle of the night.

So trying to recognize anxiety and treat it with some of the safer medications becomes a real goal of us. We'll very often see people walk through the door on multiple different, benzodiazepine is the term for it, but those are drugs like Valium, Xanax, Ativan, and they'll be on very high doses of those medications just to try and manage them, when what they really need to be on is a drug in a different class and a much safer drug, a drug that's generally termed an antidepressant.

So the treatment of anxiety in older people becomes very important, but it can be difficult because once somebody's been on Xanax for a while they may not want to stop that Xanax. It may be very difficult to get them off of it. And we're all aware that of the fact that in the 50s people used Valium right and left. There's Life magazine fold-out commercials for Valium as the drug that can get you through the day. So older people, it's a really danger with them to get them on those very addictive medications.

The other thing we haven't talked about is alcoholism, which some people will turn to to manage that anxiety. And you'll see older people who used to drink socially, just drink during the day, and now they're drinking earlier and earlier in the day. And that's a very serious problem for older people, and yet it's pretty unrecognized. Families don't like to talk about it, but alcohol use for people who are starting to drink at ten o'clock in the morning. And this might have been somebody who was a social drinker who controlled it for most of their life but when they retired or got older they started drinking earlier and earlier and drank more and more, and that's another cause of a significant amount of morbidity in older people.

Andrew Schorr:

Right.

Alcoholism and Drug Abuse

Dr. McDonald:

And we're starting to see older people who are using some of the more common street drugs.

Andrew Schorr:

Oh, my.

Dr. McDonald:

I had a 65-year-old man come in who was a cocaine addict. You know that's not something we saw 10, 15 years ago but we're now starting to see the younger people who have now aged out and they're starting to come in with really serious drug abuse problems.

Andrew Schorr:

Oh, my. Dr. McDonald, this has been quite a fruitful discussion. Promise me you'll come back some time.

Dr. McDonald:

Oh, yeah. I'd love to talk to you again.

Andrew Schorr:

There's a lot to talk about. The good news is in a number of these conditions we talked about, the depression and the anxiety related to it, there is help. So I hope that our listeners know it's worth having a discussion with your doctor, maybe, if available, seeing a psychiatrist for you or a loved one as they age and getting the care that they need and deserve.

We've been visiting with Dr. William McDonald, who's chief of geriatric psychiatry and director of the Fuqua Center for Late Life Depression at Emory University and Emory University School of Medicine in Atlanta.

Dr. McDonald, thanks so much.

Dr. McDonald:

Thank you, Andrew.

Andrew Schorr:

Thank you, sir.

As always, we remind people knowledge can be the best medicine of all. Have a great day. We'll see you tomorrow. Andrew Schorr signing off.

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