Dr. Laura Roberts (00:16):

Hi, I'm Dr. Laura Roberts Editor-in-Chief for the books portfolio of the American Psychiatric Association. And welcome to the APA Books podcast.

(00:32):

Welcome everyone to Psychiatry Unbound. I'm so delighted to be with all of you and really excited to be speaking today with Dr. Art Walaszek. He has recently published Late Life Depression and Anxiety. It's an edited text and it's really fantastic. I'm going to spend some time talking about it today, but Art has done a few other books with us and he's on a roll, has a lot of momentum, and so we're excited that we published his first big book and have now published a number of others with him. So welcome Art.

Dr. Art Walaszek (01:04):

Laura, thank you so much. And it's really just been such a wonderful opportunity to write. My background is in writing. I was a creative writing major in college and I haven't yet written the Great American Novel, but this is a great other way to sort of blend creativity with science and medicine.

Dr. Laura Roberts (01:30):

I should tell our listeners that Art is a professor of psychiatry and medicine at University of Wisconsin. There it's the School of Medicine and Public Health. He's also the Vice Chair for Education and Faculty Development in the Department of Psychiatry there. And co-leader for Outreach, Recruitment and Education at the Wisconsin Alzheimer's Disease Research Center. We'll hear maybe a little bit more about that. He's a public health pillar leader at the Wisconsin Alzheimer Institute and has done another book with us recently on behavioral and physiological symptoms of dementia. So welcome everybody to Unbound and welcome again Art. We talked with you in the summer of 2020 about a prior book and to give a little teaser to some of our listeners, we're going to be hearing much more from you in the future, but we'll come back to that in just a bit. So Art, as we always start out, why does the world need this book? Why does the world need this book on late life depression and anxiety?

Dr. Art Walaszek (02:24):

Thank you for asking. So there are several overlapping things. So one, first of all, just kind of aging in general. So rapidly aging population, not just in the US but really worldwide now. And so we're going to be seeing significantly more older adults in general and then also more older adults with mental illness and anxiety disorders like in younger adults are the most common psychiatric disorders in older adults. And depressive disorders are quite common as well. If you look at major depression prevalences, they're not quite as high, but if you look at depressive symptoms in general, it's fairly high among older adults and suicide risks.

(03:11):

So suicide risks, so in particular in older men really is quite high and is also addressable because depression, anxiety, insomnia, these are all things that contribute to suicide risk and they're actually all things that we can identify and address in older adults. So the point of the book is to help prepare clinicians for now and the future when there are going to be many, many more older adults with depression and anxiety seeking treatment and just underscoring we can identify, diagnose, and effectively treat older adults with depression and anxiety disorders.

Dr. Laura Roberts (03:51):

I love podcasts. We do this podcast and I was listening to another podcast and they were kind of lamenting the current state of our country and they were talking about the podcast post was talking about how older people, of course they're pessimistic, that there's a sense that if you aren't around you can't make the world right. And he was spinning all kinds of stuff that did not match my life experience. And then I started wondering, gosh, maybe I'm surrounded by elder optimists and I don't know, maybe he's surrounded by elder pessimists, but could you just give us accurate information as opposed to our overgeneralizing from our immediate experience?

Dr. Art Walaszek (04:31):

No, that's such a wonderful question because I agree. I think a lot of, if you just think about movies, song, images, aging equals stuff that's not good, whether it's pain or memory loss or loss of others or sadness and depression and so on that we're sort of inundated with that idea that aging is an inevitable decline and things are only going to get worse and so on. And some things are inevitable, right? But depression, anxiety are not among those inevitable things. So most older adults do not suffer from major depressive disorder, generalized anxiety disorder, panic disorder and so on. It's certainly by no means to stigmatize the folks who do. Those folks are suffering from serious conditions like diabetes and just diabetes and COPD and so on, major depression, generalized anxiety disorder are conditions that people develop and that we can address and treat. So I think the norm for many older adults, even those who are suffering from loss and pain and so on, is to not develop clinically significant psychiatric disorders.

(05:50):

And that's sort of a really interesting idea around resilience and successful aging and so on. And I think about my older adult patients who they have lost loved ones. Their kids and grandkids live across the country, they're not working, they've lost their professional identity, they're in pain, et cetera. I'm amazed that they're creative, they're social, they're going to religious services regularly, they're volunteering. It's just remarkable that despite all those things, folks can stay quite active and resilient.

(06:26):

So the norm is not depression and aging for older adults, nor really is memory loss for that matter. It's a bit of a tangential topic. We all have declines in our memory, but in terms of developing dementia until you get to your 90s, most people who are older don't have dementia. So there are lots of these really stereotypes about aging, and that's part of writing these books is all about as well is to dispel some of those myths about aging. And I'll just attach a word to that concept and that's ageism, the idea, you basically like racism or sexism or homophobia, you attribute things on the basis of a characteristic, in this case, age as opposed to other attributes. Aging does not equal depression and anxiety.

Dr. Laura Roberts (07:23):

Part of what I love about your book is that it helps begin to differentiate what would be normative, what would be expected in an older individual, and what really is a symptom, a sign of a clinical syndrome that should be addressed. When you're a geriatric psychiatrist and somebody else has recognized it, the diagnostic processes maybe a little bit different, somebody else is going to tipped you off to what the concern is. So maybe we could walk our way through that. How would an individual who's growing older recognize that their experience is not usual? How would a family member begin to think, I better talk to our primary care doctor about this, or how would the primary care doctor begin to think, oh my gosh, I need to check in with someone with psychiatric expertise to help me. So do you mind walking us through that continuum?

Dr. Art Walaszek (08:18):

Absolutely. So I'll just pick on depression just to simplify it a little bit. So of course we all experience sadness, we experience loss, we experience grief, and grief is unfortunately a normal part of the human condition. And so in general, we can weather all those things. I can feel sad in the morning, but make it to work and do the things that I need to do and get home and have a lovely dinner with my wife, and things are going great despite feeling a little sad in the morning. When the sadness becomes persistent and either starts to interfere with function like I'm sad in the morning and I don't get out of bed and I don't eat breakfast and I get to work two hours late and I'm grumpy towards my wife and so on. That's where we start to worry that we've crossed over from the normal human experience of feeling sad at times to depression, whether that's major depressive disorder or another condition.

(09:24):

So I think how pervasive the depressive symptoms are and what the outcome of that is, especially impact on function and also on quality of life of the person. And there's the usual cadre of associated symptoms around sleep and energy and appetite and hopelessness, and especially the one that makes us most nervous, suicidal ideation. So certainly again, in the context of loss, if I lost a loved one thinking about death or where is my loved one right now, or someday I'd love to be with them again, or something that isn't suicidal ideation, that's kind of normal sort of thinking after you've lost a loved one versus I shouldn't be alive, I'm not worth it, I'm a burden on others, I have nothing to live for. That's much more concerning in terms of, oh, it sounds like this is depression and the person needs some help and perhaps immediate help. And I should add that if folks are experiencing those things, we now are fortunate to have the national 988 line that people can call and immediately get help for mental health crises.

Dr. Laura Roberts (10:39):

So how will a, and maybe I've always been surrounded by stoic elders too, but often with stoic or less conversant elders talking about feelings or mental health symptoms, how would say a family member or importantly a primary care doctor begin to elicit these harder, more worrisome kinds of thoughts that a person might have?

Dr. Art Walaszek (11:04):

Absolutely. It's tough. So a lot of folks just don't have that, don't feel comfortable with or don't have that kind of psychological language around sadness or grief or loneliness. And that's okay. That's again, not to stigmatize anyone, but just some people don't have access to that kind of language or experience. It can show up in other ways. So in older adults in particular, depression or anxiety may show up as more somatic or physical concerns like chronic headaches, chronic nausea, chronic dizziness. Now there's a huge caveat with all that is that all of those things, headache, dizziness, nausea, could be other stuff besides depression and anxiety, and especially in older adults, it could be a whole bunch of other stuff. And so when a person has those sorts of somatic symptoms, we want to make sure that a primary care clinician is addressing those, doing the standard evaluation.

(12:04):

And if those standard medical evaluations don't uncover a cause and yet the person has persistent headache, nausea, dizziness, whatever, that would raise the possibility of, well, perhaps there's an recognized depression or anxiety here. And the way we talk with patients about that is the brain is part of the body and the brain has all sorts of ways of expressing things, and sometimes distress can be manifested physically, whether it's some dizziness or stomach discomfort or feeling faint or whatever.

So then we begin that language around trying to avoid the feeling that people may think it's all we're saying, oh, it's all in your head. No, it's a connection between the brain and the rest of the body and sort of sending this signal. So that might be one way to approach it. I mean, the other is, so the two core depression symptoms are low mood and lack of joy or interest.

(13:06):

So sometimes that's the thing that shows up that the person's no longer doing the stuff they used to do. They no longer have their Wednesday morning coffee clash and Saturday night bowling and church on Sunday. They've lost interest in those. Now, there could be a lot of reasons why that is. There could be mobility issues, there could be hearing problems. It isn't just depression or anxiety automatically, but depression or anxiety could cause those things. People may have lost interest, and so they may not say I'm sad, but they may say, eh, I just don't find that I don't get anything out of that anymore. That's why I'm not doing that. I'm just not interested in doing that. So that could be a cardinal depression symptom as well for families and primary care docs to listen to.

Dr. Laura Roberts (13:48):

All right. So the primary care physician, if you had four questions that you wanted them to ask or give me a few, I'm pulling that out of the air, but primary care physician or let's say the general resident who's encountering patients in different settings in their training, what would you like them to key in on?

Dr. Art Walaszek (14:09):

Yeah, well, I have a couple ways of thinking about that. I mean, one, we have validated rating scales that work in older adults just as well as they work in younger adults. There's a caveat there, which we'll get to around cognitive impairment. But in general, a cognitively intact older adult, PHQ-II, PHQ-VIII, PHQ-IX, all of those should work just fine in terms of a screening tool, not necessarily a diagnostic tool, but a screening tool for depression. You can get false positives because those physical symptoms of depression have so many mimics in the medical world, congestive heart failure and COPD and so on can show up as a lot of those physical symptoms. But as a screening tool, all of those work just fine. So in the last two weeks, have you felt sadder down in the last two weeks? Have you given up on activities or lost interest of them?

(15:02):

There's a PHQ-II basically right there. And then on the anxiety side would be the GAD-VII, which is a generalized anxiety disorder screener, but can also pick up potentially folks with panic disorder as well. So it won't cover the full range of anxiety disorders. But in terms of getting started, if we just universally did PHQ-IIs with a nine if positive, and then GAD-VIIs on older adults where you have some suspicion of depression or anxiety, that would get us in a good direction. I would add to that, so certainly, again, sort of emphasizing the suicidal ideation side of things. So if you ask the PHQ-II or VIII or GAD-VII, you don't get that. The PHQ-IX, you get that. So absolutely asking about, I usually start with, do you feel your life is worth living or not? So just a very general kind of existential question that heads us in the direction of perhaps this person has suicidal ideation.

(16:08):

And then as things get answered, as folks answer positively, then do you go to bed at night hoping you don't wake up in the morning? Do you have thoughts of wanting to hurt yourself, et cetera? All the stuff that we're taught, taught about in terms of passive suicidal ideation, thinking you'd rather be dead and active, actually wanting to harm yourself. So going through that sequence is absolutely essential. Again,

because for older adults, it's really, depression is the big driver of suicide. So in psychological autopsy studies in older adults, 90% had major depression in the time leading up to their suicide. And major depression is diagnosable and very treatable in older adults. So if we could do that with everybody who's depressed, we could probably actually have a significant impact on suicide.

(17:01):

One other subtle thing, if I could add this, is getting a little sort of inside baseball, but there's a very severe form of major depression, psychotic depression, which can sometimes be a little subtle and difficult to pick up, including in older adults because it may manifest as something like really awful guilt, especially about stuff that doesn't seem like it's a reasonable thing to be guilty about.

(17:27):

Like 30 years ago, I had some conversation with someone and then something happened, and I'm dwelling on that now for 30 years later. Oh my goodness, why did I do or say that? Or whatever that sort of may suggest or be like, I'm a very bad person, I've done something very bad and ought to feel this way as a result of it. So that could hint of a psychotic depression. And the reason that's important is because the treatment of psychotic depression is different than non-psychotic depression and may require hospitalization and more intensive treatment than non-psychotic depression.

Dr. Laura Roberts (18:06):

That's great. So let's talk about your book and how you put it together. First of all, you put some wonderful colleagues together to help you with this, and the way it's organized is you have kind of an introduction to late life depression, and then again, an introduction to late life anxiety and related disorders, and then how to assess it, which is what we spent now some time thinking through. And then right there you talk again about suicide risk reduction in older adults, really giving it a lot of emphasis and salience. We haven't yet talked quite so much about social isolation and how it might contribute to that. So I'm going to come back to that in a minute. And then the next chapter is on management on late life, depression and anxiety. It's a long chapter, it's a big chapter. You cover a lot of material.

(18:50):

You've brought in really talented people to think that through. And then the last chapter is about cultural assessment and kind of bringing a little bit of refinement to the assessment process with that. So let's talk about suicide risk reduction, which we've only touched upon a little bit, but with a little bit of a focus on how social isolation might intersect with that. And then I'd love to talk with you about how you thought about the management and therapeutics for these conditions. So suicide risk reduction, and especially post-pandemic and just everybody feels isolated in our society practically. So how do you think that through Art?

Dr. Art Walaszek (19:32):

Yeah, so loss of social network is a big component of depression, I think even more fundamentally than that, even sort of my understanding what's my place in the world? What's my role? Is really thrown off if I've lost my social circle because we're social beings. And so we are often defined in relation to, of course, our family, but also our colleagues, our friends, our neighbors, we're part of these communities. When you lose that, that's really kind of losing a fundamental part of yourself. And so I think it's important from that kind of more, meta perspective as well as being a risk factor then for the development of depression, anxiety, insomnia, cognitive impairment and so on. On The flip side, one of the protective factors with respect to suicide, things that we might lean on to help someone reduce their risk of suicide would be engaging and rebuilding a social network. And of course, many folks, when

they talk about reasons why they want to go on living or why they wouldn't want to die by suicide, they'll often cite their family or friends, and often in the context of kind of impact that a suicide would have on family and friends.

(20:55):

So a key risk mitigation strategy is to go after this social isolation to, and that often it isn't just like well go out and meet some people. Obviously there needs to be a strategy and there may need to be pharmacological tools to help with that as well. If the person has no energy, no motivation, no interest, typically like a combination of a medication and something like cognitive behavioral therapy or more specifically behavioral activation, or there's a wonderful form of psychotherapy that almost feels like it was built specifically for older adults. It wasn't. But interpersonal psychotherapy, it was all about your relationships with others and those circles of relationships with people and re-engaging those and so on. So I think that's a huge component of treating depression, anxiety, and addressing suicide risk.

(21:53):

The other risk mitigation strategies have to do with access to means. So by far and away, the main method of suicide for older adults is by firearms. So for men, it's about 80% of older adult men who die by suicide. It's by firearm. For women, it's more or less tied with overdose for older women, for younger women, it's overdose way more than firearm. But in older women, the two kind of catch up with each other. So it's relevant for both men and women to address gun safety, certainly if someone's acutely suicidal or very depressed, not having the guns in the house, having it for someone else to take them for safekeeping and so on.

(22:46):

And of course, guns are a highly lethal means of suicide, and so hence why they're such a big fact. And gun ownership is very, very high. So people have access to, ready access to a very lethal means of suicide.

(23:05):

Other risk mitigation strategies have to do with medications. Older adults may take lots of medications, and they could be things like opioids and benzodiazepines and other sedating things that could be quite lethal in overdose. And an older adult has less physical reserve and resilience. So an overdose that might make a younger adult ill, but not dead, might be lethal for an older adult. So securing medications, if there's another family member who can dispense medications, giving short supplies of potentially lethal medications, et cetera, et cetera. And then there are other things we might address. I always ask about like ropes in the house because hanging is a not uncommon means of suicide.

(23:50):

And then for folks who live in high buildings sort of addressing that, and that can happen even in skilled nursing settings, people can get out of windows and so on. So not to get too morbid, but we sort of think through, well, what are the possible means folks can use and try to reduce that? We may have to get the person into a safe place. So that may mean psychiatric hospitalization for someone who's acutely suicidal, they're not safe to be in their home, they may need a brief psychiatric hospitalization to help address that. And then the other risk mitigation strategies to be treat depression, treat anxiety, psychotherapy, medications are all of our usual interventions. And I think fundamentally it's about, I talk with my patients a lot about this meaning and purpose sort, regaining, why am I here? What's going to get me out of bed each morning? And it could be a slow process of figuring that out. It's hard to do when you're depressed to figure that out. But I think fundamentally it's about why am I here? What's keeping me going rather than wanting to end my life by suicide?

Dr. Laura Roberts (25:05):

Let's talk about management, but if I could, I'd like to invite you to comment as you go on what system and access limitations. So for example, we can talk about an ideal strategy for the care of an elder individual with fill in the blank, whatever condition, and often co-occurring physical and mental health things. But what is really accessible? What does Medicare cover? If you could comment so that we're not, I don't know how to put it. I often feel like we describe these things in this just lovely way, and then when it comes down to it, people have a very hard time making it happen either in clinical practice or whatever. So to whatever extent, you could comment on what are optimal strategies, what might be good enough strategies given the systems issues that we're all dealing with and struggling with.

Dr. Art Walaszek (25:57):

I very much appreciate that because the book is meant to be pragmatic rather than pie in the sky. And so this is really consistent with that. So I think for older adults with mental illness, it's a mixed bag. There's good news and there's bad news. Medicare for the most part, is a pretty reasonable insurance plan. And several years ago, there was a parody for mental health services. So back in the day, like psychotherapy and sort of general psychiatric services would be 50-50 split between the beneficiary and Medicare. It's now eighty-twenty, so 80% covered by Medicare, 20% by the beneficiary, which puts it at parity for medical services. So 20% can still be a lot of money, but if you have Medicare and most everybody 65 and up in the United States has Medicare, you're going to at least get it covered if you can find the service.

(26:59):

So that's where it's starts to get a little bit trickier. The inpatient benefit is remarkable, if I'm remembering right, I think it's like 90 days in a year and 180 in a lifetime. So the vast majority of folks would never exhaust that Medicare benefit for inpatient psychiatric care. Now that all sorts of nuances start appearing almost immediately. So one is there are many flavors of Medicare. So now I think about half of Medicare beneficiaries have Medicare advantage plans, and those are tricky plans, they're cheaper and there's a reason for that. And so the benefits tend to be, it's a little harder to access some of those benefits, including mental health benefits, including I just mentioned, the generous inpatient benefit. That may not be quite true if you have a Medicare advantage plan. So there's that. There's access to resources. So I'm sad to say most psychiatrists don't accept Medicare.

(28:05):

And so that means that there's a huge swath of psychiatrists who are unable to see folks over 65 because again, virtually everybody over 65 or 65 and up is going to have Medicare as their primary insurance. There are a lot of other programs, partial hospitalization programs and other programs that may not accept Medicare substance use programs. So we haven't touched on that yet, but that's a huge overlay that the rate of alcohol use, cannabis use, opioid use among older adults has just skyrocketed in the last 20 to 30 years and is projected to continue to do so and so older. And in fact, older adults do really well with substance use services, including 12 step programs and so on. But finding programs that accept, let alone cater to older adults or people with Medicare can be a challenge. We see that in the psychotherapy world as well.

(29:07):

Again, psychologists social workers not to pick at any professions. I picked on psychiatrists as well. It is kind of across the board. Many folks don't take Medicare, and so that means that that access can become a significant issue. There are remedies to that, and there could be broader policy remedies like increasing payments from Medicare to make it more appealing to more clinicians and so on. That might

be one level. But clinically, and this is an area I'm particularly interested in, it's supporting primary care clinicians to do this work. And in fact, the vast majority of mental health care takes place in primary care. So most people with depression, anxiety, including older adults, are getting their treatment in primary care, not in specialty care. And so we can do a lot of different things. There's collaborative care, there are integrated models, co-located models, e-consultation, all different kinds of models where we could support our primary care colleagues in managing depression and anxiety in older adults.

Dr. Laura Roberts (30:17):

Yeah, I think that again, is another strength of the book is that it appears to be intended, and I believe this is the case, to just build capacity at every level. I mean, we haven't commented, but there are not enough geriatric psychiatrists, right? There aren't even enough psychiatrists, and then there probably aren't in many, many areas of the country and of primary care clinicians, but we can only address so many hardships here in this conversation. But I think the intention of the book and then these management strategies really can be applied in primary care and in general psychiatry, and obviously in geriatric psychiatry and elder care kind of settings. So do you want to walk us through some of the things and principles that you outline in the management of late life, depression and anxiety?

Dr. Art Walaszek (31:04):

Absolutely. And I do want to pause and thank my colleagues here. They did just a fantastic job with their respective chapters. My ask of them was, write this as if you're talking to a colleague, A colleague has curbside consulted you, so you don't want to go into a 17-page dissertation with 100 references, but you want to be evidence-based and pragmatic about the recommendations. And I hope that comes through. That was sort of the goal. It's the tone, the hope of the book. And my colleagues did an amazing job of synthesizing the evidence base and then saying, okay, and then here's how you do this in the real world. And these are all folks who have extensive experience in geriatric specialty care, consulting with primary care, et cetera, et cetera. So a big shout-out to them. So Anna Borisovskaya, who's at University of Washington, her colleagues wrote the management chapter, which is, it is a big chapter, but hopefully well enough organized that-

Dr. Laura Roberts (32:11):

Oh, yeah, it's beautifully structured and very accessible. It really is. It's great.

Dr. Art Walaszek (32:16):

So the general principles would be, okay, you've established the diagnosis, you figured out someone has MDD, GAD, combination, et cetera. The general principles are going to be one, address any medication or medical comorbidities that might be contributing to those things. So there are medications that contribute to depression and anxiety. Alcohol, cannabis, COPD, I keep beating up on COPD, but that can cause a lot of anxiety of course, and cardiac diseases associated with depression, sleep apnea is associated. So all those things identify and address those things, and that actually might cover a pretty significant amount of the depression and anxiety treatment right there to just adequately address those issues. I've had any number of patients with undetected sleep apnea who once we addressed it, like all of a sudden their mood was way better and their energy was way, go figure. It's good to get oxygen to your brain at night. And so it's not automatically an antidepressant. You first want to uncover these potential comorbidities.

Dr. Laura Roberts (33:25):

I have to jump in and tell you that we are putting together a textbook for the first time, and I think it'll be unique in the world on sleep medicine and psychiatry.

Dr. Art Walaszek (33:35):

Oh, fantastic.

Dr. Laura Roberts (33:36):

Dr. Clete Kushida is the lead, and I'm helping him with that. He's a neurologist and leads an outstanding sleep medicine program, and I'm going to try and help to the extent that I can with some of the psychiatric dimensions, but it is really remarkable. I mean, it's the brain. It's a core function of the brain and dysfunction of the brain, which often contributes to these mental health kinds of symptoms and syndromes. So anyways, remarkable a plug in for that. We're really excited about this new textbook.

Dr. Art Walaszek (34:09):

We spend a third of our lives sleeping, and so makes sense that it's a significant contributor. And if you think about insomnia, it's pan and it's across the board. It's a trans diagnostic thing, depressed, anxious, PTSD, bipolar disorder, I mean all substance use disorders, all these cognitive disorders, all of them have sleep as an issue. And just to kind of take that in a more geriatric direction, we think about this a lot in older adults because subjective sleep problems are very common in older adults. Now, objectively, sleep is not super different for most older adults than younger adults. It does take a little longer to fall asleep in general, just general, there's less deep sleep among older adults, but in general, it's not super different. But the perception is certainly for many people that their sleep quality is not great. And then there are plenty of disorders like sleep apnea or restless leg syndrome, periodic limb movement, et cetera.

(35:05):

There's a whole long list of and medications and alcohol and so on. Okay, so then you've addressed the comorbid medical issues. The mainstays of psychiatric treatment will be depending on the disorder, some blend of pharmacology and psychotherapy. So it's a little different for depression and anxiety. So for depression, it really depends on severity. So I think a mildly depressed person is going to do perfectly well with cognitive behavioral therapy, IPT, psychodynamic psychotherapy, some sort of evidence-based psychotherapy is going to work for the majority of people, and a mildly depressed older adult does not necessarily need to be on an antidepressant. Psychotherapy should do it. Moderate is where the combo probably makes sense. So selecting an antidepressant and the book goes into great detail about safety and selecting an antidepressant for an older adult, the selections might be a little bit different for older adults and younger adults because of tolerability issues, but combining evidence-based psychotherapy with a medication for moderately severely depressed folks, and then the severe depression, that's where you're looking at hospitalization.

(36:18):

You're looking at medication combinations, perhaps electroconvulsive therapy, ketamine, there's a decent ketamine evidence base for older adults, transcranial magnetic stimulation, et cetera. So a different set of things show up for the severe depression folks. For anxiety disorders, really the mainstay is psychotherapy, especially cognitive behavioral therapy. There is a place for meds, but meds tend to be a little trickier in anxiety disorders. So folks with a lot of anxiety tend to be very somatically attuned. And so tolerability of antidepressants can be really, really tricky, and it's a tough psychoeducational road around you should expect you're going to get some side effects and they may not be side effects. They

might be your underlying anxiety that's coming through. So tolerability of medications can be a challenge. And so CBT really is the gold standard for most anxiety disorders and certainly for insomnia. So CBT for insomnia really should be the gold standard for sleep issue for insomnia in older adults rather than medications because of all the safety issues. I would add for both depression and anxiety.

(37:35):

Then there's a range of maybe complementary kinds of things. So exercise pretty much good for everything. Light. I'm a huge fan of light for depression. I live in the northern tier of the country where there are higher rates of seasonal depression, but bright light therapy, 10,000 lux, 30 minutes each morning is an effective treatment for non-seasonal depression in older adults as well. So you can really use it year round, virtually no side effects, no drug-drug interactions, etc.

(38:04):

So light exercise, social activities that can get covered in psychotherapy as well. I ask people to try to schedule one activity outside the house each day, sleep hygiene techniques, don't drink before bedtime, don't drink alcohol before bedtime. Don't smoke before bedtime, ideally, don't smoke at all. Use the bed for sleep and sex and nothing else, not doom scrolling on your tablet and so on. So all those sort of sleep hygiene techniques that are part of psychotherapy for insomnia, but also part of lifestyle modification. And there's a little bit of literature on things like yoga for reducing anxiety symptoms in older adults and so on. The book goes into detail and some of the complementary approaches. Let's stretch out then into the community.

Dr. Laura Roberts (38:52):

I know you do so much in the community, and how can people get involved? How can we elevate these issues, especially the concerns about ageism? I mean, how would you like our listeners to get involved really as a community movement to support older adults?

Dr. Art Walaszek (39:10):

Well, I'm going to say the thing that comes to mind.

Dr. Laura Roberts (39:13):

Yeah, you're getting flooded here with lots of ideas, I can tell. But yeah, pick and choose. Give us one.

Dr. Art Walaszek (39:19):

Vote for people who support older adults. And again, I'm just going to say it, someone who says, you should cut Medicare, social security is not supporting older adults. That is one of the bedrocks of our, the reason, sorry, I'm sputtering around a little bit again because there are so many different thoughts. Before social security, becoming an older adult meant poverty because you couldn't work anymore unless you're independently wealthy or someone, or your family was supporting you. That would be an option, kids and grandkids supporting you, but if you didn't have that, you were going to be poor. End of story. Because you couldn't work. So social security created a safety net that allowed aging to be what it is right now, which is obviously there are problems and downsides, but it is an automatic poverty. Now, there are older adults, unfortunately, who are unhoused, who are in the carceral system, who are below the poverty line.

(40:19):

So we haven't, obviously haven't eliminated those discrepancies among older adults, but it's significantly lower than if social security didn't exist. So Social Security guarantees an income to a vast number of people over 65 or 67. Then you couple that with Medicare, which then we talked about earlier, provides all these health benefits and covers medical issues, hospitalization, medications, et cetera, et cetera. So these are twin pillars of how people can economically survive despite not being able to work any longer. So vote for people who support those things and support expanding those things and so on. So that'd be one way to go. I think there's a lot that we can do just in our own, I reflect on my sort of stigma all the time on older adults. So I've worked with older adults for 25 years. I love doing it, but I still catch myself having those thoughts.

(41:22):

And so just recognizing them, becoming aware of those, and then just trying to fight those ageist attitudes around aging equals badness equals inability to do stuff, inability to love or be loved, et cetera. And we can do that just like the bystander versus standing up kind of trainings that we do around DEI. We can do that. We can do that with aging. Like, hey, that was just was a comment that many older adults might find offensive. I'll give you an example. There was a New Yorker cover, just the most recent New Yorker cover had a picture of a bunch of senior political leaders in the United States, and they're in wheelchairs and walkers, and it was like both agist and ableist at the same, they managed to cover both of those in one cover. So it's remarkable how pervasive that kind of stuff is. And then, so just calling it out and saying, I don't think just in the same way, I don't accept a racist statement. I shouldn't accept an agist statement.

Dr. Laura Roberts (42:28):

It seems like we covered a lot. Is there anything we forgot? Because then I want to share with our listeners our news.

Dr. Art Walaszek (42:34):

Laura, I want to thank you and your colleagues at APA Publishing again for this opportunity. This has been just a great joy of my personal and professional career to be able to write in this way. So thank you. I want to thank my co-authors. Again, I want to name them. So I named Anna and her UW, co-authors, Lisa Boyle, Rebecca Radue, Lucy Wang, Eileen Ahearn, all just outstanding colleagues both at University of Wisconsin at University of Washington. And it's an honor to work with them and to have collaborated with them on this book.

Dr. Laura Roberts (43:11):

But now I've got the chapter five people, and now I have to pronounce them.

Dr. Art Walaszek (43:16):

Yes, let's not.

Dr. Laura Roberts (43:17):

Anna Borisovskaya.

Dr. Art Walaszek (43:17):

Anna Borisovskaya.

Dr. Laura Roberts (43:21):

Okay, good. Elizabeth Chmelik.

Dr. Art Walaszek (43:23):

Yep. William Bryson, Matthew Schreiber, one of my mentors, Marcella Pascualy. Marcella was a long time Gerosike fellowship director at the University of Washington, and a phenomenal geriatric psychiatrist, Samantha May and Courtney Roberts.

Dr. Laura Roberts (43:40):

Yeah, no, they put together a beautiful chapter. And I guess that gives me kind of an occasion to reflect when you write a book. I don't know, people who've never written a book. I don't know what you think it is, but I wonder if you agree with me. I guess I've learned that in building books, basically, you're just reaffirming and strengthening a community of colleagues and scholars who care about something, who are going to work on something at 2:00 in the morning or on Saturday morning or whatever, because they want to share the insights, the evidence, the work that they do, because there's someone out there that they care about.

(44:18):

It's something bigger than themselves. And I don't think anybody thinks that that's what doing a book is. They think, oh, I don't know. I've got writer's block when I sit down with a pen and pencil or paper and pencil or sit down at the computer. But I really have seen, and I see it in your books for sure, this intentional creation of a community of scholars sharing insights in the hope of something better for people. I don't know. It's kind of corny, but it's how I feel and I see it in your work, for sure.

Dr. Art Walaszek (44:48):

Well, I appreciate that. No, thank you. I've done both. I wrote a book and then I've edited a book, and there are significant differences in those two.

(44:58):

Certainly writing a book myself, I had a lot of folks who I would workshop with and get advice from, of course, you Laura and the editors and so on. But ultimately, it was a bit of a lonely exercise in that I was a solo author. It's really quite fun doing it with the community of folks getting together regularly talking about the book. I'm still, I'm in touch regularly with the co-authors, and I would extend that out to our readership then too. So I enjoy one of my colleagues in the geriatric medicine clinic here at UW, he's got copies of both books, and we were chatting about them yesterday. So there's that community of readers out there, people who are using the material in the book as well. So I love that idea, especially in light of what you brought up earlier around isolation and its negative effects. So this is an anti-isolation technique.

Dr. Laura Roberts (46:00):

Yeah, I mean, I think it does help with, well, I mean, when think about people think about doing a book, they think, oh my God, I'm already overworked. But actually what I see, at least for some authors and editors is it actually becomes kind of a source of resilience and joy because of that connection. And the other thing I would say, as an editor with APA publishing and elsewhere, it is hard to write a great book alone in part because we all have blind spots. So when I see books that are produced out of a community of scholars where I know they're trading the manuscript back and forth, verifying, updating

the literature saying, that doesn't ring true or that's so right. I wish I had said it that way myself. It actually brings a little bit more rigor and integrity to the book itself.

Dr. Art Walaszek (46:47):

I completely agree. Exactly. And there's also funding an editor, and you enter into dialogue with your authors then, and I respect my authors, respect their process, and I also have feedback, and then it goes back and forth, and then you create this work that is the result of this dialogue between the editor and the authors.

Dr. Laura Roberts (47:12):

Well, speaking of dialogue between editors and authors, I'm sure the listeners will appreciate just how fabulous Art is. And Art's been involved with our book writing and helping us review books and is on the editorial board. And so he was very just a natural person to turn to help with the podcast. So I wrote to Art little tentatively, would you be interested in hosting some of the podcasts, doing some of these interviews, maybe doing some of these together. But to help us build out the Psychiatry Unbound podcast series years ago, we got started. I know that my cousin Terry, who might be listening to this, she listens to all of my podcasts. I'm not even sure my mother listens to all my podcasts, but I think Ian the wonderful, wonderful colleague who helps us produce these podcasts. Tim, I think listening to them, maybe you do Art, but it felt, I wouldn't say like a lonely endeavor, but it wasn't clear that it would be embraced.

(48:10):

And what I wanted to do when we started this podcast, and Tim had the idea, but why I grabbed hold of it was because when I work with authors or people who are proposing a book, I have these initial conversations with people and they tell me why they want to do a book, why it matters, what's the voice and the intention and the need that they're trying to address. And people are so generous with their time and their expertise and kind of developing books. That was what I wanted to capture in these podcasts. And actually, I think it's gone pretty well. We've certainly had an increase in the number of people who've listened, and it was embraced really by the field right away. And I'm really looking forward to this next phase where you and I collaborate. Art will be serving as a host on Psychiatry Unbound with me and building and taking it to the next level.

(49:07):

And we had a conversation, first time we talked, you were like, oh, we could do spin-offs on this, and we could do this, and we could do that. And I was like, oh my God, I should have asked her two years ago. But anyways, so I don't know if you want to comment on why, again, you would give that priority in an already very busy life, but I want to thank you for taking this on, and we'll be on an adventure together and spend more time together on podcast. But what was your thinking? Why did you say yes right away when I wrote to you about this idea?

Dr. Art Walaszek (49:38):

Well, I mean, I'm just deeply, deeply honored, Laura, the incredible work you do in so many different domains and including this one, the podcast. I mean, I'm just humbled to have been invited to be part of this. So thank you very much for the opportunity. I love the idea of using all the different means that we have to communicate with folks. So I'm a big social media guy, maybe a little less so on Twitter slash X lately, but I'm there, LinkedIn and Instagram, all that kind of stuff. And so I like that as a means of communicating with folks. Of course, I love to write, and hence the books. I like doing radio, et cetera.

So there are all these ways that we can reach out to folks. And so the podcast seems just like a natural fit. And also just talking with my colleagues, especially junior colleagues, residents, medical students, a lot of folks taking a lot of info via podcast.

(50:45):

It's become like with whether you're driving to work or running on the treadmill or going for a bike ride or whatever, it's become quite common as that is a means of getting some additional medical or psychiatric knowledge. And so I love that idea that there's no wrong way to get information to the folks who need to get there. And I also just like to be doing more podcasts, reviewing more of the books, broadening the number of topics that we're covering. So I look forward to joining you on this journey. I think it's going to be a ton of fun.

Dr. Laura Roberts (51:24):

Great. Thanks so much and thanks everybody for listening to Psychiatry Unbound.

Speaker 3 (51:34):

Psychiatry. Unbound is hosted by Dr. Laura Roberts, and produced by Ian Martin, and our executive producer is Tim Mahoney. This podcast is made possible by the generous support of Stanford University. We are a production of American Psychiatric Association Publishing. Be sure to visit psychiatryonline.org/podcast to join the conversation, access show notes and a transcript, and discover new content, or subscribe to us on your favorite podcast platform. Thank you for listening.

Speaker 4 (52:01):

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