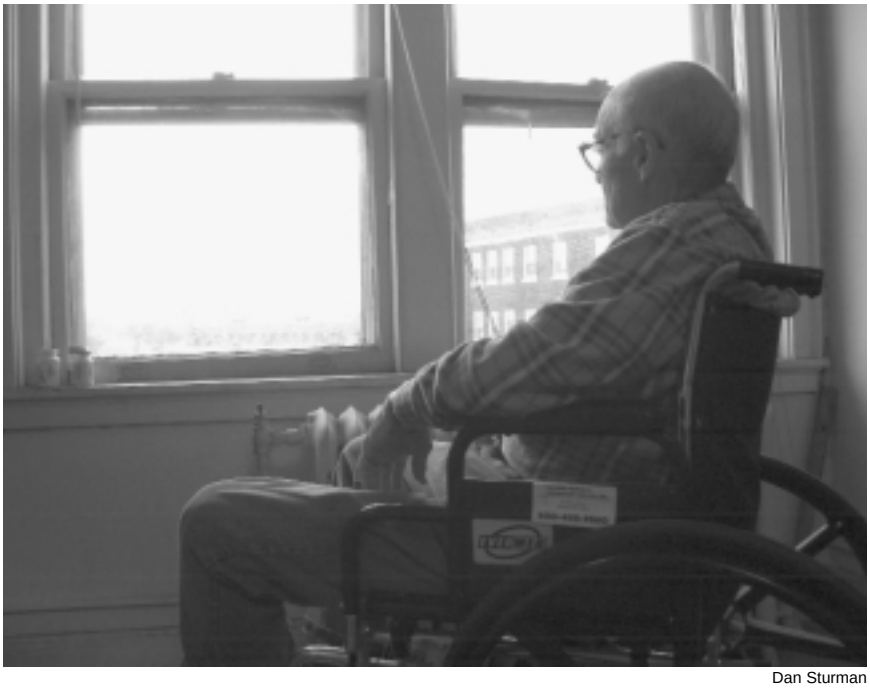


Dan Sturman

Are we psychopharming our elderly to a living "death"?

The Mass Psychotropic Drugging of the Elderly

by M. Woodward, R.N.,C.

Leo Alexander, M.D., chief witness for the prosecution at the Nuremberg Trials, in his 1949 paper, "Medical Science Under Dictatorship," describes how gargantuan crimes of the Nazi regime "started from small beginnings." "At first," he said, these "were merely a subtle shift in emphasis in the basic attitude of the physicians . . . that there is such a thing as life not worthy to be lived." Approximately 40 years later, Colorado Governor Richard Lamm, in an address on "ethics," told the Colorado Health Lawyers Association that the elderly had "a duty to die and get out of the way." He subsequently claimed that his words were taken out of context, but it is difficult to imagine what contextual intention he might have had, in uttering words as brutal as "useless eater," and directing them to our aging population.

Each of us has at least one elder whom we love, and it is essential that we take a look at how we are treating them.

In 1987, Congress passed the Omnibus Reconciliation Act (OBRA), which contained the Nursing Home Reform Amendments, upgrading the standard of care to nursing home residents. At the time, up to 74 percent of these residents throughout the United States were receiving psychotropic medications—antidepressants, antipsychotics, and anxiolytics—for periods of six months or more, although many of those people had no documented mental illness. According to one source, in the first few years after the passage of this law, the use of these medications fell by 20 to 50 percent in nursing homes.[1] However, between 1989 and 1997, overall outpatient prescriptions for antipsychotics increased dramatically (age groups were not defined in this study). "In 1989, antipsychotics were prescribed during 3.2 million office visits, compared with 6.9 million visits in 1997."[2]

More recently, though, OBRA seems to have been pushed into the Orwellian memory hole, as "[R]esearchers have found that 12.3 percent to 15.1 percent of elderly persons living in the community and up to 75 percent of long-term care residents receive psychotropic medications."[3]

Although statistics should be viewed only with a very rigorous eye (after all, it was the statistician who attempted suicide by jumping from the first floor window on 32 occasions), at times, they can reach out and grab your attention. For instance: In November 1999, the Institute of Medicine released a report estimating that as many as 98,000 patients die as the result of medical errors in hospitals each year. For instance: A study released in August 2004, noted that 41 percent of prescriptions for 765,423 people over 65 were for psychotropic medications.[4]

Polypharmacy (concurrent use of several drugs) of the elderly is somewhat like the weather: It gets talked about, but not changed. Multiple drug use in seniors increases the risk of adverse drug reactions and interactions. Taking two drugs increases the risk of an adverse drug reaction by 6 percent, but taking eight medications increases the risk to 100 percent. Yet, the aging population—which is about 15 percent of the people in the United States—consume about 30 percent of all prescribed medications, and 40 percent of all over-the-counter ones.

The Beers Criteria

In 1991, Mark H. Beers, M.D., et al., published the Beers Criteria, which lists medications and medication classes that should be avoided in people over 65 (either because they don't work for them, or because they cause bad side

effects), and medications which should be avoided in people in this age group known to have specific medical conditions. It was updated in 2003, and one particular paragraph bears close inspection:

"Recent estimates of the overall human and economic consequences of medication-related problems vastly exceed the findings of the Institute of Medicine (IOM) on deaths from medical errors, estimated to cost the nation $8 billion annually. In 2000, it is estimated that medication-related problems caused 106,000 deaths annually at a cost of $85 billion. Others have calculated the cost of medication-related problems to be $76.6 billion to ambulatory care, $20 billion to hospitals, and $4 billion to nursing home facilities. If medication-related problems were ranked as a disease by cause of death, it would be the fifth leading cause of death in the United States. The prevention and recognition of drug-related problems in elderly patients and other vulnerable populations is one of the principal health care quality and safety issues for the decade."[5]

"How is it cost-effective—even from a strictly financial point of view—to preemptively psychopharm our elders with drugs that may cause them to lose their balance, fall and break their hips, need surgery to fix or replace them, and then end up in a nursing home, where they will be further drugged?"

Philip Ulanowsky/EIRNS

Exactly what percentage of these deaths occurred in the elderly, and were related to psychotropic medications, is a study that seems never to have been done in a forthright, all-cards-on-the-table manner. The psychotropic drugging of the geriatric citizenry—virtually en masse—should be considered an obscene scandal among all health-care professionals. Instead, the so-called rationale behind it is an axiom in dire need of perforation: that the increase in number of birthdays is indeed synonymous with depression and/or psychosis.

Is it possible that in the current generation of people over 65, most of them have dopamine and serotonin receptors that aren't working properly, and therefore they are depressed, anxious, and/or psychotic? Is it possible that non-psychiatrist physicians (for example, the family doctor) are equipped to properly recognize and diagnose these conditions?

Parikh Doongaji, M.D., writes in the *Journal of Postgraduate Medicine,* "Psychiatry is defined as a branch of medicine which deals with the causes, clinical manifestations, and treatment of diseases of the mind. However, in many instances the specific cause of a psychiatric illness remains unknown. The symptoms are often not specific, and the treatment can best be described as 'hopeful.' "[6]

Doongaji explains the three types of drugs: those in which their actions are known, and have an assessment which is direct and accurate; those in which their actions "may be fairly well known," with assessments secondary and empirical; those in which their actions are "poorly known," with assessments that are "indirect and imprecise." Most psychotropes belong to the last category, he says, and none belongs to the first.

More significantly, Doongaji describes the difficulty in acquiring a consensus in diagnosing psychiatric disorders:

"There is little agreement between clinicians in evaluating the symptoms

and signs of a psychiatric disease, or in establishing its prevalence. For example, it has been reported that 50-90 percent of clinicians agree to a diagnosis of an organic brain syndrome in a given instance, while only 8-40 percent will agree to a diagnosis of a personality disorder. It has also been demonstrated that psychiatrists in the United States diagnose schizophrenia much more frequently than psychiatrists in U.K., while the reverse is true for diagnosing depression. The diagnosis of schizophrenia has been reported to vary not only from country to country but also from state to state, from hospital to hospital, and from unit to unit. 'Anxiety' is an ubiquitous term. Anxiety may exist as a trait or as a state. Anxiety can also be a manifestation of an organic disease or of some other psychiatric illness. The response to anxiolytic agents may be different in treating trait versus state anxiety. . . ."

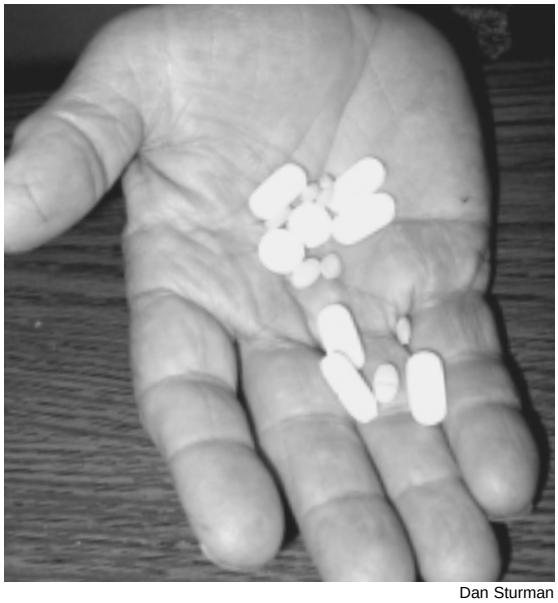
Psychotropes Increased

This paper was written in 1983, yet, looking at the increase of usage of psychotropes, it seems to have been largely ignored. How can so many people be prescribed so many medications, while the diagnoses remain unsure? Before attempting to answer this question, let us look at some ugly facts.

A study released in 1998, showed a 73.4 percent increase in the number of prescriptions for antidepressants over a five-year period, during which time diagnoses of depression increased only by 16.4 percent.[7] This same study showed a decline in the use of tricyclic antidepressants (TCAs) from 42 percent to 25 percent, and an increase in the use of selective serotonin re-uptake inhibitors (SSRIs) from 37 percent to 65 percent. It should also be noted that SSRIs are generally more expensive than TCAs.

It is not unlikely that this shift involved the geriatric population, as TCAs have been well-documented to cause a lengthening of the QT interval (on the electrocardiogram), which can lead to cardiac dysrhythmias, causing many physicians to stop prescribing them for older people, since a replacement psychotrope came on the market.

Similarly, uses of "typical" antipsychotics (for example, haloperidal) are being replaced with "atypical" antipsychotics (for example, risperidone), in an attempt to reduce horrific central nervous system side effects such as extrapyramidal syndrome (tremors, chorea, athetosis, dystonia, parkinsonism), which can be permanent, and neuroleptic malignant syndrome (NMS), which can be fatal. NMS is a combination of catatonic rigidity, stupor, unstable blood pressure, hyperthermia, breathing difficulty, incontinence, and profuse sweating, which can occur as a toxic reaction to neuroleptic drugs (those which work on the central nervous system). It has a mortality rate of up to 20 percent.



Dan Sturman

A 1995 report in the *American Journal of Medicine* noted that elderly patients who take antipsychotics not only have an increased risk of developing symptoms of Parkinson's disease—requiring pharmacological treatment—but also have an increased risk of being treated with medications not appropriate for patients with drug-induced parkinsonism (parkinsonism is caused by antipsychotics, and is given this name because it mimics the actual disease). They estimate that "37 percent of all prescriptions for the treatment of Parkinson's disease are due to neuroleptic drug use," that in 71 percent of these patients, "neuroleptic treatment was not discontinued in spite of the occurrence of parkinsonian symptoms," and that physicians "often fail to recognize that these symptoms are drug-related. . . ."[8]

SSRIs also have significant side effects, although one study claims that these adverse drug reactions go underreported.[9] One staggering account reports that within four days of SSRI exposure, rat brain cells underwent the same type of morphological changes induced by the "recreational" drug, Ecstasy.[10] Other studies show links between SSRIs and gastrointestinal bleeding,[11] SSRIs and TCAs and breast cancer,[12] and SSRIs and worsening gait disturbance in people with Parkinson's disease.[13]

"Inappropriate medication use in elderly patients remains a serious problem"

—conclusion of the 1996 Medical Expenditure Panel Survey.

Psychopharming

On New Year's Day I paid a fee to enter the archives of the *Journal of the American Medical Association* (*JAMA*), in search of substantive research on the "psychopharming" of seniors. From this prestigious publication, I expected to find many articles on this significant issue, on how this situation came to exist, and on recommendations to fix it.

I found none of the above.

The closest was a toe-almost-in-the-water report entitled "Potentially Inappropriate Medication Use in the Community-Dwelling Elderly: Findings from the 1996 Medical Expenditure Panel Survey," which concluded, "Overall, inappropriate medication use in elderly patients remains a serious problem. . . ."[14]

Readily available, though, was a fetid Orwellian bouquet of reports (some up to 18 pages long) with titles such as: "A 75-Year-Old Man with Depression"; "Is This Patient Clinically Depressed?"; "The Challenge of Depression in Late Life"; "Recognizing and Treating Depression in the Elderly"; and "Depressive Symptoms and Physical Decline in Community-Dwelling Older Persons." [15-19] The 75-year-old, counter to the Beers Criteria, was already taking

eight medications when an antidepressant was added to his daily diet (one of those was a barbiturate, although his case study showed no indication for it). The financial disclosure of the physician-author listed compensation from Eli Lilly & Co., Pfizer Inc., and GlaxoSmithKline.

The stated objective of the study on figuring out who is clinically depressed was "to review the accuracy and precision of depression questionnaires whose administration times lasted one to five minutes and the clinical examination for diagnosing clinical depression."

"The Challenge of Depression in Late Life" cites the World Health Organization's claim that "major depression was the fourth leading cause of disability in 1990" (soon to reach the number two spot after heart disease), and worries that sub-syndromal depression (depression which falls a tad short of clinical diagnosis) is not being treated.

The Friedrich article, "Recognizing and Treating Depression in the Elderly," is stunning in that it cites a pharmacist as the authority who worries that elderly patients may have diseases such as dementia and Parkinson's which might mask symptoms of depression (suggesting that we psychopharm them, just in case), and who states that "elderly individuals are just as entitled to be relieved of their depression as younger people."

"Depressive Symptoms and Physical Decline in Community-Dwelling Older Persons," by Penninx et al., "studied" 1,286 people, 71 years and older, using a "short battery of physical performance tests" in 1988, and four years later. The testing included timing how long it took for the participants to get into and out of a chair five times, and timed an eight-foot walk (approximately the distance from the entrance of my kitchen to the sink). The results showed that those people who had depressive symptoms, declined in their ability to perform these physical activities (if this is the extent of their exercise, no wonder they're bummed out). The authors lament that such sub-syndromal depression remains largely unnoticed, and that further studies are needed to show that antidepressant use would help these folk:

"[D]epressed mood is very common in the older general population, affecting more than 10 percent in our cohort. Unfortunately, depressed mood in older persons is often unrecognized, and the treatment approach when diagnosed is unclear. Although more appropriate care for depressed mood, consisting of increased counseling and use of appropriate antidepressant medications, has been shown to be cost-effective in terms of commensurate improvements in older persons' health and well-being per dollar spent, few formal clinical trials have been conducted. Our data suggest that such trials may be useful to see whether treatment of depressed mood may prevent the process whereby depressive symptoms and physical dysfunctions interact to cause a progressive downward spiral in the health status of older persons."

Human Cognition and Cost-Effectiveness

How is it cost-effective—even from a strictly financial point of view—to preemptively psychopharm our elders with drugs that may cause them to lose their balance, fall and break their hips, need surgery to fix or replace them, and then end up in a nursing home, where they will be further drugged? How cost-effective is it to stomp upon the dignity of an entire segment of the human race?

In the studies cited so far, human cognition is not recognized; the researchers do not recognize it in themselves, and they certainly do not recognize it in the people they are studying. When people have a reason to get out of bed, they get out of bed. Or, as my friend Ms. Ethel (at 88, she maintains the record as the oldest student at the University of the Virgin Islands) inversely puts it: "The less I do, the less I do."

The sublime superman Christopher Reeve needed help getting out of bed, but he emerged, nonetheless. Legendary

Falling Through the Cracks

Arriving for a 12-hour night shift, beginning at 7 p.m., I was greeted by a small group of exhausted nurses, eager to give me report on nine patients, and go home. One of the patients, a hemiplegic (paralyzed on one side, from a stroke), had been admitted from a nursing home five days earlier, to rule out a new cerebral vascular accident.

"He's NPO (nothing by mouth), his IV fluids were stopped, and he's going back to the nursing home tomorrow. He's a nasty thing; we had to tie up his good hand, because he kept pinching us. Then he started biting us, so we're giving him Haldol 'round the clock."

When asked why he was NPO, the answer was direct: "I don't know. I've only had him for four hours."

As it turned out, I was the first nurse to have him for more than a four-hour stretch. This paralyzed, non-verbal man with no family to advocate for him, had the bad fortune to be on the same floor with a VIP "walkie talkie" (fully ambulatory and fluent of speech), who demanded—and received—"continuity of care." For the VIP, entire schedules were changed, so that she would have only two nurses caring for her during her entire stay.

It wasn't until midnight that I was able to complete my Nurse Nancy Drew investigation, that this patient was supposed to be NPO for a swallowing test, which was never given. Not wanting to believe that a human being had been starved for five days—and given anti-psychotics when he tried to communicate his hunger—I entered his room and asked if he had eaten since his admission. His roommate answered, "Nah, they don't feed him."

Orders were procured for IV fluids—the dehydration and malnourishment had turned the man's urine brown—immediate food, and a discontinuation of the haloperidal, and the mute patient who had fallen through the cracks, was pulled back into the health-care system.

—M. Woodward, R.N.,C.

fitness guru Jack LaLanne, who claims that good health starts in the brain, and thinks that George Burns's longevity was the result of his having been a "social lion," recently turned 90. Spanish artist Francisco Goya did a beautiful drawing of himself as an old, bent-over man, leaning on a cane. He captioned it, "I am still learning." My plumber is 86.

One very exciting study from Australia—almost an aside to all of the other research cited—performed in a social environment, was refreshingly cognitive.[20] Led by Maria Fiatarone Singh, M.D., Professor of Exercise and Sports Science at the University of Sydney, a group of seniors (between 65 and 75 years of age) who had been actually diagnosed as being clinically depressed, were treated with progressive resistance training (PRT) and shown to have "between 50 percent to 70 percent improvement in depression, which is pretty much exactly equivalent to a good antidepressant drug effect." An obvious benefit was an increase in balance and stability with these people, in contrast to an increase in falls related to dizziness, a side effect of antidepressants.[21]

Is the increasing, and indiscriminate, psychopharming of our aging citizenry a subtle shift in the terrible direction Dr. Leo Alexander analyzed?

The psychopharming of our elders, our youth, and our really young ones has become a shameless national trend, and its need represents a horrific axiom. Could there ever be a legitimate reason to diagnose a five-year-old as suffering from Attention-Deficit/Hyperactivity Disorder (maybe he needs to go outside to ride his tricycle, instead), and give him an antihypertensive to "calm" him down?[22] The most excellent research study would be to show the correlation between the paradigm shift of the United States from the greatest producer nation, to the greatest consumer nation, with the psychopharming of every age group in our society.

A Youthful View of the Problem

To every thing there is a season. As this season is springtime, this article on the psychopharming of our seniors will end with some thoughts from a member of the previously "no future" generation. Dan Sturman, prominent LaRouche Youth Movement activist, and former Emergency Medical Technician and Certified Nursing Assistant (CNA), commented to me on the problem as follows:

"During my tenure as a CNA, I found it quite disturbing how my grandparents' generation has been catalogued somewhere in a deep dark corner, seemingly like Beethoven's "Clarinet and Bassoon Duets" that have been stored away in a cabinet somewhere in the Main Branch of the Philadelphia Free Library, to slowly age and fall apart. This human Dewey Decimal System isn't voluntary. Our most valuable treasures, the people and ideas that made this nation . . . how many are incompetently diagnosed as 'incompetent'?

"For decades, the eldest in our nation have been catalogued via the boring Dewey Decimal System, in nursing homes across the country. They have been forgotten due to our digressing modern Roman bread-and-circuses orientation, and I'm sure, the over-prescription of antidepressants, antipsychotics, and so on to the younger population in the recent decades, can only add to the number of forgotten men and women of our not-so-distant past, by their living relatives.

"But the worst of it is the anguish put upon those who built this nation; those who made this country into the industrial powerhouse that it was this past century, and who are now sent away so we can go flight-forward into a post-industrial massacre.

"This issue *must be* investigated and solved. The living standard of the elderly is quickly diminishing; moral standards are dropping quickly in the health-care fields and the elderly are paying dearly for it. The health-care industry must not be looked upon as a business, but as the basis of the U.S. Constitution, for the general welfare of the population."

Notes

1. R. Shorr et al., "Changes in Antipsychotic Drug Use in Nursing Homes During Implementation of the OBRA-87 Regulations," *JAMA,* Feb. 2, 1994.
2. R. Hermann, et al., "Prescription of Antipsychotic Drugs by Office-Based Physicians in the United States," *American Psychiatric Association,* April 2002.
3. D. Fick et al., "Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults," *Archives of Internal Medicine,* Vol. 163, pp. 2716-2724 (2003).
4. L. Curtis et al., "Inappropriate Prescribing for Elderly Americans in a Large Outpatient population," *Archives of Internal Medicine,* Vol. 164, pp. 1621-1625 (2004).
5. D. Fick et al., *op. cit.*
6. Parikh Doongaji, M.D., "Some Problems in the Conduct of Psychotropic Drug Trials (a Review)," *J. of Postgrad. Med.,* Vol. 29, pp. 67-74 (1983).
7. D.A. Sclar et al., "Trends in the Prescribing of Antidepressant Pharmacotherapy: Office-Based Visits, 1990-1995," *Clinical Therapy,* Vol. 20(4), pp. 871-84 (July-Aug. 1998).
8. J. Avorn, et al., "Neuroleptic Drug Exposure and Treatment of Parkinsonism in the Elderly," *American Journal of Medicine,* July 1995.
9. F. Song et al., "Selective Serotonin Reuptake Inhibitors: Meta-Analysis of Efficacy and Acceptability," *British Medical Journal,* Vol. 306(6879), pp. 683-7 (March 13, 1993).
10. M. Kalia et al., "Comparative Study of Fluoxetine, Sibutramine, Sertraline, and Dexfenfluramine on the Morphology of Serotonergic Nerve Terminals Using Seratonin," *Brain Research,* Vol. 858(1), pp. 92-105 (March 6, 2000).
11. F.J. De Abajo et al., "Association Between Selective Serotonin Reuptake Inhibitors & Upper Gastrointestinal Bleeding," *BMJ,* Oct. 23, 1999.
12. M. Cotterchio et al., "Antidepressant Medication Use and Breast Cancer Risk," *American Journal of Epidemiology,* Vol. 151, pp. 951-57 (2000).
13. I.H. Richard et al., "A Survey of Antidepressant Drug Use in Parkinson's Disease. Parkinson Study Group," *Neurology,* Vol. 49(4), pp. 1168-70 (Oct. 1997).
14. C. Zhan et al., "Potentially Inappropriate Medication Use in the Community-Dwelling Elderly: Findings from the 1996 Medical Expenditure Panel Survey," *JAMA,* Vol. 286, pp. 2823-2829 (2001).
15. Kurt Kroenke, M.D., Discussant, "A 75-Year-Old Man in Depression," *JAMA,* Vol. 287, pp. 1568-1576 (2002).
16. J. Williams et al., "Is This Patient Clinically Depressed?" *JAMA,* Vol. 287, pp. 1160-1170 (2002).
17. J. Gallo and Coyne, "The Challenge of Depression in Late Life," *JAMA,* Vol. 284, pp. 1570-1572, (2000).
18. M.J. Friedrich, "Recognizing and Treating Depression in the Elderly," *JAMA,* Vol. 282, p. 1215 (1999).
19. B. Penninx et al., "Depressive Symptoms and Physical Decline in Community-Dwelling Older Persons," *JAMA,* Vol. 279, pp. 1720-1726 (1998).
20. http://www.abc.net.au/rn/talks/830/healthrpt/stories/ s126125.htm
21. As more and more hospitals are being shut down across the U.S., to "save money," it is difficult to visualize such a study being done in this area of the world. My personal knowledge of any type of physical therapy—in hospitals and in rehab clinics—has shown it to be mechanistic and assembly-line rote, being a disappointment to both patient and therapist.
22. M. Romano and A. Dinh, "A 1,000-Fold Overdose of Clonidine Caused by a Compounding Error in a 5 Year Old Child with Attention-Deficit/Hyperactivity Disorder," *Pediatrics,* Aug. 2001, Vol. 108(2), pp. 471-472.