PARKINSON'S DISEASE

SPOTLIGHT ON PARKINSON'S DISEASE: HEALTHY MINDS, ADDRESSING YOUR MENTAL HEALTH

TUESDAY, DECEMBER 18, 2018

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Support for this program provided by: ACADIA® Pharmaceuticals

1

WELCOME AND INTRODUCTIONS

Stephanie Paul
Senior Vice President Development and Marketing
American Parkinson Disease Association

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SPEAKERS

Alice Cronin-Golomb, PhD

Marie Saint-Hilaire, MD, FRCPC

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PRESENTATION

Alice Cronin-Golomb, PhD
Professor of Psychological and Brain Sciences
Director, Vision and Cognition Laboratory
Boston University

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FINANCIAL DISCLOSURES

Salary & Grant Support: Boston University

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Honoraria: N/A

Speaker's Bureau: N/A

Equity & Consulting Agreements: N/A

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TODAY'S OBJECTIVES

- Describe some non-motor symptoms in PD affecting mental health
- Discuss non-pharmacological strategies to manage symptoms
- Discuss pharmacological strategies available to treat symptoms

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Why talk about mental health in Parkinson's disease (PD)?

Why do mental health problems in PD exist?

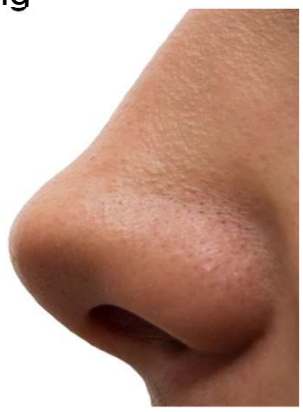
Spotlight on:

- Seeing and Hallucinations
- Thinking
- Feeling
- Sleeping

Where to go from here?

7

- **Sensory**
  - Blunted sense of smell
  - Problems with vision (including hallucinations)
- **Mood**
  - Depression, anxiety, apathy



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- **Cognition**
  - Slow processing speed
  - Difficulties with organization, planning (executive)
  - Working memory (keeping things "in mind")
  - Spatial problems (e.g., getting lost)
- **Sleep & fatigue**
  - Insomnia, acting out dreams
  - Daytime sleepiness

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WHY TALK ABOUT NON-MOTOR SYMPTOMS?

Everyone thinks of PD as a motor disorder:

- Tremor, slow movement, rigidity, postural instability, freezing

Non-motor symptoms (NMS) are important too:

- They often begin long before motor symptoms
- They can interact with motor symptoms to make them worse
- They usually do not respond to usual PD medications
- They can result in poor quality of life

10

WHY NMS EXIST

Staging of PD disease process: brainstem (mood, autonomic, sleep), cortex (hallucinations, cognition)

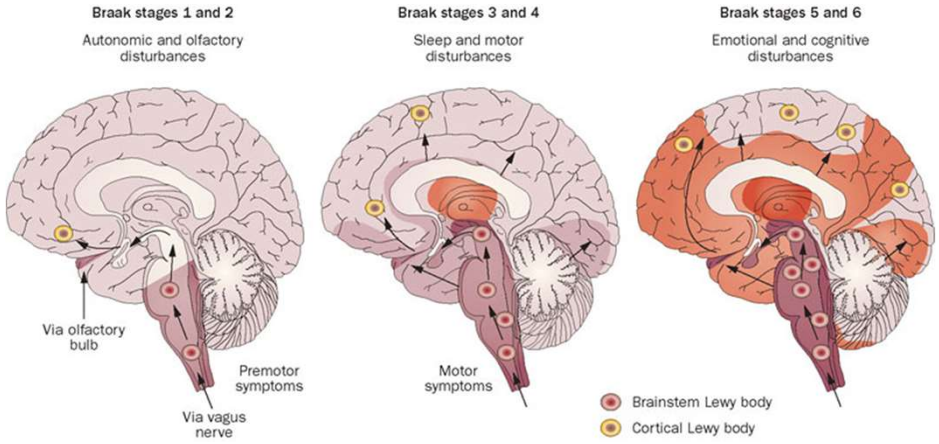

Image from: Halliday et al., Movement Disorders, 26, 2011, based on work by Braak et al.

11

SEEING: VISUAL PROBLEMS

- **Contrast sensitivity**
- **Color discrimination**
- **Depth perception**
- **Visual scanning**

People with PD with poorer contrast sensitivity (right) are more likely to have visual hallucinations

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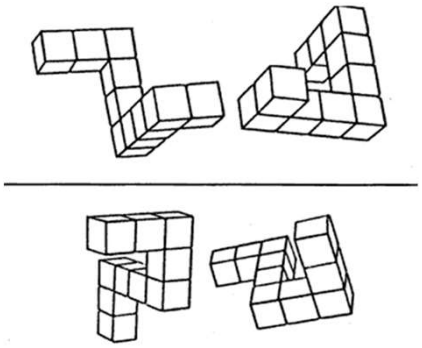
SEEING: SPATIAL PROBLEMS

- Perception of space
- Spatial orientation
- Spatial cognition (e.g., mental rotation)



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Problems with visual and spatial function make navigating the world more difficult.

These and other cognitive, motor, and sensory problems can affect driving and walking.

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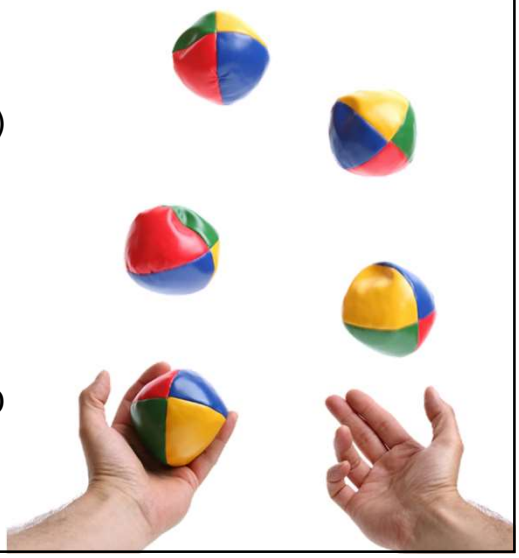
THINKING: MULTI-TASKING

- Multi-tasking is difficult! But life demands it often
- e.g., (Walking + thinking) is harder than just walking or just thinking
- This interaction between motor and cognitive function is especially difficult for those with PD



15

ATTENTION AND MULTI-TASKING

Traditional approach:
"Avoid multi-tasking. Focus just on walking."

Attention training:
Enhance attention…so you CAN walk and do something else at the same time.

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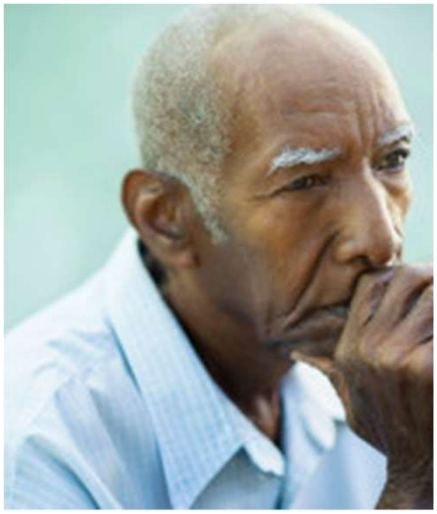
FEELING: PROBLEMS WITH MOOD AND MOTIVATION

- Depression
- Anxiety
- Apathy



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Medications work well to help mood problems in many people with PD.

"I already take so many medications. Are there ways to help my mood without taking more?"

Yes!

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(1) GET ACTIVE!





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Exercise can improve a range of NMS:

mood, cognition, sleep

…as well as balance, gait, and rigidity!

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20

EXERCISE/ MOVEMENT PROGRAMS TO TRY

Find a listing of programs at the APDA website, for your state and region (https://www.apdaparkinson.org/community/)

For example, the Massachusetts chapter lists classes in dance, boxing, yoga, exercise, Tai Chi, and art & music.

Something for everybody!

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(2) COGNITIVE-BEHAVIORAL THERAPY (CBT)

- Working one-on-one with a psychologist or social worker
- Using real-life strategies to boost mood, find fulfillment
- Thinking flexibly
- Regulating emotions
- Approaching difficult situations
- Communicating and using effective interpersonal approaches

22

SLEEPING: INSOMNIA, FATIGUE

- Waking up often in the middle of the night
- Daytime sleepiness
- Acting out dreams
- Sleep is fragmented in PD
- Affects cognition and mood

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SLEEP BETTER!

- Try to minimize naps during the day
- Minimize caffeine, especially in the afternoon; drink less water before bed
- Don't go to bed until you're sleepy
- Get out of bed if you can't fall asleep within ~15 minutes! Do something boring (and non-electronic) until you feel sleepy
- Exercise during the day!
- Keep a consistent sleep and eating schedule from day to day
- CBT also works well for insomnia in many people

24

TAKE-HOME:

Your mental health is important. Find what works for you to enjoy good mental health and quality of life.

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25

PRESENTATION

Marie Saint-Hilaire, MD, FRCPC
Professor of Neurology
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Boston University Medical Campus

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26

FINANCIAL DISCLOSURES

Salary & Grant Support: Boston University, APDA, MJFF, NIH

Research Support: Biogen, P2B

Honoraria: Acorda

Speaker's Bureau: N/A

Equity & Consulting Agreements: N/A

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27

ANXIETY

- Anxiety is common in Parkinson's and may occur in up to 40% of individuals
- Characterized by nervousness, fear, intense worry, or a panic attack
- May precede the motor symptoms in PD by years
- May increase as medications wear off at the end of a dose or during off periods

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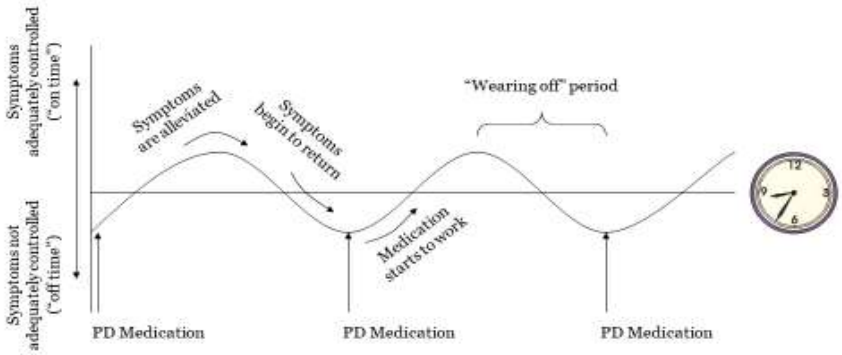
28

Motor Fluctuations



Typical Clinical Pattern of Wearing Off

Adapted from Hauser RA. Geriatrics. 2006;61:14-20.

29

ANXIETY PHARMACOLOGICAL MANAGEMENT

- Optimize Parkinson medications
- Antianxiety medications
  - lorazepam (Ativan®)
  - clonazepam (Klonopin®)
- Antidepressant medications
  - Selective Serotonin Reuptake Inhibitors (SSRI's)
    - sertraline (Zoloft®)
    - paroxetine (Paxil®)

30

ANXIETY NON-PHARMACOLOGICAL MANAGEMENT

- Important to note when it occurs, how long does it last, and what is experienced when reporting anxiety to the healthcare provider.
- Practice good sleep hygiene
- Exercise regularly
- Limit caffeine and alcohol
- Consider techniques that enhance relaxation such as meditation, yoga, tai chi
- Consider referral to psychologist, licensed social worker

31

DEPRESSION

- Characterized by feelings of sadness, worthlessness, and loss of interest in activities for a period usually greater than a week.
- Affects up to 50% of individuals
- May also include weight loss, sleep disturbance , and changes in facial expression also seen in PD
- Often accompanied by anxiety
- Under recognized by healthcare providers

32

DEPRESSION PHARMACOLOGICAL MANAGEMENT

- Antidepressant medications
  - SSRI's
    - citalopram (Celexa®)
    - sertraline (Zoloft®)
    - paroxetine (Paxil®)
    - Other medications
    - buproprion (Wellbutrin®)
    - venlafaxine (Effexor®)

33

DEPRESSION NON-PHARMACOLOGICAL MANAGEMENT

- Patients and families should be informed on how to recognize signs of depression including mood changes, feelings of guilt, loss of interest in activities, sleep changes, decrease feelings of self worth, decrease libido, and suicidal ideations (rare)
- Referral to mental health professional (psychiatrist, psychologist, counselor)
- Strength Perspectives Therapy, Cognitive Behavioral Therapy (CBT)

34

APATHY

- Presents as a flat mood, indifference, and lack of drive or motivation
- Can be distressing to family and friends
- Individuals who experience apathy are less likely to participate in activities important for health and wellbeing
- Neuropsychological testing and evaluation by a mental health provider can differentiate from depression

35

MANAGEMENT OF APATHY

- At this time there are no pharmacological treatments approved for apathy
- May consider trial of antidepressant or donepezil
- Provide support to family

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HALLUCINATIONS/DELUSIONS

- Sensations that are perceived but are not real
- Occur when a person is awake
- Can affect up to 60% of patients
- Caused by PD medications, anticholinergics (for bladder issues), sleep medications, antidepressants, muscle relaxants etc.
- Visual, auditory or tactile
- Delusions: fixed belief, paranoid in nature
- Risk Factors: polypharmacy, age, advanced disease, cognitive changes, cerebrovascular disease

37

TREATMENT OF HALLUCINATIONS

- If acute, R/O toxic/metabolic causes, especially urinary tract infection.
- Reduce or eliminate drugs of lesser priority: anticholinergics, amantadine, hypnotics, sedatives, muscle relaxants, urinary antispasmodics.
- Reduce DA,COMT inhibitor, levodopa
- Try atypical antipsychotic agents: pimavanserin (Nuplazid®), quetiapine (Seroquel®), clozapine,(Clozaril®).
- Rivastigmine (Exelon®), donepezil (Aricept®), Memantine (Namenda®) may help.

38

BUILDING A CARE TEAM

39

SOME UNMET NEEDS

We need to:

- Increase awareness of patient/family and healthcare team to better recognize and report non-motor symptoms
- Increase training of mental health providers in managing mental health issues in PD
- Increase number of experienced providers to improve patient/caregiver access to a mental health provider

40

UNMET NEEDS CONTINUED

- Support the expansion of programs that provide counseling and improve quality of life
  - Cognitive Behavioral Therapy
  - Strengths Perspectives Therapy
  - Psycho-social support groups APDA's PRESS™ Program (8-week facilitated support group)
  - Support for Care Partners

41

Thank You!

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42

QUESTION & ANSWER

Alice Cronin-Golomb, PhD

Marie Saint-Hilaire, MD, FRCPC

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43

CLOSING REMARKS

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44

FOR ADDITIONAL INFORMATION, ANSWERS TO YOUR QUESTIONS, OR FOR ADDITIONAL RESOURCES

Please visit our website
apdaparkinson.org

Or call us
1-800-223-2732

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45