Transforming the Role of Mental Health While

Living Dynamically With Parkinson's Disease

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- With slide research from the work of Dr. Laura Marsh from the Parkinson's Foundation Website:
- https://www.parkinson.org/library/videos/mental-health

We acknowledge that we are in the aboriginal territories of the Salish, Kootenai, and Kalispel people.

We honor the path they have always shown us in caring for this place for generations to come.


SAVE OUR
SISTERS

Jennifer Finley, Salish Poet

- The day we left the Bitteroot Valley for the Flathead Reservation,
- I said to my kids, "look at your arms connected to your body.
- Look at your feet connected to the ground you walk on.
- You are connected to everything.
- You are made of the land, and the trees, fish, deer, and clouds are made of your ancestors.
- You are always connected to someone who loves you."

Mental Health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development..

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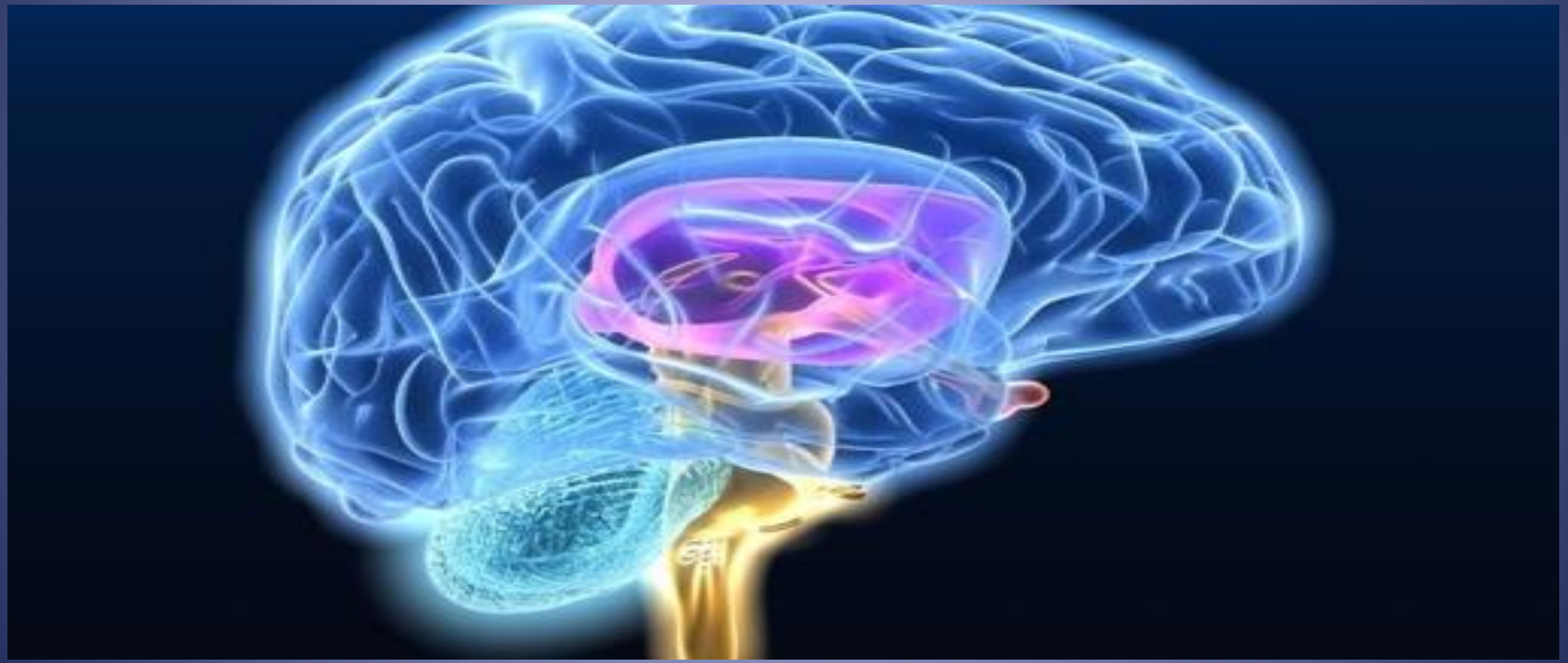
World Health Organization 2022

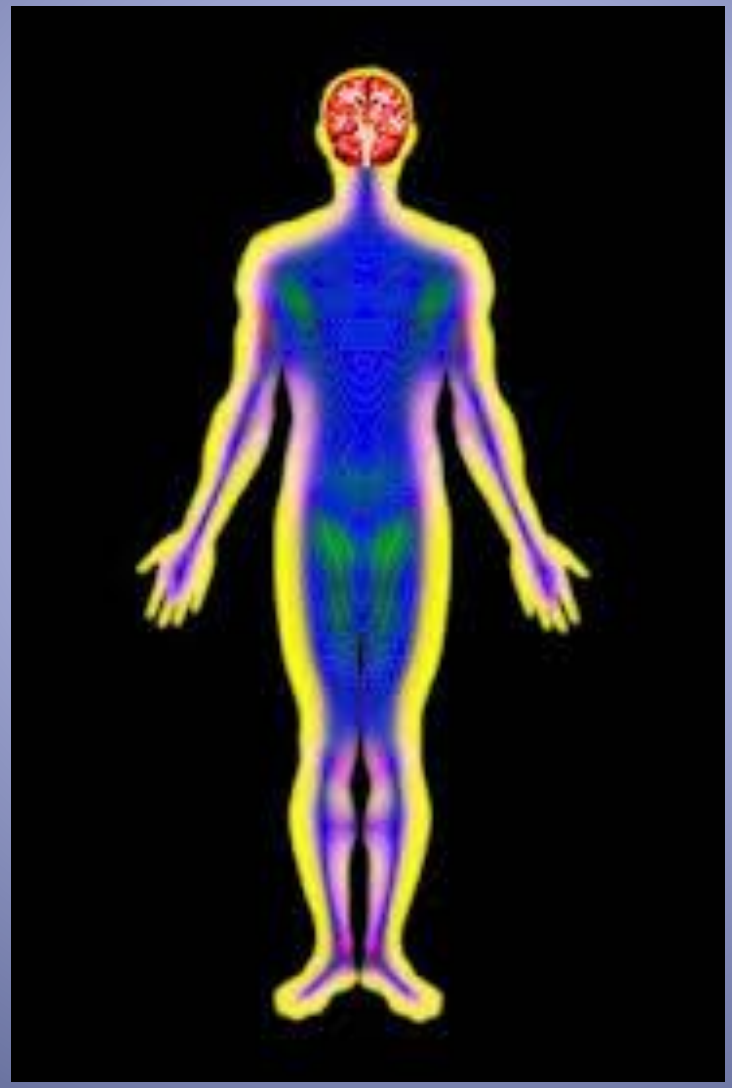
Indigenous Conception of Mental Health

- Indigenous conceptions of mental health do not assume a division between mind and body that often frames western beliefs about mental health but, rather, focus on developing an understanding of the body and mind as a whole. Mental health includes self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness.

Brain



Body



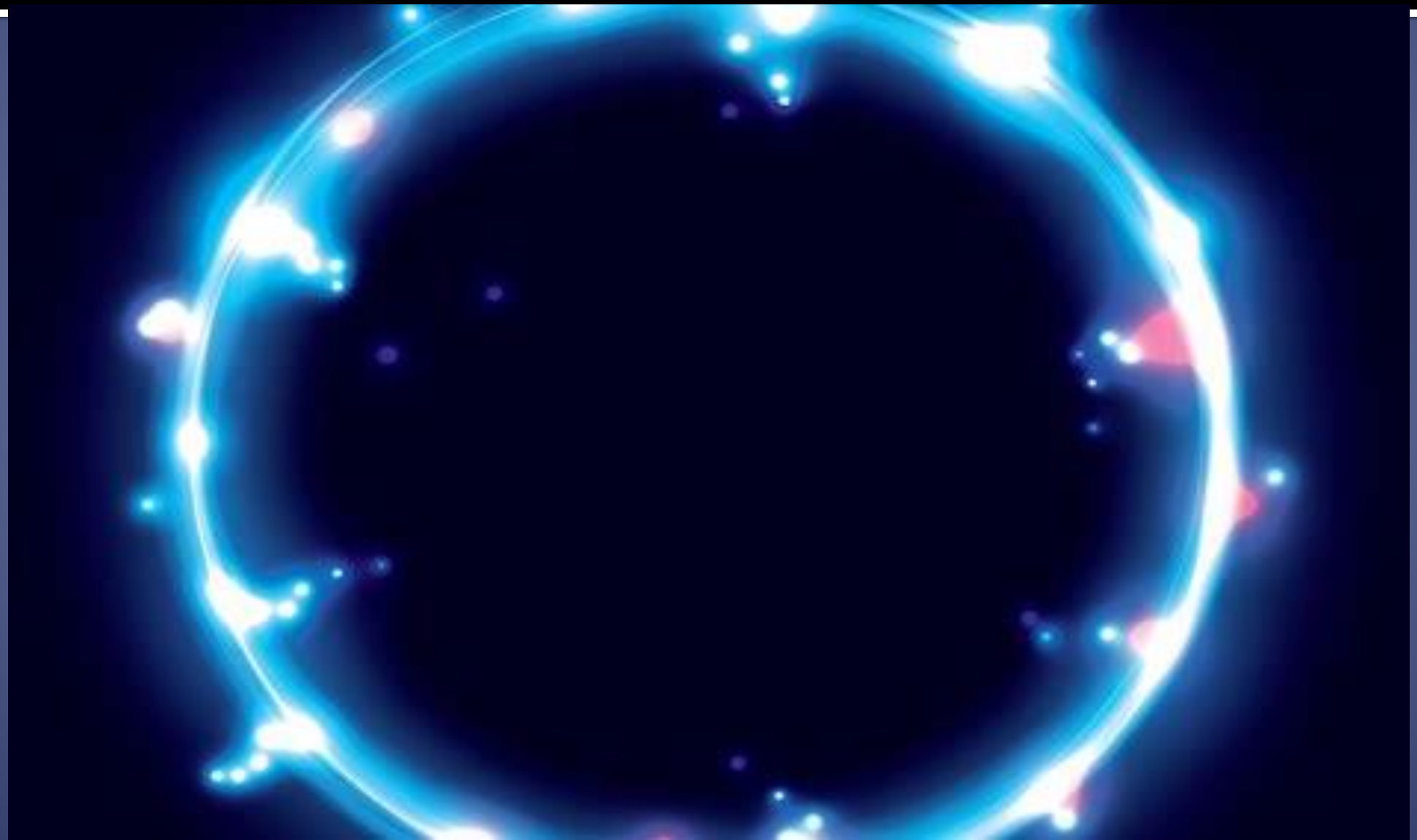
Nervous System

Jan Panskeep: Affective Neuroscience

Threat System

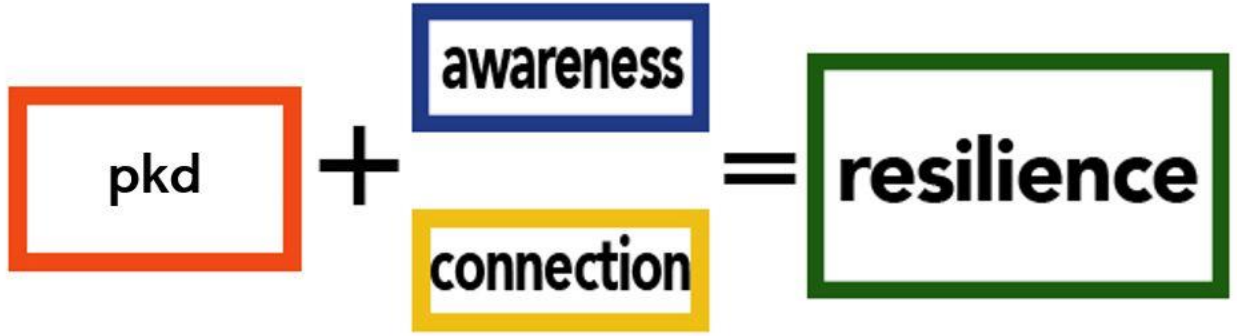
Drive System

Nurturance System

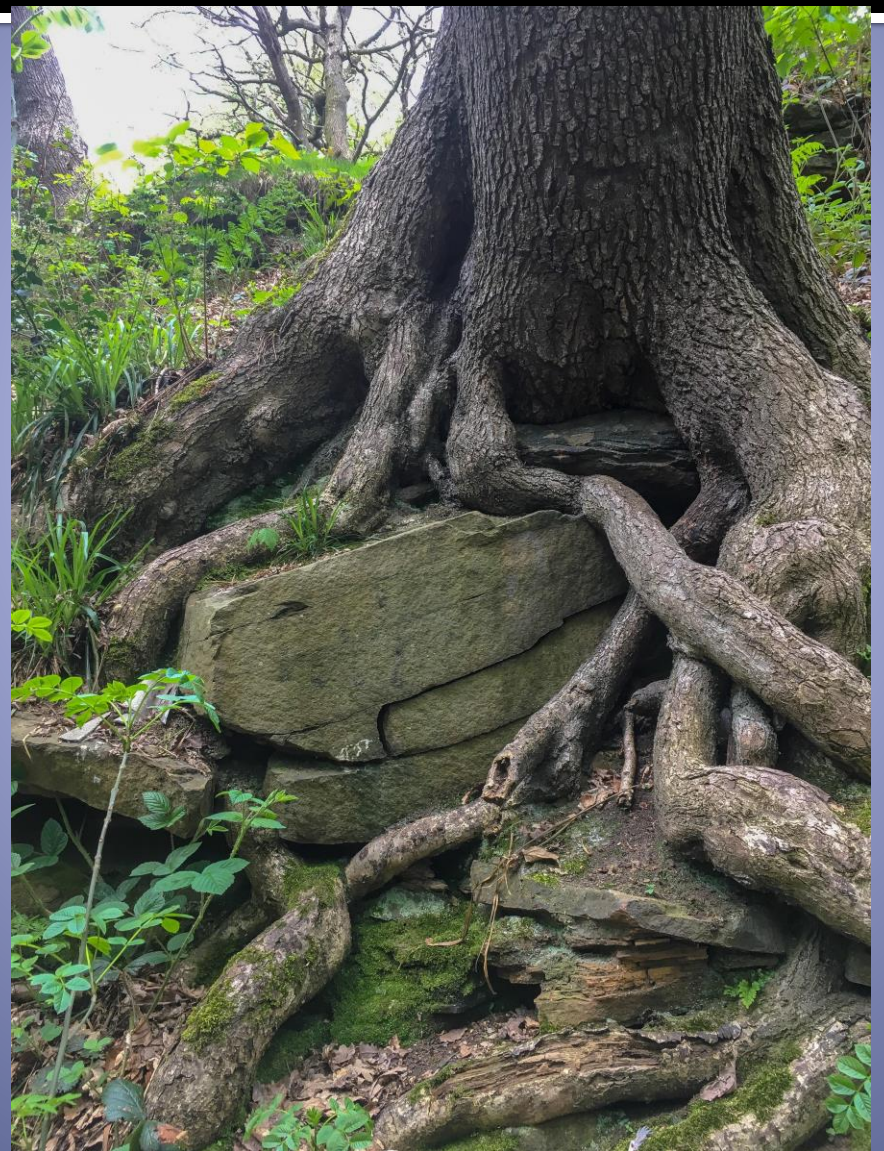


ELEMENTS OF BLUE

Degenerative Illness & Resilience



Post-Traumatic Growth



A sink hole that turns into an artesian well

U. S. GEOLOGICAL SURVEY

A. ARTESIAN WELL AT LYNCH, NEBR.

Flows more than 3,000 gallons per minute.

Pre-PD Anxiety Disturbances
Risk factor or Early Symptom of PD?

Expert Briefings
Parkinson's Foundation

Gonera et al.,1997
- Anxiety symptoms often coincide with onset of PD

Shiba et al., 2000
- Anxiety disorders, present up to 20 years before onset of motor signs, associated with development of PD

Weisskopf et al., 2002
- 12-year follow-up of 35,000 men
- High anxiety and anxiolytic use associated with increased relative risk of developing PD (1.5-1.6)

Levodopa-related Fluctuations

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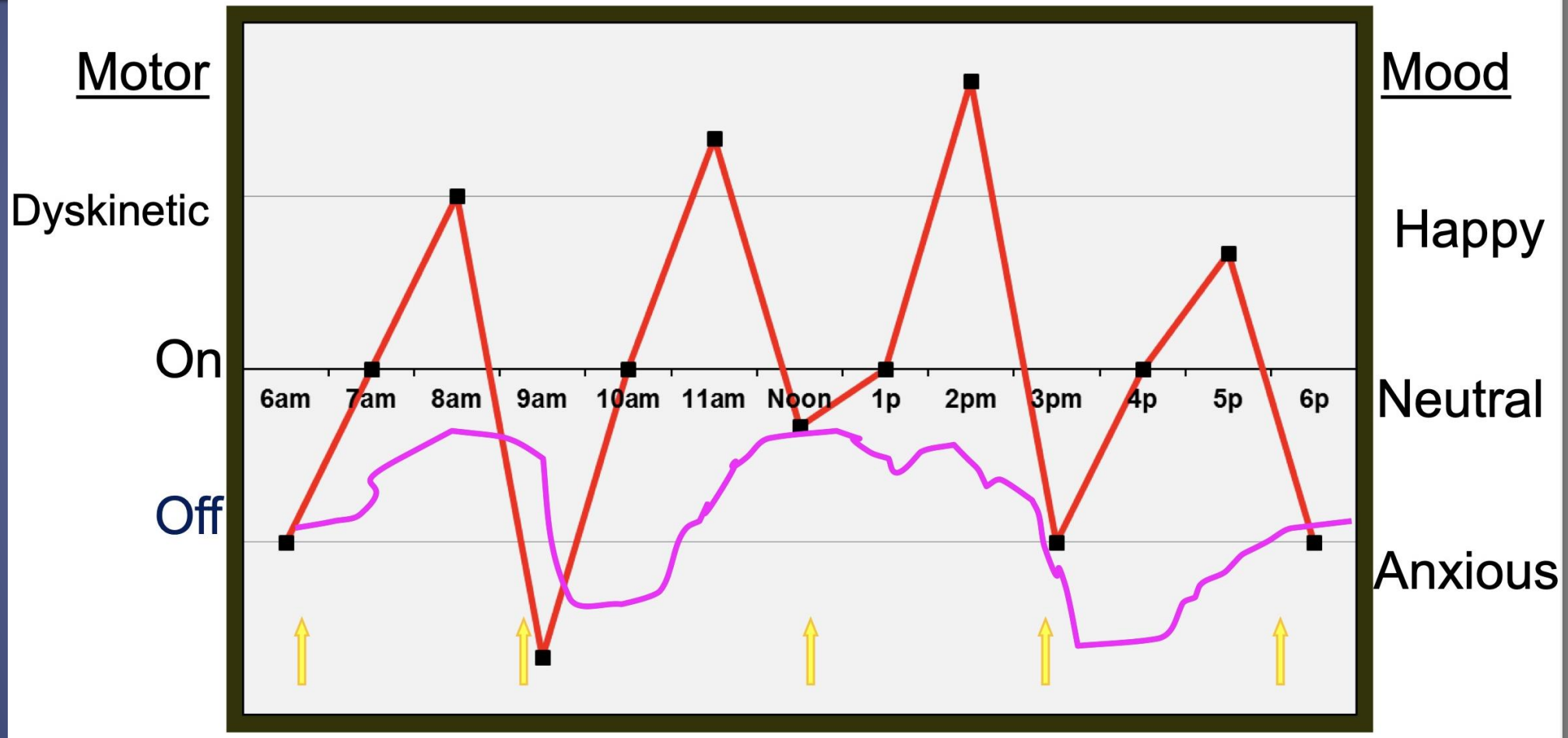
Parkinson's Foundation



Richard et al, 2004

PD Non-Motor Symptom Complex

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Neuropsychiatric Symptoms

Mood disturbances
- Depression, anxiety, apathy

Psychosis
- Hallucinations, delusions

Behavioral changes
- Impulsive, repetitive

Cognitive Changes
- Selective deficits, Dementia

Sleep Disorders

Restless legs
Periodic limb movements
REM sleep behavior disorder
Non-REM Sleep movement disorders
Insomnia, EDS, Vivid Dreams
Sleep-disordered breathing

Autonomic Symptoms

Bladder dysfunction
- Urgency, Nocturia, Frequency

Sweating
Orthostasis
Sexual Dysfunction
Dry eyes
Gastrointestinal changes
- Drooling, ageusia, dysphagia, reflux, Constipation, Incontinence

Other Symptoms

Sensory – Pain, paresthesias
Olfactory changes
Fatigue
Seborrhea
Blurred Vision, Diplopia

Chaudhuri KR, Lancet Neurology, 2006

Up to 2/3 of PD-Depressive Disturbances Under-recognized or Under-treated

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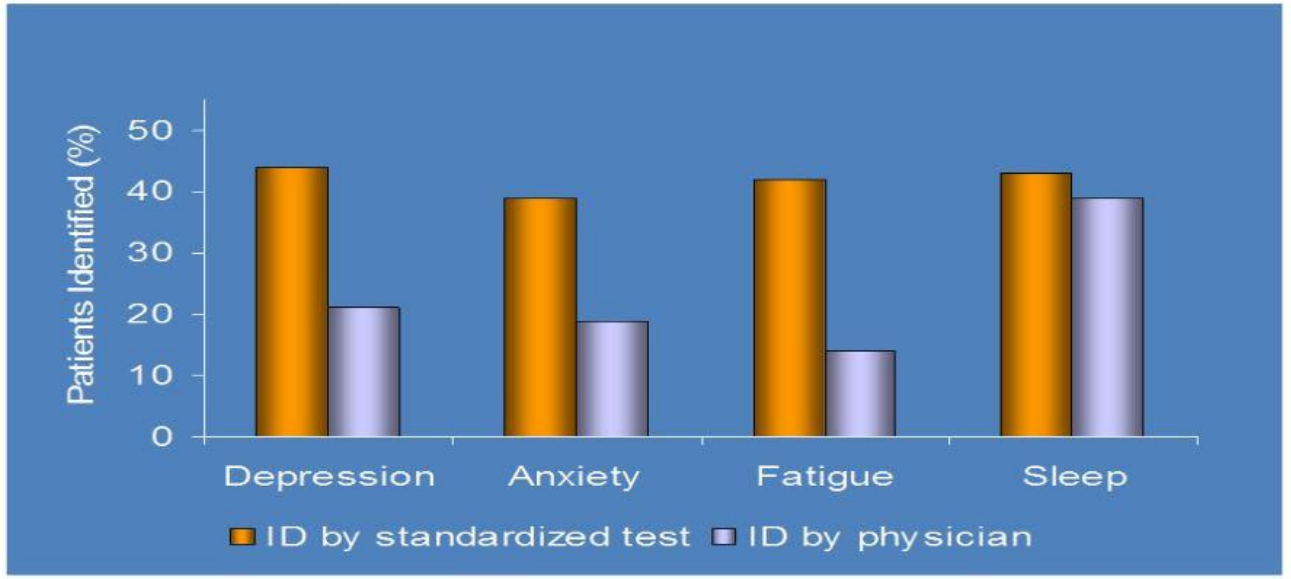
1. Shulman 2002, n=101 PD



2. Weintraub 2003, n=100 PD

   34% DSM Depressive Disorder; 2/3 were not receiving treatment

3. Hoek et al. 2011, n=256 PD

   36.3% minor depression with 8.6% treated

   12.9% Major Depression with 30.3% treated

   49.2% +Depression 61.1% not treated

Depressive Disorders in PD

- ~40% prevalence (range 3% - 90%)
- Several types of depressive disturbances
  - Clinically significant depressive symptoms 35% (Major Depression)
  - Mild states (minor depression), may remit (50%), but may also worsen
- Recurrence or treatment resistance rates unclear
  - Symptom severity, older age, PD Duration
- Onset can be before overt motor signs/PD Dx
  - i.e., onset not related to disease stage or disability
- Anxiety disorders often co-occur

Reijnders 2008; Mayeux, 1981; Starkstein, 1992; Meara, 1999; Global PD Survey, 2002; Weintraub 2004; Ravina 2009; Even 2012; Shakeri 2015; Ghaddar 2016; Reidel 2016

Anxiety Disorders in PD

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- Several Types
  - Episodic (Panic Disorder)
  - Situational (Phobias)
  - Continuous (Generalized Anxiety)
  - PD-Specific (Wearing-off anxiety/panic)
- Depressive disorders are a common co-morbidity
- Not understandable reactions to motor symptoms
  - Non-motor fluctuations
  - Onset of Anxiety may precede PD

Kummer et al. 2008; Maricle et al. 1995, Witjas et al. 2002, Arabia 2007

Other Psychiatric Diagnoses
Independent or Co-morbid with Depression

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Apathy
Emotionalism/Pathological Crying
Anxiety Disturbances
Psychosis
Impulse Control Disorders
Dementia and other Cognitive Impairment

Psychological Features of Anxiety

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Excessive

- Avoidance
- Apprehension
- Worry
- Anticipation
- Overly-detailed
- Emotional Reactivity
- Fearfulness
- Somatic concerns
- Ruminative

No pervasive

- Guilt
- Sadness
- Decreased self-worth
- Lack of interest
- Morbid

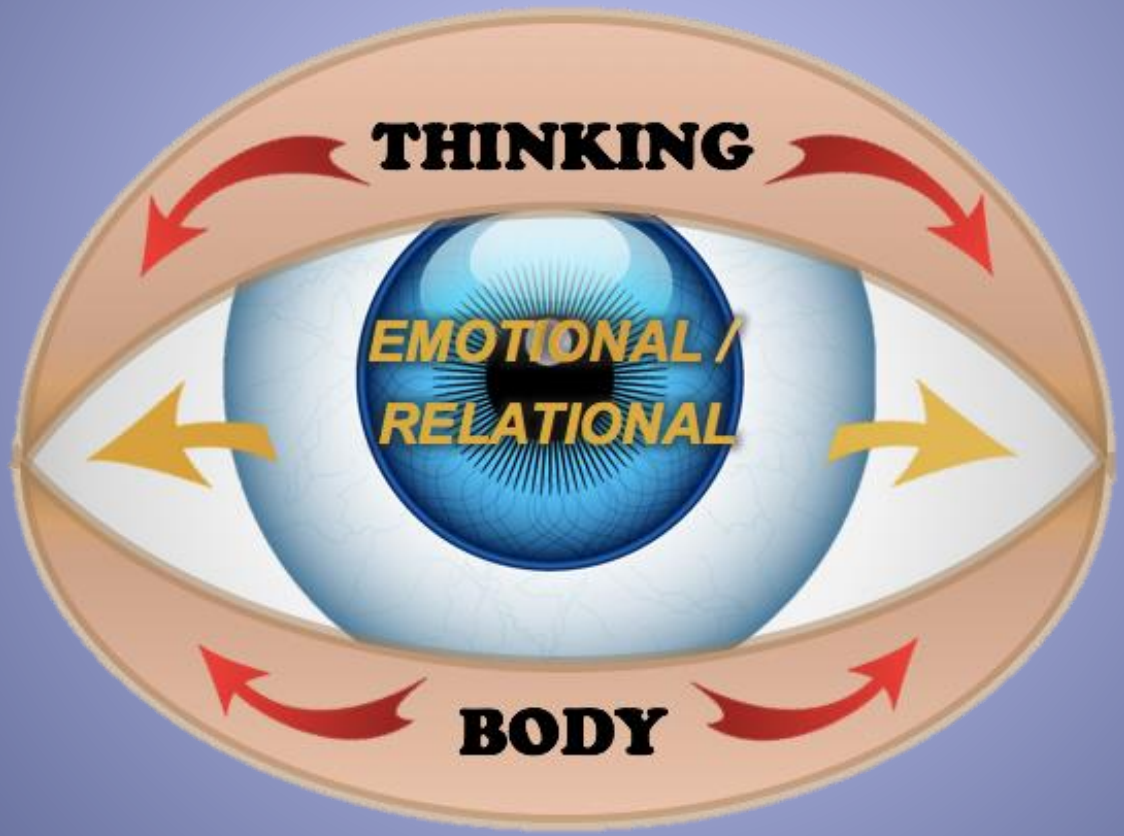
How do we regulate our nervous systems?

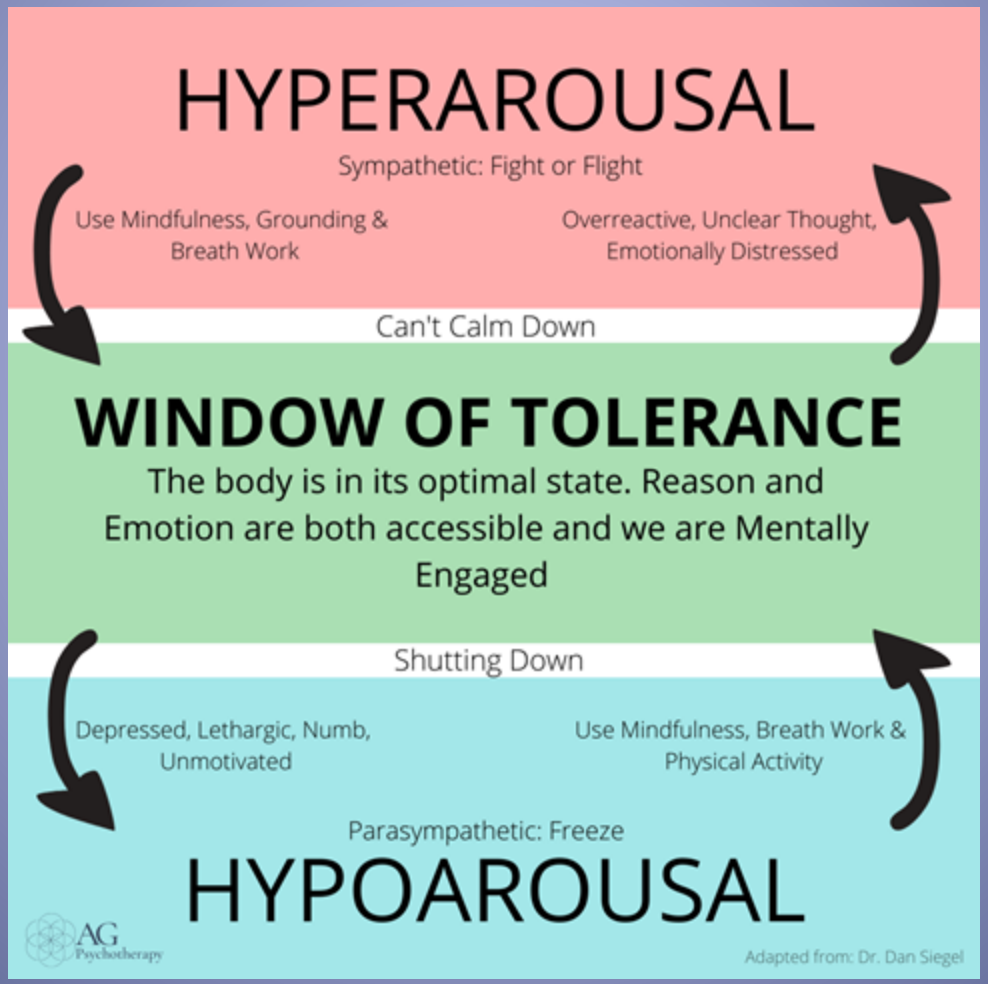
We are each unique.

Noticing

- The verb of awareness
- Tracking, not fixing
- Resilience is activated by tracking or noticing

Observational Brain

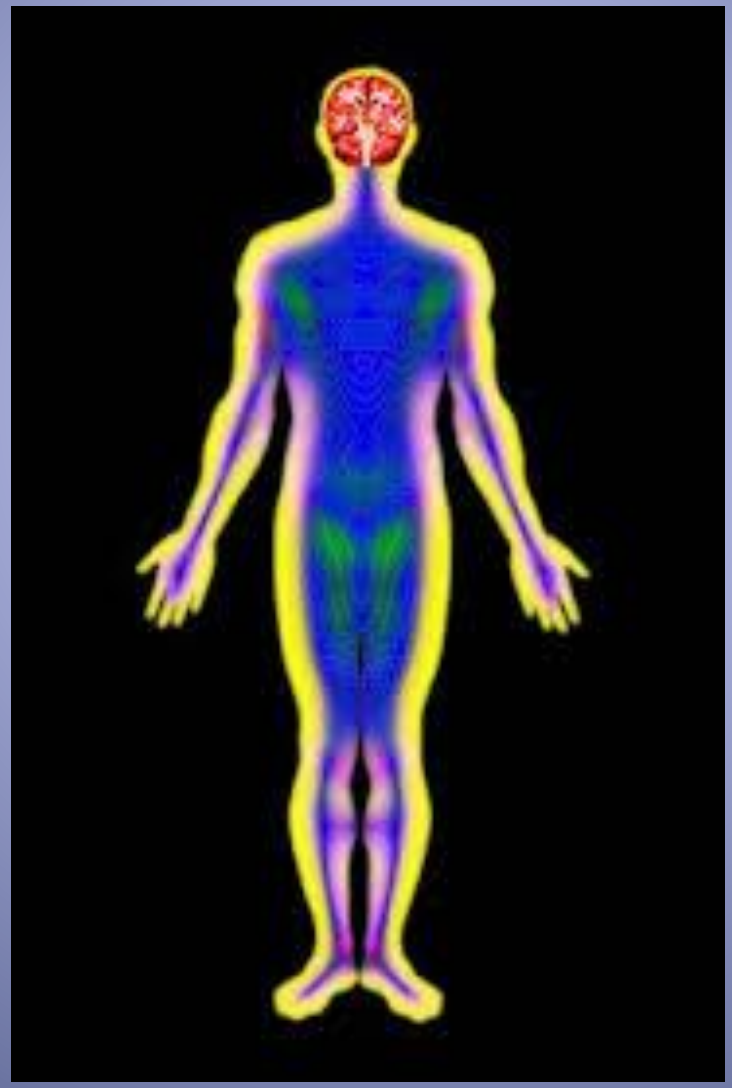



HYPERAROUSAL
Sympathetic: Fight or Flight
Use Mindfulness, Grounding & Breath Work
Overreactive, Unclear Thought, Emotionally Distressed
Can't Calm Down
WINDOW OF TOLERANCE
The body is in its optimal state. Reason and Emotion are both accessible and we are Mentally Engaged
Shutting Down
Depressed, Lethargic, Numb, Unmotivated
Use Mindfulness, Breath Work & Physical Activity
Parasympathetic: Freeze
HYPOAROUSAL
AG Psychotherapy
Adapted from: Dr. Dan Siegel

Morning Grounding Activity

- Begin each day by returning to your own grounded relationship to your body and the natural world.
- Find an anchor point in your body.
- Take some time to ground, breathe, and then track with body cues where you are tracking distress in your body

Finding an anchor point



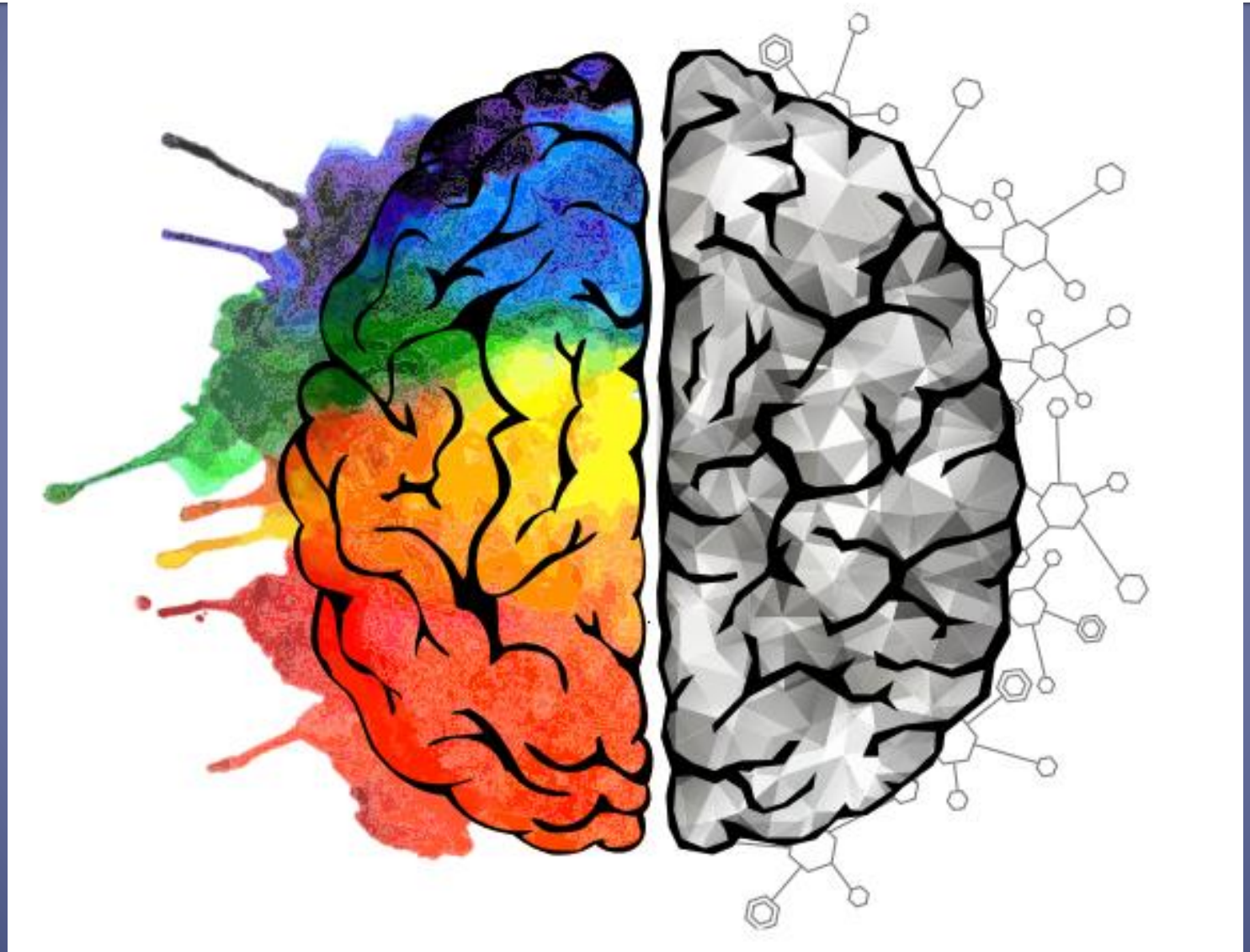
Basic Skill: Drop In

Find the Storm

- Locate it in your body
- Explore the Sensations
- Pendulate back and forth between the anchor and the storm

Power of the Natural World

Neuro-Plasticity Movement



Apathy

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Prevalence

– ~ 30% as a feature of a depressive disorder
– ~ 10% as an independent disorder

Clinical features

– Loss of motivation
– Emotional indifference
– Reduced goal-directed activities
– Patients with primary apathy do NOT complain

Weiss and Marsh, 2009

Emotionalism/Pathological Crying

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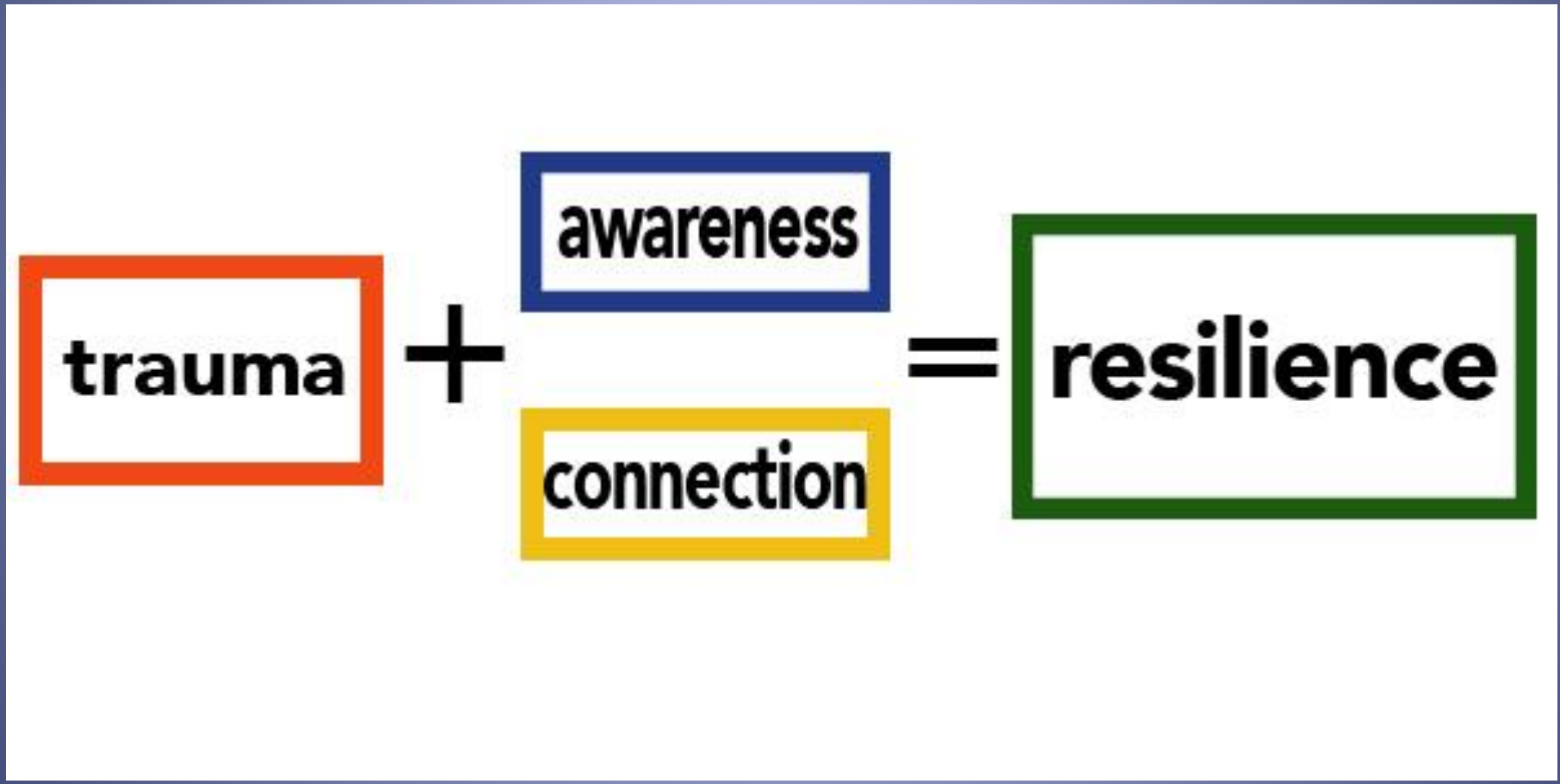
Prevalence

- 40-50%
- Associated with Depressive Disorders, Delirium, Benzodiazapines

Clinical Features

- Heightened, excessive sentimentality/tear
- Inappropriate, unmotivated, involuntary
- Precipitated by a variety of emotions
- Social embarrassment/Phobic avoidance

Resilience and Trauma

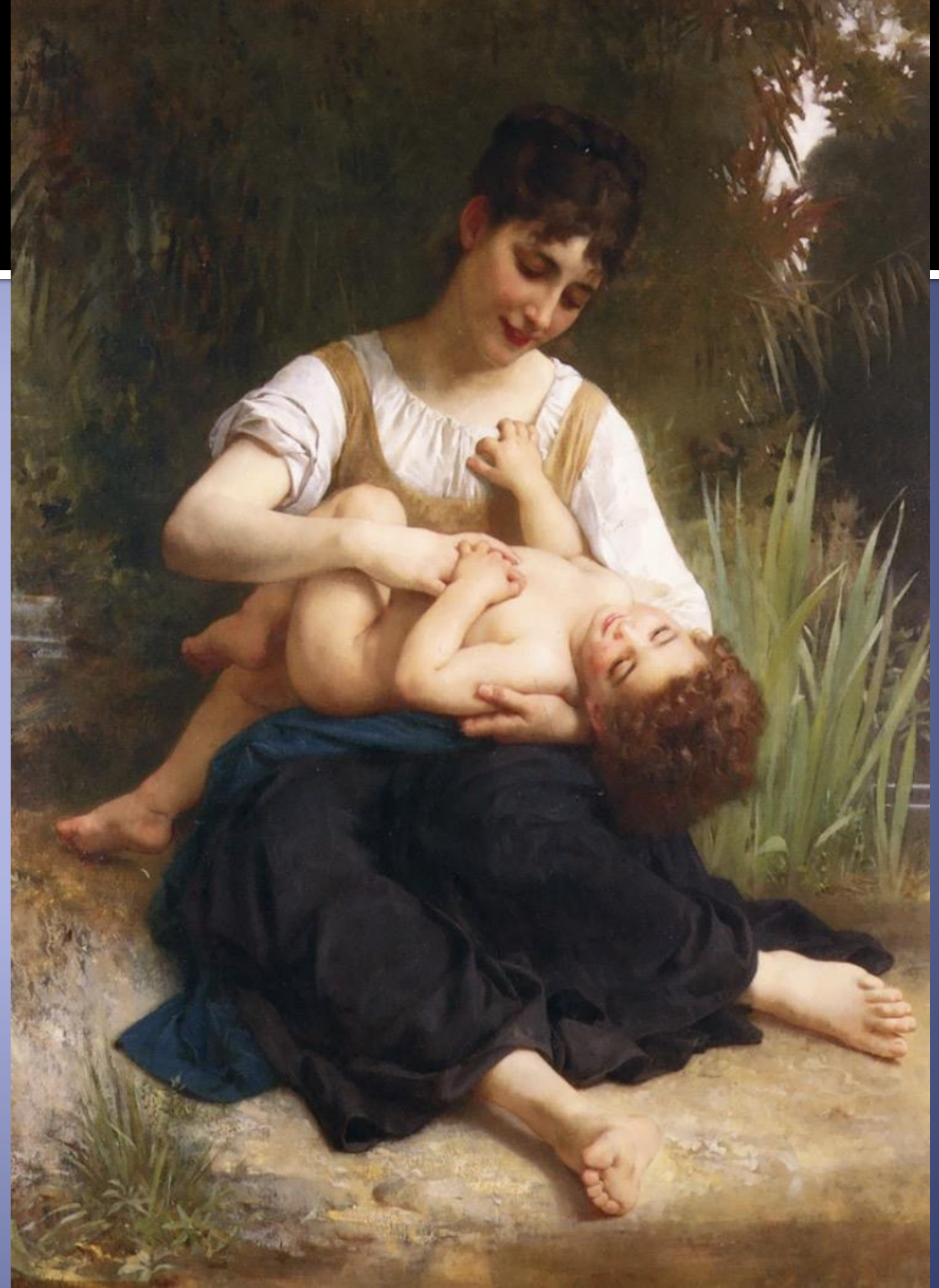


Relationships Heal

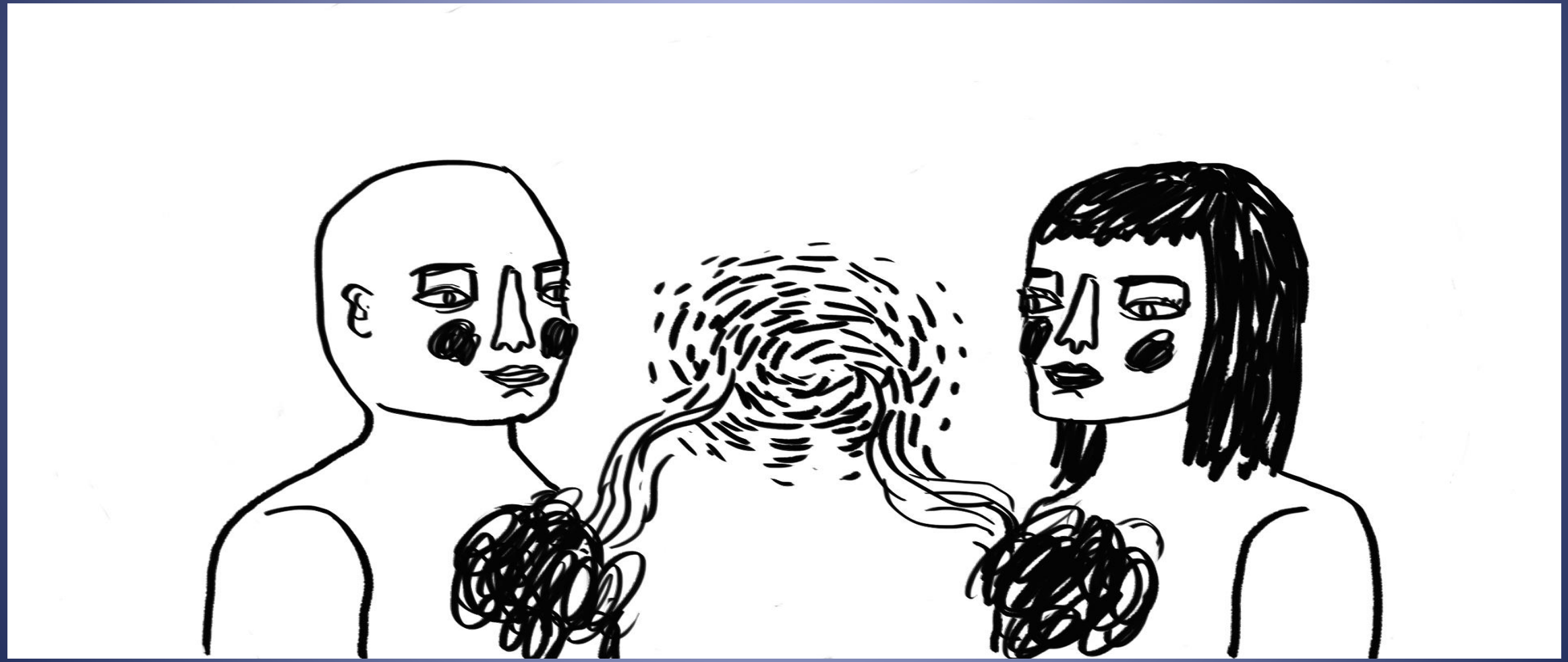
Protect

Nurture

Regulate



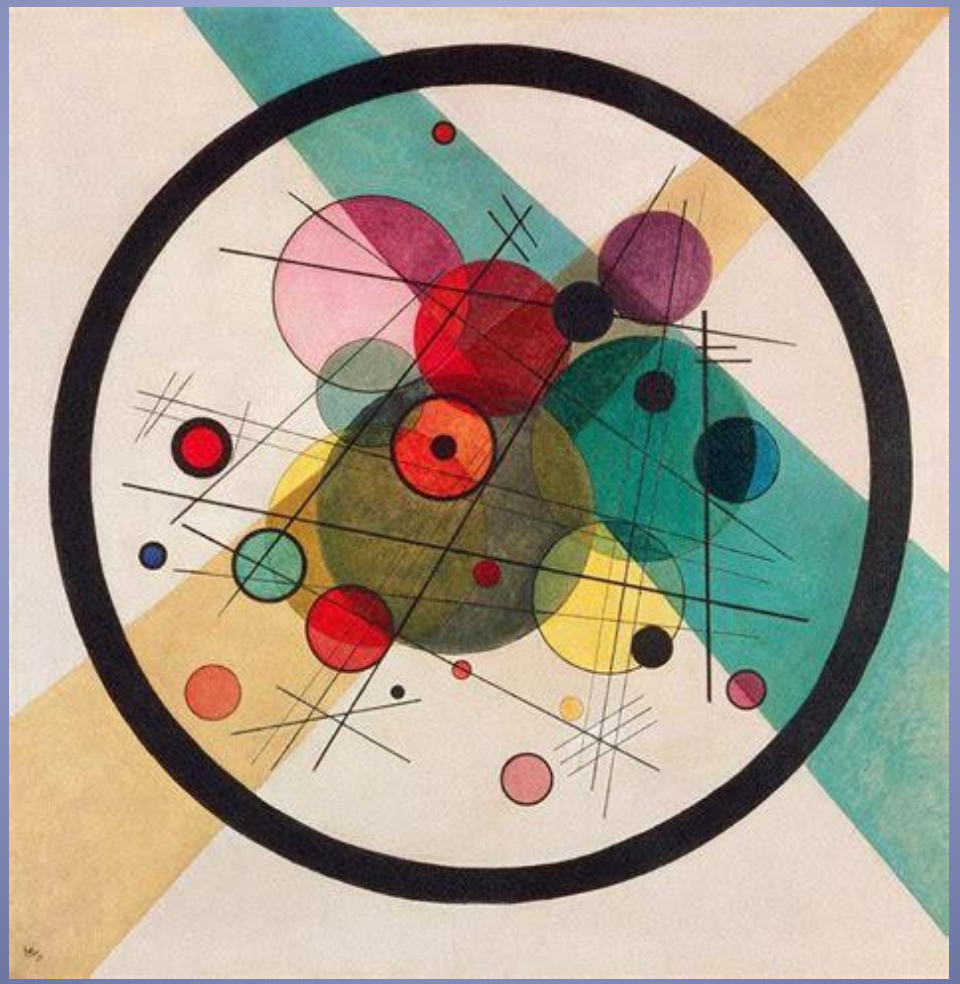
Power of Human Communication



Mirroring

Resonating

Circles of Support



Psychosis (Hallucinations and Delusions)

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I. Prevalence

- Depends on definition of psychosis, PD, and cognitive impairment
- ~ 8%–40% reported rates[1]
  - ~ 5%–17% without significant dementia
  - ~ 42%–81% with significant dementia
- Persistent and progressive[3]

II. Impact[2]

- Major Clinical Challenge
- Major source of caregiver burden
- #1 factor in nursing home placement
- Associated with increased disability and mortality
- Prognosis improved with advent of atypical antipsychotics

Greene P, et al. 1993; 60:703-706; [2] Factor SA, et al. 2003; [d]de Maindreville AD et al. 2005

Targeted and Individualized Treatment

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Medica(l)tions, Education, Skills, Support (MESS)

M - Adjust/Optimize/Adhere anti-parkinsonian medications
- » Identify and treat medical conditions, delirium
- » Adjust medications causing cognitive/psychiatric problems

ESS - Non-pharmacological approaches
- » Educational Programs
- » Skills: Psychotherapies
  - OT, PT, ST, RT
- » Social Support, Support Groups
- » Support + Exercise + Fun: Singing, Yoga, Dance, Boxing, etc.
- » Address Caregiver Needs
  - Home Care, Respite, Support

Targeted and Individualized Treatment (2)

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Medications, Education, Skills, Support (MESS)

M- Add/Adjust/Optimize/Adhere specific psychiatric medications

- Anti-depressants
- Sleep medicines
- Anti-anxiety medicines
- Anti-psychotics
- Cognitive-enhancing agents

Consider other somatic treatments

- Electroconvulsive Therapy (ECT)
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- transcranial Direct Current Stimulation (tDCS)
- Vagal Nerve Stimulation (VNS)
- Deep Brain Stimulation (DBS)


Skillfulness
Efficacy
Hope
Humility

Skillfullness

Humility

Point Positive

Hope