Lifestyle, Medications, and Hope: A Psychiatrist’s Guide to Aging Better Transcript

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Introduction to Part Two

This is the ultra marathon of marathons. It's having the aging process go more smoothly than it would otherwise if you were just reactive. It's about being very proactive and taking care of as much as you can for as long as you can.

This is Doctor Talks. Real talk from real doctors on the issues that matter to you most. Welcome back to Think Well, Age Well. This is part two of my conversation with Dr.

David Merrill. In this episode, we shift from personal experience to professional expertise, as Dr. Merrill shares what he's learned on the front lines of practicing geriatric psychiatry, brain health promotion, and dementia reversal.

If you haven't listened to part one yet, I encourage you to go back and hear the beautiful insights shared by Dr. Merrill's mom, Elaine, about her time at Marama and her own experience of aging well.

You'll also get insights from Mike, her husband, who's been uber supportive of her process. Without further ado, let's dive in. So I want to switch a bit to talking about your professional perspective and research, Dr.

Merrill. You have an MD-PhD in neuroscience. Can you talk a bit about your research? You know, in a nutshell, my life in relation to dementia, Alzheimer's, try not to dwell too long on it, but it really was the origin stories is, I think it's of note.

When I was very young, my mom's dad was struggling with Parkinson's, evolved into Alzheimer's. And then as I became a little older, my dad's dad also got diagnosed with Alzheimer's.

You know, that one, I was actually about 12 when my paternal grandfather got diagnosed.

Dr. Merrillu2019s Personal Path Into Dementia Research

The event, it was 4th of July. We were having a family picnic and he needed to run out and grab a bag of ice. And I went with him. On the drive back, we got in a pretty dramatic car accident that he was at fault for and I was the only passenger.

And so that basically unearthed the problem for them. So he ended up getting evaluated. He lost his driver's license. I learned really quickly that there's such thing as Alzheimer's disease.

And so kind of from that point, it really. you know, set me on a path to learn about this and figure out, you know, I guess, psychiatrists are like, well, my life has been a, you know, process of trying to undo stuff, but, you know, there's some things you can't change, but through applying like a persistent effort to learn about things, including the biology of aging and Alzheimer's, you know, that's really what it's been about.

It started as a personal story. for these conditions, the dementing illnesses affecting my family members, and then became a professional pursuit as I was drawn to the field.

And so, you know, as a kind of fast forwarding, as an undergraduate at Cal, I worked in adult day healthcare for Alzheimer's at a place called ASEB, which I think is still around, Alzheimer's Services of the East Bay.

It was, you know, miraculous experience for me. two or three years of working with persons living with dementia at the moderate to severe stage. And I remember like, you know, walking with clients and talking with them and just

seeing the richness that remained in their lives in the face of being in a, what some would consider a late stage of dementia.

While I was doing that, I was working in the lab, trying to figure out what was causing Alzheimer's in these patients. And to some extent, That's still where the field is hung up.

When I started grad school some umpteen years ago, a long time ago, I remember being told that it was great that I was interested in Alzheimer's, but unfortunately I'd come along at the wrong time because it was about to be cured and, you know, a couple years and that within five years it just really wouldn't be Alzheimer's.

That was 1996. The first amyloid, anti-amyloid, it was actually an active vaccination process at that point. The first immune therapies for Alzheimer's were being started with great confidence and huge investment.

Kind of the whole field got taken over by the amyloid hypothesis and a silver bullet approach to fixing, to beating the enemy of Alzheimer's and that amyloid is the enemy.

I don't know, by one way or another, I kind of sidestepped all that professionally. I studied the neurobiology of aging, trophic factors. I was one of the early investigators looking into brain derived neurotrophic factor.

I like to say, you know, before it became popular. Now it's kind of a way that people sell products. It's like, oh, your BDNF is going to go through the roof if you drink my thing.

Lo and behold, the best way to increase your BDNF is to exercise, which is wonderful because that's actually usually free or can be a free activity. So I studied the neuroscience of aging, the importance of trophic factors and not just development, but in neuroplasticity in older adults and cell survival, in particular, the memory centers of the brain.

And so it's led into, after my graduate training and medical school, I went into human studies of healthy lifestyle activities, such as diet and exercise, or how those activities affect the trajectory of aging.

Now we all talk about and know about, you know, as opposed to lifespan, What is the expected health span for an individual? And most recently, what's your brain span expected to be, your brain health span?

Can we maximize the vitality of your healthy brain aging through adoption of one or more modifiable risk factors in a positive way, things like adopting regular exercise habits, getting on a brain protective diet.

It goes down the list of the Lancet Commission. I know you're aware of, Heather, there's 15 or more modifiable risks for developing Alzheimer's that we now know.

Lifestyle and Precision Medicine for Brain Health

The more of those factors that you address, the lower your probability of developing Alzheimer's in the first place, in spite of or regardless of the non-modifiable factors like age, or genetics, even with so-called, you know, quote unquote, determinative genotypes like APOE4-4 or also the really truly the early onset Alzheimer's genetic mutations.

Those families can push back onset by 10 or more years, 10, 15 years by adopting these healthy brain habits that relate to the things we've discussed.

And that's really just the lifestyle medicine half of the equation. The other side, which is drawing me to your work, Heather, and others like our shared mentor, Dr.

Bredesen, is really the precision medicine aspect of this, where the goal becomes not to beat down, you know, amyloid is the enemy or trying to find a silver bullet, but to keep borrowing from Dale's framework that he's laid out for us, it's the idea of silver buckshot, figuring out all the targets that could possibly be driving an individual's

dementing illness and addressing all of the potential drivers that you can to try and reach a tipping point where the brain goes from a mindset of protecting itself withdrawing all the connections and shutting down the cell functions, going back to one-up connection, where growth factors like BDNF and others get re-expressed and you're sprouting new cellular connections, you're forming new memories again.

It's been a journey for me to do this both as part of a personal family journey, but then also into the professional realm, learning about as much as I can about nerdy generative illnesses and then working in the clinic day in day out trying to help individuals achieve their best outcomes and realizing like it's not about the prescription pad, it's really about people getting to know themselves and getting to know what their own personal habits, how those impact their aging process.

how the illnesses or the health stressors they might be dealing with, how those are impacting brain function and how I can help them help themselves and each other, you know, find a care team where they feel empowered to make positive changes based on data, based on their personalized health data.

So sorry, that was a lot. Yeah, that's perfect. I don't want to miss the opportunity to let listeners know that you basically wrote the seminal mapture paper on BDNF.

And so we're going to link to that in the show notes. So if you want to nerd out and dive deep into Dr. Merrill's work, please click on that link and do so.

And then also, I'm curious from your clinical perspective now having decades of working with dementia patients, At this stage, what do you think are the biggest players?

And you've mentioned lifestyle, you're a geriatric psychiatrist, so you do have medications in your tool belt. And curious, what are the top three or the top five interventions that someone might make to protect their brain?

Well, I think the number one intervention is kind of to know thyself, to become your own quarterback in the sense that You definitely want to have a quarterback coach, you want to have a general manager, you want to have an owner, you want to have teammates.

But really, to really embrace the mantra that knowledge is power, getting to know your own genetics, getting to know. I mean, unfortunately, it's not that simple of an answer, but the more you can know yourself, the better you'll do with the process of becoming older.

You've taught me about the buckets that we need to address and Dr. Bredesen talks about inflammatory factors, hormonal factors, nutritional factors, toxins and whatnot, you know, but learning about this paradigm of, which really comes out of naturopathic practices to basically look for root causes of illness in yourself and then working to correct those.

So know thyself, I think is the number one intervention, which is very personal. It's very specific to the individual. It's going to be different for different people.

Like what needs to be prioritized? I think beyond that, getting to know yourself, the foundational lifestyle exercises, there's anywhere between five to 10 pillars, depending on who's counting and how they're tallying them.

I think the diet and exercise. is a strong number two that I would intentionally link together because you're not going to get away with one or the other.

You know, fitness trainers will tell you that, you know, abs are made in the kitchen and it's not about the aesthetics of your body, but it's really that unless you're fueling yourself well and then exerting yourself in a use it or lose it fashion, You know, it's not going to be one or the other.

And you need to step away from any absolutes of like, I don't exercise and reframe that as like, in the past, I haven't been someone who's exercised. But now, because it's important that I'd be present for my child or my

spouse, like I'm embracing movement.

And so really having this flexibility of thinking to change yourself and your behavior or your behaviors. in regard to what we now know are evidence-based.

The Lancet Commission has these periodic updates of like what are modifiable risks for developmental dementia. So getting to know what those risk factors are, addressing them for yourself.

So know thyself, foundational lifestyle activities, health optimization through this investigation and then really team-based corrections. So I work now at a Neuroscience Institute, Pacific Neuroscience at St.

Medication Risks and Deprescribing in Older Adults

John's Hospital, Providence. And I'm really fortunate, like I've dropped into the middle of this wonderfully supportive multidisciplinary team where we have hearing loss specialists.

My mom came and she saw a neurooptometrist, Dr. Holmes, who shored up and made sure my mom's glaucoma is being treated, that the cataracts have been addressed, that the vision is corrected.

And so even though there's a vision problem for my mom, we haven't left it. You have corrected vision, mom. And that improvement in your eyeballs and that's supporting the survival of the brain cells that are being targeted due to your posterior cortical atrophy and so on and so forth, Heather.

So it's just, This is the ultra marathon of marathons. It's having the aging process go more smoothly than it would otherwise if you were just reactive.

It's about being very proactive and taking care of as much as you can for as long as you can through learning about yourself, changing your behaviors in a way that's based on evidence to have the most impact for your brain aging and then figuring out what health risks or health stressors are going on that you may not know about unless you get assessments.

Hugely helpful. One of the things I've really appreciated about working with you to serve patients is learning about the medications that are available.

As people age, there are, of course, mental health issues come up, anxiety and depression. We've heard from your mom, sort of the fear that comes with having these incidents and with getting a diagnosis.

This can be really disheartening and depressing. And then also sleep issues come up. There are behavioral disorders like what happened with your grandpa.

And then there are the, you know, milieu of medications that are used to treat short-term memory loss. And I'm wondering, if you can share at a high level and even at a more specific level about how you navigate choosing medications.

Then of course, there's a whole issue that a lot of these medications can actually worsen cognition. How do you help patients navigate that? Yeah, Heather, I'm more than happy to talk about medications.

A lot of times there's a joke for a psychiatrist. It's asked like, well, what's the difference between a psychiatrist and psychologist? Did you go to medical school, et cetera, et cetera?

So yes, so I did and I prescribed. But as a geriatric psychiatrist, a big part of what I do is actually the opposite, so it's deprescribing. There's something called the BEERS list, B-E-E-R-S list, which is from our friends in geriatrics, geriatric medicine.

That's a whole cataloging of drugs that are relatively contraindicated. It's not that they should never be used in

anyone over the age of 60, but they're relatively contraindicated in that they can cause more problems than they fix.

So, medications. I do want to pick your brain a little bit here. Because of your role as a geriatric psychiatrist, I think this is really confusing for people and it's one of the most common questions that I get.

Is the medication I'm on causing dementia? Is there a medication I can take that will help with my dementia? I can't sleep, but I'm afraid to take this because it's addictive.

How do I get off of this? What will happen if I stop? Who do I go to see to help me manage this long list of medications that's accumulated over the past decades?

And they seem to be added, but never subtracted. How do you help your patients navigate all of that? Absolutely, Heather. And it's all within the context of a health system that's strained, where it's under stress.

So it's hard to access providers. Even when you do succeed, the framework is that there's not enough time And there's often this subspecialization within a provider.

So I do really encourage people to try their best to learn about these things with the caveat that, you know, the information age, as we know, brings its own challenges.

So, for example, I talked about the beers criteria. So the beers list, you may as an older adult, you may be on one or more drugs chronically that is listed in the beers list.

And so it could be a goal to over time have your provider or doctor or whomever to help you transition off of a drug that has potential side effects. But.

You shouldn't stop anything suddenly because that can trigger withdrawal symptoms or discontinuation symptoms that are worse than the problem of being on the drug.

It's really case by case. So the examples can run the gamut. Anything from somebody waking up multiple times in the night. goes to use the bathroom, they go to a urologist to get a medication to help them sleep through the night.

Well, it turns out the drug they get on is anticholinergic, which then gives them cloudy thinking, blurry vision, dry mouth, constipation, and may actually lead to urinary retention.

So something that's well intended. It may indeed, they don't need to get up as frequently at night to use the bathroom, but they've tipped themselves over the edge from an MCI state to a dementia state because they're on this new drug.

And by the way, they're needing to get up at night wasn't actually from a bladder problem. It was from undiagnosed sleep apnea. Because when you obstruct your airway, that increases the pressure in your chest, which pushes down the diaphragm, which makes you have the urge to go to the bathroom.

So you're giving a drug to treat a symptom that worsens your overall health and doesn't actually address the underlying cause of the symptom. And oh, by the way, untreated obstructive sleep apnea is a known risk factor or driver of a dementing illness.

So by treating the symptom of needing to go to the bathroom at night, you're actually making it harder to figure out that you have sleep apnea, which is going to be causing you to end up with dementia even worse than the drug side effects for the symptom you've helped.

So I guess in one way it's job security, but I don't want that kind of job security. The statistics are pretty grim. So as far as I'm aware, it's still about, there's about one of me, which is a double board certified licensed geriatric psychiatrist for every 100,000 older adults just in the United States.

And so I can work pretty quickly, but not that quickly and so like One thing I've really learned from you, Heather, is how to have the biggest impact.

I think it's important to be a health educator, both of other allied professions, so you don't need to have been obsessed with being in school as long as possible.

But like me, you can actually learn a lot just from Reading, taking classes, joining groups. I think one of the most wonderful things that I've experienced in my professional work has been to facilitate, co-facilitate, or be a participant in small group sessions where we meet weekly or monthly even to just check in about how things are going with the aging process itself.

what issues are coming up for an individual and then kind of double clicking on that issue and going as deep as possible to root out like why is somebody waking up in the night to go to the bathroom, getting them to get a sleep study, making sure they get off cognitively dulling meds.

Shared Medical Visits and Team-Based Care

And if they do end up still needing some sort of sleeping pill, that it's not a sedative hypnotic, that it's more something that helps the sleep architecture.

So as they're getting good oxygenation with their CPAP or their mouth guard, that they're also getting deep sleep and REM sleep. And if they're going to use a drug to use something that won't disrupt the sleep cycle, that won't cause amnesia or be associated with increased risk of Alzheimer's, The sleeping pills are, in a way, they're an easy target, but they're also a big issue.

It's obvious that the classic sedative hypnotics, things that aren't even prescribed anymore, like the barbiturates or the benzodiazepines, which are still prescribed, those are clearly amnesia inducing and could put you at higher risk of not only falls, but also Alzheimer's.

But even the non-benzodiazepine sleeping pills, things like Ambien or Lunesta or Sonata, I'm sorry to go into drug names, but it's just easier to talk with examples.

Those, while they may be appropriate for younger adults for short-term use, what I as a geriatric psychiatrist, I see people have been on these medications for decades, and so it's hard to help them both physiologically and psychologically transition off of them.

It's a lot of work. When we're successful in that, we find that people do better. I think there's a process of assessing what's the purpose of every item of your regimen, whether it's a prescription med, an over-the-counter supplement, a tincture, a cream, a salve, a liquid, an inhalant.

It's not as simple just saying, oh, what meds are you taking? It really runs the gamut. It's more than a full-time job. And a lot of people are, I think, hoping that they'll be able to see a Medicare covered provider and do this through the system, if you will.

And I think what I've heard you say is that it's probably best, and I even actually heard your mom and Mike share this, that It might make sense to invest a little bit in seeing a provider that can spend more time with you, that can get that detailed intake, that can really understand the larger picture instead of being super specialized, and then also maybe look for groups where maybe it's not quite as individualized but you have it's less expensive because you've got that economy of scale of a provider or an expert talking to six or 12 people at a time.

So there's a couple ways that are a little outside of the box to navigate this and get the help you need. Is there any other advice that you would give people if they're looking for someone trained in the way that you are?

Or can they see someone like a nurse practitioner or a physician's assistant who might have some similar training and a little bit more time? Yeah, I want to endorse and say, you know, it's all the above of what you're talking about

is like finding a way, putting in the time and effort to navigate to improving your own knowledge.

So every encounter between a provider and a patient or client and when their family is a learning opportunity, both for the provider, but also for the patient and their loved ones or maybe the other way around.

It's a learning opportunity for the patient and their care partners, but it's also an opportunity for the provider. And so this is something that I've worked on or worked through in my practice as well, trying to adopt something called the shared medical visit or shared medical appointment where all the patients have a diagnosable problem in common.

So an easy example would be diabetes. though I'm not an endocrinologist and I don't have shared medical appointments for diabetes. But the concept is that everybody who comes to the visit agrees that they're more than able and willing to share with each other some self-disclosure about their own health issue.

Then the provider who's running the show, so to speak, focuses on each person as an individual. But as they give their knowledge in exchange to the patient, the patient is themselves are learning, but also all the other members of the group.

Brain Health, Mental Health, and Aging

If you have 6, 10, 12, 20 individuals all at the same time learning back and forth, you've suddenly expanded your impact for one resuscitation of the value of low glycemic index foods and diabetes.

You haven't just told one person, you've told 20 and it's live. There can be this exchange of questions and answers, real-time feedback. It's not as passive or abstract as watching a video or listening to a podcast, but there's really a true relationship that's formed.

And with the continued meetings, over time, you build this social network that goes beyond the provider-patient relationship into a shared experience where everybody's really aging together, trying to achieve successful brain aging.

So it's a really powerful tool and it's something that I'm working on more and more to figure out how to do that in practice. Yeah, I agree. In my experience hosting the coaching program, it's been magic to watch people connect with each other, to inspire each other, to learn from each other, as well as be able to, like you said, increase that impact through scale, through talking to 25 people at the same time instead of just one-on-one.

It's really fun. It's something that I really enjoy and hope to do more of throughout my career. I alluded to this a little bit, but I want to talk more about the intersection between brain health and mental health, particularly as folks age.

What is your perspective on that? Well, you know, the modern day field of psychiatry runs on a biopsychosocial, and I would add, spiritual model of ourselves.

And so this decades or centuries old split of there's the mind, there's the body. Like really, neuroscience is the field that is trying to bring that back together.

So as we age, just like all the other organs in the body, there are changes that happen in the biology of the brain and the function of the brain, which is affected by the function of all the other organs in the nervous system.

So you have biologically based physiologic process of aging that gets accelerated by health stressors, meaning illnesses like diabetes, heart disease, major neurologic events like strokes.

These are just examples of the normal aging process gets accelerated or exacerbated by health stressors, vision loss, hearing loss, traumas, accidents, injuries.

There's that whole biological aspect that then affects how our mental health, our psychology, there's both the grieving or the reaction to health stressors, which is regressive in nature, brings us back to like primitive defense

mechanisms, but also just affects all the circuitry that regulates things like mood and decision-making and processing and language.

So the psychological aspects of our brain function are impacted by both the aging process itself the health stressors that we work through and try to fix or treat as well as possible.

And then this all, our psyche and the way we're mentalizing and thinking about things affects the quality of our relationships, the ability of us to maintain long-term relationships, form new friendships and partnerships.

And so then the social aspects of our existence end up being impacted by, it's this downstream effect of the biology is changing, the psychological effects are happening that are impacting our social aspects of life.

And it really, you know, it's no wonder that having spiritual practices that bring kind of peace and harmony about all this that we each of us face day in day out, regardless of what phase of the lifespan we're in, that really being thoughtful about spiritual aspects of your health end up making a positive difference.

So I've gone on so much. Is that what you were asking me? Absolutely. I think that as you're describing it, I feel like I've experienced it. I think we can all relate to that, right?

Like we have this accumulation of things that show up and that can be kind of disheartening. And then we have the things that lift us up and we can relate to meditating or being with friends or being in nature and having that spiritual connection and feeling like, all right, we're lifted back up.

And as we navigate this, as we age, it's dynamic. And there's lots of variables that contribute to this. And I think having a provider, I think it's refreshing to hear from a psychiatrist.

I think many people have an experience of maybe seeing a psychiatrist once being told, hey, what you have is all in your head, go see a psychiatrist. about that, and then they get offered an SSRI, which, oh, by the way, there was recent research that shows that might increase our risk of dementia.

But to talk to a psychiatrist and hear that there's this perspective of multiple variables, that it's about kind of putting the person back together, this biological, physiological, mental, emotional, spiritual being, that there's more to it than just writing a prescription.

And I find that really refreshing and that I can relate to it. I can relate to what you're describing. which feels good. I'm curious with the time, the brief time that we have left, your work at Pacific Brain Health Center at PNI, Pacific Neuroscience Institute with Providence St.

John, what do you hope that the legacy of that is or what do you hope to build as the first leader of that center? Thank you, Heather, for that question.

I mean, essentially, we're about seven years in to the center. You know, we hit the ground running, the doors were open the first day, and we found ourselves in clinic trying to both treat but then also research every patient in terms of looking at how are the interventions that we were offering resulting in improving the outcome of the patient sitting across from us.

you know, an individual session. And so really it's the whole conversation we've had the last hour, hour and a half of how do you get to know yourself as a provider?

Pacific Brain Health Centeru2019s Mission and Legacy

How do you get to know the patients you're taking care of to figure out what are the unknowns that could be affecting the process of the aging body and aging brain for them?

How do you discover the hidden drivers of dementing illness to either stave it off or if it does manifest to slow it

down and or, you know, ambitiously yourself and others like Dr.

Bredesen report on the many, many cases where we've seen improvement in cognition where before this was a field where having a recovery was unheard of, not seen.

I mean, I I'm very cautious and very conservative about sharing or making statements about improvement, but it's without a doubt that we do see cases that shift diagnostic categories at times into a milder stage of illness or even, you know, I have not an insignificant number of patients and patient families who over the years have basically express that they're cured or that they're in remission or that they're all better and that they, you know, it's an ongoing effort.

It can certainly go back the other direction, but it is, I think the legacy is one of hope, but hope with a roadmap and hope with, if not an instruction manual, certainly a toolbox of ways to go about aging more successfully, improving the, the health span of individuals with the focus on improving the brain health span so people can maintain the vitality of life into older old age for as long as they shall live.

It's not about being unrealistic. It's not trying to simplify it. It's not a search for the fountain of youth, but it certainly is a process of instilling hope that knowledge is empowering and that there are things we do that make a difference.

And there's always something more that can be done to help improve the quality of life. My experience working with you is that humor is a big part of who you are and how you engage with patients and colleagues.

I want you to leave us with what makes you laugh and what brings you joy these days. Yeah, that's a great question, Heather. It's fine because I think I'm just not recorded enough or on camera enough.

Usually, I'm off camera, off mic when I'm starting to make lights. I try to be self-deprecating. It's much more funny to me when people make fun of themselves as opposed to others.

It really is. It's a gravely serious condition that I work in. I guess my family origin, you know, their artists and their hospitality, one of the first physicians.

So I do try to be mindful that it actually is life and death sometimes, as opposed to for my father, it was food and beverage, you know, not life and death.

So there's really a lot of happiness and joy in coming together. And so I try to bring that joy to the care I provide. And luckily, my patients and their families are not.

They don't hesitate to speak up or maybe I'm kind of like just getting too joyful in the moment, but I try to use humor as a mature defense mechanism as much as I can.

And I'm glad when it, when it goes well and helping motivate positive change. So that's about as good as I'm going to get at this time to talk about it.

Well, thank you so much. I know that you have to run to see patients. And I am just so grateful for your vulnerability, your compassion that you have for your patients, for your sense of humor and your intelligence.

Humor, Joy, and Closing Remarks

I just feel absolutely privileged every day when we get to collaborate. And also, I feel privileged to call you a friend. Thank you for being here, David.

We welcome Heather. And the feelings are mutual. It's my pleasure, my privilege. Thank you so much for listening to the Think Well, Age Well podcast. If you enjoyed today's conversation, please take a moment to subscribe, leave a review, and share this episode with someone you care about.

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Until next time, keep thinking well and aging on purpose. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health.

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