Mood Disorders in Older Adults

Karin Taifour, MA LMHC GMHS
Aging Care Consultation Services

Topics

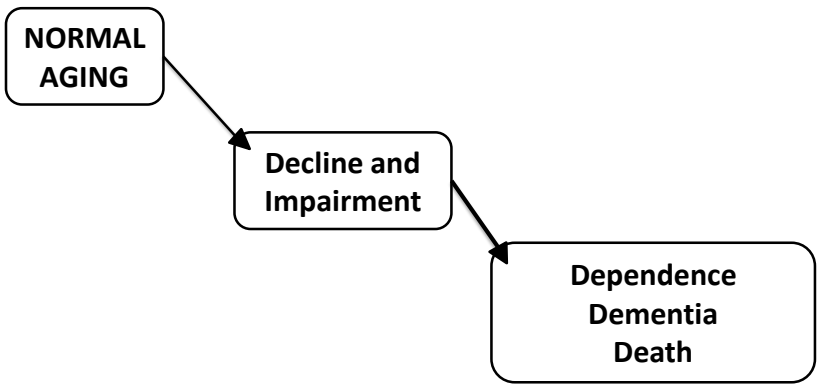
- Complicated aging and mental health
- Depression and depressive disorders
- Bipolar and related disorders
- Diagnostic tools/tests to consider

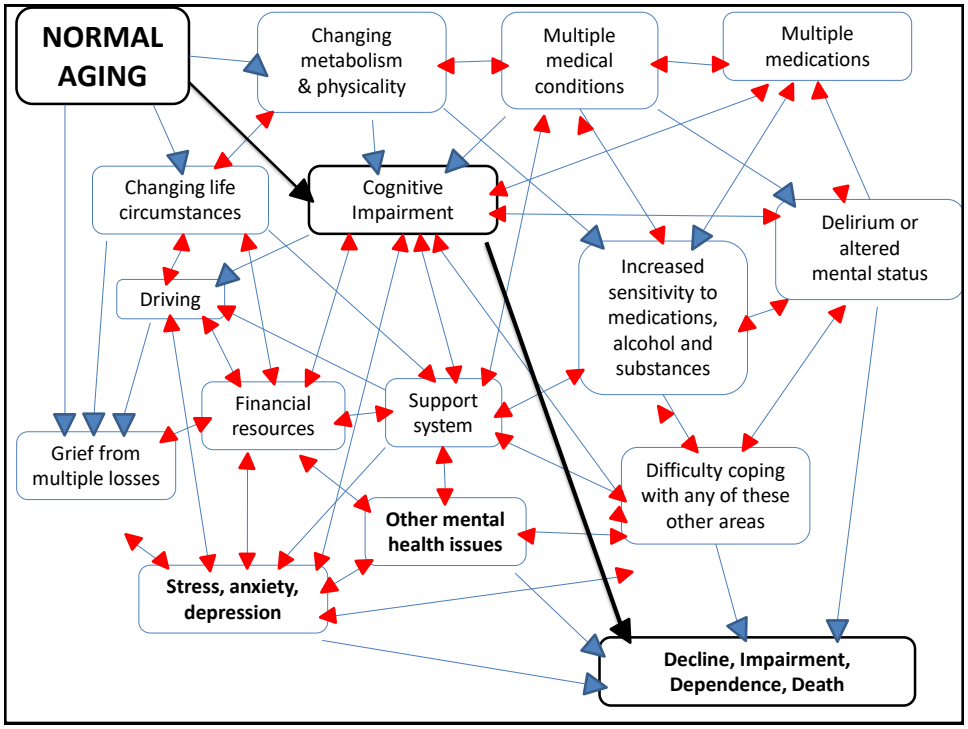
Complicated aging

- The U.S. population aged 65 and older is projected to increase to 98.2 million in 2060 (from 47.8 million in 2015) *
- Not only do we have all these older people, they also have:
  - Mental health conditions (14-20%)
  - Prescription drug complications (6-21%)
  - Alcohol/substance problems (13-17%)
  - Adjustment disorders due to life changes (100%)

* US Census Bureau "Older Americans Month" Facts for Features, March 27, 2017, from https://www.census.gov/content/dam/Census/newsroom/facts-for-features/2017/cb17-ff08.pdf

Think aging is straightforward?





Seniors and medications

- 2/3 of people age 65+ take 3+ Rx meds.
- Nearly every drug class can cause either drug-induced delirium or cognitive impairment in older persons.
- More than half of hospitalizations of older adults result from adverse drug reactions.

More than meds…

Besides pharmacy bottles:

- Over-the-counter medications
- OTC pain medications (30%)
- Alternative / naturopathic / herbal / vitamins (24%)
- Alcohol and substance use/abuse

Non-medical use of Rx meds:

- 44% of women, 23% of men
- 10% misuse prescription drugs with serious abuse potential:
  - Anti-anxiety benzodiazepines like Klonopin
  - Sleeping pills like Ambien
  - Opiate painkillers like Oxycodone

Seniors, Medications, and Alcohol

- Physiological changes in older adults can render alcohol and medications harmful at doses lower than those used by younger people.

  Most of us – and many doctors! – don't know this!

- National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends no more than one alcoholic beverage a day for men over 65 and somewhat less than that for older women.

Seniors and Alcohol

- While moderate alcohol use has been shown to protect against dementia, higher rates of consumption increase your risk
  - article: "moderate" = "up to four glasses of wine per day" (!)
  - 8.3% of seniors reported binge drinking (4+ drinks at a time)
  - 2% reported "heavy drinking"
- Drinking too much alcohol over time can cause medical problems
- Mixing alcohol with some medicines can even be deadly

Overall prevalence

- 20-22% of older adults meet criteria for a mental health disorder
- Higher rates among people in residential facilities
- 2010 study: of older people with serious psychological distress:

  only 37.7% received mental health services

First thing…

- In older adults, for all conditions, think **"Comorbidity"**
- Any new/changed symptoms: must assume physical cause.
- Mental health issues can be PRIMARY or SECONDARY.
- No lab test for mental health – have to rule out medical issues first.

Challenges: diagnosis/treatment

- Symptoms may not meet full criteria for diagnosis.
- Medical symptoms may mimic, or mask, psych symptoms.
- Co-occurring medical issues make it more likely that older adults seek help in primary care settings.
- Primary care doctors: minimal training in geriatrics, mental health.

So, let's get into it.

- DSM5 places bipolar disorders after schizophrenia and before depression
- We will cover depression first and then go into bipolar.
- For each disorder, we will review
  - Criteria and diagnostic features
  - Prevalence, development/course, risk/prognosis, cultural/gender
  - Differential diagnosis, comorbidities: "do not miss a treatable medical cause for the mental status"
  - Typical treatment approaches with case studies

Depressive Disorders

- Common features: sad, empty or irritable mood, with somatic and cognitive changes that affect functioning.
- Differences: duration, timing, presumed etiology.

Major depressive disorder

- Criteria for major depressive episode met:
- Five or more of the following symptoms,
- at least one of which is either (1) depressed mood or (2) loss of interest of pleasure,
- present during 2 week period and representing a change from previous functioning.

Depression criteria

- Depressed mood, most of the day, nearly every day, per subjective report (feels sad, empty, hopeless) or observation (e.g. appears tearful).
- Diminished interest or pleasure in almost all activities, most of the day, nearly every day.
- Significant weight loss or gain (5% in a month); or change in appetite most of the day, nearly every day.
- Insomnia or hypersomnia, most of the day, nearly every day.
- Psychomotor agitation or retardation, most of the day, nearly every day (observable by others, not merely subjectively feeling restless or slowed down).

Depression criteria, cont'd

- Fatigue or loss of energy, most of the day, nearly every day.
- Feelings of worthlessness or excessive/ inappropriate guilt.
- Diminished ability to think or concentrate, or indecisiveness, most of the day, nearly every day (either subjective report or observed).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation with or without a specific plan, or suicide attempt (not necessarily every day).

Depression criteria, cont'd

- Also:
- Symptoms cause significant distress or functional impairment.
- Episode is not attributable to substance or other medical condition.
- Not better explained by schizophrenic/ psychotic disorder.
- There has never been a manic or hypomanic episode.

What it actually looks like

- Disturbed sleep (too much or too little)
- Withdrawal from activities, social isolation
- Weight loss or gain (changes in appetite)
- Fatigue or lack of energy
- Feelings of worthlessness or extreme guilt
- Difficulties concentrating or making decisions
- Noticeable changes in speech or movement
- Frequent thoughts of death or suicide, or a suicide attempt

Depressive d/o specifiers: types

- With anxious distress, severity:
  - mild (2 anxiety sxs)
  - moderate (3 sx)
  - moderate-severe (4-5 sx)
  - severe (4-5 sx with motor agitation)
- With mixed features: at least 3 manic/ hypomanic symptoms
- With melancholic features
- With atypical features
- With psychotic features: mood-congruent, or mood-incongruent
- With catatonia
- With peripartum onset
- With seasonal pattern

Depressive d/o specifiers

- Status: in partial remission, in full remission
- Severity:
  - Mild: few, if any, symptoms in excess of those required for diagnosis; distressing but manageable intensity; minor functional impairment.
  - Moderate: between "mild" and "severe."
  - Severe: number of symptoms substantially in excess of that required for diagnosis; seriously distressing and unmanageable intensity; symptoms markedly interfere with social and occupational functioning.

Depression: prevalence

- Often insomnia or fatigue is presenting complaint: sleep or somatic symptoms bring most people first to their primary care office.
- Prevalence: 7%, 3x more in 18-29yrs than in 60+.
- Women 1.5-3x higher rates than men beginning in early adolescence
- But no apparent differences by gender or by age in terms of phenomenology, course, or treatment response.

Depression in older adults

- CDC numbers indicate:
  - 7.7% current depression, 15.7% history of diagnosis
  - 4-5% in community (lower than in younger adults)
  - 13.5% in people needing home healthcare
  - 11.5% in older hospital patients
- Suicide: older adults have highest suicide rate of any age group, especially older Caucasian men who live alone.
- Late life depression is especially costly, due to impact on physical health.

Depression: development, course

- Onset rates increase with puberty and, in US, appear to peak in 20s.
- Earlier onset: more likelihood of family history and of personality disturbances.
- But late life onset is also common.
- Course is quite variable.
- Studies suggest that most patients recover from an episode of depression: typically within 3 mos of onset for 40% of people, within 1 year for 80%.

Depression risk factors

- Personal or family history, genetics
- Chronic medical illness
- Female
- Disability
- Poor sleep
- Lonely or socially isolated
- Neurological disease
- Alcohol or drug misuse
- Stressful life events

Depression: risk factors

- Natural body changes associated with aging, e.g. lower folate levels, vascular decline, neurobiological changes.
- Lower daily activities due to old age or retirement, along with self-critical thinking.
- There also may be a link between the onset of late-life depression and Alzheimer's disease.

Depression: biological causes

- Genetic predisposition
- Brain chemistry: neurotransmitters
- Chronic pain
- Medical problems and medications, either:
  - Directly, or
  - As a psychological reaction to health issues

Depression: medical causes

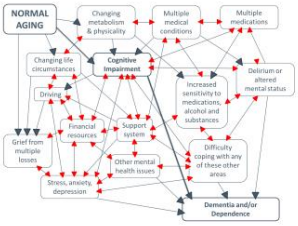
- Depression can co-occur with other serious medical illnesses such as diabetes, cancer, heart disease, and Parkinson's disease.
- Sometimes, medications taken for these illnesses may cause side effects that contribute to depression.
- Depression can make these conditions worse, and vice versa.

Depression and health

- Post-stroke: frequently severe vegetative symptoms
- Parkinson's: usually milder and with less anhedonia
- "Vascular depression" – aging process stiffens blood vessels and prevents blood from flowing normally to organs, including the brain.
  - Restricted blood flow is a condition called ischemia, and it raises the risk of heart disease, stroke, or other vascular illness.

Depression: situational causes

- Multiple "accumulated" stresses and losses
- Loneliness, isolation
- Reduced purpose in life
- Fears, anxiety
- Difficulty adjusting to change
- Grief, bereavement



Depression: risk, prognostics

- Temperamental – neuroticism / negative outlook, response to stressful life events
- Adverse childhood experiences, particularly when there are multiple diverse types
- Genetic/family – immediate family members have 2-4x risk, heritability about 40%.
- Any major non-mood disorder (substance use, anxiety, personality) increases risk of depression which often follows more refractory course.

Depression: prognosis

- The longer one goes after 6 months without recovery, the higher the risk of chronicity.
- Longer duration of remission = lower risk of recurrence.
- Severe episode or history of multiple episodes = higher risk of recurrence.
- Worse prognosis for longer current episode duration, psychotic features, prominent anxiety, personality disorders, or symptom severity.
- About 10% do not recover.

Depression and aging

Late life depression is:

- Less common than in midlife.
- Usually less severe, but…
- More devastating due to the increased burden of chronic physical conditions, impaired functioning and the risk of suicide.

Older adults vs younger:

- Less likely to be affected by psychiatric diseases.
- More likely to have cognitive changes, somatic symptoms, and loss of interest.

Depression: mortality

- 10-15% of severely depressed (enough to be hospitalized) will eventually take their own lives.
- At start of treatment, risk may increase: improved executive functioning but still depressed with suicidal thoughts = more lethality.
- Suicide risk factors: male, single or living alone, prominent feelings of hopelessness, borderline personality disorder.
- Suicide not only cause of high mortality rate: depressed people admitted to nursing homes have higher risk of death in first year.

Depression and suicide

- Suicide much more likely to result in death for older adults (1 in 4) vs. younger adults (1 in 100-200)
- Passive or indirect suicide includes behavior that occurs over time and can reasonably be expected to result in death:
  - refusing to eat, drink, take meds
  - taking unnecessary risks

Warning signs

- ❑ Hopelessness, see no reason for living, feel no sense of purpose in life
- ❑ Uncontrolled anger, seeking revenge
- ❑ Acting reckless or engaging in risky activities, seemingly without thinking
- ❑ Feeling trapped, "there's no way out"
- ❑ Increased alcohol or drug use
- ❑ Withdrawing from friends, family, and society
- ❑ Anxiety, agitation, unable to sleep, or sleeping all the time
- ❑ Dramatic changes in mood, anxiety, or sleep changes

Depression: complications

- Many people with depression are eventually diagnosed with bipolar disorder: more likely with adolescent onset, psychotic features, mixed features, family history of bipolar.
- With psychotic features: may transition into schizophrenia.
- Chronic or disabling medical conditions increase risk for depression.
- Illnesses such as such as diabetes, obesity, cardiovascular disease are complicated by depressive episodes, which are more likely to become chronic.
- Substance use, anxiety, and personality issues are often obscured by depressive symptoms.

Anxiety and depression

- Often occur together in older adults
- About half of people with major depression also have anxiety
- About 1 in 4 people with anxiety also have depression
- Rates of co-occurrence increase with age

Combination effect

- Anxiety + depression = greater memory decline and functional impairment
- Greater symptom severity and persistence
- Higher rates of substance dependence
- Poorer compliance and response to treatment
- Worse overall prognosis/outcome than either disorder alone
- Greater likelihood of suicidal ideation in older men

Depression: culture, gender

- Rates vary across cultures, but consistent in F:M ratio, onset age, and risk of comorbid substance abuse.
- Suggests substantial cultural differences in expression of depression
- In most countries, majority of cases go unrecognized in primary care settings.

Depression: differential dx

- Manic episodes with irritable mood or mixed episodes
- Substance/medication induced or due to medical condition: Carefully assess non-vegetative symptoms.
- ADHD: more irritability than sadness or loss of interest.
- Adjustment disorder with depressed mood: following a significant loss or other psychosocial stressor. Normal grief may resemble a depressive episode, while adjustment disorders don't meet the full criteria.
- Sadness: "inherent aspects of the human experience" – look at severity, duration, and significant distress or impairment.

Depression vs Grief

- Grieving a loss involves a lot of different emotions. Even in the middle of the pain, there are moments of happiness and pleasure.
- Depression involves constant feelings of emptiness and despair.
- Everyone experiences grief in unique ways: there is no time limit.
- If grieving doesn't ease over time, it could be depression.

Depression: comorbidity

- Major depression should never be thought of as a "normal" state, no matter how severe the setting.
- Even in case of cancer, dementia, or severe injury: depression, if present, should be treated.
- Avoid the stance that "I'd feel depressed too if that happened to me" – implies it's normal and not worthy of attention or treatment.

Persistent depressive disorder

- Includes both chronic major depressive disorder and the previous dysthymic disorder.
- Depressed mood for most of the day, for more days than not, for at least two years, with 2+ sx.
- During the period, not symptom free for more than 2 months at a time.
- Criteria for a major depressive disorder may be continually present for 2 years (would have both diagnoses).
- Never manic or hypomanic episode, and criteria never met for cyclothymic disorder.
- Not better explained by schizophrenic/psychotic disorder.
- Not attributable to substance or medical condition (e.g. hypothyroid).
- Symptoms cause significant distress or functional impairment.

Persistent depressive disorder

- Prevalence – estimated around 2%
- Development and course:
  - Earlier onset has higher risk of comorbid personality and substance use disorders
  - Degree of impact varies widely, similarly to effects of major depression.
- Risk and prognostic factors:
  - Poorer outcomes with higher levels of neuroticism, greater symptom severity, poorer global functioning, presence of anxiety or conduct disorders, childhood parental loss or separation.

Persistent depressive d/o specifiers

- Mood features:
  - with anxious distress,
  - mixed features,
  - melancholic features,
  - atypical features,
  - mood-congruent or mood-incongruent psychotic features,
  - peripartum onset
- Status: in partial or full remission (if applicable)
- Onset: early (before 21), or late (21 or older)
- Course:
  - with pure dysthymic syndrome,
  - with persistent major depressive episode,
  - with intermittent major depressive episodes and with current episode,
  - with intermittent major depressive episodes but without current episode.
- Severity: mild, moderate, or severe

Due to medical condition

- Clear associations between persistent depression and stroke, Huntington's, Parkinson's, and traumatic brain injury, Cushing's disease, hypothyroidism.
- Numerous other conditions are thought to be associated with persistent depression, e.g. multiple sclerosis.

Due to medical condition

- **Stroke:** usually occurs within a day to a few days, but can be 9-11 months. Acute onset is strongly correlated with left frontal location. More common in middle-aged men than women.
- **Huntington's/Parkinson's:** early in disease, often precedes major motor impairments and cognitive impairments, some evidence that depression is less common as dementia progresses
- **Gender differences** align with the medical condition (e.g. lupus more common in women)
- **Suicidality:** clear association with serious medical illnesses, particularly shortly after onset or diagnosis.

The others

- Brief Depression
  - Short duration depressive episode (4-13 days)
  - Depressive episode with insufficient symptoms.
- Substance/Medication-induced
- Due to medical condition
- Premenstrual Dysphoric D/O
- Disruptive Mood Dysregulation Disorder
- Other specified
  - Distress or impairment but criteria not met for other depressive d/o.
  - Can also specify why.
- Unspecified
  - Clinician doesn't specify why other d/o criteria not met, or
  - Insufficient info, e.g. ER

Depression: not getting help?

- They may assume they have good reason to be down or that depression is just part of aging.
- They may be isolated—which in itself can lead to depression—with few around to notice their distress.
- They may not realize that their physical complaints are signs of depression.
- They may be reluctant to talk about their feelings or ask for help.

Not "seen" in older adults

- Often undiagnosed or misdiagnosed
- Reluctance to talk about feelings or ask for help
- Isolation
- Assumptions

- Less obvious symptoms:
- Sadness is not their main complaint – apathy, irritability
- Physical symptoms are prominent.
- More sleep disturbance, fatigue, psychomotor retardation, and hopelessness about the future.

Barriers to getting help

Provider barriers

- Under-recognition of depression & anxiety in older adults
- Lack of professionals knowledgeable about aging AND mental health
- Focus on physical symptoms

Patient barriers

- Mental health stigma
- Complicated by disability, illness, sensory impairment
- Lack of transportation or limited mobility
- Cognitive slowing
- Financial / insurance limitations

Treatable even with dementia

- Depression in later life is treatable even among those with dementia.
- Evidence suggests that behavioral therapy, cognitive behavioral therapy (CBT), cognitive bibliotherapy and problem-solving therapy were effective.
- However, they were seldom used to treat older adults.

Treatment resistant depression

- Research found striking rates of psychological and medical comorbidities in patients with treatment resistant depression:
- 96.7% had a comorbid Axis I disorder,
- 89.7% had a personality disorder, and
- 90.9% had a long-term medical illness or disability.

Mindset / view of depression

How older adults view depression influences whether they seek treatment as well as whether they adhere to the program of treatment.

For professionals:

- Provide education about life stressors' role in depression – but don't over-emphasize it in such a way that depression is normalized.
- Emphasize the impact of social isolation and reduced activity as well as biological risk factors.

Goals of treatment: reduce sx

- Reduce the symptoms of depression;
- Prevent relapse, recurrence of symptoms, and suicidal thinking;
- Improve cognitive and functional status; and
- Help patients develop skills to cope with disability or other problems.
- Strong scientific proof shows that EBPs can reduce the symptoms of depression. 60-80% of older adults who receive appropriate treatment will have lower severity of symptoms.

Goals of tx: improve functioning

- Engage in self-care;
- Participate in meaningful activities related to work or relationships;
- Engage in social or community activities; and
- Engage with their peers and other members of their social network.

Goals of tx: improve health outcome

- Untreated depression in older adults is likely to lead to high levels of physical disability and functional impairment.
- May contribute to longer recovery periods for illness or surgery, as well as premature death.
- May also contribute to poor cognitive functioning in older adults.
- Appropriate treatment for depression can improve or prevent many health issues.

Look at hearing loss

- The severity of depressive, anxiety symptoms and stress increase with the severity of hearing impairment – in part because there are common central neurological, anatomical and physiological processes affected by depression, anxiety and stress and hearing loss.

Consider inflammation

- Neuroinflammation is thought to play a role in mood disorders and depression
- Patients with major depressive disorder exhibit all of the fundamental features of an inflammatory response, including increased expression of pro-inflammatory cytokines.
- Also a large percentage of individuals with inflammatory illnesses struggle with depression.

Inflammation markers

- People with treatment-resistant depression, as well as other neuropsychiatric disorders including anxiety and schizophrenia, also present with elevated markers of inflammation.
- Some evidence supports enhancing depression treatments with anti-inflammatory agents such as cyclooxygenase-2 (COX-2) inhibitors, aspirin, and TNF receptor antagonists

Typical treatment approaches

- Antidepressant medications
- Psychotherapy
- Electroconvulsive therapy (ECT): can help people unable to take other meds, or when depression is very severe.
- Magnetic stimulation treatments
  - Repetitive Transcranial Magnetic Stimulation (rTMS): newer treatment, not indicated for people with psychosis, bipolar, or suicide risk
  - Low-field magnetic stimulation: promising for depression and bipolar.

Meds vs therapy: what data says

- Medication is superior to therapy for severe depression.
- Medication and therapy are probably equal for mild to moderate depression.
- Combination of medication and therapy likely confer an advantage over either alone, perhaps a strong advantage.
- Psychotherapy may confer some protection against episodes, even after the therapy is over.

Medications - considerations

- Previous response to treatment.
- Type: psychotic and bipolar depression often require additional agents.
- Other medical problems: side effects that worsen existing medical problems must be avoided.
- Other medications: agents that interact with current medications must be avoided.

Meds info on this and following pages adapted from Blackburn, et al (2017). Depression in older adults: Diagnosis and management. BCMJ, Vol. 59, No. 3, April 2017, page(s) 171-177. from http://www.bcmj.org/articles/depression-older-adults-diagnosis-and-management

Classes of meds

- TCAs: tricyclic antidepressants
- MAOIs: monoamine oxidase inhibitors
- SSRIs: selective serotonin reuptake inhibitors
- SNRIs: serotonin-norepinephrine reuptake inhibitors
- Atypicals: newer, not in other classes
- Selective serotonin reuptake inhibitors (SSRIs) and TCAs had similar efficacy.
- More people quit TCAs because of side effects.
- TCAs should not be used within 14 days of taking an MAOI.

Meds: TCAs

- Not recommended as first choice in spite of being well studied in older patients, due to side effects:
  - postural hypotension, cardiac conduction abnormalities, and anticholinergic effects.
  - Get baseline EKG, postural blood pressure, labs before starting meds and before dose changes
  - Monitor blood levels, serum sodium.
- Nortriptyline, desipramine: lower anticholinergic burden.
- Dangerous for elevated suicide risk.

- amitriptyline (Elavil)
- desipramine (Norpramin)
- doxepine (Sinequan)
- Imipramine (Tofranil)
- nortriptyline (Pamelor)
- Amoxapine
- clomipramine (Anafranil)
- maprotiline (Ludiomil)
- trimipramine (Surmontil)
- protriptyline (Vivactil).

Meds: MAOIs

- have many drug and food interactions, significant side effects
- have largely been replaced by newer, safer meds

- phenelzine (Nardil)
- selegiline (Emsam)
- tranylcypromine (Parnate)

Meds: SSRIs

- Can increase risk of gastrointestinal/other bleeding
- Avoid fluoxetine: long half-life.
- Avoid paroxetine: anticholinergic burden.
- Citalopram and escitalopram can affect QT interval, do baseline EKG and monitor.
- Trazadone for sleep, but not for men (priapism)

- citalopram (Celexa)
- escitalopram (Lexapro)
- fluoxetine (Prozac)
- fluvoxamine (Luvox)
- paroxetine (Paxil)
- sertraline (Zoloft)

Meds: SNRIs

- Duloxetine: antidepressant, antianxiety, and central pain inhibitory effects; well tolerated by older patients, with placebo-controlled trials suggesting effectiveness in LLD.
- Desvenlafaxine still has no published studies examining its efficacy in geriatric patients.
- Duloxetine and milnacipran: avoid with glaucoma.

- desvenlafaxine (Pristiq)
- duloxetine(Cymbalta)
- venlafaxine (Effexor)
- milnacipran (Savella)
- levomilnacipran (Fetzima)

Meds: atypicals/others

- Bupropion, moclobemide, and mirtazapine: commonly used and well tolerated by older patients
- SSRIs, venlafaxine, mirtazapine, bupropion, and duloxetine are general first-line for depressed long-term care residents.
- Vortioxetine: synergistic antidepressant and antianxiety effects, plus has shown benefit to cognition. Greater rates of response and remission compared with placebo.

- bupropion (Wellbutrin)
- mirtazapine (Remeron)
- nefazodone (Serzone)
- trazodone (Desyrel, Oleptro)
- vilazodone (Viibryd)
- vortioxetine (Brintellix)

Meds: atypical antipsychotics

- May be useful as additional medications, particularly in cases of treatment-resistant depression.
- All carry a risk of extrapyramidal symptoms, falls, sedation, weight gain, dyslipidemia, and diabetes, and should be used with caution
- Black box warning for dementia.

- aripiprazole (Abilify)
- asenapine (Saphris)
- cariprazine (Vraylar)
- clozapine (Clozaril)
- lurasidone (Latuda)
- olanzapine (Zyprexa)
- quetiapine (Seroquel)
- risperidone (Risperdal, Invega)
- ziprasidone (Geodon)

"Start low, go slow"

- Start at half the normal adult dose, increase in a week if tolerated.
- Titrate up until noticeable response, or max dose is reached, or side effects are intolerable.
- Aim for therapeutic dose within 4 weeks.
- If no response after 4 weeks on max dose, consider changing meds.
- If only partial response after 8 weeks, consider switching or adding on another med:

Possible adjunctives

- Lithium
- Methylphenidate
- another antidepressant (preferably different class – if serotonergics, monitor for serotonin syndrome), or
- an atypical antipsychotic.

Supplements

- St John's wort
- 5-hydroxytryptophan (5-HTP)
- SAMe
- fish oil / omega 3 fatty acids
- L-theanine
- Acetyl-L-Carnitine

Future meds?

- Ketamine trials last summer in Australia
- Ecstasy/MDMA assisted therapy
- LSD micro-dosing

Other options

- Pharmacogenetic Decision Support Tools (DSTs) are not the standard of care for late life depression treatment, but have theoretical and anecdotal support.
- Providers should cautiously consider the use of DSTs for LLD treatment, and be aware that DSTs are a heterogeneous group of products with a rapidly evolving evidence-base.

Staying on meds?

- Stay on full therapeutic dose of medication for at least 1 year.
- Discontinuation should be done gradually over months with close monitoring.
- Response without full remission: stay on therapy indefinitely with ongoing effort to achieve full resolution.
- Hx of 2+ episodes or particularly severe episodes: should stay on meds indefinitely if tolerated.

Talk therapy

- Older adults prefer therapy to medications, but are less likely to be receiving therapy than younger people.
- Other research has pointed to the need to specifically address hopelessness in older adults with depression.

Older adults and talk therapy

- Laidlaw's model helps clinicians more appropriately conceptualize older clients by focusing on:
  - significant events and related cognitions associated with physical health,
  - changes in role investments, and
  - interactions with younger generations.
- Need to explore beliefs about aging viewed through each client's socio-cultural lens and examine cognitions in the context of the time period in which they have lived.

Laidlaw K, Thompson LW, Gallagher-Thompson D. Comprehensive conceptualization of cognitive behaviour therapy for late life depression. Behav Cogn Psychother. 2004;32(4):389-399.

Adapt: common aging challenges

- Decline in cognitive processing speed
  - Work at a slower pace.
  - Present info slowly, with frequent repetitions and summaries.
- Because older adults often have strengthened dysfunctional beliefs over a long time, modifying them takes longer.
  - Record important information and conclusions so clients can listen to them between sessions to have reminders and help them progress.
- Sensory changes
  - Use simpler handouts or worksheets, in larger print.
  - Consider modifications for other deficits.

Adapt: common aging challenges

- Decline in fluid intelligence:
  - Present new info in the context of previous experiences
- Impairments in memory or attention
  - Phone prompts or alarms can remind patients to carry out certain therapeutic measures, such as breathing exercises.
- Varying learning styles:
  - Present info in various ways. Encourage clients to take notes.

Adapt: common aging challenges

- Caregivers often provide emotional support
  - If both parties consent and it is necessary for client's progress, can have caregiver attend sessions to become familiar with strategies to support at home.
- Transportation barriers
  - In-home visits may make therapy more accessible to them, and provide more info/insight for you
  - Consider working by phone or video conference.

EBPs for older adult depression

Psychotherapy interventions:

- Cognitive behavioral therapy
- Behavioral therapy
- Problem-solving treatment
- Interpersonal psychotherapy
- Reminiscence therapy
- Cognitive bibliotherapy

Other interventions:

- Multidisciplinary geriatric mental health outreach services
- Collaborative and integrated mental and physical health care

Prevention

Research supports some approaches as preventing depression:

- education for individuals with chronic illness,
- behavioral activation,
- cognitive restructuring,
- problem-solving skills training,
- group support, and
- life review.

Types of psychotherapies

- There are a number of effective psychological treatments for depression in late life.
- Most include behavioral activation, directly addressing the problem of limited activity.
- These manualized treatments have all been, to some extent, adapted for older adults:

- Cognitive behavioral therapy
- Cognitive bibliotherapy
- Problem-solving therapy
- Brief psychodynamic therapy
- Life review therapy

Effectiveness

- Behavior therapy: quickest effect, within 4 weeks.
- CBT: most effective for depression with comorbid anxiety.
- CBT via internet: better than nothing, and better at 3 mos.
- Bibliotherapy: better than nothing at 4 weeks
- Life review: good effect at 2 to 8 weeks, better at 3 mos.
- Exercise: as effective as CBT in some studies, better at 12 and 24 weeks followup.
- Most promising for primary care settings, based on research review: bibliotherapy, life-review, PST, and behavioral activation therapy

Behavior therapy

- Focuses solely on understanding the relationship between mood and behaviors.
- Concentrates on heightening awareness of negative behaviors and helping to better identify positive moments.

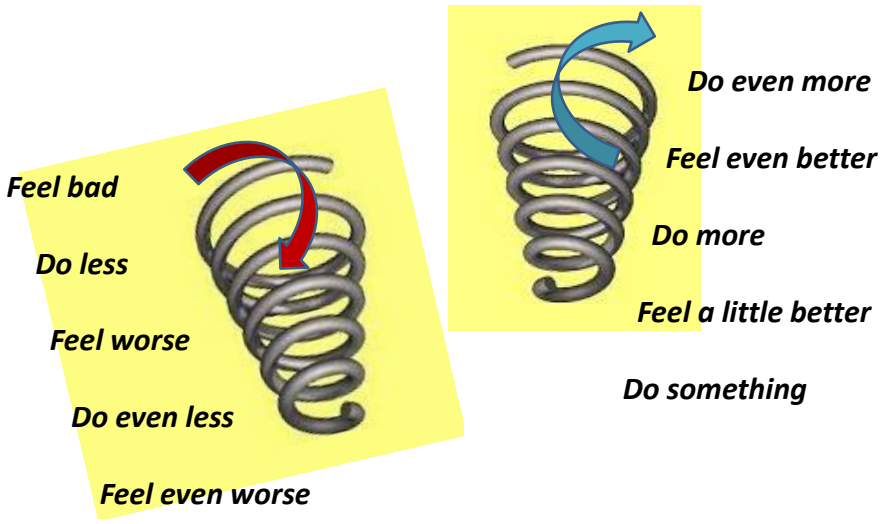
Behavior therapy approach

- Facilitate structured increases in enjoyable activities that increase opportunities for contact with positive reinforcement:
  - monitor moods and behaviors,
  - record pleasant and unpleasant events,
  - notice connections between interactions and mood, and
  - ultimately increase participation in more positive experiences.

Behavior therapy strategies

- Activity selection and scheduling
- Functional assessment and contingency management/support
- Graded task assignment, graded exposure, and rehearsals.
- Applied behavior analysis can be extremely helpful

Little steps affect the spiral



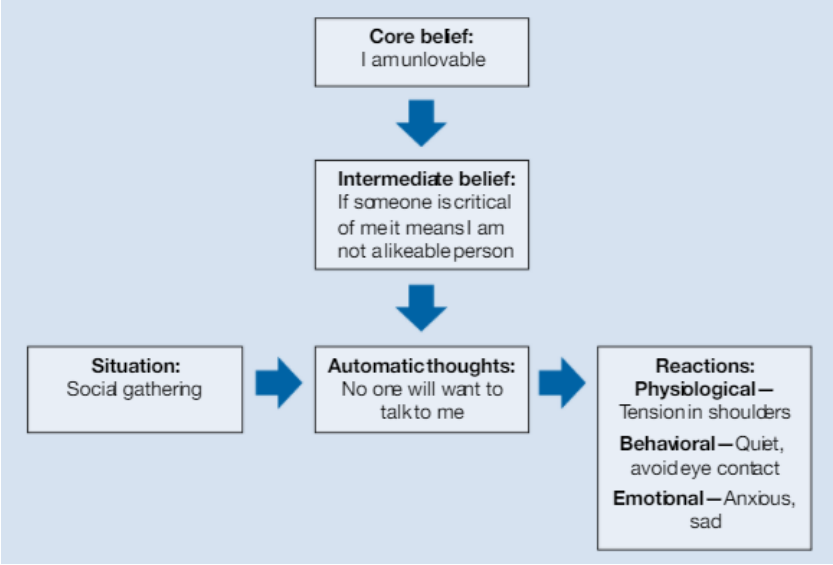
Cognitive-Behavioral Therapy

- Stresses that specific thinking patterns cause depression.
- Focus on identifying the belief systems used on a daily basis, with the end goal of correcting unrealistic beliefs by replacing them with more realistic attitudes.
- Motto: "changing how you think will change the way you feel"

CBT structure/approach

- Theory-based, but simple
- Client and therapist actively work together
- Treatment is directive, time limited, structured, and problem focused
- Focus is on the present
- Homework
- Regular feedback

CBT cognitive model



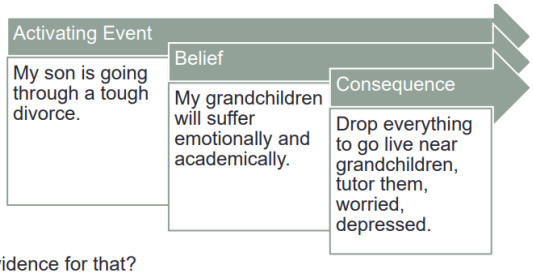
CBT process

- Change behaviors
  - Increase reinforcement in environment
  - Reduce time spend in low-reinforcement environments or activities
  - Increase approach vs. avoidance behaviors, e.g. going to the senior center instead of staying at home

CBT process, cont'd

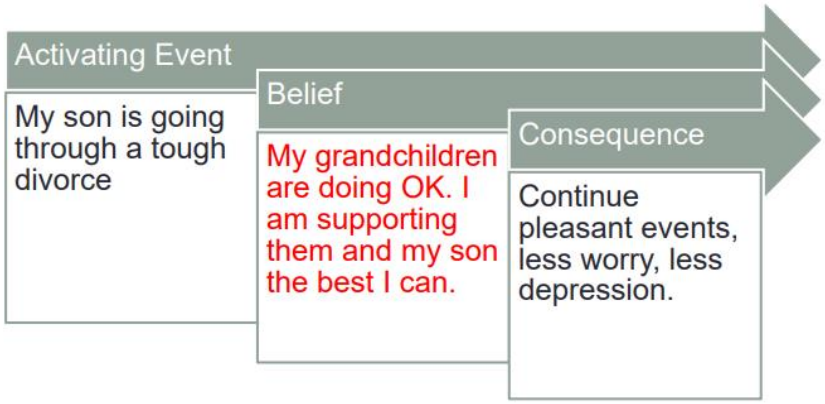
- Change thoughts
  - Practice identifying and replacing unhelpful, damaging thoughts that have become automatic, e.g.:
    - "If I go to meet that group for coffee, I'll probably say something stupid (which would be AWFUL)." vs.
    - "If I go for coffee, I'll probably have fun, and the likelihood of me saying something stupid is low. Even if I did, nothing really awful would happen."

CBT: cognitive restructuring



- Is it realistic? What is the evidence for that?
  - Grades haven't actually gone down. Grandchildren were good students up to this point and are doing OK. They have us.
- What are other possible alternatives/explanations?
  - Going into puberty. Normal grief at divorce.
- What was the actual situation?
  - Son is sad and anxious. I can help support without needing to be there 24/7. I am supporting my grandchildren, tutoring them, and making sure they are OK.
- Is it *possible* or *likely*? (feared situation)
  - It's possible but not likely that my grandsons will suffer significantly and long-term.

CBT: cognitive restructuring



CBT: behavioral activation

- Also called “pleasant events”
- Increase activities that
  1. Person finds pleasant (different for everyone!)
  2. Are happening at low frequency
- For depressed people, activities often need to be scheduled.
- For older adults, requires creativity and flexibility to find what works for them.

CBT benefits

- Client becomes "scientist" of their own behavior, active part of their treatment
- Easily connects physical problems/co-morbidities with behaviors, thoughts, and mood
- Great for older people or anyone dealing with medical problems/pain!
- Individual therapy is effective with older adults – group CBT is not

CBT for older adults

- CBT tools and worksheets are fine to use with older adults, but consider modifications:
  - slower pace
  - larger, simpler worksheets
  - may be helpful to focus on thoughts around transitions/losses
  - mid-week phone call to follow up
  - take notes, record sessions

CBT for suicide prevention

- Safety planning
- Create a "Hope Kit"
- Cognitive therapy targeting suicide-related thoughts
- Behavioral activation
- Managing medical illness
- Decreasing loneliness
- Increasing a sense of purpose
- Simple, practical homework
- Relapse prevention

Contraindications for CBT

- High levels of cognitive impairment
- Severe depression with psychotic features
- Severe anxiety with high levels of agitation
- Severe medical illness
- Sensory losses

Cognitive Bibliotherapy

- Uses books and writing exercises to help seniors identify and challenge negative thinking, fight fatigue, minimize helplessness, and challenge the maladaptive ways you think.
- Generally, a therapist will recommend books on the subject of depression or related writing exercises and check in via email, telephone or in person.

Bibliotherapy

- One study found genres most effective at improving mental health were poetry, psychology / self-help, and religion.
  - Participants were most fond of novels, history, psychology / self-help.
- Bibiotherapy was found to improve self-management as well as depression.
- Using audio-books was found to be effective for various mental health symptoms.

Dialectical Behavior Therapy

- Developed by Marsha Linehan at UW to treat borderline personality disorders and suicidality
- DBT focuses on the dialectic of accepting oneself while also acknowledging that change is necessary.
- Goal to treat symptoms by identifying emotional experiences that lead to depression, thus reducing emotional vulnerability and decreasing depressive symptoms.

DBT components

- Weekly individual therapy to target your problem behaviors and develop individualized solutions through the use of DBT Skills.
- Telephone coaching to promote skill use where it matters most – in the real world.
- Weekly Skills Training – classroom-style group, combines teaching, discussion and practice exercises.

Skills Modules:

- Mindfulness,
- Distress Tolerance,
- Emotion Regulation and
- Interpersonal Effectiveness.

Intensive Short-Term Dynamic PTx

- Theory of ISTDP is that depression arises because of unawareness of the problematic patterns or core relational themes which impact your life.
- While ISTDP accepts the presence of faulty cognitions, like CBT, the causality is thought to be reverse of CBT theory. Unconscious emotions lead to unconscious anxiety, which is managed by unconscious defenses, such as hopeless, helpless, or self-deprecating cognitions.

ISTDP approach

- Strives to quickly attain character change by using intense and focused therapeutic techniques.
- Focuses on identifying conflicts, unresolved emotional issues, heightening insight, and seeing issues beyond your awareness.
- Research has shown it to be very effective with anxiety and also with treatment-resistant depression.

Interpersonal Psychotherapy

- IPT is based on the idea that negative social interactions often precede depression and that depression can lead to further negative interpersonal conflicts.
- Aim is to learn how to identify where the glitches occur, how to better address them, and how to prevent relapse of late life depression.

IPT approach

- Focuses on current interpersonal difficulties rather than behaviors, thoughts or unresolved issues.
- For seniors, IPT looks at four areas of conflict:
  - 1) grief after the loss of a loved one;
  - 2) conflict in significant relationships;
  - 3) difficulties adapting to changes in relationships; and
  - 4) life circumstances and difficulties stemming from social isolation.

Life Review vs reminiscence

Life Review Psychotherapy

- Life Review Psychotherapy works from the long held belief that reminiscence is a universal and naturally occurring mental process.
- Helps seniors put their life story into perspective with the goal of coming to terms with losses, failures, and missed opportunities as well as marking significant moments.

Reminiscence therapy

Watt & Wong identified six types of reminiscence:

- Transmissive (sharing one's personal legacy and cultural heritage),
- Narrative (primary descriptive vs interpretive),
- Escapist (glorifying the past, aka defensive),
- Obsessive (guilt over one's mistakes/failures),

and – most beneficial to successive aging:

- Integrative and
- Instrumental reminiscence.

From https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5653382/: Musavi, Mohammadian, Mohammadinezhad (2017). The effect of group integrative reminiscence therapy on mental health among older women living in Iranian nursing homes. Nursing Open. 2017 Oct; 4(4): 303–309.

Integrative reminiscence therapy

- Aim is for a constructive re-appraisal of interpretations and emotions towards past self-defining events:
  - Accepting the past and its negative events,
  - Looking at the past life as a valuable and satisfying period,
  - Finding meaning in life,
  - Narrowing the gap between reality and the ideal,
  - Recognizing a continual pattern between past and present.

Effectiveness

- Many depressed people ignore positive information and focus on memories that support their dysfunctional views, so this therapy helps lead clients to seek fuller, more detailed accounts of their life story and more balanced interpretations of past events.
- Research showed that integrative reminiscence group therapy:
  - Increased confidence and life satisfaction
  - Reduced depressive symptoms
  - Significantly affected general mental health, physical dimensions, anxiety, insomnia, and social functioning.

Instrumental reminiscence therapy

- Process to recollect past coping activities and strategies, plans developed to solve difficult situations, goal-directed activities, and achievement of one's own goals or goals one helped others meet.
- Helps put aside roles and commitments that are no longer rewarding or attainable, and puts the focus on other goals more in tune with current conditions of living.
- Can be especially helpful for people who may not be able to do what they were once capable of doing.

Problem Solving Therapy

- Sometimes called Solution-Focused Therapy
- Short term, intensive intervention for seniors with no cognitive issues.
- Client and therapist identify problems and develop an action plan for:
  - how to clarify and define the problem;
  - how to set a realistic goal;
  - how to generate multiple solutions;
  - how to evaluate and compare your solutions, and then
  - how to put your chosen solution into action.

Effective

- Most research studied in-person PST of 6-12 weeks duration:
- Significant reduction in depression
- Also effective in reducing disability
- Found to be an effective treatment for older people with major depressive disorder.

PST for Executive Dysfunction

- Used for adults in later life who have both depression and cognitive functioning issues.
- Differs slightly from Problem Solving Therapy in that client and therapist work to:
  - Address ways to help improve day-to-day life living with cognitive decline;
  - Improve coping by helping find ways to communicate more effectively;
  - Structure the day better; and
  - Address any other issues that arise.

Other therapeutic interventions

- Bright light therapy, particularly for seasonal affective disorder
- Group music therapy
- Art therapy
- Occupational therapist home evaluation
- Mindfulness meditation

Exercise

- Provides health benefits and protecting against depression.
- Research points to high and low intensity training vs progressive resistance in terms of improving depression
- Promotes a more positive attitude towards the aging process.
- Added value of reduced isolation and increased social participation

Fall prevention

- Fear of falling is common in older adults, and is associated with social isolation and reduced social participation.
- Social participation and engagement in meaningful activities are important to healthy aging.
- Socially active older adults have improved quality of life, health, and wellbeing, and are less likely to be depressed or isolated.

Bipolar and Related Disorders

- About bipolar in general
  - Combined prevalence for all types 1.8%.
  - 60-80% of risk from genetic influences.
  - Most people who meet criteria for bipolar disorder experience a number of episodes, on average 0.4 to 0.7 per year, lasting three to six months.
  - Treatments are similar across all types of bipolar disorders.

Bipolar "kindling"

- Hypothesis: when people who are genetically predisposed toward bipolar disorder experience stressful events, their stress threshold for mood changes becomes progressively lower, until episodes start (and recur) spontaneously.
- Evidence supports an association between early-life stress and dysfunction of the hypothalamic-pituitary-adrenal axis (HPA axis) which may lead to bipolar disorder.

Manic episode criteria

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week, and present most of the day, nearly every day (or any duration if hospitalization is needed), plus:
- Three or more (4+ if only irritable mood) of the following symptoms:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep (not insomnia)
  - Pressured speech or more talkative than usual
  - Flight of ideas or racing thoughts
  - Distractibility
  - Increase in goal-directed activity or psychomotor agitation
  - Reckless/risky activities

Manic episode criteria, cont'd

- As well as:
  - Mood disturbance severe enough to cause marked impairment in occupational functioning in usual social activities or relationships, or
  - Necessitates hospitalization to prevent harm to self or others, or
  - Has psychotic features: about ¾ of people in manic episode have delusions
- Not due to substance use or abuse (e.g., drug abuse, medication, other treatment), or a general medical condition (e.g., hyperthyroidism).
  - A full manic episode emerging during antidepressant treatment, that persists, does qualify.

Manic episodes

- People in an episode often don't perceive any problem or need for treatment and resist efforts to be treated.
- Mood can shift rapidly to anger or depression.
- 10% of bipolar cases: mania onset age 50+.
- Later onset associated with more neurological impairment.

Hypomanic Criteria

- Same symptom set as manic episode
- May not be viewed by the individual as pathological, but others may be troubled by erratic behavior
- If psychotic features are present, the episode is manic.
- Shorter length of time: 4+ consecutive days
- Not as severe impairment: no marked distress or impairment in functioning, no need to hospitalize.

Bipolar I criteria

- At least one manic episode.
- May have psychotic symptoms, but occurrence not better explained by psychotic disorder.
- Minor or Major Depressive Episodes often present, but not required.

Bipolar I: prevalence, course

- 0.6% in the U.S., up to 0.6% across 11 countries
- Men 10% higher than women
- Average onset age 18
- Onset in late-mid-life or later life should point to ruling out FTD or substances, e.g. medications

Bipolar I: course

- 90% of people who have a manic episode go on to have recurrent mood episodes.
- 60% of manic episodes are immediately followed by depressive episodes.
- Longitudinal data suggests that, the more episodes one has, the shorter the periods of recovery between episodes. So early intervention is essential.

Bipolar I: risk factors

- Genetic/family history isstrongest and most consistent risk factor: 10x risk
- Socioeconomic: long-term stress, history of child abuse; more common in high-income countries; among separated, divorced, or widowed

Bipolar I: prognostic factors

- Psychotic features in an episode strongly predict psychotic features in future episodes.
- Mood-incongruent psychotic features associated with incomplete inter-episode recovery.
- Suicide risk 15x, may account for 1/4 of all suicides

Bipolar I: prognostic factors

Most severe cases (hospitalized) resulted in:

- 50% recovery (by criteria) within 6 weeks,
- 98% recovery within 2 years,
- 72% had no symptoms at all within 2 years, and
- 43% achieved functional recovery.

But 40% had another episode within 2 years,

- And 19% switched phases without recovery.

Bipolar I: culture, gender

- Little cultural information, due to lack of transculturally validated diagnostic instruments
- Women have more rapid cycling and mixed states, and different comorbidities – eating disorders, alcohol use/abuse

Bipolar I: functional impact

- 6th leading cause of disability worldwide
- Functional recovery lags behind symptom improvement
- About 30% have severe work impairment
- Poor performance on cognitive tests

Bipolar I: differential dx

- Major depression,
- Other bipolar disorders,
- Anxiety disorders,
- Substance or medication induced,
- ADHD,
- Personality disorders.

Bipolar I: comorbidity

- Most common is any anxiety disorder, in 75%
- Substance use disorder over 50%, and those with both are at greater risk for suicide attempt
- ADHD, any disruptive, impulse-control or conduct disorder
- High rates of serious and/or untreated medical conditions, especially metabolic/endocrine disorders, migraine, cardiovascular disorders, and obesity.

Bipolar II: criteria

- At least one Major Depressive Episode lasting at least 2 weeks, and at least one Hypomanic Episode lasting at least 4 days
- No full Manic or Mixed Manic Episodes
- Occurrence of episodes not better accounted for by any psychotic disorder
- Symptoms or unpredictability caused by frequent alteration in mood states causes distress or functional impairment.

Bipolar II: prevalence

- 0.8% in US, 0.3% internationally
- 5-15% rapid cycling (4+ episodes in a year)
- Mixed episodes common, particularly for women

Bipolar II: course

- Can begin in late adolescence or throughout adulthood, but average onset in mid-20s, slightly later than for Bipolar I, but earlier than for major depressive disorder.
- Most often begins with depressive disorder and isn't recognized as Bipolar II until hypomanic episode occurs:
  - About 12% of individuals had initial depression diagnosis.
  - Many have several episodes of major depression prior to first recognized hypomanic episode.

Bipolar II is *NOT* "milder"

- More lifetime episodes (at both poles) than for depression or Bipolar I.
- More chronic, more time in depressive phase, which is more enduring and disabling
- Interval between episodes tends to decrease with age ("kindling")
- High suicide risk – 1/3 report hx of attempt; lethality may be higher with II than I.

Bipolar II: risk factors

- Genetic / family history – strongest with relatives with Bipolar II vs Bipolar I or depression.
- Age of onset appears influenced by genetic factors.
- Suicidality 6.5x higher risk among first-degree relatives of Bipolar II compared with Bipolar I

Bipolar II: prognostic factors

- Rapid-cycling = poorer prognosis
- Less severe depression and younger age make recovery to previous functioning level more likely = longer illness had adverse effects
- Better functional recovery for people with more education, with fewer years of illness, and who are married.
- Earlier onset in childhood or adolescence associated with more severe lifetime course.

Bipolar II: culture, gender

- Mixed findings on gender: some samples suggest higher rate in women, but may reflect gender differences in seeking treatment.
- Childbirth may be specific trigger for hypomanic episode in early postpartum – elated mood, reduced sleep.

Bipolar II: functional impact

- Most return to full functioning between episodes.
  - 15%+ continue inter-episode dysfunction.
  - 20% go into another episode without any recovery.
- Cognitive impairment similar to Bipolar I.
- Functional, and particularly occupational recovery lags substantially behind symptom improvement.
- Prolonged unemployment associated with more episodes of depression, older age, increased rates of panic disorder, and lifetime history of alcohol use disorder.

Bipolar II: differential dx

- Major depression is most challenging, especially with irritability.
- Cyclothymia – numerous periods of symptoms that don't meet symptom or duration criteria. If a major depressive disorder occurs after the first 2 years of cyclothymia, the additional diagnosis of Bipolar II is given.
- Schizophrenia/psychotic disorders – helpful to have fuller history.
- Anxiety disorders and substance use disorders.
- ADHD often misdiagnosed as Bipolar II.
- Personality disorders.

Bipolar II: comorbidity

- 60% have 3+ co-occuring mental disorders, which have strong associations with mood states:
  - anxiety/eating with depressive states
  - substance use with manic states).
- 75% have an anxiety disorder, which most often predates bipolar onset.
- 37% substance use disorder.
- 14% at least one lifetime eating disorder.

Rapid-Cycling Bipolar I or II

- Four or more mood episodes (i.e., Major Depressive, Manic, Mixed, or Hypomanic) per 12 months
- May occur in any order or combination
- Must be demarcated by …
  - a period of full remission, or
  - a switch to an episode of the opposite polarity.
- Rapid cycling associated with worst prognosis.

Cyclothymic disorder: criteria

- For at least 2 years (1 in children and adolescents), numerous periods with hypomanic symptoms and numerous periods of depressive symptoms, none of which meet episode criteria (insufficient number or duration)
  - Present at least ½ the time and not symptom-free for longer than 2 months
  - Criteria for major depressive, manic, or hypomanic episode have never been met
  - Symptoms not better explained by any schizophrenia/psychotic disorder
  - Symptoms not attributable to substance effects or other medical condition
  - Symptoms cause clinically significant distress or functional impairment.

Cyclothymia: prevalence, course

- Lifetime prevalence 0.4% to 1%.
- In mood disorder clinics, ranges from 3% to 5%.
- Usually begins in adolescent to early adult years.
- Usually has insidious onset and persistent course.

Cyclothymia: risk, prognostic factors

- More common in family members of people with Bipolar I.
- Relatives of people with cyclothymia more commonly have major depression, Bipolar I or II.
- 15-50% risk to develop Bipolar I or II.
- Increased familial risk of substance-related disorders.
- Comorbidity with substance-related d/o, sleep disorders, ADHD

Cyclothymia: culture, gender

- Appears equally common between genders, but women may be more likely to present for treatment than men.

Cyclothymia: differential dx

- Medical-condition related bipolar or depressive disorders, e.g. hyperthyroidism: look at history, labs.
- Substance/medication induced: look at whether mood swings resolve after use ended
- Rapid-cycling Bipolar I or II: if episode criteria met, it's not cyclothymia
- Borderline personality disorder: both may be diagnosed if criteria for both are met.
- If subsequent episode of major depression, mania or hypomania, diagnoses changes to that disorder and cyclothymic diagnosis is dropped.

Other bipolar disorders

- Short-duration hypomanic episodes (2-3 days) or depressive episodes (4-13 days).
- Hypomanic episodes with insufficient symptoms.
- Hypomanic episode without prior depression.
- Short duration cyclothymia: less than 2 years.
- Substance/Medication-induced bipolar disorder.
  - Some debate about whether marijuana can induce Bipolar disorders.

Other bipolar disorders

- Due to medical condition:
  - stroke, traumatic brain injury, HIV infection, multiple sclerosis, porphyria, and rarely temporal lobe epilepsy.
- Other specified:
  - Symptoms cause distress or impairment but don't meet full criteria for any of the disorders.
- Unspecified:
  - Insufficient info, e.g. in ER

Bipolar treatment - meds

- Lithium – best evidence. Watch for thyroid levels.
- Anticonvulsants:
  - Carbamazepine (tegretol), better for manic episodes and rapid cycling, or psychotic features.
  - Sodium valproate (Depakote) – effective for manic episodes.
  - Lamotrigine (Lamitcal) – some efficacy in treating unipolar depression, particularly most severe.
  - Topiramate (Topamax) – effectiveness unknown.

Bipolar meds

- Antipsychotic medications, typically combined with mood stabilizer:
  - Olanzapine (Zyprexa) effective at preventing relapses, but not as robust as lithium
  - Quetiapine (Seroquel) suggested by some; less info on risperidone (Risperdal), ariprazole (Abilify), ziprasidone (Geodon), or clozapine (Clozaril).
- Benzodiazepines –short courses for stabilizing mood

Bipolar: other meds

- Antidepressants: no benefit, can trigger mania
- Calcium channel blockers (for heart problems/ hypertension) have lower side effects but also less effective – for people who can't tolerate other meds.
- Omega-3 fatty acids – limited evidence.

Bipolar: therapy factors

- Individuals typically seek help during depressive episode and are unlikely to complain of hypomania, so other informants can be helpful.
- While in manic phase, focus on building therapeutic alliance.

Bipolar: psychotherapy

- Focused at symptom alleviation, trigger identification, preventive maintenance, coping skills and strategies for recognizing prodromal symptoms preceding a relapse, particularly mania.
- Most evidence for CBT, family-focused therapy, psychoeducation, interpersonal, and social rhythm therapy… but most studies done on Bipolar I.

Bipolar: other interventions

- Electroconvulsive therapy (ECT): may be helpful for people who don't respond to other treatments.
- Mood stabilizing effect from keeping a strict sleep schedule and regular activity schedule, healthy diet, exercising regularly, practicing relaxation techniques, and developing a solid support system.
- Care coordination among providers: frequent and careful monitoring of symptoms and side effects.
  - Takes time to determine optional dose of meds;
  - Small difference between beneficial vs toxic dose;
  - Stopping medications risks relapse.

Assessment / tests for older adults

- Cognition/memory
- Mood/anxiety
- Functional/ADL
- Informant / collateral tools

Common cognitive testing tools

SLUMS	St Louis University Mental Status Examination More sensitive vs old MMSE mini-mental
RUDAS	Rowlands Universal Dementia Assessment Screen Useful with lower literacy, non-native English speakers
MOCA	Montreal Cognitive Assessment More sensitive to MCI, available in 35 languages
Trails	Trails A & B – correlates with driving risk
Frontal	Frontal Assessment Battery – looks at reasoning, mental flexibility, executive functioning

Mood/anxiety assessment tools

GDS	**Geriatric Depression Scale** 30 items to assess mood over past week Also has 15-item short version
GAI	**Geriatric Anxiety Inventory** 20 items to assess anxiety severity Also has 6-item short version

Functional assessment tools

ADL	**Activities of Daily Living:** bathing, dressing, toileting, transfer/mobility, grooming, feeding
IADL	**Instrumental Activities of Daily Living:** shopping, meal prep, phone use, housekeeping, laundry, transportation, medication, finances

Informant / collateral tools

IQCODE	**Informant Questionnaire on Cognitive Decline in Elderly** 26 items on everyday situations; short form has 16.
CORNELL	**Cornell Scale for Depression in Dementia** 19 items, rates signs if person may not report.
ADRS	**Aphasia Depression Rating Scale** 9 items, rates signs if person cannot speak.

Compare client's self-rated, clinician-rated, and caregiver-rated data for the most robust picture of the client's situation.

Aging Care Consultation Services

Helping you solve your puzzle so all the pieces fit into place

Karin Taifour, MA LMHC GMHS
206.999.5934
Karin @ **agingcareconsult.com**

This presentation and other resources are on my website for you to download at
https://agingcareconsult.com

at the very bottom of the "Professionals" page

Again, you're always welcome to call or email me for free information and resources!