Geriatric bipolar disorder: General principles of treatment

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INTRODUCTION

The treatment of older bipolar patients differs from the treatment of younger patients [1]. Up to 25 percent of all bipolar patients are older adults [2], and the absolute number of geriatric bipolar patients is expected to increase as the world's population ages over the next several decades [3,4].

This topic reviews the general principles of treating geriatric bipolar disorder. The epidemiology, pathogenesis, clinical features, assessment, diagnosis, acute treatment and prognosis, and maintenance treatment of geriatric bipolar disorder are discussed separately, as are the epidemiology, clinical features, diagnosis, acute treatment, and maintenance treatment of bipolar disorder in mixed-age patients.

- (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Geriatric bipolar disorder: Treatment of mania and major depression".)
- (See "Geriatric bipolar disorder: Maintenance treatment".)
- (See "Bipolar disorder in adults: Epidemiology and pathogenesis".)
- (See "Bipolar disorder in adults: Clinical features".)
- (See "Bipolar disorder in adults: Assessment and diagnosis".)
- (See "Bipolar mania and hypomania in adults: Choosing pharmacotherapy".)
- (See "Bipolar major depression in adults: Choosing treatment".)

- (See "Bipolar disorder in adults: Choosing maintenance treatment".)

DEFINITION OF GERIATRIC BIPOLAR DISORDER

The minimum age used to define geriatric bipolar disorder is generally 60 years [5,6]. However, some authorities use an age cut-off of 50, 55, or 65 years [7]. The International Society for Bipolar Disorders Task Force on Older-Age Bipolar Disorder recommends that older age bipolar disorder include patients ≥50 years [6].

Geriatric bipolar disorder includes both aging patients whose mood disorder presented earlier in life and patients whose mood disorder presents for the first time in later life [1,8]. The International Society for Bipolar Disorders Task Force uses the term “older age bipolar disorder” instead of “geriatric bipolar disorder” [6].

Bipolar disorder in both geriatric and younger patients is characterized by episodes of major depression (table 1), mania (table 2), and hypomania (table 3) [9]. The clinical features and diagnosis of geriatric bipolar disorder are discussed separately. (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis".)

GENERAL PRINCIPLES

Goal of treatment — The goal of acute treatment for late-life bipolar mood episodes is remission, which is defined as resolution of the mood symptoms or improvement to the point that only one or two symptoms of mild intensity persist. If psychotic features (eg, delusions or hallucinations) are also present, resolution of these features is required for remission. For patients who do not achieve remission, a reasonable goal is response, which is defined as stabilization of the patient’s safety and substantial improvement in the number, intensity, and frequency of psychotic and mood symptoms; response is often operationalized as a reduction of baseline symptoms ≥50 percent, using standardized assessment scales. (See 'Monitoring' below.)

After acute treatment, the goals are functional recovery and prevention of recurrent mood episodes. Functional recovery includes restoring occupational performance, social relationships, daily routines, and meaningful life interests [10].

Initial evaluation — Treatment for geriatric bipolar patients begins with a psychiatric and general medical history, mental status and physical examination, and focused laboratory and imaging studies. The evaluation establishes the diagnosis of bipolar disorder, the comorbid

disorders that require treatment, contraindications to treatment (eg, renal impairment and use of lithium, or hepatic disease and use of valproate), as well as biopsychosocial factors that may affect treatment and recovery. The assessment for late-life bipolar disorder is discussed separately. (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Assessment'.)

Level of care — The treatment setting for geriatric bipolar disorder depends upon the type and severity of symptoms, presence of comorbid psychopathology (eg, substance use disorder), level of psychosocial functioning, and available support. Hospitalization may be required for safety and stabilization, particularly for severely ill patients with:

- Suicidal ideation with a specific plan and intent
- Delusions or hallucinations that place the patient at imminent risk of coming to harm
- Catatonia, mixed features, or rapid cycling
- Significant behavioral disturbances (eg, aggression or wandering)
- Substance use that is exacerbating the mood episode
- Impaired functioning (eg, inability to feed or clothe oneself) and lack of support

Moderately ill patients with late-life bipolar disorder can generally be treated in a partial hospital (day) program or residential facility (eg, nursing home), including patients with suicidality that does not pose an imminent risk (eg, fleeting thoughts of killing oneself with vague or nonexistent plans and no intent). An outpatient clinic may be suitable for less acutely ill patients (eg, thoughts that family members would be better off if the patient was dead, with no plan or intent to commit suicide).

Pharmacologic issues — Clinicians should “start low and go slow” when prescribing medications for geriatric bipolar patients, especially frail, medically compromised patients who have difficulty tolerating medications [11-15]. Comorbid diseases, concomitant medications, and age-related physiologic changes can alter a drug’s pharmacodynamics and pharmacokinetics, which often affect therapeutic and adverse responses. Thus, we suggest that clinicians:

- Start the drug at a low dose
- Increase the dose by small increments every one to seven days
- Exercise caution regarding side effects
- Coordinate care with other clinicians who are managing general medical comorbidity

Older bipolar patients taking multiple medications due to comorbid illnesses are at risk for drug-drug interactions. As an example, serum concentrations of lithium may be increased by concomitant use of angiotensin converting enzyme inhibitors, calcium antagonists,

cyclooxygenase 2 inhibitors, loop diuretics, nonsteroidal anti-inflammatory drugs, and thiazide diuretics [16], and adjustment of lithium doses to target an age-appropriate therapeutic serum level is warranted [17]. Specific interactions of any drug with other medications may be determined by using the Lexicomp drug interactions tool (Lexi-Interact Online) included in UpToDate.

A review of 34 treatment guidelines from 19 countries found that recommendations for choosing medications for geriatric bipolar disorder are generally similar to recommendations for younger adults, with the caveat that general medical comorbidity and concomitant medications can render older adults more vulnerable to adverse effects [18]. The relative lack of recommendations that are specific to older patients is due in part to the lack of randomized trials in this population. Other than trials such as GERI-BD, which compared lithium with divalproex for acute, late-life mania [19], evidence for the efficacy of medications largely comes from subgroup analyses of results for geriatric patients enrolled in randomized trials conducted with mixed-age adult bipolar patients (18 to 65 years). These studies generally show that response is comparable for older and younger patients [20,21]. However, target serum concentrations (eg, lithium) may be lower for older patients than younger patients [22].

Geriatric bipolar mania and bipolar major depression are commonly treated with a combination of psychotropic medications [23-25]. In addition, mood episodes with psychotic symptoms generally require a second-generation antipsychotic such as quetiapine or olanzapine, either as monotherapy or combined with lithium or valproate [26-28]. More detailed information about choosing medications for patients with geriatric bipolar disorder is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression" and "Geriatric bipolar disorder: Maintenance treatment".)

Monitoring — Compared with younger patients, geriatric bipolar patients suffer more general medical comorbidity and medication side effects, and thus often require more vigilant treatment monitoring [29]. Hospitalized geriatric patients are monitored daily. Outpatients are commonly seen on a weekly basis until they have responded (eg, the number, intensity, and frequency of mood symptoms has improved by at least 50 percent) and have tolerated the medication regimen for two to four weeks. At that point the patient can be seen every two to four weeks until they remit. Following remission, patients receive maintenance treatment and the schedule for monitoring is decreased. (See "Geriatric bipolar disorder: Maintenance treatment", section on 'Monitoring the patient'.)

The patient's psychiatric status can be quantified with standardized rating scales such as the clinician administered Brief Psychiatric Rating Scale (assesses psychosis) [30], clinician administered Young Mania Rating Scale (assesses mania) [31], and the self-report Patient Health

Questionnaire – Nine Item (assesses depression) (table 4) [32], but this is not standard clinical practice.

Adjunctive psychoeducation — Patients with geriatric bipolar disorder may possibly benefit from adding group psychoeducation to pharmacotherapy:

- A two-year randomized trial compared a group psychoeducation program plus usual care with usual care alone in 183 patients with serious mental illness (including 20 percent with bipolar disorder) [33]. The group program met weekly during year 1 and monthly during year 2, and focused upon social rehabilitation and social skills training; usual care included pharmacotherapy and case management. Follow-up assessments one year posttreatment found that improvement of psychiatric symptoms and psychosocial functioning was greater in patients who received adjunctive psychoeducation.

- A prospective observational study evaluated a 12-week, adjunctive group psychoeducation program focused upon medication adherence in 21 older bipolar patients, most of whom were depressed [34]. Clinically small to moderate improvement in depressive symptoms occurred in the 16 patients who completed the study.

General medical comorbidity — Geriatric bipolar mood episodes, which are comorbid with or secondary to general medical conditions, are managed with concurrent treatment of the medical condition and mood symptoms. Mood episodes associated with general medical conditions are discussed separately. (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'General medical conditions'.)

Managing nonresponse — If patients with geriatric bipolar disorder do not respond to initial treatment, we suggest the following steps:

- Verify that the patient has bipolar disorder rather than a different condition such as secondary mania. (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Differential diagnosis' and "Bipolar disorder in adults: Assessment and diagnosis", section on 'Differential diagnosis'.)

- Ask about adherence with treatment because nonadherence is common during treatment of psychiatric disorders; improving adherence with pharmacotherapy or psychotherapy homework can convert nonresponders to responders. (See "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy".)

- Determine whether there are significant life stressors (eg, social isolation) that need to be addressed.

- Establish if comorbid psychopathology (eg, anxiety disorder, substance use disorder, or dementia) is present and treated (see "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Psychiatric disorders'). If a disorder other than bipolar disorder is more salient, treatment should refocus upon the primary problem.

Making referrals — Primary care clinicians often treat geriatric patients with bipolar disorder. However, the diagnosis may not be clear or these clinicians may not be comfortable managing the disorder and thus refer patients to psychiatrists; referrals are also made if requested by patients. In addition, referral is usually indicated for patients with:

- Severe mood episodes
- Numerous recurrent episodes (eg, three or more in the span of three years)
- Suicidal ideation or behavior (see "Suicidal ideation and behavior in adults")
- Aggressive behavior (see "Bipolar mania and hypomania in adults: Choosing pharmacotherapy", section on 'Agitation' and "Assessment and emergency management of the acutely agitated or violent adult")
- Psychotic features (eg, delusions or hallucinations) (see "Bipolar disorder in adults: Clinical features", section on 'Psychosis')
- Catatonia (see "Catatonia in adults: Epidemiology, clinical features, assessment, and diagnosis")
- Mixed features (see "Bipolar disorder in adults: Clinical features", section on 'Mixed features')
- Poor judgment that places the patient or others at imminent risk of harm
- Psychiatric comorbidity, such as anxiety disorders or substance use disorders (see "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Psychiatric disorders')
- Nonresponse to pharmacotherapy and psychotherapy
- Bipolar major depression (table 1)

In addition, referral to social work may be appropriate; indications include problematic social circumstances, such as intimate partner violence or other trauma, social isolation, poverty, or homelessness. Social workers may also facilitate treatment uptake and/or additional supports

that may be needed to help manage aging-related issues such as reduced ability to drive/travel or need for assistance with meals.

CHOOSING SPECIFIC TREATMENTS

Choosing specific treatments for geriatric bipolar disorder is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression" and "Geriatric bipolar disorder: Maintenance treatment".)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Bipolar disorder".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Bipolar disorder (The Basics)" and "Patient education: Coping with high drug prices (The Basics)")
- Beyond the Basics topics (see "Patient education: Bipolar disorder (Beyond the Basics)" and "Patient education: Coping with high prescription drug prices in the United States (Beyond the Basics)")

These educational materials can be used as part of psychoeducational psychotherapy. (See "Bipolar disorder in adults: Psychoeducation and other adjunctive maintenance

psychotherapies", section on 'Group psychoeducation'.)

The National Institute of Mental Health also has educational material explaining the symptoms, course of illness, and treatment of bipolar disorder in a booklet entitled "Bipolar Disorder," which is available online at the website or through a toll-free number, 866-615-6464. The web site also provides references, summaries of study results in language intended for the lay public, and information about clinical trials currently recruiting patients.

More comprehensive information is provided in many books written for patients and family members, including The Bipolar Disorder Survival Guide: What You and Your Family Need to Know, written by David J. Miklowitz, PhD (3rd edition, published by The Guilford Press, 2019); An Unquiet Mind: A Memoir of Moods and Madness, written by Kay Jamison, PhD (published by Random House, 1995); and Treatment of Bipolar Illness: A Casebook for Clinicians and Patients, by RM Post, MD, and GS Leverich, LCSW (published by Norton Press, 2008).

The Depression and Bipolar Support Alliance (their website or 800-826-3632) is a national organization that educates members about bipolar disorder and how to cope with it. Other functions include increasing public awareness of the illness and advocating for more research and services. The organization is administered and maintained by patients and family members, and has local chapters.

The National Alliance on Mental Illness (their website or 800-950-6264) is a similarly structured organization devoted to education, support, and advocacy for patients with any mental illness. Bipolar disorder is one of their priorities.

OTHER RESOURCES

The International Society for Bipolar Disorders (ISBD) is a global organization which fosters international collaboration in education, research, and clinical care to improve the lives of those living with bipolar disorder and related conditions. The website provides general resources to help educate and support patients with bipolar disorder and their families. One of their publications is the Patient and " Patient and Family Guide to the CANMAT and ISBD Guidelines on the Management of Bipolar Disorder." In addition, the ISBD Older Adults with Bipolar Disorder task force, which focuses on improving outcomes for older-age patients with bipolar disorder, published "A Guide for Older Adults with Bipolar Disorders and Care Partners," which is available online.

SUMMARY

- **Definition** – The minimum age used to define geriatric bipolar disorder is generally 60 years. Bipolar disorder in both geriatric and younger patients is characterized by episodes of major depression (table 1), mania (table 2), and hypomania (table 3). (See 'Definition of geriatric bipolar disorder' above.)

- **Initial evaluation** – Treatment for geriatric bipolar patients begins with a psychiatric and general medical history, mental status and physical examination, and focused laboratory and imaging studies. (See 'Initial evaluation' above.)

- **Pharmacologic issues** – Pharmacotherapy for older age bipolar disorder generally requires starting the drug at a low dose, increasing the dose by small increments every one to seven days, caution regarding side effects, and coordinating care with other clinicians who are managing general medical comorbidity. Treatment guideline recommendations for choosing medications for geriatric bipolar disorder are generally similar to recommendations for younger adults, with the caveat that general medical comorbidity and concomitant medications can render older adults more vulnerable to adverse effects. (See 'Pharmacologic issues' above.)

- **Monitoring** – Compared with younger patients, geriatric bipolar patients often require more vigilant treatment monitoring. (See 'Monitoring' above.)

- **Adjunctive psychoeducation** – Patients with geriatric bipolar disorder may possibly benefit from adding group psychoeducation to pharmacotherapy. (See 'Adjunctive psychoeducation' above.)

- **Managing nonresponse** – Management of acute, geriatric bipolar mood episodes that do not respond to initial treatment generally includes verifying that the patient has bipolar disorder rather than a different condition, asking about adherence with treatment, determining whether there are significant life stressors that need to be addressed, and establishing if comorbid psychopathology is present. (See 'Managing nonresponse' above.)

- **Making referrals** – Primary care clinicians often treat geriatric patients with bipolar disorder. However, the diagnosis may not be clear or these clinicians may not be comfortable managing the disorder and thus refer patients to psychiatrists. In addition, referral is usually indicated for patients with severe mood episodes, numerous recurrent episodes, suicidal ideation or behavior, aggressive behavior, psychotic features, catatonia, mixed features, poor judgment, psychiatric comorbidity, nonresponse to treatment, or bipolar major depression. (See 'Making referrals' above.)

- **Choosing specific treatments** – Several specific treatments are available for geriatric bipolar disorder. (See "Geriatric bipolar disorder: Treatment of mania and major depression" and "Geriatric bipolar disorder: Maintenance treatment".)

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