Older Adults with Bipolar Disorder: Guidelines for Primary Care Providers

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Activity Objectives

1. Identify epidemiologic statistics related to older adults with bipolar disorder.
2. Describe differences between older adults and younger individuals with regard to bipolar disorder.
3. Describe signs and symptoms of bipolar disorder in older adults.
4. Identify the recommended tool for assessing bipolar disorder in older adults.
5. Discuss clinical implications for nurses working with older adults with bipolar disorder.

Author Disclosure Statement

The authors disclose that they have no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.

Abstract:

The purpose of this article is to present evidence-based guide-lines to facilitate early diagnosis and appropriate treatment of older adults with symptoms of bipolar disorder. Assessment criteria, diagnostic tools, and interventions to optimize care of older adults with bipolar disorder—with a focus on implications for primary care providers—are described.

Article:

The U.S. Department of Health and Human Services (1999) reported that 44 million adults, or approximately 23% of the U.S. adult population, were diagnosed with a mental illness during a 1-year time frame, with symptoms continuing beyond 1 year in approximately 7% of those diagnosed. It is estimated that the number of older adults with a psychiatric disorder will grow to 15 million by the year 2030 (American Association for Geriatric Psychiatry, 2004). With a prevalence of 5% to 20%, dementia and depression are the most common psychiatric diagnoses in adults age 65 and older (Kennedy-Malone, Fletcher, & Plank, 2004). Older adults are not as likely as younger people to seek help for mental health issues (American Psychological Association, 2003), and when they do, they are more likely to do so through their primary care practitioners (Areán, Alvidrez, Barrera, Robinson, & Hicks, 2002).

Although bipolar disorder is considered an illness of the young, it is reported that 10% of inpatient psychiatric ad-missions among older adults are for bipolar disorder (Aizenberg, Olmer, & Barak, 2006). This is impressive, considering that older adults are reported to more frequently seek outpatient help and to less frequently be hospitalized for mental illness (Jin et al., 2003). Greater incidence of bipolar disorder is seen among the young-old (ages 60 to 64) group, and the incidence progressively declines in older cohorts (Gilmer, Ojeda, Folsom, & Fuentes, 2006). This age-related attrition might be due in part to age-related mortality, but it also means that older adults living with bipolar disorder are doing so during their most active years.

Despite bipolar disorder being treatable, the mortality, social, and economic impacts are significant (Swann, 2006). The disease is markedly underdiagnosed, with estimates of true incidence as high as 40% (Phelps & Ghaemi, 2006). The cost of caring for older adults with bipolar disorder or schizophrenia are greater than for other psychiatric diagnoses with which older adults are more likely to receive (Gilmer et al., 2006). In addition, older adults with mood or affective disorders are at highest risk for suicide, and the majority of those who committed suicide had visited their primary care provider within the previous month (Conwell & Duberstein, 2001).

NEED FOR ACCURATE AND EARLY DIAGNOSIS

Comorbidities and polypharmacy often mask the presence of bipolar disorder, leaving many individuals untreated or treated incorrectly (Kennedy, 2008). Misdiagnosis precludes accurate assessment of the number of older adults living with bipolar dis-order. One survey among individuals with bipolar disorder found that an astounding 69% were originally misdiagnosed. They received an average of 3.5 diagnoses and saw an average of four physicians before an accurate diagnosis was determined (Glick, 2004). Depression was a frequent misdiagnosis, and those with bipolar disorder were prescribed antidepressant medications, which inadvertently placed them at risk for manic episodes and increased risk of rapid cycling (Glick, 2004). The purpose of this article is to offer guidelines to improve accurate assessment and appropriate treatment of bipolar disorder in older adults.

TABLE

COMMON SYMPTOMS OF MANIA AND DEPRESSION

Mania	Depression
Heightened self-esteem, with tendency to make grand and unattainable plans	Sad mood
More goal-directed activity	Reduced interest in most or all activities
Talkative; pressured speech	Psychomotor irritation or slowing
Flight of ideas and poor judgment	Indecisiveness or lack of focus
Easily distracted, restless	Hypersomnia or insomnia
Diminished need for sleep	Lack of energy
Risky behavior; unnecessary participation in enjoyable activities that have harmful outcomes	Decreased or increased hunger, with weight loss or gain
Excessive happiness, excitement	Feelings of insignificance or guiltiness
Irritability; agitation; aggressive behavior	Persistent thoughts of dying
Spending sprees	Hopelessness
Drug abuse	Anxiety

IDENTIFICATION OF BIPOLAR DISORDER IN OLDER ADULTS

Because primary care providers may be the first to encounter older adults with symptoms of bipolar disorder, it is important for them to have basic knowledge of the symptoms (Table) (Depp & Jeste, 2004; Evans, 2000; Hoblyn, 2004; McDonald, 2000; Sajatovic, 2002a). Providers who are not familiar with this disorder will find evidence-based information beneficial.

Diagnostic Challenges

Differential assessment must include consideration of alternate psychiatric and medical conditions and comorbidities, which should be assessed, considered, and ruled out. Substance abuse, posttraumatic stress disorder, anxiety, and dementias are among the psychiatric diagnoses that may be seen in older adults with bi-

polar disorder (Sajatovic, Blow, & Ignacio, 2006). Manic behavior may be caused by untoward effects of infection or medications, as well as medical diagnoses such as cardiac, cerebral, thyroid, and metabolic disorders (Depp & Jeste, 2004; Hoblyn, 2004).

Symptoms may include confusion, disorientation, irritability, and distractibility (Kennedy, 2008), which correspond to numerous other dis-ease processes and medication side effects. Symptoms are often seen as milder than those in younger patients (Sajatovic, 2002a). In addition, prodromal symptoms in the cognitive, behavior, or affective realms are only reported in half of those diagnosed with bipolar disorder (Mantere, Suominen, Valtonen, Arvilommi, & Isometsä, 2008). Mania occur-ring in later life can be attributed to medication or to medical conditions, including cardiovascular disease, cerebrovascular accident, metabolic disorder, infection, and brain tumor (Hoblyn, 2004; McDonald, 2000).

ALGORITHMS

Using current evidence, the Assessment of Older Adults with Symptoms of Bipolar Disorder Algorithm (Figure 1) and the Interventions for Older Adults with Bipolar Disorder Algorithm (Figure 2) were developed to guide primary care providers in the appropriate diagnosis and management of care of older adults with bipolar disorder. The assessment algorithm guides providers through a differential diagnosis decision path using assessment tools and diagnostic examinations. By following the assessment algorithm, it can be determined whether the behavior is likely due to bipolar disorder. If it is determined that bipolar disorder is the appropriate diagnosis, the interventions algorithm presents psychoeducational, psychotherapeutic, pharmacological, consultative, and referral options.

Assessment

Figure 1 contains an algorithm for the assessment of older adults with suspected symptoms of bipolar dis-order. Clinical assessment includes accurate history taking, interviewing, and reviewing medications, as well as using established assessment tools. Taking an accurate history has crucial importance in making the diagnosis of bipolar disorder. Bipolar disorder is minimally characterized by at least one manic or hypomanic episode of at least 1-week duration with at least one depressive occurrence (American Psychiatric Association, 2000; Hoblyn, 2004). Manic episodes are diagnosed with the significant presence of at least three of the following: grandiosity, increased self-esteem, pressured speech, decreased need for sleep, racing thoughts, flight of ideas, easy distractibility, psychomotor agitation, increased goal-directed behavior, and excessive participation in apparently pleasurable behaviors that may have disagreeable consequences (Hoblyn, 2004). Intervals of racing thoughts, reduced sleep, agitation, distractibility, or disorientation that alternate with depressed features and are combined with a family history of bipolar disorder are highly indicative of a diagnosis of bipolar disorder (Hoblyn, 2004; Kennedy, 2008). In contrast, low energy and anhedonia combined with a depressed mood are only moderately indicative of this diagnosis (Phelps & Ghaemi, 2006).

Patient interviews should include detection of symptoms associated with depression, mania, and/or hypomania, as well as an accurate family history (Evans, 2000; Hoblyn, 2004). Patient and family information should be obtained from the patient, caregiver, or a close family member/friend. This assessment should include an individual and family history of mental illness (Depp & Jeste, 2004; Hoblyn, 2004; McDonald, 2000; Umpathy, Mulsant, & Pollock, 2000) and an exploration of the person's coping abilities and strengths (Craighead & Miklowitz, 2000; Depp & Jeste, 2004), as well as the person's internal and external resources (Craighead & Miklowitz, 2000; Depp & Jeste, 2004; Hoblyn, 2004).

A thorough physical examination must also be performed to exclude physical causes of the symptoms and comorbidities (Colenda, 2002; Hoblyn, 2004; Shulman & Herrmann, 1999). Complete medication review should identify drug-drug interactions, drug-food interactions, adverse side effects, and dosage not appropriate to the person and behavior. Examples of medications that can produce unusual or abnormal behavior include antidepressant agents, benzodiazepines, amphetamines, prednisone, and captopril (Colenda, 2002; Hoblyn, 2004).

Laboratory and radiological diagnostics can eliminate other etiologies of symptoms that are diagnostic of bipolar disorder. They can also provide baseline information that can be used if pharmacological intervention is deemed appropriate. The following diagnostic tests should be considered: complete blood count to exclude infection and determine platelet count (Colenda, 2002; Hoblyn, 2004; McDonald, 2000), complete metabolic panel to eliminate electrolyte imbalance and evaluate renal function (Colenda, 2002; Ho-blyn, 2004; McDonald, 2000; Neu & DeNisco, 2007), thyroid-stimulating hormone to detect inadequacies of the thyroid gland (Colenda, 2002; Hoblyn, 2004), drug levels based on the person's current regimen to exclude drug toxicology (Neu & DeNisco, 2007), electrocardiogram to assess cardiac function (Colenda, 2002; McDonald, 2000; Neu & DeNisco, 2007), and computed tomography or magnetic resonance imaging to exclude neurological processes (Evans, 2000; McDonald, 2000; Neu & DeNisco, 2007).

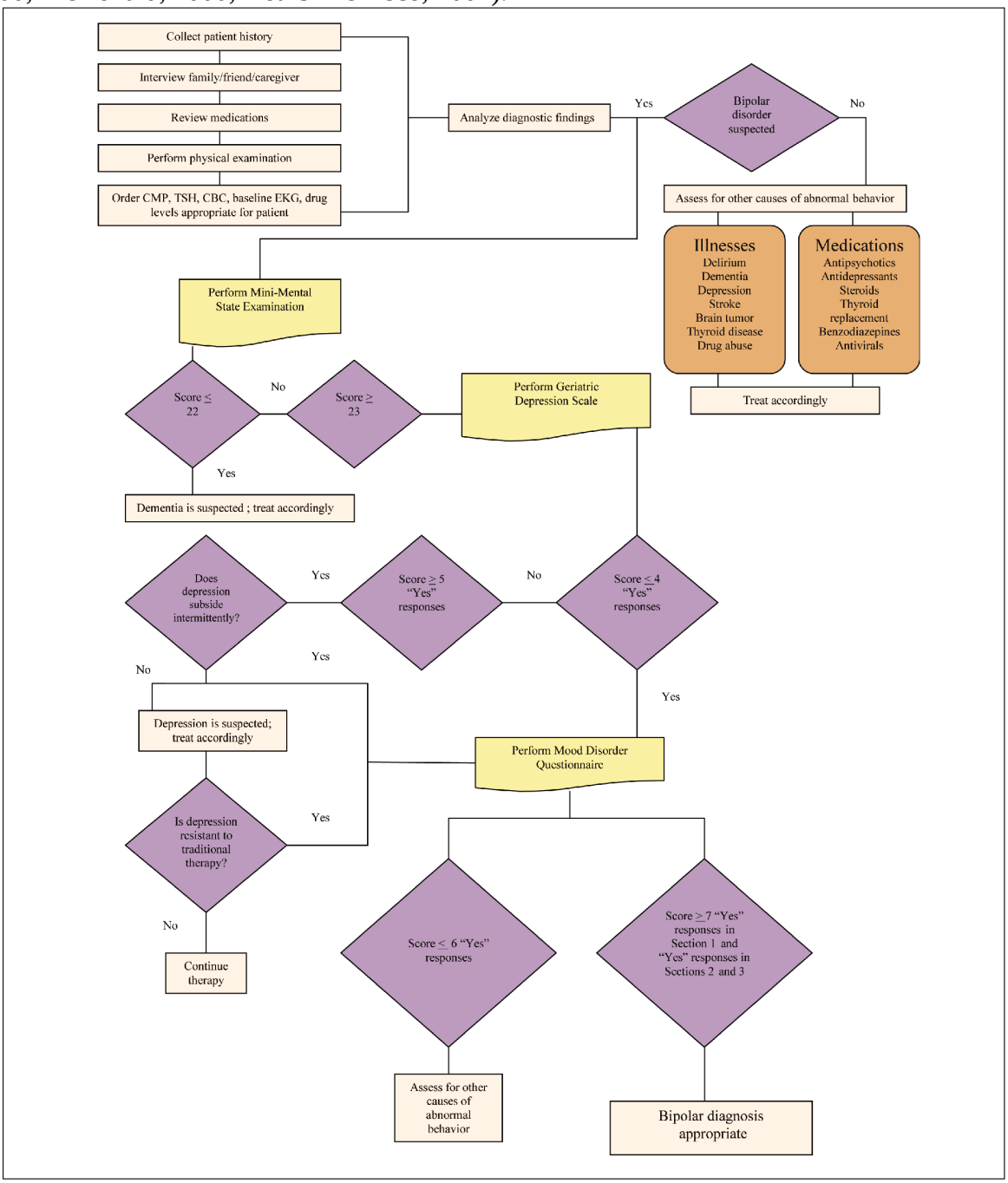

Figure 1. Assessment of older adults with symptoms of bipolar disorder.
Note. CBC = complete blood count; CMP = complete metabolic panel; EKG = electrocardiogram; TSH = thyroid-stimulating hormone.

Several tools or questionnaires are widely available to assess older adults with symptoms consistent with bipolar disorder. The 20-item Mini-Mental State Examination is the most widely used tool to screen cognitive

function and how it changes over time (Folstein, Folstein, & McHugh, 1975; Tombaugh, 2005). During original testing in 1991, it was found to have good test-retest reliability and convergent validity (Mitrushina & Satz, 1991).

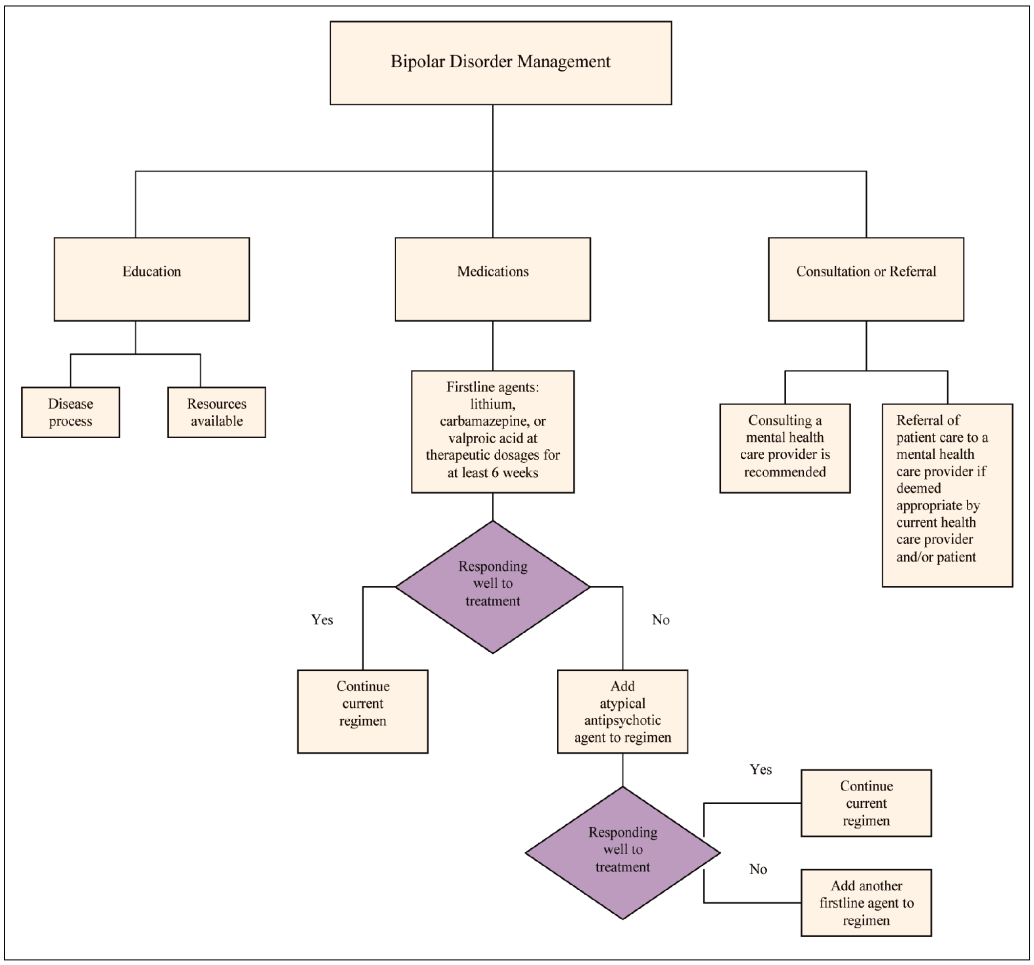

Figure 2. Interventions for older adults with bipolar disorder.

The 30-item Geriatric Depression Scale (GDS) is considered the best tool to screen for geriatric depression (Kurlowicz, 2002; Yesavage et al., 1982-1983). The shorter 15-item GDS was validated with good internal consistency reliability (0.86), retest reliability (0.81), and validity consistent with earlier versions (Brown & Schinka, 2005). While specificity of the 15-item GDS was found to be lower than that of the original, sensitivity was higher with similar criterion validity; criterion validity is reported as comparable or superior to other depression screening tools (Wancata, Alexandrowicz, Marquart, Weiss, & Friedrich, 2006).

KEYPOINTS

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1. Because older adults with mental health issues often seek help through their primary care providers, it is imperative for providers to facilitate early diagnosis, appropriate treatment, and referral when necessary.
2. Differential assessment of bipolar disorder in older adults must include consideration of alternate psychiatric and medical conditions and comorbidities.
3. Clinical assessment includes accurate history taking, interviewing, and reviewing medications, as well as using established assessment tools.
4. Psychoeducational and psychotherapeutic support, as well as medication, are important components in the treatment of bipolar disorder among older adults.

The Mood Disorder Questionnaire is commonly recommended and used to screen patients for bi-polar disorder (Phelps & Ghaemi, 2006; Twiss, Jones, & Anderson, 2008). While the predictive value of the Mood Disorder Questionnaire has been questioned related to scores indicating low to moderate sensitivity (detecting the presence of bipolar disorder), moderate to high specificity (detecting the absence of bipolar disorder) is reported (Hirschfeld et al., 2003; Phelps & Ghaemi, 2006). Therefore, this tool is still deemed useful and is recommended.

Interventions

Figure 2 contains an algorithm to guide provider intervention for older adults with bipolar disorder. Psycho-educational and psychotherapeutic support are important components in the treatment of bipolar disorder among older adults (Dolder, Depp, & Jeste, 2007). They are crucial to successful treatment and need to be avail-able for patients, caregivers, family members, and friends (Dolder et al., 2007). Health care providers need to offer information about the disorder as well as resources available online and in the community, such as sup-port groups (Craighead & Miklowitz, 2000; Depp & Jeste, 2004; Hoblyn, 2004). Online information and support are available from nation-ally accredited associations, including the American Psychological Association (2003), the Geriatric Mental Health Foundation (http://www. GMHFonline.org), the National Alliance on Mental Illness (http://www. nami.org), and the National Institute of Mental Health (http://www.nimh. nih.gov).

Medication is an important element of care. Although bipolar disorder is a chronic illness, symptom severity often decreases with pharmacological intervention (Hoblyn, 2004). Medication management requires frequent monitoring of the patient for adverse reactions and of laboratory reports specific to the medication (Colenda, 2002; Hoblyn, 2004). Older adults are at increased risk for developing ad-verse reactions, as well as medication toxicity related to comorbid disease processes and multiple medications, such as nonsteroidal anti-inflammatory drugs, thiazide diuretics, and angiotensin-converting enzyme inhibitors, which may decrease kidney function, causing an increase in patients' lithium levels (Colenda, 2002; Neu & DeNisco, 2007). When choosing a medication, primary care providers should con-sider the patient's allergies, current medications, comorbidities, and renal and hepatic function.

Recommended firstline agents for treatment of bipolar disorder are mood-stabilizing agents including lithium (Eskalith®), valproic acid (Depakene®), and carbamazepine (Tegretol®) (Dolder et al., 2007; Kennedy, 2008). As with many medications, it is recommended that doing begin low then slowly increase (Sajatovic, 2002b). Patients need to be closely monitored for adverse effects (Dolder et al., 2007; "Reviewing Treatments," 2004). Regular monitoring of lithium levels is required every 3 months for the first 6 months; closer surveillance is needed if the patient becomes symptomatic (Taylor & Laraia, 2009). If the patient does not respond to mood-stabilizing agents, atypical antipsychotic drugs are possible alternative treatments; however, there are no current safety data related to use of these medications with older adults, and these medications are not recommended if dementia is suspected ("Pharmacotherapy," 2001).

If a trial with one of these medications is not successful, referral to a psychiatric provider for further evaluation is recommended. If medication is not effective or not tolerated in managing bipolar disorder, electro-convulsive therapy may be an option (Kennedy, 2008; Sajatovic, 2002b). Consultation needs to be considered, as management of bipolar disorder is complicated (Hoblyn, 2004). Close collaboration between the primary care practitioner and psychiatric provider is essential (Hoblyn, 2004). If the patient is not agreeable to the referral, the management guidelines in Figure 2 are recommended.

IMPLICATIONS

When caring for older adults with bipolar disorder, patient safety is a major nursing concern. First, medication management requires monitoring of safe therapeutic serum levels, as well as symptoms of the numerous side effects. Adverse effects such as dehydration and electrolyte imbalances, for example, with lithium, need to be monitored (Sicuro, 2003). Second, since it is estimated that 10% to 15% of all patients with bipolar disorder commit suicide (Evans, 2000), it is important for nurses to be aware of suicide risk.

Nurses at all levels of care are in optimal positions to educate patients and families about bipolar disorder, assessment criteria, medications, and other interventions. Collaboration with patients, families, primary care providers, and mental health care providers is essential to plan and implement the most effective treatment; shared decision making remains the preference for patients with psychiatric disorders (Adams, Drake, & Wolford, 2007). Care needs to be focused on decreasing morbidity and mortality in bipolar disorder. Advanced practice nurses who assess, diagnose, and coordinate the care of older adults need to be familiar with the diagnostic criteria and treatment options to best manage bipolar disorder in this population. It is advantageous for advanced practice nurses to establish with the patient and family a plan outlining safety precautions and referral for emergency treatment when the patient exhibits signs of harmful behavior to himself or herself and others. Finally, family members can assist older adults with bipolar disorder by monitoring adherence to medication regimens and by surveillance of patient- and family-identified triggers and prodromal signs of relapse.

CONCLUSION

The incidence of bipolar disorder in older adults is increasing (Depp & Jeste, 2004). The quality of life of these individuals can improve with early and appropriate diagnosis and intervention. To optimize care of older adults with bipolar disorder, primary care providers need to be informed regarding symptoms, assessment criteria, diagnostic tools, and care management options. It is imperative that primary care providers of older adults incorporate current evidence-based knowledge of bipolar disorder into their practice to facilitate early diagnosis, appropriate treatment, and referral when necessary.

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