

**Minnesota Gerontological Society
Center on Aging
MAGEC**

Co-sponsored Webinars

Bipolar Disorder in the Older Adult

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Our case study

- 83 year old white male, 6 ft, ~160 lbs
- Retired Lutheran Minister
- Retired Navy Reserve Chaplain
- Coast Guard in his early 20's
- Married to third wife, adult children on both sides

Bipolar Disorder diagnosis

- Diagnosed at age 50
- First onset likely 17
- Bipolar Disorder II
 - Major Depression
 - Hypomania
 - Possibly rapid cycling

Treating Bipolar Disorder in Older Adults

- We know very little.
- Older adults rarely recruited specifically and rarely analyzed as a subgroup
- And those who are included in studies are usually...



So we still rely on expert opinion for treatment for old adults

- Lithium as first-line mood-stabilizer – most evidence for any age
- Valproate as second-line – based on about 830 (non-elder) patients
- A handful of FDA-approved for mania, no anti-depressants
- Some evidence for behavioral therapies
 - CBT
 - Family system therapy

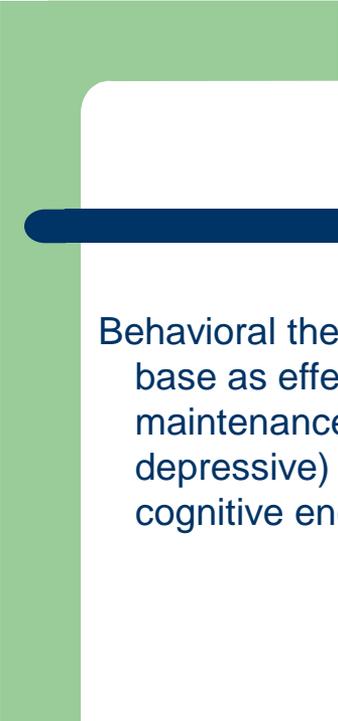


The biggest issue for cognitively healthy older adults may be related to drug toxicity and potential polypharmacy problems

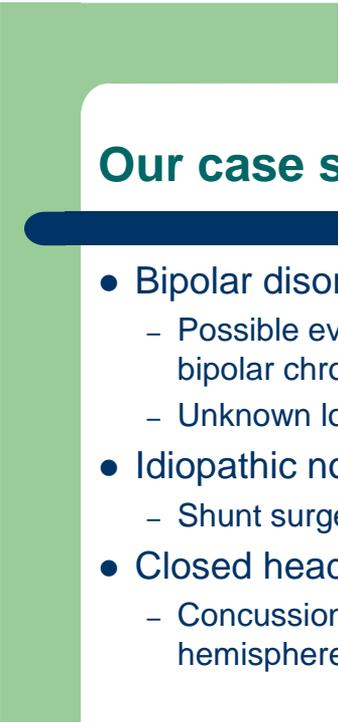


Our case study – pharmacological issues

- Impaired renal function
- Allergic to lithium
- Uses gabapentin (Neurontin) as mood stabilizer
- Uses escitalopram (Lexapro) for depression (currently)
- Uses risperidone (Risperidal) for behavioral issues believed related to bipolar disorder



Behavioral therapies also have some evidence base as effective, particularly for bipolar maintenance phase (neither manic nor depressive) – but this relies on the patient's cognitive engagement and training capacity.



Our case study – brain health

- Bipolar disorder
 - Possible evidence of brain volume loss with bipolar chronicity
 - Unknown long-term effects of psychotropic drugs
- Idiopathic normal pressure hydrocephalus
 - Shunt surgery, second surgery to reposition
- Closed head TBI
 - Concussion, 2 small brain bleeds, right hemisphere (where the shunt is)



So what might we expect to see in our case study?



Bipolar II with trauma

- Depression
- Often comorbid anxiety
- Hypomania with agitation, aggression
- Balance problems (left leg weak from TBI)
- Cognitive impairment , short term memory loss
- Paranoid delusions
- Memory problems

Dementia (in addition)

- SLUMS – validated on educated men in VA – best fit for case study - few months post-TBI: mild cognitive impairment
- Speech and language problems
- Trouble eating or swallowing
- We haven't seen wandering or restlessness

Our case study – LTC career

- Pre-TBI
 - Cognitive capacity for compensation and collusion with spouse
- Post -TBI precipitated LTC for both spouses
- 3 settings so far (in order):
 - Rehab for TBI
 - Pod-based LTC up to hospice but not full SNF
 - Assisted living community (long hallways)

Our case study – current issue



Our case study - symptoms

- 83 year old white male presenting with
 - Severe incontinence
 - Aggression/ agitation
 - Verbal outbursts (that would make a sailor proud!)
 - Excessive sleeping
 - Socially withdrawn
 - Wheelchair dependent
 - Only ADLs without assist is brushing teeth and feeding.

Possible explanations

- Bipolar Disorder
- NPH
- Other progressive dementia

- Ruled out infections – UTI, pneumonia

Bipolar Disorder

- Major depressive episode
 - If so, this one is unlike any before
- The diagnosis of bipolar disorder
 - Bipolar may have higher risk for developing dementia than unipolar

- Doesn't cover all symptoms,
- Could assign incontinence to deliberate intent (or lack thereof)
- Conversely, lack of motivation is a historical issue
- Action would be pharmaceutical
 - Different antidepressant
 - Discontinue risperidal for apathy but leaves behavioral issues unaddressed

NPH

- Known cause for dementia – usually frontal lobe and includes apathy, inertia, memory problems, incontinence, mobility problems
- Possibly the shunt no longer works
- Doesn't account for aggression and verbal outbursts
- (But what if in combination with bipolar II??)

Other progressive dementia

- Other undiagnosed forms – may be history on his father's side, but uncertain.
- Given all of the issues listed above, is it possible his brain is just at it's limit?
- And given this kind of difficulty, the idea of late-onset bipolar is pretty challenging

“Responsible party” issues

- The worry staff rely too much on the “bipolar” label and not see what else is there?
- The fantasy of handing off to the County the parent who has always been intensely high-maintenance
- The fear of being forced to take him into my home
- The gardening philosophy of benign neglect

- The often quiet but pervasive social pressure of “doing everything you can” to improve QoL or longevity or – often – both
- The pervasive social pressure for a “good death”
- What is the treatment goal? Whose QoL do we improve? His? His wife’s? The community? How do I find balance for all within this system of individuals and communities?

The only thing I have to offer (nothing new)

These are “wicked problems” we face for complex frail elderly people.

Let us all be as kind to one another as we all muddle our way through decisions with no universal right answers, or even right at all. Practice self-compassion.

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Next Webinar – August 21 at noon
The Impact of Hoarding Disorder on Seniors
with Janet Yeats, MA LMFT