# 9 Psychotherapy and Psychosocial Interventions, Family Psychoeducation, and Support for Older Age Bipolar Disorder

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## 9.1 Introduction

Psychological interventions are critical in the treatment of bipolar disorders (BDs) as an adjunct to pharmacotherapy and other somatic treatments. These interventions are particularly important in older adults, who face psychosocial challenges, cognitive difficulties, high rates of medical comorbidity, disability, and increased rates of suicide [1, 2]. In this chapter, we review outpatient psychological treatments for older adults with bipolar disorders (OABDs). We broadly define as psychological any intervention, program, or model that includes psychological approaches, e.g., psychotherapeutic, psychosocial, skills training, psychoeducational, and family support interventions. We discuss potentially relevant clinical issues, such as disability, cognitive impairment, emotion regulation, and suicidality. Finally, a clinical vignette and a list of clinical "pearls" highlight important therapeutic targets for this population.

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## 9.2 Literature Search

We selected studies in older adults with bipolar patients through searches of PUBMED (1968–2015), PsychINFO (1968–2015), and Cochrane database. The searches used combinations of the following keywords: psychosoc*, psychother*, psychoedu*, family support, bipolar, mood disorders, old*, and elder* (the * denotes any combination of the word). We also explored previous reviews and meta-analyses in this population [1–5]. As a comparison, we selected articles, reviews, and meta-analyses on psychological interventions for BD in young and middle-aged adults [6–13].

The searches generated 257 articles. Forty-four of these articles were literature reviews (including systematic reviews and meta-analyses) and twelve reported results from clinical trials. Two of the latter twelve articles discussed a day hospital treatment for older adults with unipolar or bipolar depression [14] and an inpatient dual-diagnosis program for patients with alcohol dependence and unipolar or bipolar affective disorder [15]. One trial focused on an educational intervention for families living with a bipolar patient [16]. Three were clinical trials involving young to middle-aged patients (average age <55 years): smoking cessation for people with severe mental illness [17] (mean age = 47.2 years); a pharmacist-psychiatrist collaborative medication therapy management clinic for patients with severe mental illness [18] (mean age = 49 years; 7 %, $N = 5$, BD); and a psychoeducational program for euthymic patients with BD [19] (mean age = 52).

The main focus of this chapter is a review of the remaining six (out of the twelve) clinical trials' articles that concentrate on older adults with bipolar disorders (OABDs) (i.e., the study participants or a designated group of participants had an average age of 60 years or older). These six articles reported results of four distinct clinical trials (three RCTs) that include the following four outpatient interventions: a manualized psychosocial skills and psychoeducation training program [Helping Older People Experience Success (HOPES)] [20, 21]; an intensive clinical and psychosocial management program [Enhanced Clinical Intervention (ECI)] [22]; a medication adherence intervention [Medication Adherence Skills Training for Bipolar Disorder (MAST-BD)] [23]; and a bipolar disorder medical care model [Bipolar Medical Care Model (BCM)] [24, 25]. Table 9.1 summarizes the studies and the interventions in these six manuscripts.

In summary, the four distinct clinical trials shared the following characteristics: (1) The whole sample or a subgroup of the sample had a diagnosis of BD I, II, or NOS; (2) the average age of the whole sample (or a designated subsample of older adults) was 60 years or older; and (3) each trial tested an outpatient psychological intervention. In the following section, we present a detailed description of each intervention and summarize the study findings.

**Table 9.1** Description of studies of psychological interventions for older adults with bipolar disorder

| Articles | Groups | RCT | Total *N* | Mean age | Sample description | Recruitment | Attrition |
|---|---|---|---|---|---|---|---|
| Bartels et al. [20], Mueser et al. [21] (same sample) | HOPES versus TAU | Yes | 183 | 60.2 | 20 % BD, 28 % schizophrenia, 28 % schizoaffective, 24 % MDD | Community Mental Health Centers | Social skills: attendance across sites 75 % year 1, 70 % year 2; Preventive health care: attendance 66 % across sites |
| Fagiolini et al. [22] | SCBD versus SCBD + ECI | Yes | 463 | 40.2 (39 participants were ≥65 years of age) | BD I ($n$ = 313), BD II ($n$ = 87), NOS ($n$ = 53), or schizoaffective disorder bipolar type ($n$ = 10) | University Specialty Clinics for BD; Behavioral Health Clinic | Whole sample: 32 % discontinued over 2 years |
| Kilbourne et al. [24, 25] (same sample) | BCM versus TAU | Yes | 58 | 55.3 (30 % were ≥60 years of age) | BD I (77 %), BD II (5 %), or BD NOS (18 %), and cardiovascular disease risk factors | VA Mental Health Facility | Self-management: 85 % of participants completed all session; Care management: 73 % completed at least 6 contacts |
| Depp et al. [23] | MAST-BD | No | 21 | 60 (range: 53–73 years) | BD I (62 %), BD II (38 %) | Different sources (e.g., VA, geropsychiatry service) | 76 % of participants completed the intervention; 86 % of sessions were attended by completers |

(continued)

**Table 9.1** (continued)

| Articles | Groups | Outcomes | Summary of results |
|---|---|---|---|
| Articles | Groups | Outcomes | Summary of results |
| Bartels et al. [20], Mueser et al. [21] (same sample) | HOPES versus TAU | Functioning, symptoms, self-efficacy, and service use | HOPES had greater improvement than TAU in performance measures of social skill, psychosocial and community functioning, negative symptoms, self-efficacy, and service use |
| Fagiolini et al. [22] | SCBD versus SCBD + ECI | Clinical status and quality of life | No significant differences in improvement in Clinical Global Index (CGI) and the Global Assessment of Functioning (GAF), but ECI participants had significantly greater improvement in quality of life. No significant differences in treatment outcomes were found between patients of different ages, except for a greater GAF improvement in late-life versus adult participants |
| Kilbourne et al. [24, 25] (same sample) | BCM versus TAU | Physical and mental health-related quality of life, functioning and bipolar symptoms, self-management efficacy | BCM participants had greater improvement in physical health-related quality of life, no difference in mental health-related quality of life, functioning, symptoms, and self-management efficacy |
| Depp et al. [23] | MAST-BD | Feasibility and acceptability, adherence to psychiatric medications, medication management ability, attitudes toward medication, symptoms, and health-related quality of life | Evidence of feasibility (76 % completed the intervention and 86 % of sessions were attended), acceptability (participants reported high treatment satisfaction) and improvement in medication adherence, medication management ability, depressive symptoms, and quality of life |

*BCM* Bipolar Medical Care Model, *ECI* Enhanced Clinical Intervention, *HOPES* Helping Older People Experience Success, *MAST-BD* Medication Adherence Skills Training for Bipolar Disorder, *SCBD* Specialized Care for Bipolar Disorder, *TAU* Treatment as Usual

## 9.3 Helping Older People Experience Success (HOPES)

HOPES is a manualized psychosocial skills and psychoeducation training program developed for older adults with severe mental illness, including bipolar disorder, schizophrenia, schizoaffective disorder, and major depression, living in the community. The aim of the intervention is to improve overall psychosocial function, while reducing long-term medical burden [20, 21, 26]. The HOPES program includes one year of intensive skills training and health management, followed by a 1-year maintenance period. Both the first intensive year and second maintenance years include weekly skills classes, bimonthly community practice trips, and one-on-one meetings with a nurse, monthly in the first year, with decreased frequency in the second year (Table 9.1).

### 9.3.1 Intensive Psychosocial Skills Training

HOPES interventions are grounded in the principles of social skills training through the use of modeling and role-playing techniques, provision of positive and corrective feedback, and completion of homework assignments. The curriculum includes seven modules: communicating effectively, making and keeping friends, making the most of leisure time, healthy living, using medications effectively, and making the most of a healthcare visit [21]. Each module includes 6–8 component skills with one specific skill taught each week by a master's prepared rehabilitation specialist. Participants practice the skills in community group outings. Another form of community practice involved the participant identifying an "indigenous supporter" (family member, friend, clinician, spouse) who could help facilitate opportunities to practice the targeted skills in a safe and natural space.

### 9.3.2 Healthcare Management

HOPES care management is delivered by registered professional nurses who evaluate each participant's medical history and current healthcare needs. The nurses and participants set health-related goals and focus on preventative and primary healthcare benchmarks. The skills training clinicians and registered nurses meet weekly to coordinate each component of HOPES.

### 9.3.3 Comment

As indicated in Table 9.1, one RCT study demonstrated that HOPES participants had greater improvement than treatment as usual (TAU) in measures of

performance skills, psychosocial and community functioning, symptoms, and self-efficacy[1] at 1, 2, and 3 years [20, 21].

The multicomponent HOPES intervention is appropriate for older adults with severe mental illness, including BD, who face a combination of psychosocial and medical issues and have persistent impairment in multiple areas of functioning (e.g., work and self-care). The benefits of the program were unrelated to psychiatric diagnosis, i.e., psychotic disorders (schizophrenia–schizoaffective) versus mood disorders (MDD and BD). Nevertheless, because of the small percentage of older adults with BD in the sample, evaluation and potential adaptation of the HOPES program specifically for older adults with BD are needed. Furthermore, because study participants had persistent impairment in functioning, validation of the HOPES program in older adults with higher level of functioning is recommended.

## 9.4 Enhanced Clinical Intervention (ECI)

Enhanced clinical intervention (ECI) is a manualized intensive clinical and psychosocial management program provided by a nurse or masters-level clinician and consists of four educational components (including education about BD, pharmacotherapy, sleep, and social rhythm hygiene), five management components (including review of symptoms, medication side effects, discussion of early warning signs, and 24-h on-call service), and a support component [22]. ECI clinicians meet with patients for 20–30 min before a scheduled appointment with the psychiatrist. Patients receive ECI weekly for 12 weeks, every other week for the following 8 weeks and monthly for the duration of treatment (mean = 20 months; range: 18–34 months). If patients had a recurrence of mood episode, they would return to weekly visits.

### 9.4.1 Comment

One study, an RCT, compared Specialized Care for Bipolar Disorder (SCBD) versus SCBD with ECI [22] in patients with a wide age range including adolescents ($N = 75$, 12–18 years of age), young and middle-aged adults ($N = 349$, 19–64 years of age), and older adults ($N = 39$, 65 years of age and older). SCBD is a manualized system of clinical disease management for bipolar patients, which includes assessment of psychiatric symptoms and standardized algorithm-driven pharmacotherapy [22]. Because SCBD does not include a psychosocial component,

[1]According to Albert Bandura, perceived self-efficacy is "the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations." Bandura A. Self-efficacy: Toward a Unifying Theory of Behavioral Change. Psychological Review 1977;84 (2): 191–215.

the Enhanced Clinical Intervention (ECI) was added to SCBD. As indicated in Table 9.1, the groups showed comparable improvement on the Clinical Global Index (CGI), the Global Assessment of Functioning (GAF), and Quality of Life Enjoyment and Satisfaction Questionnaire over 18 months of treatment [22]. However, participants in the SCBD + ECI group had greater improvement in the quality-of-life measures. Even though there were no separate analyses in the group of older adults, there were no significant differences in treatment outcomes among age groups [22].

Future investigations may concentrate on the application of ECI in older adults with BD and identification of the most useful and efficacious components in improving symptoms and quality of life in this population.

## 9.5 Bipolar Medical Care Model

The Bipolar Medical Care Model (BCM) [24, 25] is an adaptation of the Bipolar Disorder Collaborative Chronic Care Model [27, 28] and aims to improve medical outcomes and reduce cardiovascular risk in patients with BD [25; mean age = 55.3, range = 30–73]. The model proposes that effective strategies to reduce symptoms are necessary to improve adherence to medical treatment, promote health behavior change, and achieve optimal health outcomes [25]. It includes three main components: self-management education, care management, and guideline implementation (Table 9.1).

### 9.5.1 Self-Management Component

This component is based on the Life Goals Program, a group psychoeducational program for BD [29]. The program is enhanced with additional material on the cardiovascular disease risk, on diet and exercise, and on engagement of general medical providers. The self-management component is delivered by a care manager in four two-hour group sessions [25] and complementary phone sessions.

### 9.5.2 Care Management Component

In this component, a nurse care manager served as a liaison between patients and providers, addressed patients' health concerns, referred urgent issues to appropriate medical and mental health providers, reinforced self-management, and followed patient's progress over time [25]. This component was delivered by regular phone calls for up to 6 months.

### 9.5.3 Guideline Implementation Component

Continuing medical education sessions addressed cardiovascular disease risk factors following the American Diabetes Association and American Heart Association guidelines, for all primary care and mental health providers.

### 9.5.4 Comment

In an RCT, BCM was associated with significantly greater improvement in physical health-related quality of life compared to TAU, but there were no significant differences between the two groups in other outcomes including symptoms and functioning (Table 9.1). Evaluation of specific components of BCM and effects in older patients is needed.

## 9.6 Medication Adherence Skills Training for Bipolar Disorder (MAST-BD)

Medication Adherence Skills Training for Bipolar Disorder is a 12-week manualized group intervention that combines educational (weeks 1–3), motivational (weeks 4–6), medication management skills (weeks 7–9), and symptom management training (weeks 10–12). Each part is comprised of three, 90-min sessions. The content of each session is derived from psychosocial interventions typically used for younger adults with BD and included elements of cognitive behavioral therapy and structured group therapy [30, 31]. The medication adherence component was derived from the Functional Adaptation Skills Training program, which is an intervention targeted for older adults with psychotic disorders [32] (Table 9.1).

### 9.6.1 Comment

Non-adherence to pharmacotherapy is associated with increased risk for relapse, recurrence, hospitalization, and high healthcare costs [12, 23, 33]. MAST-BD is a promising and needed intervention that focuses on this critical issue of medication adherence in older adults with BD. In a pilot study [23], MAST-BD provided the evidence of feasibility, acceptability, and improvement in medication adherence, medication management ability, depressive symptoms, and quality of life (Table 9.1). Future investigations may evaluate its effects in a randomized controlled trial.

## 9.7 Limitations

The studies and these interventions have the following limitations:

1. Only 3 out of the 4 studies are RCTs (Table 9.1). Further, the interventions that were tested in an RCT were long-term interventions (from 6 months to 2 years), which makes it difficult to apply for acute treatment.
2. Only the MAST-BD intervention (which was not tested in an RCT) is designed for and tested exclusively in older adults with BD. HOPES is designed for older adults with severe mental illness, including patients with schizophrenia, schizoaffective, major depression, and BD. ECI and BCM were tested in the studies of mixed-aged samples (ECI study: 8.4 % of the sample, i.e., 39 participants, were older adults aged 65 or older; BCM study: 30 %, i.e., 18 participants, were 60 years or older).
3. All interventions had multiple components, which highlights the clinical complexities of treating BD. Future investigations may investigate the beneficial effects of individual components in older patients with BD.

## 9.8 Other Interventions for Young and Middle-Aged Adults

Because of the sparse literature on RCTs in older bipolar patients, we include other promising interventions that have been tested in RCTs in mixed samples of both young and middle-aged adults (cognitive behavioral therapy, interpersonal and social rhythm therapy, family-focused therapy, and psychoeducation). In the section below, we briefly describe each intervention and summarize our conclusion.

### 9.8.1 Cognitive Behavioral Therapy, Interpersonal and Social Rhythm Therapy, and Family-Focused Therapy

In young to middle-aged adults, these three interventions have been studied separately [34–42], but also as part of the Systematic Treatment Enhancement Program for BD (STEP-BD) [43, 44].

Cognitive behavioral therapy has been adapted for BD and includes (1) psychoeducation on the course of BD, medication adherence, and stress management; (2) scheduling of life events; (3) cognitive restructuring; (4) problem-solving training; (5) plans for early detection and intervention; and (6) selected interventions for comorbidity [43, 45, 46].

Interpersonal and social rhythm therapy [11] consists of psychoeducation, social rhythm therapy, and interpersonal psychotherapy. Psychoeducation focuses on

pharmacotherapy, medication side effects, and early episode warning signs and detection of prodromal symptoms [11]. Social rhythm therapy identifies strategies to prevent the disruption of social routines and sleep/wake cycles [47]. Interpersonal psychotherapy focuses on reducing interpersonal difficulties because of grief, role transitions, role disputes, and interpersonal deficits. An additional area of "grief for the lost healthy self" was added to interpersonal and social rhythm therapy [11].

Family-focused therapy includes psychoeducational sessions focusing on symptoms, course of illness, treatment, and self-management of BD [48]. In the intermediate phase, after psychoeducation, patients and family members participated in exercises to enhance communication skills. In the final phase, families focused on solving problems related to the illness.

#### 9.8.1.1 Conclusion

Results from the STEP-BD study and other RCTs on the individual effects of each intervention (CBT, interpersonal and social rhythm therapy, family-focused therapy) [9, 34–42] are encouraging for young and middle-aged adults, but future investigations are needed to examine these therapies in older adults with BD, especially in those who are 75 years of age or older.

### 9.8.2 Psychoeducation

Psychoeducation has been a significant component of the interventions for older bipolar patients, as we described above, but to our knowledge, there are no clinical trials of stand-alone psychoeducation in older adults with BD [12, 34]. Psychoeducation has been widely utilized in a group or individual format as a stand-alone intervention or as an adjunct to other psychosocial interventions for young to middle-aged adults with BD and their families [12, 34, 42, 49–51]. It helps patients and their families develop skills to identify early signs and symptoms, monitor the patients' sleep patterns and symptoms, and avoid relapse [12, 42, 49–51].

#### 9.8.2.1 Conclusion

Again, studies of stand-alone psychoeducational programs have concentrated mainly on young and middle-aged adults, and future investigations focusing on older adults with BD are needed.

## 9.9 Clinical Issues Related to Bipolar Disorder in Older Adults

Emotion regulation, suicidality, social and family support, disability, cognitive impairment, and caregiver tension and burden are critical issues in older adults that need to be systematically assessed and addressed. These issues are important for

OABD, especially in those who are 75 years or older, a population that has not been adequately investigated. The following section highlights these clinical challenges.

### 9.9.1 Emotion Regulation

Because of emotional lability in BD, assessment and regulation of negative and positive emotions in patients with BD are critical. Emotion regulation strategies have been effective in improving depression and reducing disability in older adults with unipolar or bipolar major depression and varying degrees of cognitive functioning, including older patients with major depression and significant cognitive impairment, or middle-aged and older adults after successful electroconvulsive therapy (ECT) [52, 53]. Emotion regulation techniques that follow the process model of emotion regulation [54] may be effective in the management of emotions associated with a depression, hypomanic, or manic state. These techniques include situation selection (i.e., selecting situations that promote adaptive positive emotions and reduce negative emotions), situation modification (i.e., modifying situations to promote adaptive positive emotions and reduce negative emotions), attentional deployment (i.e., shifting attention to promote adaptive positive emotions and reduce negative emotions), cognitive change (i.e., changing the appraisal of a situation to modify the emotional response, similar to "cognitive restructuring" that is used in cognitive behavioral therapy) or response modulation (i.e., utilizing direct efforts to alter one's emotional responses).

### 9.9.2 Suicidality

According to the latest statistics from the Centers for Disease Control and Prevention [55], suicide rates in older adults are alarmingly high and older white men (aged 85 and older) have the highest rate of suicide (54/100,000) [55]. Even though the suicide risk appears to be higher in young adults than in older adults with BD [56, 57], studies on suicide risk in older adults with BD are sparse [58, 59]. In a study of 1354 older adults who died by suicide, BD had a stronger association with suicide (OR 9.20; 95 % CI 4.38–19.33) than depression (OR 6.44; 95 % CI 5.45–7.61) or anxiety disorders (OR 4.65; 95 % CI 4.07–5.32) [60]. Despite the need for interventions to prevent suicide in older adults with mood disorders, no interventions for older patients with BDs have been designed or tested. Clinicians must assess suicidal ideation, past suicide attempts, as well as risk and protective factors for suicide in older adults with BD [58, 61].

### 9.9.3 Social and Family Support

Decreased social support is critical in older adults with severe mental illness [62], including BDs, and is associated with increased isolation and decreased pleasure [63, 64]. Belonging to a large family network and having increased instrumental support are associated with a shorter bipolar episode [64]. Social support and family support become increasingly important as disability and cognitive impairment increase [65]. Therefore, clinicians must evaluate the social and family support of an older adult with BD and seek to increase social support and reduce interpersonal tension in the family.

### 9.9.4 Disability

Disability is prevalent in older adults and is associated with increased depression, medical morbidity and mortality, and reduced quality of life of patients and caregivers [66, 67]. Careful assessment of disability domains, the impact of disability on an individual's emotions and quality of life, and its contribution to increased family stress is critical.

### 9.9.5 Cognitive Impairment

Cognitive impairment, especially deficits in executive functioning, memory, psychomotor speed, and sustained attention, is associated with BD in adults of all ages [13, 68–75]. Cognitive deficits may contribute to reduced quality of life, increased disability, and, in some cases, poor treatment outcomes [13, 76, 77]. Clinicians should assess the specific cognitive deficits and their impact on daily functioning and interference with adherence to pharmacotherapy or psychosocial treatments. A formal neuropsychological assessment may be necessary to fully evaluate these cognitive deficits.

### 9.9.6 Family/Caregiver Participation

BD has a significant impact on both the individual with BD and the family. Furthermore, family stress may contribute to worsening of bipolar symptoms. It is important to engage family members and/or caregivers as part of the treatment for older adults who are faced with increased medical illnesses, disability, and cognitive impairment. However, most family interventions for BD focus on young and middle-aged patients [78]. Caregiver participation may exacerbate potential caregiver burden. Clinicians need to evaluate a caregiver's availability and motivation to help, disability, and cognitive impairment. Caregivers of older adults with major depression and cognitive impairment have shown high treatment satisfaction and found their participation in treatment to be productive [52].

**Clinical Vignette 9.1**

Mr. Y, a recently retired 68-year-old, was hospitalized for a manic episode. His episode was characterized by alcohol abuse and extramarital affairs, reduced sleep, and increased energy that led to significant interpersonal tension with his wife and adult son. During his hospitalization, he cycled into a depressive syndrome with features that included guilt, hopelessness, and suicidal ideation. Mr. Y responded to ECT. He was discharged with a continuation management program (psychiatrist and therapist). The therapist and the psychiatrist had continuous communication during the treatment.

Mr. Y and his treatment team focused on the following clinical areas identified in our chapter: assessment of cognitive deficits, medication adherence, emotion regulation, apathy and lack of initiation, psychoeducation, and reduction of interpersonal tension. The following sections discuss the 12-week acute treatment following discharge and biweekly or monthly booster sessions for the next 6 months.

***Assessment of Cognitive Deficits***

Mr. Y had short-term memory difficulties due to ECT, and the psychotherapist used compensatory strategies and tools, including reminders, a notebook to summarize treatment and highlight the homework, and a weekly schedule to reduce apathy and increase engagement in activities. As expected, after 4 weeks, Mr. Y's short-term memory had significantly improved, based on subjective reports by patient and his family

***Suicidal Ideation***

Mr. Y had re-emergent passive suicidal ideation, without any intent or plan, after his discharge. His suicidal thoughts were fueled by his hopelessness and guilt related to his manic behavior. Mr. Y ruminated about his extramarital affairs and about how much he hurt his family. The therapist explored with Mr. Y the effect that his behavior had on his family, confronting the all-or-none thinking that there "was no way out" and regulating negative emotions during stressful situations that triggered his suicidal ideation.

***Medication Adherence***

The therapist educated Mr. Y about the side effects of medication (lithium and antidepressant medication) and discussed the pros and cons of medication adherence and relapse prevention. Mr. Y demonstrated insight and identified the pros of medication adherence and relapse prevention (i.e., reduce symptoms, promote recovery, improve his functioning, and prevent another episode) and was encouraged to discuss the potential side effects of medication with his psychiatrist.

***Emotion Regulation***

Mr. Y identified problems, concerns, and triggers of negative emotions, such as guilt, feelings of worthlessness, hopelessness, and anxiety. For each problem, Mr. Y developed emotion regulation strategies to reduce these negative emotions. These strategies, based on Gross' process model of emotion regulation [54], included situation selection (selecting the situations the patient is exposed to), situation modification (modifying potentially emotion-eliciting situations), distraction (shifting patient's attention within a situation), cognitive reappraisal (changing patient's perspective about a situation, which is mostly utilized in cognitive behavioral therapy), and response modulation (utilizing direct efforts to alter patient's emotional responses, e.g., stress management tools). Distraction (e.g., concentrating on a pleasurable or rewarding activity when feeling sad) and situation selection (e.g., avoiding upsetting conversations or situations) were effective emotion regulation strategies in the beginning of treatment, when the patient's short-term memory was impaired. Cognitive reappraisal (e.g., changing patient's perspective on medication adherence) was used later in the treatment when the cognitive functioning was significantly improved.

***Interpersonal Tension with Wife and Adult Son***

Tension between the patient and his family was high due to patient's prior manic symptoms and risky behavior. His wife wanted to separate and did not want to participate in treatment, while the son said that he did not trust his father any longer. The interpersonal tension contributed significantly to patient's depression. The therapist used practical, hands-on strategies to de-escalate the tension, e.g., prepared to stop the discussion if tension increased. The patient was able to temporarily move in with his son, while the wife was convinced to begin couples treatment to explore whether the marriage can be saved. Weekly sessions with the patient and either the son or the wife helped educate the family as well as promote the rebuilding of trust between the patient and his family.

***Psychoeducation and Recognition of Early Symptoms***

Mr. Y and the therapist discussed extensively the early signs and symptoms of his episodes. Mr. Y's wife and son also participated in the discussion. The therapist created a list of early signs and symptoms and how they can be recognized and reduced. Mr. Y incorporated his family's help in identifying at-risk situations and developed a step-by-step plan on how to deal with these signs and symptoms.

***Learning Points***

- Psychological intervention for bipolar disorder in older adults needs to include a multidimensional approach consisting of medication adherence,

emotion regulation, psychoeducation, evaluation and treatment of suicidal ideation, and reduction of interpersonal conflicts.
- Evaluation of cognitive deficits and strengths is important for the treatment of older adults with bipolar disorder.
- Maintenance evaluation and early recognition of symptoms are critical for relapse prevention.

## 9.10 Summary

- Psychological approaches are critical in the treatment of OABD, in conjunction with pharmacotherapy and other somatic treatments.
- Clinical issues that are important for older adults and need to be systematically assessed and addressed include emotion regulation, suicidality, family and social support, disability, cognitive impairment, and caregiver participation.
- There is a paucity of peer-reviewed literature of randomized controlled clinical trials of psychological approaches including psychotherapies, skills training, psychosocial, family-focused, and psychoeducation interventions used for the management of OABD.
- Three interventions have demonstrated efficacy in randomized controlled trials in a subgroup of OABD: Helping Older People Experience Success (HOPES), Enhanced Clinical Intervention (ECI), and Bipolar Medical Care Model (BCM).
- Medication Adherence Skills Training for Bipolar Disorder (MAST-BD), a promising intervention for medication adherence for OABD, needs to be further investigated in an RCT.
- Most psychotherapy intervention studies focus on young and middle-aged older adults. Further investigation of such interventions in adults 75 years or older with BD is needed.

**Clinical Pearls**

- Cognitive Impairment: The clinician must evaluate a patient's cognitive performance and explore how cognitive impairment impacts daily functioning and treatment. Screening tools such as the Mini Mental State Exam (MMSE) [79] or the Montreal Cognitive Assessment (MOCA) [80] are helpful, but a formal neuropsychological evaluation is recommended to fully assess cognitive deficits.

  - Questions to consider: What domains of cognitive performance are impaired and how severe are these deficits? What are the patient's cognitive strengths and limitations? How do cognitive limitations affect daily functioning, medication adherence, and insight? How do cognitive deficits affect the administration of a psychosocial intervention? What compensatory strategies (e.g., reminders, notebooks, and signs) that may help improve functional capacity?

- Disability and Functioning: The clinician shall assess the patient's areas of physical and behavioral disability and impairment in functioning.

  - Questions to consider: What is the patient's overall psychosocial and occupational functioning? What domains of functioning have been affected (e.g., interpersonal, activities of daily living)? Is the patient currently involved in adaptive pleasurable and rewarding activities?

- Maladaptive Negative or Positive Emotions: The clinician must explore negative emotions and their triggers and develop practical emotion regulation techniques to reduce negative emotions and their impact on a patient's life. The clinician will also identify adaptive and maladaptive positive emotions and help the patient promote adaptive and regulate maladaptive positive emotions.

  - Questions to consider: What are the negative emotions that the patient experiences? What situations trigger these negative emotions? How do these negative emotions affect the patient's thinking and actions? What strategies can be used to reduce these negative emotions? Are there any positive emotions, e.g., pleasure and hyperthymia that contribute to risky behavior? How does the patient feel about the impact of these emotions on daily functioning and quality of life?

- Suicide Risk: The clinician must thoroughly assess suicide risk (e.g., substance abuse, disability, pain, and family history of suicide) and protective factors (e.g., religion and family support) and explore any previous suicide attempts. Access to firearms and other lethal means must be evaluated.

  - Questions: Does the individual have a history of suicidal ideation or attempts? What precipitated any prior suicide attempts? What symptoms (manic, hypomanic, depression) were associated with suicidal ideation or past suicide attempts? Are there any protective factors, including religiosity?

- Social Support: The clinician must evaluate family and social support and the effect of BD on his or her relationships.
  - Questions: Has the patient been isolated from his or her social circle or the family? What were the effects of manic, hypomanic, or depression symptoms on the patient's family and social network?
- Caregiver/Family Member/Significant Other Participation: The clinician will explore whether a caregiver is available and willing to participate in treatment. Reduction of interpersonal tension between the patient and family members or significant others is critical. The clinician must assess caregiver's cognitive and functional abilities.
  - Questions: What was the effect of a patient's behavior on the relationship with his or her family? Is the caregiver/family member/significant other willing and available to participate in treatment? Are the family and the patient educated about the symptoms and course of illness, medications and their potential side effects, and importance of adherence to medication treatment?

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