Psychiatric Treatment Options in the Older Adult

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- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
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Faculty

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Faculty Disclosure

Contributing faculty, Megan Hawk, APRN, PMHNP-BC, CNP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all nurses involved in the care of older patients, particularly those with mental health concerns.

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Course Objective

The purpose of this course is to review psychiatric treatment options for the older adult and improve outcomes for older adults receiving mental health care.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline characteristics of the older adult population in the United States.
2. Describe how medical conditions may impact the mental health of the older adult.
3. Review pharmacokinetic considerations when planning psychopharmacotherapeutic approaches for older adults.
4. Identify medications included in the Beers criteria and the potential safety concerns with medications on this list.
5. Discuss nonpharmacologic interventions that can be used for the older adult with mental health conditions.
6. Identify safety needs for the older adult patient and how to implement treatment plan changes while maintaining patient dignity.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

The oldest person in the United States is 115 years old, and in the 2010 Census, there were 53,364 centenarians (individuals 100 years of age or older) [1]. Older adults, considered to be individuals 65 years of age and older, make up 16% of the U.S. population. Moreover, the number of individuals 85 years of age and older is projected to double by the year 2040, and by 2050, it is projected that one in five people in the United States will be older than 65 years of age [2; 3]. By the year 2060, it is projected that 589,000 people will be 100 years of age or older [4]. These figures alone demonstrate the need for increased familiarity and comfort with the mental health care of the older adult. Aside from age, the older adult presents with other potential complications, such as living in extended care facilities.

The probability of an older adult living in an extended-care facility increases with age, with 1% of individuals 65 to 74 years of age, 2% of those 75 to 84 years of age, and 8% of those 85 years of age and older living in an extended-care facility [2]. As the general population grows older, it is expected that the number of those in extended-care facilities will increase as well.

One in four older adults is impacted by a behavioral health disorder, such as depression, anxiety, dementia, and substance use disorder [5]. However, it is important to note that mental health disorders, including depression and dementia, are not normal parts of aging and can and should be treated. However, it is important to note that some mental health symptoms in older adults may present differently from a younger patient. It can be easy for younger caregivers to lose sight of just how much the older adult has been through; they may have already lost many of the people closest to them. Older adults are often experiencing life-altering changes in physical and cognitive functioning. These challenges can be compounded with new or chronic mental health conditions.

Consider the following case scenario: Patient A presents to the office for an initial psychiatric evaluation. She is 85 years of age. There is an almost palpable sadness that can be felt while in her presence, though she appears to smile through whatever pains her as she answers basic social questions. She denies depressive symptoms and history of trauma and reports only anxiety, with a desire to come off the "nerve pill" that she has been prescribed by her family physician. After a review of her current psychiatric symptoms and a brief break for small talk, talk becomes comfortable enough to disclose that she fled Poland during World War II. It is after a simple, "That had to have been really tough," that she begins to open up, speaking freely to the nurse. Patient A's father died in a concentration camp and she fled Poland with her mother. After coming to the United States, she endured years of physical, emotional, and sexual abuse from a now ex-husband. She cries as she tells her story. It feels like it is her first time feeling comfortable describing these traumatic events. The nurse offers active listening and patience as Patient A works through the topics that have been so difficult to discuss. After she finishes her story, the patient is tearful but looks as though a weight has been lifted off her. With shared decision making, a plan is put in place to taper the previously prescribed benzodiazepine slowly and carefully. She is referred to psychotherapy following a discussion on the benefits.

After this appointment, here are a few points to consider:

- Are healthcare providers doing the very best for older patients?
- Are older patients leaving their appointments feeling heard?
- What are older patients' thoughts and feelings toward receiving mental healthcare?
- Are healthcare providers engaging in shared decision making, taking patients' preferences into account?

- Have healthcare professionals, and nurses in particular, lost touch with older adults' complex needs?

The experiences of the elderly population have helped to form them into the people they are today. They come from a generation that is less likely to reach out for help, especially in terms of mental health care.

Nurses are in a unique position. We can either ignore the stories of older adult patients or hear them, learn from them, and seek out ways to improve their care. It is of utmost importance for nurses to understand how mental health concerns manifest in older adults patients; what pharmacologic interventions are appropriate and inappropriate for the elderly, including what the most up to date Beers criteria state; how medical conditions may play a role in the mental health of the older adult patient; and nonpharmacologic treatment options for the elderly with mental health concerns, recognizing safety concerns in the older adult. A thorough review of these topics is necessary to enhance the care of these patients, thus improving outcomes.

MENTAL HEALTH CONCERNS IN THE ELDERLY

DEMENTIA

Dementia is a general term for difficulties with cognitive functioning, including impairment in executive functioning (e.g., balancing a checkbook), memory loss, poor judgment, impulsivity, getting lost in familiar places, and taking longer than usual to complete daily tasks. Although the likelihood of developing dementia increases as one ages, it is not considered a normal part of aging. Dementia is further categorized by type and severity. Alzheimer disease is one of the most common forms of dementia, with an estimated 6.5 million individuals 65 years of age and older in the United States affected [6]. Other types of dementia include frontotemporal dementia, vascular dementia, and dementia with Lewy bodies. It has been suggested that the total number of Americans with some form of dementia could rise to 14 million by 2040 [7].

Behavioral and psychological symptoms of dementia (BPSD) can be challenging for patients and caregivers and can include psychosis, anxiety, agitation, depression, wandering, and apathy [8]. Patients with BPSD are more likely to experience delusions than hallucinations, and the more commonly experienced delusions revolve around theft from the home and intruders within the home [8]. The specific symptoms experienced by the patient with BPSD may vary by different types of dementia; for instance, dementia with Lewy bodies has a higher incidence of hallucinations, while vascular depression has a higher incidence of depression and anxiety [9]. The patient with BPSD may try to leave the home, often requiring caregivers to be home with the patient full-time. Caregivers of patients with dementia may experience financial stress associated with decreased employment or leaving their job to provide care. Caregiver financial strain is associated with higher levels of role overload among caregivers in general [10].

DEPRESSION

Much like dementia, older adults are at increased risk for depression, though this should not be considered a normal part of aging. In some cases, depression in older adults is dismissed by providers, brushed off as loneliness or grief—things that cannot be avoided. Risk factors for depression in the older adult include a history of depression, sensory losses, social losses, functional impairment, stressful life events, and increased dependence on others [11]. It is important to note that depression in the older adult can and should be treated. Although the overall symptom profile of depression is the same for older adults as for younger individuals, it is important to point out that older adults are more likely to display physical health-related symptoms when depressed. For example, the older adult is more likely to experience non-specific aches and pains or gastrointestinal distress associated with depression [12]. Furthermore, the older adult may struggle more with loneliness as they grow older. Not being close to family members, friends, or other supports can have a negative impact on the older adult as their functional capacity decreases.

Suicide

Suicide is a public health concern in the United States and worldwide; in 2020, older adults experienced a suicide mortality rate of 16.86 deaths per 100,000 population [13]. Loneliness, dementia, and depression are commonly seen characteristics of the oldest individuals who complete suicide; also, older men had the highest rates of death by suicide in nearly all countries [14]. The older adult is more likely to choose a more violent means of attempting suicide and are more likely to die following an attempt than younger patients [5]. Working with older adults through complex grief, finding meaning in life, relieving psychiatric symptoms, and, above all, establishing a strong therapeutic alliance are crucial to improving quality of life and decreasing suicide risk [12]. Problem solving and problem adaptation therapy are two psychotherapeutic modalities that have shown some promise in decreasing suicide risk in the older adult [12]. Contributing factors should be continually assessed by the nurse caring for the older adult.

ANXIETY

Anxiety disorders are thought to be more common in older adults than depression, with a prevalence rate of 7% to 14.2% for this population [12]. Anxiety can manifest differently in older individuals compared to younger populations due to various factors, including age-related changes, comorbidities, and life circumstances. Furthermore, the older patient may also experience lower self-confidence, reduced activity and movement, loss of friends/social supports, reduced financial and physical independence, and medical comorbidities, all of which can further fuel anxiety symptoms [16]. These factors culminate to the development of anxiety surrounding death among older adults; additionally, generalized anxiety disorder, anxiety related to a general medical condition, and agoraphobia are more likely to occur in late adulthood [12; 17]. As individuals get older, they may experience death anxiety, or a heightened awareness and fear of death, whether conscious or unconscious. The mental health and quality of life of the older adult improves if death anxiety is addressed psychotherapeutically. Lower death anxiety is associated with higher levels of meaning in life [18]. Nurse psychotherapists can be very important in helping the older adult patient find meaning in life to mitigate the risk of depression and anxiety in late life [12].

When assessing an adult with possible social anxiety disorder, the National Collaborating Centre for Mental Health recommends that clinicians be aware of comorbid disorders, including avoidant personality disorder, alcohol and substance misuse, mood disorders, other anxiety disorders, psychosis, and autism.

(https://www.nice.org.uk/guidance/cg159/resources/social-anxiety-disorder-recognition-assessment-and-treatment-pdf-35109639699397. Last accessed January 24, 2025.)

Level of Evidence: Expert Opinion/Consensus Statement

BIPOLAR DISORDER

Bipolar disorder in the older adult population encompasses both those who experience late onset of the disease and those who were diagnosed with bipolar disorder at a younger age (early-onset bipolar disorder). Some epidemiological studies use an age cutoff of 50 years of age to identify older adults with bipolar population, in part due to the shorter life expectancy of individuals with bipolar disorder [19].

As the population grows older, it stands to reason that the number of elderly patients with bipolar disorder will increase. Individuals with late-onset bipolar disorder are more likely to present with bipolar II disorder than bipolar I disorder and are more likely to have co-occurring neurologic disorders or cognitive decline. Most of the literature surrounding bipolar disorder focuses on adolescents and working-age adults rather than older adults, showing a gap in research and knowledge in this area. It is unclear if clinical guidelines focused on younger populations can be safely extrapolated to the older adult population due, in part, to the physical and metabolic changes that occur with age [20]. Due to the lack of available data on treatment recommendations for late- and early-onset bipolar disorder in older

adults, experts recommend that treatment should be similar to that of a younger patient, keeping in mind the potential risk factors of common bipolar disorder treatments that may come with advanced age [19]. Safety and tolerability should be taken into account as much as efficacy when choosing a treatment option for the older adult with bipolar disorder [20]. Considerations for psychopharmacology in older adults will be discussed in detail later in this course.

Lithium is considered the criterion standard of bipolar disorder treatment, particularly for the control of mania. Lithium is also known for its narrow therapeutic index for the treatment of mania, with blood levels typically needing to fall between 0.8 mEq/L and 1.2 mEq/L to be effective. In addition to the potential for damage to the thyroid and kidneys with long-term use, lithium can reach toxic levels in the blood. Early signs of lithium toxicity include tremor, sedation, and confusion, all of which can be missed in older adult patients. At higher lithium levels, patients can experience delirium, seizures, and coma [21]. Because of these risks, blood levels of lithium should be monitored periodically. There is some evidence that older patients may respond well to "subtherapeutic" serum levels of lithium, and signs of toxicity may occur at levels less than 1.2 mEq/L in older adults [20; 21].

SCHIZOPHRENIA

People of all age groups can have schizophrenia, with onset most commonly occurring in those around 20 years of age; late-onset schizophrenia develops after 45 years of age. The prevalence of schizophrenia in older adults is projected to double and reach 1.1 million people in the United States by 2025 [22]. It is suggested that healthcare costs will be significantly impacted with the increasing number of older adult patients with schizophrenia [23]. Still, the life expectancy of an individual with schizophrenia is lower than the national average by about 10 years.

Characteristics of schizophrenia in older adults can vary widely from younger individuals diagnosed with the disorder [24]. This may be due to a combination of a different symptom profile among those with late-onset schizophrenia and significant symptom reduction among those with early-onset disease who have reached older adulthood. Older adults with schizophrenia are also more likely to have acquired medical comorbidities that complicate the clinical picture. It has been noted that individuals with late-onset schizophrenia have better premorbid functioning than those who develop the disorder earlier in life [23]. Those who develop schizophrenia later in life tend to have fewer negative symptoms and less severe neurocognitive impairments [23].

There are risks associated with the treatments for schizophrenia that are exclusive to the older adult population, particularly related to drug reactions and interactions.

POST-TRAUMATIC STRESS DISORDER

Older adults experience post-traumatic stress disorder (PTSD) at rates lower than younger populations. It has been suggested that older adults are less likely to be assessed or diagnosed with PTSD due to a lack of research on this demographic. However, this appears to be changing [12]. It has been noted that the prevalence of PTSD in individuals older than 60 years of age ranges from 1.5% to 4.0%; this is lower than the lifetime prevalence of all adults (8.0%) [25]. This raises the question: Do older adults have less trauma, or is this population less treatment-seeking? Experts have suggested that older adults may be less likely to recognize symptoms as trauma-related and may also be less likely to seek care; conversely, clinicians may be less likely to assess for trauma-related disorders in this population [26].

The diagnosis of PTSD was first introduced to the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980; individuals who experienced an onset of symptoms before this time may have received a different diagnosis or have not been diagnosed at all, leading to gaps in identification and treatment that persist into older age [26]. It is reasonable to assume that older adults have lived through global and personal events that could create and elicit trauma-related symptoms.

The psychiatric treatment-seeking views of older adults are marked by stigma and a perception of personal responsibility over psychiatric symptoms linked to a lack of psychiatric treatment-seeking [27]. Research indicates that older veterans with PTSD are more likely to endorse somatic complaints (e.g., headache, memory problems, gastrointestinal distress) than PTSD-related symptoms (e.g., hypervigilance, increased startle response) in comparison to their younger counterparts [25].

SUBSTANCE USE DISORDERS

Alcohol use among older adults has increased over time, and an increase in substance use in general has been noted in the "baby boomer" generation (defined as those born between 1946 and 1964) [12]. Age-related changes to pharmacokinetics in older adults, including slowed metabolism of substances, can place this population at greater risk of adverse outcomes related to substance use and misuse.

Alcohol can cause difficulties with cognition, increase the risk of falls, and contribute to potentially dangerous alcohol-drug interactions for the older adult [28]. Careful assessment is required in this group, as changes can be mistakenly attributed to normal age-related changes, other chronic diseases, and/or dementia. When identified, this group requires individualized treatment that considers the impact of advanced age. One study attempted to reduce risky drinking among older male veterans presenting to primary care. It was found that integrated care behavioral health models were more effective at reducing risk drinking than no alcohol-use specific treatment referral at all; there were differences in the changes in risky drinking patterns depending on the treatment facility/location [28]. In one literature review, all studies examined found correlations between alcohol use and cognitive decline and dementia in older adults [29]. Nurses should consider increasing rates of substance use disorder among the older adult population and screen for substance misuse in all patient populations.

PSYCHOPHARMACOTHERAPY IN OLDER ADULTS

When formulating a treatment plan for older adults, nonpharmacologic options should be considered first as a safer alternative. If medication is necessary, adhering to the principle of "start low, go slow, don't stop, be patient" is crucial [30]. "Start low" acknowledges that older adults often require lower initial doses compared to younger patients. In some cases, as little as half or even one-quarter of the recommended starting dose may be appropriate for older adults [21; 30]. "Go slow" advises avoidance of aggressive dose titration commonly used with younger patients. "Don't stop" emphasizes the need to avoid abrupt discontinuation of antipsychotics or any medications in the elderly. "Be patient" suggests allowing older patients sufficient time to adjust to new medications. Demonstrating patience is important when evaluating the effectiveness of psychiatric medication in older adults. Even with a low dose, they may still be sensitive to side effects, so close monitoring is essential to prioritize the safety of the older adult.

PHARMACOKINETICS IN OLDER ADULTS

Older adults account for approximately one-third of all prescription drug use, with a significant amount of over-the-counter usage as well [21]. When considering psychopharmacologic treatment for older adult patients, it is important to consider age-related changes in the absorption, distribution, metabolism, and excretion of medications; medical comorbidities; and drug-drug interactions.

AGE-RELATED CHANGES

It is common knowledge that as individuals age, total body water content decreases, muscle mass decreases, body fat increases, and function of several organ systems (e.g., hepatic, renal) decrease. These age-related changes can contribute to differences in drug absorption, distribution, metabolism, and excretion. However, nurses should consider (on an individual basis as much as possible) to what extent these body systems have and will change. For example, glomerular filtration rate (GFR) can decrease with age, and this is considered a normal part of aging [87]. Further, some degree of decreased liver function is expected as hepatic size and blood flow decrease with age. Despite some degree of decreased function, enzyme induction of the CYP450 system can remain relatively unchanged in the older adult; others may experience a decrease of up to 30% of enzyme action [88]. Genetics may play a greater role in aging and in pharmacokinetics and drug metabolism in older adults than is generally appreciated [89]. Although decreases in hepatic and renal function are highly variable from patient to patient, an overall decrease in both hepatic and renal function is expected and should be part of prescribing decisions and drug monitoring in this group.

MEDICAL COMORBIDITIES

As a patient ages, they are increasingly likely to accrue medical comorbidities. The NCOA has reported that 80% of adults 65 years of age and older have at least one chronic condition, while 68% have two or more [5]. Medical concerns to be particularly watchful of in older adults include dehydration, hyponatremia, and impaired renal function. Some of the most common medical comorbidities in older patients include hypertension, type 2 diabetes, osteoarthritis, coronary artery disease, and hyperlipidemia—all of which often require at least one medication for control [5].

DRUG-DRUG INTERACTIONS

More medical conditions tend to lead to more medications, and older adults are particularly susceptible to polypharmacy. In a scoping review, researchers found that the most current clinical practice guidelines fail to offer guidance on safe prescribing practices for the patient with multimorbidity; most guidelines focus guidance on a single condition only [15]. Safe prescribing practices when caring for older adults with psychiatric disorders rely on knowledge of patient medical comorbidities, accurate medication reconciliation, and knowledge of any over-the-counter, vitamin, supplement, or herbal preparations the patient may be taking. Co-administration of drugs that act on the same or similar receptors are increase the risk of pharmacodynamic drug interactions, including serotonin syndrome, anticholinergic intoxication, seizures, and QTc prolongation.

POLYPHARMACY

At every visit, conducting medication reconciliation and ensuring its accuracy is crucial. Nurses should have a comprehensive understanding of all medications the patient is currently taking, encompassing prescriptions, herbal supplements, vitamins, and over-the-counter medications. It is important to approach medication reconciliation in a manner that encourages the patient to disclose all types of medications, minimizing the risk of unintentional omissions. Caregivers and home health providers can play a valuable role in verifying the patient's medications at their residence and providing updates on functional status. Armed with this information, one can proactively work toward preventing harmful drug-drug interactions and the potential for polypharmacy in older patients.

Polypharmacy is a term used to describe the use of five or more prescription medications at one time. One study found that 16.8% of individuals 65 to 74 years of age have polypharmacy [69]. This number increases to 25.8% for those 75 to 84 years of age and to 34.2% for those 85 to 94 years of age. Polypharmacy and physiologic changes both contribute to the risk and severity of drug-drug interactions in older adults. There are several potential negative outcomes of drug-drug interactions in older patients, including but not limited to shorter life expectancy, decreased overall quality of life, increased hospitalization and rehospitalization, and increased financial burden. It is estimated that one in six older adults is at increased risk for a significant drug-drug interaction [88].

As discussed, it is important for nurses to be well versed in the normal physiologic changes that impact drug absorption, distribution, metabolism and excretion; the risks of polypharmacy; and potential drug-drug interactions. For example, if a patient is prescribed both lithium carbonate and hydrochlorothiazide, this combination carries an increased risk of lithium toxicity and nephrotoxicity; nurses involved in the care of this patient should be vigilant for the signs and symptoms of lithium toxicity and provide patient and/or family/caregiver teaching regarding this potential effect. Medication interaction checkers can provide point-of-care information for provider and patient regarding the potential drug-drug interactions. Nurses should also remember that non-prescription drugs and natural products (e.g., supplements, herbal medications, vitamins) should be included in care planning and monitoring; checkers are also available for natural and over-the-counter products.

BEERS CRITERIA

The Beers criteria were first developed in 1991 by Mark Beers, MD, and colleagues and have since transitioned to the American Geriatric Society (AGS) [31]. The purpose of the Beers criteria is to identify medications that may pose a higher risk to older adults; these risks include drug-drug interactions, increased risk of side effects, increased risk when used with certain medical comorbidities, and dosing adjustments required for the physiological changes that occur with aging [31]. The Beers criteria aim to assist prescribers in making pharmacologic decisions in the best interest of the patient while acknowledging risks and potentially seeking alternatives to the medications on the list. The list serves to identify specific potentially inappropriate medications, with the goal of decreasing exposure to these drugs in older patients. The AGS released the most recent update to the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults in 2023 [31]. The Beers criteria is intended for use by prescribers, though a strong case can be made for its importance to nurses who administer medications and spend more time observing the patient. The list is also not intended to be punitive or as a replacement for clinical judgment by providers.

POTENTIALLY INAPPROPRIATE PSYCHIATRIC MEDICATIONS AND THE ELDERLY

Benzodiazepines

Benzodiazepines are anxiolytic medications known for their calming, sedating effects and have been a topic of discussion, and controversy, for decades among the medical community. In 1955, chemist Leo Sternbach identified the first benzodiazepine, chlordiazepoxide [32]. Variations of chlordiazepoxide emerged, and by the 1970s, benzodiazepines were among the most prescribed medications in the United States. This increase in prescribing coincided with increased issues associated with use of these

medications, which are still relevant today: misuse, diversion, and unfavorable side effects. In the 1990s, benzodiazepines began to undergo scrutiny, with additional questions surrounding safety. Although it was initially believed that this class of medications was non-habit-forming, this was discovered to be untrue.

Despite potential drawbacks, benzodiazepine prescribing continues to rise in general, with a 2019 study noting a rise in prescription of this drug class among primary care providers and other specialty providers (except for psychiatrists, whose benzodiazepine prescribing remained stable) [33]. Clinical indications remain for benzodiazepines, though their use should be limited to short-term courses, with caution. Specifically, the 2023 Beers criteria note that benzodiazepines may be appropriate for seizure disorders, REM sleep disorder, benzodiazepine or ethanol withdrawal, severe generalized anxiety disorder, and procedural anesthesia [31]. A short course of a benzodiazepine may also be used for acute agitation.

Special consideration should be given when using these agents in older adult patients, due to the discussed age-related physiologic changes. Slowed metabolism and excretion of medications with increased age results in extended effects of longer-acting benzodiazepines (or those with longer half-lives); these drugs should be assessed closely for appropriateness. Benzodiazepines with longer half-lives include diazepam, clonazepam, and chlordiazepoxide. Examples of shorter-acting benzodiazepines include alprazolam, temazepam, and lorazepam. The benefit-to-risk ratio should be carefully evaluated any time a benzodiazepine is prescribed, due to their potential for drug-drug interactions and psychological and/or physiological dependence. Short-term benefits possible with benzodiazepines may not be worth the risk of prescribing to older adults; other classes of drugs should be considered, when possible [30]. General side effects of benzodiazepines include sedation, dizziness, confusion, and slurred speech. In older adults, benzodiazepines are associated with an increased risk of falls and potential fractures, cognitive impairment, delirium, and motor vehicle crashes [31].

Nurses play a crucial role in patient education, facilitating informed consent and shared decision-making. In cases in which a patient has been on a long-term benzodiazepine prescription, they may not recall the associated risks, benefits, side effects, and alternatives. By providing education, nurses can equip the patient with sufficient information to consider tapering off the benzodiazepine. When assuming the care of a patient on benzodiazepine therapy, nurses can engage in discussions about safe and gradual tapering, while ensuring regular follow-up appointments based on mutual agreement between the patient and provider. While complete discontinuation may not be feasible for some patients, dose reductions can still be beneficial in managing side effects. Additionally, it is important for to be familiar with their state's prescription drug monitoring program, allowing for a thorough review of any controlled substances prescribed to the patient.

Antipsychotics

The term antipsychotic is frequently used to describe medications that target dopamine receptors, serotonin receptors, or both, though use is considered outdated and confusing due to the medication class's utility in the treatment of psychosis, mania, or depression—not just psychosis [34]. Also referred to as neuroleptics, these medications were introduced in the 1950s and were originally developed to treat psychosis. Chlorpromazine was found to improve mania and to have sedating, antihistamine effects; however, it was nearly entirely disregarded [35].

Additional first-generation antipsychotics were developed, including haloperidol, perphenazine, and fluphenazine. These drugs mainly acted by means of dopamine-2 antagonism. Side effects of these first-generation antipsychotic medications include sedation, dry mouth, extrapyramidal symptoms, and neuroleptic malignant syndrome. Extrapyramidal symptoms encompass several different types of movement-related side effects caused by antipsychotics, including akathisia, tardive dyskinesia, neuroleptic-induced parkinsonism, and dystonia. These symptoms can be particularly troublesome for many patients. Initially, it was thought that the more extrapyramidal symptoms the medication caused, the more effective the drug would be in managing psychotic symptoms; this is now known to be untrue.

The very first atypical, or second-generation, antipsychotic was clozapine, developed in 1958. During trials, it was found that clozapine relieved psychotic symptoms without causing as many extrapyramidal symptoms as the first-generation agents. Clozapine prescriptions increased in Europe until the 1970s, when patients started developing agranulocytosis (more commonly referred to as neutropenia) [36]. This caused withdrawal of the drug from the market in the countries in which it was approved and delayed its approval in the United States. In the 1990s, clozapine was approved for limited use in the United States for treatment-refractory schizophrenia, under strict monitoring and dispensing guidelines [36]. Clozapine's different mechanism of action than the first-generation antipsychotics led to the development of more medications that worked on both the dopamine D2 receptor and the serotonin 2A receptors.

As other second-generation antipsychotic medications entered the market, they were observed to cause fewer extrapyramidal symptoms than the typical antipsychotics. However, the second-generation antipsychotics are associated with a new potential drawback: metabolic side effects. Many of the second-generation antipsychotics are known to cause weight gain, dyslipidemia, elevations in blood pressure, abdominal circumference, and blood glucose levels. Furthermore, both first- and second-generation antipsychotic medications are on the Beers criteria list as a class with the suggestion to avoid use unless being used to treat schizophrenia, bipolar disorder, or for short-term management of chemotherapy-associated nausea and vomiting [31]. Other possible side effects of both first- and second-generation antipsychotics include QTc prolongation, hyperprolactinemia, and orthostatic hypotension.

The entire drug class of antipsychotic medications carries a boxed warning specific to the elderly population related to increased mortality in patients with dementia-related psychosis. The package insert for olanzapine reads, "Cerebrovascular adverse events (e.g., stroke, transient ischemic attack), including fatalities, were reported in patients in trials of olanzapine in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of cerebrovascular adverse events in patients treated with olanzapine compared to patients treated with placebo" [37].

Akathisia

Akathisia is the subjective feeling of internal restlessness; this can often be observed as shifting, resituating, crossing and uncrossing legs, rocking, pacing, self-reported anxiety symptoms, and/or a rapid shift from sitting to standing [21]. The underlying mechanisms of akathisia have not been clearly defined, though it is suspected to be related to the dopamine D2 binding affinity of antipsychotic medications [38]. Women are more susceptible to akathisia than men. Akathisia can be quite distressing for the patient and careful assessment should attempt to differentiate other conditions (e.g., anxiety) from akathisia. The Barnes Akathisia Rating Scale (BARS), a four-item scale, is the most-used screening tool for akathisia [21].

Tardive Dyskinesia

Tardive dyskinesia is a delayed effect of antipsychotic medications and includes stereotypical, involuntary, abnormal movements of the muscles of the head, limbs, and trunk [21]. Tardive dyskinesia can more specifically be observed as lip smacking, puffing of the cheeks, or other repetitive perioral movements. It typically presents after six months of treatment but has been observed as early as one month following the initiation of a dopamine D2 receptor antagonist [39]. Women are more susceptible to developing tardive dyskinesia than men. First-generation (typical) antipsychotic medications bind more tightly to the dopamine D2 receptor and therefore are more likely to cause tardive dyskinesia than second-generation (atypical) antipsychotic medications [39].

The DSM-5-TR recognizes tardive dyskinesia and outlines diagnostic criteria for its diagnosis; it is important to note that the symptoms must persist for one month following discontinuation of the offending medication in order to qualify for diagnosis [40]. Tardive dyskinesia symptoms range in severity from mild to debilitating. Patients may be assessed using the Abnormal and Involuntary Movement Scale (AIMS) to evaluate abnormal or involuntary movements that may be associated with tardive dyskinesia.

Neuroleptic-Induced Parkinsonism

Neuroleptic-induced parkinsonism can cause a cluster of symptoms, including muscle stiffness, tremor, drooling, shuffling gait, cogwheel rigidity, shuffling gait, and stooped posture [21]. Like akathisia and tardive dyskinesia, women are more likely than men to develop neuroleptic-induced parkinsonism; however, with this side effect, older adults are also more susceptible than younger patients. Higher potency medications and agents with lower anticholinergic effects (e.g., haloperidol) are more likely to cause this side effect [21]. The efficacy of antipsychotic, or neuroleptic, medications in the elderly is not well-established, though they are used with relatively high frequency. Differentiating neuroleptic-induced parkinsonism from genuine Parkinson disease can be difficult for general practitioners, psychiatric providers, and even neurologists. The recommended tools to assess for parkinsonism and related movement disorder symptoms are the Unified Parkinson's Disease Rating Scale and the Hoehn and Yahr (H&Y) Staging Scale [41].

Dystonia

Dystonia is a movement disorder characterized by intermittent or constant muscle contraction causing slow, twisting movements that may lead to abnormal postures [42]. These sometimes-abrupt muscle movements can be painful and frightening to the patient and can include oculogyric crisis, acute torticollis, abnormal postures of the limbs and trunk, tongue protrusion, and laryngeal-pharyngeal dystonia [21]. Dystonic reactions are more common in young men who have been given doses of high-potency antipsychotic medications [21].

Treatment of Extrapyramidal Symptoms

The treatment of any extrapyramidal symptoms involves administration of anticholinergic medications and/or antihistamines. Certain novel agents that act by reversibly depleting monoamines (e.g., dopamine, serotonin, norepinephrine, histamine) from nerve terminals that are approved for the management of tardive dyskinesia [43]. Improvement in symptoms is also possible via decreasing the dose of or discontinuing the offending agent. It is worth mentioning that antipsychotic medications/neuroleptics are not the only medications that can cause extrapyramidal symptoms, but they are common causes.

Neuroleptic Malignant Syndrome

Aside from extrapyramidal symptoms, antipsychotic medications are known to be associated with the rare but potentially life-threatening complication of neuroleptic malignant syndrome. Neuroleptic malignant syndrome can occur at any time during antipsychotic treatment and has symptoms that initially closely resemble a dystonic reaction. This syndrome can be differentiated from dystonia by its autonomic symptoms of diaphoresis, tachycardia, hypertension, and hyperthermia [21]. Neuroleptic malignant syndrome may also present with abnormal laboratory findings, including elevations in white blood cell counts, creatinine phosphokinase, and liver enzymes [21]. Cases of neuroleptic malignant syndrome in older adults are not well-studied; however, one case report suggested that prescription of antipsychotic medications for older adults at unadjusted dosages (appropriate for younger adults) leads to increased risk.

Despite this extensive side effect profile, first- and second-generation antipsychotics still cautiously have a place in a treatment regimen for older adult patients. A commentary on the *Expert Consensus Guidelines for Using Antipsychotic Agents in Older Patients* suggests that it is inappropriate to use antipsychotic medications in the older adults with generalized anxiety disorder, panic disorder, insomnia, nonpsychotic major depressive disorder, and severe nausea and vomiting [44]. The 2016 APA guidelines recommend that use of non-emergency antipsychotic agents for treatment of dementia-related psychosis should be limited to those patients with severe or dangerous symptoms or symptoms that cause significant distress to the patient (or care partner) after objective discussions about the risks and benefits. Second-generation antipsychotics (e.g., brexpiprazole, pimavanserin) are often considered for short-duration off-label use under close monitoring when absolutely necessary [45]. Antipsychotic medications can be used with caution in the older adult with schizophrenia and bipolar disorder.

Antidepressants

The discovery of the first medication for depression, like the first antipsychotic, happened somewhat by accident. During the period when isoniazid was being used to treat tuberculosis infections, another drug called iproniazid was being developed for the same purpose. Interestingly, it was observed that "side effects" of iproniazid included improvements in sleep, mood, appetite, and psychostimulation, although these effects were not well understood at the time [46]. Subsequently, in 1958, iproniazid became the first antidepressant medication in the class of monoamine oxidase inhibitors (MAOIs). However, as its use increased, adverse reactions (e.g., hypertensive crisis) were noted, often due to MAOIs' interactions with tyramine-rich foods, including aged meats and cheeses [46].

Around the same time, while efforts were underway to develop newer and more effective antipsychotic medications, imipramine was discovered as the first tricyclic antidepressant. Although it did not show improvement in psychotic symptoms, it demonstrated significant efficacy in treating severe depressive symptoms [46]. In the 1960s and 1970s, research began to focus on the role of serotonin in mood and other functions. Subsequently, in the 1980s, fluoxetine emerged as the first selective serotonin reuptake inhibitor (SSRI). Following this, agents targeting norepinephrine and dopamine, such as venlafaxine and duloxetine, were developed.

The Beers criteria identify antidepressants with strong anticholinergic activity, alone or in combination, as drugs to avoid in older adults, as these medications are sedating and may cause orthostatic hypotension. Specifically, antidepressants to avoid include amitriptyline, amoxapine, clomipramine, desipramine, doxepin (>6 mg/day), imipramine, nortriptyline, and paroxetine. The effects of these agents predispose older adults to falls and related injury [31]. Paroxetine affects both anticholinergic and antihistamine receptors, leading to more sedation compared to other SSRIs [47]. It is worth noting that doxepin in doses of 6 mg or less has a safety profile similar to placebo.

In addition to anticholinergic effects and falls risk, certain antidepressants may pose other risks to older adults. SSRIs may cause hyponatremia, a relatively common side effect in older patients [21]. Research has identified frequent coprescription of antidepressant medications with other central nervous system (CNS)-acting agents, which may contribute to increased falls risk in this population [47].

Anticholinergic Medications

Anticholinergic medications block acetylcholine, thus inhibiting the action of the parasympathetic nervous system and can be further differentiated into antimuscarinic blockers and antinicotinic blockers [48]. Common anticholinergic medications include benztropine, trihexyphenidyl, oxybutynin, and scopolamine. Benztropine and trihexyphenidyl are two commonly prescribed medications to treat extrapyramidal symptoms caused by antipsychotic medications. Older adults have decreased acetylcholine-induced transmission within the central nervous system, making them more susceptible to undesirable effects of the medications [48]. Older adults are also more likely to have acquired medical conditions that require treatment with anticholinergic agents, like prostatic hypertrophy, urinary retention, and narrow-angle glaucoma [21].

DE-PRESCRIBING

The treatment plan for the older adult experiencing unacceptable side effects of psychopharmacology should include the practice of deprescribing or tapering and/or discontinuing medications that have been deemed to be more harmful than helpful. Some have proposed a distinction between the terms polypharmacy and medication overload [49]. As noted, polypharmacy is defined as taking five or more medications, which may or may not be associated with adverse effects. Conversely, medication overload describes cases of multiple medications (with no clear quantification as to number of medications) being prescribed to the patient in which the harms outweigh the benefits [49]. Some groups have called for a national strategy to address the issue of medication overload and thus improve the quality of life of older adults. In many cases, older adults can benefit significantly from deprescribing to mitigate problematic and life-altering side effects.

Patients with behavioral and psychological symptoms of dementia are at heightened risk for psychiatric medication-related risks and side effects associated with the antipsychotic medications. The American Psychiatric Association (APA) guidelines suggest deprescribing antipsychotic medications to older patients with dementia after three months [50]. There is a lack of consensus of the dosing recommendations for older adults with dementia, and higher antipsychotic dosages have been associated with worse discontinuation syndromes among these patients [51]. The APA recommend limiting doses to maximums of 50 mg of quetiapine, 1.75 mg of olanzapine, and 0.5 mg of risperidone in those with dementia [51].

Deprescription of antipsychotics in the older adults with behavioral and psychological symptoms of dementia did not experience worsened symptoms following discontinuation of the antipsychotic medication [52; 53].

Nursing and advanced practice nursing care of the older adult extends beyond the patient with psychiatric diagnoses, as potentially inappropriate medications could be prescribed off-label for a variety of reasons. For example, quetiapine may be prescribed in low doses for insomnia in psychiatry and primary care practice. Tricyclic antidepressants (which may prolong the QTc interval) may be used for a combination of insomnia, chronic pain, and nocturia. Anticholinergic medications (e.g., benztropine) may be prescribed alongside antipsychotic medications without evidence of movement-related side effects. A combination of the Screening Tool of Older Person's Potentially inappropriate Prescriptions and the Screening Tool of Alert doctors to the Right Treatment (STOPP/START) can be used to detect prescribing omissions and potentially inappropriate medications in this population [54].

In one qualitative study, most patients did not think they were taking an inappropriate number of medications but were open to the idea of deprescription [55]. A strong therapeutic alliance is necessary in helping the patient to understand the risks associated with medication overload. Factors that contribute to a positive attitude of older adults toward deprescribing include trust in the healthcare provider, adverse effects on quality of life from current medications, prospect of follow-up and monitoring, and alternative treatment options [55].

It is important to remember that polypharmacy may be necessary, particularly for patients with chronic conditions. It is up to the nurse to consider each patient situation on a case-by-case basis.

UNDERSTANDING HOW MEDICAL COMORBIDITIES IMPACT MENTAL HEALTH

As discussed, individuals are more likely to develop medical comorbidities as they age; the most common chronic conditions in older populations include depression, osteoarthritis, dementia, neck and back pain, cataracts, and chronic obstructive pulmonary disease (COPD) [56]. Older adults often have multiple diagnoses simultaneously, which can have varying effects on their mental health and affect treatment options.

FRAILTY

Frailty is a condition commonly observed in older adults, characterized by the cumulative decline in multiple physiological systems over a lifetime [57]. This change disrupts the body's homeostasis and increases vulnerability to minor insults. Frailty in older adults is associated with an elevated risk of falls, delirium, and varying degrees of disability [57]. Medical comorbidities, decreased immune response, and social and psychological vulnerabilities further complicate the healing process for older adults, making it more challenging for them to recover from illnesses [58].

CHRONIC PAIN CONDITIONS

Pain and depression often coexist in older adults, with each condition often exacerbating the other. Research has supported a correlation between depression and chronic pain, as well as between depression and sleep disturbances; sleep and physical activity level are mitigating factors [59]. Chronic pain can have adverse effects on older adults, not only in terms of physical well-being but also socially and emotionally. Another study involving Chinese nursing home residents reported that 46% experienced mild-to-severe pain and 20.7% exhibited symptoms of depression [60]. Monitoring nursing home residents with pain is essential, as they may experience lower levels of social support and self-rated health and are more likely to exhibit higher levels of depression compared with those with stronger perceived social support or better self-rated health [60]. Chronic pain can also contribute to functional impairments in certain patients.

COVID-19

The COVID-19 pandemic was associated with uncertainty and anxiety, particularly for the older population, who were at higher risk due to medical comorbidities and frailty [58]. Older individuals face an increased risk of developing severe COVID-19 or medical complications associated with infection. During the first waves, older adults had a three times higher risk of death from secondary pneumonia compared with the general population [58]. Social distancing measures, implemented to control the spread of the virus, posed additional challenges for older adults, who often already are experiencing loneliness and disconnection [58]. Moreover, those living in long term-care facilities often experienced complete isolation, leading to limited physical interactions with others.

During the early peak of the pandemic, older adults experienced prolonged periods of isolation, which exacerbated existing mental health symptoms or resulted in the development of new mental health disorders in some patients [61]. In one study, increased stress, anxiety, depression, and PTSD symptoms were noted across different age groups during the initial and subsequent waves of COVID-19. Interestingly, older adults demonstrated more adaptive and relaxed coping strategies compared with younger participants [61]. The lower likelihood of developing PTSD-related symptoms in older adults is consistent with their generally lower rates of PTSD [26].

CHRONIC ILLNESS

In addition to physical symptoms, those with chronic conditions may experience psychological and emotional manifestations that may result from the physical symptoms of and treatments for the disease. Because the diagnosis process can be protracted for many chronic illnesses, individuals who receive the diagnosis may be relieved to finally have a name for the condition that afflicts them; the chronic nature of the condition may not be of immediate importance. Initially, the individual may be more focused on treating the symptoms rather than the realization that there is no cure. Individuals with chronic illness often face the uncertainty of the disease process, including the unpredictability of disease flares and remissions. Thus, living with a chronic disease can be overwhelming for patients, marked by uncertainty and the potential loss of function secondary to the disease process.

The psychological impacts of chronic disease can be variable, affecting family life, work, sexual activity, social activities, finances, and day-to-day living [62]. The diagnosis may impact one's current lifestyle and result in a need for changes in that lifestyle pattern. It may affect the ability to maintain employment status, alter financial stability, and create a potential for the loss of a role, status, or independence, all of which can be further affected by advanced age.

NONPHARMACOLOGIC TREATMENT OPTIONS

According to the MacArthur model of healthy aging, maintaining a low risk of disease-related disability and remaining engaged in social activities are key factors in promoting healthy aging [12; 63]. Considering the potential risks associated with certain medications in older adults, there are numerous options available for addressing psychiatric symptoms in this population aside from pharmacotherapy. Nonpharmacological options such as phototherapy, reminiscence therapy, cognitive-behavioral therapy (CBT), creating a familiar environment in long-term care, tai chi, and walking are worth exploring.

For older adults (65 years of age or older) with mild-to-moderate major depressive disorder, the Department of Defense/ Veterans Affairs suggests offering a first-line psychotherapy (e.g., cognitive-behavioral therapy, interpersonal therapy, mindfulness-based cognitive therapy). Patient preference and the additional safety risks of pharmacotherapy should be considered when making this decision.

(https://www.healthquality.va.gov/guidelines/MH/mdd/VADODMDDCPGFinal508.pdf. Last accessed January 24, 2025.)

Strength of Recommendation: Weak for

PSYCHOTHERAPY

Psychotherapy is a noninvasive and evidence-based approach for treating various mental health conditions, often considered a safer alternative to medication for older patients. When providing psychotherapy to older adults, it is important to consider their unique needs. These patients may strive to find a balance between self-acceptance, contentment, engagement, and personal growth in later life [12]. Functional limitations, family stressors, and social support factors should be considered during psychotherapy sessions.

Reminiscence Therapy

Reminiscence therapy is a treatment that places focus on reflections on life and the aging process and makes use of the patient's remote memory [12; 64]. Simple, or unstructured, reminiscence therapy focuses on the telling of life events with focus on the positive to enhance well-being. Unstructured reminiscence therapy can be done in a group format and does not have to be provided by a psychotherapist. Conversely, structured reminiscence therapy involves moving through the life events in an organized way and reframing thoughts about the events in a positive light [12].

In one study, reminiscence therapy was found to be effective at decreasing death anxiety and increasing adaptation to the aging process among older adults [17]. Reminiscence therapy has a growing body of research and may help with improving self-esteem, enhance socialization, and improve symptoms of depression and anxiety in older adults [17; 64].

Cognitive-Behavioral Therapy

CBT is widely used in psychotherapy, including with older adults, for treating various conditions such as depression, anxiety, schizophrenia, insomnia, dementia, and bipolar disorder [12]. This approach aims to identify and challenge faulty or harmful perceptions, enhance understanding of the problem, promote healthier thinking patterns, and improve behavioral outcomes. When working with older adults, adjustments to the treatment plan may be necessary. The therapist can address multiple physical, emotional, social, and cognitive issues brought by the older adult by setting weekly agendas, prioritizing topics, building skills, and focusing on abilities rather than disabilities [12].

CBT for insomnia (CBT-I) is a particularly effective nonpharmacological treatment option for insomnia in older adults. Instead of prescribing potentially inappropriate medications, CBT-I targets the underlying causes of insomnia and has demonstrated efficacy and safety as a first-line treatment for healthy older adults [65]. In general, CBT should be considered as a primary treatment approach for various psychiatric symptoms in older adults.

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the National Collaborating Centre for Mental Health, the recommended high-intensity psychological intervention for persons with generalized anxiety disorder is cognitive-behavioral therapy (CBT) or applied relaxation.

(https://www.nice.org.uk/guidance/cg113. Last accessed January 24, 2025.)

Level of Evidence: Expert Opinion/Consensus Statement

PHOTOTHERAPY

Phototherapy, also known as bright-light therapy, is a nonpharmacologic intervention most notably used in the treatment of seasonal affective disorder. With this approach, the patient follows the daily habit of sitting in front of a 1,500–10,000 lux lightbox each morning before sunrise [21]. One study explored the use of phototherapy in the treatment of mild-to-severe dementia. The researchers found that the phototherapy was more effective in managing the behaviors associated with severe dementia than mild-to-moderate dementia, but overall, the phototherapy was no more effective than placebo [66]. Another study focused on the treatment of sleep-related problems and the potential role of phototherapy, finding the approach effective for improving the sleep of healthy older people [67]. Another study noted the documented efficacy of phototherapy for seasonal affective disorder and bipolar depression, but studies including and/or focusing on older adults are limited.

COMPLEMENTARY AND ALTERNATIVE THERAPIES

Tai Chi

Tai chi originated as a form of martial art and can also be implemented as a form of Chinese medicine [68]. It is important to note that what is commonly referred to as tai chi in the literature does not represent the ancient, complex traditional practice and is often a modified version [81]. It has been adapted in some places as a low-impact exercise that employs slow, gentle movements with breathing and cognitive techniques to strengthen and relax the body and mind [82]. These modifications, along with video streaming services, have made tai chi a more accessible practice for those who want a gentle, low-impact form of exercise.

One study sought to compare measures related to fall risk (e.g., strength, fear of falls, balance, functional mobility) in a group receiving a tai chi course and a group who did not (i.e., control group) [68]. This study found that the tai chi group improved in all measures, while the control group did not. The improvements in strength and ability to perform functional tasks can serve as a potential fall prevention intervention [68]. This supports the use of community-based tai chi programs in improving fall-risk measures in older adults. There is evidence that tai chi is effective in decreasing symptoms of depression and anxiety, managing stress, and ensuring exercise self-efficacy [10; 70].

In a 2018 study, depressive symptoms improved among older adults who participated in a tai chi program for one hour, three times per week for 24 weeks [10]. Evidence supports tai chi as a reasonable option for older adults. These patients should seek guidance of their primary care provider, physical therapist, and other relevant providers prior to starting a new exercise program.

Chamomile and Lavender

Drinking herbal tea, particularly chamomile-based and lavender-based teas, is a traditional approach to managing symptoms of insomnia. Chamomile is commonly found in commercially available herbal teas and has been promoted for inducing a sense of calm and relaxation. One study involving hospitalized older adults with sleep disorders provided participants with oral preparations of chamomile for four weeks [71]. The intervention significantly improved the sleep quality of the older adults compared with placebo. Similarly, a separate study demonstrated the utility of lavender tea in improving sleep, depression, and anxiety symptoms in the intervention group [72]. In addition, diffusing lavender oil at bedtime for older adults has been found to enhance sleep quality and reduce early morning arousals [73].

Aromatherapy

Aromatherapy is considered a gentle intervention appropriate for all age groups, including older adults [74]. There is, however, very little literature supporting the use of essential oils alone to treat psychiatric symptoms in any population. Limited studies have found that aromatherapy, when paired with massage, can significantly decrease depression- and anxiety-related symptoms in older adults [75; 76]. Most of the literature surrounds the use of diffused lavender oil to support relaxation and sleep. Aromatherapy can also be paired with therapeutic massage as a complementary treatment.

ELDER ABUSE

Elder abuse is a significant issue in the United States, but it is often under-reported; nurses play a crucial role in the identification and reporting of this abuse. An estimated 10% of older adults living at home have experienced elder abuse, including exploitation and neglect [77]. Having knowledge about the different types of elder abuse can assist nurses and other healthcare providers in recognizing signs and symptoms. Their vigilance and action are essential in addressing this problem and ensuring the safety and well-being of older adults.

Elder abuse encompasses physical, sexual, emotional/psychological, neglect, and financial abuse/exploitation. It is often perpetrated by individuals known to the older adult, contributing to significant under-reporting [77]. Victims may be financially dependent on the abuser and lack social support, making help-seeking complicated. They may choose not to question suboptimal care (e.g., missed baths) due to the awareness of caregiver busyness. A qualitative study explored the perceptions and experiences of older adults who had been victims of abuse [78]. One participant described increased vulnerability due to limited mobility and dependence on others for transportation when wheelchair-bound [78]. The study identified four overlapping themes in the participants' reports [78]:

- Vulnerability associated with old age
- Early-life experiences
- Perceptions of abuse
- Consequences and suffering resulting from the abuse

Intimate partner violence (IPV) can manifest in various settings and contexts, often intertwined with other forms of elder abuse, making it challenging to identify specific population needs [79]. In a study involving rural women, many reported experiencing highly controlling behavior as a significant source of stress, although not necessarily identified as IPV [79].

Another study revealed a high prevalence of elder abuse within institutions [80]. The most reported types of institutional elder abuse were psychological/emotional (33%), followed by physical (14.1%), financial (13.8%), neglect (11.6%), and sexual (1.9%) abuse [80].

There is a lack of consensus regarding an appropriate screening tool for assessing elder abuse and the circumstances under which assessment should take place. Nurses, however, hold unique positions that allow them to inquire about abuse during routine visits, potentially recognizing signs of elder abuse and providing necessary interventions.

CULTURAL PERSPECTIVES

International migration, childbearing patterns, and mortality trends have a significant impact on the cultural diversity of the United States [83]. It is the responsibility of all healthcare providers to deliver culturally competent care that takes the patient's own self and culture into consideration; this has been shown to reduce healthcare disparities and improve health outcomes [83]. The U.S. population is becoming increasingly diverse, with notable increases projected in African American, Asian, Pacific Islander, and Native American populations by 2050 [83]. These demographic shifts necessitate an increased ability for nurses and all healthcare providers to provide culturally competent care. It is crucial, however, for nurses to engage in personal reflection and confront their own potential implicit and explicit biases. Implicit bias is defined as attitudes toward a specific social group of which one is not consciously aware and that could negatively influence care. Acknowledging and addressing areas of possible implicit bias are important steps to truly providing culturally competent care.

One key element of culturally competent care includes using professional interpreters instead of relying on family or friends ("ad-hoc" interpreters) for interpretation when caring for a patient with limited English proficiency [84]. When working with an interpreter, it is important for the provider and the interpreter to face the patient directly, with nurse addressing the patient directly rather than focusing on the interpreter.

When treating older adult patients of cultures different from one's own, it is important to ascertain any values or beliefs related to health care or treatment the patient would like to discuss [84]. If in doubt, one may simply ask if there are any aspects of the patient's culture they would like to discuss prior to the appointment. It is important to note older adults who are part of the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+) community will encounter similar challenges to their cisgender, heterosexual peers, along with challenges specific to belonging to a minority group, like discrimination and social/structural barriers [85].

Both organizations and individual nurses have a responsibility to provide culturally competent care to a quickly growing older population. At the organizational level, the American Association of Colleges of Nursing has curated a list of cultural competencies for baccalaureate nursing and master's nursing programs to consider when developing programs and courses [86]. Colleges and universities follow these standards to ensure that methods to address social determinants of health and the health needs of minority groups are included in their curricula; the goal is to prepare the future nurse to address these issues in practice. Individual techniques for overcoming bias among healthcare providers include understanding as much as possible as one can about a certain culture and broadening one's understanding of racism, ethnocentrism, and disenfranchisement that affect people of color and other minority groups [83].

CONCLUSION

The older adult population (those 65 years of age and older) of the United States is rapidly growing and is projected to reach 1 in 5 individuals by 2050 [3]. This significant increase necessitates a greater focus on addressing the mental health needs of older adults. Due to medical comorbidities, age-related changes affecting drug metabolism, drug-drug interactions, and potential frailty, older adults are particularly vulnerable when it comes to mental health care. Nurses should possess the ability to explain mental health conditions and understand how these conditions may manifest differently in the older adult. They should also have knowledge of age-related changes that impact medication pharmacokinetics. Familiarity with psychiatric medications, including their mechanisms of action, side effects, effects specific to the elderly, and dosing requirements, is crucial when providing best-quality care to this population. It is worth noting that certain medical comorbidities can complicate the clinical picture. Nurses should also be well-versed in non-pharmacologic treatment options for older adults with mental health concerns. Providing culturally competent care to this growing population while ensuring patient safety and optimal outcomes is of utmost importance.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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