Geriatric Psychiatry Assessment and Treatment Guide

A Comprehensive Guide for Psychiatric Providers

Purpose: This guide provides psychiatric nurse practitioners, physician assistants, and other mental health clinicians with evidence-based approaches to assessing and treating mental health disorders in older adults, with special attention to the unique biological, psychological, and social factors affecting this population.

Introduction

Geriatric psychiatry requires specialized knowledge and approaches that address the unique needs of older adults. As the population ages, psychiatric providers increasingly encounter older patients with complex presentations that differ significantly from those seen in younger adults. This guide
provides practical, evidence-based approaches to geriatric psychiatric assessment and treatment, with special attention to the biological, psychological, and social factors that influence
mental health in later life. The importance of specialized geriatric psychiatric care cannot be overstated. Older adults experience mental health disorders in the context of age-related physiological changes, multiple medical comorbidities,
cognitive changes, medication effects, and significant life transitions. Without attention to these factors, psychiatric assessment may be inaccurate and treatment may be ineffective or even harmful.

This guide moves beyond general psychiatric principles to provide geriatric-specific approaches that can be immediately implemented in clinical practice. Each section includes practical assessment tools, treatment considerations, and clinical pearls
specific to older adults. Special attention is given to distinguishing normal aging from pathological processes, managing the complex interplay between physical and mental health, and addressing the unique social and ethical considerations that arise in geriatric psychiatric care.

Comprehensive Geriatric Psychiatric Assessment

Comprehensive assessment is the foundation of effective geriatric psychiatric care. This approach integrates standard psychiatric evaluation with geriatric-specific elements to ensure accurate diagnosis and appropriate treatment planning.

Initial Assessment Framework

The initial geriatric psychiatric assessment should be comprehensive but adapted to the patient's stamina and cognitive status. Key components include: **History taking considerations:** - Allow extra time for comprehensive assessment - Include collateral information from family/ caregivers (with patient consent when possible) - Focus on recent changes rather than long-standing patterns - Assess for both psychiatric and physical symptoms - Document baseline functional status and recent changes - Review complete medication list, including over-the-counter medications and supplements

Clinical Pearl:
Medical History Icon

When interviewing older adults, sit facing them at eye level, ensure adequate lighting, minimize background noise, and speak clearly (not loudly) at a moderate pace. These simple adjustments accommodate common sensory changes and significantly improve the quality of the clinical interview.

Essential screening tools: - Cognitive screening (Mini-Cog, MMSE, or MoCA) - Depression screening (Geriatric Depression Scale) - Anxiety assessment (GAD-7 or Geriatric Anxiety Scale) - Functional assessment (ADLs and IADLs) - Pain assessment (Verbal Descriptor Scale or Pain Assessment in Advanced Dementia for cognitively impaired) - Substance use screening (including alcohol, prescription medications, and cannabis) - Elder abuse screening

Physical health assessment: - Review of systems with attention to neurological symptoms - Medication review with focus on psychoactive properties - Vital signs including orthostatic blood pressure - Basic neurological examination - Review of recent laboratory and imaging studies - Assessment of sensory function (hearing, vision) - Evaluation of gait and balance

Social and environmental assessment: - Living situation and safety - Available support system - Financial resources and concerns - Cultural factors affecting care - Advance directives and end-of life preferences - Caregiver assessment when applicable

Cognitive Assessment

Cognitive assessment is essential in geriatric psychiatric evaluation, both to identify cognitive disorders and to understand how cognitive status affects other psychiatric conditions.

Recommended cognitive screening approach: 1. Initial brief screening with Mini-Cog (3-minute clock drawing and 3-item recall) 2. If concerns identified, proceed to more comprehensive screening: - Montreal Cognitive Assessment (MoCA) - more sensitive for mild cognitive impairment - Mini Mental State

Examination (MMSE) - widely used but less sensitive for mild impairment 3. Domain-specific testing as indicated: - Trail Making Test for executive function - Verbal fluency for language and executive function - Clock drawing test for visuospatial function

Cognitive Assessment Interpretation Guide:

Physical Health Icon 

Mini-Cog Interpretation: - Score 0-2: Positive screen for dementia - Score 3-5: Negative screen for dementia **MoCA Interpretation:** - Score 26-30: Normal cognition - Score 18-25: Mild cognitive impairment - Score 10-17: Moderate cognitive impairment - Score <10: Severe cognitive impairment - Add 1 point for ≤12 years of education **MMSE Interpretation:** - Score 24-30: Normal cognition - Score 19-23: Mild cognitive impairment - Score 10-18: Moderate cognitive impairment - Score <10: Severe cognitive impairment

Distinguishing delirium, dementia, and depression:

Onset	Acute, often sudden	Gradual, insidious	Variable, often subacute
Course	Fluctuating, worse at night	Progressive, relatively stable day to-day	Diurnal variation, often worse in morning
Attention	Significantly impaired	Generally intact until late stages	Minimally impaired, but poor concentration
Alertness	Fluctuating	Normal	Normal
Memory	Recent and immediate impaired	Recent and remote impaired	Selective or "spotty" deficits
Thinking	Disorganized, incoherent	Impoverished, concrete	Intact but with negative themes
Perception	Hallucinations common (visual)	Hallucinations less common	Rarely hallucinations
Psychomotor	Variable, often increased	Often normal	Often slowed or agitated
Reversibility	Usually reversible	Generally irreversible	Reversible with treatment

Functional Assessment

Functional assessment provides critical information about the impact of psychiatric and cognitive disorders on daily life and independence. **Basic Activities of Daily Living (BADLs):** - Bathing - Dressing - Toileting - Transferring - Continence - Feeding **Instrumental Activities of Daily Living (IADLs):** - Managing medications - Managing finances - Using telephone - Shopping - Preparing meals - Housekeeping - Laundry - Transportation

Clinical Pearl:

Decline in IADLs often precedes decline in BADLs and can be an early indicator of cognitive impairment. Pay particular attention to changes in medication management and financial activities, which require complex executive function and are often the first abilities affected in early dementia.

Recommended functional assessment tools: - Katz Index of Independence in Activities of Daily Living - Lawton-Brody Instrumental Activities of Daily Living Scale - Performance-based assessments when possible (observe medication organization, etc.)

Interpreting functional assessment: - Document baseline function and recent changes - Distinguish physical from cognitive causes of functional decline - Assess impact of sensory impairments on function - Consider cultural factors in functional expectations - Evaluate safety concerns related to functional impairments

Physical Health and Medication Review

Physical health and medication effects significantly impact mental health in older adults and must be thoroughly assessed. **Essential physical health screening:** - Comprehensive metabolic panel - Complete blood count - Thyroid function tests - Vitamin B12 and folate levels - Urinalysis - Electrocardiogram - Neuroimaging when indicated by neurological signs/symptoms **Common medical conditions affecting mental health:** - Thyroid disorders - Cerebrovascular disease - Parkinson's disease - Sensory impairments - Chronic pain - Sleep apnea - Urinary tract infections - Dehydration and electrolyte imbalances

Medication review principles: - Review all medications, including over-the-counter and supplements - Assess for potentially inappropriate medications using Beers Criteria - Evaluate anticholinergic burden using Anticholinergic Cognitive Burden Scale - Consider medication interactions and cumulative effects - Assess adherence and ability to manage medications - Review recent medication changes that coincide with symptom onset

Common Medications with Psychiatric Effects in Older Adults:

Medications that can cause depression: - Beta-blockers (propranolol, metoprolol) - Corticosteroids - Benzodiazepines - Opioid analgesics - Statins - Proton pump inhibitors - Calcium channel blockers - Interferon - Levodopa

Medications that can

cause anxiety: - Bronchodilators (albuterol) - Decongestants (pseudoephedrine) - Stimulants - Thyroid supplements - Caffeine - Corticosteroids - SSRIs (initial activation) **Medications that can cause psychosis/delirium:** - Anticholinergics (diphenhydramine, oxybutynin) - Dopaminergic agents (levodopa) - Benzodiazepines (paradoxical reactions) - Opioid analgesics - Corticosteroids - H2 blockers (cimetidine, ranitidine) - Fluoroquinolone antibiotics

Psychosocial Assessment

Psychosocial factors significantly influence mental health in older adults and must be thoroughly assessed. **Key psychosocial domains:** - Recent losses and grief - Retirement adjustment - Financial stressors - Social isolation and loneliness - Family dynamics and caregiver relationships - Elder abuse and neglect - Housing and environmental safety - Access to transportation and services - Cultural and spiritual factors - End of-life concerns and advance care planning

Elder Abuse Screening:

Use the Elder Abuse Suspicion Index (EASI) or similar validated tool to screen for potential abuse. Key questions include: 1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? 2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with? 3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened? 4. Has anyone tried to force you to sign papers or use your money against your will? 5. Has anyone made you afraid, touched you in ways you did not want, or hurt you physically? A "yes" to any question warrants further assessment. Remember mandatory reporting requirements in your jurisdiction.

Caregiver assessment: - Caregiver strain and burden - Caregiver knowledge and skills - Caregiver physical and mental health - Available respite and support services - Financial resources for caregiving

Cultural considerations: - Cultural beliefs about aging and mental illness - Cultural expectations regarding family caregiving - Language barriers in assessment and treatment - Cultural influences on treatment preferences - Immigration and acculturation experiences

Geriatric Depression

Depression in older adults often presents differently than in younger populations and requires specialized assessment and treatment approaches. Late-life depression is associated with increased morbidity, mortality, functional decline, and caregiver burden.

Assessment Considerations

Unique presentation in older adults: - More somatic complaints and less sadness - More anhedonia and apathy - More anxiety symptoms - More cognitive complaints ("pseudodementia") - More psychomotor changes (agitation or retardation) - More psychotic features - Less likely to endorse feeling "depressed" **Recommended screening tools:** - Geriatric Depression Scale (GDS) - 15-item version - Patient Health Questionnaire (PHQ-9) - Cornell Scale for Depression in Dementia (for patients with cognitive impairment)

Geriatric Depression Scale (GDS-15) Scoring:

- Score 0-4: Normal - Score 5-8: Mild depression - Score 9-11: Moderate depression - Score 12-15: Severe depression **Key GDS-15 Questions:** 1. Are you basically satisfied with your life? (No = 1 point) 2. Have you dropped many of your activities and interests? (Yes = 1 point) 3. Do you feel that your life is empty? (Yes = 1 point) 4. Do you often get bored? (Yes = 1 point) 5. Are you in good spirits most of the time? (No = 1 point) 6. Are you afraid that something bad is going to happen to you? (Yes = 1 point) 7. Do you feel happy most of the time? (No = 1 point) 8. Do you often feel helpless? (Yes = 1 point) 9. Do you prefer to stay at home, rather than going out and doing new things? (Yes = 1 point) 10. Do you feel you have more problems with memory than most? (Yes = 1 point) 11. Do you think it is wonderful to be alive now? (No = 1 point) 12. Do you feel pretty worthless the way you are now? (Yes = 1 point) 13. Do you feel full of energy? (No = 1 point) 14. Do you feel that your situation is hopeless? (Yes = 1 point) 15. Do you think that most people are better off than you are? (Yes = 1 point)

Essential medical workup: - Complete blood count - Comprehensive metabolic panel - Thyroid function tests - Vitamin B12 and folate levels - Urinalysis - Medication review for depressogenic agents

Risk assessment considerations: - Suicide risk (older adults have highest suicide rates of any age group) - Self-neglect risk - Functional decline - Cognitive impact - Caregiver burden

Treatment Approaches

Pharmacotherapy considerations: - Start at lower doses (typically half the adult starting dose) - Titrate more slowly ("start low, go slow") - Aim for same target doses as younger adults - Monitor for side effects more frequently - Consider drug interactions with medical conditions - Assess for anticholinergic burden - Evaluate fall risk with all psychotropic medications
First-line antidepressants for older adults: - SSRIs: sertraline, escitalopram, citalopram - SNRIs: venlafaxine XR, duloxetine - Mirtazapine (particularly for patients with insomnia or poor appetite) - Bupropion (particularly for patients with fatigue or cognitive slowing)

Antidepressant Dosing in Older Adults:

Sertraline (Singh & Saadabadi, 2023)	25 mg daily	50-150 mg daily	Low drug interactions; minimal impact on QTc
Escitalopram (Landy & Estevez, 2023)	5 mg daily	10-20 mg daily	Well-tolerated; minimal drug interactions
Citalopram	10 mg daily	20-30 mg daily	Max 20mg in patients >60 years (QTc concerns) (Shoar et al., 2023)
Venlafaxine XR (Mayo Clinic, 2024)	37.5 mg daily	75-225 mg daily	Monitor blood pressure; discontinuation syndrome
Duloxetine (Mayo Clinic, 2025)	20 mg daily	30-60 mg daily	Beneficial for pain; avoid in hepatic impairment
Mirtazapine	7.5 mg at bedtime	15-45 mg at	Helps with sleep and appetite; sedation decreases at higher

		bedtime	doses

Bupropion XL (Huecker et al., 2024)	150 mg morning 150-300 mg daily	Activating; avoid in seizure	disorders

Psychotherapy approaches: - Problem-Solving Therapy (PST) - Cognitive Behavioral Therapy (CBT) adapted for older adults - Interpersonal Therapy (IPT) - Life Review Therapy - Behavioral Activation - Supportive therapy

Somatic treatments: - Electroconvulsive Therapy (ECT) - often well-tolerated and effective in older adults - Transcranial Magnetic Stimulation (TMS) - Esketamine (with caution and close monitoring)

Integrated care approaches: - Collaborative care models - Home-based depression care management - Telehealth interventions - Exercise programs (supervised) - Social engagement interventions - Caregiver support and education
Treatment-resistant depression strategies: - Optimization (adequate dose and duration) - Switching (to different class of antidepressant) - Combination (two antidepressants with different mechanisms) - Augmentation strategies: - Aripiprazole (2-10 mg) - Lithium (with careful monitoring) - Methylphenidate (for apathy, fatigue) - Thyroid supplementation

Clinical Pearl:

For older adults with depression and cognitive impairment, consider SSRIs with the least anticholinergic effects (sertraline, escitalopram) or SNRIs (duloxetine). Avoid tricyclic antidepressants and paroxetine due to high anticholinergic burden. For patients with Parkinson's disease and depression, SSRIs may worsen motor symptoms; consider bupropion or an SNRI as first-line options.

Anxiety Disorders in Late Life

Anxiety Icon

Anxiety disorders are common but often underrecognized in older adults. Late-life anxiety frequently co-occurs with depression, cognitive

disorders, and physical health conditions, requiring specialized assessment and treatment approaches.

Assessment Considerations

Unique presentation in older adults: - More somatic complaints (palpitations, dizziness, GI symptoms) - More focus on physical health concerns - More sleep disturbance - Less likely to report psychological symptoms of worry - Often presents as agitation in dementia - Frequently comorbid with depression

Recommended screening tools: - Geriatric Anxiety Scale (GAS) - Geriatric Anxiety Inventory (GAI) - Penn State Worry Questionnaire-Abbreviated (PSWQ-A) - Rating Anxiety in Dementia (RAID) scale for patients with cognitive impairment

Differential Diagnosis for Anxiety Symptoms in Older Adults:

Anxiety Icon

Medical conditions: - Cardiovascular: Arrhythmias, angina, heart failure - Respiratory: COPD, pulmonary embolism, sleep apnea - Endocrine: Hyperthyroidism, hypoglycemia, pheochromocytoma - Neurological: Parkinson's disease, dementia, stroke, seizures - Other: Electrolyte imbalances, B12 deficiency, anemia **Medication-induced anxiety:** - Stimulants (including caffeine) - Bronchodilators (albuterol) - Steroids - Thyroid supplements - Anticholinergics - Dopaminergic agents - Decongestants **Substance-related:** - Alcohol withdrawal - Benzodiazepine withdrawal - Caffeine excess - Nicotine

Essential medical workup: - Thyroid function tests - Comprehensive metabolic panel - Complete blood count - Electrocardiogram - Medication review - Consider sleep study if sleep apnea suspected - Consider cardiac workup if cardiovascular symptoms prominent

Treatment Approaches

Pharmacotherapy considerations: - Avoid benzodiazepines as first-line treatment (fall risk, cognitive impairment, dependence) - Start antidepressants at lower doses than for younger adults - Monitor for activation syndromes with SSRIs - Consider impact on comorbid conditions - Evaluate drug-drug interactions - Assess for anticholinergic burden **First-line medications:** - SSRIs: escitalopram, sertraline, citalopram - SNRIs: venlafaxine XR, duloxetine - Buspirone (particularly for generalized anxiety) - Mirtazapine (if comorbid insomnia)

Benzodiazepine Use in Older Adults: Treatment Icon

Benzodiazepines should generally be avoided in older adults due to: - Increased sensitivity to CNS effects - Increased risk of falls and fractures - Cognitive impairment and potential contribution to delirium - Paradoxical reactions (agitation, disinhibition) - Respiratory depression, especially with comorbid conditions - Risk of dependence and withdrawal If absolutely necessary for short term use: - Use lowest effective dose - Choose shorter-acting agents with no active metabolites (lorazepam, oxazepam) - Prescribe for shortest possible duration - Create clear tapering plan - Avoid combining with other CNS depressants - Monitor closely for adverse effects - Document risk-benefit discussion

Psychotherapy approaches: - Cognitive Behavioral Therapy (CBT) adapted for older adults - Relaxation training - Mindfulness-based interventions - Problem-Solving Therapy - Supportive therapy - Exposure therapy (for specific phobias and some cases of PTSD)

Non-pharmacological interventions: - Exercise programs - Sleep hygiene education - Breathing exercises - Progressive muscle relaxation - Meditation and mindfulness practices - Yoga or tai chi - Music therapy - Pet therapy - Reduction of caffeine

and alcohol **Specific approaches for anxiety with cognitive impairment:** - Environmental modifications to reduce triggers - Consistent routines and caregivers - Validation therapy - Sensory interventions (music, aromatherapy) - Caregiver education and support - Behavioral management strategies

Clinical Pearl:

For older adults with anxiety and insomnia, consider mirtazapine (7.5-15mg at bedtime) or trazodone (25-50mg at bedtime) as alternatives to benzodiazepines or Z-drugs. These medications can improve sleep while addressing anxiety symptoms, with less risk of falls, cognitive impairment, or dependence compared to traditional sedative-hypnotics.

Neurocognitive Disorders

Neurocognitive disorders, including various forms of dementia and mild cognitive impairment, are common in older adults and require comprehensive assessment and management approaches that address cognitive, behavioral, and functional aspects.

Assessment and Diagnosis

Diagnostic criteria for major neurocognitive disorder (dementia): - Significant cognitive decline from previous level in one or more domains - Interference with independence in everyday activities - Not occurring exclusively during delirium - Not better explained by another mental disorder **Diagnostic criteria for mild neurocognitive disorder:** - Modest cognitive decline from previous level in one or more domains - Cognitive deficits do not interfere with independence - Not occurring exclusively during delirium - Not better explained by another mental disorder **Key cognitive domains to assess:** - Complex attention - Executive function - Learning and memory - Language - Perceptual-motor function - Social cognition

Differentiating Common Dementia Types:

Neurocognitive Icon

Early Symptoms	Memory impairment	Executive dysfunction	Visual hallucinations, fluctuations	Personality/ behavior changes
Progression	Gradual, steady	Stepwise, fluctuating	Fluctuating attention	Gradual
Memory	Prominently affected	Variable, patchy	Less prominent initially	Relatively preserved initially
Motor Features	Late in disease	Early gait problems	Parkinsonism	Variable
Hallucinations	Late in disease	Uncommon	Early, recurrent visual	Rare
Neuroimaging	Hippocampal atrophy	Infarcts, white matter changes	Often normal	Frontal/ temporal atrophy

Essential workup for cognitive complaints: - Comprehensive cognitive assessment - Functional assessment - Neurological examination - Standard laboratory tests: - Complete blood count - Comprehensive metabolic panel - Thyroid function tests - Vitamin B12 level - Folate level - Urinalysis - Neuroimaging (MRI preferred over CT) - Consider additional testing based on clinical presentation: - HIV testing - RPR/VDRL for syphilis - Heavy metal screening - Paraneoplastic panel - Cerebrospinal fluid analysis - Neuropsychological testing

Potentially reversible causes of cognitive impairment: - Medication effects (anticholinergics, benzodiazepines, opioids) - Depression ("pseudodementia") - Vitamin B12 deficiency - Hypothyroidism - Normal pressure hydrocephalus - Subdural hematoma - Brain tumor - Infectious processes (meningitis, encephalitis) - Metabolic disorders (electrolyte imbalances, hepatic or renal failure) - Sleep apnea - Alcohol use disorder

Pharmacological Management

Cognitive enhancers: - Cholinesterase inhibitors: - Donepezil (Aricept): 5-10 mg daily - Rivastigmine (Exelon): 1.5-6 mg twice daily or 4.6-13.3 mg/24h patch - Galantamine (Razadyne): 8-24 mg daily - NMDA receptor antagonist: - Memantine (Namenda): 5-20 mg daily **Indications by dementia type:** - Alzheimer's disease: Cholinesterase inhibitors and/or memantine - Lewy body dementia: Cholinesterase inhibitors (first-line) - Parkinson's disease dementia: Cholinesterase inhibitors - Vascular dementia: Consider cholinesterase inhibitors - Frontotemporal dementia: Cognitive enhancers generally not effective

Cognitive Enhancer Side Effects and Monitoring:

Cholinesterase inhibitors: - Common side effects: Nausea, vomiting, diarrhea, anorexia, weight loss - Less common: Bradycardia, syncope, increased gastric acid secretion - Monitoring: Weight, GI symptoms, heart rate, syncope - Contraindications: Sick sinus syndrome, bradycardia without pacemaker **Memantine:** - Common side effects: Dizziness, headache, constipation, confusion - Less common: Hallucinations (especially in Lewy body dementia) - Monitoring: Confusion, hallucinations - Contraindications: Severe renal impairment (adjust dose for moderate impairment) **Practical tips:** - Take cholinesterase inhibitors with food to reduce GI side effects - Consider starting with patch formulation of rivastigmine if GI side effects are concerning - Titrate doses slowly (typically every 4 weeks) - If switching between cholinesterase inhibitors, no washout period needed - Combination therapy (cholinesterase inhibitor plus memantine) may be more effective than monotherapy in moderate-severe Alzheimer's disease

Management of behavioral and psychological symptoms of dementia (BPSD): - Non pharmacological approaches should be first-line - Identify and address underlying causes (pain, constipation, infection) - Consider medication review and elimination of contributing medications - If pharmacotherapy necessary, choose based on target symptoms: - Antidepressants (SSRIs) for depression, anxiety, irritability - Trazodone for insomnia, agitation - Anticonvulsants (valproate, carbamazepine) for aggression, agitation - Antipsychotics (with caution) for psychosis, severe aggression - Start with lowest doses - Reassess frequently - Discontinue if ineffective - Document risk-benefit discussion (black box warning)

Medication management principles in dementia: - Regularly review all medications - Discontinue unnecessary medications - Avoid medications with high

anticholinergic burden - Minimize psychotropic polypharmacy - Use "start low, go slow" approach for all new medications - Consider deprescribing when risks outweigh benefits - Simplify medication regimens when possible - Assess adherence and need for assistance with medication management

therapy - Redirection techniques - Behavioral analysis and intervention

DICE Approach for Managing BPSD:
Medication

Management Icon 

Non-Pharmacological Approaches

Cognitive interventions: - Cognitive stimulation therapy - Cognitive rehabilitation - Cognitive training - Reality orientation - Reminiscence therapy - Computer-based cognitive exercises
Behavioral interventions: - Structured daily routines - Simplified communication - Environmental modifications - Validation

D - Describe: - Characterize the behavior (frequency, severity, timing) - Identify antecedents and consequences - Obtain multiple perspectives (patient, caregivers, staff) **I - Investigate:** - Medical conditions (pain, infection, constipation) - Psychiatric comorbidities - Medication effects - Environmental triggers - Caregiver factors - Unmet needs (hunger, thirst, toileting) **C - Create:** - Develop person-centered care plan - Address underlying causes - Implement environmental modifications - Educate and support caregivers - Consider appropriate activities **E - Evaluate:** -
Monitor effectiveness of interventions - Adjust plan as needed - Reassess regularly - Document outcomes

Environmental interventions: - Reduce excess stimulation - Enhance visual cues and signage - Improve lighting - Reduce fall hazards - Create familiar surroundings - Provide safe wandering areas - Use adaptive equipment

Caregiver interventions: - Education about dementia - Training in communication techniques - Problem-solving strategies - Stress management and self-care - Respite care arrangements - Support groups - Individual counseling - Case management services **Lifestyle interventions:** - Physical exercise programs - Social engagement opportunities - Meaningful activities - Music

therapy - Art therapy - Pet therapy - Sensory stimulation - Outdoor activities and nature exposure

Clinical Pearl:

For patients with dementia and sleep disturbances, prioritize non-pharmacological approaches: maintain regular sleep-wake schedule, increase daytime physical activity, ensure adequate exposure to natural light during the day, limit caffeine and alcohol, and create a quiet, comfortable sleep environment. If medication is necessary, consider low-dose trazodone (25-50mg) or melatonin (1-3mg) rather than benzodiazepines or Z-drugs, which can worsen cognition and increase fall risk.

Late-Life Psychosis

Psychotic symptoms in older adults can arise from various causes including primary psychotic disorders, mood disorders, dementia, delirium, and medical conditions. Assessment and management require careful consideration of multiple potential etiologies and age-specific treatment approaches.

Assessment Considerations

Common presentations of late-life psychosis: - Psychosis in neurocognitive disorders (hallucinations, delusions) - Late onset schizophrenia (after age 40) - Very-late-onset schizophrenia-like psychosis (after age 60) - Delusional disorder - Mood disorder with psychotic features - Delirium with psychotic features - Charles Bonnet syndrome (visual hallucinations with vision loss) - Medication or substance induced psychosis **Key assessment components:** - Comprehensive psychiatric history - Thorough medical evaluation - Cognitive assessment - Sensory evaluation (vision, hearing) - Medication review - Substance use assessment - Functional assessment - Collateral information from family/ caregivers

Differentiating Features of Late-Life Psychosis by Etiology:

Psychosis Icon

Onset	Gradual	Gradual	Acute	Subacute

Hallucinations	Predominantly auditory	Visual more common	Visual predominant	Mood-congruent
Delusions	Paranoid, persecutory	Misidentification, theft	Poorly formed	Guilt, nihilistic, grandiose
Cognition	Relatively preserved	Impaired	Fluctuating	May have pseudodementia
Course	Chronic	Progressive	Fluctuating	Episodic
Negative Symptoms	Present	May mimic apathy	Absent	May mimic depression

Essential medical workup: - Complete blood count - Comprehensive metabolic panel - Thyroid function tests - Vitamin B12 and folate levels - Urinalysis - Medication levels when applicable - Neuroimaging (MRI preferred) - Electroencephalogram if delirium suspected - Consider additional testing based on presentation: - Heavy metal screening -
Paraneoplastic panel - Autoimmune encephalitis panel - Cerebrospinal fluid analysis - Sleep studies

Unique features of late-onset schizophrenia: - More visual, tactile, and olfactory hallucinations (compared to early-onset) - More prominent paranoid and persecutory delusions - Less prominent negative symptoms and formal thought disorder - Better premorbid functioning - More sensory impairments (hearing, vision) - Better response to lower doses of antipsychotics - Higher risk of tardive dyskinesia and other side effects

Pharmacological Management

General principles for antipsychotic use in older adults: - Use lowest effective dose (typically 25-50% of adult dose) - Start with even lower doses in dementia (25% of adult starting dose) - Titrate more slowly than in younger adults - Choose antipsychotics with favorable side effect profiles - Monitor closely for adverse effects - Regularly attempt dose reduction or discontinuation - Document risk-benefit discussion (black box

warning for dementia) - Avoid antipsychotic polypharmacy
Preferred antipsychotics in older adults: - Quetiapine (less EPS, but more sedation and orthostasis) - Aripiprazole (less metabolic and anticholinergic effects) - Risperidone (effective but higher EPS risk) - Olanzapine (effective but higher metabolic and anticholinergic risk) - Brexpiprazole (emerging evidence for favorable profile)

Antipsychotic Dosing in Older Adults: (Alexopoulos et al., 2004)

Quetiapine	12.5-25 mg	50-200 mg	Sedation, orthostasis; lower EPS risk
Aripiprazole	2 mg	5-15 mg	Activating; lower metabolic risk
Risperidone	0.25-0.5 mg	0.5-2 mg	EPS risk; hyperprolactinemia
Olanzapine	2.5 mg	5-10 mg	Metabolic effects; anticholinergic
Brexpiprazole	0.5 mg	1-3 mg	Lower metabolic and EPS risk
Pimavanserin	34 mg	34 mg	For Parkinson's disease psychosis

Monitoring recommendations: - Baseline: Weight, BMI, waist circumference, blood pressure, fasting glucose, lipid panel, ECG (if cardiac risk factors), AIMS - Follow-up: Weight (monthly for 3 months, then quarterly), blood pressure (monthly for 3 months), glucose and lipids (3 months, then annually), AIMS (quarterly) - Symptom monitoring: Sedation, orthostatic hypotension, extrapyramidal symptoms, falls, cognitive changes

Special considerations by diagnosis: - Dementia-related psychosis: - Use non-pharmacological approaches first - Consider antipsychotics only for severe symptoms causing distress or danger - Plan for tapering/discontinuation after 3-6 months of stability - Pimavanserin for Parkinson's disease psychosis - Late-onset schizophrenia: - Lower doses than early

onset schizophrenia - May require longer-term treatment - Consider clozapine for treatment-resistant cases (with careful monitoring) - Delirium with psychosis: - Address underlying causes first - Short-term, low-dose antipsychotics if necessary - Avoid benzodiazepines except in alcohol withdrawal

Clinical Pearl:
Treatment Icon

For patients with Lewy body dementia or Parkinson's disease with psychosis, traditional antipsychotics can significantly worsen motor symptoms. If pharmacotherapy is necessary, quetiapine (starting at 12.5mg) is generally the safest option. Pimavanserin, a selective serotonin 5-HT2A inverse agonist, is FDA approved specifically for Parkinson's disease psychosis and does not worsen motor symptoms, but requires careful QTc monitoring.

Non-Pharmacological Approaches

Environmental interventions: - Optimize sensory input (glasses, hearing aids) - Provide adequate lighting - Reduce noise and overstimulation - Maintain consistent routines and caregivers - Use orientation cues and signage - Ensure safe environment - Remove triggers for delusions when possible
Behavioral approaches: - Validation therapy (avoid direct confrontation of delusions) - Redirection techniques - Reality orientation when appropriate - Structured daily activities - Simplified communication - Behavioral analysis and intervention

Caregiver interventions: - Education about psychosis in older adults - Training in communication techniques - Strategies for responding to hallucinations and delusions - Stress management and self-care - Support groups - Individual counseling - Respite

care arrangements

Psychosocial interventions: - Cognitive Behavioral Therapy for psychosis (CBTp) adapted for older adults - Supportive therapy - Social skills training - Cognitive remediation - Group therapy - Music therapy - Art therapy - Reminiscence therapy - Sensory interventions

Responding to Delusions and Hallucinations:

Psychosocial Icon

DO: - Acknowledge the person's experience ("I understand you're seeing/hearing...") - Validate the emotional response ("That must be frightening for you") - Provide reassurance of safety - Gently redirect to reality-based activities - Identify and address unmet needs - Modify the environment to reduce triggers - Use distraction when appropriate **DON'T:** - Directly challenge or argue about the delusion/ hallucination - Pretend to see/hear the hallucination - Dismiss or minimize the experience - Express frustration or impatience - Use complex explanations - Reinforce delusional content

Substance Use Disorders in Older Adults

Substance use disorders in older adults are often underrecognized and undertreated. Age-related physiological changes, multiple medical comorbidities, and polypharmacy create unique vulnerabilities and treatment considerations in this population.

Substance Use Icon

Assessment Considerations

Common substances of concern in older adults: - Alcohol - Prescription medications (especially benzodiazepines and opioids) - Over-the-counter sleep aids - Cannabis (increasing with legalization) - Tobacco - Less commonly: cocaine, methamphetamine, heroin

Screening approaches: - Universal screening regardless of appearance or socioeconomic status - Age-appropriate screening tools: - Alcohol: AUDIT-C, SMAST-G (Short Michigan Alcoholism Screening Test-Geriatric Version) - Prescription medications: Prescription Drug Use Questionnaire (PDUQ) - General: DAST-10 (Drug Abuse Screening Test) - Lower thresholds for concern due

to age-related physiological changes Alcohol Icon

SMAST-G (Short Michigan Alcoholism Screening Test-Geriatric Version): 1. When talking with others, do you ever underestimate how much you drink? 2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry? 3. Does having a few drinks help decrease your shakiness or tremors? 4. Does alcohol sometimes make it hard for you to remember parts of the day or night? 5. Do you usually take a drink to relax or calm your nerves? 6. Do you drink to take your mind off your problems? 7. Have you ever increased your drinking after experiencing a loss in your life? 8. Has a doctor or nurse ever said they were worried or concerned about your drinking? 9. Have you ever made rules to manage your drinking? 10. When you feel lonely, does having a drink help? Scoring: 2 or more "yes" responses indicates potential alcohol problem requiring further assessment.

Unique presentation in older adults: - More subtle signs and symptoms - May be mistaken for normal aging or other conditions - Often presents as functional decline, falls, cognitive changes - May manifest as failure to thrive - Frequently comorbid with
depression, anxiety, insomnia - Often involves prescription medications rather than illicit substances - May develop in late life in response to losses, pain, or sleep problems

Assessment components: - Comprehensive substance use history - Detailed medication review (prescription and over-the counter) - Assessment of quantity, frequency, and pattern of use - Evaluation of consequences and functional impact - Screening for withdrawal risk - Assessment of readiness to change - Evaluation of cognitive status - Assessment of social support system - Identification of triggers and maintaining factors -

Evaluation of pain and sleep problems

Treatment Approaches

General principles: - Age-specific treatment approaches - Lower thresholds for intervention - Harm reduction when abstinence not feasible - Integration with medical care - Involvement of family/caregivers when appropriate - Attention to comorbid conditions - Consideration of cognitive status - Accommodation for sensory and mobility limitations - Recognition of generational attitudes toward substance use **Pharmacotherapy for alcohol use disorder:** - Naltrexone: 50mg daily or 380mg monthly injection (first-line) - Lower doses (25mg) may be used initially - Monitor for GI side effects and hepatotoxicity - Use with caution in patients on opioid analgesics - Acamprosate: 666mg three times daily - Dose reduction for renal impairment - No hepatotoxicity (advantage in liver disease) - Pill burden may affect adherence - Disulfiram: Generally avoided in older adults due to risk of severe reaction

Benzodiazepine Tapering in Older Adults:

Treatment Icon

General principles: - Gradual tapering essential to prevent withdrawal - Typically reduce dose by 10-25% every 2-4 weeks - Slower tapers (5-10%) for long-term use - Consider switching to longer-acting benzodiazepine for taper - Provide psychosocial support during taper - Treat emerging symptoms (insomnia, anxiety) - Educate about expected withdrawal symptoms - Consider adjunctive medications for specific symptoms **Sample taper schedule for diazepam equivalent:** - Weeks

1-2: Reduce by 10% - Weeks 3-4: Reduce by additional 10% - Weeks 5-8: Reduce by additional 10% - Weeks 9-12: Reduce by additional 10% - Continue with 5-10% reductions every 2-4 weeks - Slow or pause taper if significant withdrawal symptoms emerge **Adjunctive medications:** - Hydroxyzine for anxiety symptoms - Trazodone
for insomnia - Propranolol for autonomic symptoms - Carbamazepine for severe withdrawal (with monitoring)

Pharmacotherapy for opioid use disorder: - Buprenorphine: Start at lower doses (2mg) and titrate slowly - Consider lower maintenance doses (8-16mg) - Monitor for sedation, cognitive effects - Advantage of pain management benefits - Methadone: Requires specialized program - Start at lower doses (10-20mg) - More drug interactions and QTc concerns - Naltrexone: 50mg daily or 380mg monthly injection - Requires complete opioid discontinuation first - Contraindicated if pain requires opioid management

Psychosocial interventions: - Motivational Interviewing adapted for older adults - Cognitive Behavioral Therapy for substance use - Supportive therapy - Case management - Age specific group therapy - Family therapy - Contingency management - Twelve-step facilitation - Relapse prevention training - Pain management alternatives - Sleep hygiene education

Clinical Pearl:
Psychosocial Icon

For older adults with alcohol use disorder and insomnia, avoid prescribing sedative hypnotics which can increase fall risk and may lead to cross-addiction. Instead, address the alcohol use disorder first with appropriate pharmacotherapy (naltrexone or acamprosate) and behavioral interventions, then treat residual insomnia with sleep hygiene education, CBT for insomnia, and if necessary, low dose trazodone (25-50mg) or low-dose doxepin (3-6mg).

Level of care considerations: - Outpatient treatment: First-line for most older adults -

Intensive outpatient programs: Consider age-specific programs - Residential treatment: Consider programs with geriatric expertise - Medically managed withdrawal: Lower thresholds for inpatient detoxification - Age-specific programs when available - Integrated care with medical services

Special considerations: - Pain management in recovery: - Non opioid analgesics - Non-pharmacological pain management - Physical therapy - Interventional approaches - Careful use of certain opioids with close monitoring if necessary - Sleep management in recovery: - Sleep hygiene education - Cognitive Behavioral Therapy for Insomnia - Environmental modifications - Low-dose trazodone or mirtazapine if necessary - Melatonin - Avoid benzodiazepines and Z-drugs

Conclusion

Geriatric psychiatry requires specialized knowledge and approaches that address the unique biological, psychological, and social factors affecting older adults. By implementing the evidence-based assessment and treatment strategies outlined in this guide, psychiatric providers can deliver more effective, safe, and compassionate care to their older patients.

Effective geriatric psychiatric care requires a comprehensive, multidimensional approach that considers the complex interplay between mental health, physical health, cognitive status, functional abilities, and social context. The field continues to evolve, with emerging evidence supporting new approaches to assessment and treatment. Clinicians are encouraged to maintain current knowledge through continuing education and consultation with specialists when complex cases arise.

By recognizing the unique needs and presentations of psychiatric disorders in older adults, providers can avoid both under-treatment and inappropriate treatment, ultimately improving quality of life and functional outcomes for this vulnerable and growing population.

"The art of medicine consists of amusing the patient while nature cures the disease." - Voltaire

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