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Breaking the Silence: Addressing the Hidden Crisis of Elder Abuse

Rehan Aziz, MD. Program director, geriatric psychiatry fellowship program, Jersey Shore University Medical Center, Neptune, NJ; associate professor of psychiatry and neurology at Hackensack Meridian School of Medicine, Nutley, NJ.

Dr. Aziz has no financial relationships with companies related to this material.

Ms. Dee is an 82-year-old woman with mild Alzheimer's dementia who lives with her son and daughter-in-law. During a routine follow-up visit, Ms. Dee appears uncharacteristically withdrawn and avoids making eye contact. Her son answers most of the questions, stating that she has become more forgetful and clumsier. He mentions that she frequently falls and has difficulty managing her medications.

Elder abuse is a violation of the basic human and civil rights of vulnerable older adults (Cooper C and Livingston G, *Clin Geriatr Med* 2014;30(4):839–850). It is a global public health issue, impacting about 10% of older adults annually (Lachs MS and Pillemer KA, *N Engl J Med* 2015;373(20):1947–1956). Recent estimates suggest it may have become more pervasive since the COVID-19 pandemic, with one in five older adults now experiencing some form of abuse (Chang ES and Levy BR, *Am J Geriatr Psychiatry* 2021;29(11):1152–1159). Elder abuse often presents alongside psychiatric conditions like depression, anxiety, and cognitive impairment, making it important for clinicians to stay attentive to its signs.

Recognizing elder abuse
Elder abuse takes various forms, including physical, emotional, sexual, and

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Q&A With the Expert

Complexities of Elder Abuse
Elizabeth (EJ) Santos, MD, MPH

Associate professor of psychiatry, neurology & medicine; clinical chief, division of geriatric mental health & memory care, University of Rochester Medical Center, Rochester, NY.

Dr. Santos has no financial relationships with companies related to this material.

CGPR: What are the different types of elder abuse?
Dr. Santos: Elder abuse can take the forms of neglect or abandonment, physical abuse, sexual abuse, psychological abuse, or financial exploitation (Hoover RM and Polson M, *Am Fam Physician* 2014;89(6):453–460). While some forms of abuse may leave visible marks or evidence, others, like financial exploitation and psychological abuse, are more subtle and require a closer examination of changes over time. For example, withdrawing from family and friends can be a sign of control and manipulation. Elder abuse affects about one in six older adults worldwide (Yon Y et al, *Lancet Glob Health* 2017;5(2):e147–e156).

CGPR: Which patients are at higher risk of elder abuse?
Dr. Santos: The "young old"—those more likely to live with a spouse or adult children—along with older women, those living in shared living environments, individuals with lower income, and those experiencing poor

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social support or isolation are at a higher risk of elder abuse (Lachs MS and Pillemer KA, *N Engl J Med* 2015;373(20):1947–1956). Additionally, older adults living in institutional settings are at high risk for abuse, with over 60% of staff members admitting to elder abuse in the past year (Yon Y et al, *Eur J Public Health* 2019;29(1):58–67).

CGPR: How can psychiatrists distinguish between behavioral changes due to elder abuse and those stemming from mental health conditions common in later life?

Dr. Santos: When considering problems affecting older adults, you need to think about timing and history. While there are DSM diagnoses that are always correlated with time, distinguishing changes due to elder abuse from other mental health conditions requires a focus on recent events. Psychotic behaviors may be attributed to nuanced cognitive impairment, and paranoia could be a response to actual threats. Many people simply attribute unusual behavior to a person's inherent nature or dementia. However, unlike long-standing depression or cyclical disorders like bipolar disorder, elder abuse often involves new occurrences such as the entrance of new people into the older adult's life or financial loss.

CGPR: What role do cultural factors play in the recognition of elder abuse?

Dr. Santos: Understanding someone's cultural background is vital when trying to differentiate between behavioral changes caused by elder abuse and those resulting from mental health conditions common in later life. Misinterpretations can arise when cultural norms are not taken into account. For example, we encountered a family where it was culturally normal to communicate loudly with each other. This practice, combined with the older adults' hearing loss, made their conversations seem even louder and more aggressive to outsiders. Without understanding the context, such interactions could easily be misinterpreted as abuse. Similarly, in some patriarchal cultures, it is common for an adult son to make decisions on behalf of older family members, even if it means withholding a diagnosis. The line between cultural practice and abuse becomes clear when behaviors result in physical, emotional, or psychological harm; neglect; or exploitation of the older adult. The key is to assess the impact of the behavior on the individual's well-being. When cultural practices infringe on an older adult's rights, autonomy, or safety—such as withholding a diagnosis without informed consent—they may cross into the territory of abuse, breaching ethical boundaries even if intended as protective.

CGPR: What are you looking for during the visit when you suspect elder abuse?

Dr. Santos: Be alert: Look for signs of disheveled appearance or other indications that something may be wrong. When patients are accompanied by caregivers, make sure that the patient's voice is heard. Relying solely on collateral informants, such as family members or aides, can be ageist and may prevent your patient from sharing their own history. Even if the patient has dementia, spend some time alone with them to assess their mood and ask relevant questions. When bringing in the informant, observe their interaction with the patient. Look for physical changes, such as the patient shrinking back or becoming quiet. Pay attention to clues like patients wringing their hands or not trusting their own judgment. If something feels off, get collateral information, as the person with the patient may not be their trusted individual. Additionally, educate families on what to look for, as they may not be familiar with the signs of abuse or exploitation.

CGPR: How do you talk to family members about what to look for?

Dr. Santos: I try to frame the conversation in a way that empowers them to protect their loved one without causing undue alarm. I usually say something like, "It's really important to keep an eye on any physical changes or shifts in behavior. If you notice unexplained bruises, especially in areas like the face, inner arms, or back, or if your loved one seems more withdrawn or anxious than usual, these could be signs that something's not right. Sometimes these signs are easy to overlook, so don't hesitate to reach out if anything feels off. It's always better to check in if you're unsure."

CGPR: Can you speak more about physical findings that make you concerned about elder abuse?

Dr. Santos: The location of any injuries or bruises can help tell you whether the person fell or if they were held and pushed (Rosen T et al, *Ann Emerg Med* 2020;76(3):266–276). For example, when we see bruising on the face, lateral aspect of the right arm, or the posterior torso, it raises red flags for potential abuse (Wigelsworth A et al, *J Am Geriatr Soc* 2009;57(7):1191–1196). Understanding the stages of healing can also provide valuable information. As a

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trusted individual, you may be the only one the person confides in, so it's important to listen and believe your patient's experiences. While some injuries may be the result of frail skin and accidental bumps, the presence of fingerprints or other signs of physical force is not normal and may indicate abuse.

CGPR: If you notice concerning physical marks, how do you broach the subject with the patient in a way that will make them want to talk to you about it?

Dr. Santos: I approach the conversation with the patient in a gentle and nonthreatening manner. I start by expressing general concern for their well-being, saying something like, "I noticed some marks on your arm, and I just want to make sure you're okay. How have you been feeling lately?" This opens up the conversation without immediately implying anything negative, which can help the patient feel more comfortable. Next, I ask open-ended questions to give them space to explain in their own words, such as, "Can you tell me a bit more about how these marks happened?"

CGPR: Can you tell us about detecting financial exploitation?

Dr. Santos: Financial exploitation, like other forms of elder abuse, can be subtle and gradual, making it difficult to detect. Unlike physical abuse, which often leaves signs such as bruises or hospital visits, financial exploitation is more covert. While anyone can fall victim to external scams, such as phishing emails and phone scams, most financial abuse is perpetrated by people the victim knows, like family members or caregivers. These trusted individuals may misuse funds, withhold money, or coerce the older adult into financial decisions against their will. For instance, a child or caregiver with access to an older adult's bank account may make purchases for themselves rather than using the funds to support the older adult's needs, such as clothing, food, or medical care. Detecting this type of abuse requires attention to changes in financial behavior, like unusual withdrawals, unpaid bills, or sudden amendments to legal documents like powers of attorney. Observe patterns and ask questions if you suspect financial exploitation to prevent further harm.

"The location of any injuries or bruises can help tell you whether the person fell or if they were held and pushed. Bruising on the face, lateral aspect of the right arm, or the posterior torso, raises red flags. Understanding the stages of healing can also provide valuable information. As a trusted individual, you may be the only one the person confides in, so it's important to listen and believe your patient's experiences."

Elizabeth (EJ) Santos, MD, MPH

CGPR: How might you discuss scams and other types of financial exploitation with patients?

Dr. Santos: When discussing scams, I might say something like, "These days, we're seeing a lot of people being targeted by scammers, especially through emails and phone calls. They can be very convincing, and it's easy to get caught off guard. Have you noticed anything unusual with your finances or received any calls or messages that seemed suspicious?" For family-related exploitation, I approach with sensitivity, saying, "Sometimes, those we trust with finances may make decisions that don't align with our best interests. Has anything like that happened to you?" This opens the door to identifying potential issues without making the patient feel judged or defensive.

CGPR: How can clinicians intervene?

Dr. Santos: Communication with family members is key. Educate them about the warning signs of financial exploitation and encourage open dialogue. Teach patients to always verify any urgent financial requests independently by contacting the supposed requester directly. Future planning is essential. Help your patients establish healthcare proxies and powers of attorney with trusted individuals, and document these decisions in their medical records. This ensures their wishes are respected and helps prevent exploitation. You can also involve social workers, financial advisors, or elder abuse specialists when you suspect exploitation.

CGPR: Any tips for documentation if we suspect elder abuse?

Dr. Santos: If you are documenting bruises or suspicion of abuse, and the patient's abuser has proxy access or is looking in the chart, then your patient could be in trouble and may never see you again. You should still document carefully, just be careful about who can access your patient's chart—always ask and verify who has access to their records. You may have to block your note. If you can, take pictures to document any suspicious injuries. Also think about the stages of healing; if you have suspicions, then consult with your patient's PCP and request X-rays if necessary. It's also important to write the names of the people you are talking to, not just 'the daughter.' By specifying the name, you can track who received important information and use it for restitution and justice.

CGPR: At what point do you consider reporting abuse?

Dr. Santos: Reporting suspected abuse is a serious step, and you should consider it when there is reasonable evidence that abuse is occurring or when there is significant concern for the patient's safety. If you've observed physical signs of abuse, like suspicious bruises or injuries, especially if these are coupled with behavioral changes in the patient, consider reporting. Additionally, if the patient confides in you about being mistreated, or if family members or caregivers express concern, take their concerns seriously. Before making a report, I usually try to have a candid conversation with the patient—if it's safe to do so—to understand their perspective and ensure that I'm not misinterpreting cultural norms or personal relationships. However, if there is any immediate danger to the patient or if the situation seems to be escalating, I err on the side of caution and report the abuse. It's better to act to protect the patient than to wait and risk further harm.

CGPR: Tell us about working with individuals at risk for abuse due to cognitive impairment.

Dr. Santos: To build a trusting relationship, we need to be mindful of our tone, avoiding judgmental or prescriptive attitudes. By building trust, patients will feel comfortable sharing their concerns with us. In addition, we

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need to have conversations about the patient's goals, control, and what healthy aging means to them. We should emphasize our role in protecting their rights and wishes. However, when discussing vulnerability to abuse and exploitation, patients may become defensive and believe that their rights are being taken away. To overcome this, we can frame the conversation around empowering them to make choices and emphasize that everyone needs help at times. You could say, "My job isn't to take away your control but to help you make decisions that protect your well-being." By approaching the conversation this way, and by identifying people they trust, we can assist them in making decisions while they still have the capacity to do so. Additionally, when patients make unfounded accusations, such as claiming family theft, it helps to acknowledge their feelings with a simple "I understand why you're concerned." This approach maintains trust and supports their sense of control.

CGPR: Are there agencies that can detect abuse or help protect older adults?

Dr. Santos: Collaborating with local agencies that offer home visits can be helpful in ensuring a healthy environment. EMS workers can also play a role in identifying potential abuse by checking the patient's living conditions, such as the state of their cupboards and fridge. Medication dates can provide clues about the patient's medical history. In care facilities, just being vigilant and regularly checking on residents can help protect them from abuse.

CGPR: How can we educate people about the risks of elder abuse and encourage them to be more aware of their surroundings and neighbors?

Dr. Santos: You can educate patients about elder abuse by informing them about common scams, such as unscrupulous contractors charging exorbitant fees for unnecessary repairs. You can also address the issue of romance scams, where lonely individuals are targeted for emotional manipulation and financial exploitation. However, it's also important to address the fact that abuse often occurs within families, where relatives may misuse finances or fail to provide adequate care despite having access to resources. Reach out to those who may be more vulnerable and lonelier, offering support and acting as a sounding board. Encourage patients to have open conversations about their financial arrangements and caregiving needs, and to stay mindful of family dynamics. Support family members in setting healthy boundaries and promoting respectful caregiving. Additionally, encourage patients to join groups and platforms that facilitate regular communication among older adults, as it provides a sense of connection and support. However, keep in mind that these platforms can be exploited by individuals.

CGPR: How can clinicians use technology to monitor and address elder abuse?

Dr. Santos: There's potential for clinicians to use information from wearable technology, such as monitoring heart rate, together with education and support services to help identify situations of discomfort or to track violence (Conti A et al, *Int J Environ Res Public Health* 2022;19(4):2357). Clinicians and staff could use this information to create behavioral care plans and ensure that patients are comfortable with their caregivers.

CGPR: What are the most effective clinician interventions to reduce elder abuse?

Dr. Santos: Consider using the Elder Abuse Suspicion Index (https://tinyurl.com/4fnu9v8v) in patients with risk factors for abuse. There's little evidence on effective interventions, but expert recommendations include making sure to discuss your concerns privately, assess your patient's capacity to make decisions, consider referrals to social service agencies, and report your suspicions as a mandated reporter (Wang XM et al, *CMAJ* 2015;187(8):575–581).

CGPR: Thank you for your time, Dr. Santos.

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financial abuse, as well as neglect. Recognizing the signs of abuse is critical in initiating timely interventions.

Physical abuse

This involves the intentional use of force that results in physical harm, pain, assault, or impairment. Physical abuse includes hitting, slapping, pushing, kicking, or restraining an older adult. Look for unexplained injuries or a pattern of repeated trauma, especially in uncommon areas like the jaw or cheekbone. Multiple injuries in various stages of healing should also raise suspicion.

Sexual abuse

Sexual abuse occurs when an individual is subjected to nonconsensual sexual activity, such as rape, inappropriate touching, forced nudity, or when they are unable to provide informed consent (Patel K et al, *Cureus* 2021;13(4):e14375). Red flags are unexplained sexually transmitted diseases (STDs) or genital injuries (Lachs and Pillemer, 2015).

Emotional/verbal abuse

Emotional abuse refers to verbal or nonverbal behaviors that cause fear, mental or emotional distress (eg, yelling, threats, humiliation, intimidation, isolation, or controlling behaviors). Patients may appear withdrawn, depressed, or anxious. They often avoid eye contact or defer to their caregiver.

Financial abuse

This includes the unauthorized use of a victim's finances, often by a trusted person (eg, a family member). Financial exploitation is a distinct and increasingly recognized form of elder abuse, particularly in patients with cognitive decline. Unlike other forms of abuse, financial

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exploitation may have fewer overt risk factors, requiring a higher degree of vigilance (Fraga Dominguez S et al, *J Appl Gerontol* 2022;41(4):928–939).

Neglect
This occurs when a caregiver fails to provide for an older adult's basic needs, including food, water, medication, shelter, or hygiene. It can be intentional or due to the caregiver's inability to provide care. Signs of neglect are malnourishment or dehydration, poor hygiene or unsuitable clothing (eg, not wearing a coat on a cold winter's day), or evidence of inadequate or delayed medical care.

Elder abuse during COVID-19
One study found an 83.6% increase in elder abuse prevalence during the pandemic, with financial strain and isolation being major contributing factors. When using telehealth in detecting abuse, pay close attention to nonverbal cues (eg, subtle body language, concerning comments made by patients or caregivers, living conditions) (Chang and Levy, 2021).

Risk factors for elder abuse
Victim characteristics
The risk of abuse is higher in older women and those with impaired cognition. Elder abuse happens most commonly in people with dementia, especially those with substantial neuropsychiatric symptoms. Cognitive impairment is also a risk factor for financial abuse, as patients with dementia are more susceptible to exploitation. In many cases, financial abusers are family members who have gained access to resources through legal means, such as a power of attorney (Cooper and Livingston, 2014). Those in shared living arrangements have a higher risk of mistreatment, since most abusers are family members, often adult children or partners. Older adults who experience abuse are more likely to have had previous victimization or to be dependent on the perpetrators financially or for care (Fraga Dominguez et al, 2022).

Perpetrator characteristics
Perpetrators often struggle with issues like substance use (especially alcohol), depression, and anxiety. Those with substance use disorders can also have problematic attitudes like ageist beliefs, hostility, and unrealistic expectations of the victim (Fraga Dominguez et al, 2022).

While observing Ms. Dee, you notice that she has multiple bruises in different stages of healing on her arms and legs. When questioned privately, she hesitates but eventually discloses that her son sometimes gets angry with her, especially when she asks for help with daily tasks. She mentions that she often feels afraid to ask for assistance. Her financial situation also seems to have changed—she can no longer pay for her medications, although she has a steady retirement income.

Elder abuse assessment
When assessing for elder abuse, ask open-ended questions about the patient's daily life, their relationships with caregivers, and any recent changes in their social or financial circumstances. Pay particular attention to their relationships with adult children or partners. In patients with dementia, ask about their finances. If you suspect abuse, interview the older adult privately to allow them to express concerns without feeling threatened.

Consider asking these questions:
- *Do you feel safe at home?*
- *Has anyone stopped you from getting things you need, like food, clothes, medications, or medical care? How about from seeing friends or family?*
- *Do you get help when needed?*
- *Does anyone ever yell or curse at you?*
- *Has anyone tried to force you to sign papers or use your money when you didn't want to?*
- *Has anyone touched you inappropriately or physically hurt you?*

Source: (Yaffe MJ et al, J Elder Abuse Negl *2008;20(3):276–300.)*

Managing elder abuse
The first priority is the older adult's safety. If they are in imminent danger, involve your institution's social worker to guide next steps. Hospitalization is not needed unless there are severe medical concerns. Contact Adult Protective Services (APS) to initiate an investigation, which focuses on the older adult's vulnerabilities and home environment.

Steps to take
1. Involve your social worker to assess and guide actions.
2. File a report with APS—even a low level of suspicion is sufficient to initiate an investigation.
3. For financial abuse, contact local law enforcement (use non emergency lines unless there is immediate danger).
4. Consider alternative housing if the environment is unsafe.

All states have mandatory reporting laws for elder abuse, so ensure you follow local procedures. For more on management visit: www.thecarlatreport.com/InterventionsforElderAbuse.

To assist Ms. Dee, you start by prioritizing her safety. Given the signs of physical and financial abuse, you contact Adult Protective Services. You consider hospitalization or securing alternative living arrangements. You also involve legal representatives or law enforcement to safeguard her financial assets, including possibly revoking her son's financial authority.

CARLAT VERDICT Elder abuse is often hidden and worsened by financial strain and isolation. Clinicians are mandated reporters, and early intervention with Adult Protective Services and law enforcement can make a significant difference in protecting vulnerable older adults.

Q&A With the Expert

Managing Treatment-Resistant Anxiety Disorders in Older Adults

Carmen Andreescu, MD

Professor of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA.

Dr. Andreescu has no financial relationships with companies related to this material.

CGPR: Can you speak about the challenges in diagnosing and recognizing anxiety in older adults?

Dr. Andreescu: Anxiety in older adults is often overlooked or minimized due to stigma, especially in primary care settings. Older adults may downplay their symptoms or use terms like 'stress' instead of 'anxiety' or 'worry.' Clinicians might assume that anxiety is a normal part of aging and thus fail to provide appropriate treatment. Or they may provide inappropriate care (eg, by prescribing benzodiazepines or sleep aids). However, when psychiatrists are involved, as seen in collaborative care models, anxiety outcomes improve significantly across various settings when compared to usual care (Reynolds CF 3rd et al, *World Psychiatry* 2022;21(3):336–363). Adults with anxiety often present with comorbid late-life depression, which requires a different treatment approach.

CGPR: Tell us about the long-term effects of anxiety.

Dr. Andreescu: There is growing evidence suggesting that long-term anxiety can have negative effects on the aging brain and body (Perna G et al, *Neural Plast* 2016;2016:8457612). We have new data from our lab showing that anxiety has an effect on the age of brain gray matter. People who have severe worry lose about 1.3 months of brain age with each 1-point increase in a 70-point scale that measures severe worry (Karim HT et al, *Neurobiol Aging* 2021;101:13–21). You can imagine that many years of anxiety will have an impact on brain regions like the prefrontal cortex or the hippocampus—regions that are involved in emotion regulation and emotion reactivity. So far, we have managed to map out these factors, but we still need to understand their association to treatment resistance. While more research is needed to fully understand the association between anxiety and cognitive decline or dementia, there is evidence suggesting that chronic anxiety may increase the risk of cognitive decline over time (Santabárbara J et al, *J Clin Med* 2020;9(6):1791).

CGPR: Can you tell us more about this relationship?

Dr. Andreescu: We are increasingly seeing a link between long-term anxiety and cognitive decline, though the direction of the causality is unclear. Chronic anxiety might lead to brain changes, reducing cognitive reserve and raising dementia risk. Alternatively, early dementia, which progresses slowly, might first present with what we call mild behavioral symptoms (eg, anxiety or worry). Few studies have explored this, but existing evidence suggests that chronic anxiety over decades increases the risk of cognitive decline. Both causal paths are thus likely, making treatment more challenging (Santabárbara et al 2020).

CGPR: What are the primary factors contributing to treatment-resistant anxiety among older adults?

Dr. Andreescu: Anxiety is a vague term, and there is a lot of heterogeneity among anxiety disorders (Garakani A et al, *Front Psychiatry* 2020;11:595584). Under the umbrella of anxiety disorders, we find very different clinical experiences—from panic to obsessive-compulsive disorder. Treatment resistance is generally recognized after two or more adequate treatment trials fail to yield significant improvement (Domschke K et al, *World Psychiatry* 2024;23(1):113-123). It can be due to different anxiety disorders requiring different treatments. For instance, panic responds to treatment differently than generalized anxiety disorder (GAD). It's also important to consider the appropriateness of the medication dose. Anxiety often requires higher doses than depression, and many older adults do not receive a dose that can keep them well. Additionally, some older adults may be taking medications that are less suitable for their age group, such as benzodiazepines or antihistamines, which can increase the risk of confusion, falls, and cognitive decline. Furthermore, there are multiple medical conditions associated with increased anxiety in older adults, such as chronic obstructive pulmonary disease (COPD) and Parkinson's disease, and the medications used to treat these conditions can also contribute to treatment resistance.

CGPR: Can you tell us about the different types of anxiety phenotypes and how they respond to treatment?

Dr. Andreescu: Absolutely. Panic symptoms or obsessive-compulsive symptoms may be carried over from mid-life or younger years and may not be as prominent in older adults. These types of anxiety symptoms often respond well to antidepressants like SSRIs and low-dose benzodiazepines. On the other hand, GAD has two peaks of incidence—one in teenagers and another in older adults (DeGeorge KC et al, *Am Fam Physician* 2022;106(2):157–164). Treating severe worry and GAD in older adults can be particularly challenging because standard antidepressants may not have a dramatic effect on these late-onset cases. Individuals with severe worry also often have concerns about medication side effects, which can lead to treatment dropout. Among psychological treatments in older adults, cognitive behavioral therapy (CBT) can effectively reduce anxiety severity immediately following treatment compared to minimal management, but this reduction in anxiety

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may not be maintained over time (Hendriks GJ et al, *Cochrane Database Syst Rev* 2024; 7(7):CD007674).

CGPR: In your experience, what are the most effective techniques for distinguishing between different anxiety phenotypes during clinical assessment?

Dr. Andreescu: The key to distinguishing among anxiety phenotypes is to focus on the unique characteristics of each disorder. For GAD, the emphasis is on persistent and excessive worry about a variety of topics. In contrast, panic disorder is identified by spontaneous panic attacks and ongoing worry about additional attacks or their consequences. Social anxiety disorder is marked by intense fear and avoidance of social situations due to the fear of scrutiny and negative evaluation by others. Specific phobias are easier to pinpoint because they relate to an irrational fear of a specific object or situation that leads to avoidance behavior.

CGPR: Any theories on why treatment-resistant anxiety might develop in older adults?

Dr. Andreescu: One hypothesis is that there is an increased burden of cerebrovascular disease, what we see as white matter hyperintensities in the brain (Gerlach AR et al, *Am J Geriatr Psychiatry* 2024;32(1):83–97). Cerebrovascular disease leads to changes in white matter tract connectivity between various brain regions involved in emotion regulation, such as reappraisal—emotional regulation that is standardly used in CBT. Once this dysconnectivity syndrome appears, it's harder for people to respond to treatments such as CBT.

CGPR: Let's talk about strategies for managing treatment-resistant anxiety. What are your recommendations?

Dr. Andreescu: Lifestyle interventions, such as getting enough sleep, engaging in physical activities, and participating in social activities, have been found to be beneficial in improving mental well-being of older adults (Reynolds et al, 2022). Traditional CBT, the gold standard for middle-aged adults, doesn't work as well for older adults, particularly those with severe anxiety. This is why newer therapies tailored for older adults focus less on cognitive restructuring and more on behavioral interventions like relaxation, which are more effective. While there are data indicating the effectiveness of other types of therapy beyond CBT, such as acceptance and commitment therapy and mindful meditation, a therapist specializing in these treatments is harder to find (Delhom I et al, *Front Psychiatry* 2022;13:976363).

> **"Older adults with anxiety often prefer therapy over medications even though medications tend to be more effective. A combination approach may offer the most benefits. Starting treatment with a modified form of CBT or mindful meditation can help. Once the patient feels less overwhelmed by their emotions, medication can be introduced."**
>
> Carmen Andreescu, MD

CGPR: When do you consider therapy vs medications in treating late-life anxiety?

Dr. Andreescu: Older adults with anxiety often prefer therapy over medications due to fewer side effects and the human connection it offers. However, a meta-analysis shows that while therapy works slightly better for depression in older adults, the opposite is true in anxiety—medications tend to be more effective (Pinquart M and Duberstein PR, *Am J Geriatr Psychiatry* 2007;15(8):639–651). A combination approach may offer the most benefits. Starting treatment with a modified form of CBT or mindful meditation, both validated approaches for addressing anxiety in older adults, can help. Once the patient feels less overwhelmed by their emotions, medication can be introduced, followed by another layer of therapy, possibly incorporating cognitive restructuring or lifestyle interventions. This sequential treatment approach may be more effective, as it allows cognitive interventions to work better when the patient is not in the middle of an emotional crisis.

CGPR: Tell us how you think through your first medication trial for late-life anxiety.

Dr. Andreescu: First, I assess previous medication trials, considering dosage, duration, and any side effects. I often start with antidepressants such as sertraline or escitalopram. I usually start at a low dose—about a quarter of the standard adult dose—and gradually increase the dose over several weeks to minimize side effects. For example, I might start sertraline at 12.5 mg daily and increase by 12.5 mg every two weeks, assessing the patient's response and side effects at each step, until reaching a therapeutic dose that ranges from 50 to 100 mg per day. After reaching a therapeutic dose, I will wait a few weeks to assess response before titrating further—patients with anxiety disorder often require higher dosages for full resolution of symptoms. This cautious approach has been effective in my practice.

CGPR: Where do buspirone, gabapentin, and benzodiazepines fit in?

Dr. Andreescu: In healthy older adults with mild anxiety, I might consider buspirone as an alternative if patients are worried about the sexual side effects of SSRIs (Chen A et al, *J Geriatr Psychiatry Neurol* 2024;8919887241289533). Gabapentin does not have randomized trials supporting its use in GAD in either older or younger adults, but there are studies demonstrating efficacy in social anxiety disorder, preoperative anxiety, and anxiety in breast cancer survivors (Chen A et al 2024). While I don't avoid benzodiazepines, I ensure their use is carefully controlled, with clear guidelines to avoid dependency and abuse, such as limiting use to no more than twice a week and regularly reviewing the necessity of the medication. I might prescribe lorazepam 0.25 mg, to be taken only as needed for acute anxiety symptoms.

CGPR: Tell us more about your next steps if your first few medication trials are ineffective.

Dr. Andreescu: I couple medication use with lifestyle interventions—often underestimated but

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Evidence-Based Options for Treatment-Resistant Depression in Older Adults

Julia Cromwell, MD. Medical director, geriatric and adult inpatient psychiatrist at Mass General Brigham Salem Hospital, Salem, MA.

Dr. Cromwell has no financial relationships with companies related to this material.

A 72-year-old woman presents to your clinic due to worsening depression. Previously she was on sertraline but switched to venlafaxine 10 weeks ago. She still does not feel better—what should you do next?

Treatment-resistant depression (TRD) is common in depressed older adults, with over 50% not responding to initial treatment (Lenze EJ et al, *Lancet* 2015;386(10011):2404–2412). TRD is defined by the failure of two or more adequate antidepressant trials (typically from different classes). Lack of improvement with psychotherapy, electroconvulsive therapy (ECT), or transcranial magnetic stimulation (TMS) would also support this diagnosis. It is helpful to differentiate TRD from "pseudo-resistance" caused by inadequate medication dosing (not reaching the target dose for depression for at least four weeks), poor medication adherence, or an incorrect diagnosis.

TRD in older adults is also known as treatment-resistant late-life depression (TRLLD). It leads to worse prognosis, disability, poor medical outcomes, and cognitive decline (Blaszczyk AT et al, *Drugs Aging* 2023;40(9):785–813). There is a vicious loop where depression accelerates biological aging and predisposes patients to a variety of medical issues (eg, depressed individuals have a 45% higher risk of stroke), and medical issues increase the risk of LLD. Various biological aging factors that contribute to depression include increased vascular disease, inflammation, and amyloid accumulation (Alexopoulos GS, *Transl Psychiatry* 2019;9(1):188). Certain psychosocial stressors are also more common in older adults, including social isolation, financial instability, unemployment, elder abuse, disability, and chronic pain (for more on depression in older adults, see *CGPR* OctNovDec 2022). Here, we review the evidence-based treatment strategies for TRLLD.

Medication options

First-line treatment options

Antidepressants are more effective than placebo for LLD, although certain subsets of LLD (eg, depression related to dementia) have worse responses to antidepressants compared to others (eg, recurrence of early-onset depression; depression related to inflammation) (Alexopoulos, 2019). All antidepressants are effective, but common first-line agents are SSRIs (eg, sertraline, escitalopram) or SNRIs (eg, duloxetine, venlafaxine). You should reserve paroxetine, TCAs, and MAOIs for more severe cases due to their side effects. If used, nortriptyline and selegiline are the most common choices amongst TCAs and MAOIs respectively (Blaszczyk et al, 2023). Nortriptyline (25-150 mg/day) has the most evidence among TCAs due to its safety profile, whereas selegiline offers the flexibility of both oral (20–60 mg/day) and transdermal patch (6–12 mg/24 hours) formulations.

Second-line treatment options

Unfortunately, there is limited evidence from controlled trials to guide next steps after older adults fail first-line treatment. Clinicians typically maximize the dosage of the current antidepressant before considering a switch or augmentation. The 2023 OPTIMUM trial compared the most common augmentation strategies (adding aripiprazole, bupropion, or lithium) to switching antidepressants (to bupropion or nortriptyline) for TRLLD. Aripiprazole augmentation had the best overall results, although all strategies showed some benefit. Bupropion was associated with an increased risk of falls compared to aripiprazole. A different RCT for low-dose aripiprazole augmentation for TRLLD also showed benefit (Lenze EJ et al, *N Engl J Med* 2023;388(12):1067–1079).

Another promising option for TRLLD is methylphenidate augmentation. Combining an SSRI with methylphenidate can be well-tolerated and may lead to higher remission rates, but the benefit appears to fade with time (Alexopoulos, 2019; Blaszczyk et al, 2023).

Despite common usage in practice, there are no studies on mirtazapine for treatment of TRLLD. Similarly, there are theoretical benefits, but not much data, to support most supplements or alternative therapies, such as L-methylfolate or bright-light therapy. Limited data (although not specific to TRLLD) support triiodothyronine or S-adenosyl-L-methionine (SAMe) augmentation (Blaszczyk et al, 2023).

IV ketamine has emerged as a potential treatment for TRLLD, but the data are still evolving. A recent small pilot clinical trial showed good tolerability and improvements in depression and executive functioning (Oughli HA et al, *Am J Geriatr Psychiatry* 2023;31(3):210–221). However, other reports have had mixed results, and a different RCT of esketamine augmentation for TRLLD failed to show a statistical difference between esketamine and placebo (Blaszczyk et al, 2023). See table for a summary of the evidenced-based treatment options for TRLLD.

Therapy and lifestyle interventions

Psychotherapy

While psychotherapy may not be as effective as a standalone treatment for severe LLD, it can be a valuable adjunctive treatment. The best evidence supports problem-solving therapy and cognitive behavioral therapy, with some evidence for interpersonal therapy (Raue PJ et al, *Curr Psychiatry Rep* 2017;19(9):57). There are a variety of small studies showing promising results that look at therapies prioritizing treatment adherence, and therapies tailored to patients' cognitive abilities and medical comorbidities (Raue et al, 2017). Despite the potential benefits, limited access to specialized therapies continues to be a barrier in using these treatments.

Lifestyle interventions

In addition to therapy, lifestyle interventions can help older patients with depression. No formal trials recommend specific dietary interventions for TRLLD, but there has long been a correlation between the "Western diet" and sugary drink intake with depression. Alternatively, the Mediterranean diet and tea drinking are associated with lower risk of depression. Exercise also has a moderate effect as an adjuvant treatment for TRD in general (Blaszczyk et al, 2023).

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Neuromodulation
Neuromodulation is also an option for TRD, particularly if patients cannot tolerate medications.

Transcranial magnetic stimulation (TMS)
Improvements in TMS have allowed it to target deeper brain structures, increasing its effectiveness in LLD (Alexopoulos, 2019). A small RCT of 52 patients assessing the efficacy of bilateral rTMS for TRLLD showed 40% of participants in the rTMS group achieved remission, versus 14.8% in the sham group (Blaszczyk et al, 2023).

Electroconvulsive therapy (ECT)
ECT is still the gold standard for patients who need urgent improvement, such as those with severe psychosis, catatonia, or life-threatening medical complications. ECT is the most effective treatment for LLD, and maintenance ECT combined with pharmacotherapy reduces the risk of relapse in TRD (Alexopoulos, 2019). For more on ECT in severely depressed patients, see *CHPR* Apr/May/June 2023.

Novel therapies
Novel therapies on the horizon targeting specific sub-types of LLD include:
- Neurobiology-based psychotherapy
- Adding dopamine agonists like pramipexole
- Using anti-inflammatory agents, cytokine inhibitors, and statins

(Source: Alexopoulos, 2019)

After confirming your patient has major depressive disorder, is medication adherent, and is on the maximum dose of venlafaxine, you consider adding adjuvant aripiprazole. After discussion with the patient, you add adjuvant aripiprazole.

Evidence-Based Treatments for TRD in Older Adults

Strategy	Evidence	Pros	Cons
Aripiprazole augmentation (5–15 mg oral daily)	Good	Minimal weight gain, QTc prolongation, cardiac complications, or tardive dyskinesia	• Can cause akathisia and Parkinson symptoms • Interacts with some antidepressants (eg, duloxetine, paroxetine)
Lithium augmentation (aim for a serum level between 0.4–0.8)	Good	Possible anti-suicidal properties	• Kidney dysfunction • Thyroid dysfunction • Tremor
Electroconvulsive therapy	Good	Highly effective	• Anesthesia risks • Limited access • Time consuming
Antidepressant combinations	Some	Multiple options available (most common - adding bupropion ER)	• Increased polypharmacy • Increased falls
Methylphenidate augmentation	Some	Well-tolerated	Benefit might fade over time
Switching to a second-line antidepressant	Some	Multiple options available (eg, nortriptyline)	Increased side effects
Transcranial magnetic stimulation	Some	Limited side effects	• Limited access • Time consuming

CARLAT VERDICT: Reevaluate diagnoses and identify and address any barriers to treatment before formally diagnosing TRD. Evidence-based strategies for treating TRD in older adults include switching antidepressants, augmentation with aripiprazole, bupropion, or lithium, and referring patients to TMS or ECT.

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important—and at least one form of therapy, such as mindful meditation, if accessible. When standard antidepressants are ineffective, I might consider augmentation with mirtazapine (by itself, mirtazapine's effects are modest). I consider low-dose quetiapine as a fourth-line treatment, as patients who are otherwise restless appreciate the sedation. I use it cautiously at low doses to avoid akathisia and over-sedation and to minimize potential anticholinergic effects. It's important not to dismiss an entire class of medication based on one failed response and to explore all treatment stages before labeling a patient as treatment-resistant. Sometimes what we diagnose as treatment-resistant anxiety in older adults is not actually treatment-resistant, just poorly explored. I've seen patients not respond to venlafaxine, but they respond to duloxetine. Venlafaxine is more anxiogenic if titrated too fast, in contrast to duloxetine, which has a much more sedating effect in older patients.

CGPR: Can you discuss some of the unique challenges of using medications in older adults with late-life anxiety?

Dr. Andreescu: One concern with older adults is whether their dosages are appropriate, as anxiety often requires higher doses of antidepressants than depression. Older adults also need prolonged treatment due to a higher risk of relapse. Unfortunately, two-thirds of older adults do not receive effective, sustained treatment, often relying on quick fixes that can be harmful in the long run (Andreescu C et al, *JAMA Psychiatry* 2023;80(3):197–198). As patients age, treating them with benzodiazepines becomes increasingly problematic due to the higher risk of cognitive decline, falls, and tolerance. Many older adults turn to over-the-counter medications like diphenhydramine, which are not ideal for older adults due to increased confusion and cognitive decline. This can lead to a cycle of increased anxiety and medication use, as patients believe something is wrong with their brains, exacerbating the problem. To combat this, we can prioritize nonpharmacologic strategies like CBT, exercise, mindfulness, and dietary changes (Aucoin M et al, *Nutrients* 2021;13(12):4418). Educating patients and caregivers about the dangers of inappropriate medication use and the benefits of regular therapy can help break the cycle of inadequate treatment and dependency on harmful quick fixes.

CGPR: How does comorbid cognitive impairment influence treatment choices?

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Research Updates IN PSYCHIATRY

COGNITIVE DISORDERS

Linking Alzheimer's and Depression in Patients after Fifty

Talya Shahal, MD. Dr. Shahal has no financial relationships with companies related to this material.

REVIEW OF: **Wingo TS et al, *Alzheimers Dement* 2023;19(3);868–874.**

STUDY TYPE: Prospective cohort study

We know that depression in late life doubles the risk for Alzheimer's disease (AD). There's also an association between dementia and depression diagnosed in early and middle life (Elser H et al, *JAMA Neurol* 2023;80(9):949–958). A recent, large, genome-wide association study found that depression and AD share a genetic basis (Harerimana NV et al, *Biol Psychiatry* 2022;92(1):25–33). However, establishing causality is challenging—does late life depression increase the risk for AD, or is depression an early sign of AD? This study attempted to find an answer.

Using a large database, researchers looked at the full genetic data of 6656 individuals of European ancestry who were 50 years or older and who had normal cognition. Their median age was 56 years at baseline, and 59% were women. The researchers assessed the participants' cognitive function and depression every two years for about 16 years. They analyzed the subjects' DNA for various genetic patterns that have been associated with a higher risk of AD, and from this data came up with these polygenic risk scores (PRS).

Researchers found that people who were genetically more prone to AD, meaning they had a higher PRS, were also more likely to feel depressed after age 50. This finding held up even after adjusting for the genetic predisposition to depression, sex, age, and education. The association between AD and depression was *not* explained by the ApoE4 allele, which is the strongest genetic risk factor for AD. This suggests that genetic variations contributing to AD risk may also contribute to late-life depression risk.

The study focused on Europeans, so may not be generalizable to non-Europeans. The study also measured depression by self-report, which may miss cases.

CARLAT TAKE

Depression after the age of 50 may be a possible indicator for AD, even many years before AD symptoms first appear. The risk of dementia varies with the presence or resolution of depression at different ages, although we don't know how treating depression influences a patient's risk for dementia. Regardless, it's a good idea to keep a close eye on cognitive function in patients with depression in late life.

Which Leisure Activities Can Lower Dementia Risk?

Paroma Mitra, MD. Dr. Mitra has served as a consultant for Bristol Meyers Squibb. Relevant financial relationships listed for the author have been mitigated.

REVIEW OF: **Su S et al, *Neurology* 2022;99(15):e1651–1663.**

STUDY TYPE: Meta-analysis of longitudinal cohort studies

When patients ask us what they can do to lower their risk of dementia, we often recommend exercise or eating a healthy diet. This study looks at dementia prevention from another angle—how patients spend their free time.

This meta-analysis reviewed 38 studies from around the world and included more than two million participants without dementia with a mean age of 45-93 years at baseline. Participants were followed for at least three years and completed questionnaires and interviews about their leisure activities. Leisure activities were defined as activities participants engaged in for well-being or enjoyment and were separated into cognitive, physical, and social activities. Cognitive activities included crossword puzzles, reading books, and writing for pleasure. Physical activities included yoga, hiking, running, and dancing. Social activities included going to a center and meeting with friends or relatives.

The authors found that participants who engaged in leisure activities had a 17% lower risk of developing all-cause dementia (ACD) compared to participants who did not engage in leisure activities. Participants who engaged in cognitive activities had a 23% lower risk, those who engaged in physical activities had a 17% lower risk, and those who participated in social activities had a 7% lower risk. Physical and cognitive pursuits were related to a reduced risk of Alzheimer's disease (13% and 34%, respectively), and physical activity was also associated with a 33% reduced risk of vascular dementia.

Although the authors attempted to address systematic differences between studies, there was a considerable amount of heterogeneity between the meta-analyzed studies. Additionally, the studies looked at self-reported behavior, which is often unreliable.

CARLAT TAKE

As is true for any observational study, these findings can only show that a correlation exists between certain activities and a lower rate of dementia. Whether this correlation implies that these activities actually reduce dementia risk is unknown. Nonetheless, being active in old age has many other benefits on a patient's body and mood, so we can encourage our patients to spend time on any activities that bring them joy.

CME Post-Test

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1. According to Dr. Andreescu, what is the recommended initial step in treating late-life anxiety for older adults?
   [ ] a. Starting with medications followed by therapy
   [ ] b. Beginning with therapy, such as CBT or mindful meditation
   [ ] c. Initiating simultaneous therapy and medication treatments
   [ ] d. Using only therapy due to its superior effectiveness in older adults

2. Which sign might indicate elder neglect, as discussed in the elder abuse guidelines?
   [ ] a. Avoidance of eye contact
   [ ] b. Excessive crying
   [ ] c. Malnourishment or dehydration
   [ ] d. Frequent trips to the emergency room

3. According to Dr. Santos, which of the following factors is associated with a higher risk of elder abuse?
   [ ] a. Living independently with high social support
   [ ] b. Residing in an institutional setting
   [ ] c. Being a middle-aged adult with a high income
   [ ] d. Having strong familial relationships

4. What lifestyle intervention is associated with improved outcomes in older adults with depression?
   [ ] a. Regular physical activity
   [ ] b. Omega-3 fatty acid and Vitamin D supplementation
   [ ] c. Elimination of caffeine
   [ ] d. High-protein supplementation

5. According to a 2023 study, what does the genetic link between Alzheimer's disease (AD) and depression suggest?
   [ ] a. Late-life depression is unrelated to AD risk.
   [ ] b. Depression reduces the genetic risk for Alzheimer's disease.
   [ ] c. Genetic predisposition to AD increases the likelihood of late-life depression.
   [ ] d. ApoE4 completely explains the genetic overlap between AD and depression.

6. According to Dr. Andreescu, which of the following is a common pitfall encountered by clinicians when treating older adults with late-life anxiety?
   [ ] a. Treatment is often prolonged unnecessarily in older adults, resulting in undue stress on patients who are at lower risk of relapse than the general population.
   [ ] b. Patients are not given high enough doses of antidepressants to treat anxiety.
   [ ] c. Clinicians are unwilling to prescribe benzodiazepines for anxiety in older adults.
   [ ] d. Clinicians often advise patients against over-the-counter treatment options, like diphenhydramine, which are a cheaper and safer alternative to prescription medication options.

7. What is a recommended question for detecting elder abuse in clinical settings?
   [ ] a. "Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?"
   [ ] b. "Is the person next to you harming you?"
   [ ] c. "Do you enjoy spending time with your caregiver?"
   [ ] d. "Please tell me about your home."

8. How can clinicians detect financial exploitation in elder abuse cases?
   [ ] a. Ask about unusual financial transactions or account changes
   [ ] b. Wait for patients to mention concern about their finances
   [ ] c. Investigate caregiver behavior in isolation
   [ ] d. Question caregivers directly about their use of the patient's finances

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Dr. Andreescu: CBT becomes harder, so it's better to focus on relaxation strategies or mindful meditation, which remain effective longer, rather than on cognitive restructuring. When considering pharmacological options, avoid medications with anticholinergic effects. In later stages, patients can become more agitated, and I've often seen excessive use of antipsychotics, which not only have anticholinergic effects but also cause akathisia, leading to increased anxiety and difficulty in treatment. It's important to manage polypharmacy in these patients, the first step of which is to avoid making the situation worse, so select medications with the best possible side effect profiles to support these patients effectively.

CGPR: What's the relationship between late-life anxiety, medical comorbidities, and treatments?

Dr. Andreescu: There are multiple medical conditions that are associated with increased anxiety. COPD is one of the classic ones—people with COPD are 85% more likely to develop anxiety disorders than the general population (Yohannes AM et al, *J Fam Pract* 2018;67(2 Suppl):S11–S18). Parkinson's disease is another one—about half of people with Parkinson's disease experience anxiety. Medications can also increase the risk of anxiety, or they can give patients side effects that make them more anxious—for example, SSRIs can cause hyponatremia or GI bleeding. When patients are given an antidepressant, they may get a "dirty antidepressant" like paroxetine, which has its own side effect profile that's not ideal for older adults. Then there are interactions between their antidepressant and the medications for their medical ill-

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nesses. When side effects start to appear, it is more difficult to keep patients in treatment.

CGPR: Can you share insights about emerging research in treatment-resistant anxiety in older adults?

Dr. Andreescu: There have been many attempts at new molecules because SSRIs and SNRIs didn't really live up to their promise. Molecules like pregabalin did not get too far. One area of emerging research is focused on understanding the neural circuits involved in maintaining pathologic worry in older adults with anxiety. By mapping these circuits, we hope to develop targeted interventions using techniques like transcranial magnetic stimulation to modify brain activity and break the cycle of chronic worry. Additionally, there is ongoing research into modifying existing therapies like CBT to better suit the needs of older adults with severe worry. This may involve emphasizing behavioral interventions like relaxation techniques rather than cognitive restructuring. Another trend is combining different treatment approaches sequentially, such as starting with therapy or mindful meditation followed by medication and then another round of therapy focusing on cognitive restructuring.

CGPR: Thank you for your time, Dr. Andreescu.

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