Anxiety Disorders in the Elderly: An Update

McGill UniversityRefresher course 2019

Conflict of interest:

None.

3 Questions (Objectives)

What are its prevalences?

What are its comorbidities and different clinical manifestations?

What should be its therapeutic approach?

Source of information

"Quick and Dirty" literature review
1996-2019

Anxiety disorders in late life: A comprehensive review

Rajesh R. Tampi [1*], **Deena J. Tampi** [2]

1 Department of Psychiatry, MetroHealth, Cleveland, OH, USA 2 Saint Francis Hospital and Medical Center, Hartford, CT, USA

Abstract

Anxiety disorders are not uncommon in late life. These disorders are associated with greater rates of comorbidities with other psychiatric and medical disorders. Anxiety disorders are also associated with greater morbidity and mortality in late life. These disorders are often under- and misdiagnosed in older individuals given their symptomatic overlap with other medical disorders and drug side effects. Additionally, the diagnostic criteria for anxiety disorders have been developed for younger individuals and not for older adults. Although limited, data from controlled studies indicate that both psychotherapeutic and pharmacotherapeutic modalities are beneficial in the treatment of anxiety disorders in late life.

Citation: Tampi RR, Tampi DJ (2014) Anxiety disorders in late life: A comprehensive review. Healthy Aging Research 3:14. doi:10.12715/har.2014.3.14

Received: November 26, 2014; **Accepted:** December 22, 2014; **Published:** December 31, 2014

Competing interests: The authors have declared that no competing interests exist.

*Email: rajesh.tampi@gmail.com

Late-life Anxiety Disorders: A Review

Josien Schuurmans · Anton van Balkom

Abstract Anxiety disorders are a major clinical problem in late life; estimated prevalence rates vary from 6% to 10%, and the disease impact is considerable and equal to that of depression. However, anxiety disorders often remain undetected and untreated in older adults. This discrepancy may be accounted for by a combination of patient variables (eg, a lack of help-seeking behavior and long duration of illness) and variables related to current clinical practice (eg, a lack of knowledge regarding late-life anxiety and ageism). Because anxiety disorders usually have an age at onset earlier in life, patients and mental health professionals may be inclined to attribute the anxiety and avoidance symptoms to personality factors instead of a treatable syndrome. Comorbidity with other psychiatric disorders, such as depressive disorder, may complicate the appropriate diagnosis. Identification may be further obscured because the phenomenology of anxiety disorders in older adults tends to differ from the phenomenology in younger adults. Randomized controlled trials have yielded support for the effectiveness of cognitive-behavioral therapy and serotonergic antidepressants. However, both treatments seem hampered by relatively high dropout rates, and the available data are based primarily on a relatively healthy, well-educated, and "young" older population. The dissemination of knowledge regarding late-life anxiety disorders is vital,

More evidence based…

ELSEVIER
SAUNDERS

Psychiatr Clin N Am
28 (2005) 871–896

PSYCHIATRIC
CLINICS
OF NORTH AMERICA

Evidence-Based Treatment of Geriatric Anxiety Disorders

Julie Loebach Wetherell, PhD[a], Eric J. Lenze, MD[b], Melinda A. Stanley, PhD[c,*]

[a] *Department of Psychiatry, University of California San Diego, VA San Diego Healthcare System, 3350 La Jolla Village Drive (116B), San Diego, CA 92161, USA*

[b] *Western Psychiatric Institute and Clinic, Room E1124, 3811 O'Hara Street, Pittsburgh, PA 15213, USA*

[c] *Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, 2002 Holcombe Boulevard (152), Houston, TX 77030, USA*

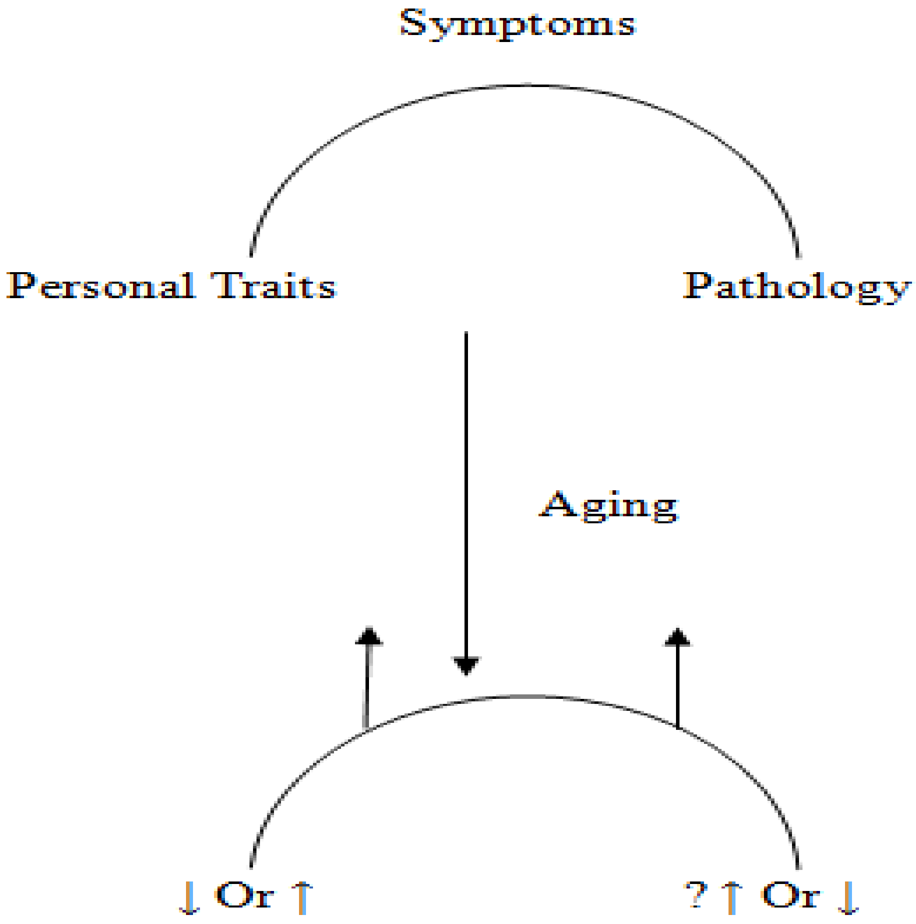
PREVALENCES….

Table 1 The 6-month prevalence of anxiety disorders in mixed-age populations vs older adults

Diagnosis	Mixed-age populations (age <65 years), %	Older adults (age >55 years), %
All anxiety disorders	12.4	6–10
Panic disorder	2.2	1-2
Agoraphobia	0.8–1.6	0.65
Simple phobia	7.1	4
Social phobia	4.8	1.3
Generalized anxiety disorder	1.2	1–7.3
Obsessive-compulsive disorder	0.9	0.6
Post-traumatic stress disorder	0.4	0.9
Hypochondriasis	4.2–6.3	4.2–6.3

Data from Beekman et al. [2], Kessler et al. [18], and Bijl et al. [48]

PREVALENCES (SUITE)



Generalized Anxiety Disorder

Diagnostic Criteria

300.02 (F41.1)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

COMORBIDITY

- Direct → > 40-50% comorbid lifetime depression but reverse course more…

- Other physical disorders

TABLE 2. SOME GENERAL MEDICAL CONDITIONS CAUSING ANXIETY

TABLE 2. SOME GENERAL MEDICAL CONDITIONS CAUSING ANXIETY

Cardiovascular Disorders
- Angina pectoris
- Arrhythmias, especially paroxysmal
- Atrial tachycardia
- Mitral valve prolapse
- Myocardial infarction
- Orthostatic hypotension

Respiratory Disorders
- Asthma
- Chronic obstructive respiratory disease
- Hypoxia resulting from any cause
- Pulmonary embolism

Drugs
- Toxicity
  - Sympathomimetic compounds
  - Theophylline
  - Thyroid replacement agents
  - Steroids
  - Neuroleptics (e.g., akathisia)
  - Psychostimulants
  - Antidepressants
- Withdrawal
  - Alcohol
  - Sedative hypnotics
  - Caffeine
  - Nicotine

Endocrine Disorders
- Acute intermittent porphyria
- Carcinoid syndrome
- Cushing's syndrome
- Hyperthyroidism
- Hypoglycemia
- Hyperparathyroidism
- Hypothyroidism
- Insulinoma
- Pheochromocytoma

Neurologic Disorders
- Aura of migraine
- Cerebral neoplasia
- Delirium
- Demyelinating disease
- Early dementia
- Partial complex seizures
- Vestibular dysfunction

COMORBIDITY (CONT.)

- Indirect→ Investigation and use of services (ER…)

PSYCHOSOCIAL OR SOMATIC SIGNS OR SYMPTOMS OF ANXIETY

Psychological or Somatic Signs and Symptoms of Anxiety

- Anorexia
- Backache
- "Butterflies" in stomach
- Chest discomfort
- Diaphoresis
- Diarrhea
- Dizziness
- Dyspnea
- Dry mouth
- Faintness
- Fatigue
- Flushing
- Headache
- Hyperventilation
- Light-headedness
- Muscle tension
- Nausea
- Pallor
- Palpitations
- Paresthesia
- Sexual dysfunction
- Shortness of breath
- Stomach pain
- Sweating
- Tachycardia
- Tremulousness
- Urinary frequency
- Vomiting

Comorbidity (cont.)

- Indirect → meds (BDZ, Other, psychotropes…)

QUESTIONABLE PRESCRIBING FOR ELDERLY PATIENTS IN QUEBEC

Questionable prescribing for elderly patients in Quebec

TREATMENT

- Complete evaluation- Physical, labs, others?
- Reversible vs. non-reversible symptoms (personality?)
- Target symptoms

Treatment (cont.)

Non-Pharmalogical

- CBT / Mindfulness / relaxation
- Inerpersonal
- Exercise

TREATMENT (CONT.)

Pharmacotherapy:

BDZ… Short term (?) lyrica and buspar(?)

“Antidepressant”… Long term (SSRI-SNRI…)

Buspirone (?efficacy)

Very few controlled studies…

Treatment (cont.)

Pharmacokinetic and dynamic changes

“start lower, go slower but treat”

BJPsych The British Journal of Psychiatry (2013) 203, 8–9. doi: 10.1192/bjp.bp.112.127639

Editorial

Lack of interventions for anxiety in older people†

Richard C. Oude Voshaar

Summary
Although anxiety disorders are common in later life, only a minority of patients receive appropriate treatment. The scarcity of clinical trials and decreasing effectiveness of current treatment modalities with advancing age, as shown by Wetherell and colleagues in this issue, argue for more clinical trials and development of age-specific psychotherapeutic techniques.

Declaration of interest
None.

Richard C. Oude Voshaar is a consultant psychiatrist and Professor of Old Age Psychiatry. He leads research on late-life affective disorders, covering depressive, anxiety and somatoform disorders.

Reported prevalence rates for anxiety disorder in later life vary between 3.2 and 14.2%.[1] Setting aside specific phobias, generalised anxiety disorder is the most common in nearly all population surveys (range of prevalence rates 1.2–7.3%), followed by social phobia (range 0.6–2.3%), obsessive–compulsive disorder (range 0.1–0.8%), panic disorder (range 0.1–1.0%) and post-traumatic stress disorder (PTSD) (range 0.4–1.0%).[1] A Canadian study showed that 12-month prevalence rates for late-life anxiety disorder increased from 5.6% based on DSM-IV criteria to 26.2% when well-defined subthreshold disorders were also included.[2] Interestingly, older persons with full-blown anxiety disorders and those with subthreshold anxiety disorders did not differ in health and health behaviour characteristics, whereas compared with respondents without anxiety both groups were psychiatrically and somatically less healthy and used healthcare services more frequently.[2]

More optimistic is the great progress in the treatment of anxiety disorder over the past decades. Many well-designed randomised controlled trials (RCTs) have proven the efficacy for both cognitive–behavioural therapy (CBT) and serotonergic antidepressants. Moreover, the availability of disorder- and symptom-specific cognitive–behavioural techniques for anxiety is still increasing. The wealth of RCTs has led to evidence-based treatment algorithms summarised in guidelines for most, if not all, individual anxiety disorders.

associated with increased healthcare consumption, reduced quality of life and high disability rates. When left untreated, it has a tendency to become chronic and substantially increases the risk for developing major depression. Furthermore, between 25 and 43% of older people with anxiety disorders use benzodiazepines chronically (e.g. Grenier et al[3]), the majority of whom without ever having received a trial of serotonergic antidepressants or CBT. Although guidelines leave room for the use of benzodiazepines, these agents are never considered first choice. Based on their risk–benefit ratio, their use becomes even less favourable with increasing age, and is reserved for short-term crisis management or a final step if CBT and serotonergic antidepressants have failed.

Several factors contribute to the low treatment rates of late-life anxiety disorder. Ageism may be an important explanation as it hinders both adequate detection and, if recognised, adequate treatment. Physicians, therapists, older patients as well as next of kin, often interpret anxiety symptoms and avoidance behaviour in later life as normal and more or less acceptable, when in reality the patient may have a psychiatric disorder. Furthermore, as a result of the ageing process itself, somatic morbidity increases and may partially overlap with symptoms of panic and anxiety. In addition, symptoms of arousal as well as anxiety cognitions tend to decline with increasing age, resulting in some authors characterising anxiety in later life as a less devastating condition compared with anxiety disorder earlier in life. Nonetheless, avoidance behaviour, an important negative consequence of anxiety, does not seem to decline with age.

Available evidence

REFERENCES

1. Tamp: R.R., Tamp: D.J. Anxiety disorders in late life: A comprehensive review. Healthy aging research, 3:14, 2014.
2. Schumans, J., VanBaltrom, A. Late life anxiety disorders: A review. Curr. Psychiatry Rep. Springer 2011.
3. Wetherell J. et al Evidence-based treatment of geriatric anxiety disorders. Psychiatr. Clin. N. AM. 28 (2005) 871-896.


NO... NO...
I SAID I'VE GOT
ACUTE ANGINA