ANXIETY DISORDERS IN THE ELDERLY

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LATE-LIFE ANXIETY TOPICS TO BE COVERED

- Classes of Anxiety Disorders
- Diagnosis
- Comorbidities
- Pharmacologic Management
- Psychological Management

LATE LIFE ANXIETY (LLA) DISORDERS

- Twice as prevalent as dementia in older individuals
- Four to eight times more prevalent than major depressive disorders
- Highly comorbid with depression
- Highly comorbid with many medical illnesses
- Challenging both to diagnose and treat

IMPACT OF LATE-LIFE ANXIETY

- Increased depression
- Decreased quality of life
- Greater physical disability
- Increased comorbidity
- Decreased perceptions of physical and mental health
- Increased use of health services in both outpatient and hospital settings

THE COSTS

- Older adults with anxiety spend 50% more time with their primary care physician than those with no psychiatric diagnosis
- Incur more medical evaluations
- More hospitalizations
- Estimated healthcare costs due to late-life anxiety (LLA) disorders in 1994 was $65 billion
- Lags behind depression in terms of research

CHANGES IN DSM-5

- Obsessive-compulsive disorder and posttraumatic stress disorder are no longer categorized as anxiety disorders
- Panic disorder and agoraphobia are now unlinked
- Agoraphobia, specific phobia, and social anxiety phobia criteria no longer require the individual to recognize that their anxiety is excessive or unreasonable
- Clinician judges the anxiety to be out of proportion to the actual danger or threat in the situation
- The anxiety must be of at least 6-month duration
CLASSES OF ANXIETY DISORDERS
(1 of 2)
- Agoraphobia
- Panic disorder
- Specific phobia
- Generalized anxiety disorder
- Substance/medication-induced anxiety disorder
- Anxiety disorder due to another medical condition

CLASSES OF ANXIETY DISORDERS
(2 of 2)
- Panic attack (specifier)
- Social anxiety disorder (formerly social phobia)
- Separation anxiety disorder
- Selective mutism
- Other specified anxiety disorder
- Unspecified anxiety disorder

LATE-LIFE ANXIETY (LLA)
- 12-month prevalence in those ≥ 65 yrs is 7-10%
- May be underdiagnosed because the elderly tend to somatize psychiatric problems
- Detection and diagnosis is complicated by medical comorbidity, cognitive decline, and changes in life not often faced by younger adults

CHALLENGES TO THE DIAGNOSIS
- Patient and physician may view fear, anxiety, and avoidance as normal given aging circumstances
- Adaptive versus pathological anxiety
- Often attribute their symptoms to physical illness
- May have difficulty recalling or characterizing symptoms

SUBTHRESHOLD ANXIETY DISORDER
- Older adults tend to minimize symptoms
- Subthreshold anxiety disorders contribute to underestimates
- Combined estimates of syndromal and subthreshold anxiety as high as 29%
- May not be appropriate to ask patients to rate their anxiety in terms of autonomic responses

RISK FACTORS FOR LLA
- Having several chronic medical conditions
- Being single, divorced, separated
- Lower education level
- Being female
- Stressful life events
- Lack of social support
- Impaired subjective health
- Functional physical limitations
AGORAPHOBIA

PANIC DISORDER

SPECIFIC PHOBIA

GENERAL ANXIETY DISORDER

SUBSTANCE/MEDICATION-INDUCED ANXIETY DISORDER

ANXIETY DISORDER DUE TO ANOTHER MEDICAL CONDITION
  • Hyperthyroidism
  • Hypoglycemia
  • Cardiac dysrhythmia
  • Coronary artery disease
  • Chronic obstructive pulmonary disease
  • Asthma
  • Dementia
  • Pheochromocytoma
  • Vestibular dysfunction
PANIC ATTACK
SOCIAL ANXIETY DISORDER

OTHER SPECIFIED ANXIETY D/O
UNSPECIFIED ANXIETY D/O

ADJUSTMENT DISORDER WITH
ANXIOUS MOOD

OBSESSIVE-COMPULSIVE DISORDER
POSTTRAUMATIC STRESS DISORDER
ASSESSMENT: HISTORY

• Events surrounding onset of symptoms
  – Recent life changes
  – New medical diagnosis
  – Worsening of chronic condition
  – New medications or increased doses
  – Early life history of anxiety disorder
  – Medication review, including OTC and herbals
  – Consider pill counts

SCREENING

• Discuss caffeine intake
• Screen for depression
  – Clinical presentation of anxiety in late life may more likely include depressive symptoms
• Screen for alcohol/substance abuse
  – High comorbidity rates with anxiety disorders as is the case in younger adults

ASSESSMENT: PHYSICAL EXAMINATION

• Consider an anxiety disorder as a diagnosis of exclusion in older adult with new onset
• Be alert for signs of medical comorbidities
• Screen for vision changes
  – Visual impairment is associated with higher levels of anxiety
• Screen for cognitive impairment

DIAGNOSTIC TESTING

• Guided by your clinical judgment
• Proceed with appropriate diagnostic testing
  – Thyroid function tests
  – Complete blood count
  – Complete metabolic panel
  – Consider urine drug screen

MEDICAL COMORBIDITIES

• Coronary artery disease
• Cardiac dysrhythmia
• Asthma
• COPD
• Hyperthyroidism
• Diabetes mellitus
• Vestibular dysfunction
• Irritable bowel syndrome

CARDIAC DISEASE

• 24% to 31% of cardiac patients have symptoms of anxiety
• Association with anxiety disorders is of a reciprocal nature
  – Anxiety disorders seem to increase the risk of future heart disease
  – Baseline GAD was associated with 74% increase in cardiovascular events in a prospective study of 1015 patients with stable coronary heart disease
**GERIATRIC ANXIETY INDEX (GAI)**

- Validated tool
- Minimizes emphasis on somatic symptoms
- Self report or administered if vision or reading deficit is present
- 20 items in a “agree” or “disagree” format
  - “Do you think of yourself as a nervous person?”
  - “Do you find it hard to relax?”
- Available to clinicians at GAI website

**GAI-SHORT FORM (SF)**

1) I worry a lot of the time.
2) Little things bother me a lot.
3) I think of myself as a worrier.
4) I often feel nervous.
5) My thoughts often make me anxious.

>3 “agrees” has 75% sensitivity and 86.8% specificity

**PHARMACOLOGIC TREATMENT**

- High drop-out rates in LLA patient population
- To optimize adherence, alert the patient to potential side effects
- First line treatment is antidepressants
- Panic disorder patients are particularly sensitive to the anxiogenic effects of antidepressants

**ANTIDEPRESSANTS**

**SSRIs and SNRIs**

- First tier medication therapy
- Keep in mind that the maximum FDA-recommended dose of citalopram for those >60 yrs is 20 mg
- Paroxetine has the most prominent anticholinergic side effects (I avoid it)
- Fluoxetine is best avoided because of long high-life
- Venlafaxine probably best-studied SNRI for anxiety
- Be alert for hyponatremia (SIADH)

**BENZODIAZEPINES**
BUSPIRONE

NOT RECOMMENDED

• Antihistamines, including hydroxyzine
  – Anticholinergic effects are problematic
  – Risks may outweigh the benefits
• Antipsychotics
  – Should be avoided in the nonpsychotic older patient with an anxiety disorder
  – May be appropriate if the anxiety has a prominent psychotic feature

PSYCHOSOCIAL TREATMENT APPROACHES

• Often combined with pharmacotherapy
• Cognitive behavior therapy (CBT)
• Relaxation training
• Mindfulness-based stress reduction
• Combining pharmacotherapy with psychotherapy reduces relapse

COGNITIVE BEHAVIOR THERAPY

• Focuses on how patient’s thoughts/beliefs influence their mood and actions
• Those with anxiety disorders tend to “catastrophize”
• CBT helps the anxious patient develop a more adaptive response to fear
• The best efficacy data
• May require longer course in the elderly
• Limited availability

ANXIETY AT THE END OF LIFE

• Benzodiazepines certainly appropriate
• Be aware that lorazepam can build up active metabolites
• Anxiety with prominent psychotic features warrants use of an antipsychotic