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Anxiety Disorders in Old Age Psychiatry

Expert Led Session

Anxiety in Older Adults

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Anxiety Disorders in Old Age Psychiatry

To achieve this

- Case Presentation
- Journal Club
- 555 Presentation
- Expert-Led Session
- MCQs

- Please sign the register and complete the feedback

Anxiety Disorders in Old Age Psychiatry

Aims and Objectives

- The overall aim of the session is for trainees to gain an overview of anxiety in later life

- By the end of the sessions trainees should:
  - understand the epidemiology of anxiety and anxiety disorders in the older person
  - understand the aetiology of anxiety and anxiety disorders
  - understand how anxiety disorders present in later life, their classification, the basic assessment process and the principles of treatment of anxiety

Prevalence in the Elderly

- Anxiety disorders are very prevalent mental health conditions in older age
  - While the state of anxiety, an experience of tension and apprehension, is an ordinary response to a threat or danger, excessive anxiety that causes distress or interferes with daily life is not a normal part of the aging process
  - The overall prevalence of anxiety disorders is 11.4% in over 65s (Andreas et al 2017)
  - Over their lifetimes, about 15% of those who survive past the age of 65 will have had an anxiety disorder (Kessler et al 2005)

Prevalence in the Elderly

- **Prevalent** in the elderly (Hellwig and Domschke 2019)
  - Many studies note anxiety symptoms
    - **1.2-15%** in community dwelling elderly
    - **agoraphobia most frequent** (4.9%)
    - panic disorder (3.8%)
    - generalized anxiety disorder (GAD) (3.1%)
    - Specific phobias (2.9%)
    - social phobia (1.3%)

- Often coupled with **depression**
  - Either an anxiety disorder leading to depression or the presentation of anxiety as part of a depressive disorder
  - Schoerers et al. 2005
    - Those with GAD became depressed over time
      - 40% had anxiety/depression or just depression 36 months later

Anxiety in the Elderly

- Important feature of **Dementia**
  - May be part of a **prodromal phase** in the early stages of dementia
  - High levels of anxiety exist in patients with dementia (Ballard, et al 1995)
    - 22% subjective anxiety
    - 11% autonomic anxiety
    - 38% tension
    - 13% situational anxiety
    - 2% panic attacks

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Anxiety in the Elderly

- In general, older adults with anxiety disorders have **poorer outcomes** (Wolitzky-Taylor, Castriotta, Lenze, Stanley, & Craske, 2010)
  - More difficulties managing their day-to-day lives than older adults with normal worries
  - Greater risk of physical illness, falls, depression, disability, premature mortality, social isolation, and placement in institutions.

Risk/Precipitating Factors

- A number of risk factors have been identified (De Beurs 2001)

- **Genetics**- twin study estimates of heritability GAD 32% agoraphobia 67% (Gottschalk, M.G. and Domschke, K., 2016). Influence of genetic variance to increase at an accelerated pace from approximately age 60 years onward (Lee et al 2016)
- **Brain structure**- increased activation in amygdala in social phobia (Stein et al. 2002.) Increased blood flow in caudate nucleus and cingulate gyrus in OCD (Breiter et al. 1996.)
- **HPA axis** alterations with aging
- **Early experiences**- Parental loss linked to GAD (Zahner and Murphy 1989) as well as martial conflict/poor parenting
- **Social Adversity**- low occupational class, unemployment, poor housing, limited access to amenities
- **Life events**- bereavement, retirement and institutionalization. Threat events rather than loss events tend to lead to anxiety (De Beurs 2001)

Risk/Precipitating Factors

- **Premorbid personality**
- **A lack of social support**
- **Medical illness**
- **Poor self-rated health**
- **The presence of another psychiatric illness-** other anxiety disorders or mood disorders may give rise to other anxiety problems.
- **Substance Misuse**
- **Female gender**
  - Panic disorder- F:M- 2:1
  - GAD- F:M- 3:2

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Anxiety in the Elderly

- Interacts with physical health in a number of ways
  - Anxiety, alone or in combination with depression, also frequently co-occurs with physical disorders that become more prevalent with aging, such as **cardiac conditions, respiratory problems, and balance problems.**
    - The co-occurrence of anxiety disorders and physical diseases considerably raises the risk of poor physical outcomes (Wolitzky-Taylor et al 2010)
  - Anxiety presents with physical symptoms such as chest pain and palpitations
  - Physical health problems can present with anxiety symptoms (see next slide)

Anxiety Disorder Due To General Medical Condition

- Again more likely in the elderly
  - The elderly have more medical problems

- This is a partial list of common conditions
  - **Cardiovascular:** CCF, arrhythmia, MI
  - **Endocrine:** hypoPTH, thyroid, hyperadrenalism
  - **Immunological:** RA, SLE, TA
  - **Lung disease:** Asthma, COPD, PE
  - **GI disease:** Crohns, UC
  - **Neurological illness:** CVA, MS, MG, neurosyphillis, post-concussive syndrome, seizures, TIAs, vertigo

Substance Induced Anxiety Disorder

- More likely to happen with advancing age
  - more likely to be on medication(s)

- Anxiety related to the use, abuse or withdrawal from medications or drugs
  - Alcohol, amphetamines, anticholinergics, antidepressants, anti-TB drugs, anti-HTN, caffeine, cannabis, beta-blockers (w/d), cocaine, digitalis, dopamine, ephedrine, L-dopa, methylphenidate, NSAIDs, pseudoephedrine, sedative-hypnotics (w/d), steroids, theophylline, thyroid

Recent Research

- **‘Anxiety disorders in older adults are twice as common as dementia and 4-6 times more common that major depression’**

- Factors that may account for this prevalence:

  – History of anxiety/mental health problems makes relapse more likely in older age

  – Older adulthood can bring difficulties such as increased loss of role, loved ones, sense of belonging and purpose

  – When experiencing anxiety, one is much more likely to avoid the perceived threat, which serves to reinforce the threat, developing an unhelpful, engrained cycle.

  – A dependence on medication to help ’fix’ the anxious symptoms can be unhelpful, if not been prescribed in combination with cognitive behavioural therapy.

(Koychev & Ebmeier 2016)

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Psychiatry Anxiety Disorders

- An important learning point is that an older person with anxiety may also be presenting with a dementia (often a prodromal phase), affective disorder, psychotic disorders as well as anxiety disorders….

- Panic disorder
  - With agoraphobia
  - Without agoraphobia
- Agoraphobia without panic disorder
- Social phobia
- Specific phobia
- Generalized anxiety disorder
- Obsessive-compulsive disorder (OCD)
- Acute stress disorder
- Post-traumatic stress disorder (PTSD)
- Due to general medical condition
- Substance-induced
- NOS

Clinical Features

- These are generally similar to those seen in younger adults but the following are more common in the elderly:
  - Anxious preoccupation with physical illness, finance, crime and family
  - Sleep
    - May increase as a way to avoid fears
    - More likely be impaired due to ruminating about imagined or exaggerated dangers

Clinical Features

- Somatic symptoms of anxiety which may be misattributed to physical causes
- Appetite
  - Overeating may calm patients
  - Patients may skip meals and lose weight.
- Abuse and over-prescription of sedative drugs and alcohol
- Patients find fewer activities pleasurable as they become more fearful and stay at home to avoid their fears.

Clinical Features

Social isolation is a major sign of anxiety and/or depression

- People who are socially isolated may have lost their relationships with family/friends, do almost nothing that gives them pleasure, and may not leave their homes except for doctors' visits or to buy groceries.
- Some people are isolated because of physical problems, depression or frightened to leave their homes.
- A vicious cycle emerges. Social contact and activity would lift spirits and calm fears, but they are too anxious and/or depressed to do what would help them most.
- Due to isolation they are increasingly anxious and/or depressed.
- Breaking the cycle of isolation is exceedingly difficult and often requires persistent outreach and great patience

(Brennan, Vega, Garcia, Abad, & Friedman, 2005).

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Assessment of Anxiety

Clinical evaluation

Full psychiatric history and physical examination, with particular attention to:

- Past medical history and medication use (important to access GP and medical notes for information)
- Alcohol and substance misuse
- Family and personal/social history

Mental state exam

Distractibility, much motor movement, easily startled, wide-eyed, feeling of dread, low mood

Associated cognitive aspects of underlying anxiety disorders include hyper-vigilance to threat, seeing oneself as vulnerable, and perceiving the demands of life as exceeding the available resources to cope (Beck 1985)

Physical exam

Trembling, racing heart, rapid breathing, sweating, dry mouth

Laboratory testing

Rule out common conditions that lead to anxiety

Formulation

- A common anxiety formulation:
  - Trigger
  - Perceived threat → Worry → Checking behaviour/scanning/hypervigilance → increased physiological arousal → avoidance → misinterpretation → confirming perceived threat.

Distinguishing Anxiety from Depression

- Based on Beck's triads (i.e. models of content specificity, Beck, 1976).

- Suggest that the affective disorders can be characterised by three themes, concerning perception of the self, the world and the future.

- In terms of **depression**, patients see themselves as being **worthless**, the world as **hostile**, and their future as **hopeless**.

- In contrast, those with **anxiety**, see themselves as **vulnerable**, the world as **chaotic**, and the future as **unpredictable**.

Management Principles

- There are NICE guidelines for a anxiety disorders but the focus of these guidelines are for younger adults but they are still applicable to the older population but consider the uniqueness of the older adult

- A first presentation of anxiety in an elderly person should prompt a search for an underlying physical health problem or a depressive disorder (Flint and Gagnon 2003)

- In the elderly, the approach to treatment is similar to that of anxiety disorders in younger adults (Flint and Gagnon 2003)

- Preference for psychological and behavioural interventions, and cautious use of medication

Treatment – Supportive Interventions

- Improving or nurturing a relationship with a family member or carer who directly addresses isolation and inactivity can be helpful

- Engaging people with anxiety in social activities they find interesting also can be helpful

- Assisting older adults with matters that may be a source of anxiety, such as dealing with health issues or financial matters

Treatment - Psychotherapies

- CBT
- Problem solving (learnt most quickly)
- Interpersonal therapy

Therapy often involves education and support in managing anxiety in structured ways, such as progressive muscle relaxation, sleep hygiene and deep breathing

- Important consideration is the impact of cognitive impairment on such interventions

- In addition, some older patients may have a health belief that medications are the answer rather than this type of therapy

Treatment - Medication

- There are risks of using medications in older adults due to the side effect profiles of medications used in the treatment of anxiety disorders

- Classes of medications used:
  - Antidepressants
  - Benzodiazepines
  - Pregabalin
  - Antipsychotics
  - Hypnotics
  - Beta blockers
  - Buspirone

Treatment - Medication

- **Selective Serotonin Reuptake Inhibitors (SSRIs)**
  - Relatively safe in the elderly
  - Mild GI symptoms
  - Irritability, anxiety and sexual dysfunction
  - Hyponatraemia can contribute to delirium in the elderly
  - Discontinuation syndrome also important, most common with paroxetine
  - Evidence of using Citalopram (Lenze 2005) but due to problems of a raised QTc, this is used less frequently.

- **Venlafaxine/Duloxetine (SNRIs)**
  - SNRIs used commonly as a second line treatment (Ketz 2002)
  - Heightens blood pressure
  - Duloxetine can be helpful if there issues of neuropathic pain

Treatment - Medication

- **Mirtazapine**
  - Again, often used as a second line
  - Sedating and appetite enhancing at low doses (15mg) due to antihistamine effects
  - Data exists supporting the medication being used in anxiety disorders

- **Tricyclics (TCAs)**
  - Clomipramine could be used for OCD
  - ‘Dirty Drug’ due to the interactions with a number of receptor classes
  - Anticholinergic side effects are a significant issue in the elderly
  - Other issues- sedation, confusion, and hypotension
  - Cardiac toxicity

Treatment - Medication

- **Pregabalin**
  - Usually used when there has been an adequate trial of an SSRI and SNRI
  - Inhibits release of excess excitatory neurotransmitters, presumably by binding to the α2-δ subunit protein of widely distributed voltage-dependent calcium channels in the brain and spinal cord.
  - Works within 1-2 weeks (which makes it attractive as the SSRIs and SNRIs can take 2-4 weeks to work)
  - Titration is slow

Treatment - Medication

- **Benzodiazepines**
- Still a common treatment for anxiety in the elderly despite the absence of specific evidence for efficacy in this population and associated side effects (Madhusoodanan, 2004)
- Used for short term use only
- Usually used whilst other medications take effect (for example, antidepressants can take 2-4 weeks to work)
- Number of problems in the elderly including
  - Dependence/addiction
  - Withdrawal syndrome
  - Increasing confusion
  - Changes in mobility
  - Respiratory depression due to sedative effects
  - Aggression
  - Risks of overdose

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Treatment - Medication

- Other medications potentially used
  - Hypnotics (Z-drugs and Melatonin)
  - Beta-blockers
  - Antipsychotics
  - Buspirone

- A key point is to keep up to date with most current evidence….

National Institute for Health and Clinical Excellence

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Summary

- Anxiety is a key symptom and disorder in old age psychiatry
- Consider behavioural approaches, psychological therapies and medications when managing the disorder
- Keep up to date with the evidence base

Any Questions?

Thank you

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Old Age Module

MCQs

1. Regarding the diagnosis of anxiety:

   A. MMSE is a useful tool
   B. The ‘worry scale’ is a carer’s report tool
   C. HADS is a useful tool
   D. Cornell scale is the most useful if you are 70+
   E. None of the above are true

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Old Age Module

MCQs

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Old Age Module

MCQs

2. A diagnosis of GAD can only be made after how long?

   A. 6 months
   B. 3 months
   C. 6 weeks
   D. 3 weeks
   E. 1 year

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Old Age Module

MCQs

2. A diagnosis of GAD can only be made after how long?

   A. 6 months
   B. 3 months
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Old Age Module

MCQs

3. In the elderly, anxiety is most closely associated with which disorder:

   A. Schizophrenia
   B. Depression
   C. Alzheimer's disease
   D. Diogenes Syndrome
   E. Delusional Disorder

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Old Age Module

MCQs

3. In the elderly, anxiety is most closely associated with which disorder:

   A. Schizophrenia
   B. Depression
   C. Alzheimer's disease
   D. Diogenes Syndrome
   E. Delusional Disorder

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Old Age Module

MCQs

4. A 78 year old lady has recently been started on a new medication for anxiety but has developed hyponatraemia. Which of the following has most likely caused this?

A. Lamotrigine
B. Risperidone
C. Lithium
D. Citalopram
E. Quetiapine

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Old Age Module

MCQs

4. A 78 year old lady has recently been started on a new medication for anxiety but has developed hyponatraemia. Which of the following has most likely caused this?

A. Lamotrigine
B. Risperidone
C. Lithium
D. Citalopram
E. Quetiapine

Old Age Module

MCQs

5. Which is the most prevalent anxiety disorder in adults aged 65 and older?

   A. Generalised anxiety
   B. Agoraphobia
   C. Specific phobia
   D. Social anxiety
   E. Health anxiety

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Old Age Module

MCQs

5. Which is the most prevalent anxiety disorder in adults aged 65 and older?

A. Generalised anxiety
B. Agoraphobia
C. Specific phobia
D. Social anxiety
E. Health anxiety

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Old Age Module

Any Questions?

Thank you

Please provide feedback/suggestions on this presentation to the module lead anthony.peter@lancashirecare.nhs.uk