Anxiety in Older Adults

3RD ANNUAL GERIATRIC BEHAVIORAL HEALTH CONFERENCE

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Relevant to the content of this educational activity, I do not have any relationships with commercial interest companies to disclose but I do intend to discuss off-label uses of commercial products/devices.

Disclosures

• No financial interests in any healthcare-related company
• My work is partially funded by HRSA grant for geriatrics workforce enhancement
• I will be discussing the use of medications, in some cases not FDA-approved indications.

Existence really is mostly nothing.

But here we are, looking at pictures of cats.
Objectives

• Differentiate between the different forms of anxiety, particularly in comparing what is typically seen in younger and older adults
• Summarize the difficulties in treating anxiety as a comorbid condition with other physical and mental diagnoses in the older adult
• Discuss the therapies available in the treatment of anxiety in older adults, and risks and benefits in comparison between younger and older populations.
• Discuss the challenges of treating anxiety in the patient with dementia

Outline

• Overview: The problems of treating anxiety in the older adult
• Cognitive Behavioral Therapy
• Specific anxiety syndromes
• Pharmacologic treatment of anxiety
• Anxiety and agitation in the pt with dementia

OVERVIEW
Overview

• Few scientific anxiety studies in Older Adults
• Psychiatric disease, specifically the affective disorders (neuroses) may well behave differently in OAs compared to younger cohort  
  – Poor understanding of differences in early vs late onset of anxiety
• Comorbidities probably have a significant effect on psychiatric disease (exacerbate)
• GAD most common

Prevalence

• GAD most common
• Prevalence
  – Any anxiety disorder 5-10%
  – GAD 2.7%
  – Phobia 3-5%
  – Panic 0.1-1%
  – All others negligible
• Dementia exacerbates anxiety
• Polypharmacy can exacerbate anxiety  
  – steroids, adrenergics, theophylline, levodopa

Table
CBT vs. Rx

- A few studies suggest Rx is more effective than CBT in treatment of anxiety in older adults
- But no real consensus
- CBT works better in cognitively intact vs. dementia
- Combination therapy
- Lack of providers is a major issue

Pharmacotherapy Mention

- Benzodiazepines most commonly used despite increase in falls, disability, and cognitive decline
- SSRIs are useful especially in GAD
- SNRIs probably also effective
  - Side effects and drug-drug interaction may limit use
- One study showed pregabalin helpful in GAD
- Atypical antipsychotics really haven’t been studied and probably won’t be
- Ideally CBT + Rx
The Anxious Patient

- OAs may avoid words like anxiety and use anxiety equivalents:
  - “jittery”, “sick all over”, “restless”, “flustered”
- Challenge:
  - Little consensus on when to treat
  - Insufficient good studies in OAs
- All the problems of polypharmacy, Beers, etc.

PANIC DISORDER

- Chronic, repeated, unexpected panic attacks
- Spontaneous bouts of overwhelming irrational fear, terror, or dread without cause
Panic Disorder

- Usual onset 15-40 y/o
- <1% of new cases in older adults
- Prevalence also <1%
- Often associated with medical illness
  - COPD
  - Hyperthyroidism
  - Arrhythmia
  - Irritable bowel syndrome

Agoraphobia

- Similar to panic disorder
- In OAs, may be brought on by fear of falling
- Incidence ~10%

AGORAPHOBIA
Specific Phobia

- Marked, persistent, excessive, unreasonable fear in the presence of or anticipation of a distinct trigger
  - Persons
  - Animals
  - Place
  - Object
  - Event
  - Situation

Examples of Phobias

- Heights, acrophobia
- Flying, aviaphobia
- Elevators, elevatophobia
- Snakes, ophidiophobia
- Falling, basophobia
Social Anxiety Disorder

- Often situations or conditions which will produce intense worry or embarrassment
  - Tremor
  - Incontinence
  - Urination in public toilets (men)
- Usually begins in childhood
- Prevalence ~5%
Generalized Anxiety Disorder

- Prevalence 5-10% of Older Adults
- 2:1 F:M
- <1% new onset
- 14% of pts also had depression
- 34% had other anxiety disorders (phobias)

Zhang et al.
OCD

Persistent thoughts (obsessions)

+ Persistent behaviors (compulsions)

- Persistent handwashing
  - Fear of disease (obsession)
  - Washing (compulsion)
- Cleaning (vacuuming, dusting)
- Counting, arranging
- No pharmacotherapy is helpful
- CBT can work but no RCTs have been done
- Incidence low

HOARDING DISORDER
Hoarding Disorder

- Once thought to be a variant of OCD
- Difficulty in parting with or discarding possessions
- “Squalor Syndrome”, “Diogenes Syndrome”
  - Often accompanied by self-neglect
- Prevalence of 5%
- Associated with frontotemporal syndrome

POST-TRAUMATIC STRESS DISORDER
PTSD

- Borne of earlier traumatic event
  - War (shell shock, combat fatigue)
  - Personal violence
    - Physical
    - Sexual
    - Emotional
- May be personal or witnessed
- Acute episodes may be triggered
PTSD

• <50% of severe traumatic exposures result in PTSD
• May be modified by societal or personal conditions (social support)
• May be expressed as
  – Insomnia
  – Flashbacks
  – Panic

ANXIETY IN DEMENTIA

• Generally treated same way anxiety is otherwise treated
• Be aware of drug-drug interactions
• There is no FDA-approved treatment for acute delirium.
• Benzodiazepines turn a hyperactive delirium into a hypoactive delirium.
Antidepressants

• SSRIs shown beneficial in younger adults in OCD, GAD, PTSD
• Fewer studies in older adults
  – But effective especially in GAD (citalopram)
Principles of Management

- Measure severity and provide objective criteria for assessing response. Additionally, assess comorbidity, prior treatment, cognitive status, and need for a medical workup.
- Avoid knee-jerk benzodiazepine prescription.
- Provide psychoeducation about anxiety and treatment, including potential health benefits.
- Determine first-line treatment according to patient preference, provider preference and competence, and treatment availability.
- Provide frequent follow-up, particularly within the first month of treatment or dosage change, to encourage adherence and monitor treatment response.
- With medications, start low, go slow, but go—as aggressively as required to treat symptoms to remission.
- Consider augmentation treatment and refer to experts if necessary.
- Provide maintenance treatment, evaluate the need for such if treatment is discontinued.

Treatment with Medications

- The perfect anxiolytic has yet to be invented
- Benzodiazepines are now used less with the availability of SSRIs
- Buspirone not effective in panic, slower onset, possibly better tolerated.
- TCAs now seldom used but could be considered an alternative

Side effects
- Alpha adrenergic blockade (arrhythmia, orthostasis)
- Anticholinergic effects (dry)
- Antihistaminic effects (sedation)
- ie, cardiac, orthostatic hypotension
- SSRIS are now the first-line treatment
<table>
<thead>
<tr>
<th>Disorder</th>
<th>First-line treatments</th>
<th>Second-line treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder; agoraphobia</td>
<td>SSRIs, SNRIs, CBT</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>SSRIs plus CBT</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Social anxiety disorder; specific type (eg, public speaking)</td>
<td>β-blockers plus CBT</td>
<td>Buspirone</td>
</tr>
<tr>
<td>Specific phobia (rats, smoke)</td>
<td>CBT or PRN benzodiazepines</td>
<td>SARI</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>SSRIs, SNRIs, CBT</td>
<td>Clomipramine (adverse effects in older adults)</td>
</tr>
</tbody>
</table>

Supplements & Naturals

- Kava, valerian, passionflower, chamomile
Summary

- Anxiety disorders are common and impairing in older adults.
- The most common manifestation appears to be generalized anxiety disorder. However, existing epidemiological instruments may be insufficient to detect anxiety disorders in this age group.
- Treatment for anxiety disorders in older adults includes serotonergic antidepressants and CBT. Benzodiazepines are not recommended for chronic treatment given their risks in this age group.
- The ability to modulate anxiety in the elderly is undermined by age-related structural changes in the prefrontal-limbic network.
- Careful clinical management is essential and is more important than the specific pharmacotherapeutic agent chosen.

References