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
Volker Geriatric Anxiety

3 October 2019

CBT

Education
- Biopsychosocial model of anxiety
- Daily practice motivational interviewing

Relaxation Training
- Mindful breathing
- Guided imagery

Problem-solving training
- Breaking down the problem into a series of steps
- Identify a specific problem to be addressed
- Brainstorm solutions
- Evaluate, select & implement a solution

Skills practice
- Discuss future situations
- Review skills and strategies

Cognitive Therapy
- Identify distortions
- Challenge overestimation of risk and catastrophization

Coffee and Cummins
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\textsuperscript{OL} 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.

Abu-Saleh et al.
PANIC DISORDER

Edvard Munch
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

ἀγορά, marketplace
-φοβία, fear
Agoraphobia

- Similar to panic disorder
- In OAs, may be brought on by fear of falling
- Incidence ~10%
SPECIFIC PHOBIA
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
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
GAD
Generalized Anxiety Disorder - 7

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>GAD-7 Score</th>
<th>Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>0 - 5</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>5 - 9</td>
<td>6 - 10</td>
<td>Mild</td>
<td>Watchful waiting, repeating at follow-up. Consider CBT and pharmacotherapy. Immediate initiation of pharmacotherapy and CBT. Initiation of pharmacotherapy and CBT. Consider specialist referral to psychiatrist.</td>
</tr>
<tr>
<td>10 - 14</td>
<td>11 - 15</td>
<td>Moderate</td>
<td>Consider CBT and pharmacotherapy.</td>
</tr>
<tr>
<td>15 - 19</td>
<td>16 - 21</td>
<td>Severe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Use &quot;✓&quot; to indicate your answer)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
</tr>
<tr>
<td>Not at all</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

(For office coding: Total Score T___ = ___ + ___ + ___ )
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.
OBSESSIVE-COMPULSIVE DISORDER
OCD
OCD

Persistent thoughts (obsessions) + Persistent behaviors (compulsions)
OCD

• 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

*Diogenes (1882)*
by John William Waterhouse
POST-TRAUMATIC STRESS DISORDER
PTSD
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
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.
TREATMENT
Approach to managing Anxiety in Older Adults

Bower at al.
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

Abu-Saleh et al.
Treatment with Medications

• 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 or Adjunctive Therapies</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&lt;sup&gt;OL&lt;/sup&gt; plus CBT</td>
<td>Buspirone</td>
</tr>
<tr>
<td>Specific phobia (rats, blood)</td>
<td>CBT or PRN benzodiazepines</td>
<td>SSRI</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>SSRIs, SNRIs, CBT</td>
<td>Clomipramine (adverse effects in older adults)</td>
</tr>
</tbody>
</table>

<sup>OL = off label</sup>  

Harper et al.
<table>
<thead>
<tr>
<th>Disorder</th>
<th>First-line treatments</th>
<th>Second-line treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-traumatic stress disorder</td>
<td>SSRIs, SNRIs</td>
<td>CBT, Prazosin</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>SSRIs, SNRIs, CBT, relaxation training</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Anxiety and medical disorders</td>
<td>Identify and treat underlying cause; use SSRIs or SNRIs in primary anxiety disorder</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Depression with severe anxiety</td>
<td>SSRIs, SNRIs, CBT</td>
<td>Buspirone, benzodiazepines</td>
</tr>
</tbody>
</table>

Harper et al.
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