Anxiety Disorders in the Geriatric Population

Geripsych Conference
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Objectives:

- Differentiate between various different anxiety disorders
- List psychosocial and psychotherapeutic interventions used to treat anxiety disorders in the geriatric population
- Discuss risks and benefits of various medications used to treat anxiety disorders in the geriatric population

- The bow too tensely strung is easily broken.

Publilius Syrus
85-43 BC

- Merriam and Webster's Dictionary defines anxiety as:

"an abnormal and overwhelming sense of apprehension and fear often marked by physical signs (such as tension, sweating, and increased pulse rate), by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it."

How is this important?

- Professionals working in primary care settings are likely to come into contact with older adults suffering from anxiety disorders. The disorders are often difficult to distinguish from the normal worries of older adults, from nervous personalities, physical illnesses with symptoms similar to some that accompany anxiety, and mental and emotional changes related to the development of cognitive impairment or dementia. Physicians can play an important role in helping patients cope with anxiety disorders and possibly overcoming them.

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Common stresses in the geriatric population

- Retirement
- Declining physical health
- Loss of a spouse
- Loss of support system/friends
- Financial worries
- Decline in cognitive functioning
- Fear of falling
- Dependence on others
- Death

Differentiation of "normal" worry vs an anxiety disorder

- Severity of worry
- Number of worries
- Time spent worrying– Occasional to constant rumination
- Level of distress associated with the anxiety
- Functional impairment associated with the anxiety—eg. Decreased interest or capacity to leave home

DSM5 Anxiety Disorders

- Panic Disorder
- Generalized Anxiety Disorder (GAD)
- Obsessive-Compulsive Disorder (OCD)
- Specific Phobia
- Social Phobia (Social Anxiety Disorder)
- Agoraphobia
- Posttraumatic Stress Disorder (PTSD)

Diagnostic and Statistical Manual 5th Edition (DSM5) (American Psychiatric Association 2013)

"Geriatric giants"

- Twice as prevalent as dementia among older adults
- Four to eight times more prevalent than major depression
- Prevalence rate of 10-20%
- GAD represents about 50% of anxiety diagnosed in geriatric adults
- Majority are earlier onset with late life exacerbations
- Annual U.S. health care costs due to late life anxiety disorders in 1990 estimated to be $42.3 billion

- K.Cassidy, MD; N. Rector, PhD Geriatrics and Aging 2008;11(3): 150-156

Specific Phobia

- Per DSM5 (APA 2013)—Marked anxiety or fear triggered by exposure to a specific object or situation eg- flying, spiders, needles, enclosed spaces
- Older adults commonly fear lightening, heights, flying, death or injury of a loved one, fear of possible homosexuality
- Rarely seek treatment

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Social Anxiety Disorder (Social Phobia)

- Per DSM5 (APA 2013):
- Fear of one or more social situations that involve potential scrutiny by others
- The affected person fears they will act in a manner or show anxiety symptoms that will result in humiliation, embarrassment, rejection
- Eg- Public speaking, eating or drinking while being watched
- Severe cases people dread any situation in which a social interaction may take place—eg can't walk down the street
- People don't seek treatment

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OCD/hoarding

- Characterized by recurrent, intrusive thoughts and impulses and associated mental or physical behaviors that are performed in reaction to them.
- Often very debilitating
- Hoarding obsessions ego syntonic (thoughts related to saving and fear of discarding possessions)
- OCD obsessions ego dystonic, triggering intense anxiety which often results in ritualistic/compulsive behavior to decrease anxiety

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Panic Disorder

- Unexpected attacks with cognitive and physical symptoms which develop suddenly and peak within a short period of time
- Must have had fear of having a future attack for at least one month
- Accompanied by avoidance behaviors, and in severe cases, agoraphobia
- In older adults, symptom severity is often somewhat attenuated
- Associated with increased rates of somatization and alcohol use disorder

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PTSD

- A specific causal factor must be identified (ie traumatic stressor)
- Intrusive re-experiencing—eg intrusive thoughts, nightmares, flashbacks
- Avoidance of trauma reminders such as people, places, feelings
- Negative changes in mood and cognition—eg exaggerated negative beliefs about oneself, others, and the world; chronic negative emotional state
- Increased arousal—eg difficulties sleeping, hypervigilance, exaggerated startle response, impaired concentration
- In general, older adults are apt to show a pattern of symptoms in which intrusion/re-experiencing symptoms decline and arousal and avoidance symptoms increase

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GAD

- Close association with Major Depression (commonly comorbid)
- Uncontrollable worry about multiple everyday concerns (eg interpersonal issues, family concerns, finances, health) lasting at least six months and occurring most days
- Tend to worry about their worrying– perceive their worry as negative, harmful and associated with disastrous consequences
- May also view their worry as serving a positive function—eg helping to prepare for and reduce negative reactions to negative outcomes, assisting with problem solving, preventing negative outcomes from happening, and creating the impression that one is a conscientious and caring person.

GAD (cont.)

- Must have at least three additional symptoms other than worry
- Motor tension (muscle tension, restlessness, fatigue)
- Vigilance and scanning (impaired concentration and disrupted sleep)
- Irritability
- Tend to have bias toward selectively processing threat-related information, and tend to interpret ambiguous situations as threatening
- Intolerance of uncertainty can lead to procrastination, avoidance of new situations, double-checking, excessive information seeking, refusal to delegate, excessive list-making, and reassurance seeking
- Relatively few cases with onset greater than mid-30's
- Late onset more likely to be secondary

GAD (cont.)

- Comorbidity is the rule, not the exception—most commonly Major Depression or another anxiety disorder
- Older adults may actually worry more and for longer periods of time
- Many GAD symptoms may be mistaken for normal age-related changes, or attributed to other causes (eg concentration problems, fatigue, restlessness)
- Those with GAD have more worry about minor matters, finances, interpersonal matters, and personal health
- Frequency and uncontrollability of worry, degree of distress or impairment, muscle tension, and sleep disturbance can also help distinguish
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Evaluation

- Rapport is crucial– Seniors may be reluctant to discuss emotional matters
- Be patient—It may take time and multiple contacts to get to the issue
- Normalize the patient's experience—eg. Acknowledge the development of avoidance symptoms after a traumatic event
- Use of structured interviews and self assessments
- Suicide assessment—highest risk associated with Panic Disorder
- Need for mandatory reporting– vulnerable adult

Evaluation (cont.)
Rule out medical causes

- Cardiovascular Ds– eg. Mitral valve prolapse, congestive heart failure
- Neurologic Disorders—eg. Seizure disorder, stroke
- Pulmonary Ds—eg. Pulmonary emboli, asthma
- Endocrine Disorders—eg. Diabetes, hypoglycemia, thyroid
- Lupus
- Infections
- Withdrawal from alcohol or other sedatives

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Evaluation (cont.)--Other considerations

- Some seniors may be less likely to report trauma due to self-blame and shame
- Failure to report a traumatic event may be related to rigid pre-existing beliefs—eg. Rape is only perpetrated by strangers
- Hoarding creates particular problems for the elderly– risk of falls, sanitation problems, fire (vulnerable adult reporting)
- Anxiety is very uncomfortable and people often seek immediate relief
- Education is very important—provide realistic expectations about the timeline for expected improvement while maintaining support
- Provide information about coping skills such as deep breathing and muscle relaxation

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Overall goals of treatment of anxiety disorders

- Reduce fear
- Correct maladaptive cognitive patterns
- Reduce avoidance
- Decrease physiologic withdrawal
- Address comorbid disorders
- Restore daily function
- Improve quality of life

- J.R.T. Davidson, (2006) Social phobia: Then, now, the future; edited by B.O. Rothbaum (pp. 115-131)

Treatment
Supportive Interventions

- Minimize substances that can increase anxiety:

• Caffeine	Steroids
• Nicotine	Theophylline
• Some antidepressants	Antihistamine
• Some antipsychotics	Pseudoephedrine
• Calcium channel blockers	Analgesics
• Digitalis	Muscle relaxants
• Estrogen	NSAID's
• Thyroid medications	Bronchodilators

K. Cassidy, MD; N. Rector, PhD Geriatrics and Aging, 2008; 11(3): 150-156

Supportive interventions (cont.)

- Minimize alcohol—even moderate use can cause mood problems
- Relationships with caring others—increase activity, interaction
- Physical activity of all kinds can decrease anxiety
- Assistance with managing real stressors like finances
- Meditation, tai chi, yoga
- Religious/spiritual communities
- Highly somatizing individuals may respond best to multiple, brief, scheduled contacts with medical personnel (phone calls and visits)

Treatment
Psychotherapies

- Cognitive behavioral therapies are the mainstay of treatment
- Systematic desensitization—exposure to increasingly noxious stimuli
- Social skills training
- Cognitive restructuring—challenging catastrophic thoughts and negative assumptions
- Problem-solving skills
- Psychoeducation—eg. Explanation of source of physical symptoms
- Deep breathing and progressive muscle relaxation

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Treatment
Medication

- Antidepressants are the primary medications
  - Help address comorbities like depression
  - No physiologic dependence (caveat- withdrawal syndrome)
  - Relatively more benign side effects
  - Generally once daily dosing

Social Anxiety

- Paroxetine and sertraline have FDA approval
- Escitalopram and fluvoxamine with literature showing superiority over placebo (off label)
- Fluoxetine with mixed results (off label)
- Other antidepressants used off label (SSRI, SNRI)

Panic Disorder

Paroxetine, venlafaxine, sertraline, fluoxetine FDA approved

GAD

Escitalopram, paroxetine, venlafaxine, duloxetine FDA approved

OCD

Fluoxetine, sertraline, paroxetine, fluvoxamine, clomipramine FDA approved (Often requires higher doses and longer time)

PTSD

Sertraline, paroxetine FDA approved

Benzodiazepines

- Enhance inhibitory neurotransmitter systems involving GABA
- Rapid onset of action
- Generally to be avoided in the geriatric population
  - Oversedation
  - Psychological and physiologic dependence
  - Gait problems
  - Cognitive impairment
  - Potentially dangerous withdrawal syndrome

Buspirone

- FDA approved for GAD
- Requires multiple daily dosing
- No impact on the physical symptoms of anxiety
- Limited long term benefit
- Often not beneficial in those who have been treated with benzos

Antipsychotics

- No FDA approval for treatment of anxiety disorders
- Black box warning re: increased risk of mortality in the elderly
- Side effects including tardive dyskinesia, metabolic syndrome, oversedation, extrapyramidal symptoms, akathisia
- Must carefully weigh risks and benefits
- Include patient and family members in the decision, especially in patients with cognitive impairment

Risperidone

- Use low doses (0.25 mg to 3 mgs)
- Once to twice daily (minimize risk of sedation by giving at hs)
- Available in long acting injectable form (Consta)
- Available as a rapidly dissolving wafer
- More likely to see EPS and akathisia
- May be most appropriate for anxiety related to psychosis

Quetiapine

- Use the lowest possible dose (available in 25mg tabs)
- Sometimes used as a PRN to avoid benzos and antihistamines
- Oversedation and hypotension more likely
- Risk of increased appetite, weight gain, and metabolic syndrome
- Minimize risk of sedation by giving at hs (XR available but often not covered by insurance)
- No injectable form

Other agents– “Hail Mary’s”

- Low dose trazodone used during the day
- Gabapentin (multiple daily dosing)
- Propranolol (use with great caution in seniors)
- TCA’s and MAOI’s (effective but lots of side effects)
- Prazocin at hs for trauma-related nightmares and sleep disturbance
- Low dose antihistamine (increased risk of cognitive impairment and other side effects)
- Again, must carefully weigh risks and benefits