

## MENTAL HEALTH AND OLDER ADULTS

### CHAPTER 2: ANXIETY DISORDERS IN OLDER ADULTS

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#### Significance

- ◆ Anxiety Disorders often are associated with common age-related medical and psychosocial problems.

Epidemiological evidence suggests that anxiety is a common and major problem in later life, yet it has received less attention than depressive disorders have. Anxiety disorders are often associated with common age-related medical and chronic conditions such as asthma, thyroid disease, coronary artery disease, dementia, and sensory loss (Diala & Muntaner, 2003).

- ◆ Late life anxiety is a risk factor for greater disability in general, less successful recruitment and engagement in rehabilitation services.

Anxiety in later life has been identified as a risk factor for greater disability among older adults in general and has also been associated with less successful recruitment into and outcomes of geriatric rehabilitation services (Bowling, Farquhart, & Grundy, 1996). Researchers and practitioners are beginning to recognize that aging and anxiety are not mutually exclusive; anxiety is as common in the old as in the young, although how and when it appears is distinctly different in older adults. Additionally, further effectiveness research on evidence-based treatments for late life anxiety is needed (Mitte, 2005).

- ◆ Diagnostic Difficulties
  - Medical conditions: It is difficult to separate physical symptoms of anxiety disorders from medical conditions due to higher prevalence of certain medical conditions, realistic concerns about physical problems, and higher use of prescription medications.
  - Dementia: It is difficult to separate agitation from anxiety; impaired memory may relate to anxiety or dementia; fear may be excessive or realistic depending upon the situation.

- Depression: In late-life, anxiety may be more likely to include depressive symptoms.

Recognizing anxiety and anxiety disorders in an older person poses several challenges. Aging brings with it an increased risk for certain medical conditions; a number of realistic concerns about physical problems, life situations, and functioning; and a high use of prescription medications. As a result, separating a medical condition from physical symptoms of an anxiety disorder is complicated in the older adult. Diagnosing anxiety in individuals with dementia can be difficult, too: agitation typical of dementia may be difficult to separate from anxiety, impaired memory may be interpreted as a sign of anxiety or dementia, and fears may be excessive or realistic depending on the person's situation.

### **Epidemiology of Anxiety Disorders**

- ◆ Anxiety disorders are the most common class of psychiatric disorders in older adults—more common than either depression or severe cognitive impairment.

Although anxiety disorders, like most psychiatric conditions, may be less common among older adults than among younger people, epidemiological evidence suggests that anxiety is a major problem in late life (Salzman & Lebowitz, 1991; U.S. Department of Health & Human Services, 1999). Anxiety disorders overall appear to be the most common class of psychiatric disorders among older people, more prevalent than depression or severe cognitive impairment (Beekman et al., 1998; Kessler et al., 2005; Regier et al., 1988).

- ◆ 10 to 15% of people 65+ are coping with at least one anxiety disorder.

One study involving interviews with nearly 6000 people nationwide reported a lifetime rate of 15.3% for DSM-IV-diagnosed anxiety disorders in respondents over age 60 (Kessler et al., 2005). Myers and colleagues (1984) report a 6-month prevalence of anxiety disorders in late life ranging from 6.6% to 14.9% across three Epidemiologic Catchment Area (ECA) sites.

- ◆ Most common anxiety disorders among older adults are Generalized Anxiety Disorders (GADs).

Phobias and GADs account for most anxiety disorders in late life (Beekman, van Balkom, Deeg, van Dyck, & van Tilburg, 2000; LeRoux, Gatz, & Wetherell, 2005). Among people 55 years of age and older, Douchet, LaDouceur, Freeston, and Dugas (1998) found that 12.8% meet criteria for GAD. By comparison, ECA prevalence rates for older adults are 1.8% for major depression, 2.8% for dysthymia, and 4.9% for severe cognitive impairment (Blazer, 1997; Regier et al., 1988).

- ◆ Prevalence of anxiety may be higher in Primary Care settings than in the community.
  - 30% of older adults present with GAD symptoms.
  - Since only about one third of anxiety disorder cases is detected in primary care settings, estimates likely substantially underestimate the true prevalence.

It is possible that the prevalence of anxiety is higher in primary care settings than in the community at large. Krasucki, Howard, and Mann (1999) have found that, in primary care settings, 30% of older adults present with generalized anxiety symptoms. Because evidence suggests that only approximately one third of such cases are detected in primary care (e.g., Kessler, Lloyd, Lewis, & Gray, 1999), these data likely represent a substantial underestimate of the prevalence of anxiety in that setting. Furthermore, Levy, Conway, Brommelhoff, and Merikengas (2003) found that, compared to younger adults, older adults tend to minimize and underreport their anxiety symptoms. Thus the number of older adults who experience anxiety may be underestimated (Levy et al., 2003).

- ◆ Subthreshold Anxiety Symptoms: Clinically significant anxiety, including symptoms that do not meet criteria for a specific disorder, is common among older adults (20-29%).

Clinically significant anxiety, including symptoms that do not meet criteria for a specific disorder, is common among older adults, and the prevalence may be as high as 20-29% (Davis, Moye, & Karel, 2002; Lenze et al., 2005).

- ◆ Many of the symptoms of anxiety are physical and overlap with medical problems; conversely, anxiety is often associated with common age-related medical and chronic conditions such as asthma, thyroid disease, coronary artery disease, dementia, and sensory loss. It is also associated with stressors, such as bereavement and care-giving.

There is also controversy over whether the prevalence of anxiety has been accurately determined in older adults, because DSM-IV criteria may not fit well with this population, anxiety symptoms may be expressed as somatic features or behavior changes (e.g., aggression, assaultive behaviors), and the clinical presentation of anxiety in late life may be more likely to include depressive symptoms (Beck & Averill, 2004; Diefenbach & Goethe, 2006; Fuentes & Cox, 1997; Kim, Braun, & Kunik, 2001; Palmer, Jeste, & Sheikh, 1997).

### **Comorbidity Issues: Medical**

- ◆ High comorbidity of anxiety with medical illness is multidimensional.
  - Anxiety may be a reaction to medical illness.
  - Anxiety may be expressed as somatic symptoms.
  - Anxiety may be a reaction to medications.
- ◆ Anxiety may impact medical care—prevent seeking or following through with care, provoke excessive help-seeking behavior.
- ◆ Anxiety is associated with markedly higher health care costs (even after adjusting for medical comorbidity).
- ◆ Studies have found an association between anxiety and medical illnesses, such as diabetes, coronary heart disease, cancer, chronic obstructive pulmonary disease, gastrointestinal disorders, Parkinson’s disease, and dementia.

Studies have found an association between anxiety and medical illnesses such as diabetes (Blazer, 2003), dementia (Wrag & Jeste, 1989), coronary heart disease (Artero, Astruc, Courtet, & Ritchie, 2006; Kuzbansky, Cole, Kawachi, Vokonas, & Sparrow, 2006), cancer (Deimling, Bowman, Sterns, Wagner, & Kahana, 2006; Ostir & Goodwin, 2006), chronic obstructive pulmonary disease (Karajgi, Rifkin, Doddi, & Kolli, 1990), and Parkinson’s disease (Stein, Heuser, Juncos, & Uhde, 1990).

### **Comorbidity Issue: Depression**

- ◆ Anxiety in older adults often co-occurs with depression.
- ◆ Twenty-five percent of older adults with anxiety also have major depression; up to 50% of older adults with major depression have comorbid anxiety disorder; and approximately 20% of older adults with bipolar disorder report having had GAD at some point in their life.

As with young adults, anxiety in older adults has been found to often co-occur with depression (Beck & Averill, 2004; Beekman et al., 1998; Blazer, 1997). Community survey research has revealed that up to 50% of older adults with major depression had a comorbid anxiety disorder, and 25% of older adults with anxiety also had major depression (Beekman et al., 2000; Blazer, 2003; Jeste, Hays, & Steffens, 2006). Finally, approximately 20% of older adults with bipolar disorder reported having GAD at some point (Goldstein, Hermann, & Shulman, 2006).

- ◆ There is an increased risk for poor outcome in cases of comorbid anxiety and depression: poor treatment response and increased dropout, increased suicidality, and reduced psychosocial support.

Comorbid anxiety in late-life depression is associated with poor treatment response and increased likelihood of dropout (Lenze et al., 2003). Also, older people with anxious depression report increased suicidality and reduced psychosocial supports (Jeste et al., 2006).

- ◆ Sequence of anxiety and depression.
  - Anxiety far more commonly precedes depression than vice versa.
  - Some episodes of depression may begin with anxiety symptoms.

Anxiety symptoms have been found to lead to depressive symptoms (Wetherell, Gatz, & Pederson, 2001).

### **Consequences of Anxiety**

- ◆ Medical consequences.
  - Hypertension, hypoglycemia, and coronary heart disease can be worsened through chronic stress and anxiety.
  - Men reporting  $\geq 2$  anxiety symptoms had elevated risk of fatal coronary disease.
  - Anxiety is related to pain in nursing home residents.
  - High levels of anxiety are related to increased use of pain medications and more disability post-surgery.

Hypertension, hypoglycemia, and coronary heart disease can be worsened through chronic stress and anxiety (Hersen & Van Hasselt, 1992). Compared with men reporting no symptoms of anxiety, men in the Normative Aging Study reporting two or more anxiety symptoms had elevated risk of fatal coronary heart disease (Kawachi, Sparrow, Vokonas, & Weiss, 1994). Higher levels of anxiety have been associated with greater use of pain-relieving medications and more postoperative disability days for surgical patients (Taenzer, Melzack, & Jeans, 1986). Anxiety was also related to pain in a sample of nursing home residents (Casten, Parmelee, Kleban, Lawton, & Katz, 1995).

- ◆ Well-being and Quality of Life (QOL).
  - Anxiety symptoms and disorders are associated with increased fatigue, increased disability, more chronic physical illness, lower levels of well-being, worse life satisfaction, and inappropriate use of medical services.

- Older adults with GAD reported QOL impairments comparable to those of persons with major depression and greater than those of persons with serious medical conditions like myocardial infarction and Type II diabetes (Non-Insulin Dependent Diabetes Melitis, NIDDM).

Among older adults, anxiety symptoms and disorders are associated with increased fatigue, high levels of chronic physical illness, increased disability, lower levels of well-being, substandard life satisfaction, and inappropriate use of medical services (Gellis, 2006).

(Martin, Bishop, Poon, & Johnson, 2006; Brenes et al., 2005; de Beurs, et al., 1999; Hunt, Issakidis, & Andrews, 2002; Jones, Ames, Jeffries, Scarinci, & Brantley, 2001; Wetherell et al., 2004; Wittchen, Carter, Pfister, Montgomery, & Kessler, 2000). Furthermore, a sample of older adults with GAD reported impairments on QOL measures that were worse than impairments reported by comparable individuals who had serious medical conditions such as myocardial infarction or type II diabetes and comparable to individuals with major depression (Wetherell et al., 2004).

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### **What do Older Adults Say When Asked About Anxiety?**

“I worry so much, I can’t control it.”

“A feeling of fear comes over me, and I get short of breath. My heart pounds, and I think that I’m going to die.”

“I feel very nervous around other people, and I try to avoid having any attention called to me.”

“I can’t get these thoughts out of my head, and they make me very anxious.”

“Ever since the accident, I can’t stop thinking about it.”

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### **Identifying, Screening, Assessing, and Diagnosing Anxiety Disorders in Older Adults**

- ◆ Presentation of Anxiety Disorders in older adults.
  - Anxiety symptoms can be part of a reaction to illness, declined functioning, or care-giving.
  - Anxiety may be expressed solely in terms of somatic symptoms that have no medical cause.
  - Older adults may complain of headaches, chest pains, fatigue, stomach pains, etc.
- ◆ Gap between Prevalence and Treatment.

- Older adults with anxiety are less likely to receive treatment from a mental health specialist than those with depression, dementia, or any other mental disorder.
- Older adults tend to minimize and underreport their anxiety symptoms.

Older adults with anxiety disorders are less likely than older adults with depression, dementia, or any other mental disorder to receive treatment from a mental health specialist (Ettner & Hermann, 1997). Levy et al. (2003) found that, compared to younger adults, older adults tend to minimize and underreport their anxiety symptoms.

- ◆ Detection precedes treatment.
  - Detection rates are poor due to:
    - Reluctance of elderly to seek care.
    - Lack of knowledge and/or reluctance of Human Services/primary care physicians to detect or refer.
    - Disguised presentation of anxiety related to medical conditions.
- ◆ Anxiety becomes constructed as an emotional problem:
  - If it is experienced with great frequency and intensity.
  - If it interferes with psychosocial functioning.
  - If it occurs when there is no threat.
- ◆ To help identify anxiety it may be useful to phrase questions in the following way.
  - To identify anxiety:
    - Have you been concerned about or fretted over a number of things?
    - Is there anything going on in your life that is causing you concern?
    - Do you find that you have a hard time putting things out of your mind?
  - To identify how and when physical symptoms began:
    - What were you doing when you noticed the chest pain?
    - What were you thinking about when you felt your heart start to race?
    - When you can't sleep, what is usually going through your head?
    - Adapted from Lang, A. J., and Stein, M. B., (2001). *Geriatrics*, 56(5), 24-27, 31-34.

## Treatment of Anxiety Disorders in Older Adults

### Pharmacological Treatment

- ◆ In part due to the tendency for older adults to present to primary care physicians for treatment of anxiety symptoms, anxiolytic medications, including benzodiazepines, are most common treatments for late life anxiety.
- ◆ Pharmacological interventions must be used cautiously in older adults: older adults experience changes in metabolism that influence dose range and side effects, risk of interactions with other drugs, and effects of medication on comorbid medical problems.
- ◆ Benzodiazepines:
  - Higher use in older than in younger adults: a community survey in California found 20% of older adults had used benzodiazepines  $\geq 2$  times in past year.
  - Benzodiazepines have a calming effect, produce sedation, promote sleep, and have some muscle relaxant and anticonvulsive effects.
  - Short-term use with minimal therapeutic doses is recommended.
  - Onset of the effects of these drugs is rapid; therefore, they are used for symptomatic relief of acute anxiety.
  - Disadvantages:
    - They can become addictive; withdrawal symptoms, which mimic symptoms of anxiety, can occur upon cessation of use; potential for drug interactions particularly with sedating drugs, such as alcohol; due to changes in metabolism benzodiazepines take longer to clear from bloodstream of older adults and can build up leading to toxicity.
  - Side effects:
    - Fatigue, sedation, amnesia, and slurred speech and ataxia (staggering) at high dosages.
  - Risks associated with use:
    - Users more likely than non-users to experience accidents requiring medical attention due to increased risk of falls, hip fractures, and auto accidents.
    - Older adults taking benzodiazepines more likely to develop disabilities in both mobility and activities of daily living (ADLs).
    - Impairment of memory and other cognitive functions.

Data from the ECA study suggest that benzodiazepine use among the elderly is approximately 14%, higher than the rate for younger adults (Swartz et al., 1991). A community survey of older adults in southern California showed that 20% had used benzodiazepines at least twice in the previous 12 months; these individuals were more than twice as likely as nonusers to take 10 or more drugs (Mayer-Oakes et al., 1993). Benzodiazepine users are also more likely than nonusers to experience accidents requiring medical attention, due to increased risk of falls, hip fractures, and automobile accidents (Tamblyn, Abrahamowicz, du Berger, McLeod, & Bartlett, G, 2005). Older patients taking benzodiazepines are also more likely to develop disabilities in both mobility and ADLs (Gray et al., 2006). Benzodiazepines can impair memory and other cognitive functions (Wengel, Burke, Ranno, & Roccaforte, 1993). These medications can also cause tolerance and withdrawal, interactions with other drugs, and toxicity (Krasucki et al., 1999; Salzman & Lebowitz, 1991).

- ◆ Selective serotonin reuptake inhibitors (SSRIs).
  - Serotonin selective reuptake inhibitors (SSRIs) may be relatively safe in older adults and are more effective for many anxiety disorders (e.g., PTSD, OCD).
  - They can cause unpleasant side effects and some older adults prefer not to take them.
  - Nausea, diarrhea, nervousness, and insomnia are the most frequently reported adverse effects of SSRIs. Headache, tremor, anxiety, somnolence, and sexual dysfunction are also reported.

Although safer medications than benzodiazepines, particularly SSRIs, are often used to treat geriatric anxiety, they can cause unpleasant side effects, and some older people prefer not to take them. Furthermore, SSRIs have not completely replaced benzodiazepines as a treatment for anxiety in older people (Keene, Eaddy, Nelson, & Sarnes, 2005).

- ◆ Other Medications.
  - Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) are effective in treating anxiety disorders. They have been used less frequently since the development of newer antidepressants, such as SSRIs.
  - TCAs are associated with unpleasant side effects, toxicity, and the potential for adverse cardiac effects, particularly when used in older adults.
  - MAOIs are associated with very serious interactions with other drugs and need to avoid foods with tyramine.

Both monoamine oxidase inhibitors and tricyclic antidepressants have been demonstrated to be effective in treating anxiety disorders, such as panic disorder and obsessive compulsive disorder. Due to the discomfort and dangerousness of their side effect profile, they currently are used less frequently than newer medications such as SSRI's (Kelsey, Newport, & Nemeroff, 2006).

### Psychosocial Treatments

- ◆ Several studies have provided support for the use of relaxation training, cognitive behavioral therapy (CBT), and even supportive therapy for treatment of anxiety, though effects are greatest for relaxation training for anxiety symptoms and CBT for anxiety disorders. Relaxation training is a low-cost and effective intervention that can be used by a range of professionals in a variety of settings.

Wetherell and colleagues (2005) reviewed the literature and reported that progressive muscle relaxation, CBT, and even supportive therapy have empirical support documenting their efficacy for treating geriatric anxiety. However, the authors report that, when compared to waitlist and supportive control conditions, the psychological treatments with the greatest effect sizes (.20 or greater) are relaxation training (for anxiety symptoms) and CBT (for anxiety disorders).

- ◆ Cognitive behavioral Therapy (CBT).
  - CBT has the strongest evidence for effective treatment of GAD.
  - CBT is better tolerated than pharmacotherapy and studies suggest that CBT plus medication is no more effective than CBT alone.
  - CBT also provides reductions in comorbid depression.
  - CBT protocols include: problem solving skills training, behavioral activation, sleep hygiene, life review, and memory aids.
  - CBT can be conducted either in group or individual formats.

In recent years, CBT has been shown to be superior to waitlist conditions, medication management-only conditions, supportive control conditions (e.g., supportive counseling, minimal contact, discussion group), and usual primary care (Barrowclough et al., 2001; Gorenstein et al., 2005; Mohlman et al., 2003; Stanley, Beck, et al., 2003; Stanley, Hopko, et al., 2003; Wetherell, Gatz, & Craske, 2003). In some of the other studies, compared to waitlist or supportive control conditions, CBT also provided greater reductions in comorbid depression, as well as improvements in QOL (Barrowclough et al., 2001; Stanley, Beck, et al., 2003; Stanley, Hopko, et al., 2003; Wetherell et al., 2003). However, in a recent study comparing CBT plus medication

management with medication management alone, the combined approach was not found to be superior in reducing anxiety, worry, and total distress (Gorenstein et al., 2005). These mixed results warrant further understanding and research as to the most effective treatment approaches for late life anxiety

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## Curriculum Resources



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### Case Study: Mrs. C.

Mrs. C. is a 76-year-old woman who lives alone in an apartment in a quiet residential neighborhood. She frequently contacts her primary care physician (PCP) with concerns about her health. When seen by her PCP, she expresses a number of worries about other areas of her life. For example, she has concerns about the safety of the neighborhood where she lives, she worries about her finances even though she receives both social security and a retirement pension from teaching school, and she worries that other people avoid her because she is no fun to be around. She states that she has always been a “worry wart” and that this constant worry has made her life difficult. She states that she has difficulty concentrating and making decisions. She reports feeling restless and having difficulty going to sleep because of excessive rumination about her worries. She states that she feels fatigued and doesn’t feel like doing anything.

**Activity #1.** Have students divide into pairs. In the first part of the exercise, one student will be Mrs. C. and the other will be a social worker working in the ambulatory care clinic where Mrs. C’s PCP sees her. Ask the social worker to use Lang and Stein’s Useful Questions to elicit information about anxiety and about physical symptoms. The student portraying Mrs. C. will use the information provided in the vignette plus other information as needed to complete the clinical picture and context (e.g., symptoms, cultural factors, environment, family) as needed to develop the role. After the initial screening and overview, ask the students to switch roles.

**Activity #2.** Students should switch roles. The new social worker will either conduct a HAM-A interview and rate the symptoms or will introduce and administer BAI and review Mrs. C.’s scores with her after she completes the BAI.

**Activity #3.** Based on information gathered in the screening and the HAM-A/BAI, have the pair work together to develop a hypothetical plan. What should be done? By whom? [Activity #3 may be delayed until after the section on treatment, if desired.]