DEPRESSION AND ANXIETY IN OLDER ADULTS

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DEPRESSION

Depression is a major public health problem around the world

Affects 1:5 older people living in the community

Affects 2:5 older people living in care homes

Various treatment options available, irrespective of age

Morbidity and mortality increased with age as more vulnerable to consequences of self neglect

Placebo effect can be significant

AETIOLOGY

BIOPSYCHOSOCIAL FACTORS INVOLVED

- Painful events; past depression; family history; physical illness; medication; alcohol

SOME PARTICULAR STRESSORS AS YOU AGE:

- RETIREMENT
- HAVING LESS MONEY
- HEALTH PROBLEMS
- LOSS OF PARTNER OR FRIENDS
- SOCIAL ISOLATION

IMPORTANT TO….

Not dismiss depression as part of normal ageing or as "understandable" in context of life events

Make sure that what you think is depression is not actually apathy secondary to subcortical damage or hypoactive delirium

Not attribute all symptoms to depression without checking for physical health issues first – comprehensive blood screen required (FBC, U&E, LFTS, TFTS, glucose, calcium,, B12 and folate, possibly Vitamin D)

Check alcohol and substance abuse history (including prescribed medication)

DIAGNOSTIC CRITERIA (ICD 10)

At least 2 weeks of sustained low mood (varying little from day to day and unresponsive to circumstances), loss of interest or enjoyment and reduced energy

Reduced concentration

Reduced self esteem and confidence

Ideas of guilt and unworthiness

Pessimistic views of the future

Ideas of acts of self harm or suicide

Disturbed sleep

Decreased appetite

HOW BAD?

MILD

- 2 of the above symptoms

MODERATE

- At least 3 and of a level that leaves considerable difficulty in continuing with social, work or domestic activities

SEVERE

- Over 4 of the above and individual is unable to continue with activities except to a limited extent

PARTICULAR PROBLEMS FOR OLDER PEOPLE

Physical symptoms and depression

- Important to exclude physical illnesses that can cause similar symptoms – thyroid problems, arthritis, heart disease, respiratory difficulties

Long-term illness

- Depression can cause increased distress about health issues even where these are stable – repeated phone calls....

Confusion and memory problems

- Depression, worry and anxiety can all affect memory and make confusion more apparent (even on validated testing)

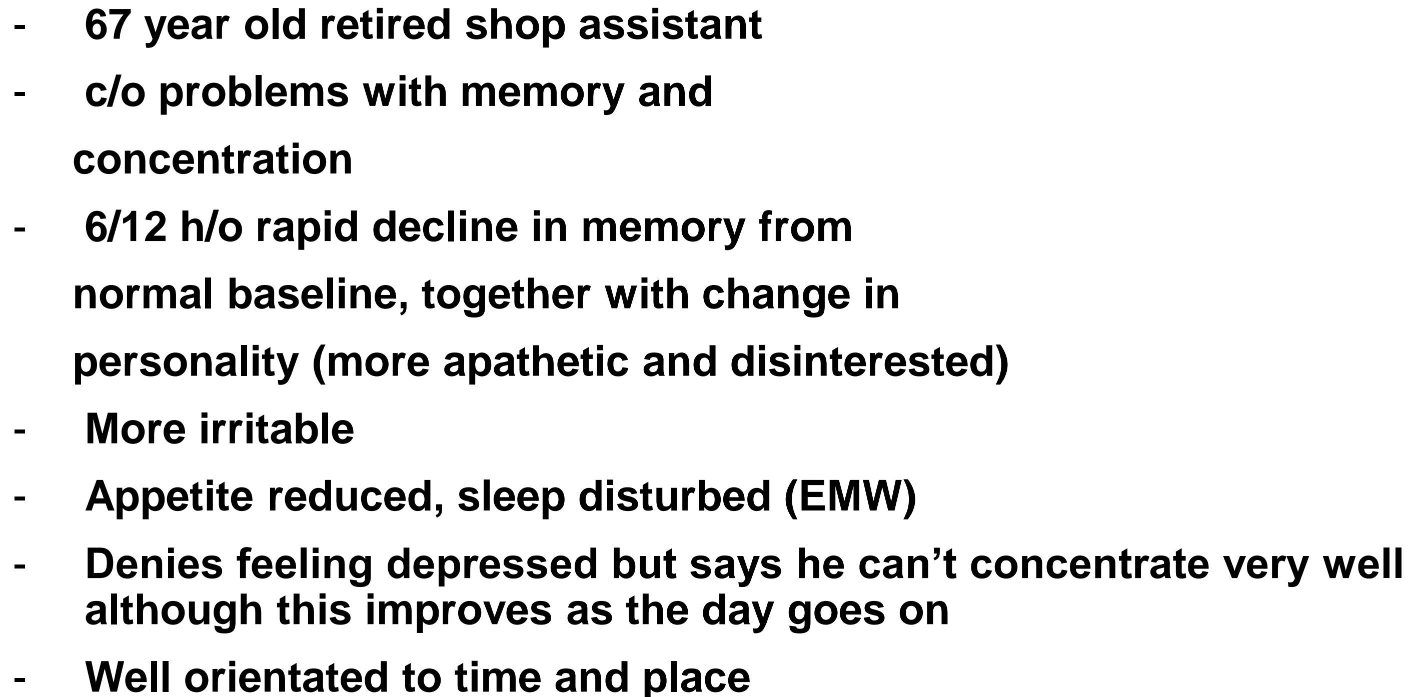
A new sense of loneliness

- Living alone does not automatically cause depression, but feeling lonely for no obvious reason may be a sign of depression

HOW MIGHT IT PRESENT IN OLDER ADULTS?

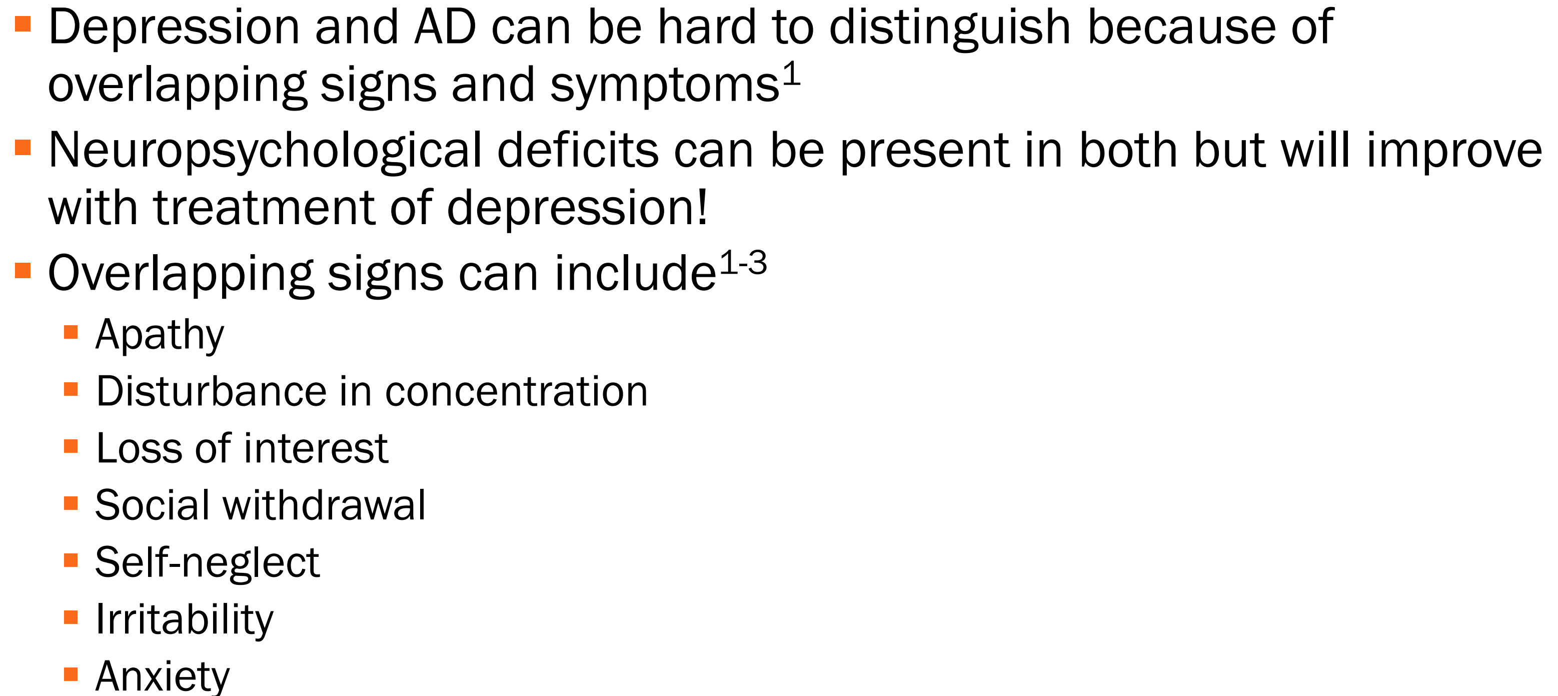
Older people tend to think more about physical illness, rather than mental disorder, so may present with repeated calls to GP, emergency services, family and resist explanations that there is nothing physically wrong.

CASE PRESENTATION



- 67 year old retired shop assistant
- c/o problems with memory and concentration
- 6/12 h/o rapid decline in memory from normal baseline, together with change in personality (more apathetic and disinterested)
- More irritable
- Appetite reduced, sleep disturbed (EMW)
- Denies feeling depressed but says he can’t concentrate very well although this improves as the day goes on
- Well orientated to time and place

HOW TO DISTINGUISH DEPRESSION FROM DEMENTIA



- Depression and AD can be hard to distinguish because of overlapping signs and symptoms[1]
- Neuropsychological deficits can be present in both but will improve with treatment of depression!
- Overlapping signs can include[1-3]
  - Apathy
  - Disturbance in concentration
  - Loss of interest
  - Social withdrawal
  - Self-neglect
  - Irritability
  - Anxiety

DEPRESSION VS DEMENTIA

Depression -

Relatively acute onset

Low mood (+ psychomotor retardation in some)

Biological symptoms

Diurnal variation in cognitive impairment

Past or family psychiatric history

TREATMENT

NICE GUIDELINES FOR MANAGEMENT OF DEPRESSION IN PRIMARY CARE

Depends on severity of condition

20% of completed suicides occur in the elderly

If the individual has severe depression, is suicidal or psychotic – REFER TO SPECIALIST MENTAL HEALTH SERVICES

IF MILD…..

Psychological, social and self-help

- Consider specific needs e.g. social care, bereavement counselling, social care
- Encourage the individual to talk about thoughts and feelings
- Consider referral for counselling/voluntary sector support
- Self-help material/information leaflets
- Encourage a structured day
- Encourage a balanced diet
- Reduce alcohol intake
- Consider problem solving/solutions focused interventions
- Exercise

- HOWEVER COCHRANE CONCLUSIONS – no strong support for psychotherapeutic treatments in the management of depression in older people

IF MODERATE (OR MILD WITH PAST HISTORY OF DEPRESSION)…

Psychological/social and self help strategies as before

Antidepressant trial for at least 8 weeks

- If a drug has worked before, usually first choice (but not TCA unless nothing else has worked before)
- SSRIs are standard first choice
- Mirtazapine if very agitated, poor sleep, poor appetite symptom profile
- Start at ½ dose for 2 weeks, then increase
- Review at 8 weeks….

AT 8 WEEK REVIEW…

Partial remission or deterioration

- Increase dose if partial response (within BNF limits)
- If no response, consider second line treatment
  - Review diagnosis
  - Review comorbidity
  - Review suicidal ideation – REFER TO CMHT
  - Review presence of psychosis – REFER TO CMHT
- Review again after another 8 weeks …

AT 16 WEEK REVIEW…

If symptoms still present (after trial of 2 drug and 1 nondrug treatment)

- Consider if physical cause present
  - Medication e.g. BZDP, opiates, betablockers
  - Compliance check
  - Alcohol useage
  - 10% of first episode depression in older age due to cerebrovascular disease – vascular depression

If depression still present, refer to CMHT

DRUGS OF CHOICE

SSRI

- Sertraline: start 25mg mane, increase to 50mg mane, can then increase in stages to 100 – 150mg daily if tolerated
- Citalopram : start 10mg mane, increase to 20mg mane (watch QTc)

Mirtazapine

- Start 15mg nocte, increase to 30mg nocte and can go to 45mg nocte – if tolerated

WATCH OUT FOR…

Hyponatraemia – particularly SSRIs but mirtazapine too

QTc prolongation – citalopram

Nausea and GI disturbance – SSRI

Increase in agitation - SSRI

Excess drowsiness impaired mobility – mirtazapine

Altered FBC – mirtazapine – check if infections

GI bleeds – SSRIs (protect with PPI) esp if on NSAID, CEI, steroids

Increased bleeding time - SSRI

SECOND LINE TREATMENT…

Change class of antidepressant e.g. from SSRI to mirtazapine

Venlafaxine XL – start at 37.5mg od, then increase to 75mg XL od, up to 150mg XL od (measure BP if going above this)

Escitalopram

Augmentation regimes

- E.g. SSRI or VLF +mirtazapine

ARE ALL ANTIDEPRESSANTS THE SAME?

Effective

- Mirtazapine
- Escitalopram
- Venlafaxine
- sertraline

BEST FOR ELDERLY

Less effective

- Duloxetine
- Fluoxetine
- Fluvoxamine
- paroxetine

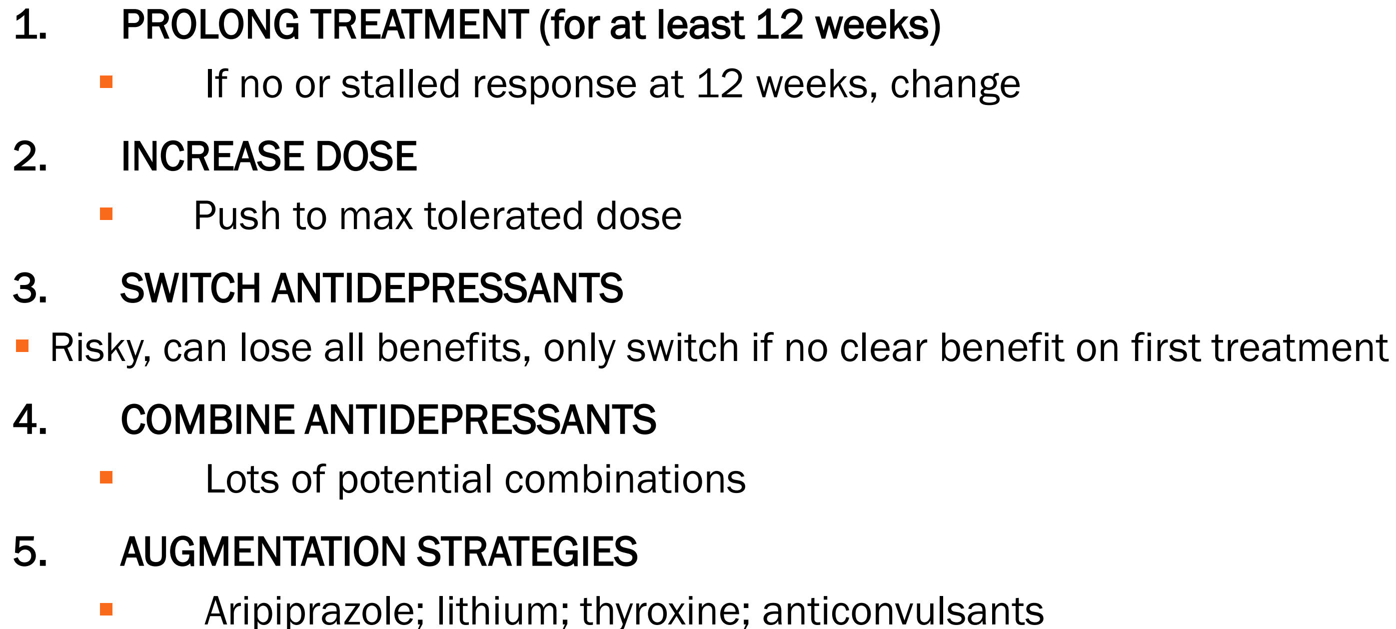
IF REMISSION ACHIEVED…

Continue at the dose that achieved remission (no reduction to a “maintenance” dose), for

- 1 episode depression : 6-9 months
- 2 episodes depression : 2-3 years
- 3 episodes or more : no reason to ever stop!

HIGH RECURRENCE RATES IN FIRST EPISODE LATE LIFE DEPRESSION (61% RECURRENCE ONCE AD withdrawn)

STRATEGIES FOR ACHIEVING REMISSION…



1. PROLONG TREATMENT (for at least 12 weeks)
   - If no or stalled response at 12 weeks, change
2. INCREASE DOSE
   - Push to max tolerated dose
3. SWITCH ANTIDEPRESSANTS

- Risky, can lose all benefits, only switch if no clear benefit on first treatment

4. COMBINE ANTIDEPRESSANTS
   - Lots of potential combinations
5. AUGMENTATION STRATEGIES
   - Aripiprazole; lithium; thyroxine; anticonvulsants

VASCULAR DEPRESSION

10% first episode depression in older adults due to cerebrovascular disease

Clinical picture :

- Prominent apathy; anergia; anhedonia with slowness of processing

Cause = subcortical vascular disease

If this diagnosis is being considered, CT scan and if positive or clinically suspiciou investigate and treat as if they had TIA or other end stage cerebrovascular disease

POOR PROGNOSTIC INDICATORS…

Medical illness burden

Comorbid (persistent) anxiety

Cognitive impairment

White matter hyperintensities

ANXIETY

Lots of types of anxiety disorder

- GAD – most frequent anxiety disorder encountered in primary care
- Panic disorder
- Specific phobia
- PTSD
- OCD
- Dissociative states etc.etc

GENERALISED ANXIETY DISORDER

ICD definition

- Anxiety, **generalised and persistent**, but not restricted to, or even strongly predominating in, any particular environmental circumstances i.e. free-floating
- Dominant symptoms variable but include
  - Persistent nervousness
  - Trembling
  - Muscular tension
  - Sweating
  - Lightheadedness
  - Palpitations
  - Dizziness
  - Epigastric discomfort

DIFFERENTIATING FEATURES

GAD

- Excessive anxiety and apprehensive expectation
- Free-floating anxiety
- Many physical complaints
- No phobic avoidance behaviour
- No severe depressed mood or anhedonia
- No frequent panic attacks

Panic disorder

- Spontaneous recurrent anxiety attacks occur at any time an in any setting

Social phobia

- Avoidance, not only fear, of social or performance situations in a public setting

DIFFERENTIATING FEATURES

Agoraphobia

- Fear of being trapped in a situation (which can be nonsocial) from which escape is difficult or embarassing, clearly avoidant phobic behaviour

Specific phobia

- Unreasonable fear and avoidance of a specific object or situation

PTSD

- A traumatic event is persistently re-experienced

Major depressive disorder

- Primary symptoms are severe depressed mood and marked anhedonia

GAD

Most frequent anxiety disorder in primary care (primary care prevalence 8.5%)

Source of major morbidity

Anxiety disorders associated with high use of primary care resources (reported as main reason for contact by 4.6% of people going to see primary care)

High rate of disorders co-occurring with GAD

GAD

Associated with high levels of impairment in daily function, even when compared to individuals with other chronic and disabling medical conditions

In older adults increases carer burden and could lead to placement

Lifetime prevalence increases with age

Women almost twice as likely to have GAD than men

PRIMARY CARE BURDEN

On average, people with GAD (with or without co-occurring major depressive disorder) have 2x as many visits to primary care as those with neither GAD or MDD

Patients with GAD +/- MDD visit their primary care physician more than once every month

Associated with low rates of remission (38% of patients of all ages achieved full remission over 5 years (least likely in those with poor family relationships or personality disorder) *Ref: Yonkers et al*

DIAGNOSTIC CHALLENGES

Under-recognised and undertreated in approximately 2/3 of patients with the disorder

Low rate of diagnosis due to :

- Lack of physician knowledge
- Lack of time
- Competing demands during consultation
- Prioritisation of physical symptoms/conditions
- Co-occurrence with other anxiety and depressive disorders e.g hypochondriasis, MDD – 90% of patients with GAD have at least one other psychiatric diagnosis
- Waxing and waning of symptoms
- Poor description of symptoms by patient
- Patients typically have their symptoms for 5-10 years before appropriate diagnosis and treatment

ANXIETY IS OFTEN NOT THE PRIMARY COMPLAINT IN GAD (only 13% of patients with GAD presented to primary care c/o anxiety)

- Physical symptoms
- Pain
- Depression
- Insomnia

WHAT TO CONSIDER

Does the patient suffer from normal, appropriate anxiety or excessive worry?

Is there an underlying organic illness – full examination and history to exclude this?

Is there a co-occurring psychiatric condition?

Any use of medication/substances known to cause anxiety?

Multiple visits to primary care with MUS?

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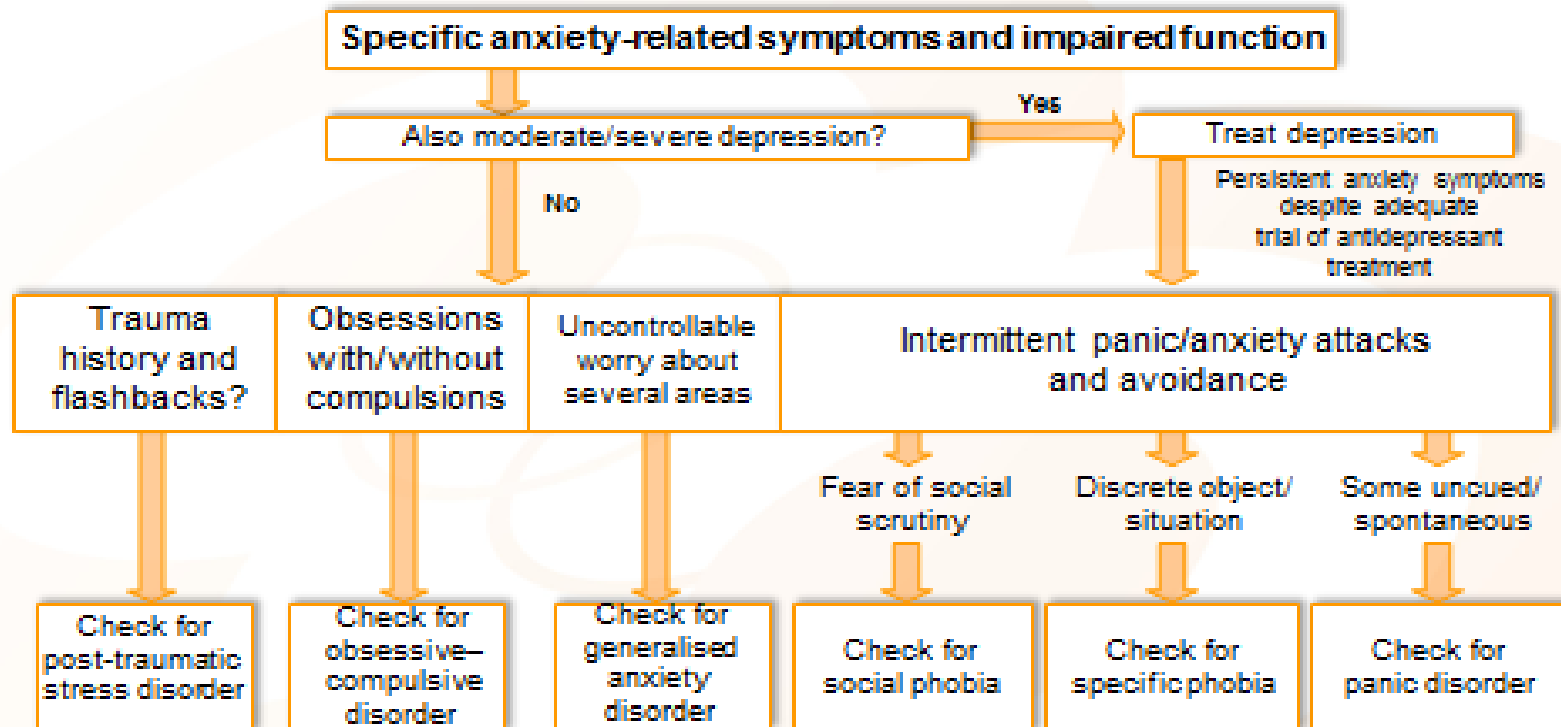
Guidance for exploring a suspected anxiety disorder



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Note: more than one anxiety disorder may be present in an individual concurrently

Adapted from Baldwin D, et al. *J Psychopharmacol* 2005;19:567–96.

RESOURCES

British Association of Psychopharmacology – evidence based guidelines on management of anxiety disorders

GAD – 7 : screening tool for GAD

Patient health questionnaire – 2 : screens for depressed mood and anhedonia

Hospital Anxiety and Depression scale : screens for anxiety and depression

BUT CONFIRM DIAGNOSIS USING ICD 10 CRITERIA

HOW DOES GAD PRESENT?

Most people present with a combination of symptoms

- Behavioural (reassurance seeking), psychological (nervousness, poor concentration, restlessness, muscular tension, poor problem assessment and response) and physical (sleep disturbance, IBS symptoms)

Worry out of proportion to the likelihood of the event – excessive and non-specific, intolerance of uncertainty

Symptoms can:

- Wax and wane
- Vary between different individuals
- Become more persistent with age

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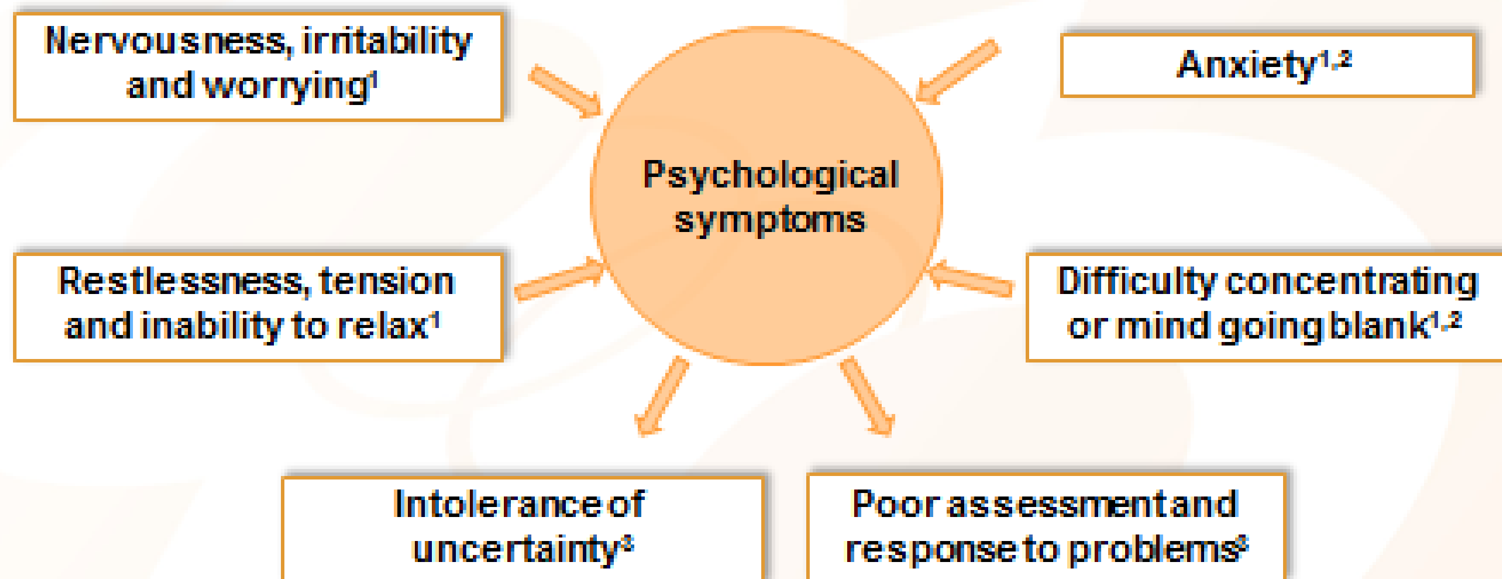
Psychological symptoms associated with generalised anxiety disorder



anxiety in practice

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, text revision. Washington DC: American Psychiatric Association; 2000;
2. World Health Organization. *International Classification of Diseases*. 10th revision. Geneva: World Health Organization; 1992; 3. Dugas MJ, *et al. Behav Res Therapy* 1998;36:215–26.

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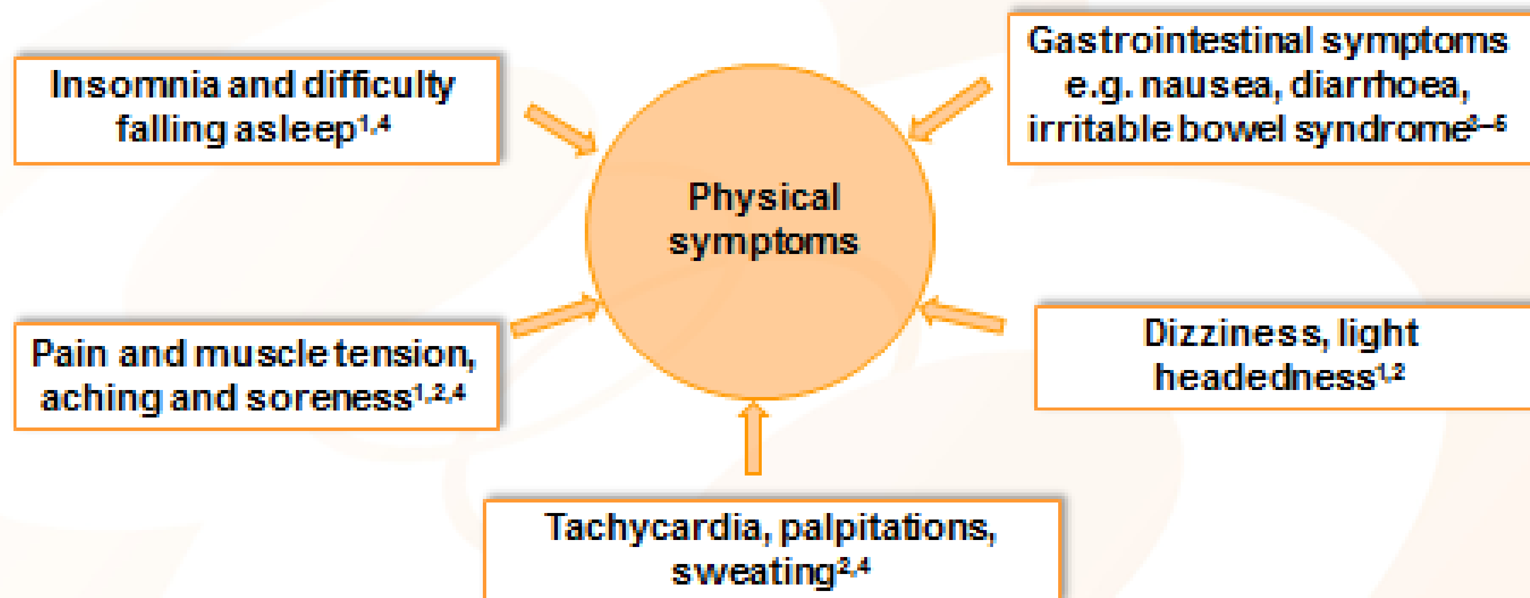
Physical symptoms associated with generalised anxiety disorder



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4. Gorman J. *CNS Spectrums* 2001;6:37–46; 5. Gros DF, et al. *J Anxiety Disord* 2009;23:290–6.

COMORBID CONDITIONS

88% of individuals with GAD report co-occurring anxiety disorders, mood disorders or substance misuse disorders

Social phobia/simple phobia – 34%

Panic disorder – 22%

Agoraphobia – 21%

Substance misuse – 33%

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Overlap in symptoms between generalised anxiety disorder and depression

Generalised anxiety disorder

- Anticipatory anxiety
- Uncontrollable worry
- Irritability
- Muscular tension
- Tension pains
- Physical symptoms

Overlap (both disorders)

- Fatigue
- Poor concentration
- Sleep disturbances
- Restlessness
- Agitation

Major depressive disorder

- Depressed mood
- Apathy
- Withdrawal
- Loss of interest
- Worthlessness/guilt
- Weight loss
- Suicidality

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American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, text revision. Washington DC: American Psychiatric Association; 2000.

TREATMENT AIMS

Reduce psychiatric and physical symptoms

Improve quality of life

Achieve remission

Reduce disability

Prevent relapse or recurrence of co-occuring disorders

Longer duration of untreated illness may be associated with worse clinical course

GAD independently predicts increased risk of hypertension and coronary heart disease

MANAGEMENT

Appropriate diagnosis essential

Treatment aims

- Reduce psychiatric and physical symptoms
- Improve quality of life
- Reduce disability
- Prevent relapse or recurrence of co-occurring disorders
- Achieve remission

PRIMARY CARE MANAGEMENT PLAN

Use a stepped approach (after discussion with patient and considering patient preference)

- Step 1 : recognition and diagnosis
- Step 2 : treat in primary care
- Step 3 : review and consider alternative treatments
- Step 4: review and refer to specialist mental health services (if no relief of, or an increase in, their symptoms after two trial interventions i.e. psychotherapy, self help, pharmacotherapy)
- Step 5 : step up to secondary mental health services

NON-PHARMACOLOGICAL TREATMENTS

Provide information about GAD

Relaxation

- Slowed diaphragmatic breathing, meditation, visual imagery

Cognitive techniques e.g. CBT

- Learn to manage difficult situations and stop anxiety spiralling out of control

Behavioural techniques

- Build up level of activity and improve self confidence

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Overview of cognitive behavioural therapy (CBT)

- CBT is effective in reducing symptoms of anxiety[1,2]
- Aims to help with the core symptom of generalised anxiety disorder – excessive worry and anxiety[3]
- Principles of CBT are based on:[3]
  - self-monitoring
  - relaxation training
  - cognitive therapy
  - rehearsal of new learned relaxation and cognitive coping responses

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1. Bandelow B, et al. World J Biol Psychiatry 2008;9:248–312; 2. Hunot V, et al. Cochrane Database of Systematic Reviews 2007, Issue 1. Art. No. CD001848.
3. Borkovec TD, et al. CNS Spectrums 2003;8:382–9.

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Overview of other non-pharmacological treatments (1)

Self-help

The use of written or online material to help patients:

- understand their psychological problems and
- learn ways to overcome problems by changing their behaviour[1]

Psychodynamic therapy

Uses the therapeutic relationship to explore and resolve unconscious conflict

- change in character is measured as a therapeutic goal
- relief of symptoms taken as an indirect outcome[2]

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1. National Institute for Health and Clinical Excellence (NICE). Anxiety (amended). Clinical Guidance 22 April 2007;
2. Hunot V, et al. Cochrane Database of Systematic Reviews 2007, Issue 1. No. CD001848.

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Overview of other non-pharmacological treatments (2)

Supportive therapy

1. Active

Psychological therapy underpinned by humanistic principles, e.g.:

- person-centred therapy
- counselling
- supportive listening

2. Inactive

Therapies without a defined psychotherapeutic framework, e.g.:

- discussion groups
- face-to-face sessions whilst on a waiting list for therapy

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Hunot V, et al. Cochrane Database of Systematic Reviews 2007, Issue 1. Art No. CD001848.

PHARMACOLOGICAL TREATMENTS

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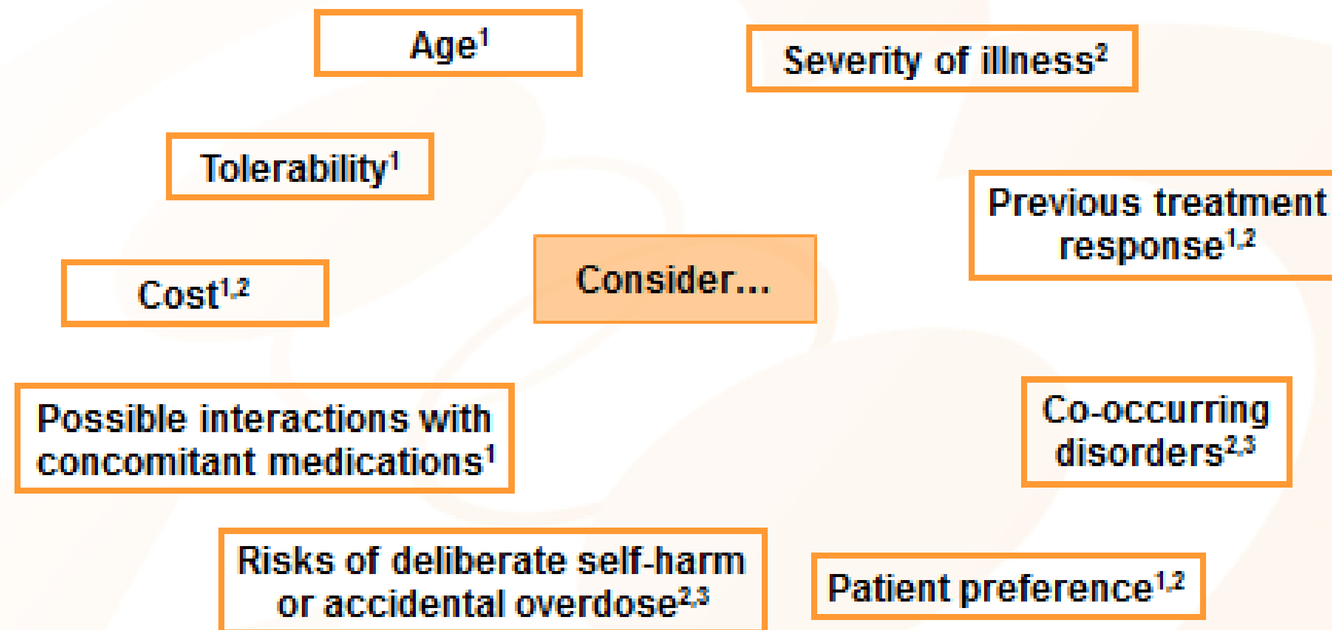
Before prescribing pharmacological therapy for generalised anxiety disorder



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2. Bandelow B, *et al*. *World J Biol Psychiatry* 2008;9:248–312; 3. Coplan JD, *et al*. *J Clin Psychiatry* 1993;54(Suppl):69–74.

AVAILABLE PHARMACOLOGICAL TREATMENT FOR ANXIETY DISORDERS

SSRI – FIRST LINE

Start at half starting dose for depression

- Titrate upwards as tolerated
- May see initial worsening of anxiety
- Response usually seen in 6 weeks (older may take longer)
- Treat for at least 1 year
- Effective treatment of GAD may present development of MDD
- Fluoxetine most effective, but sertraline best tolerated

PREGABALIN

Calcium channel blocker

Licensed for GAD

In older adults, start low e.g. 25mg bd and increase as tolerated

Don’t stop abruptly as may precipitate rebound anxiety and seizures

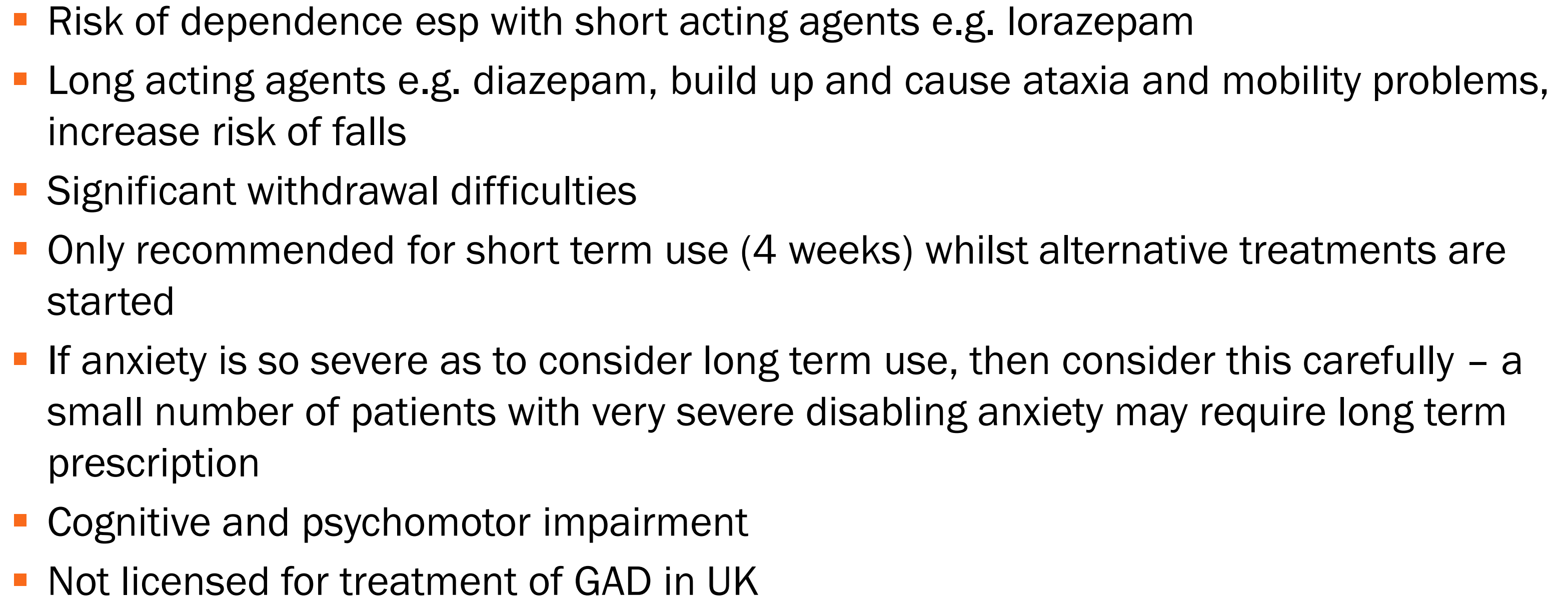
Rapid onset of effect

Few drug interactions

Side effects

- Dizziness, sedation, weight gain, discontinuation symptoms, dry mouth, increased risk of falls

BENZODIAZEPINES



Rapid symptomatic relief BUT lots of problems in elderly

- Risk of dependence esp with short acting agents e.g. lorazepam
- Long acting agents e.g. diazepam, build up and cause ataxia and mobility problems, increase risk of falls
- Significant withdrawal difficulties
- Only recommended for short term use (4 weeks) whilst alternative treatments are started
- If anxiety is so severe as to consider long term use, then consider this carefully – a small number of patients with very severe disabling anxiety may require long term prescription
- Cognitive and psychomotor impairment
- Not licensed for treatment of GAD in UK

OTHER DRUGS

Mirtazapine

Venlafaxine

Duloxetine

Beta blockers

Atypical antipsychotics e.g. quetiapine, aripiprazole

TREATMENT FOLLOW UP

Review within 2 weeks of starting treatment and every couple of weeks thereafter (may take longer than 12 weeks to see response in older adults)

Has there been an improvement after 12 weeks?

- YES – continue
- NO – reassess and try another intervention
- IF NO RESPONSE AFTER AT LEAST SECOND INTERVENTION TRIED – REFER TO CMHT

TREATMENT DURATION

GAD

- Tends to wax and wane
- Reassess patient weekly during first few weeks to assess drug performance, early discontinuation associated with higher relapse rates
- After remission, continue treatment for at least 1 year in order to reduce risk of relapse

Treatment resistance may indicate organic anxiety e.g. secondary to cerebrovascular damage to limbic system

PARTICULAR CONCERNS

Co–occurring disorders

- Medical
- Psychiatric : ssri may be effective in GAD and MDD

Suicidality

- Potential risk factor when GAD coexists with MDD
- Start an antidepressant, avoid use of BZDP

Insomnia

- Reported by 2/3 patients with GAD
- Discuss lifestyle choices – sleep hygiene, diet, exercise
- Some antidepressants may help with sleep more than others e.g. mirtazapine better than SSRI

Subtance abuse

- Patients with GAD may self medicate with alcohol or other substances