Anxiety in Older Patients

Presented by: Maham Bangash DO

Tyler Zahrli MD, MA
Rebecca Lundquist MD
Broadlawns-UnityPoint Psychiatry Residency Program

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Disclosures

Presenters have no financial disclosures.

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Objectives

- To recognize the prevalence of anxiety among older patients.
- To review common anxiety disorders among elderly patients.
- To determine how to evaluate anxiety.
- To assess management options for older patients with anxiety.

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Epidemiology of anxiety in older patients

- The most common psychiatric disorders
- About 15% of the US population is older than 65 years of age
- Between 10-15% have an anxiety disorder (4.5-7.5 million individuals)
- A higher percentage have some symptoms of anxiety
- Over 40% of older adults with disability/limiting chronic medical illness
- Specific phobia is the most common

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Risk Factors

- Heritability
- Personality-neurotic, introverted, vulnerability, low self-efficacy
- Disability, limited chronic medical illness, spousal events
- Physiological
  - Hyperactive HPA axis-increased cortisol
  - Increased limbic activity
  - Reduce volume of hippocampus and amygdala

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Consequences

- Decreased quality of life
- Decreased physical activity
- Comorbid psychiatric conditions
  - depression and substance abuse
- Comorbid medical conditions
  - pain, migraine, lung/cardiac disease
- Increased risk of cognitive impairment/dementia
- Increased mortality

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Anxiety Disorders

- Specific phobia
- Generalized Anxiety Disorder
- Agoraphobia
- Panic Disorder
- Social Anxiety Disorder

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Specific Phobia

- Marked fear of specific object or situation
- Object or situation almost always causes fear/anxiety
- Avoiding situation
- Fear is out of proportion to actual danger
- Clinically significant distress
- Not explained by other factors
- Examples: Falling, stroke/MI, choking

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Generalized Anxiety Disorder

- Excessive worry more days than not
- Difficult controlling worry
- Three or more
  - Restlessness
  - Fatigue
  - Decreased concentration
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Clinically significant distress
- Not contributable to medical illness or substances
- 6 months duration

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Agoraphobia

- Two or more causing fear
  - Public transport
  - Open spaces
  - Enclosed spaces
  - Crowds/lines
  - Outside the home
- Fear/avoidance because cannot escape
- Situation(s) cause fear/anxiety and are avoided or require companion
- Out of proportion fear
- Not other medical cause
- Clinically significant distress
- 6 months

Does not respond well to medications.

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Panic Disorder

- Four or more of following
  - palpitations, sweating, shaking, SOB, choking sensation, chest pain, nausea, dizziness, chills/heat, paresthesia, derealization, fear of losing control, fear of death
- Can have culturally specific symptoms
- 1 month or more
- Maladaptive behavior
- Non-medical cause

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Social Anxiety Disorder

- Fear/anxiety possible scrutiny such as social interactions, observation, performing in front of others
- Fears that anxiety will be negatively evaluated
- Avoidance
- Anxiety/fear out of proportion to situation
- Clinically significant distress
- Non-medical cause
- 6 months or more

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Approach to Evaluation

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Differential Diagnosis

Another anxiety disorder – easy to mix them up

Another psychiatric disorder

- neurocognitive disorder
- psychotic disorder
- personality disorder – paranoid, avoidant, dependent

A medical condition contributing to anxiety symptoms

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Medical Rule Out

- Obtain history and estimate baseline function
- Physical examination-medical and neurological origins
- Review medications-polypharmacy
- Lab work
  - Common: Metabolic Panel, CBC, Vitamin B12, folate, thyroid studies, UA, UDS
  - Less Common: metaneph/catechol, RPR, HIV, homocysteine, methylmalonic acid
- EKG
- Neuroimaging

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Assessment Tools

- Self-reported measures
  - GAD-7
  - Worry Scale
  - Beck Anxiety Inventory
  - Penn State Worry Questionnaire
- Clinical-rated
  - Structure clinical interview
  - Anxiety Disorders Interview Schedule
  - Hamilton Anxiety Rating Scale
  - Physician Withdrawal Assessment
- Complicated picture
  - Neuropsychological assessment

GAD-7 Anxiety

Scoring GAD-7 Anxiety Severity

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Treatment

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Recent Literature

- Recent research has limited usefulness in clinical practice
- CBT with behavioral activation and problem solving may be helpful
- Most recent studies have had sample sizes that are quite small
- Little research on anxiety and coexisting depressive disorders

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Psychotherapy

- Combination with pharmacology is often superior
- Specific phobia
  - exposure and response therapy
  - SSRIs sometimes are helpful
  - Benzodiazepines for certain situations (fear of flying, lorazepam)
- GAD
  - CBT relaxation, cognitive restructuring, behavioral activation
- Agoraphobia
  - CBT or psychodynamic therapy
- SAD
  - psychotherapy first line-CBT or social rehabilitation focus

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Pharmacology-FDA Approved Agents

- Specific Phobia
  - (paroxetine), sertraline
- Generalized Anxiety Disorder
  - (paroxetine), escitalopram, venlafaxine, duloxetine, alprazolam, clonazepam, buspirone
- Panic Disorder
  - sertraline, (paroxetine), fluoxetine.
  - *can augment with non-serotonergic antidepressant*
- Social Anxiety Disorder
  - (paroxetine), sertraline, venlafaxine.
  - beta-blocker (propranolol for anxiety with public speaking)
- *Can take up to 8 weeks to see effects of SSRIs/SNRIs*
- *Start low, go slow*
- *Are all these medications good options?*

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Treating anxiety in patients with cognitive decline

- Consider severity of both conditions
- CHEIs can contribute to mood symptoms
- Polypharmacy at low doses of each med can work better in some patients than larger doses of single medications

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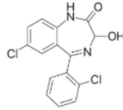
Benzodiazepine benefits and risks

- Benefits
  - Work quickly
  - Can be used to “break” a cycle of high levels of acute anxiety or severe insomnia
- Risks
  - Physiologic dependence / withdrawal phenomena
  - Often misused with other drugs of abuse
  - Falling – leading to broken bones including hips and skulls which can be catastrophic and possibly deadly
  - Connection with dementia – recent meta-analysis showed a significant increased risk, especially in those taking long half-life BZD and for longer than 3 years



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Questions?

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