Current PSYCHIATRY

How anxiety presents differently in older adults

Age-related changes, medical comorbidities alter presentation and treatment

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Although anxiety disorders are common at all ages, there is a misconception that their prevalence drastically declines with age. For this reason anxiety disorders often are underdiagnosed and undertreated in geriatric patients, especially when the clinical presentation of these disorders in older patients differs from that seen in younger adults.

In older persons, anxiety symptoms often overlap with medical conditions such as hyperthyroidism and geriatric patients tend to express anxiety symptoms as medical or somatic problems such as pain rather than as psychological distress.[1] As a result, older adults often seek treatment for depressive or anxiety symptoms from their primary care physician instead of a psychiatrist. Unfortunately, primary care physicians often miss psychiatric illness, including anxiety disorders, in geriatric patients.

Anxiety may be a symptom of an underlying psychiatric disturbance, secondary to a general medical condition, or induced by dietary substances, substances of abuse, or medications. Late-life anxiety often is comorbid with major depressive disorder (MDD) (***Box, page 66***) and other psychological stressors as older adults recognize declining cognitive and physical functioning.[2]

Anxiety disorders commonly begin in early adulthood, tend to be chronic and interspersed with remissions and relapses, and usually continue into old age.[3] In generalized anxiety disorder (GAD), there is a bimodal distribution of onset; approximately two-thirds of patients experience onset between the late teens and late 20s and one-third develop the disorder for the first time after age 50.[3]

continued

Anxiety in older adults

Clinical Point

Handwashing and fear of having sinned are more common in older OCD patients than in younger ones

Box

Comorbid anxiety and depression: Highly prevalent, poorer outcomes

The Longitudinal Aging Study Amsterdam study—one of the largest epidemiologic studies to examine comorbidity of anxiety disorders and depression in patients age 55 to 85—found that 48% of older persons with primary major depressive disorder (MDD) also had a comorbid anxiety disorder, whereas approximately one-fourth of those with anxiety disorders also had MDD.[a] Pre-existing anxiety disorders, such as social phobia, obsessive-compulsive disorder, specific phobia, agoraphobia, and panic disorder, increase the risk of developing depression.[b] Rates of comorbid anxiety and depression increase with age.[c]

Late-life MDD comorbid with generalized anxiety disorder or panic disorder is associated with greater memory decline than MDD alone.[d] In addition, comorbid anxiety and depression is associated with greater symptom severity and persistence, greater functional impairment, substance dependence, poorer compliance and response to treatment, worse overall prognosis and outcome than patients with either disorder alone,[e] and greater likelihood of suicidal ideation in older men.[f]

Source: For reference citations, see this article at CurrentPsychiatry.com

Prevalence rates for anxiety disorders among older adults (age ≥55) range from 3.5% to 10.2%.[4] These rates are slightly lower than those for younger adults.[5] Among older adults, presence of a 12-month anxiety disorder was associated with female sex, lower education, being unmarried, and having ≥3 or more chronic conditions.[6]

Anxiety and disability risk

Anxiety disorders affect geriatric patients more profoundly than their younger counterparts. Persons age >65 who have an anxiety disorder are 3 to 10 times more likely to be hospitalized than younger individuals.[1] Anxiety is associated with high rates of medically unexplained symptoms, increased use of health care resources, chronic medical illness, low levels of physical health-related quality of life, and physical disability.[7,8]

Anxiety symptoms may predict progressing physical disability among older women and reduced ability to perform activities of daily living over 1 year.[9] Anxious geriatric patients are less independent and increase the burden on family and caregivers.[10] Anxiety disorders are associated with lower compliance with medical treatment, which could worsen chronic medical conditions and increase the risk for nursing home admission.[11] Anxious older adults report decreased life satisfaction, memory impairment, poorer self perception of health, and increased loneliness.[12]

Generalized anxiety disorder

Although GAD is the most common anxiety disorder among geriatric patients, with a prevalence of 0.7% to 9%,[13] it remains underdiagnosed and undertreated.[14] In a cross-sectional observational study of 439 adults age ≥55 with lifetime GAD, approximately one-half experienced onset after age 50.[15] Late onset is associated with more frequent hypertension and a poorer health-related quality of life than early onset.[15]

Compared with younger individuals, older persons with GAD have a greater variety of worry topics, including memory loss, medical illnesses, and fear of falls,[16] but worry less about the future and work than younger patients. This type of anxiety is largely situational and temporary, and often accompanies comorbid medical problems (***Table 1***).

Obsessive-compulsive disorder

A study comparing older (age ≥60) and younger obsessive-compulsive disorder (OCD) patients found that the clinical presentation of the disorder does not substantially differ between age groups; however, geriatric patients had fewer concerns about symmetry, needing to know, and counting rituals. Handwashing and fear of having sinned were more common.[17]

OCD is fairly uncommon in geriatric patients. Prevalence rates decrease with age, ranging between 0% and 0.8% among persons age ≥60.[18] OCD seldom begins in

Table 1

DSM-IV-TR criteria for generalized anxiety disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
B. The person finds it difficult to control the worry
C. The anxiety and worry are associated with 3 or more of the following symptoms with at least some symptoms present for more days than not for the past 6 months: 1. Restlessness or feeling keyed up or on edge 2. Being easily fatigued 3. Difficulty concentrating or mind going blank 4. Irritability 5. Muscle tension 6. Sleep disturbance
D. The focus of the anxiety and worry is not confined to features of an axis I disorder
E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
F. The disturbance is not due to the direct physiological effects of a substance or a general medical condition and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder

Source: Diagnostic and statistical manual of mental disorders, 4th ed, text rev. Washington, DC: American Psychiatric Association; 2000

late life; most geriatric patients with OCD have had symptoms for decades. By late life, most individuals with OCD improve, although they may continue to experience clinical or subclinical symptoms.[19] However, 1 report found a second peak of incidence of OCD in women age ≥65.[20] Case reports of late-onset OCD have found evidence of cerebral lesions, often in the basal ganglia, which suggests a possible neurodegenerative pathophysiology.[21]

Posttraumatic stress disorder

Untreated posttraumatic stress disorder (PTSD) often is assumed to be a chronic disorder. Recollections of past trauma may lead to new PTSD symptoms in older patients. Neurodegeneration of memory pathways and cognitive impairment associated with Alzheimer's disease or vascular or alcohol-related dementia may disinhibit PTSD symptoms in patients whose PTSD was fairly well controlled.[22]

Life events associated with aging—death of a spouse, financial and physical decline, chronic pain, or diminished cognitive coping resources—may precipitate or revive PTSD symptoms associated with earlier exposure to severe psychological trauma.[23] These life changes also may precipitate so-called delayed PTSD, when symptoms relating to past traumatic experiences present for the first time. Geriatric patients may be more likely than younger persons to deny their PTSD symptoms if their cultural background emphasizes stoicism and fortitude.[24]

Clinical Point

Life changes may precipitate so-called delayed PTSD, when symptoms relating to past traumatic experiences present for the first time

Phobias

Specific phobias. The prevalence of specific phobias drops dramatically in late life, although older patients might underreport symptoms. Many older persons are afraid of falling. Approximately 60% of older adults with a history of falling—and 30% of older individuals with no such history—report this fear. Fear of falling is more prevalent in women and increases with age.[25,26] This fear may be a protective response to a real threat that prevents older persons from attempting high-risk activities, but it also can cause patients to restrict their activities, which can result in decreased social, physical, or cognitive functioning and loss of independence.[25]

Social phobias (social anxiety disorder). Among older adults, common social phobias include eating food around strangers, and—especially in men—being unable to urinate in public bathrooms. In a cross-

Table 2

Pharmacotherapy for anxiety disorders in older adults

Medication	Comments
Selective serotonin reuptake inhibitors	May be useful for GAD, panic disorder, OCD, and PTSD
Serotonin-norepinephrine reuptake inhibitors	May be useful for GAD, panic disorder, OCD, and PTSD
Tricyclic antidepressants	Potential for cardiotoxicity and overdose, anticholinergic properties
Benzodiazepines	Chronic use can lead to cognitive impairment, falls
Buspirone	Effective for GAD, but not panic disorder; may take 2 to 4 weeks to be effective

GAD: generalized anxiety disorder; OCD: obsessive-compulsive disorder; PTSD: posttraumatic stress disorder

Source: Reference 35

Clinical Point

Older patients may present with panic symptoms, such as shortness of breath, dizziness, or trembling, that overlap with medical conditions

sectional observational study, social anxiety disorder (SAD) was more common among older persons who reported stressful life events, such as death of a spouse.[27] MDD, specific phobia, and personality disorder are associated with SAD in geriatric patients.[27] Prevalence rates of SAD appear to slightly decrease with age, although the condition remains common in geriatric patients—5% of older adults report lifetime prevalence—and its presentation is similar to that seen in younger adults.[27]

Agoraphobia. In older persons the prevalence of agoraphobia is 0.6%.[28] Most cases are of early onset but the condition can present de novo following a stroke or other medical event and can inhibit activities needed for successful rehabilitation. Agoraphobia can present within the context of panic attacks as is seen in younger adults but most geriatric patients with agoraphobia do not have concurrent panic disorder. This phobia is more common in women, widowed or divorced individuals, patients with chronic health conditions, and those with comorbid psychiatric disorders.[29]

Panic disorder

Panic disorder (PD) rarely starts for the first time after age 60, and most late-onset panic attacks are associated with medical and psychiatric comorbidities. PD tends to be less severe in older individuals than in younger adults.[30] Recent stressful life events or losses can predict onset and maintenance of PD. Older patients may present with panic symptoms, such as shortness of breath, dizziness, or trembling, that overlap with age-related medical conditions. PD may be prevalent in older patients with chest pain and no evidence of coronary artery disease.[31] Panic symptoms that are secondary to underlying medical conditions, such as chronic obstructive pulmonary disease exacerbation, usually wax and wane.[32]

Treatment

Treatment for anxiety disorders in geriatric patients may involve a combination of psychotherapy, pharmacotherapy, and complementary and alternative therapies. Treatment may be complicated if patients have >1 anxiety disorder or suffer from comorbid depression, substance abuse, or medical problems. As is seen with younger adults, the course of anxiety disorders in older patients waxes and wanes, but most disorders are unlikely to remit completely.[33]

Aging may influence the effects of psychotropic medications in older patients. Increased distribution and decreased metabolism and clearance of medications results in higher medication plasma levels and longer elimination half-lives. Medication compliance in older patients may be complicated by:

- older patients' sensitivity to anticholinergic side effects
- coexisting medical illnesses
- polypharmacy, particularly in institutionalized settings
- sensory and cognitive deficits.[34]

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Anxiety in older adults

Related Resources

- Wetherell JL, Lenze EJ, Stanley MA. Evidence-based treatment of geriatric anxiety disorders. Psychiatr Clin North Am. 2005;28(4):871-896,ix.
- Lenze EJ, Wetherell JL. Anxiety disorders. In: Blazer DG, Steffens DC, eds. The American Psychiatric Publishing textbook of geriatric psychiatry. Arlington, VA: American Psychiatric Publishing, Inc; 2009:333-345.

Drug Brand Name

Buspirone • BuSpar

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article, or with manufacturers of competing products.

Clinical Point

SSRIs and SNRIs may be useful for several anxiety disorders in older patients; TCAs may be cardiotoxic and can lead to serious side effects

Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) generally are safe and produce fewer side effects compared with tricyclic antidepressants (TCAs), especially in geriatric patients. SSRIs and SNRIs may be useful for GAD, PD, OCD, and PTSD in older patients.[35] TCAs can effectively treat anxiety symptoms but may be cardiotoxic and their anticholinergic properties can lead to serious side effects. Benzodiazepines often are used for acute or short-term anxiety management, but chronic use in geriatric patients can cause cognitive impairment, falls, and other serious side effects. Buspirone may be beneficial for GAD but is not effective for PD.[36] The drug is well tolerated in older persons, but may take 2 to 4 weeks to be effective (***Table 2, page 68***).[35]

Pharmacotherapy for anxiety disorders in geriatric patients often is used in conjunction with psychotherapy. Psychotherapeutic approaches include cognitive-behavioral therapy (CBT), exposure therapy, dialectical behavioral therapy, and interpersonal therapy. Increasing evidence supports the effectiveness of psychotherapy in treating anxiety disorders in younger adults as well as in older patients, often in combination with pharmacotherapy.[37] In older patients with GAD, CBT is associated with a greater improvement in worry severity, depressive symptoms, and overall mental health compared with usual care.[38]

In addition to traditional pharmacotherapy, complementary and alternative therapies often are used for late-life anxiety. These therapies include biofeedback, progressive relaxation, acupuncture, yoga, massage therapy, art, music, or dance therapy, meditation, prayer, and spiritual counseling.

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Bottom Line

Anxiety disorders often are underdiagnosed and undertreated in older adults, especially when the clinical presentation of anxiety differs from that seen in younger adults. Late-life anxiety symptoms may be a manifestation of stresses/losses, depression, coexisting medical problems, substance abuse, medication/herb side effects, withdrawal syndromes, or general disability. Effective treatment may include pharmacotherapy, psychotherapy, and complementary and alternative therapies.

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Clinical Point

In older patients with GAD, CBT is associated with improvements in worry severity, depressive symptoms, and overall mental health

Box

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